# THE EVALUATION OF THE LOCAL MULTIDISCIPLINARY FACILITATION TEAMS IN PRIMARY HEALTH CARE, IN LIVERPOOL.

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**PhD.**

A thesis submitted in partial fulfilment of the requirements of Liverpool John Moores University for the degree of Doctor of Philosophy, and achieved through collaboration between the Liverpool Health Authorities, the Local Multidisciplinary Facilitation Teams, the Primary Health Care Teams, and the University Research Team.

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# ABSTRACT

The purpose of this study was to evaluate the implementation of the Local Multidisciplinary Facilitation Teams project in Primary Health Care (PHC) in Liverpool, and explore the role of evaluation in the process of learning, development and change in PHC.

The LMFTs project was conceived as a contribution to creating and supporting an integrated and co-ordinated system of PHC, particularly through developing networking, teamwork and collaborative action. It was founded on the principles of adult learning, organisation and community development. Fundamental to the LMFTs Project was a belief that participation was necessary for achieving sustainable change and so used a problem solving approach to get people involved in an intervention programme which was implemented over three years.

To achieve an evaluation that was complementary to the aims of the LMFTs project a Participatory Action Research (PAR) approach was used. Key stakeholders in the LMFTs project became involved in the development and implementation of the framework for evaluation. The emerging evaluation framework was a product of negotiation between the stakeholders. Three PAR cycles were instrumental to achieving the refinements in the research design. The design of the evaluation started out as a quasi-experimental approach but finally emerged, following critical reflection and refinement by stakeholders, as a longitudinal case study in which a mixed methods design was used. The use of multiple data collection methods provided a multifaceted description of the LMFTs project, and aimed to enhance the evaluation's usefulness to the stakheolders. The active involvement of the stakeholders grounded the evaluation, its approach and findings, in its contextual reality.

The research findings demonstrated that the LMFTs project was a developmental model but one that tried to achieve too much. PHC was found to be a rapidly changing and largely unreceptive environment in that the level of organisational development in Practices was lower than anticipated. As a model for change the LMFTs project was most successful in the context of personal development. It demonstrated that by helping the people working in PHC to develop both organisation and service developments automatically began to change. This is in keeping with the tenets of the learning organisation. Once people have become actively involved in a collaborative

activity it is their personal learning and knowledge development that subsequently has the potential to cause ripples of change to radiate outwards over the whole system and augment the process of organisation transformation.

The study findings have implications for those wanting to develop PHC in the future. Generally more attention needs to be paid to the fact that the organisation of PHC, and the PHCTs within, are not directly comparable with counterparts in the private sector which are oriented towards business and productivity. Consequently, change strategies borrowed from the private sector are likely, therefore, to be inappropriate for use in PHC with its service orientation. Thus, it is considered that a new model for understanding organisational change in PHC is needed. Following the experience within this study a synthesis of organisational theory and evaluation science is proposed in order to create a new model for achieving organisational change and development in PHC. At a theoretical level, the new model combines PAR with the principles of adult learning, organisation and community development and, in practice, by adopting a developmental approach to achieving organisational change, it draws on and utilises the knowledge and experience of those involved to develop PHC for the future.

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# THE RESEARCH AIM

1. **The research aim was to explore the role of evaluation in the process of learning, development and change in Primary Health Care.**

   The research question was:

   - How was the Participatory Action Research approach used as a tool for promoting learning and enhancing the process of change in the context of an evaluation of the implementation of an organisational development model for change in Primary Health Care?

2. **The evaluation objective aimed to measure the effectiveness of the Local Multidisciplinary Facilitation Teams project as it was implemented in the four designated areas in Primary Health Care, in Liverpool.**

   - This was to be achieved by assessing the extent to which the Local Multidisciplinary Facilitation Teams promoted change and development in the Practices in their designated areas.

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# GLOSSARY

| | |
|---|---|
| Cluster | A Cluster consisted of two neighbourhoods. A neighbourhood being a geographical area comprising approximately 60,000 people compatible with FHSA, Community Trust and Local Authority boundaries. |
| DHA | District Health Authority |
| D.N. | District Nurse |
| LFHSA | Liverpool Family Health Services Authority |
| GMS | General Medical Services |
| GP(s) | General Practitioner(s) |
| LEG | Local Enabling Group |
| LHA | Liverpool Health Authorities |
| LMFTs Model for Change | Philosophical and theoretical framework underpinning the LMFTs project. |
| LMFTs model | The abbreviated version of LMFTs model for change |
| LMFTs Project | The unit by which the LMFTs model was delivered |
| The LMFT(s) | The facilitation team(s) which implemented the LMFTs Project |
| LMFT(s) Blue | ) These are the four LMFTs that were involved in the Project. |
| LMFT(s) Green | ) The colour codes have been used to protect the identity of |
| LMFT(s) Navy | ) the members in each team. |
| LMFT(s) Red | ) ..... |
| Managers | Liverpool Health Authority Managers |
| NHS | National Health Service |
| NCM(s) | Neighbourhood Commissioning Managers |
| OD | Organisation Development |
| PAR | Participatory Action Research |
| PCG(s) | Primary Care Groups |
| PHC | Primary Health Care |
| PHCT(s) | Primary Health Care Team(s) involved in the LMFTs project |
| P.N. | Practice Nurse |
| Practice(s) | Health workers and members from other health involved organisations associated with delivering services from general medical practices involved. |
| RHA | Regional Health Authority |
| RSG | Research Steering Group |
| UK | United Kingdom |
| S.W.O.T. | Strengths, Weaknesses, Opportunities and Threats |

# INTRODUCTION TO THE THESIS

This thesis reports on the evaluation of the implementation of the Local Multidisciplinary Facilitation Teams (LMFTs ) project in Primary Health Care (PHC) in Liverpool, in a period of rapid change. It focuses on an evaluative study of that process which attempted to adopt an evaluative approach that replicated the philosophy underpinning the LMFTs project. In doing so it will explore the role of evaluation in the process of learning, development and change in Primary Health Care. The thesis examines the evaluation process, the changes that took place within the LMFTs, and the impact on those Primary Health Care Teams (PHCTs) involved in the project. It is important to note that the appendices provide significant additional information about the process of the evaluation, and that a glossary is provided to clarify the meaning of the terms used in the thesis.

Chapter one describes the LMFTs project and its underlying philosophy. It outlines the trends and impacts of public policy on PHC, and considers Liverpool Family Health Services Authority's (LFHSA) response to the problem of developing teams and teamwork in Liverpool in order to position the LMFTs project within the setting. The LMFTs project was based on a developmental model for change and chapter two explores the different approaches to organisational change, focusing particularly on the principles and practice of the organisation development change strategies.

The LMFTs project was evaluated using a Participatory Action Research (PAR) approach and chapter three outlines the proposed evaluation framework and explores the different approaches to evaluation. It describes the foundations of the PAR approach, the connections it has with hermeneutic inquiry and the relationship between PAR and learning. Chapter four describes the process of implementing the evaluation approach based on a systematic reflection of that process and of the methods used.

Chapter five describes the changes that occurred within the LMFTs and PHCTs involved in the LMFTs project. The way the LMFTs project was implemented is examined in chapter six. This is discussed in terms of the way the structural and processual constraints, created by the implementation, prevented the project working as intended, and in terms of the role of the evaluation. Chapter seven explores the researcher's experience of the evaluation process in the light of the conclusions drawn that change was a personal change for those stakeholders involved in the evaluation. The eighth and final chapter summarises the key points from the preceding chapters and considers the implications these have for the development of PHC in the future.

# CHAPTER ONE

# CHANGE AND DEVELOPMENT OF PRIMARY HEALTH CARE, IN LIVERPOOL

## 1.1 INTRODUCTION

The Local Multidisciplinary Facilitation Teams project was an experimental model for facilitating change and development in Primary Health Care. It was unique in view of the process of change being facilitated by four teams of facilitators. It was implemented in Liverpool between September 1993 and March 1997. This chapter provides a description of the LMFTs project in the first section. The trends in PHC generally are then discussed before focusing on the Liverpool Family Health Services Authority's (LFHSA) response to the problems of developing teams and teamwork in PHC, in Liverpool. Finally, the philosophy underpinning the LMFTs project is described.

The LMFTs project was implemented by four teams of local PHC workers in their own practice areas. The members of the facilitation teams (the LMFTs) simultaneously attended a Facilitation Course which provided the knowledge and skills of facilitating organisational change and development in PHC. The LMFTs were expected to use the principles of adult learning together with participatory group methods to assist members of Primary Health Care Teams develop team-work, networks and collaborative activities and adopt the principles of a learning organisation.

The formal evaluation of the LMFTs project was commissioned, through a tendering process, by the Liverpool Family Health Services Authority. An outline framework using a PAR approach to evaluate the LMFTs project was accepted, and a researcher, myself, was appointed after the completion of the tendering process. The researcher was responsible for initiating, implementing, and sustaining a PAR approach throughout the course of the evaluation. In outline this meant establishing a research steering group (RSG) which was representative of the key stakeholder groups in the LMFTs project, and, thereafter, constantly seeking ways to engage stakeholders in participatory activities that promoted dialogue and achieved a critical reflection on the process of implementing the LMFTs project. The researcher, working as an instrument of the evaluation, undertook a significant proportion of the data collection and the primary analysis of each of the three rounds of data that was collected. The researcher fed this information back to stakeholders within their participatory workgroup activities and used it to provide an agenda for discussion and

critical reflection on action undertaken within the LMFTs project. The evaluation aimed to measure the effectiveness of the LMFTs project in the light of the stated aims and objectives as outlined below, and clearly laid down in appendix 1.

## 1.2 THE LOCAL MULTIDISCIPLINARY FACILITATION TEAMS PROJECT

The LMFTs project was an experimental approach to facilitating change and development in PHC. The model for change underpinning the LMFTs project was the vision of a GP who worked as a PHC facilitator. It was conceived following experience and practice in the Liverpool Primary Health Care Facilitation Project (Thomas, 1994). Facilitated activities to promote organisational change had been developed from the basis that change needed to be participatory for it to be sustainable. The LMFTs, as PHC facilitators, were expected to arrange and facilitate interventions that helped people in PHC work together well, maximally using local resources to effectively address local priorities.

### 1.21 Aims Of The LMFTs Project

The underlying and long term aim for development of PHC was to create and support integrated primary health care with a broad definition and proven effectiveness and efficiency. The formal proposal for the LMFTs project stated,

> "the LMFTs aim to assist and hasten the change of primary health care from an isolated, reactive, fragmented, disease-focused service towards a planned, holistic, supported health-oriented service with efficient use of different skills and driven by the health needs of the local population. It also provides a model for sustaining the new state. This means that individuals will be self-directed learners and organisations will be learning organisations because then they will possess the skills of reflection, audit, organisational vision and strategic planning necessary to detect and respond to the health needs of the population served," (LPHCFP, 1993:4).

The aims of the LMFTs were to assist people involved in PHC incorporate the principles of *Health For All*, particularly networking, teamwork and collaborative action, into their working lives. These three activities were the key components of the facilitation activities. The LMFTs project emerged from stages one and two of the PHC Facilitation Project, operating between September 1989 and March 1994 (Thomas, 1994).

## 1.22 The Origins Of The LMFTs Project

The PHC Facilitation project, developed in three stages, each providing the foundation for the next (table 1).

**Table 1 Three Stages Of The Liverpool Primary Health Care Facilitation Project**

| STAGE ONE | STAGE TWO | STAGE THREE |
|---|---|---|
| **September 1989 - Mid Summer 1991** | **Mid summer 1991- April 1994** | **September 1993 - March 1997** |
| **Two facilitators employed to develop General Practices across Liverpool** | **A facilitation team, part -time, employed to develop primary health care teams in one targeted area** | **Four facilitation teams employed, part-time, to develop primary health care teams in four targeted areas** |
| **Introducing and using facilitation to promote change** | **Developing particular methods to facilitate change** | **Implementing the experimental model for facilitating change** |

The first stage established the foundations of using facilitation to promote change in General Practices. The second stage saw the emergence of five particular activities in which facilitation processes could be used to promote change, and the third stage involves the implementation of the LMFT project for facilitating change and development in primary health care. Activities and interventions were held locally to bring together experts and non-experts to work on identifying, prioritising and resolving their own local health issues.

### 1.22.1 Stage One: Establishing The Foundations For Using Facilitation To Promote Change

Stage one concerned the development of General Practices across Liverpool City. A successful bid made by the Local Medical Committee and the Family Practitioner Committee permitted the employment of a general practitioner (latterly known as a PHC facilitator), a nurse (who left early on and was not replaced) and some administrative support for two years to undertake facilitation activities in General Practices.

By the end of stage one the PHC facilitator, with support, had achieved the following:

- generated uni-disciplinary and multidisciplinary meetings which looked at various issues, e.g. contracts of employment, clinical protocols;
- developed a new practice nurse course;
- initiated a support programme for practice nurses from 6 practice nurse mentors;

- initiated an increase in the number of practice nurses employed from 8 to 110; and,
- helped to develop three projects each concerned with different aspects of promoting health, e.g. establishing health promotion initiatives, audit projects and performing health needs assessment using a rapid appraisal method (Thomas and Graver, 1997).

### 1.22.2 Stage Two: Emergence Of The Five Facilitated Activities

Stage two broadened the scope of facilitation work to encompass whole PHCTs. The number of facilitators increased to form a 'multidisciplinary facilitation team'. The team, all part time apart from Dr P. Thomas who was full-time, included a practice manager, a district nurse, a practice nurse, a general practitioner, a health visitor and an administrator. They moved beyond working solely with the GPs and practice nurses to include health visitors, midwives, community nurses and lay health workers in their facilitation activities. The scope of their activity focused on one deprived urban area. A geographical area that comprised approximately 60,000 people and twenty two PHCTs. The facilitation team worked to create an environment in which people could learn by doing things for themselves and facilitated change by developing activities at a local level and using a non-expert, listening, problem solving approach (Thomas, 1994). The PHC Facilitation project team arranged and facilitated various multi-disciplinary activities locally to promote change in primary health care. Neighbourhood health care professionals and lay workers were invited to these events and asked to give their views on what they saw as the major problems in their locality.
Examples include:

1. a health visitor with concerns about duplicating the work of practice nurses in relation to the immunisation of children;
2. the high local rate of smoking and its attendant health problems.

Both these examples represented obstacles to progress where a collective effort, between one or more health care workers and agencies, could be of use in improving the effectiveness of the PHC service. The facilitators gathered the local information from the interventions and fed it back to participants at follow-up multi-disciplinary meetings. The aim of these follow-up meetings was to try to arrive at a consensus for action. Action could take place inside a General Practice and PHCT, across several PHCTs in the local area, within health involved organisations, or involve all three, dependent on the scope of the topic under discussion.
The facilitators found in their experience that multi-disciplinary activities:

- brought people with common interests or concerns together to generate solutions to their own local problems;

- were useful for highlighting problems common to both General Practices and Primary Health Care, and thereafter, for bringing them to the attention of the appropriate health service managers.
- gave health workers the support necessary for them to learn for themselves how to solve local health issues;
- assisted health workers to learn how to become active and use their combined influence to try to resolve problems beyond their immediate control;
- were useful for helping PHC staff develop support and information networks between themselves;
- started to build the infrastructure necessary to allow debate of and form consensus on effective action to meet local health needs (Thomas, 1994).

The facilitators through experience and practice of facilitating change came to know five different ways in which they could facilitate change and development in PHC (figure 1). These were the most practical and effective ways of working with PHCTs that emerged out of facilitating events during the second stage of the PHC facilitation project.

**Figure 1**

**Five Facilitated Activities Emerging From The PHC Facilitation Project**

| | |
|---|---|
| **Workshops** | A multidisciplinary workshop that was a one hour and a half event where a problem common to several PHCTs was explored in a participative way. |
| **Multidisciplinary Forum** | This was a discussion group which debated the relevance of a local initiative or idea. Some joint action or statement relevant to the initiative is developed during the session. |
| **Interactive Bulletins** | This was a regular summary of new events and opportunities coupled with a questionnaire asking the target group to prioritise or opt into different facilitated activities being arranged. |
| **Shared Projects** | This was a collaborative project which intended to produce a lasting piece of work. It originates from the enthusiasm or interest of local people and links people into a joint activity. |
| **Roadshows** | This was an in-practice management / education workshop of one and a half hours attended by up to twelve members of a PHCT. A visiting team was made up of disciplines comparable with those of the home team. The aim was to assist the development of teamwork and skills to solve complex PHCT problems. |

The model for facilitated change that emerged from the PHC Facilitation project combined a philosophy of human learning and a process approach to promote organisational change (table 2).

**Table 2**

**Model Of Facilitated Change In Primary Health Care**

| | |
|---|---|
| **Content** | **facilitated change as a...** |
| *what:* | philosophy and a process |
| *how:* | facilitating and problem solving |
| *to what end:* | human learning |
| **Context** | |
| *for people and organisation:* | creating co-operation and collaboration |
| *how:* | via bottom-up collective learning in action |

The philosophy and process approach continued in the third stage but the structure expanded to become four local multidisciplinary facilitation teams of facilitators who were to undertake a programme of facilitated activities in their own local areas.

### 1.22.3 Stage Three - Local Multidisciplinary Facilitation Teams Project

**Structure**

The PHC Facilitation project was disbanded in April 1994 but its founder believed many people had come to believe in its approach and trust in its methods (Thomas, 1994). It was considered that health workers had learned how to be facilitators and become skilled at enthusing others to make things happen in their own area. Some examples, given in three categories, were:

- **teamwork development**:

  *"the work that the PHC Facilitation Project has done in the last few years to enable professionals to work in teams has been a building block for everyone involved in Primary Health Care to move forward from"* ... a Locality Manager;

- **effective service delivery**:

  - improvement of immunisation and cervical cytology uptake in high 'Jarman Score' areas;
  - establishment of several collaborative projects, e.g. Occupational Health Project; Schools Asthma Project; Health Promotion on Wheels ...;

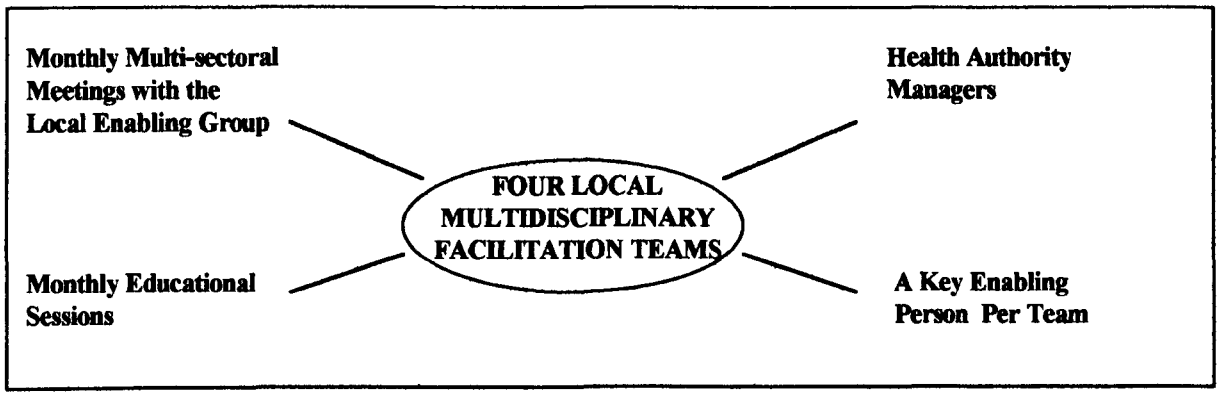
- **multidisciplinary education**: almost all practices attended some form of multidisciplinary event; (Thomas, 1994:7-17).

The FHSA, with financial help from the Department of Health and Glaxo Pharmaceuticals Company, undertook to move facilitation, change and development of PHC on to a third stage by

employing twenty people in a network across the city. The Local Multidisciplinary Facilitation Teams project consisted of four teams of PHC facilitators (the LMFTs) and four supporting structures (figure 2).

**Figure 2**

**Structure Of The LMFTs Project**




In figure 2 above the 'Enabling Group' refers to a group comprised of significant health involved Managers from different health involved agencies, e.g. Public Health, Health Promotion and the Medical Advisory Audit Group, and a 'key enabling person' was someone from the enabling group who was designated to provide support to a LMFT and promote facilitation activity within their designated area.

Each of the four teams were anticipated to replicate as closely as possible the more usual composition of the PHCT, e.g. health visitor, practice nurse, district nurse, general practitioner and practice manager, although a school nurse and two psychiatric nurses were also involved. An interview process and skills workshop was to be used to identify and enable selection of team members who had either actual or latent facilitation skills. They were to be employed for five hours a week to facilitate a programme of events in association with establishing repeated personal contact with PHCT members (Thomas, 1994). The remaining time of team members was to be spent on their original PHC jobs undertaken in the same area where they worked as LMFTs.

There were four different support structures for the LMFTs, the members of which were to be drawn from different aspects of PHC to provide education, support and guidance. The monthly multisectoral meetings were to enable groups to meet and permit a cross-fertilisation of ideas. The intention was for the practical experiences of the PHC facilitators, at the grassroots, to intersect with

views and ideas of the managers. The LMFTs project marked the end of the PHC Facilitation project as it became an initiative,

> "recognising that an infrastructure of facilitation and communication is an essential part of efficient primary health care in a complex world, easing the interfaces, among other, between the 'bottom up' and 'top down' processes, different disciplines and different world views, involving many organisations and influencing the policy making machinery," (Thomas, 1994:19).

The development of this type of infrastructure was seen as vital to the sustainability of the change process.

**Target Clusters**

The four teams were to serve four of the seven "Clusters" in Liverpool. A Cluster consisted of two neighbourhoods, a neighbourhood being a geographical area comprising approximately 60,000 people compatible with FHSA, Community Trust and Local Authority boundaries. The four Clusters to be targeted by the LMFTs were designated as deprived urban areas (Jarman, 1983). The number of PHCTs in each Cluster varies, fluctuating in correspondence with forming or disbanding of Practices, additionally, only a few, those in LMFT Red cluster, had been involved in stages one and two of the Project.

**Process**

The means of achieving facilitation of PHC was primarily through developing teamwork, networking and interprofessional / agency collaboration. This was believed to be an effective way of bringing about change in PHC. The LMFTs were to engage in a dynamic, responsive, interactive developmental process of solving emergent problems that were flowing from the various policy, political, professional, cultural, social and organisational contexts of PHC, to try to achieve sustainable change. Thomas, the founder, envisaged that the LMFTs would explore these emerging problems by:

- "developing the skills of addressing several agendas and dimensions at the same time - personal development, service development and organisational development simultaneously;
- using principles of adult learning so that people can learn on a daily basis from each other and from their daily work;
- using action research as a tool for development - involving all of the target group (those General Practices and PHCTs involved in the Project ) in the research design and execution and feeding back results to all involved so that they are able to learn and develop at the same time;

- developing different dimensions of audit - quantity, quality and consensus - helping people to understand the meaning of health as well as being able to measure it and to understand how well teams have communicated in relationship to it;
- developing self directed learning where primary health care workers ( and others) are able to develop the skills of understanding what their learning needs are and how to achieve them;
- helping General Practices to become learning organisations - organisations that are able to identify their own problems and develop shared solutions to these problems, in the context of a changing world, focusing on the health of the local population, driven by shared vision and learning from the past;
- providing an infrastructure of facilitation whereby it is easy to assess skills, information and ideas from other places by effective management of networks;
- linking effectively with the locality purchasing system.

They [were] expected to do this by the systematic application of the five interventions (table 3), by continued personal contact with people on the ground and by use of networks involving all health involved organisations, thereby promoting teamwork not only in a horizontal, but also in a vertical direction," (Thomas, 1994:20).

**Table 3**

**LMFTs Intervention Programme**

The LMFT Interventions Report (1993) described a list of interventions that an LMFT could develop in one year. These were:

- five primary interventions:

1. one cross practice development workshop per month, *a multi-disciplinary forum;*
2. one *Interactive Bulletin* per three months;
3. one cross practice workshop, *a multi-disciplinary workshop*, per three months;
4. three in-practice management workshops, *roadshows*, per year;
5. stimulating and supporting 2 or 3 *Shared Projects*, per year;

- and five supplementary activities:

6. maintaining an updated *register of workers* in the area;
7. a *regular personal presence*, in all General Practice premises in the target area, monthly;
8. *learn of the education needs* of workers of the area;
9. *link* with established education and policy making organisation;
10. *recruit* practices to cross-city residential team-building workshops, city-wide research and other centrally organised training.

(LPHCFP, 1993:6)

The LMFTs project formed part of a city-wide PHC development strategy adopted at the time by the Local Health Authorities (LHA) to comply with the then Conservative Government's National Health Service (NHS) reforms. These reforms encouraged a shift towards offering preventive health

strategies, introduced new public management and market principles, and promoted teamwork and collaboration among health workers. PHC generally, and in Liverpool, has come under increasing pressure from recent policy reforms to seek more effective ways of using existing resources (Gunn, 1989; Nurse, 1993). In Liverpool, PHC, and General Practice in particular, had for the most part since the inception of the NHS been isolated, crisis driven and disease-focused with many general practitioners (GPs) working single-handedly and disinclined towards teamwork or collaborative activities with other health professionals (Thomas and Graver, 1997). The NHS reforms for PHC aimed, in the early 1990's, to incorporate health promotion and disease prevention activities and improve the quality of service provision. The reforms were influenced by the approach to PHC originally launched at the Alma Ata Conference (WHO, 1978) and from the economic principles and systems of management adopted after the Griffiths report (DHSS, 1983). The aims of the LMFTs project were to attempt,

> "to hasten the change of primary health care from an isolated, reactive, fragmented, disease focused service, towards a planned, holistic, supported, health-oriented service," (LPHCFP, 1993:4).

The foregoing has provided a description of the LMFTs project, the remainder of this chapter will position the LMFTs project within the PHC setting. The trends in PHC in relation to Public Policy and its impacts on development are discussed before focusing on the local context of Liverpool. In the local setting the Liverpool Family Health Services Authority's response to the problem of developing teams and teamwork in PHC and the LMFTs project, its foundations and theoretical underpinnings, are described.

## 1.3 TRENDS IN PRIMARY HEALTH CARE GENERALLY

As long ago as 1978 PHC, in the Alma Ata declaration, was envisaged as a commitment to greater justice and equity in health-resource allocation (WHO, 1978; Macdonald, 1993). The key principles were equity, community participation and intersectoral collaboration. The definition, based on the Alma Ata declaration emphasises the promotion of health; partnerships between health workers and the community; and a system of treatment that balances promotive, preventive, curative and rehabilitative services to meet the needs of the majority of the population served (Ebrahim and Ranken, 1988; Chen, 1988; Hooker, 1994). Thus, the declaration raised awareness that PHC goes beyond the biomedical model of care (Fry, 1986). The Alma Ata declaration has provided a vision

for 'Health for All' to which signatory countries, the UK included, commit themselves to encompassing three key principles into their PHC systems (Macdonald, 1993). PHC in the UK, in common with many other countries, has, however, struggled to reach this ideal and continues to be (Allsop, 1986; Beattie, 1991; Macdonald, 1993; Glendinning, 1998).

In the UK, the health care system continues to be dominated by hospitals and provider groups, and provides services that are led by the increasing expectations of and demands for highly specialised and technical care (Macdonald, 1993; Pearson, 1996). PHC has mostly been described in terms of the activities of general medical practice without linking it to the broader 'Health for All' vision (Hooker, 1994; Pearson and Spencer, 1997). Many of those involved, the doctors, health planners and health workers have equated PHC with the activities of primary medical care and appear to know little of its broader concept, principles or practices (Walton, 1983; Stewart, 1990; Costongs and Springett, 1997). The biomedical model of health, with its historical development, curative approach and medical-intervention focus has proven difficult to move away from. Macdonald records the reaction to Alma Ata "as one, not of deafening silence, but of deafness," (1993:10) a response that, in the UK, has meant a continued expansion of the biomedical approach to health and the health care delivery.

Historically, the medical profession has driven the delivery of the PHC services. The GPs established themselves as the providers of primary medical care and became the gateway for accessing specialist hospital care, from the beginning of twentieth century onwards (Poulton and West, 1993). They have worked as independent and autonomous professionals, either single-handedly or in small partnerships, since the inception of the NHS (Bond et al. 1985). Before the mid-1960s (and before the introduction of Health Centres) GPs, although receiving some clerical support from spouses, sought minimal assistance from, or interaction with, other health professionals such as district nurses, health visitors or midwives. Thus, the GP as an independent and autonomous professional with limited clerical support and minimal contact with other health professionals typified what has been commonly understood as the General Practice team (Usherwood, et.al., 1997).

Despite the many calls for General Practices to develop closer working relationships with other health professionals between 1948 and the mid-1960s, the General Practice team remained largely unaltered. It was not until the British Medical Association published radical proposals for change in the Charter for the Family Doctor Service (GMSC, 1965) that the structure of General Medical

Practice began to change. In this Charter GPs received 70% reimbursement for employing receptionists, secretaries and practice nurses and a group practice allowance if three or more GPs agreed to work together. Thus, the General Practice team began to expand but in a way that allowed GPs to retain a large measure of control. Further expansions came later as proposals for attaching community health professionals to general medical practice were gradually but reluctantly observed (SMAC, 1963). The attachment of community nurses marked the beginning of broadening the membership of a PHCT. More recently, during the Conservative Government's last term of office, the general medical practices have, through the NHS reforms, gained a broader remit and begun to evolve as small to medium sized businesses. These changes have led to the need for improving practice management and increasing the clinical capacity of the Practice. The practice manager has emerged as a new type of professional who possesses considerable autonomy and power in running the Practice (Macmillan and Pringle, 1992). Another new development is that of practice nurses whose role has been extensively developed to provide the extended range of health promotion and other clinical services now offered by Practices ( Hasler, 1992).

A key emphasis in the Conservative Government's policy documents has been the idea of the team. In the search for efficiency the solution has been sought through the creation of teams and the advocation of teamwork and collaborative activities (Secretaries of State for Social Services, 1989; Secretary of State for Health, 1992; DOH, 1993). The most commonly quoted definition of a PHCT is from the Harding Report which described it as:

> "an interdependent group of general medical practitioners, secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his/her function and those of other members so that all pool skills and knowledge to provide an effective primary health care service" (DHSS, 1981:2).

This definition clearly outlines who belongs to the team (it does not include the practice manager or practice nurse) and indicates the way in which teamwork should be developed. Furthermore, it suggests that the development of interagency and interprofessional collaboration is the way to deliver an effective PHC service. The NHS reforms: 'Working For Patients' (Secretaries of State for Social Services, 1989); 'Health of the Nation' (Secretary of State for Health, 1992); and, 'New World New Opportunities' (DOH, 1993) all advocated closer working relationships and a better co-ordination of primary health services. But it has long been acknowledged that the continued separation of general medical practice, community health and hospital services makes it difficult to

provide a co-ordinated, comprehensive, health care service (Royal Commission on the NHS, 1979; Bond, et.al., 1985; Hey, et.al., 1996).

PHCTs have struggled with developing teamwork and collaborative activity (Reid and David, 1994; Rowe, 1996; Pearson, 1996). For example, the conclusion of the Audit Commission (1992) investigating community health was that there was a prevailing lack of teamwork. The problems impeding multidisciplinary teamwork, particularly within in PHC, were stated as:

> "[The] separate lines of control, different payment systems leading to suspicion over motives, diverse objectives, professional barriers and perceived inequalities in status, all play a part in limiting the potential of multidisciplinary teamwork. These undercurrents often lead to rigidity within teams with members adhering to narrow definitions of their roles preventing the creative and flexible responses required to meet a variety of human need presented. They are also likely to lower morale. For those working under such circumstances efficient teamwork remains an elusive ideal," (1992:20).

Notwithstanding these difficulties teams and teamwork continue to be advocated as the basis from which changes in the delivery of PHC can be achieved. The search for efficiency and the need to create effective teams and teamwork as the solution to the problems of efficiency are the key elements within current public policy reforms. Within the movement towards encompassing the principles of the Alma Ata declaration and a primary care led NHS the LMFTs project, with its emphasis on teamwork and collaborative activity, was one attempt to make the public policy reforms work in Liverpool.

## 1.4 PRIMARY HEALTH CARE IN PUBLIC POLICY

At the time when the LMFTs project was implemented great changes were taking place in the NHS as a result of the public policy reforms that occurred between 1980 and the early 1990s. In particular, the following Conservative Government's White Papers have changed the direction of the NHS: The 'Griffiths Report' (DHSS, 1983); 'Promoting Better Health' (Secretaries of State for Social Services, 1987); 'Working For Patients' (Secretaries of State for Social Services, 1989); 'NHS and The Community Care Act' (DOH, 1990a) 'The New GP contract' (DOH, 1990b); and, 'The Health of the Nation' (Secretary of State for Health, 1992). A whole range of policy documents marked a major change in thinking about the role of the state in health (Le Grand, 1991; Marsh and Rhodes, 1992; Hill, 1993; Klein, 1995). The introduction of new public management,

economic and market principles were all part of a broader ideology which shifted the control of the welfare services from traditional civil service administration to governance via a quasi-market system (Hill, 1993; Day and Klein, 1997). The new ideology and ensuing policies were part of a cost-cutting exercise which introduced market principles into welfare, and sought to challenge its bureaucratic and professional dominance. The policy directives advocated new management styles; quality assurance; economic values of efficiency and cost effectiveness in the search for efficiency (Gunn, 1989; Hill, 1993; Glendinning, 1998) and, the notion of teamwork and intersectoral collaboration (Webb, 1991; Springett, 1995) as part of the solution.

The health policy reforms cited above contained four major themes that signalled the way in which the NHS and PHC were to change. These were:

- an increased emphasis upon health promotion and disease prevention;
- the introduction of general management;
- the introduction of market principles and the purchaser / provider split,
  (the Labour Government has since, through the NHS Executive, confirmed its intention to end GP fundholding (DOH, 1997) and replace it with Primary Care Groups on April 1st 1999 (PCGs) (DOH, 1997; DOH, 1998); and,
- an emphasis on collaborative activities and multidisciplinary teamwork.

The impact on the focus on preventive care and a new management approach concerns individual skill development, affects clinical practice, professional autonomy and patterns of service provision to local people in the community. The policy changes call for multiagency responses, multidisciplinary activities and closer working together in health service delivery (Secretaries of State for Social Services, 1987; Hey, et.al., 1996). The impact the four major themes had on PHC will be discussed next.

## 1.5 THE IMPACT OF PUBLIC POLICY REFORMS ON PRIMARY HEALTH CARE

### 1.51 Policy Directives On Health Promotion And Disease Prevention

The Conservative Government signalled it had placed an increasing emphasis on illness prevention on the political agenda in a number of key proposals published in 'Promoting Better Health: The Governments Programme for Improving Primary Health Care' (Secretaries of State for Social Services, 1987). These proposals stressed a shift from providing an illness service to offering a

health service that would help to prevent disease and disability. The Health of the Nation (HMSO, 1992) document that followed similarly indicated a move towards a broader based approach which included developing health promotion and disease prevention services. This policy tried to mirror the WHO strategy 'Targets for Health for All' (1985) by setting objectives and target levels for reducing health risks in key areas where illness and premature death was preventable, e.g. coronary heart disease, stroke, cancers, smoking, prevention of accidents. Both of these directives envisaged the provision of health care as a shared responsibility between all health agencies involved (both statutory and voluntary organisations). These policies promoted collective action for health through interagency and interprofessional collaboration, and multidisciplinary team work approaches as the way different agencies were to explore and meet community needs (Nutbeam, 1994; Delaney, 1994; Springett, 1995; Huxham and Vangen, 1996; Hey, et.al., 1996). Thus, the inclusion of health promotion and disease prevention in PHC has demanded more teamwork and intersectoral collaboration of its health professionals.

## 1.52 Policy Directives - Introduction Of New Public Management

The Griffiths report of 1983 was only one of a number of politically driven public policy reforms of the 1980s and early 1990s. Pettigrew et.al., (1992) point to it being the 'keystone of the arch' and suggested that without this report it was difficult to conceive how later health reforms, e.g. NHS self-governing trusts, the new GP contract, or the introduction of market principles could have been carried forward. Griffith's principles of management were based on the American economist Enthoven's (1985) system of management for utilising resources more effectively. This new managerial approach replaced traditional NHS administration, known as consensus management, with changes that intended to alter not only NHS structure but function, process and ultimately its professional culture (Pettigrew, et.al., 1992; Nurse, 1993). The aims were: to change roles and the way of doings things; to introduce entrepreneurial leadership style and fast decision-making processes; and, most ambitiously, to produce a new market culture that was founded on the introduction of managerial and market principles (Pollitt, 1989; Nurse, 1993; Wistow and Hardy, 1996). The solution to the problems of the spiralling costs of health provision in the NHS, and the lack of a clearly defined general management function, was seen as the need to introduce management principles. These principles were characterised by:

- using a new language of 'drive and 'leadership';
- having a concern for strategy;

- creating a cadre of centrally appointed general managers;
- focusing on processes and roles much more than formal structure;
- operating at various levels of the system;
- operating with a much greater variety of levers than has traditionally been the case;
- extending accountability reviews;
- being more actively concerned with Human Resource Management;
- recognising the management of change;
- identifying implementation gaps as problems.

(Based on Pettigrew, et.al., 1992:51)

As a framework for management the principles focused on achieving organisational excellence, effectiveness and efficiency, and stress measuring performance against a set of pre-determined standards and objectives (Pollitt, 1989; Gunn, 1989; Cox, 1991). The new management approach represented a serious departure from earlier structural type re-organisations of the NHS. The framework combined mechanical and organic change expectations which formed three different managerial agendas. These were: achieving value for money and financial control (Parston, 1988); promoting strategic change - particularly avoiding NHS 'drift' (Nurse, 1993); and, using organisational development and human resource management principles as the basis for developing economy, efficiency, enterprise, effectiveness and a culture of 'excellence' (Gunn, 1989). These three agendas converge to create a more energetically driven 'top down' change effort than those previously used. Henkel (1991) discussed the Thatcher Government's attitude to the provision and evaluation of public (health) services as follows,

> "they sought to reverse the trend of pluralism and to weaken the institutional arrangements on which it was based. Their epistemological stance was unequivocally positivist. They assumed that the complexities of provision could be broken down and objectively assessed on measurable indicators of performance to nationally established standards. Resource constraint and control were taken as incontestable priorities, from which unassailable values could be derived: economy, effectiveness, performance and value for money," (1991:122).

The above quote offers a core statement about the Conservative Government's ideological values and attitudes which became, through the various policies, key concepts in the management of change in the NHS. The success of Griffiths and other health policy reforms were to be realised through the belief in, and use of, a strong management approach (Cousins, 1987; Nurse, 1993). Thus, the introduction of managerialism and market principles has enclosed the managers and health professionals within a system that has increased their level of personal accountability and introduced

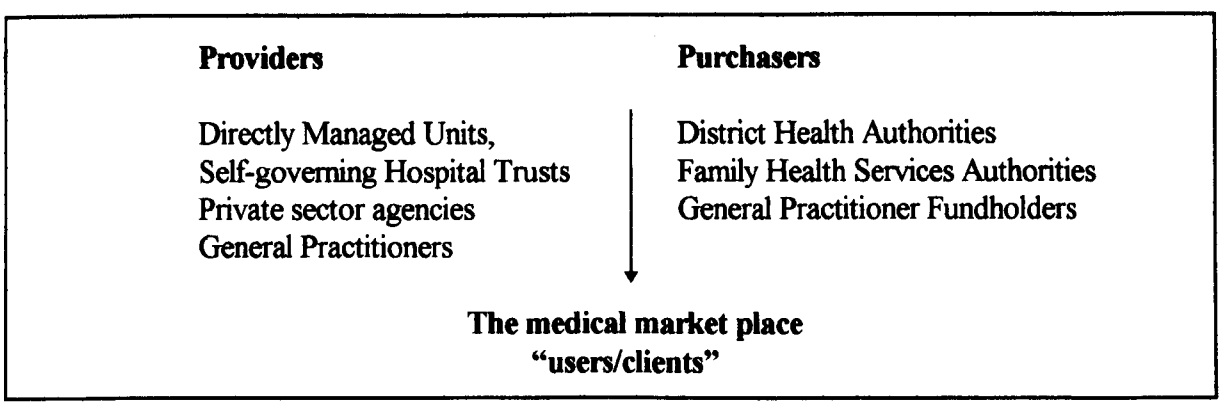
competition between the different health agencies, but not necessarily a system that has drawn them closer together in terms of collaborative working relationships.

## 1.53 Policy Directives - Introduction Of Market Principles

The introduction of the internal market in 1990 divided health care purchase from supply functions within the NHS (DOH, 1990a). A system of contractual arrangements was established between the purchasers and providers of health care who were now operating within a medical market place (figure 3). The providers: the Directly Managed Units; the self-governing Hospital Trusts; and, the private sector agencies, were now in competition for the service contracts of the commissioning authorities. The purchasers of health care were: District Health Authorities, Family Health Services Authorities and General Practitioner Fundholders. The forces of competition were used as a means for promoting greater efficiency and consumer responsiveness in the delivery of PHC services (Taylor, 1991).

**Figure 3**

**Purchasers And Providers Of Health Care**




In the new structural relations in each Health Region, the District Health Authorities and the Family Health Services Authorities were placed alongside each other in a relationship where their activities were co-ordinated by the Regional Health Authority (Taylor, 1991). The District Health Authorities (DHA) were given a lead purchasing role and the Family Health Services Authorities (FHSA) were given a stronger management role. The FHSA was expected to develop and monitor strategies that made PHC services more responsive to individual patients and to health needs of the local population as a whole (DOH, EL79, 1994). The political imperatives emphasised cost containment together with proposals for ensuring the clinical effectiveness and quality of health care services

(Goodwin, 1995). The FHSAs, on the basis of their strengthened role and extended remit, were to become the,

> "development agencies ensuring effective delivery of primary health care thereby involving them in the assessment of health needs" (Connolly, 1995).

In later reforms, the DHA and FHSA were merged to form Local Health Authorities (LHA) and combine their regulatory and developmental functions (Taylor, 1991).

The changes at the level of the LHA made a strong impact on the way general medical services were to be provided. The powerful new management role invested in the LHAs involved interpreting the rules and making judgements over the payments a General Practice would receive for the general medical services it had provided, e.g. the number of patients that had received immunisation or general health screening - new patient 'check-ups', or specialist health screening - hypertension, diabetes, cervical smears etc. Thus, the relationship between the General Medical Practices and the LHAs, which had traditionally operated in an environment with minimal management, was radically altered (Lawrence, 1992). The emphasis on developing quality PHC services culminated in three different pressures, political, organisational and clinical, being directed towards general medical services in the effort to promote change. First was the pressure to expand the membership of the PHCT and adapt member's roles to meet the change to health promotion and preventive practice. Second was the demand for practice reports, audit, computerisation, teamwork and skill development which in turn emphasised the need for education, training, information technology, management and administration in general medical practice. Third was a prescription for what may be regarded as a 'clinical evolution' whereupon,

> "doctors will increasingly have to accept the primacy of others in areas where their skills are traditionally less developed, in particular in nursing and management," (Pringle, 1992a:626).

Thus, the three simultaneous pressures, the result of introducing the internal market, new managerialism and focusing on promoting health and disease prevention, disturbed the traditional working patterns of PHCTs. Teams and teamwork were being advocated as the best way of delivering high quality services to patients (Pearson and Spencer, 1995) but the simultaneous bid to achieve competition, cost efficiency and interprofessional collaboration were, potentially, contradictory imperatives. The achievement of such diverse aims would, it seemed, be dependent upon finding the right basis on which to develop both PHC and intersectoral collaboration (Wiles and Robison, 1994; Wistow and Hardy, 1996).

## 1.54 Policy Directives On Teamwork And Collaboration

The health policy directives of the early 1990s broadened the scope of PHC to include health promotion and disease prevention initiatives together within general medical practice. These trends have continued more recently via the activities of Primary Care Groups (PCGs) (DOH, 1998). The provision of this wider range of services requires a variety of different skills and for this reason a team approach to delivering health care was advocated as part of the NHS reforms (Poulton and West, 1993). The idea of teamwork is not new, it first appeared in the Dawson Report (CCMAS, 1920) when suggestions were made for GPs to be based in health centres and to work with a range of other health professionals. The idea lay dormant until the Gillie Report, in 1963, which proposed the attachment of community nurses to general medical practices and their populations. It was from this moment onwards that 'attachment' became synonymous with teamwork (Bond, et.al., 1985). Later the Harding Report (DHSS, 1981) investigating PHCTs acknowledged that achieving co-ordinated work activities was a difficult task.

This report issued the following guidelines as the fundamental requirements needed for the satisfactory integration of a team:

- a common objective for the team which is accepted and understood by all members;
- a clear understanding by each team member of his/her role function and responsibilities;
- a clear understanding by each team member of the role, function, skills and responsibilities of the other team members; and,
- a mutual respect for the role and skills of each member, allied to a flexible approach (DHSS, 1981).

The progress on achieving teamwork was slow as is evident in the Cumberlege Report (DHSS, 1986). This report investigating community nursing services, concluded that PHCTs existed in name only. The concern was that potential skills were not being tapped as care was concerned with crisis intervention and not health promotion and illness preventing activities. This report recommended that written agreements be made between community nursing services, e.g. between neighbourhood managers and general medical practices, to define objectives and roles for 'attached' community nurses. It envisaged that this would help to clarify relationships and thus, promote better teamwork.

In the NHS reforms of the early 1990's (Secretaries of State for Social Services, 1989; Secretary of State for Health, 1992; DOH, 1993) teamwork and collaboration were given a new impetus. The

concern was to develop an integrated approach to PHC, and the PHCT was visualised as the medium through which to deliver services that promoted and maintained the health of the local population. The notion of developing an integrated approach to PHC is furthered through the creation of PCGs with their multidisciplinary composition and expectations of forming collaborative relationships (DOH, 1998). The new managerial approach encouraged a new 'enterprise culture' to emerge in the NHS (Kelly, 1989; Pettigrew, et.al., 1992), and made its impact in PHC through the introduction of the new GP contract (DOH, 1990b). The GP contract identifies levels of good practice for GPs. These tie health promotion and consumer responsiveness into Practice service provision and are assessed in terms of target achievement. The GP, alone, cannot meet these target levels, there is an in-built reliance on other health professionals within PHC. Furthermore, the new role of the LHA, as manager and paymaster, has also underlined the need for teamwork. GPs were now required to provide evidence that targets had been achieved. The emphasis was on undertaking audits, collecting and analysing data on performance, and submitting formal reports to the LHA before service payments would be made to general medical practices. Thus, General Practice income became inextricably bound to and reliant upon the contribution of others in the PHCT. In the NHS reforms the highest achievers, largely measured according to target-based measures, were to be rewarded but to qualify GPs needed to engage the commitment and effort of the whole PHCT in order to attain the higher levels of income. The target levels a Practice achieved may, therefore, be perceived as a measure of how well the PHCT works together (Poulton and West, 1993) but this is not necessarily an indicator of the quality of care that has been provided.

The NHS reforms of the 1990's have described PHC as being led by GPs. The GP model was seen as the means by which the local population (of which 99% are registered with a GP) were to receive screening and advice on health risk factors, and the necessary lifestyle changes to reduce the likelihood of disease (Secretaries of State for Social Services, 1987). The GP model was according to Beattie (1991) a top-down or prescriptive approach to health promotion wherein health professionals use a health persuasion model to try to shape and modify an individual's behaviour. This approach emphasises a biomedical model of health and focuses on screening and detection and therefore on medical rather than social problems. GPs have long been concerned with social problems and the detrimental impact these have on health which, in turn, increases their workload (Acheson Report, 1981; Jarman, 1983). The problem has been how to assess the level of health and social needs and provide the appropriate type of health and social services (Jarman, 1983; Dockery, 1996). The adoption of a biomedical model of health was, however, perceived as useful for both

policy makers and managers in that it would be able to meet "the necessity of producing quantifiable results" (Williams, et.al., 1993:46). Thus, the biomedical model was perceived to readily fit in with the new managerial approach with its preference for objectives, targets and performance related pay.

The Conservative Government's publication of the 'Health of the Nation' (Secretary of State for Health, 1992) represented a broader approach and a significant advance of government thinking on public health issues. A shared or collective responsibility was envisaged wherein a range of government departments e.g. employment, transport and various health agencies, contributed to planning, co-ordinating and providing health promoting and disease preventing services. There was, however, disappointment expressed about the way strategic targets were being stressed without providing any effective means of achieving them, and also about the way medical or lifestyles models for promoting health were emphasised (Tones, 1989; Williams, et.al., 1993). In the range from individualistic to community oriented models for promoting health Beattie (1991) described the initiative as a top-down but more collective type of model (figure 4). This model stresses the need for shared responsibility, that is 'legislative action' for health and a responsibility for health that rests with the individual. Of the different health promotion models Beattie (1991) proposes both personal counselling and community development models as alternative ways to promote health. He argues that these are the models through which to develop negotiation, participation and collaboration as key ways to work with people in the effort to foster joint action on health related issues.

**Figure 4**

**Range Of Models For Promoting Health**

| | **Top-down approach** | **Participatory approach** |
|---|---|---|
| **Individual models** | *NHS model*<br>individual<br>models for health | personal counselling<br>negotiated models for health |
| **Collective models** | *NHS model*<br>collective<br>models for health<br>legislative action for health | community development<br>collaborative models for health |

(Based on Beattie, 1991:167-178)

In brief, the recent health policies have made a shift from top-down individualistic models to endorsing a more collective approach to the development of health interventions. This shift, Williams et.al., (1993) suggested, provides an opening for the development of more participatory and collaborative models, given that few ground rules were presented. Thus, an opportunity may have been created for developing teamwork, collaboration and effective action for health in a setting that had previously shown little response to such developments.

## 1.6 THE RESPONSE TO THE PROBLEM OF DEVELOPING TEAMS AND TEAMWORK IN PRIMARY HEALTH CARE IN LIVERPOOL

In 1989, Liverpool had 240 general practitioners working in 110 general medical practices, 42 of which were single handed. The GPs employed a total of 8 practice nurses between them and had an average number of 1.43 whole time equivalent ancillary staff per principal doctor (Thomas, 1994). This, in comparison with other FHSAs in the locality, provided a low level of support for the GPs (Personal Communication, 1994). It was also common for General Practices to employ staff at lower rates of pay than in neighbouring authorities, not offer job descriptions, written contracts of employment or training opportunities (Personal Communication, 1994). Furthermore, the level of resources from external bodies for the support and training of primary care staff was very limited. The suitability of practice premises varied considerably across the city, it ranged from an excellent standard to unacceptable in terms of facilities, fabric or location of the building (Personal Communication, 1994). The GPs, a large proportion of whom were single handed and elderly, worked independently in a way that preserved their professional independence.

Thomas noted that,

> "the health involved organisations worked in relative isolation from each other - there was little history or experience of co-ordinated, collaborative work anywhere," (1994:1).

Thus, PHC in Liverpool was being delivered by segregated groups of health workers who followed their own disciplines and who made little reference to others who were working towards similar goals.

In 1990, the Liverpool Family Health Services Authority agreed to follow the WHO's strategy for achieving Health for All by the year 2000 for Europe (WHO, 1985). The LFHSA strategy was based on promoting healthy lifestyles, eliminating and reducing preventable disease and

environmental health risks and redirecting the focus of health care towards primary care (LFHSA, 1994). The LFHSA was committed to ensuring the delivery of PHC services which were:

- of high quality;
- accessible;
- comprehensive;
- effective;
- value for money;
- targeted to the health needs of the population.

In doing so it recognised that this had to be done in partnership with the relevant health care professionals who would provide these services, and with other agencies whose services affected health. The LFHSA was, along with other health involved agencies, working towards the common aim of a 'Healthy Liverpool' (LHA, 1996). The LFHSA also agreed to target the deprived areas with the greatest needs to meet national targets as contained within the Health of the Nation (Secretary of State For Health, 1992) and those problem areas that were defined locally. These were areas where GPs were under the greatest pressure owing to the socio-economic condition of the community they served. The Jarman Index (Jarman, 1983) was used to establish which areas were to be given the extra support. Those areas that scored 30 or more were regarded as being deprived. Eight electoral wards in Liverpool were recognised as being deprived and thus targeted to receive extra resources.

The LFHSA strategy emerged gradually over time and was developed by adopting the following four pronged approach:

1. **establishing practice priorities**: assessing General Practices problems and prioritising those for development;
2. **weighted resource allocation**: deploying resources to General Practices taking the area Jarman score into account;
3. **minimum standard setting**: setting eleven standards as a minimum requirement of a high quality General Practice;
4. **working with community groups**: utilising a 'bottom up' approach to inform planning of future services, fostering multidisciplinary working groups to think about and prioritise local health population issues, and developing a process of neighbourhood planning as a way of working collaboratively to make planning for health services more responsive to local needs, (Enabling Group Meeting, 1994).

The strategy included all 110 General Practices in the Liverpool area, each of which were to receive support and practical help, commensurate with the Jarman assessment, in the effort to raise standards and improve the range, quality and accessibility of General Practice services.

The Liverpool FHSA was part of a Regional Health Authority (RHA) that considered itself to hold flagship status among RHAs in general. In accordance with this notion the Liverpool FHSA was ready to adopt innovative ideas to maintain the flagship status of the region. It actively promoted opportunities for developing teamwork and collaboration to achieve effective action for improving the health of the population. Various resources were deployed to assist with general medical practice development, these included: 'neighbourhood' commissioning managers (NCMs), training officers, technical experts, clinicians, financial personnel and audit facilitators. The following list demonstrates a few of the different initiatives that have been developed in Liverpool since 1990:

- Establishing the Vauxhall Health Forum: a community development group, made up of residents and local health professionals who acted locally and lobby nationally as part of the drive to achieve better local health;
- Encouraging General Practices to join the Local Organising Teams programme of 'awayday' team building activities for PHC staff;
- Employing two facilitators to work with PHCTs to foster evidence based practice;
- Medical Audit Advisory Group facilitated, among other things, the development of audit in Practices;
- Supporting the implementation of the Local Multidisciplinary Facilitation Teams project.

The LFHSA funded, in particular, initiatives that aimed to strengthen personal, organisational and service dimensions of PHC service provision. The Local Multidisciplinary Facilitation Teams project was one such initiative as it aimed to promote teamwork and collaborative activity within and between PHCTs in Liverpool. As discussed earlier, in section 1.3, the facilitation teams were to help health workers to develop shared learning and shared action in certain areas in Liverpool. Additionally, they were to help General Practices improve practice organisation, management and service delivery. Thus, the implementation of the LMFTs project formed part of the LFHSA strategy for developing PHC in Liverpool.

## 1.7 FOUNDATIONS UNDERPINNING THE LMFTs PROJECT

The model underpinning the LMFTs project was unique. It promoted organisational change through the use of four teams of facilitators (PHC workers) to facilitate the process of change in PHC. It was one attempt to address the need to develop teamwork and collaborative activity in PHC. The key foundations underpinning the LMFT model chiefly followed the principles of adult learning and the organisation development (OD) approach to facilitate change and development of PHC (figure 5) (please read the figure from bottom upwards). In addition, the model incorporated the 'grassroots approach' of the community development approach.

**Figure 5**

**Overview Of The LMFTs Model For Change**

| | | |
|---|---|---|
| • Participants | ^ | all PHC workers in the four designated areas |
| • Implementation | ^ | four facilitation teams locally employed within their areas |
| • Organising framework | ^ | participatory interventions: teamwork / problem solving |
| • Purpose | ^ | promote effective action for sustainable change in PHC |
| • Theoretical framework | ^ | organisation and community development: participatory |
| • Philosophical foundations | ^ | principles of adult learning |

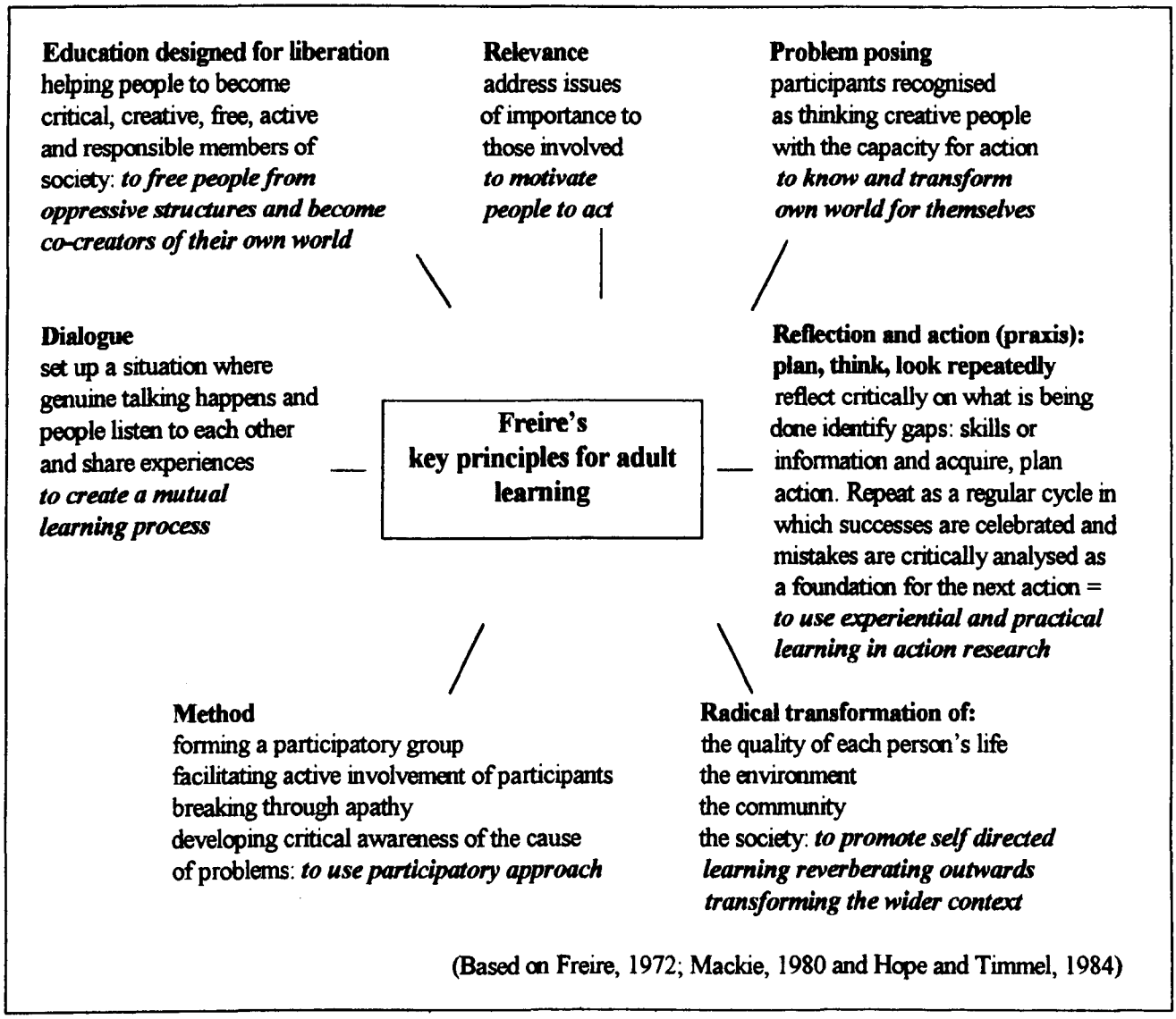
* the specific 'community' referred to are the group of health workers and members from other health involved organisations, e.g. health promotion units, public health specialists, pharmacists, voluntary workers etc., associated with delivering services from the 56 General Practices involved in the LMFTs project.

### 1.71 Philosophical Foundations: Adult Learning

The principles of adult learning were chosen by the founder because the learners become active participants in the process of learning (Rogers, 1983; Knowles, 1990). In following this approach within the LMFTs project, use was made of the learner's range and volume of experience through experiential learning techniques, e.g. group work, paired activities, use of reflective practices and emphasising the practical application of learning (Kolb, 1984; Brookfield, 1986; Burnard, 1991). Adult learning stresses education as an interactive process that is presented in context and connected with living situations which people are involved in. Freire (1972) provided a philosophy and

practical method of adult education and development that promoted education as a liberating process (figure 6). The *italics* used in figure 6 denote how the adult learning principles were translated for use in the LMFTs project.

**Figure 6** **Key Principles Of Freire's Philosophy And Practical Method Of Education**




(Based on Freire, 1972; Mackie, 1980 and Hope and Timmel, 1984)

Freire was concerned to enable people to achieve their own radical transformation of life in local communities in a way which would impact on the whole society (figure 6). He argued that education has to involve people and local communities in such a way that continually engages them, which means they became evermore deeply committed to the process of change, of transforming the concrete, objective realities of their present life. This suggested education is a tool for learning how to change the 'given' structures of lived experience, a dynamic interchange where Freire envisaged that, "subjectivity and objectivity thus join a dialectical unity producing knowledge in solidarity with action and vice versa," (1972:17). In this educational process, adults become knowing participants,

learning is what shapes their lives - individuals learn what they can do to transform it for themselves (Mackie, 1980). Learning is seen as a joint venture between the learner and teacher; each learns something from the other as they participate in an adult educational process.

In the LMFTs project, involving the LMFTs and PHCT members as adult learners in the process of change was envisaged as a means of promoting self-direction and, in the longer term, a means of becoming a learning organisation. The aim was for the LMFTs to view change as a process of learning and development. The LMFTs role was,

> "to create the conditions that help people to do things for themselves - making it easier to understand others and effectively work with others so that energies are harnessed in a similar direction," (Thomas, 1994:2).

The LMFTs were to use the principles of adult learning to create a dynamic and interactive process to encourage PHCT members to explore together their own world of PHC and learn what shaped their lives within it and what they could do to change it (figure 6). The adult learning principles were situated within a framework that combined the principles of organisation and community development for promoting change and development in PHC.

## 1.72 Theoretical Approach: A Combination Of Organisation And Community Development Principles

A combination of organisation and community development principles were adopted to enable those involved in the LMFTs project to learn how to effectively change their own work practices. The focus of organisation and community development is on different settings, people and agendas but both were found, from the literature review, to base their approach to promoting change on similar philosophical positions and practical activities. A comparison of the principal activities within community and organisation development approaches confirms that they share the same basic principles but use them differently according to the orientation of the setting (figure 7). Both organisation and community development, together with adult learning approaches, draw on humanist principles, in particular the aspect of being optimistic about human possibilities and enthusiastic about human achievement (Huxley, 1961; Ayer, 1968; Cohen and Uphoff, 1980). The concern is about helping people to change their circumstances as they learn from the fusion of experience and knowledge in the process of becoming more self directed and self actualised (Maslow, 1968; Jarrett, 1973). The concern is to eliminate, as far as is possible, the degree to which

human completeness is distorted by an unjust order that brings about dehumanisation, alienation and disaffirmation of men and women as persons. These ideas move beyond the individual in the setting, here the intention is for adults to learn together, from each other, and become co-creators of their own world (Reason, 1988).

**Figure 7**

**A Comparison Of Principal Activities Within Organisation And Community Development**

| **Community development** | **Organisation development** |
|---|---|
| ***Principal activities*** | ***Principal activities*** |
| teamwork | teams and teamwork |
| participatory groups | participative management (inclusion of workers in decision making processes) |
| personal vision building | organisational vision building |
| local support networks | information networks |
| co-operation, collaborative & collective action | co-operation, collaboration & collective action |
| non-competitive internally | competitive internally (ind./group targets set) |
| starting where people are at | starting where the organisation is at |
| enabling and motivating personal commitment | enabling / motivating organisational commitment |
| taking responsibility for shaping lives and community to achieve personal and community goals | taking responsibility for shaping work to achieve organisational objectives |
| ***how*** | ***how*** |
| facilitating, involving local people | facilitating, promoting, directing workers |
| ***to what end*** | ***to what end*** |
| human completeness: self direction and learning in action | human expression, identity and achievement for organisational efficiency |

(Based on Beckhard, 1969; Bennis, et.al., 1976; Hope and Timmel, 1980; Jones, 1990)

This philosophical position establishes the humanistic and historical task underlying community and organisation development approaches to promoting change. It also creates an epistemological and ontological challenge of avoiding dualism, of making processes into things, and of separating the knower from what is known, which is discussed later in chapter three. This way of thinking is different to the conventional views. In this alternative view Bateson (1972), discontented with conventional theories of evolution and learning promotes an ecological way of thinking, urging scholars to find the 'pattern which connects' and to learn new ways of thinking. Reason (1988) suggests a response to this challenge is by using experiencing, acting and reflecting-on-acting in a

process of critical inquiry. This is proposed as a way of developing other forms of knowledge and understanding about the world and our place within it.

There is within organisations and communities, indeed throughout world, a prevailing culture of science and technology that Skolimowski (1994) has called Mechanos. Reason (1988) suggests that this is now being challenged and that, although a replacement cosmology has not yet crystallised, new themes such as wholeness and evolution have begun to emerge. Where Mechanos is piecemeal, divisive and fragmenting the new visions are unitary, integrative and holistic, perceiving the world in the shape of whole systems that in time are capable of spontaneously shifting to higher levels of complexity (Prigogine and Stengers, 1984; Stacey, 1995). Skolimowski (1994) describes the emergent worldview to replace Mechanos as 'Evolutionary Telos' wherein participation forms its methodology and through which comes the challenge to find ways of knowing. Ways that do not regard separateness and detachment as central concepts and yet, in the embrace of participation, demand inquiry that remains both rigorous and self-critical (Reason, 1988).

The LMFTs model makes a link with the 'Evolutionary Telos' world view and its participatory methodology through its use of dialectical interchange between the different people involved within an action research evaluation framework. In practice, in the LMFTs project, the activities seek to engage and gain commitment from those involved. Fundamental to adult learning, organisation and community development approaches is a belief in and use of participation for achieving and promoting sustainable change whether it is at a personal, organisational or service level / dimension of development. The LMFTs project intended to bring people together in such a way that they could learn from each other and use that learning to transform the structures of, or co-create anew, the world of PHC.

The sum of both community and organisation development approaches was not concerned with doing things for people but with enabling and motivating them to see that the way things are, is not necessarily, the only way they could be. It is from this premise that those using these principles hoped to assist people to take responsibility for shaping their own lives whether at home, at work, in an organisation or community (Hope and Timmel, 1984; Pasmore and Woodman, 1988). Underpinning organisation and community development approaches with a participatory methodology determines the way an initiative is to be presented and how the implementation process will proceed. With a community development approach often the focus of development is to

work against the tyranny of bureaucracy and towards creating more democratic decision-making. A parallel in organisations may be conceived where people may be oppressed by company bureaucracy. Bureaucracy in each case attempts to induce people to conform as those without power keep quiet and submit to the decisions of those with power (Freire, 1972). For these reasons Kanter (1985) has viewed the structures of bureaucracy as constraining as they stifle organisational creativity and innovation.

The use of a participatory methodology affirms the value of each person and the importance of community. It profoundly affects how meetings, projects, decision-making procedures etc. are organised and work for cohesion, community and coherence in organisations and in wider society. It uses group methods to promote the sharing of ideas and genuine listening, to affirm value to the wisdom of ordinary people and belief in the insights of the ordinary person (Hope and Timmel, 1984). The use of a participatory methodology in initiatives, strategies or programmes for development advocates starting from the bottom up and growing out of the expressed needs of the people. The facilitators' role, those with education and skills, was to enable people to participate actively in identifying and analysing critically the causes of their problems and uniting them to find solutions. The LMFTs were expected to implement a programme of interventions, along with personal supporting activities to facilitate change and development by using a participatory methodology. In the LMFTs project the principles of adult learning, organisation and community development were combined within a participatory methodology to achieve effective action for change and development in PHC. The LMFTs project was paralleled by an evaluation approach that attempted to replicate the philosophy of the model underpinning the LMFTs project. The evaluation was framed within an action research approach and used participatory methods to promote learning and enhance change.

## 1.8 SUMMARY AND CONCLUSION

This chapter has described the PHC context of the study, the LMFTs project and the philosophy underpinning the project. The concept of PHC and the way it has manifest within the UK health system was discussed in relation to the historical, political, professional and organisational influences that have impacted on its development. PHC in the UK is largely orientated towards the biomedical model of health where those involved, the doctors, health planners and health workers, have largely equated PHC with the activities of primary medical care. The NHS policy reforms of the early

1990's have subjected the health care services to major organisational and cultural changes. In brief, the aims of these reforms have been,

> "to usher in a new era of preventive activity, particularly in the primary care sector, within a much more tightly managed, efficient and competitive NHS," (Williams, et.al., 1993:44).

As a result of the NHS reforms in the 1990s the role of the LHA changed and they gained the responsibility for developing strategies that aimed to improve the quality of health service delivery in Liverpool. The strategy was, amongst other things, concerned to develop Practices and actively promote opportunities for developing teamwork and collaboration to achieve effective action for health. The LMFTs project was, as part of that strategy, funded by the LHA to promote teamwork and collaboration within four of the poorest geographical areas within Liverpool. It involved four teams of facilitators implementing a programme of interventions in the four designated areas of Liverpool. The LMFTs were expected to use the principles of adult learning together with the participatory interventions methods, as laid down by the founder, to assist members of PHCTs develop team-work, networks and collaborative activities and adopt the principles of a learning organisation.

The LMFTs project represented the ideal as written in the end of the PHC Facilitation project report (Thomas, 1994) and the 'Interventions Report' (LPHCFP, 1993). The LMFTs project implemented an experimental model for change in PHC that was primarily based on an organisation development (OD) approach to change and one that incorporated the principles of adult learning. It had been developed from the basis that change needed to be participatory for it to be sustainable and was to be implemented via the facilitation teams delivering a programme of interventions to PHCTs in four clusters in Liverpool. The purpose of this study was to explore what happened to this LMFTs project in practice. However, before doing this it is necessary to explore the approaches to organisational change in order to inform the process of change in PHC. This will be undertaken in the next chapter.

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# CHAPTER TWO

# APPROACHES TO ORGANISATIONAL CHANGE

## 2.1 INTRODUCTION

This chapter provides a brief outline of the different perspectives on organisational change before examining the main constructs of the organisation development strategy for change relevant to the LMFTs project. The LMFTs project was designed as a developmental model for change. It was largely founded on the principles of organisation development and followed a participatory approach to achieving organisational change among members of PHCTs, within PHC.

There is a vast literature on organisational change with many theories and perspectives on offer. As Sturgeon and Barwell suggest the literature,

> "staggers unsteadily under its own weight of contradictory and confusing theories, models and metaphors" (1991:33).

Most work in this area has been dominated by work undertaken in the industrial and business sectors. While some has recently taken place within the public sector (Pettigrew, et.al., 1992) the degree of relevance of the theory base of the organisational literature to organisational change in the health care system must be questioned. The approaches to organisational change are largely oriented towards productivity in the business sector and may, therefore, be inappropriate for use in the health care sector.

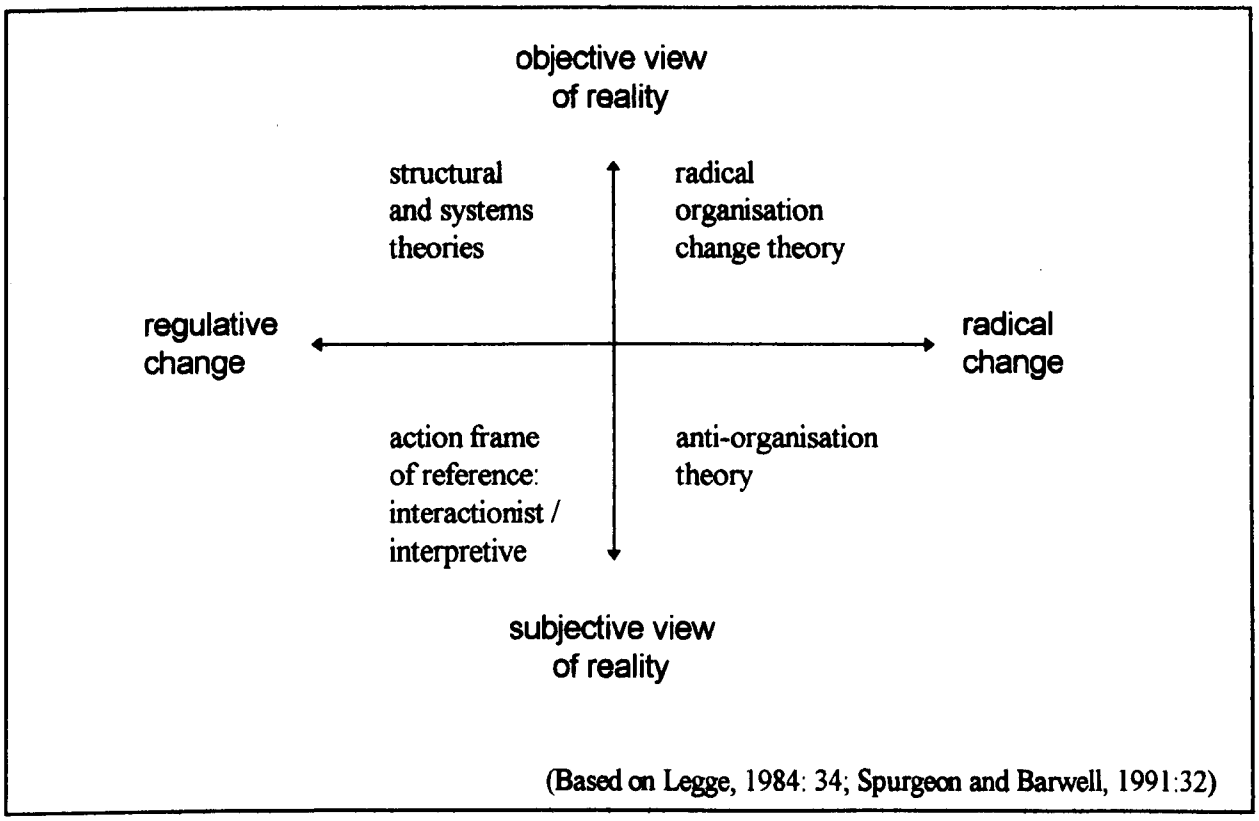
The definition of organisational change is a difficult task, its meaning varies depending on whom is describing it. Kanter et.al., in their review have defined the conventional modern idea of change as one that, "typically assumes that it involves movement between some discrete and rather fixed 'states', so that organisational change is a matter of being in State 1 at Time 1 and State 2 at Time 2" (1992:9). The origins of this perspective primarily developed from Lewin's (1946) model of change which has become a classic model of change that is used, either explicitly or implicitly, by managers and practitioners alike (Kanter, et.al., 1992). Lewin's model (1946) promoted a simple, static and linear conception of organisational change. It involved human beings progressing through three phases: unfreezing, changing and refreezing, in a process of change (Schein, 1996). This model (1946), after further development by Lewin (1952) and his associates, likewise provided the foundations of the action research model that underpins all organisation and community

development strategies (Legge, 1984), which is discussed later in this chapter. In this view the organisation is perceived as a static entity, and the process of achieving organisational change as a planned, systematic, linear, rational process (Harrison, et.al., 1990; Spurgeon and Barwell, 1991). Within this conventional perspective various alternative philosophies underpinning the approaches to organisational change have developed.

A useful way of characterising these alternative philosophies is to divide them into two dimensions: the objective-subjective view of reality continuum and the regulation-radical change continuum (Burrell and Morgan, 1979) (figure 8).

**Figure 8**

**Four Perspectives On Organisational Change**




(Based on Legge, 1984: 34; Spurgeon and Barwell, 1991:32)

In the objective-subjective dimension, change when viewed as a subjective reality - as something that occurs from within the mind, is conceived as a dynamic process of *becoming* different. The emphasis is on the processes involved. When change is viewed as an objective reality, as something that occurs outside of the mind, it is regarded as something that can be planned, initiated and managed, or reacted to in situations of unplanned change. Here, the emphasis is on outcomes - *the*

*difference* - that can be achieved (Legge, 1984). In the regulative-radical dimension change is explained in terms of regulation, i.e. organisational unity, integration or cohesiveness, or in terms of radical change, i.e. structural conflicts, contradictions and modes of domination in the organisation (Burrell and Morgan, 1979; Legge, 1984; Stacey, 1995). The regulative change process is "not remarkably different from a theory of ordinary action," (March, 1981:564). It is perceived as ordinary adaptive organisational behaviour and, "is conceptualised, analysed and explained from the same theoretical stance as any other episode of organisational behaviour that the analyst holds," (Legge, 1984:33). Radical change, however, is perceived as creating a discontinuity between past and present activities and thus, generating a qualitative shift within the organisation's dynamics. The greater this shift the more radical the innovation is considered to be.

These explanations, in theory, provide four different perspectives from which to choose, or analyse, an approach to change. In reality, however, much of the literature assumed without question that change was an objective phenomenon (Bennis, et.al., 1976; Legge, 1984; Pettigrew, et.al., 1992). Secondly, it suggested that most practitioners conceptualised the change process from a regulative / objectivist position. There were, however, other examples from within community development that, similar to the LMFTs project, used 'bottom up' problem solving approaches and interpretive models of analyses and explanation. In these studies, practitioners followed more of an action frame of reference and adopted the middle ground between the objectivist and subjectivist positions (Legge, 1984; Bruce, et.al., 1995). However, from this examination of the literature, both general and specific to the NHS, the most common perspective guiding the approach to, and analysis of, organisational change was one that was based on the regulative / objectivist position (Legge, 1984; Henkel, 1991). A position that was clearly presented in Pettigrew et.al.'s, (1992) studies of the management of strategic change processes within the NHS, between 1986 and 1990, and, moreover, a stance that the LHA adopted during the implementation of the LMFTs project in this study, which is discussed later in chapters four and six.

The four alternative philosophies, outlined in figure 8, summarise the way the conventional modern idea of change has been theorised. The LMFTs model for change did not, however, readily fit into any of the four theoretical categorisations but philosophically is best positioned within the regulative-subjective quadrant in figure 8. Organisational change, in the LMFTs model, is viewed as a dynamic process of becoming different via what may be described as small-c "changes" (small incremental changes) which may, over time, cumulatively produce a sudden qualitative shift or

capital-C "Change" (Kuhn, 1962). The LMFTs model departed from the conventional approaches to change in that it adopted a developmental approach towards achieving organisational change and, to do this, the LMFTs utilised a 'bottom-up' or 'grassroots' problem solving approach (Lewin, 1952). The LMFTs approach was based on Lewin's (1952) action research model which was used as a means of encouraging learning and, in turn, was anticipated to lead to organisational change. In the LMFTs model it was intended that the members of the PHCTs should learn from being involved in a process of change. It was believed that their participation in a process of change was key to sustaining the changes made within their Practices. Thus, learning was conceived as a vehicle for achieving organisational change in PHC.

The LMFTs model for change has much in common with Kanter et.al.'s, (1992) integrative dynamic model of organisational change in that they both subscribe to an action view of organisations and stress the importance of motion in organisations. Kanter et.al., describe organisations as,

> "bundles of activity with common elements that allow activities and people to be grouped and treated as an entity. As activities shift, as new or different units or people are included in activity clusters, what is identified as "the organisation" also shifts," (1992:12).

This is a useful perspective for it identifies three interconnected aspects of an organisation that influence the implementation of a process of organisational change. Kanter et.al., identified these as,

> "the forces, both internal and external, that set the events in motion; the major kinds of change that correspond to each of the external and internal change pressures; and the principal tasks involved in managing the change process," (1992:14).

This is a framework that permits an examination of the key areas that operate to influence a process of change as it is happening, and, by doing so, allows the development of an explanation as to what different kinds of organisational motion are occurring and how these may lead in different directions which result in unexpected and unanticipated outcomes during the implementation of a change project. Thus, the action view of the process of organisational change readily fits in with the philosophy of the LMFTs project. It enables organisational change to be viewed as a dynamic concept and adds a rich historical and political dimension to the more conventional ways of analysing organisational change.

Before moving on to a more detailed exploration of the organisation development change strategy underpinning the LMFTs project, an overview of the three major groups of change strategies that are used to achieve organisational change is provided.

## 2.2 CHANGE STRATEGIES

There are many different approaches used to influence the adoption of change in organisations. One element common to all approaches, whether the change strategy concerns technologies or people, is the conscious use and application of knowledge as an instrument or tool for changing patterns and institutions of practice. Bennis et.al., (1976) categorise the different approaches to achieving organisational change into three major groups: empirical-rational, power-coercive, and normative-reeducative, which differ according to their underlying philosophical view of human beings and the ingredients of power that they emphasise. These three groups are summarised in figure 9.

**Figure 9**

**Three Major Groups Of Change Strategies**

**Empirical-rational: a non-participative change process**

*Assumption*

People are rational and will adopt a change if a) it is rationally justified, b) a personal gain is perceived;

*Method of intervention /Activities of the change agent*

Providing knowledge and expertise as a rational inducement for people to change.

**Power-coercive: a non-participative change process**

*Assumption*

People with less power will comply with the plans, directions and leadership of those with greater power;

*Method of intervention /Activities of the change agent*

Using some form of power to pressurise people into complying with the change.

**Normative-reeducative: a participative change process**

*Assumption*

People possess a system of beliefs that provides a normative framework for guiding their actions. Change to patterns of practice or action will only occur when people develop and commit themselves to a re-construction of their personal meanings, their perceptions of norms and values these norms have for them.

*Method of intervention /Activities of the change agent*

Facilitating a problem solving process in a participatory manner to help people identify the problem and need to change, to devise and evaluate various solutions and to choose from among them.

(Based on Bennis, et.al., 1976:23)

In the LMFTs project the notion of facilitators assisting Practices to adopt the principles of a learning organisation is a change strategy that belongs in the normative-reeducative group (figure 9). As a concept a learning organisation may be defined as, "an organisation that facilitates the learning of all its members and continuously transforms itself," (Pedlar, et.al., 1991:1), alternatively it may be defined as an organisation, "learning to learn," (Swieringa and Wierdsma, 1992:xvii). In practice it is more difficult to pin down exactly what a learning organisation is. Pedlar et.al., (1991) provide 101 'glimpses' of the learning company, each give an example of the different ways to engage the individual and the organisation in a learning situation. The learning organisation is about learning from acting, action alone is not enough (Pedlar, et.al., 1991). Action in a learning organisation has two purposes, the first is to resolve immediate problems and the second, is to learn from that process. In the LMFTs project, the use of participatory methods and problem solving approaches to generate self and organisational learning formed the key components of an OD change strategy that aimed to assist the development of a learning organisation within Practices in PHC.

The next section will examine the foundations and key constituents of an OD change strategy that are relevant to the understanding, and analysis of, the LMFTs project. The other perspectives on organisational change, e.g. structural or system theories etc., will not be examined unless an aspect is directly relevant to the LMFTs project.

## 2.3 ORGANISATIONAL DEVELOPMENT CHANGE STRATEGY RELEVANT TO THE LMFTs PROJECT

The design of the LMFTs project, as laid down by the founder, offered a long-range change strategy and promoted two modes of intervention: problem solving and fostering personal growth. This was thought, by the founder, to be the best way to produce organisational change in Practices. The LMFTs model for change was developed during stages one and two of the Liverpool Primary Health Care Facilitation Project and the participants in the LMFTs project (stage three) were not involved its development. The LMFTs project was a normative-reeducative OD change strategy that implemented an intervention programme which concentrated on the people working within PHCTs.

## 2.31 Foundations Of Organisation Development

The concept of OD does not appear to have a single philosophy or one theory or definition. The concept, considered to be in its infancy, became prominent in the 1950s and is still being nurtured towards a fuller maturity. It is an evolving collection of concepts and techniques that aim to improve the performance of an organisation by intervening in its social systems (Schein and Beckhard, 1991). There does, however, appear to be one distinct emerging thread whatever the OD design, which is the purpose of improving human effectiveness within an organisational context. An effectiveness that is to be reached by the efforts of more than one person achieving a commonly agreed goal, in a cost effective and humanly sound way within the organisational setting (Blake and Mouton, 1988). Thus, the notion of OD may be said to rest on humanist principles and, in particular, the aspect of being optimistic about human possibilities and enthusiastic about human achievement.

An OD change strategy is concerned with helping people change their circumstances and helping them learn how to become more self-directed and self actualised. Iles and Auluck describe it as being,

> "characterised by its emphasis on process rather than task, by its focus on human and social relationships, by its use of an action research model and by its emphasis on collaboration and participation of organisational members in the diagnosing, planning, implementing and evaluating change efforts," (1990:50).

In its broadest sense an OD change strategy can include any organisational change effort that is designed to improve organisational effectiveness. In practice, however, it tends to refer more especially to efforts that intend to improve processes and culture in an organisation (Marguiles and Dundon, 1987; Boss, 1989; Spurgeon and Barwell, 1991). Thus, an OD change strategy is a long-range strategy that focuses on an organisation's problem solving and renewal processes in the effort to achieve more collaborative management of the organisational culture (French and Bell, 1973).

The OD change strategies are primarily based on psycho-social knowledge and inter-disciplinary socio-technical systems theories (Bennis, et.al., 1976; Legge, 1984; Chisholm and Ziegenfuss, 1986; Mirvis, 1988). In brief, these are theories which, among other things, emphasise personal openness, group problem solving, participative management practice and optimising efficiency through effective work system designs. OD change strategies target either the organisation as a whole, a particular group of people, or the relationships between organisational groups. In the case of the

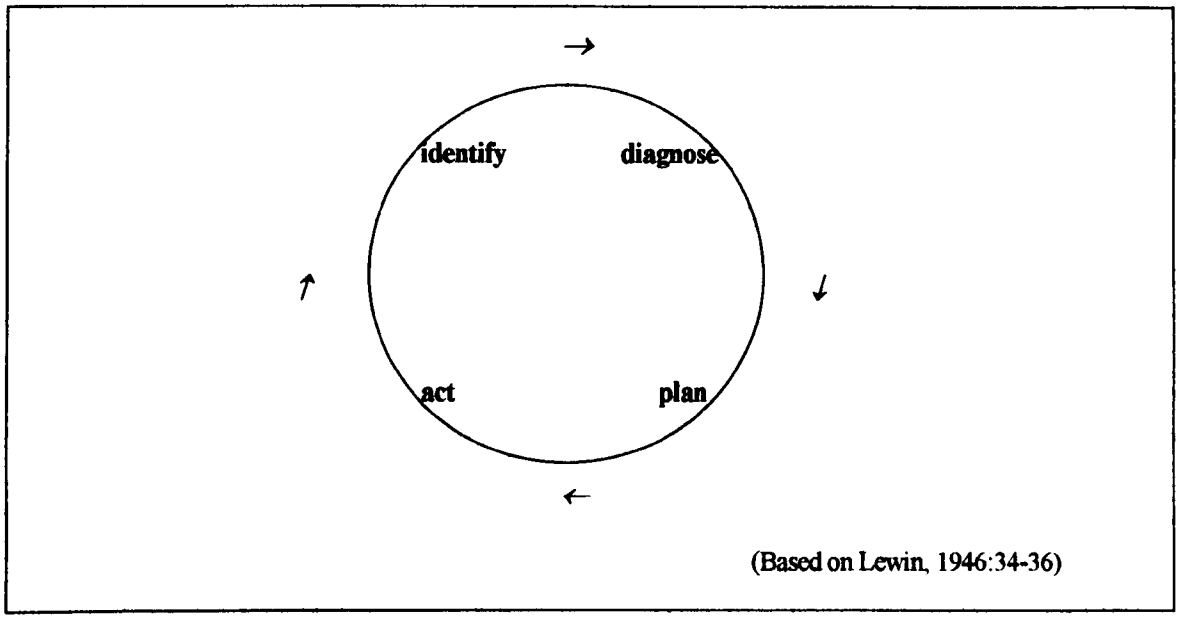
LMFTs project the PHCTs formed the target group. The concept of OD is founded on the idea that there is a direct relationship between people participating in the decision-making process and improving organisational production (Lewin, 1952). The whole process can be conceptualised as establishing a system of learning that becomes part of, and instrumental to, a process of organisational change. Revans suggests that a learning system, "seeks the means of improvement from within, indeed, from [people undertaking] the common task," (1982:283). In this view, a system of learning is developed from the experience and practice of the those taking part. Revans (1982), however, also noted that learning often gets lost in a process of organisational change and postulated that this happened because of an emphasis on action rather than learning. This may be particularly relevant in the NHS where Turrell (1993) observed that maintaining the status quo of the organisation during a process of change was often preferred to exploring new ways of doing things. A key aspiration of the LMFTs project was that each PHCT would be able to establish its own system of learning as members sought to improve their own working practices. The problem solving approach used by the LMFTs as they implemented the intervention programme was specifically intended to promote a process of learning among PHCT members.

## 2.32 Organisation Development Change Strategies

The main model on which most OD change strategies are based is the action research model (Legge, 1984; Boss, 1989) (figure 10). The basis for learning in the action research model, and therefore implicit in OD change strategies, is through assisting individuals learn from their everyday experiences and actions (Lewin, 1952). The OD designs at the macro organisational level are many and varied, and may focus on strategic planning, socio-technical systems, survey feedback methods or the use of the managerial 'Grid' model (Cummings, 1986; Pettigrew, et.al, 1992; Blake and Mouton, 1994). The designs at the micro or group level also vary widely and include process consultation, conflict management, team building, survey feedback, education and training, third party facilitation, coaching and counselling, and goal setting models to name just a few (Brill and Pierskalla, 1982; Spurgeon and Barwell, 1991; Pedlar, et.al., 1991).

**Figure 10**

**Action Research Cycle**




An OD change strategy is usually managed from the top and implemented by either an external or internal change agent who uses one or several of the above approaches, in sequence or in parallel. The purpose is to improve the efficiency and effectiveness of individuals, groups and intergroup processes. This is intended to strengthen their personal and interpersonal qualities and as a result raise the competence of the total organisation (Beckhard, 1969; Bennis, et.al., 1976; Blake and Mouton, 1988). In the LMFTs project, the LMFTs were expected to establish a process of action research through using the problem solving approach within PHCTs in such a way that it generated a self-sustaining system of action learning between the members. It was hoped that the LMFTs would be able to utilise the four stages of the action research cycle (figure 10) to enable PHCT members to learn for themselves how to develop their clinical and organisational activities in PHC.

## 2.33 Mode Of Intervention

The focus of OD change strategies is on the people in the organisation. The general aim is to develop, and subsequently take advantage of, the full potential of the human system in order to help achieve the organisational goals. Change approaches with this underlying philosophy fall into the normative-reeducative group of strategies referred to earlier (Bennis et.al., 1976) (figure 9). Here, the emphasis is on individuals participating in their own re-education. This is achieved via two

distinct modes of intervention: the first focuses on improving the problem solving capacity of a human system; and the second concentrates on releasing and fostering growth in the persons within the system to be changed (Chin and Benne, 1976). Although the two modes are distinct in their intentions they are both underpinned by similar general objectives, these are as follows,

to:

- build trust among people across the whole organisation (and thus dissolving hierarchical barriers);
- foster a climate in which problems are confronted and differences among people are exposed and clarified (as opposed to conflict avoidance activities);
- bring decision-making and problem solving activities as near as possible to the source of information and relevant resources (rather than being the domain of top management);
- increase members sense of ownership of, and commitment to, the organisational goals (involving members and management in the formulation of organisational goals rather than management alone);
- encourage collaborative activities and 'open competition for resources' (avoiding the destructive consequences of subversive rivalry and benefiting from activities produced by open competition);
- increase knowledge of group process, leadership styles and struggles, conflict resolution, communication, and of how poor working relationships reduce morale and adversely affects work performance (based on Sherwood, 1971; Buchanan and Boddy, 1992).

These objectives aim to simultaneously address the needs of the organisation and the individual. The 'process factors' outlined in the objectives above indicate the type of activities that the LMFTs in this project, and other change agents pursuing this mode of intervention, become involved in developing within an organisational setting.

In these normative-reeducative change strategies, organisational change cannot be achieved without an effective use of power, and empowering the individual is an underlying theme of the interventions (Bennis, et.al., 1976; Boss, 1989; Handy, 1993). The interventions aim, through the process of resolving problems, to help people understand what power they possess and how they may use it to maximise control of their own environment. The interventions seek to enable those who are in a disabling '*power over*' position to have the '*power to*' make a difference to their situation (French, 1994). The intention is to help people expand their choices, gain skills in negotiation and decision making, and create win-win situations in which they can grow and become more successful at the same time as realising the goals of the organisation (Boss, 1989). A key part in these types of OD change strategies is to avoid the disruptive effects inherent in the use of fear, threat, pressure and leverage, and to defeat the misuses of power and coercive effects of conformity that promote

traditional norms which stand in the way of change (Blake and Mouton, 1988). In this view, it is the misuse of power and the coercive effects of conformity that pose the two major barriers to achieving organisational change. These change strategies use a process approach to find constructive ways of utilising power and authority. This may be achieved by operating a parallel learning structure, or by finding ways to alter or by-pass the norms and standards that can adversely affect the effort to achieve change (Kanter, 1985; Bushe and Shani, 1991; West, 1994). In addition, it is suggested that change agents adopt participative styles of leadership and modes of intervention in support of a normative-reeducative type of change strategy (Tsjovold, 1987; West and Farr, 1989; Bernhard and Walsh, 1995). The LMFTs, following a normative-reeducative mode of intervention, could be perceived as a parallel learning structure that operated alongside the more formal organisational mechanisms of the LHA (Bushe and Shani, 1991) as they attempted to foster a process of personal growth and re-education between PHCT members.

## 2.34 Process Of Intervention

The process of OD change strategies, irrespective of size, tend to follow a similar pattern of activity. Each OD design usually involves the processes of diagnosis, planning, intervention and evaluation to measure the success of the intervention. The design of the LMFTs project included the implementation of these four processes within Practices in PHC. These four processes form the key elements of Lewin's (1952) action research model which explicitly underpins all organisational and community development strategies and, less obviously, some of the other change strategies where there is, in some form or other, participative modes of intervention (Legge, 1984; Hope and Timmel, 1984; Spurgeon and Barwell, 1991).

In the use of this model it is anticipated that the processes of research, training and action will become interrelated within a collaborative working relationship in which those involved work out for themselves the solution to their problems (Lewin, 1952). The model prescribes a set sequence of events that involves (1) planning, (2) acting, (3) observing and (4) reflecting in an iterative cycle (figure 10). Events or processes 1 to 4 represent one complete cycle of the action research process, several of which may be repeated during the implementation phase until the problems are resolved. The activities undertaken in each of the different phases of the action research cycle are evaluated to inform actions in the subsequent phase. The process forms an iterative spiral of action and reflection-on-action (Boss, 1989). The action research model is designed to provide immediate

feedback of progress to those involved in resolving their problems, and participants are expected to learn from their dialogical and dialectical interchange with each other as they move through each cycle of events.

Key to this process is the view of human change as a psychological dynamic process that progresses through three phases: unfreezing, changing and refreezing (Lewin, 1952; Schein, 1996) (table 4). Stability in human behaviour is considered to be the result of balancing the constraining and resisting the social forces within the organisation. It is this 'balance' that is said to establish a 'quasi-stationary equilibrium' within an organisation's social field. Lewin argues that to change a social field, "one has to consider the total social field: the groups and subgroups involved, their relations, their value systems etc. The constellation of the social field as a whole has to be studied and so re-organised that social events flow differently," (1952:224). In this view, the organisation is conceived as a 'field of social forces' in which changes in the organisational social system may be brought about by interventions that target the people within the organisation and thus, destabilise the balance of forces in the system as a whole. Following such interventions the organisation is expected to make a qualitative shift or capital-C Change as a result of an accumulation of many small-c changes.

**Table 4**

**Three Phases Of The Psychological Dynamic Process of Human Change**

| | | |
|---|---|---|
| 1. | **unfreezing** | involves the process of an individual unlearning: disconfirming their previous expectations or hopes without suffering any loss of identity; |
| 2. | **changing** | moving from old cognitive views, going through the difficulty of relearning in the attempt to redefine their cognitive definitions - their thoughts, perceptions feelings and attitudes, in such a way that they achieve congruence with their own personality and with the behaviour of the rest of their social field; |
| 3. | **refreezing** | the new cognitive definitions become permanent once congruency is achieved and the person is able to live harmoniously with the newly acquired convictions and with the rest of his or her personal social world. |

(Based on Lewin, 1952; Schein, 1996)

The process of intervention described above is a popular approach and often used in local level interventions in the NHS and PHC where efforts are directed towards improving teams, teamwork and task achievement (Waddington, 1994; Dolby, 1995; Bryar and Bytheway, 1996; Bond, 1997; Pearson, and Spencer, 1997). Indeed, it was experience with this type of intervention in the earlier

stages of the Liverpool PHC facilitation project, that led the founder to adopt a problem solving approach and aim for small-c changes as the basis for promoting learning among health professionals and thus, the development of their own PHCTs within the local PHC setting.

## 2.35 Development of Teams In General

Team building is the term most often used to describe the various ways of assisting the development of a team and teamwork. Liebowitz and De Meuse describe team building as,

> "a long term, data-based intervention in which intact work groups experientially learn, by examining their structures, purposes, norms, values, skills for effective teamwork. It is a direct attempt to assist the group in becoming more adept at identifying, diagnosing and solving its own problems, usually with the aid of a behavioural science consultant,"(1982:1).

The frameworks for team development interventions, in business and health care sectors, are most usually based on a problem solving approach and commonly involve engaging a consultant (an external change agent) to facilitate a pre-determined plan for change. A team, the nature of which is discussed in section 2.41, usually becomes involved at the implementation stage when a prescribed solution is ready for application to an organisation's technical problems.

The implementation process tends to follow either a rational-linear or participative model (Bennis, et.al, 1976; Spurgeon and Barwell, 1991). In the rational-linear models the task is of prime importance. A change agent is concerned with instructing, controlling and monitoring progress towards task completion. The development of the team and effective teamwork rely on the processes involved in achieving task effectiveness. In the participative models, a change agent's focus is on building effective team relationships through using their interpersonal and social skills to improve a team's collective performance and innovativeness (Torrington, et.al., 1989). In yet other team development interventions a change agent takes an even broader perspective and harnesses the political elements in the setting to support the process of change. In these latter interventions a change agent deploys his or her interpersonal and social skills to create mechanisms, e.g. informal support networks, to support the change process and block interference which impedes its progress (Buchanan and Boddy, 1992). The LMFTs were expected to use a combination of these three different ways of developing effective teams.

The various different methods of intervention used in planned change are categorised by Blake and Mouton (1976) as: prescriptive; use of principles, models and theories; acceptant; catalytic; and confrontational. Of these acceptant, catalytic or confrontational are the most commonly used interventions in OD change strategies. The catalytic intervention method, commonly called team-building, is the most popularly applied behavioural science model. The 'catalytic' team-building methods may be defined according to the focus of intervention. Those most commonly used are: goal setting (Locke, et.al., 1982); interpersonal model, (Kaplan, 1979); role model (Bennis, 1966) and the problem solving approach (Buller and Bell, 1986). The focus is on improving the interpersonal relations in the group. The change agent uses different techniques, drawing on counselling models, to help people deal with the emotional tensions and feelings that exist either in the individual, in a group or between one or more groups. In catalytic intervention methods the change agent aims to provide an alternative view of a situation to facilitate group interactions that will generate, for the team, a better understanding of their problems. Blake and Mouton (1976) although in favour of using principles, theories and models as the theoretically most comprehensive approach conclude that there is not one best way to intervene. They suggest that each situation needs to be assessed and receive intervention(s) according to its requirements. In addition they, together with other authors, suggest that often preliminary ground work may be needed, e.g. first reducing emotional blockages and revealing hidden tensions, in order to create the necessary 'readiness to change' among those involved in an organisational change process (Blake and Mouton, 1976; Prochaska and Di Clemente, 1982; Kanter, 1985; Pettigrew, et.al., 1992). The LMFTs were expected to assess the needs of the PHCTs involved and use the intervention model that was most appropriate.

The literature on team development interventions provides a contradictory picture of their success. The majority take place in industry and make comparisons of teams of individuals with similar occupations and backgrounds (Poulton and West, 1993). In Sundstrom's et.al., (1990) review of thirteen studies, practitioners used any of the above four models in various combinations with a mixed level of success. A positive outcome was perceived in nine of the studies. In four of the nine studies, team performance was improved and in eight of the nine studies that used an 'interpersonal model' team viability increased. The remaining studies, however, reported some adverse effects, e.g. a study of a cafeteria service team that used a combination of problem solving and interpersonal models demonstrated little improvement in costs, output or profit and, furthermore, a greatly decreased sense of job satisfaction and commitment (Porras and Wilkins, 1980). These authors,

along with several others, argued that there was still little evidence available to confirm that teambuilding is an effective team development intervention (Porras and Berg, 1978; DeMeuse and Liebowitz, 1981; West, 1994).

In PHC the evidence of successful teamwork was limited but has suggested there were some positive responses to multidisciplinary teamwork (West and Poulton, 1997). In brief, teamworking in PHC was reported to have improved: job satisfaction and interprofessional relationships (Peiro, et.al., 1992); commitment to, and participation in, collaborative activity (West and Wallace, 1991); and service delivery (Adorian, et.al., 1990; Wood, et.al., 1994). The PHCT workshop strategy (Spratley, 1989,1990) has provided the exemplar for current team development interventions. In the team-workshops, which predominantly used a problem solving approach, the PHCTs generally managed to create a coherent basis for working together. However, despite these positive views, there was considerable evidence of problems of working in teams in PHC (McClure, 1984; Bond, et.al., 1985; Iles and Auluck, 1990; Cant and Killoran, 1993; Armstrong, et.al., 1994; Wiles and Robison, 1994; West and Field, 1995). In these studies, the problems of working in teams chiefly rested on the way team members related to each other and the way teamwork was organised. The issues were best summed up by West and Field (1995) who reported that PHCTs failed to set aside time for regular meetings to define objectives, clarify roles, apportion tasks, encourage participation and handle change. Other reasons for poor teamwork were cited as the difference in status, power, educational background, assertiveness of members of the team, the assumption that the GPs would be leaders, and the lack of preparation or support for GPs to take on the responsibility of managing their Practices.

In a more recent study of PHCTs West and Poulton (1997) have shown that teamworking continues to be problematic. In their study, the PHCTs differed significantly from other health service teams in that they demonstrated markedly lower levels of participation, support for innovation and less clarity of, and commitment to, objectives. They also showed much lower levels of task orientation than the community mental health and social service teams. In addition, the PHCTs demonstrated no relationship between team structure and team effectiveness and a negative correlation between participation and size. Their interactions and co-operation between each other decreased once PHCT membership increased to 14 or more members in a team. West and Poulton (1997) concluded that the most powerful predictors of PHCT effectiveness were the team process factors, e.g. group interactions, norms, goals and cohesion. These same authors also noted that the clarity of

objectives were found to be the best predictors of the PHCTs' effectiveness in terms of task design, team viability and organisational efficiency. As a result of their work West and Poulton (1997) made two recommendations: firstly, that team development interventions should focus on developing PHCT objectives and criteria that aimed to improve teamwork and team effectiveness; and secondly that, these criteria should be used to help PHCTs determine and evaluate their own level of team effectiveness. In West's (1994: xii) view there were three critical components of team effectiveness:

1. task effectiveness - the extent to which a team is successful in achieving its task-related objectives;
2. mental health - refers to the well-being, growth and development of team members;
3. team viability - the probability that a team will continue to work together and function effectively.

West (1996) considered the achievement of these were influenced by a team's social and task reflexivity, i.e. the extent to which a team is able to reflect and modify its objectives, processes, task and social support strategies appropriately in changing circumstances. Subsequently, West and Poulton (1997) have explored and developed these three components to create a guideline for improving team effectiveness in PHCTs, see table 5.

**Table 5**

**West And Poulton's Guidelines For Improving PHCT Effectiveness**

- teams should have intrinsically interesting tasks to perform to generate interest, commitment, motivation and challenge the group.
- individuals should feel important to the fate of the group. Social loafing * is probable where individuals feel they are dispensable. A clear idea of everyone's role and anticipated function and individual objectives gives a clear indication of responsibility that the individual and the others can see.
- individuals should have intrinsically interesting tasks to perform. In the same way as the group requires a positive boost to interest, commit, motivate and challenge them so does the individual.
- individual contributions should be identifiable, specific, unique, indispensable and evaluated against a standard. This aims to reduce the effects of social loafing by helping a person to perceive her work as indispensable to the team's performance.
- clear team goals should be established with in-built accurate performance feedback to promote performance of the team.

* Social loafing is when individual performance is diminished as a result of individual contributions becoming anonymised through belonging to a large group

(Based on West and Poulton, 1997:21-22)

Thus, effective teamwork in PHC may, therefore, be said to rest on developing a PHCT's ability to be reflexive with regard to both its task activities and social processes. PHCTs are, however, subject to organising structures that militate against the development of teamwork, and many

interprofessional influences that make it difficult for the team to be effective. Although there was limited research data, there were many descriptive accounts, often without any systematic form of evaluation, of teambulding interventions. These accounts provided considerable evidence of the problems of developing effective teamwork in PHC, and thus gave an indication of the type of problems the LMFTs were likely to encounter as they implemented their intervention programme. These will be discussed next.

## 2.4 DEVELOPMENT OF TEAMS AND TEAMWORK IN PRIMARY HEALTH CARE

The problems of developing effective teamwork in PHC are examined, in this next section, in terms of the constraints found within the environment of PHC, and in terms of the problems of developing teams, teamwork and collaborative activities within PHCTs. While there is a long tradition of research into working in teams in organisations there was little on teamworking in PHC and, additionally, little to suggest organisational group psychology was being used in the development of PHCTs (Poulton and West, 1993). More recently, however, the interprofessional agenda and the strong interest in developing interprofessional education and practice in Britain has begun to change this as theorists, educators, researchers and practitioners have started to explore the conceptual and practical aspects of interprofessional collaboration (Soothill, et.al., 1995; Owens, et.al., 1995; Ovretveit, 1997; Hughes and Lucas, 1997; Barr, 1998; Hammick, 1998). Despite these recent developments there remains, to date, sparse evidence in the literature to suggest that teamwork and collaborative activities exists in anything other than name only, as Saks remarked,

> "one of the most significant aspects in this respect [interprofessional development] ..., is how far health and welfare professions will seek to expand their own professional territory in future rather than embrace an interprofessional agenda," (1998:194).

In Saks' (1998) quote the root of the environmental constraints is identified and thus where some of the influences and the problems of working in teams may come from. Before exploring these in detail, a working definition is made of teams, teamwork and collaborative activity.

### 2.41 What Is A Team, Teamwork And Collaborative Activity?

**Teams.** The characteristics of PHCTs are only to a certain extent comparable with a conventional team described in the organisational psychology literature. A conventional team is described as

possessing a specific identity and designated a particular function that contributes to the achievement of the organisational goals (West and Poulton, 1997). Teams are characterised by having shared work objectives and a need for mutual interaction to achieve the objectives. Each member in a team fulfils a unique role in a group the size of which is small enough to work without developing vertical or horizontal hierarchies (Belbin, 1981; Guzzo and Shea, 1992; West, 1996). Teams appear in different forms e.g. project teams, task forces, multidisciplinary groups, research and development groups, training groups, cross-functional groups to name a few. These may be temporary, disbanding on completion of a specific project as in a task force; or permanent, operating as a constant group working closely together (Belbin, 1981; Kanter, 1985; Hackman, 1990). The use of a team is seen as providing an opportunity to generate creativity and innovation for problem-solving by side-stepping the hierarchical constraints and normative social frameworks of the formal organisation (Kanter, 1985; Stacey, 1995). PHCTs possess many of the characteristics given in this outline. They differ, however, in that they include a multiprofessional membership, have multiple lines of accountability, are often unclear as to their objectives and role definition and, on the whole, are a more fluid and dynamic entity than is described here (Hey, et.al., 1996).

**Teamwork.** The concept of teamwork is generally problematic and perhaps more so in PHC given the multidimensional nature of delivering health care (Taylor, 1991; Rye, 1996). Conventionally the study of working relationships in organisations is examined from structuralist and functionalist perspectives (Bruce, 1980) wherein the concept of teamwork refers to members of a team having common goals to aim for (Bond, et.al., 1985). In these perspectives teams and teamwork are conceived in terms of the tasks they undertake and the product they achieve rather than by the processes in which they engage. This approach is exemplified by Gilmore et.al.,'s (1974) description of the characteristics of teamwork that occur most frequently in health care settings: "

1. That the members of a team share a common purpose which binds them together and guides their actions.
2. That each member of the team has a clear understanding of his own functions, appreciates and understands the contribution of the other professions represented on the team and recognises commonness of interest and skill.
3. That the team does the practising by pooling knowledge, skills and resources and that all members share responsibility for the total outcome of their decisions.
4. That the effectiveness of the team is related both to its capabilities to carry out its work and its abilities to manage itself as an independent group of people." (1974:238-243).

**Collaborative Activity.** Teamwork in PHC is a difficult concept to master and measure given the multi-organisational and multiprofessional nature of the setting (Bond, et.al., 1985). Bruce (1980) points out that as 'teamwork' is difficult to measure in PHC, professional collaboration is potentially easier. The concept of collaboration takes a wider view of joint working relationships. It includes two complementary and interrelated elements,

> "that of joint working and that of a relationship which engenders creativity among the collaborators," (Bond, 1985:13).

The development of a process of collaboration requires a willingness on the part of participants to interact and co-operate with each other in a joint decision making process and, additionally, a working environment that is conducive to such activities (Davidson, 1976; Bond, et.al., 1985). Bruce (1980) suggests that there are three critical variables essential for collaboration to occur: physical proximity, social proximity and positive motivation. A necessary condition of collaboration is interaction. This manifests itself in several different forms for which both Armitage (1983) and Davidson (1976) propose classification schemes that they developed from studies of joint working in PHC. Armitage (1983) focuses on interaction at the level of individuals and suggests that collaboration may be distinguished as one of five stages of collaboration, see table 6.

**Table 6**

**Armitage's Taxonomy Of Collaboration**

| Stages of Collaboration | Definitions |
|---|---|
| 1. **Isolation** | Members who never meet, talk or write to one another. |
| 2. **Encounter** | Members who encounter or correspond with others but do not interact meaningfully. |
| **Communication** | Members whose encounters or correspondence include the transference of information. |
| 3. **Collaboration between two agents** | Members who act on that information sympathetically; participate in patterns of joint working; subscribe to the same general objectives as others on a one to one basis in the same organisation. |
| 4. **Collaboration throughout an organisation** | Organisations in which the work of all members is fully integrated. |

(Based on Armitage, 1983:77)

Davidson (1976), on the other hand, examined the interactions of people in and between groups in the primary care sector and classified these as interorganisational relationships. In Davidson's (1976) typology there are five different types of interorganisational relationships, see table 7. This

classification may be conceptualised as an extension of Armitage's individual taxonomy and thus, creating a ladder of development along which individuals and groups may progress or regress in terms of collaborative activity.

**Table 7**

**Davidson's Typology Of Interorganisational Relationships**

| Typology | Definitions |
|---|---|
| 1. **Communication / Consultation** | when talking together means sharing information, ideas, feelings about the shape of their shared world; |
| 2. **Co-operation** | when communication leads to the suggestion of organisations working together on some small project; |
| 3. **Confederation** | when arrangements become more formalised and tasks clearly limited and defined. The situation is still loose without formal sanctions for non-participation; |
| 4. **Federation** | when organisations are willing to define goals and tasks precisely and create a formal structure to carry them out, yielding some of their autonomy to the joint structure; |
| 5. **Merger** | when the structure is formalised to the point that original organisations are willing to give up their identity as organisations with respect to the specific domain(s) in which co-operation occurred, to form a new organisation. |

(Based on Davidson, 1976:120)

In each of these models collaboration is conceptualised as a dynamic and interactive process. Additionally there is the notion of accommodation, i.e. participants find a middle ground, a consensus, on which to base agreement or action. In collaboration it is necessary, therefore, for participants to enter into an informal process of mutual adjustment with each other if they are to achieve co-operative relationships (Mintzberg, 1979). Ordinarily decision making commonly occurs through the enforced decision of a key person with superior authority (Leavitt, 1951; Mintzberg, 1979). In terms of the network theory approach an organisation may be conceptualised as a set of power relations that influence individual and organisational actions (Benson, 1975; Nohria and Eccles, 1992). There is a core-periphery relationship within an organisational network which is comprised of a set of strong and weak relational ties (Granovetter, 1973), and particular cognitive and structural orientations flowing through them that induce people or organisations to act (Heimer, 1992; Stacey, 1995). Individual power is a highly influential factor whether, actual or perceived, and the way it is distributed exerts a pressure on the people in the network to move in a particular direction (Kapferer, 1969; Galaskiewicz and Shatin, 1981; Brass and Burkhardt, 1992; Krackhardt,

1992). The use of such central authority in teamworking and collaboration threatens the premise on which such activities are founded and is, therefore, likely to destroy democracy and the potential for co-operative or collaborative relationships.

It is the process of mutual adjustment that is suggested as a means by which some of the control in decision making can come to rest in the hands of the participants involved (Lindblom, 1968; Mintzberg, 1979; Lindblom and Woodhouse, 1993). Lindblom (1968) identifies a number of methods for achieving mutual adjustment, these include mutual persuasion, using a partisan analysis of the issues or through the exchange of threats or promises. Other methods include creating and discharging obligations, indirect mutual adjustment through third persons and adaptive adjustment involving an adaption, perhaps only partial, of one member to the other. Negotiation is said to occur when two or more people,

> "enter an explicit negotiation [*sic*] with each other in order to reach an explicit basis for operation," (1968:94).

In terms of the exchange theory approach, negotiation involves costs and benefits for each person and organisation involved, the probable results of which are weighed before a final agreement is reached (Benson, 1975; Hindmoor, 1998). In the PHC setting, in this study, the LHA and the PHCTs may be perceived as being interlocked within an exchange process where a trade off of costs and benefits occur as part of the process of developing a more efficient and effective PHC system. The LMFTs, perceived as an instrument of this process of development, were expected to, in addition to the teambuilding processes, find ways, e.g. developing informal support networks, through which to enable the process of mutual adjustment to take place. Thus, they were to help the PHCTs involved in the LMFT project balance their costs and benefits within the LHA led development process and, as a consequence of achieving mutual adjustment, overcome some of their environmental constraints and problems of working in teams.

## 2.42 Environmental Constraints On Team Development In PHC

The obstacles to developing effective teamwork in health care settings were said to emanate from the special nature of managerial and organisational problems that occurred in the large health care systems (Beckhard, 1974; Weisbord, 1976; Luke and Boss, 1981; Pasmore, et.al., 1986). These authors, who focused on the US health system, described the obstacles as the political and cultural constraints that emerged from within the context of the health care setting. These were constraints

that were not found within business or industrial organisations and were thought to be due to the service, as opposed to business, orientation of the health care sector (Tichy, 1985).

Iles and Auluck reported similar difficulties in the UK health care system, which they described as being due to,

> "the multiple power levels and reporting lines in health as compared to industry, its professional as opposed to managerial orientations, its need for multidisciplinary working teams, and the different goals and priorities" (1990:51).

In PHC, in particular, these were difficulties that were likely to manifest as power struggles over roles and boundaries in and between the different medical, nursing and administration groups (Kilcoyne and Peitroni, 1996).

The system of PHC comprises staff from a diverse range of disciplines who were frequently described as a team. Members were, however, often based at different locations, held different views on health care provision, possessed different lines of accountability and met infrequently as a whole team (Pearson, 1994; Ovretveit, 1996). The team approach has been widely advocated for many years now but as yet there is little evidence to suggest that teams were successfully integrating their activities to provide a comprehensive PHC service (Bond, et.al., 1985; DHSS 1986; Poulton and West, 1993; Pearson and Spencer, 1995; Long, 1996). Poulton and West have suggested that,

> "to some extent, the separate development of the different professional groups and the history of the PHCT provide an understanding of why barriers to PHC teamwork exist," (1993:919).

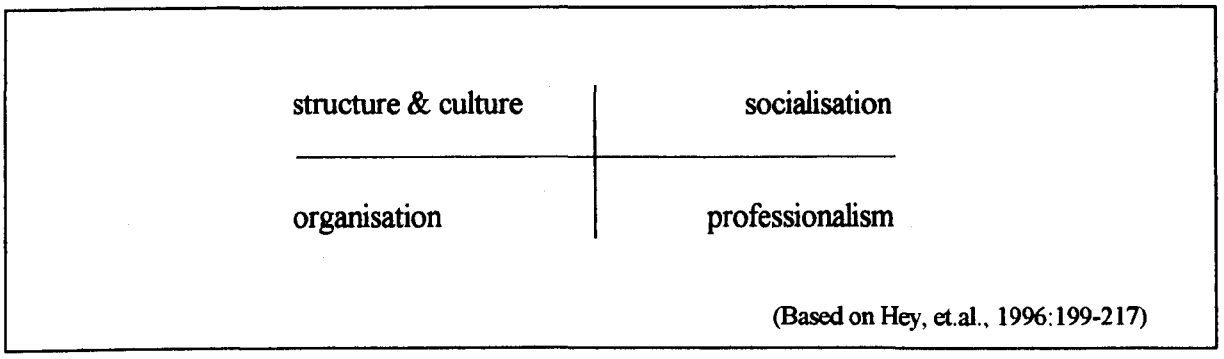
Similarly, Kilcoyne and Pietroni (1996) have asserted that the struggle to develop effective teamwork in PHC appears to be constrained by the historical, political, professional and socio-cultural development of the various different services.

Historically each profession in the NHS developed separately to emerge with specifically defined roles and carefully devised boundaries that protected their own professional livelihood (Bond, et.al., 1985; Taylor, 1991). Consequently, each health worker is oriented differently in the way he or she relates to the patient or client, and to each other. In the early 1990's, the introduction of general management, market principles and the emphasis on health promotion and disease prevention (DHSS, 1983; Secretaries of State for Social Services, 1987 and 1989; DOH, 1990a; DOH, 1990b; Secretary of State for Health, 1992) has led to a significant increase in tension between different

PHC workers as each struggle to maintain professional survival amidst the restructuring of roles, boundaries and functions of professional practice (Wiles and Robison, 1994; Rye, 1996). The impact of the NHS reforms on the PHCTs, and therefore the environmental constraints that emerge, may be understood by considering the way the changes threaten a professional's role. The change may be perceived as a personal loss despite increasing the potential for achieving service development gains. To explain how these sentiments constrain the development of effective teamwork, PHC can be conceptualised as consisting of four dimensions: structure and culture, socialisation, professionalism and organisation (figure 11), (Pietroni and Pietroni, 1996; Hey, et.al., 1996). The influence each dimension exerts upon a professional's capacity for working together is discussed in turn. This is an arbitrary division to ease the discussion, in reality all four dimensions are interdependent and interrelated.

**Figure 11**

**Four Dimensions Of A Primary Health Care System**




(Based on Hey, et.al., 1996:199-217)

### 2.42.1 Structure And Culture

The structural divides in PHC contribute to a continuation of the already well-developed notion of separateness among the different health care professionals. The structure and culture of PHC is formed by the various different groups of lay and health workers who contribute to the provision of health care services. Each originating discipline is shaped by its own particular frame of reference. A 'specific occupational consciousness' develops as a result of a group of like-minded health professionals working in regular close association and sharing common experiences and sentiments (Huntington, 1981). This is a process of orientation which begins when members join a profession and absorb its particular organisational practices and attitudes. The extent to which members become aware of the aspects they absorb and how this influences their work and work relationships

varies, some practices and attitudes are more obvious to detect than others even for those mindful of their occupational consciousness (Huntington, 1981; Hey, et.al., 1996). The implications are that professionals, as a result of their specific occupational consciousness, will advance their own self interests at the expense of developing effective teamwork within PHCTs.

The NHS reforms in the early 1990's resulted in a reconfiguration of relationships among members of the PHCT. The GPs were expected to achieve specific levels of efficiency and effectiveness by meeting pre-set targets for health promotion and disease prevention activities, and community nurses and health visitors were expected to work with the doctors and contribute towards meeting their objectives. The thrust of managerial objectives were clear, if unwelcome, for GPs who feared a loss of their autonomy (Pringle, 1992a; Williams, et.al., 1993; Connolly, 1995). The GPs were encouraged to expand their range of services, improve their systems of administration and wherever possible form group medical practices. Receptionists and secretaries were expected to operate the new administrative systems for the GPs and, the practice nurses were expected to expand their role and undertake health promotion and disease prevention activities within general medical practice (Secretaries of State for Social Services, 1989; DOH, 1990; Secretary of State for Health, 1992). The community nurses and health visitors similarly perceived their role as threatened. They felt their role was endangered in three different ways, first by the lack of specificity despite recognition of their health promotion role in 'Promoting Better Health' (Secretaries of State for Social Services, 1987) secondly, by the emphasis on a GP-led model and third, by the proposed extensions of the practice nurse role (Connolly, 1995). Thus, the gains to general medical practice were perceived as losses for district nurses and health visitors. They expressed considerable resentment on what they saw as an erosion of their role by practice nurses who they considered to be less well trained than themselves (Portykus, 1991; Traynor and Wade, 1992).

The NHS reforms of the early 1990's reconfigured the pattern of relationships among staff in PHC and disrupted the traditional boundaries of clinical practice without making any formal unification between community health services, general medical services and acute health services (Kilcoyne and Pietroni, 1996). The retention of separate organisational structures continued to divide the care of the whole person between three different health service areas. This tripartite structure has contributed to major problems of organisational, political and socio-cultural dimensions in the development of interprofessional and interagency collaboration as endorsed by government policy 'Promoting Better Health,' (Secretaries of State for Social Services, 1987), which has been

demonstrated in studies on joint planning and action (Delaney, 1994; Costongs and Springett, 1997). Thus, the separate organisational structures has compounded the difficulty of establishing an integrated approach to delivering health care services within PHC.

### 2.42.2 Socialisation

The process of socialisation within each of the health professions makes it difficult for individual health workers to cross their professional boundaries and develop effective teamwork. The NHS reforms of the early 1990's meant PHC professionals were experiencing a blurring of their role boundaries. This was threatening both the meaning and purpose of their clinical practice. The formerly distinct boundaries of professional practice were being forced to accommodate the explanatory models of health from other disciplines. In PHC several explanatory models of health operate in parallel. In social work, for example, the explanatory model is based on counselling wherein participatory processes are used to assist clients find their own way forward, whereas doctors use a medical model of explanation in which patients consult them as experts who provide them with a definitive diagnosis (Hey, et.al., 1996).

In the process of socialisation health professionals experience their own view, "as obvious, as of central importance; indeed, as simply the way things are," (Robinson, 1978:20). It is in each professional's interest to hold onto their own frame of orientation in order for them to function. In the current acquisitive mode of society, their capacity to act depends on it and, in the final analysis, so does their sense of identity (Fromm, 1976). In situations where others provide ideas that question an individual's personal frame of reference, the reaction to those ideas will be as to a vital threat. It is this stance that makes it difficult for one professional to readily understand the view of another professional from a different discipline. This suggests that for one professional to appreciate the other's view they first have to become detached from their own standpoint and not invest their identity in their own role. And secondly, if teamwork and interdisciplinary collaboration are to develop, each professional needs to understand both their own discipline and become aware of the system of thinking of the other health professionals involved in the process.

### 2.42.3 Professionalism

Professionalism is the qualities and features of a profession that develop over time. It results in the creation of a professional doctrine and development of a particular world view for its membership. In PHC several different health care professions practice side by side and rarely combine their world views in collaborative activities (Thomas, 1994; Hey, et.al., 1996). Health professionals consider themselves guardians of their professional role and as such work to maintain the distinctions between the disciplines. The effect of the interaction of education, experience and culture on the different PHCT members has led to the development of very different world views, knowledge bases and practices among them (Munghan, 1975; Metcalfe, 1992; Hey, et.al., 1996). Each discipline now has an established framework for action, a particular professional style and a variety of interventions in keeping with its professional doctrine. Whilst this is necessary for maintaining professional integrity it impedes the development of teamwork and interdisciplinary collaboration. The approach a professional adopts for working with the client, customer or patient reflects the underlying ideology held by their particular profession. Hey et.al., (1996) have identified the different approaches as predominantly following one of four professional models: practical, expert, managerialist and reflective (table 8).

**Table 8**

**Four Different Professional Models In Practice**

| | |
|---|---|
| **Practical Professional** | **Practice** is informed by long experience and the use of common-sense.<br>**Competence** is built up through time as actual situations are dealt with and solutions found that result from trial and error.<br>**Decision making** partially involves the client. |
| **Expert Professional** | **Practice** is informed by 'long education' and the use of expertise.<br>**Competence** is presumed, expertise is claimed and deference looked for regardless of uncertainty.<br>**Decision making** does not involve the client. |
| **Managerialist Model** | **Practice** is informed by top level professional leaders, deference is expected.<br>**Competence** is presumed by reference to their views of what forms an effective intervention.<br>**Decision making** does not involve practitioners. Practitioners perform the tasks managers decided upon. |
| **Reflective Practitioner** | **Practice** is informed by views of the professional and others assumed to have important and relevant knowledge.<br>**Competence** is developed through using uncertainty as a source of learning.<br>**Decision making** is participatory. People work together to find a solution and reflective practitioners allow respect for their own expertise to emerge.<br><br>(Based on Schon, 1983:300; Hey et.al., 1996:202) |

In both the NHS and the business sector the expert and managerial model predominate (Allen and Lupton, 1988; Spurgeon and Barwell, 1991). The 'expert professional' model prevails within medicine and as a result leads other health professions to emulate a similar type of relationship with their own clients. The managerial model is in common use by managers and administrators in the NHS and by government policy makers and managers in the business sector. In both these models deference is shown to the person with expert knowledge who accordingly gains a high level of status and power and becomes a dominant person within the setting. Expert knowledge is held in high regard in the NHS which puts those gaining expertise through experience and practice at a disadvantage. Experience based knowledge is perceived as being less objective and thus of lesser value than scientific knowledge (Schon, 1983). The supremacy of the expert professional models and therefore experts, whether medical or managerial, is currently being challenged by the move to increase teamwork and collaborative activity (Schon, 1983). The models for developing teamwork and collaboration stem from a fundamentally different philosophy. In these models, as in the LMFTs project, participation and equality are promoted within a group decision making process and different forms of knowledge are acknowledged as having equal value in decision making (Schon, 1983; Spratley and Pietroni, 1996; Reason, 1996).

The participatory and reflective practitioner models are frequently used in counselling, community and organisation development. Examples from which provide illustrations of successful participatory activities within communities and with colleagues and clients (Argyris and Schon, 1978; Jones, 1983; Schon, 1987; Bruce, et.al., 1995; Hey, et.al., 1996). A participatory approach expects and respects another's contribution to a situation without any loss of one's own sense of self or identity, it reflects the principles of equality, participation and learning in action (Schon, 1987). Hey et.al., have noted that in these models practitioners were,

> "expected to select their responses having reflected about the situation as it unfolds, so no single set of rules for action is prescribed. It follows that education and training should emphasise the principles involved and encourage the use of reflection in order to understand how action is dependent upon, and continually modified by, the context and the meaning ascribed by other participants in the situation" (1996:202).

These two models represent an entirely different way of relating to clients and colleagues and way of knowing about the situation in hand. They have mainly been used by social workers, counsellors and some nursing specialists, e.g. hospice nurses working in health care. The participatory models are in

stark contrast with the dominant medical and managerial models that venerate expert knowledge. From the foregoing discussion it may, therefore, be concluded that the different orientation of the professional disciplines in PHC will militate against health workers spontaneously developing teamwork and collaborative activities.

### 2.42.4 Organisation

The delivery of PHC is recognised as being a multidimensional, multiprofessional, dynamic and interactive process (West and Wallace, 1991; Poulton and West; 1993; Pearson and Spencer, 1997). There are some aspects of the work that bring PHC staff together in a close working group and other parts which only require health workers to remain in touch without any close connections between each other. In the process of delivering health services Hey et.al., (1996) have identified three different types of organisational groups: genuine teams; larger working groups and case related teams (table 9) at work in PHC.

**Table 9**

**Different Organisational Groups Found In Health Service Delivery**

| | |
|---|---|
| **Genuine teams** | **Comprised** of small groups of people originating from different disciplines.<br>**Membership** of the group is largely constant.<br>**Activities** are characterised by having mutual patients, sharing common tasks and making face to face interactions. |
| **Larger working groups** | **Comprised** of a large group of people originating from different disciplines.<br>**Membership** alters according to requirements of the task in hand.<br>**Activities** are characterised by having mutual patients but ***not*** sharing common tasks.<br>As a group they pursue a wide range of tasks but may meet infrequently.<br>Different primary health care staff join in or drop out of the group surrounding any particular issue as and when their services become necessary or can be dispensed with. |
| **Case related teams** | **Comprised** of pairs or co-workers as sub-units of the larger group.<br>**Membership** is constant throughout the joint activity.<br>**Activities** are characterised by working together to pursue joint or co-work with a particular case, e.g. investigative or assessment work.<br>(Based on Hey, et.al., 1996:204) |

This was a conventional classification of organisational groups made according to the functional variations found within the PHCTs. The working groups found in PHC, however, possess a fluidity of formation as membership changes reflect a group's response to emergent issues. Different health workers join or leave a group according to whether their input is required. In development strategies

for PHC the ideal team is advocated as the 'genuine team' and a general practitioner put forward as the PHC team leader (Bond, et.al., 1985; Goodwin, 1995) for reasons identified above. Gilmore et.al., (1974) pointed out that teamwork and collaboration did not just happen but occurred as a result of conscious planning and effort among the individuals involved in the team. The implication was that simply advocating teamwork and collaborative activity in keeping with the various health policies was not enough. This suggests that LHA need to be proactive and help PHCTs to develop effective teams, teamwork and collaborative activity if the desired political and socio-cultural changes are to be accomplished.

### 2.42.5 Summary

To sum up, the environmental context of PHCTs creates a number of problematic issues for the development of PHCTs in general, and for the LMFTs project in particular. In outline, the constraints were identified as: the structures of bureaucracy, hierarchy and power (Campbell-Heider and Pollock, 1987; Pettigrew, et.al., 1992); the confines of professionalism and socialisation (Beddome, et.al., 1993; Hey, et.al., 1996); educational isolationism (Hilton, 1995), the continuing organisational fragmentation (Kilcoyne and Pietroni, 1996) and the effects of political bargaining at individual and institutional levels (Webb, 1991). These are all factors that militate against the development of effective teams, teamwork and collaborative activities in PHC. The implications were that change strategies, and thus the LMFTs project, needed to use interventions that built trust and commitment between individuals, and within PHCTs, if fruitful relationships were to develop, and the social and environmental constraints were to be overcome.

## 2.5 PROBLEMS OF WORKING IN TEAMS

### 2.51 General Problems Of Working In Teams

There was a substantial body of literature on the performance of groups in other work organisations although not in PHCTs themselves. In context with the LMFTs project, this review focuses on the problems of working in teams. A review of a range of theories and empirical evidence in organisation psychology suggested that there were several key factors that had a major influence on the development of teams and their ability to be effective. These factors are identified, together with the conditions for optimising team development and effectiveness, in table 10 below (Hackman,

1990; Guzzo and Shea, 1992; Turrell, 1993; Poulton and West, 1993; West, 1994; Field and West, 1995; Poulton and West, 1997)

**Table 10**

**Summary Of Key Factors Influencing Working In Teams**

| Factor | Conditions For Optimising Team Development / Effectiveness |
|---|---|
| • **Team composition:** | the smallest number of members possible to achieve the goals/tasks;<br>a capacity to adopt a range of roles in order to achieve success;<br>an appropriate level of ability and skill to undertake the tasks; |
| • **Team interaction processes:** *(interpersonal processes, roles, cohesion)* | the development of trust and commitment between members,<br>a commitment to communicate, interact and participate in the teamwork; |
| • **Team norms:** | a propensity for innovation to reduce the stifling effects of conformity and cohesion; |
| • **Nature of the task:** | a challenging task to motivate teamwork; |
| • **Team vision and goals:** | a clear vision and goals to provide direction for the teamwork; |
| • **Performance feedback:** | a review of progress and recognition and reward of team effort; |
| • **Organisational context:** | the support of the organisation, i.e. top management to promote team effectiveness. |

(Based on Hackman, 1990; Guzzo and Shea, 1992; Poulton and West, 1993; Turrell, 1993; West, 1994; Poulton and West, 1997)

The general view was that teams operating in conditions that were less than optimal, e.g. over 14 members (Hackman, 1987); discontinuous membership patterns (Turrell, 1993); limited role understanding, personal adaptiveness or ability (Bond, et.al., 1985; Audit Commission, 1992; Hey, et.al., 1996); low levels of commitment, communication, interaction and participation (Field and West, 1995; West, 1994) mundane nature of tasks (Hackman and Oldham, 1980; Hackman, 1987); task oriented over innovativeness, (West, 1996, 1994); lack of clear vision, goals and valuing achievement (Peters and Waterman, 1982; Plant, 1987; Turrell, 1993) and, an unsupportive organisational climate (Kanter, 1985; Turrell, 1993) faced more difficulty in developing teams and effective teamwork processes. Katz and Kahn (1978) argued, however, that team's were able to surmount these various obstacles and that they were able to reach the same level of outcome, by a variety of means, despite variations in initial conditions. This implied, for the LMFTs and others involved in team development, that there was no single strategy or intervention that worked equally

well for different teams, and that the development of an effective team required an approach that took an account of the specific team and environmental conditions.

## 2.52 Problems Of Working In Primary Health Care Teams

### 2.52.1 Team Composition

The size and composition of the group was shown to influence group outcomes for different reasons. Hackman (1987) argued for a group to be the smallest possible to achieve the task in hand. This was to avoid the difficulties found when trying to co-ordinate activities in large groups (Steiner, 1972), and the effect of 'social loafing' where performance diminished as individual's contributions become anonymised through belonging to a large group (Latane, et.al., 1979). In PHC, the size and composition of a PHCT is, to a certain extent, governed by the size of the Practice and the population that it serves. Bond et.al., (1985) proposed that GPs and Community Nurses who shared the same patients could use this as a basis for collaborative activities, and suggested that they were in a logical position to decide on a PHCTs size and composition. Many teams in PHC, however, develop in an 'ad-hoc' manner on the basis of historical criteria (Lightfoot, et.al., 1992). In addition, research into PHCTs activities demonstrated there was a lack of role understanding and consequently an inappropriate use of member knowledge and skills (Bond, et.al., 1985; Audit Commission, 1992; Hey, et.al., 1996). Finally, there is a drive to encourage small Practices to form consortia or larger groupings in order to maximise the use of their resources and achieve cost effectiveness (Pringle, 1992a). These are organisational changes that are likely to expand PHCT membership beyond the optimum number of fourteen and will, in turn, reduce a PHCTs capacity for co-ordination and potentially each member's motivation to perform (Steiner, 1972; Latane, et.al., 1979; Hackman, 1987, 1990). The development of consortia and large group Practices will, for the LMFTs, provide an opportunity for them to engage in a Practice's change process but also a challenge, in that, Practices may resist the LMFTs interventions on the grounds that were already involved in a process of change and development.

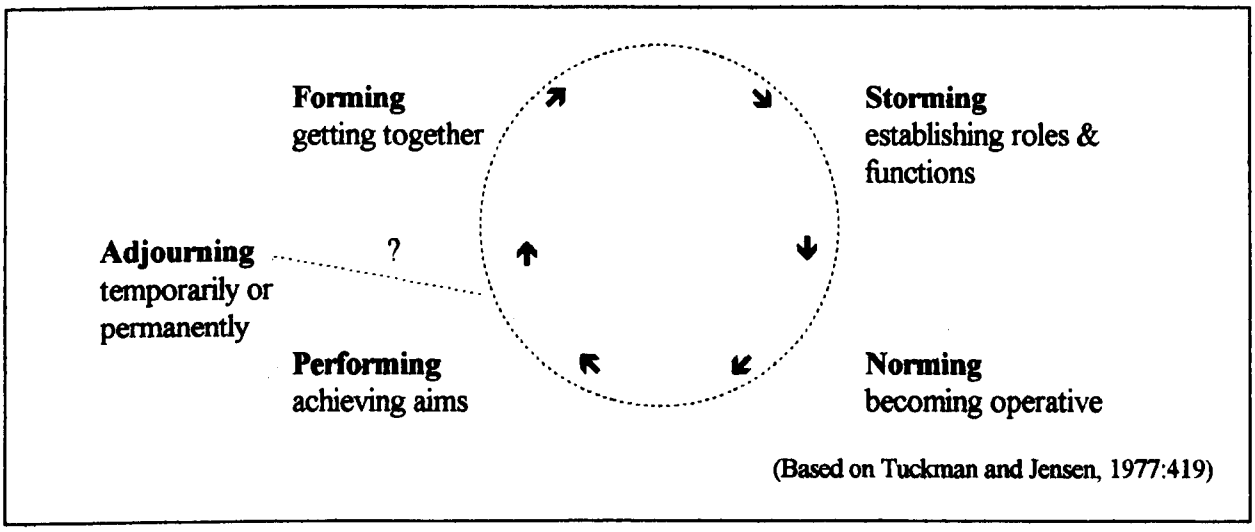
### 2.52.2 Team Interaction Processes

The nature of team development as proposed by Sundstrom et.al., (1990) suggested teams go through various stages in their development. A team's life cycle was considered to have five stages

(Tuckman and Jensen, 1977) (figure 12). In each stage a team was expected to demonstrate particular activities which reflected where they were in the process of team development, e.g. 'forming' - finding commonalties on which to base future activities, or 'storming' - making efforts to define roles and functions within the group in accordance with their team goal. The life cycle model implied team development was a progressive process as teams moved on through the stages to arrive at the 'performing' stage. The final stage was adjournment wherein the teams disbanded, either temporarily or permanently, having completed their given task.

**Figure 12**

**Five Stage Group Life Cycle**




Sundstrom et.al., (1990) proposed that team development comprised four developmental features: interpersonal processes, roles, norms and cohesion. The interpersonal or interaction processes are the way team members respond towards each other as they express ideas, exchange information, create coalitions and support each other (Guzzo and Shea, 1992). It is the nature of these group interaction processes that influence how teams develop, how effectively they teamwork and how they fulfil their tasks (Hackman and Morris, 1975; Guzzo and Shea, 1992). Hackman and Morris (1975) suggested that it was the level and appropriate utilisation of member's knowledge and skills, the nature and use of varying task performance strategies to suit the task, and the level and co-ordination of member effort which particularly influenced the achievement of effective group work. In PHC, however, the problems of poor communication, lack of role understanding and collaborative activity as identified in various reports (DHSS, 1981; NHSME, 1993) and studies (Bond et.al., 1985; Audit Commission, 1992; Hey, et.al., 1996) are more likely to lead to the

inappropriate use of members knowledge and skills and thus, reduce each PHCT's level of effectiveness.

The development of team roles was considered an important influence on the achievement of effective teamwork (Bales and Cohen, 1979). Belbin (1981) argued that achieving effective teamwork required the development, and appropriate utilisation of, a range of team roles (table 11).

**Table 11** **Useful Team Roles**

| Role | Typical Features | Positive Qualities | Allowable Weaknesses |
|---|---|---|---|
| **Company Worker** | Conservative, dutiful predictable. | Organising ability, practical common-sense, hardworking, self-discipline. | Lack of flexibility, unresponsiveness to unproven ideas. |
| **Chairman** | Calm, self-confident, controlled. | Capacity to treat and welcome all potential contributors on their merits & without prejudice A strong sense of objectives. | No more than ordinary in terms of intellect or creative ability. |
| **Shaper** | Highly strung, outgoing, dynamic. | Drive & a readiness to challenge inertia, ineffectiveness, complacency or self-deception. | Proneness to provocation, irritation and impatience. |
| **Plant** | Individualistic, serious-minded, unorthodox. | Genius, imagination, intellect, knowledge. | Up in the clouds, inclined to disregard practical details or protocol. |
| **Resource Investigator** | Extroverted, enthusiastic, curious, communicative. | A capacity for contacting people and exploring anything new. An ability to respond to challenge. | Liable to lose interest once the initial fascination has passed. |
| **Monitor Evaluator** | Sober, unemotional, prudent. | Judgement, discretion, hard-headedness. | Lacks inspiration or the ability to motivate others. |
| **Team Worker** | Socially oriented, rather mild, sensitive. | An ability to respond to people and to situations, and to promote team spirit. | Indecisiveness at moments of crisis. |
| **Completer Finisher** | Painstaking, orderly, conscientious, anxious. | A capacity for follow-through, perfectionism. | A tendency to worry about small things. A reluctance to 'let go'. |

(Based on Belbin, 1981:78)

Team roles may be considered to fall into two categories those that referred to the knowledge and skill members utilise for the benefit of a team (Bond, et.al., 1985) and those that referred to,

"the ways in which members characteristic personalities and abilities contribute to a team (Belbin, 1981:9).

Belbin (1981) proposed that successful teams need only a few 'useful team roles' and that their success depended on how these roles interlocked to generate positive group interactions (table 11). Less successful teams were those which were characterised by clashes, voids or overlaps of these team roles. These studies suggested that there should be the right mix of roles available to provide the skills necessary for the task, and that roles should be flexible and evolve in response to change. In PHC, however, roles in PHCTs were usually the result of selection according to historical criteria and not need (Lightfoot, et.al., 1992), and role protection and role misunderstanding was noted to be rife among the various members of the PHCTs (DHSS, 1981; Bond, et.al., 1985; Audit Commission, 1992; Pearson and Spencer, 1995).

### 2.52.3 Team Norms

The effect of being in a group was observed to produce group norms which induced members to conform and withhold ideas when they differed from the dominant group or organisational view (Asch, 1956; Brown, 1988). In terms of decision making, those individuals subject to the dominant norms of the group were, therefore, unlikely to offer contrary information, opinions or ideas. As a consequence, deeper insight into a problem may be lost with a resulting likelihood for making serious collective errors (Janis, 1982). In relation to PHCTs, it is, therefore, the less powerful members of the team, most notably the receptionists, that may feel unable to contribute (Field and West, 1995). The minority voice, however, does not always become submerged. There was evidence that when a lone individual voice was deemed an expert, or when those in the minority joined forces and formed a coalition, their opinions and contributions were more likely to be heard and accepted (Torrance, 1959; Perrucci and Potter, 1989). In relation to teamworking, it was the team norms that formed the basis for mutual expectations and mutual exchanges within a team (Sherif and Sherif, 1969), and, therefore, influenced the extent to which a team strove for high quality in its performance (Roethlisberger and Dickson, 1964; West, 1994).

Group norms were shown to be malleable and capable of yielding to other forces. These may be external forces, e.g. those emanating from the organisational culture (Sundstrom, et.al., 1990), or internal forces, e.g. those resulting from participation in group decision making, or from 'constructive controversy' where team members monitor and question their own and each other's

performance (Coch and French; 1948; Lewin, 1952; Ouchi, 1981; West; 1994). In addressing norms, Sundstrom et.al., (1990) acknowledged that groups may develop specific group norms which were in opposition to those of the parent organisation. In PHC, for instance, the creation of the internal market placed a responsibility on Practices to become more cost conscious and cost effective (Goodwin, 1995). This resulted in a market culture that demanded Practices produce quantifiable results to demonstrate their cost effectiveness (Williams, et.al., 1993; Poulton and West, 1993). These principles may be in opposition to any altruistic values within a PHCT. Examples include the drive for Practices to become 'fundholding' (NHMSE, 1994) and the imposition of the "Patients Charter" in PHC (NHSME, 1992). Practices were being urged to become business oriented and manage their own budgets and service contracts in terms of fundholding, and use the national guidelines, e.g. patient waiting times or complaints procedures, as a framework for developing their own Practice charters. Both examples impose organisational norms that may oppose Practice's / PHCT's norms where patients, not markets, drive activities, and where patients needs, and not 'throughput figures', dictate the length of consultations. Thus, these were conflicts of interest that may potentially undermine any imposed targets which opposed a Practice's norms.

The effects of working together in a team creates a potential for unity and cohesion. It was generally assumed that groups that achieved cohesion were a more effective, creative and productive group (Hoffman, 1979; Raven and Rubin, 1983; West, 1994). Group cohesion was said to increase the opportunity for participation, open communication, acceptance of group goals and reduce tensions and hostilities (Hoffman, 1979; Hackman, 1990; West, 1994 and 1996). A cohesive team was one that was characterised by members demonstrating warmth and mutual support for each other. Cohesiveness, however, may also result in a greater pressure to conform which, in turn, stifles criticism, dissent and innovativeness (Asch, 1956; Brown, 1988; West, 1994, 1996). Cohesiveness may induce a tendency to be more concerned with achieving agreement than finding the right quality solution, and reduce the quality of decision making, the 'groupthink' effect (Janis, 1982). There was evidence to suggest that groupthink may especially occur in autonomous work groups when decisions were made without outside influence (Liebowitz and De Meuse, 1982; Manz and Simms, 1982). Janis (1982) recommended challenging the stifling effects of cohesiveness and groupthink by engaging the group in a critical analysis of team processes and outputs as an integral part of their team task, e.g. the use of the action research cycle as proposed within the LMFTs project.

### 2.52.4 Nature Of The Task

The nature of the task and its design was found to have motivating consequences for group members (Hackman and Oldham, 1980; Hackman, 1987). The nature of the task influenced the level of effort group members were prepared to expend to achieve the group task. Those tasks that allowed team members to make maximum use of their knowledge and skills, provided performance feedback and incurred minimal managerial control motivated group members the most (Hackman and Oldham, 1980; Hackman, 1987). In addition, Sundstrom et.al., (1990) suggested that a clear mission or goal, a sufficient level of complexity to be of interest, a determination and acceptance of shared objectives, and clarification of professional and organisational role boundaries, all helped a team to define the parameters of a task and thus, what constituted its effectiveness. Guzzo and Shea (1992) stressed the importance of teams receiving feedback on their progress towards the goal for achieving effective teamwork. The level of performance in teams not receiving feedback, despite working towards group goals, was found to equate with the lowered performance of teams who were working without group goals (McCarthy, 1978; Becker, 1978; Komaki, et.al., 1978). In a small study of PHCTs, West and Field (1994) found that PHCT members regarded their work important and intrinsically interesting but that individual contributions to group tasks were unclear. Furthermore, none of the PHCTs in the study had clear, explicit group goals or received any performance feedback. It would, therefore, seem important for the LMFTs, and others involved in the development of PHC, to assist PHCTs to clearly define the nature of their task: its goals, boundaries, work strategies and feedback mechanisms, if effective teamwork is to be achieved.

### 2.52.5 Organisational Context

In recent studies on work group effectiveness there was a strong focus on the organisational context of the work group (Shea and Guzzo, 1987; Sundstrom, et.al., 1990). Its importance lay in the recognition that for effective teamwork to manifest it required the development of optimal working relations between the social and technical systems of the organisation - a socio-technical systems theory (Trist and Bamforth, 1951; Guzzo and Shea, 1992). For PHC, it is the reward and human resource support systems and the level of control groups have over transactions within their environment (Hackman, 1987; Sundstrom, et.al., 1990; Guzzo and Shea, 1992; Weldon and Weingart, 1993) that were considered to be particularly relevant. From the studies of PHCTs that have been reviewed, apart from the work of Poulton and West (1997), no obvious link has been

made between team effectiveness and improving the delivery of effective PHC services. Poulton and West (1997) have generated criteria that focused on output measures in terms of PHCT task or work activity but were unable to develop outcome measures in terms of health gain for service users as this was beyond the scope of their study.

The context of PHC was acknowledged to consist of multiple structures (Hey, et.al, 1996; Poulton and West, 1997). Sims (1986) identified these as: multiple employers; multiple constituencies; multiple power levels; multiple rules for procedures and multiple expectations. These multiple structures in PHC are experienced by PHCT members in the following way. The Health Visitors and District Nurses are accountable to Community Trusts who pay their salaries, they are managed by Community Nurse Managers and are attached to Practices. They are expected to contribute to different sets of organisational goals as well as upholding their own professional goals. In the case of the Receptionists and Practice Nurses, they are employed by GPs but 70% of their salaries is reimbursed by the LHA. Finally, there are the GPs. They are managerially accountable to no one and operate as self-employed workers who are contracted to provide particular services for a 'Practice population.' The reward system for delivering the services from the Practice is based on a complicated system of payment structures. The GPs may perceive the Practice as a small business and themselves as a managing director who control the activities of employed and contracted staff in the PHCT. This can cause some PHCT members to feel resentment, e.g. the health professionals who fear they are loosing some of their professional autonomy, and others to feel undervalued, e.g. the receptionists who may feel less powerful (Field and West, 1995; Hey, et.al., 1996). In PHC, it is these multiple structures that create a PHC system which is unequal in terms of management and reward, and that generates conflicts of interests and asymmetrical power bases between its organisational members.

## 2.6 SUMMARY AND CONCLUSION

In brief, the problems of working in teams in PHC may be said to arise from the environmental constraints and from the dynamics of group interactions. PHCTs in comparison with formal work groups in industry and business were found to differ considerably. PHCTs were classed as unique in that they had diverse management structures, a multi-professional constituency with divergent agendas and objectives and one member, a GP, that had an anomalous status as an independent contractor in a team of professionals who did not share the same status or reward system. These

multiple structures of accountability and management increased the potential for conflict and reduced the likelihood of sharing objectives. In recent studies on effective teamwork and team function West (1994), West and Field (1995), Poulton and West (1997), West and Poulton (1997) concluded that teamwork was very difficult to achieve in PHC given the unique nature of PHCTs.

This chapter has identified from the literature the main constructs of the OD change strategies relevant to understanding the implementation of the LMFTs project and its components. The organisational change processes that were discussed in the literature mainly related to large-scale planned changes in the business and industrial sector. Those studies that did investigate organisational change in the health care sector examined large scale hospital changes. There were very few studies that concentrated on changes that occurred in either small business organisations or in PHCTs or General Medical Practices. Those studies that have examined PHCTs functioning and effectiveness offered a very gloomy picture of the current state of teamwork within the PHC services (West, 1994; Field and West, 1995; Poulton and West, 1997; West and Poulton, 1997).

At the macro-organisational level the process of developing PHC was shown to be subject to a range of contextual forces that emanated from the organisational environment (Hey, et.al., 1996). During Hey et.al.'s, (1996) study some of these influences were considered likely to emanate from: the new public management approaches being used by the Neighbourhood Commissioning and Locality Managers; the introduction of general management and market principles, the emphasis on health promotion and disease prevention and collaborative activity, the introduction of information technology, the increasingly limited resources, the increasing expectations of patients and others that will emerge from the structures and people within PHC. These were all influences that provided constant triggers for change. They were notable for their ability to produce reactive changes in professional responsibility, organisation, service and community development within the NHS (Pettigrew, et.al., 1992; Nurse, 1993) and for being able to invoke hostility, conflict, resistance or precipitating a crisis within and between the PHCTs (Morley, et.al., 1990; Scott and Marinker, 1992; Pringle, 1992b; Long, 1996).

At the micro-organisational level the process of developing PHCTs was shown to be a difficult process to achieve given the uniqueness of their nature (West, 1994; Field and West, 1995; Poulton and West, 1997; West and Poulton, 1997). Three key points emerged from this review of the literature, first PHCTs were shown to lack co-ordination of their activities which resulted in

structures that did not facilitate a team approach. Secondly, they were found to lack clear objectives and thirdly, they failed to receive feedback on their performance. The image of PHC that emerged was that of a complex and difficult setting in which to develop and implement a change project. The received wisdom was that to achieve change in such complex settings change strategies needed to be able be adaptable. Additionally, change agents, implementing change strategies, needed to anticipate and accommodate the impact of environmental influences, and needed to intervene in ways that met the specific needs of PHCTs and provided feedback on their performance if effectiveness was to be achieved.

This literature review served to demonstrate that the LMFTs project faced difficult challenges in achieving its objectives. Its underlying philosophy of a focus on teamwork, networking and collaboration and the interventions proposed to achieve this, provided a 'bottom up' problem solving approach to achieving change in PHC. The LMFTs project did not follow the conventional approach to achieving change in the NHS. More usually, change projects first aimed to achieve organisational change and only afterwards expected the people in the organisation to learn. In the LMFTs project, there was a primary concern for helping people to learn from the actions they undertook as they were involved in a process of change. It was only after the members of the organisation had learnt that the organisation was expected to change. The means of encouraging people to learn, and subsequently, the organisation to change was the action research cycle that was embodied within the problem solving approach. The foregoing discussion has set the scene in terms of the task of the LMFTs project, the next two chapters will describe the approach to the evaluation of the LMFTs project (chapter three) and the process of its implementation (chapter four).

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# CHAPTER THREE

# METHODOLOGY

## 3.1 INTRODUCTION

The LMFTs project was evaluated using a participatory action research (PAR) approach. The initial aims and the research framework were pre-determined by the University Research Team within a research bid for the evaluation and before a dedicated researcher was appointed to the Project (for an elaboration of the research bid see appendix 2). This chapter presents the researcher's exploration of the research literature. The work culminated in the generation of a scheme from which the evaluation framework could be developed which was subsequently presented to, and utilised by, the stakeholders within their RSG meetings, (see chapter 4).

This chapter outlines the proposed evaluation framework (table 12), explores approaches to evaluation in general, and compares the positivist and hermeneutic paradigms. The final section describes the foundations of the PAR approach, the connections it has with the hermeneutic form of inquiry and the relationship between the PAR approach and learning, before presenting a tentative scheme for developing the evaluation framework for the LMFTs project.

**Table 12**

**The Evaluation Framework As Defined By The Research Team In The Research Bid**

- ***Principles of the proposed evaluation framework:***

1. The Project was to be evaluated in a number of ways using both internal and external evaluation criteria.
2. A PAR framework and a combination of qualitative and quantitative assessment tools, both internally and externally derived would be followed.
3. It was of particular importance to gain acceptance of criteria from stakeholders in the Project since this would enhance the possibility of the continued implementation of the elements of the Project following its completion to ensure cultural change in the longer term.
4. Both process and impact as well as outcome evaluation were to be addressed but the emphasis would be on evaluating change.
5. An area of similar size and population characteristic, not subject to the activities of the LMFT project, was to be chosen to operate as an independent control.

- **The expected consequences included:**
  - improvement in the quality of the delivery of General Practice;
  - increased consensus and greater collaboration with regard to decision-making and action in service development;
  - greater awareness and understanding of the issues by participants in the process, in particular the facilitation workers;
  - an increased level of innovation and response to change amongst Practices and individuals involved in the Project.
  - This was to manifest itself in team work, networking and a facilitation infrastructure.

The philosophy underpinning the LMFTs project was drawn from the notions of adult learning (Knowles, 1990) and the learning organisation (Pedlar, et.al., 1991; Swieringa and Wierdsma, 1992). Correspondingly, the University Research Team sought to adopt an approach that complemented the philosophy of the LMFTs model. In addition, they sought an approach that had to be able to address the complexity of the change process and the information needs of the wide range of stakeholders involved. The use of PAR was proposed because it was felt to have the power and flexibility to simultaneously: allow the evaluation of complex dynamic systems with multiple agendas; allow for the evaluation of unexpected outcomes resulting from the process; promote learning and enhance and evaluate change through the use of dialogue and timely feedback.

## 3.2 APPROACHES TO EVALUATION

### 3.21 Purpose Of Evaluation

An evaluation is principally concerned with: measuring change; determining the value or worth of some activity or intervention (Patton, 1980; Guba and Lincoln, 1981; de Koning and Martin, 1996) or assessing the effects or effectiveness of an initiative, strategy, policy, project, practice or service (Fricke and Gill, 1989; Robson, 1993). Evaluation has increasingly gained importance as the emphasis on accountability, quality assurance management and performance indicators has risen, particularly in the last decade, in the public and private sectors (Pollitt, 1989; Henkel, 1991; Beattie, 1991). Its increasing use, however, has not necessarily led to 'high quality' evaluations. The criticisms have been concerned with methodology, e.g. a lack of rigour and a systematic approach (Weiss, 1977; Cronbach and Associates, 1980; Guba and Lincoln, 1981) and with the dominant focus on cost-effectiveness. Evaluations have tended to be acontextual and aprocessual (Pettigrew, et.al., 1992) and are noted for an absence of social or environmental factors being presented in the findings (Kusher, 1989; Freudenburg, 1990).

### 3.22 Types Of Evaluation

Evaluation has been undertaken using experimental, survey or case study strategies or by using combinations in a hybrid form (Robson, 1993), and there are more than 100 different models available for use (Patton, 1981). Whilst each has a particular emphasis, e.g. achieving behavioural

objectives (Tyler, 1969), various forms of systems analysis (Checkland, 1981), or illumination of innovatory programs (Parlett and Hamilton, 1972), Robson (1993) suggests using an eclectic approach to evaluation rather than one single model. The focus of an evaluation varies, it may concentrate on technical features, e.g. structure or techniques, on the responses of participants or on both, depending on its objectives.

The models for evaluation, considered mostly prescriptive in nature (Guba and Lincoln, 1981; Legge, 1984; Robson, 1993) have been categorised, by the Evaluation Research Society, according to the purposes and activities involved:

1. **Front-end analysis**: a pre-installation, context, feasibility analysis which occurs prior to the start of an intervention as a guide to planning and implementation;
2. **Evaluability assessment**: feasibility assessment of approaches and methods of evaluation;
3. **Formative evaluation (also known as or process or developmental) evaluation**: produces information during the evaluation to enable improvements to be made;
4. **Impact evaluation, or summative, outcome or effectiveness evaluation**: produces results and determines the effectiveness of programmes especially for decision making on project continuation;
5. **Programme monitoring**: checks for conformation with current policy and tracks numbers of people, services delivered and so on;
6. **Evaluation of evaluation, or secondary, audit or meta-evaluation**: a critique of an evaluation as a whole (Based on Evaluation Research Society, 1980:3-4).

These six categories provide a general view of the different types of evaluation that most often occur either singly or in combination. Inside these categories lie a subset of specific evaluative activities, e.g. cost benefit analysis, criterion referenced or quality assurance, as determined by the specific purpose of an evaluation. The models for evaluation, whatever the type, prescribe the way it should be conducted. Patton, offers a broad characterisation of evaluation as involving,

> "the systematic collection of information about the activities, characteristics and outcomes of programs, personnel and products for use by specific people to reduce uncertainties, improve effectiveness, and make decisions with regard to what those programs, personnel or products are doing and affecting," (1982:15).

As a definition it suggests a move beyond the objective - outcome orientated definitions to include formative - developmental processes of evaluation as well. In general, it outlines the character of an evaluation as:

- a systematic collection of information using quantitative or qualitative methods, or in combination;
- having the capability to use a large range of topics to provide information;
- having the potential to offer information for use by people in a position to take action;
- having the purpose of providing information to reduce uncertainty and improve effectiveness;
- having the purpose of providing information to enable decision making.

The particular character of an evaluation is determined by its purpose. Evaluations that focus on the extent to which an intervention has met its intentions, criteria or objectives tends to be more factually inclined and process activity is treated as a black box, and the report covers the products and not the process of the evaluation (Robson, 1993). This 'thin' factual report tends to meet the needs of a limited number of stakeholders, e.g. funders or managers, and often glosses over how the products or outcomes were achieved. Proponents of evaluation as a developmental process suggest that reports should describe what goes on inside the 'black box' and provide what Geertz (1973) described as a 'thick' description, a case study, of the evaluation to fill in the gaps between inputs and outputs. Thick description gives a detailed account of the participants and the context and their activities, the meaning of the data having been interpreted in terms of the prevailing socio-cultural norms, mores and values of the particular community under study.

## 3.23 Contextual Issues Influencing Evaluation Design And Implementation

Evaluations inevitably contain stakeholder, methodological and other contextual biases. In any evaluation a multitude of contextual issues, constantly compete for, and demand, the meticulous attention of researchers doing an evaluation (table 13).

**Table 13**

**Examples of Contextual Issues That Influence Evaluation Design And Implementation**

| | |
|---|---|
| **political:** | • who is the real client: sponsor or recipient of the service?<br>• whose interests are to be served by an evaluation?<br>• how does the evaluation address, seek to balance, power issues?<br>• what does the type and style of evaluation, objectives, criteria chosen<br>• reflect about the way some perspectives, values and goals are to be served above others?<br>• who is to benefit most? |

**Table 13 continued,**

| | |
|---|---|
| **change:** | • does it seek to produce / encourage change in those involved?<br>• is it there to indicate what changes are necessary to make an intervention more effective?<br>• what methods are to be used to increase ownership, engage commitment and reduce resistance? |
| **communication:** | • who needs to receive information?<br>• what form, visual, verbal or written, is best suited to the purpose of evaluation?<br>• what is the appropriate language form and how is jargon to be avoided? |
| **organisational:** | • what boundaries of the research need to be established?<br>• who is affected and who needs to be involved? |
| **economic:** | • what funds, people and time-span are to be made available? |
| **practical:** | • what skills and expertise will be needed and are they available?<br>• how are the different vested interests to be taken account of? |
| **ethical:** | • what safeguards have to be built in to protect those 'at risk' from the results of an evaluation?<br>• what measures are to be taken to preserve confidentiality but gain access to local knowledge?<br>• what measures are to be taken to ensure the well being of the researcher(s)? |

(Based on Guba and Lincoln, 1989; Robson, 1993; Marshall and Rossman, 1995; Patton; 1997)

There are also those issues which emerge and cannot be anticipated until the evaluation proceeds. Contextual issues invariably make an impact from the outset of an evaluation as it is often a commissioned piece of work with clients or sponsors determining the topic if not always the methods for evaluation (Patton, 1980; Robson, 1993; Park, et.al, 1993). Whilst this is of potential benefit, since findings may subsequently be used rather than shelved (Alkin, et.al., 1979; Springett, in-press; Patton, 1997), stakeholder demands inevitably add constraints that have to be met if an evaluation is to fulfil its designated purpose. Evaluations, therefore, often demonstrate bias, they may address only certain vested interests, may be used as a diversionary tactic - a political tool - to stop something else happening or have leanings towards a particular research model (Suchman, 1967; Guba and Lincoln, 1989). Thus, an evaluator needs to be able to discern what these biases are and decide what role, if any, an evaluation plays in counteracting such prejudices and finally, acknowledge their effects in the report.

The list in table 13 above is not exhaustive but provides examples of the general contextual issues that a researcher has to think about in the design and implementation of an evaluation. The emergent

contextual issues call on the ethical principles and the strategic and interpersonal skills of a researcher throughout the whole evaluation process (Marshall and Rossman, 1995). Contextual issues, both general and emergent, create a set of tensions that are an integral part of any evaluation which have to be carefully managed by a researcher if a successful evaluation process is to be sustained (Patton, 1997).

## 3.24 Role Of The Researcher In The Evaluation

A variety of roles are adopted by a researcher during the course of an evaluation (Marshall and Rossman, 1995). These are primarily governed by the philosophy underpinning the research design, the expectations that sponsors, clients, funders, academics and researcher(s) have about the way an inquiry is to be carried out, the purpose of the evaluation and the contextual issues of a specific setting (Cronbach and Associates, 1980; Smith, 1989; Robson, 1993). Factors influencing the role of a researcher may be summed up as follows:

1. **influences from the underpinning research design:**
    - if a traditional positivist approach with a methodology that follows a scientific method is used, a researcher adopts a detached role from the object of study and thus carries through a principle of objectivity;
    - if a hermeneutic (interpretive) approach with a methodology that follows a dialectical method is used, a researchers adopts an interactive stance with research participants to establish dialogue and interchange of participant's views and thus carries through a principle of critical subjectivity.
2. **influences from expectations of clients/funders/academics/researcher: if the researcher is required to...**
    - **act as a consultant:** then she/he has a say in choice of research design, strategies and methods but thereafter a watching brief, advising on problems and identifying milestones achieved as others inside the organisation implement the evaluation process. An external researcher position is adopted;
    - **act as a research or project adviser:** then she/he provides advice, information and support to the internal researcher - practitioners setting up and doing an evaluation. The researcher tries to overcome any lack of expertise the practitioners may have. Although an external 'researcher' position is adopted, the researcher moves in and out of the context under study to facilitate the evaluation process;

- **act as an active practitioner - researcher:** then she/he carries out an evaluation whilst being employed within the setting under study. An internal researcher position is adopted.

**3. influences from the purpose of the evaluation:**

- **if an evaluation is concerned with assessing merit or worth:** an impact or outcome evaluation may be chosen;
- **if an evaluation is concerned with improvement:** a process or developmental evaluation may be chosen.

**4. influences from contextual issues of a specific setting:**

- a researcher <u>cannot</u> anticipate everything that may occur but must detect the set of contextual tensions present.

(Based on Guba and Lincoln, 1989; Robson, 1993; Marshall and Rossman, 1995; Patton, 1997)

This framework highlights that several variants of the researcher role are possible. These are dependent on the extent to which the evaluation design and implementation is an internal process, is a partnership between researcher and internal participants, or is the sole responsibility of the researcher. There are advantages and disadvantages to being either inside or outside, e.g. outsiders may have difficulty grasping a clear understanding of some contextual issues whereas insiders may be steeped in internal issues and not see the whole picture. A researcher, therefore, needs to decide how best to minimise the disadvantages of the position adopted (Guba and Lincoln, 1989; Robson, 1993).

In evaluations designed to promote change, the distinction between researcher and research subjects becomes blurred as collaborative partnerships grow and all become research participants in the interest of achieving change (Wisner, et.al., 1991; Greenwood, et.al., 1993). A researcher may be considered as an instrument of evaluation, someone that faces, and resolves, a range of strategic, ethical and personal issues during the design and implementation process (Locke, et.al., 1993). The issues for a researcher are perceived as an interrelated set of technical and interpersonal considerations (figure 13). A researcher involved in the design and implementation of an evaluation needs to think about and anticipate issues of negotiating entry, reciprocity, role maintenance and receptivity, and deal with these in a manner that adheres to principles for ethical research (Marshall and Rossman, 1995).

**Figure 13**

**Strategic, Ethical And Personal Issues In Evaluation**

| *Technical Considerations* | *Interpersonal Considerations* |
|---|---|
| **Deployment of the self and resources = efficiency**<br><br>**Self**:<br>establishing degree of participation,<br>disclosure, intensiveness, extensiveness;<br>focusing on the specific or diffuse;<br>**Resources:**<br>ensuring a full response to research questions;<br><br>maximising opportunities for data gathering;<br>providing a limit to the scope of the study; | **Role maintenance and reciprocity**<br><br>**Interpersonal:**<br>building trust, maintaining good relations;<br>respecting the norms of reciprocity;<br>teaching participants about own and research role;<br>**Personal:**<br>conversing easily, being an active and thoughtful listener;<br>being sincere and authentic in research role;<br>being patient, allowing time for trust and confidence to emerge through interaction; |
| **Negotiating and maintaining access and becoming accepted**<br>establishing a rapport;<br>presenting aspects of self that may be useful;<br>offering an 'opt out' clause for participants;<br>being patient, persistent and persevering;<br>showing sensitivity to norms and rhythms of group;<br>being receptive to participant's concerns, personal and workplace; | **Ethical principles**<br><br>**General:**<br>ensuring informed consent;<br>protecting participants anonymity;<br>**Specific:**<br>expecting routine ethical issues to occur;<br>preparing to make on-the-spot decisions;<br>adhering to ethical principles for research;<br>demonstrating sound reasoning; |

(Based on: Patton, 1980; Robson, 1993; Marshall and Rossman, 1995)

The foregoing has discussed the general aspects of evaluation design and implementation. The next section considers the research foundation of evaluation approaches which, according to Robson (1993), are based on an underlying research model and are not, in themselves, a new or different research model. The approaches to evaluation may generally be conceived as following either a traditional (positivist) or hermeneutic (interpretive) model of research (Denzin and Lincoln, 1994). These two different perspectives will be discussed next.

## 3.25 Traditional Or Positivist Approaches To Evaluation

Traditional forms of evaluation dominate the literature on measuring change and have treated evaluation as a scientific process. These attempt to model the conventional natural sciences which have been held to be more objective, valid and reliable (Pfeffer and Coote, 1991; Sechrest, 1992; Smithie and Adams, 1993). The traditional examples cover a broad range of disciplines and have

looked at organisation development (Legge, 1984), managers and the management of change (Bennis, et.al., 1976), education and assessment (Cronbach and Associates, 1980; Marquand, 1992), psychology and behaviour change (West, 1994) individuals health and lifestyle (Blaxter, 1990; Dawson, 1994) and improving the quality of health care services (Henkel, 1991; Koch, 1994; Young, 1994). In traditional evaluation models, a classic example of which is the Tyler (1969) model, measurement and evaluation were synonymous. These models have, in the main, utilised pre and post intervention tests methods and researchers have sought to strengthen their findings by using hard measurement data. Traditional evaluations have adhered to research practice that has upheld the principle of objectivity.

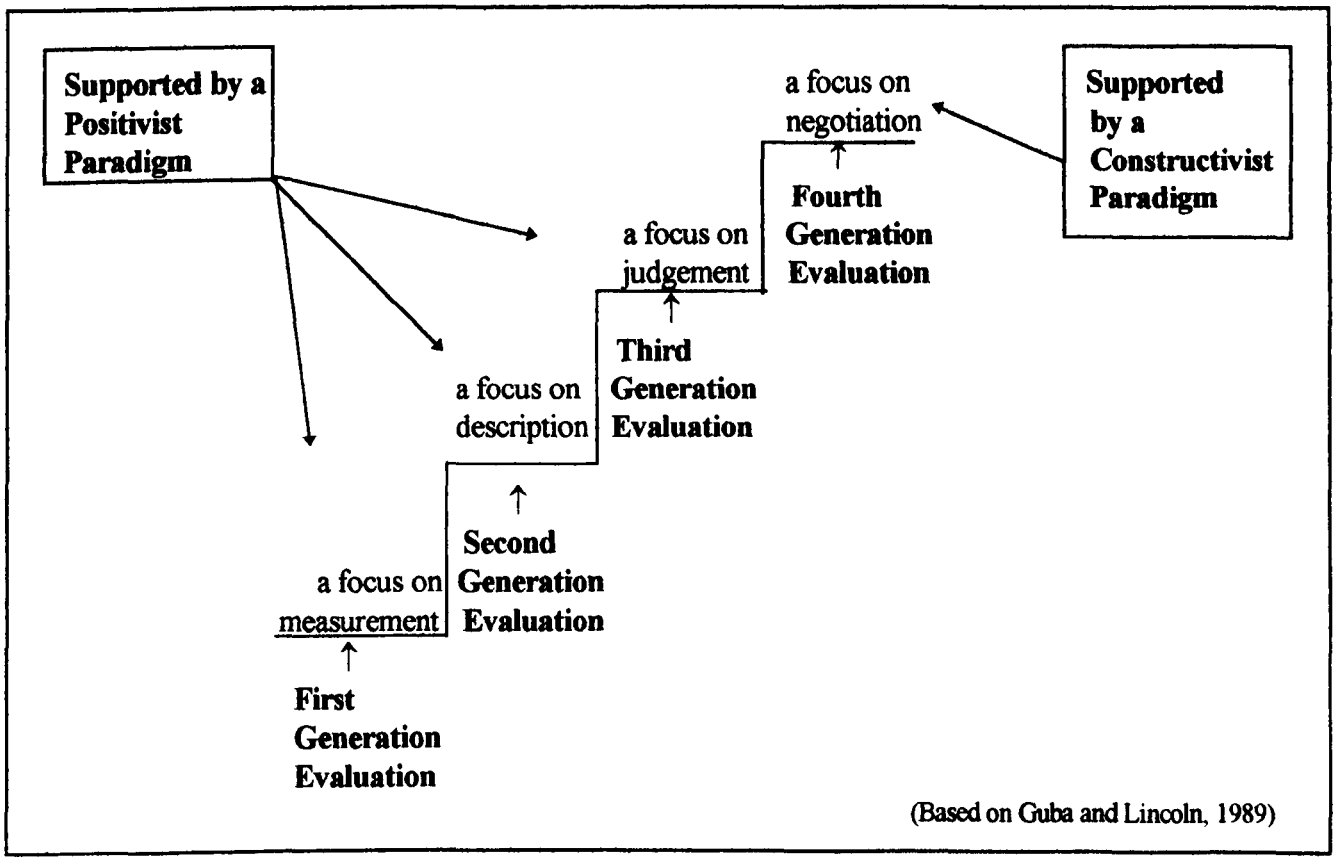
### 3.25.1 Traditional Research Approaches In Evaluation Practice

Traditional research approaches to evaluation are designed to enable the researcher to remain distanced and therefore assume objectivity through this detachment from the object of study. The aim is to avoid 'researcher influence' on the work wherever possible. A valid methodology is maintained by approaching data collection and analysis in an objective manner and using procedures that have undergone rigorous validation prior to use. In the use of a positivist approach a researcher has a testable proposition or hypothesis which has been constructed before an evaluation begins and from which an evaluation framework is developed by the researcher(s) alone. The use of a systematic scientific research approach to evaluation seeks to prove or disprove the original proposition - usually by undertaking an experiment or some other form of empirical enquiry. The data, analysed from an objective stance, produces results that either confirm, modify or refute the original proposition. This research cycle may be repeated, within an evaluation, in an attempt to verify a modified version of the theory. Following on from these research cycles a formal report usually marks the completion of a particular research study (Robson, 1993). A formal 'end of study' report is the usual way a traditional scientific approach to evaluation finishes. The findings are disseminated via the report, thus adding to knowledge and informing action after the cycle of research within the evaluation has finished. The traditional research approach follows a natural sciences model where single variables can be isolated and easily controlled. In recent years the use of this approach in the human sciences has come under increasing critique for its emphasis on instrumental action and technical interest in controlling nature and the environment (Guba and Lincoln, 1994). This is a critique that has also been taking place in other areas of science, e.g. investigating complex systems (Whyte, 1991; Dahlbom and Mathiassen, 1993).

Traditional research approaches in evaluation has been considered to have three pervasive problems: a tendency towards managerialism; a failure to accommodate pluralistic values; and an over-commitment to the scientific paradigm of inquiry (Guba and Lincoln, 1989). Evaluations have been criticised for a lack of quality, systematic application, relevance or usefulness and for producing findings that have often reflected academic or funders concerns but failed to address issues of importance to their stakeholders (Weiss, 1977; Cronbach and Associates, 1980; Guba and Lincoln, 1981 and 1989; Patton, 1997). In a four 'generation' classification of evaluation Guba and Lincoln (1989) class the first three 'generations' as measurement-orientated, description-orientated and judgement-orientated (figure 14).

**Figure 14**

**Successive Steps In The Generation Of Evaluation**




These were classified as generations because each represented successive steps in the development of evaluation. The first three generations of evaluation, all supported by a scientific mode of inquiry, have typified the way evaluations have largely been undertaken throughout this century (Guba and

Lincoln, 1989; Koch, 1994). Guba and Lincoln have attributed the failure to use evaluation findings as simply,

> "illustrat[ing] the poverty of traditional evaluations, which are likely to fail precisely because they do not begin with the issues and concerns of their actual audiences and because they produce information that, while statistically significant, does not generate truly worthwhile knowledge." (1981: ix).

Guba and Lincoln's (1989) fourth generation evaluation, which is supported by the constuctivist paradigm and follows a hermeneutic form of knowledge creation, represents a shift towards using a subjectivist epistemology. In this hermeneutic form of inquiry, unity is sought between researcher and stakeholders (the knower and the known), and its key dynamics, negotiation and interaction, offer participants the advantage of gaining knowledge and learning as they act as catalysts for action and empowerment.

## 3.26 Hermeneutic Approaches To Evaluation

Alternative approaches to evaluation follow a hermeneutic philosophy. This is concerned with understanding the actions of people, institutions or their products e.g. texts or works of art, as essentially intentional. It is not concerned with explanation or prediction. Hermeneutics is derived from the Greek word meaning interpretation. It stresses the importance of participation in a social process and the method of dialectic interaction as a way to understand what is happening. An investigation and interpretation of a situation, whether human action or organisational activity, is arrived at through establishing a process of dialogue between research participants that make up a 'research community'. Understanding comes through a 'fusion of horizons' as those participating in the inquiry move back and forth, in a dialectic, between the parts and the whole to produce a consensus or a non-consensus on the situation (Skinner, 1985; Rabinow and Sullivan, 1987; Guba and Lincoln, 1994). Thus, those involved create a new social reality that is derived from critically examining, and setting, their own individual constructions of reality against those of fellow participants. Hermeneutics has developed as an ontology, an epistemology and a methodology in the effort to provide a phenomenological interpretation of *Verstehen* - understanding (Rabinow and Sullivan, 1987; Smith, 1989; Schwandt, 1994). *Verstehen*, was defined by Schutz (1967), as having three ways in which it could be understood:

1. An experiential form of common-sense knowledge of human affairs.

   This relates to the intersubjective character of the world and the complex processes we use to recognise actions, our own and others, as meaningful.

2. An epistemological problem - asking how is *Verstehen* possible?

   This relates to the idea that 'the lifeworld' is ontologically prior. The lifeworld provides the grounds from which an inquiry starts and from within which it can only proceed.

3. A method in human sciences.

   The method has two 'orders,' the first relates to everyday occurrences in which we understand and live in the world; the second relates to its use as a process, by social scientists, to make sense of first order understandings (based on Schutz, 1967:56-59).

The use of hermeneutics has provided researchers with an alternative approach to inquiry other than positivism. However, those engaged in these developments have faced the difficulty of trying to produce an inquiry that can demonstrate trustworthiness of research findings and have thus struggled with the notion of developing an objective interpretive science of subjective human experience (Hammersley, 1992). Some scholars have resolved the paradox by insisting that the interpretive inquiry remained a rigorous and systematic process (Reason and Rowan, 1981; Lather, 1986; Hammersley, 1992) which Smith (1989) has described as travelling down the 'middle ground of methodology'. Others, following Gadamer (1975), have denied the existence of paradox and accepted the 'hermeneutical character of existence', of being in the world (Rabinow and Sullivan, 1987; Schwandt, 1994).

This latter approach is hermeneutics as an ontology. It is concerned with *being*, with *existence*, and with a phenomenological explanation of the what and how of being-in-the-world (Gadamer, 1975; Rabinow and Sullivan, 1987, Taylor, 1987). Gadamer (1975) reflecting on dialectic as a method, or non-method, considered language and history were constitutive of being human. As Schwandt elaborates,

> "we do not simply live out our lives *in* time and *through* language; rather, we *are* our history. The fact that language and history are both the condition and the limit of understanding is what makes the process of meaning construction hermeneutical," (1994:120).

This suggests hermeneutics encompasses all and that it is not so much a method as a,

> "never-ending circle of interpretation [that] constitutes social reality as it is for those involved in it at any given historical time and cultural place," (Smith, 1989:137).

### 3.26.1 Hermeneutic Research Approaches In Evaluation Practice

In the use of hermeneutic research approaches in evaluation practice, it is the hermeneutical circle that provides a connection between local and specific constructed realities and the wider cosmos. Bleicher described it as,

> "an ontological condition of understanding; [it] proceeds from a communality that binds us to tradition in general and that of our object of interpretation in particular; [it] provides the link between finality and universality, and between theory and praxis," (1980:267).

In other words, a researcher undertakes a systematic and rigorous research inquiry that involves using participatory methods to establish dialogue and interaction between research participants involved in the evaluation. The participants are engaged in a process of dialogue, the purpose of which is to enable them find out what meaning they give to their activities and actions. Their interpretation of their own activities gives an account of reality as they see it and not as the researcher sees it. Thus, the evaluation participant(s) provide their own construction of reality, this is said to be a 'first order' or primary construction of reality (Lincoln and Guba, 1985; Guba and Lincoln, 1989).

The process of interpretation may be advanced to a secondary level or construction of reality. Primary interpretations stand alone in that they are a reflection of an individual's view of the world whereas a secondary construction of reality takes other views of reality into account within the process of interpretation. In an evaluation a process of 'dialectical interchange' is created in which the participants move back and forth between their own primary constructions of reality and other participants versions of reality, e.g. other local views or theoretical accounts, to produce a secondary construction or view of the whole. A researcher may be the sole producer of the secondary interpretation or it may be the sum of negotiations between participants in an evaluation. The participatory methodology is a means for achieving this dialectical interpretive process, the hermeneutical circle, with the participants involved in an evaluation.

Hermeneutic inquiry has drawn criticism for it is possible to draw on a very narrow field of interpretation to construct a version of reality, e.g. where it has been used solely as a method for data gathering without regard for constructing knowledge via an interactional process with the participants in an evaluation. The subsequent, researcher only, interpretation becomes devoid of its historical and social context and thus its meaning becomes questionable. The purpose of a

hermeneutic inquiry is to construct interpretations with participants in a context where the historical and social processes that constitute, and therefore influence, thought and action are included (Rabinow and Sullivan, 1987; Olsen, 1994; Stansfield, 1994; Schwandt, 1994). Notwithstanding these criticisms, the hermeneutic tradition has provided a foundation on which it has been possible to construct different forms of inquiry other than scientific research models. These hermeneutic models encompass interactive and participatory modes of activity that fall within the eclectic and wide ranging framework of what Guba and Lincoln (1989) have begun to call the 'constructivist paradigm'.

## 3.3 COMPARING POSITIVIST AND HERMENEUTIC RESEARCH MODELS

The approaches to evaluation have been generally conceptualised as being supported by either positivist, e.g. experimental and randomised control trials, or hermeneutic models of research, e.g. case studies of developmental projects. The hermeneutic model has also been called naturalistic, constructivist or interpretive. Although there are slight variations in meaning they are all based on subjectivist forms of interpretation. In their account of competing paradigms in qualitative research Guba and Lincoln (1994) draw a clear distinction between positivist and constructivist paradigms. A paradigm is in their definition,

> "a basic belief system or worldview that guides the investigator, not only in choices of method but in ontological and epistemological ways," (Guba and Lincoln, 1994:105).

An outline of the historical field of qualitative research (table 14) serves to locate the time when hermeneutics, alongside other qualitative perspectives, began to be used as a basis for the construction of knowledge (hence the use of the overarching term of 'constructivism').

**Table 14** **The Historical Field In Which Qualitative Research Currently Operates**

| | |
|---|---|
| 1. 1900 - 1950 **Traditional** | associated with positivist paradigm |
| 2. 1950 - 1970 **Modernist** ) | associated with postpositive paradigm and new qualitative perspectives: hermeneutics, structuralism, semiotics, phenomenology, cultural studies and feminism; humanities became the central resources for critical, interpretive theory, and awareness of multiple, potentially conflicting, realities developed; |
| 1970 - 1986 **Blurred Genres** ) | |
| 3. 1986 - 1990 **Crisis of Representation** | associated with the researchers struggle to locate both themselves and their subjects in reflexive texts. |
| 4. 1990 - today **Post Modernism** | associated with a new sensibility that doubts all previous paradigms. |

(Based on Denzin and Lincoln, 1994:2)

The early, original, positivist stance shifted to accommodate new understanding of the form of nature to produce the philosophical variation of postpositivism. Subsequently, scientific orientations have moved even further away from objectivism, as human beings and the meaning they ascribe to their activities have become an integral part of the interpretive process of constructing knowledge. These later developments have given rise to critical theory and constructivism as paradigms that follow the hermeneutic tradition of supporting research inquiry (Guba and Lincoln, 1989).

A comparison of positivism and Guba and Lincoln's (1989) notion of constructivism reveals two paradigms that philosophically lie far apart because of a difference in orientation towards the creation of knowledge (table 15). Historically positivism grew out of a mechanistic world view and constructivism emerged later as a reaction to positivism, it offered a critique and an alternative approach to research ***with*** rather than ***on*** human subjects (Smith, 1989; Dahlbom and Mathiassen, 1993). Positivism asserts that an external objective reality exists and knowledge about this is, in itself, valuable (Heron and Reason, 1997). Positivism is concerned to determine and make generalisations (laws) about nature, that is perceived as an external objective reality. These, mainly quantitative, research designs stress control of a situation, an elimination of bias and seek to verify or falsify hypotheses in the effort to explain nature and make future predictions. The traditional application of scientific theory and technique to the instrumental problems of practice is the heritage of positivism and technical rationality is the positivist epistemology of practice (Schon, 1983).

Constructivism differs from positivism in that it asserts that objective knowledge does not exist and values knowledge as locally situated and context related, and it offers a tool and an instrument for emancipatory change (Vanderplaat, 1995; Fetterman, et.al., 1996; Heron and Reason, 1997) (table 15). Constructivism is concerned with finding specific, local knowledge that is created within an inquiry process via interaction with the people involved. These, mainly qualitative, research designs dissolve the separation between ontology and epistemology and commit the inquiry process to a hermeneutic, dialectical methodology which studies a natural setting from the interacting individual point of view (Schon, 1983; Guba and Lincoln, 1994). Thus, a constuctivist, hermeneutic inquiry differs both conceptually and practically with the traditional research model of the logical empiricist that dominate social science evaluations (Rabinow and Sullivan, 1987; Smith, 1989).

**Table 15** **Comparison Of The Different Philosophical Positions Of Positivism And Constructivism**

| ISSUE | POSITIVISM | CONSTRUCTIVISM |
|---|---|---|
| **Ontological Question:**<br>What is the form of nature and how may it be known? | **'Naive' Realism**<br>• The assumption is that an apprehendable, external objective reality exists.<br>• Assumes that there is an objective external reality upon which research inquiry can converge. | **Relativism**<br>• The assumption is that there is no such thing as objective knowledge of realities independent of the knower.<br>• Assumes that multiple, apprehendable and potentially social conflicting realities exist as products of human intellect.<br>• Realities are socially and experientially based and may be more or less informed, and change as a person or group becomes more informed. |
| **Epistemological Question:**<br>What is the relationship between knower or would-be knower and what is known? | **Position is dualist and objectivist**<br>• Objective observation: researcher and research objects are assumed to be independent entities.<br>• Rigorous procedures undertaken to eliminate values and bias of researcher or research object from influencing outcomes.<br>• Assumes that objectivity can determine 'how things really are' or 'how they really work'.<br>• Findings are replicable and considered true. | **Position is transactional and subjectivist.**<br>• Researcher and researched are interactively linked.<br>• Conventional separation of ontology and epistemology disappears in the course of dialectical interchange.<br>• Knowledge is created through interaction between researcher and researched.<br>• Findings are created as the inquiry proceeds. |
| **Methodological Question:**<br>How can the inquirer find out whatever he or she believes can be known about...? | **Experimental and manipulative**<br>• Hypotheses, in propositional form, are subjected to empirical tests<br>• Confounding variables are manipulated and controlled to avoid undue influence<br>• Focus is on verification or falsification of hypotheses<br>• Emphasis: quantity<br>• Provides a surface view<br>• Explanation and prediction<br>• Basic posture is reductionist and deterministic | **Hermeneutic and dialectical.**<br>• Social constructions are of a personal 'intramental' nature.<br>• Previously held constructions become elicited and refined through interaction between the researcher and the researched.<br>• Constructions are subject to continuous change and refinement as they are compared and contrasted through a dialectical interchange.<br>• Focus is on the distillation of a consensus construction that is more informed and sophisticated than predecessor.<br>• Emphasis: quality<br>• Basic posture is emergence and discovery. |
| **Axiological Question:**<br>What is intrinsically valuable in human life, what sort of knowledge is intrinsically valuable? | • **General 'propositional' knowledge**<br>• Propositional knowing about the world is an end in itself, is intrinsically valuable<br>• **Aim:** the power to control; the collection of facts | • **Specific local knowledge**<br>• Propositional, transactional knowing is instrumentally valuable as a means to social emancipation, which is an end in itself is intrinsically valuable<br>• **Aim:** enlightenment; edification; enrichment; personal growth<br>(Based on: Guba and Lincoln, 1994:109; Heron and Reason 1997:289) |

Constructivist and interpretivist perspectives on human inquiry, in Schwandt's view,

> "share the goal of understanding the complex world of lived experience from the point of view of those who lived it," (1994:118).

Researchers working within these perspectives seek knowledge that is local and context bound. They work with participants to access and understand their 'world of meaning' and use hermeneutics as the methodology for studying the humanities. The research purpose keeps what Dahlbom and Mathiassen, call a

> "fundamentally subjective motivation behind all quest for knowledge. All true knowledge is edifying, and as such knowledge is always good," (1993:217).

These hermeneutic forms of inquiry have to meet a different set of criteria to that of the positivist model to establish trustworthiness of the research findings. This will be discussed in the next section.

## 3.31 Establishing Trustworthiness Of Research Findings

Establishing trustworthiness involves adopting an approach and particular techniques, during the research process, that add rigor and help to establish confidence in the truth of the findings (Patton, 1980; Lincoln and Guba, 1985; Robson, 1993; Guba and Lincoln, 1994; Denzin and Lincoln, 1994). A researcher, intent on persuading an audience that the findings of an inquiry are noteworthy, needs to ensure the research process meets certain criteria. The question of trustworthiness applies to both research models but the approach, criteria and corresponding techniques will be different.

In the traditional research model the conventional criteria that need to be met for achieving trustworthiness correspond with the positivist philosophy of 'naive' realism and a dualist and objectivist research position (Lincoln and Guba, 1985) (table 15) are:

- **validity,**
  *external:* means ensuring findings have a high degree of applicability in other contexts;
  *internal:* means establishing a causal connection between independent and dependent variables;
- **reliability:** means minimising the risk of subject and observer bias and error - a pre-condition of validity;
- **objectivity:** means using methodology to avoid human contamination;
  means achieving intersubjective agreement (collective judgement) on a phenomenon.

Researchers using a traditional research model aim, by meeting these criteria, to place a layer of 'objective instrumentation' between themselves and the object of research. The criteria by which the constructivist (hermeneutic) research model tries to achieve trustworthiness cannot be the same as the traditional approaches. The underlying philosophy of constructivism is relativism which advocates a principle of critical subjectivity and a transactional, subjectivist and interactive means of creating research findings (table 16). This different research stance, in which the researcher becomes an instrument of the research process and interacts with the participants, has involved re-theorising the criteria for use in postpositivist, constructivist, feminist and interpretive research inquiries (Lincoln and Guba, 1985; Hammersley, 1992; Smith, 1992; Lather, 1993). Guba (1981) proposed four new terms and accompanying operational techniques as having a better fit with constructivist (hermeneutic) epistemology for a researcher to use to establish trustworthiness (table 16).

**Table 16**

**Establishing Trustworthiness In Hermeneutic Forms Of Inquiry**

| Term | Accompanying Operational Technique |
|---|---|
| **credibility** (in place of internal validity) | ***prolonged engagement and persistent observation:*** meaning an investment of sufficient time to become open to contextual shapers and factors and identify those characteristics and elements most relevant to the issue studied whilst avoiding overrapport. ***triangulation:*** of the different modes: using multiple methods to collect data from multiple sources offers a means that are compatible with this research model for verifying the meaning of data. ***peer debriefing:*** regularly undergoing a dispassionate analytical session with a disinterested peer to discover what ideas are implicitly held, by the researcher, about the inquiry. ***negative case analysis:*** using a process to reduce exceptions in the data to a zero rating (zero-rating was later thought to be too rigid a criterion). ***member checking:*** using a process whereby data, analysis, interpretations and conclusions are 'checked' by the stakeholding groups who provided the data originally. |
| **transferability** (place of external validity) | ***thick description:*** providing an illustration which includes in the widest possible range of information gained from a purposive research sample that has been analysed and interpreted according to the contextual influences and norms of the group involved. |

| | | |
|---|---|---|
| • **dependability** (in place of reliability) | : | ***audit trails:*** using intentions and dispositions, raw data, documentation, process notes, summaries of field notes, data reduction, analysis, reconstruction's and synthesis work to demonstrate the process of change. ***instrument development information*:** indicate development process which includes preliminary field work, tests, observation checklists, surveys and pilot data. |
| • **confirmability** (in place of objectivity) | : | ***audit trail:*** as above. ***reflexive journal:*** demonstrating researcher development which includes a daily schedule and logistics, a personal diary and a methodological log. |

(Based on Guba, 1981:75-92 and Lincoln and Guba, 1985:289-331 )

The criteria in table 16 provided guidelines to address mainly the methodological aspects of a constructivist inquiry. Guba and Lincoln (1989) were also concerned to address issues of quality, and later expanded their criteria to make the quality control process within the hermeneutic process more explicit. Quality control was achieved through a public inspection process. This offers an open, questioning, reflective and negotiating process to reduce the chance of non-credible outcomes, e.g. bias, distortion, secrecy or information shortage. This 'quality control' mechanism was thought to be an invisible process. Thus, to make the goodness and quality of a constructivist inquiry more explicit Lincoln and Guba (1985) argued that the following 'authenticity criteria' should be met:

| | | |
|---|---|---|
| • **fairness of findings** | : | achieved through proper representation of stakeholders in a group; achieved by open and honest negotiations; |
| • **ontological authenticity** | : | demonstrated by an improvement of an individual or groups conscious experience of the world; |
| • **educative authenticity** | : | demonstrated by greater understanding of other people's views; |
| • **catalytic authenticity** | : | action stimulated and facilitated by the evaluation process; |
| • **tactical authenticity** | : | more than achieving participation it is the degree to which participants are empowered to act. |

(Based on Lincoln and Guba, 1985:289-331)

The extent to which this set of criteria has been achieved may be recognised from individual testimonies and / or the documents within an audit trail. Guba and Lincoln (1989) argue that

achieving the methodological and authenticity criteria in constructivist (hermeneutic) inquiry is equivalent to achieving the criteria of validity, reliability and objectivity in a positivist inquiry, in that both establish the trustworthiness of research findings. These authors also acknowledge that the issue of quality criteria is not well resolved and still needs further critique (Guba and Lincoln, 1994). In terms of research practice Lincoln and Guba assert that it is,

> "not the [researcher's] task to provide an *index* of transferability; it *is* his or her responsibility to provide the *data base* that makes transferability judgements possible on the part of potential appliers," (1985:316).

This implies in evaluations that follow a hermeneutic research model that it is essential for researchers to present a sufficiently 'thick description' e.g. as in a detailed case study, from which readers can judge its trustworthiness, quality and degree of transferability to their own situation.

## 3.4 PARTICIPATORY ACTION RESEARCH APPROACH TO EVALUATION

This final section describes the foundations of the PAR approach, its connections with hermeneutic forms of inquiry and the way it can be used to encourage learning and the development of knowledge.

Participatory action research is an approach to evaluation that is located within the hermeneutic tradition and has been used in a variety of contexts including education, socio-economic development, particularly in third world contexts, and management (Argyris and Schon, 1978; Reason, 1988; Whyte, 1991). Its use has increasingly been advocated in the area of health (Baum, 1992; Park, et.al., 1993; de Koning and Martin, 1996; Poland, 1997; Costongs and Springett, 1997; Springett, in-press). Recent literature suggests that PAR, including variants of action learning and process management, is an appropriate way to develop the required skills and competencies of professionals and managers facing rapid change especially where there has been a shift of focus from content to process (Argyris and Schon, 1974; Peters and Waterman, 1982; Limerick, et.al., 1984; Whyte, 1991). Characteristically this form of evaluation unfolds in a steadily evolving process in which stakeholders are brought together, in a dialogical interchange, for the purposes of creating local knowledge. PAR is seen as a means of generating new knowledge, at local or grassroots level, by and for those who have a 'stake' in the outcome (Whyte, 1991; Patton, 1997; Springett, in press). The purpose of the PAR approach to evaluation is that it explicitly seeks action to enhance the process of change.

PAR has been used extensively in three different disciplines: community development, adult education and management science (Argyris and Schon, 1974; Rovers, 1986; Zuber-Skerritt, 1991; Whyte, 1991; Elden and Chisholm, 1993). Particular noteworthy examples are found in third world contexts where the indigenous population have been encouraged to become actively involved in the socio-economic development of their local communities (Hope and Timmel, 1984; Marsden and Oakley, 1990; Kirkpatrick, 1990). For example, the 'Participatory Planning Process' in Bangladesh (Bloem, et.al., 1996) and the development of the Pallisa Community Development Trust in Eastern Uganda (Okurut, et.al., 1996). The examples provide valuable frameworks for developing collaboration from which we, the 'West', can learn and utilise as we promote urban and rural community development (McTaggart, 1987; de Koning and Martin, 1996). These uses of PAR were characterised by inclusivity, where everyone and everything are in the process of development, and rooted in a concern to address issues of empowerment, capacity building and grassroots participation in community development (Park, et.al., 1993).

In Western liberal democracies action 'for change' research has emerged as organisations have sought to develop new strategies and competencies. These efforts have been directed towards assisting organisations become learning companies and centres of excellence in response to changes in government policy and current business practice (Peters and Waterman, 1982; Shani and Eberhadt, 1987; Whyte, 1991; Bushe and Shani, 1991; Ledford and Mohrman, 1993). PAR has been described by Whyte as emerging from intellectual development and action in three areas:

1. social research methodology;
2. participation in decision making by low-ranking people in organisations and communities;
3. socio-technical systems thinking regarding organisational behaviour (1991:7).

Researchers keen to recognise and establish the link between research and practice have eschewed traditional research approaches, assumed to *eventually* lead to improved practice, to develop applied social research in which research and action are closely linked (Shani and Eberhadt, 1987; Whyte, 1991; Bushe and Shani, 1991; Ledford and Mohrman, 1993). Schon (1983) argues that applied social sciences have been following what he called the professional expert model in which a researcher, as consultant, has been called in to investigate the problems in a situation, determine the facts and recommended remedial action. This research process, under the control of the researcher has been feasible where the purpose was to examine the facts and action implications. This approach

has failed those who were intent on achieving major processes of socio-technical change (Weisbord, 1976; Boss, 1989). The professional expert model was limited by the detached relationship of the researcher to organisational members and, therefore, in the ability to develop and nurture a process of change that resulted in organisational learning (Argyris and Schon, 1978; Argyris, 1992).

PAR, on the other hand, combines the intention to produce practical results and demonstrate research advances with enhancing change. Whyte (1991) defines it as having two basic characteristics, the first is the active involvement and participation of the members of the organisation or community being studied in all the steps of the process from design, through data gathering and interpreting the data to making decisions and taking subsequent action. The members participate actively with the researcher rather than be treated as passive recipients. The second characteristic concerns the intention of PAR to produce research findings that will lead to a practical application. These characteristics are particularly useful for illustrating how the participants become involved in the research process and for distinguishing PAR from other forms of participatory research that are not explicitly action oriented.

In social anthropology, long before participatory forms of inquiry became popular, many studies would have fitted the label of participatory research. The anthropological researcher as a participant observer served the community under study and participated in their way of life. There was, however, no ***explicit*** intent to produce action or change. The researcher as a participant observer was, however, found to be beneficial for discovering the key people in the group, identifying those who were particularly perceptive, insightful and knowledgeable about the rhythms and norms of the group, community or organisation (Patton, 1980). In PAR the distinction between researcher and researched becomes blurred (Guba and Lincoln, 1989; Whyte, 1991; Park, et.al., 1993). The relationship between key informant and researcher is one in which both become active participants in a research process that seeks to produce information on which to base action (Schon, 1983; de Koning and Martin, 1996). In participatory research the emphasis is on establishing dialogue between researcher and the people to find out and assist planning ways to help meet their needs. PAR differs from participatory research in that there is ***always an intent*** to combine the development of understanding and interpretation with an explicit commitment to create local knowledge for meeting and implementing specific proposals for change (Whyte, 1991).

## 3.41 Relationship Between PAR And Learning

PAR approach is particularly well suited to encouraging learning and knowledge development among those participants involved. Traditionally knowledge has come in the form of 'programmed' knowledge, that is expert professional knowledge delivered by expert authorities in the halls of academia, which has been said to inhibit the development of questioning and thus learning (Zuber-Skerritt, 1991). Revans (1982) provides an equation for learning as L = P + Q (figure 15).

**Figure 15**

**Revans' Equation For Learning**

$$L = P + Q$$

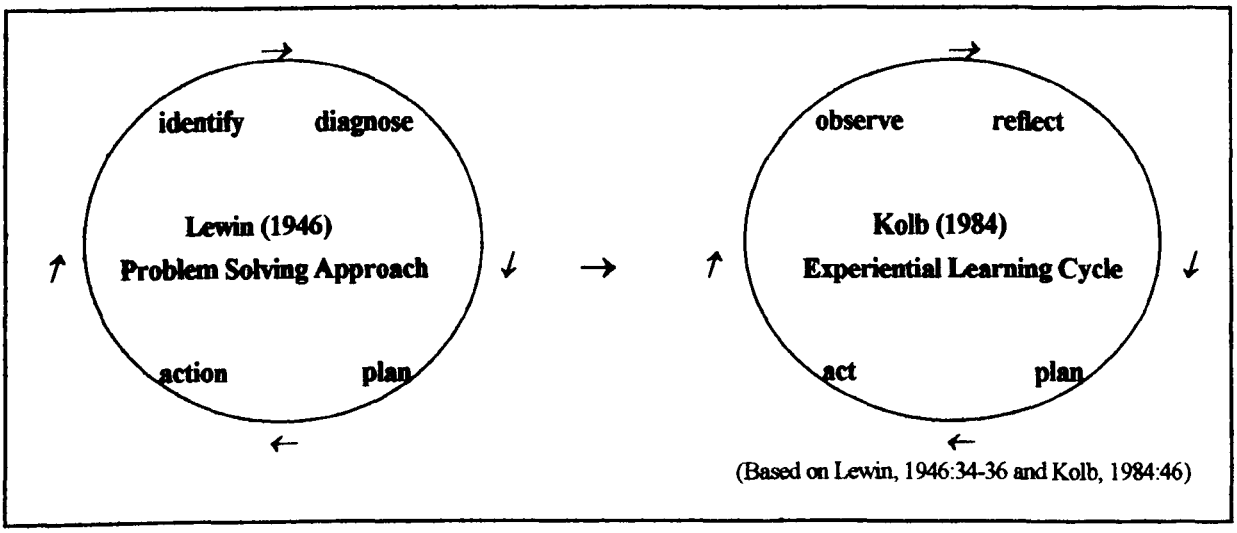
Learning = Programmed knowledge plus Questioning insight, which is the field of action learning

Schon (1983) has pointed to there being a crisis of confidence in expert professional knowledge and called for a shift from using technical rationality to adopting a process of reflection-in-action, citing this as the way to expand professional knowledge by supplementing it with questioning insight. In practice this implies that to expand P there has to be a development of Q in order to achieve L. Revans (1982) proposes action learning as the process by which groups of people, professionals of all kinds and learners generally, can learn in real time. This means working with real problems, under real conditions, which carries a real responsibility. The solutions created may need organisational change and challenge senior management decisions, but they are thought to be of greater benefit. The advantage of people finding their own solutions to problems is that they are more likely to act if they feel that their knowledge and beliefs are valid and valued (de Koning and Martin, 1996). The solutions are generated in a shared learning environment, e.g. learning as a very informal activity through the use of dialogue, and owned and acted upon by the people themselves (Zuber-Skerritt, 1991). Revans (1982) proposal shifts learning to within a group setting that bears the hallmarks of Freirian empowerment education and conscientization (Friere, 1972) as it is characterised by the notion of learning together via participation and dialogue. It is this process of action learning lying within the process of PAR that encourages learning and knowledge development among the participants.

The process of action research was first conceived by Kurt Lewin (1946) in research looking at group dynamics and was further developed by Kolb (1984) and Carr and Kemmis (1986) among others. The original problem solving model was linear and consisted of four stages: identify, diagnose, plan and act but in later developments the action research model was revised to consist of a spiral of cycles of action and research with four major phases: plan, act, observe and reflect (figure 16).

**Figure 16**

**Development Of The Action Research Cycle**




In Kolb's (1984) view the plan includes identifying and analysing the problems and designing an overall plan; action refers to the implementation of the plan; observation involves evaluation of the action undertaken, and reflection concerns looking at the whole: the action, the evaluation process and the results produced. This may, in turn, lead to the discovery of new problems which are then addressed by engaging in a new action research cycle. The basic assumption, given by Zuber-Skerritt was that,

> "people can learn and create knowledge,
>
> (1) on the basis of their concrete experience, (2) through observing and reflecting on that experience, (3) by forming abstract concepts and generalisations, and (4) by testing the implications of these concepts in new situations, which will lead to new concrete experience and hence, the beginning of a new cycle" (1991: xiv).

Lewin (1952) considered that training, research and action and a collaborative relationship with the research participants provided the basis for action research. It was these foundations that led to an

emphasis on action research as a strategy for change and participation in groups as the vehicle for managing and learning about the change process in human systems.

## 3.42 Role Of The Researcher In Participatory Action Research

In PAR approaches to evaluation the researcher is concerned to establish participatory activity for:

- developing dialogue and interaction;
- creating a dialectical interchange of views;
- establishing consent for action;
- creating conditions conducive to learning from experience and each other;
- creating the opportunity to work together to achieve change.

In PAR the role of the researcher extends beyond that of a project adviser as described earlier. It is more interactive and participative as it involves developing, co-ordinating, educating and facilitating a process of evaluation among a group of people in a particular organisational or community setting. The evaluation begins with the issues of research participants, following which its development and implementation is emergent, convoluted and often disorderly, in comparison with the linear models portrayed in traditional evaluation (Springett and Leavey, 1995; Marshall and Rossman, 1995). The cyclical flows of the action research process enables development of some elements and the implementation of other parts of the evaluation in tandem. It is useful to consider this type of evaluation as constituted of two phases: development and implementation, which often move along side by side, and not in a linear flow as separate parts of the evaluation make progress at different rates. The pace of progress is dependent on participants engaging in the action research cycle and learning how to negotiate conflict and arrive at an understanding of their common world (Taylor, 1987). The different views may see-saw back and forth in the dialectical process before stakeholders are able to establish consent which can be used as a basis for action. Meanwhile, those things already agreed go forward for implementation. The role of the researcher is to try to keep the evaluation process on track and help people to learn whilst co-developing and co-implementing the evaluation framework with the research participants. Amidst the evaluation process, it is also the researcher's responsibility to maintain a valid methodology according to the principles underpinning the hermeneutic research model and to act in accord with ethical principles for the research.

## 3.5 EVALUATING THE EFFECTIVENESS OF THE LMFTs PROJECT

Evaluating the effectiveness of the LMFTs project was to be achieved by stakeholders developing an evaluation approach from within a PAR framework. Some of the key points that emerged from the literature on organisational change (chapter two), and from this discussion on evaluation, will be drawn together in this section. These were used to form a frame of reference for the stakeholders to consider as they developed their approach to the evaluation of the LMFTs project.

Arguably the whole process of organisational change may be seen as an evaluatory act (Legge, 1984). In the preceding discussion on organisational change (chapter 2) the approaches and models all employ, in some form, an assessment to identify the gap between the present and the desired future state and an evaluation of the most appropriate change strategy to use. Thus, planning processes may be perceived as synonymous with change processes, and both as constituting an evaluation process (Legge, 1984).

The discussion on organisational change suggests that change programmes may be messy and problematic ventures to evaluate and that both change and evaluation are likely to be highly political and value laden processes. Moreover, how the effectiveness of the organisational change programme is conceptualised by the stakeholders (this includes the researcher) will have implications for the evaluation design and implementation (Patton, 1980; Robson, 1993; Park, et.al., 1993; Marshall and Rossman, 1995; Patton, 1997). In addition, organisational change may be seen as the province of many and composed of multi-level activities where outcomes can no longer be assumed to be the product of boundedly rational decisions (Cyert and March, 1963; Cohen, et.al., 1976; Dutton, et.al., 1983; Hill, 1993). Whipp et.al., (1989) assert that outcomes are more likely to be the result of shaping forces arising from vested interests (personal and group), bureaucratic momentum and a manipulation of the structural context. Change in this view is emergent and is often recognised as 'strategic' after the fact (Buchanan and Boddy, 1992). This suggested that the evaluation of the LMFTs project needed a broad perspective to encompass the way the political and cultural dimensions of the change process influenced the process of implementation (Quinn, 1980; Pettigrew, 1985; Pettigrew, et.al., 1992).

The most common forms of evaluating effectiveness at the level of the organisation are the normative models relating to goal achievement (Perrow, 1961; Weiss and Rein, 1970; Patton,

1997), system resource acquisition (Yuchtman and Seashore, 1967; Legge, 1984) or participant-satisfaction (Keeley, 1978; Williams and Calnan, 1991). All of these models encounter practical and conceptual problems in implementation (Legge, 1984). These approaches result in problems of identifying and prioritising between conflicting goals, or system-resource acquisition strategies and or participants' satisfaction criteria (Legge, 1984) as well as the difficulty of how to weight the preferences of different programme participants (Mohr, 1982). Legge concludes that evaluating planned organisational change is,

> "generally speaking a formal evaluation [that] often founders through different interest groups' inability to agree on evaluation criteria or on the functions an evaluation should serve. If one of the normative models for assessing effectiveness is employed as the basis for an evaluation design, expectations are often unrealistic as the difficulties involved may not be fully understood or anticipated," (1984:44).

Evaluating the effectiveness of the LMFTs project in PHC could therefore, to a limited extent, be examined by using the goal-achievement model (Perrow, 1961; Weiss and Rein, 1970; Patton, 1997). This model does not however readily embrace the four dimensions of PHC outlined in chapter two or the aspects of team effectiveness identified as relevant to the development of PHCTs.

A broader perspective on organisational change can be achieved by applying a systems approach to organisational analysis. This is an approach that considers the organisation as a functional whole system (Bertalanffy, 1968; Checkland, 1981). An assumption is made that an organisation has boundaries which enables a definition of its limits and an analysis of its interchanges, e.g. within or across a boundary. The system is comprised of a set of subsystems that are distinct from, but mutually interactive with each other, and the environment. The organisation is seen as processual and is assumed to survive by making continual interactions with the environment via inputs, transformation, outputs and feedback processes. Change is perceived in terms of the adaptions and mutual adjustments an organisation makes to maintain it's equilibrium (Pugh and Hickson, 1989). A system is viewed as being either pulled toward or away from a stable state. An organisation's equilibrium is characterised by stable regular behaviour and instability by conflicts, disorder and the occurrence of unanticipated events (Stacey, 1995).

In a systems approach it is the processes organisations use to regulate activities within their subsystems that are the prime focus for analysis (Pugh and Hickson, 1989). The focus is on finding

regularities and patterns that reveal how a system is responding and adapting to its environmental stressors (Pugh and Hickson, 1989; Stacey, 1995). A primary concern is to establish connections and determine the level of equilibrium within the system. A successful change is expressed in terms of achieving, "equilibrium and thus stability, regularity and predictability," (Stacey, 1995:477). The assumption is that environmental changes are identifiable and that organisations are able, through the processes of restructuring, to adapt and transform themselves in predictable and patterned ways to meet the new demands (Zajac and Kraatz, 1993). Organisational change can be perceived as adaptive or part of a selective ecological survival process (Aldrich, 1979; Hannan and Freeman, 1977, 1984; Pettigrew, et.al., 1992), whichever perspective is used both consider it is the organisational processes that maintain pressure and 'pull' the organisation towards the a state of equilibrium.

In addition, Stacey (1995) suggests organisations can operate in 'bounded instability' - a paradoxical state of order and disorder. He argues that it is irregularity and non-equilibrium that are necessary conditions from which new structural forms, self-organisation and unanticipated outcomes emerge (Stacey, 1995). This implies an organisation should be observed for both its state of equilibrium and dis-equilibrium. In this view disorder is not, as often supposed, the result of incompetence, ignorance or inertia but perceived as vital conditions for achieving changeability and innovation within an organisation (Wolfram, 1986). This suggests order may emerge out of disorder and be the product of a combination of informal network connections and the formal laws governing the system. The systems approach offers a perspective that can embrace the four dimensions of PHC but it does not, however, provide a frame of reference for assessing team effectiveness.

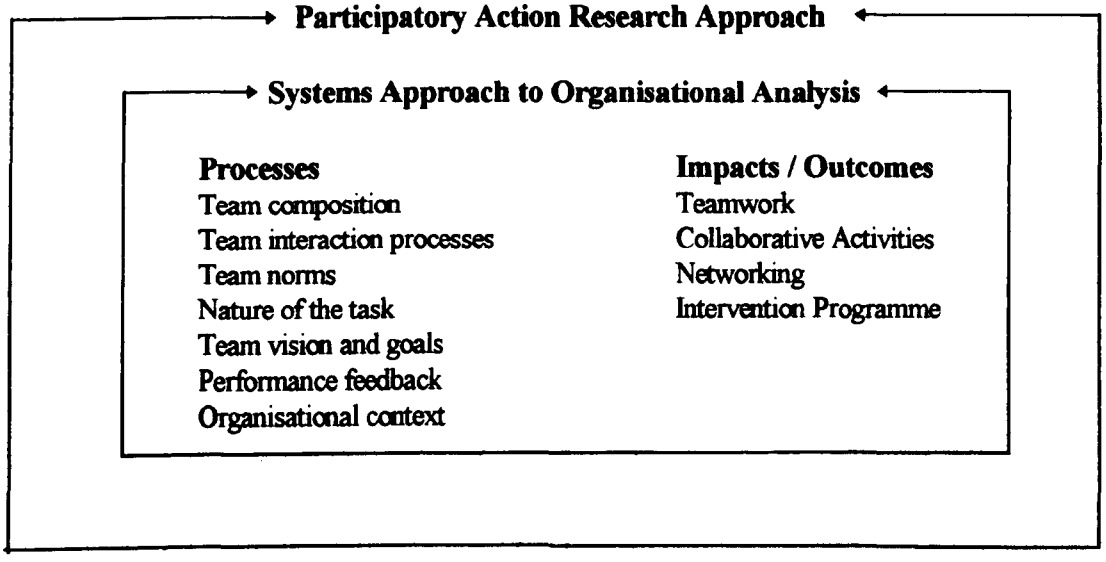
Assessing team effectiveness may be approached by applying a combination of certain aspects of those models developed in organisation psychology to PHCTs in PHC. In particular the key factors (figure 17) together with the critical components of team effectiveness (West, 1994; West and Poulton, 1997), potentially offer a heuristic scheme for evaluating the processes involved in the implementation of the LMFTs project.

Thus, where the goal-achievement model provides an 'outcome' frame of reference for the stakeholders, the dynamics of organisational groups offers a 'group processes' frame of reference. The combination of these two frames of reference within a systems view of organisational analysis

offered the stakeholders a tentative scheme to consider as they developed the evaluation of the LMFTs project from within a PAR approach (figure 17).

**Figure 17**

**A Tentative Scheme For Developing The Evaluation Framework For LMFTs Project**




This tentative evaluation scheme permitted PAR, case study and systems approaches to be combined within the overarching framework of a hermeneutic form of inquiry. It was argued that these different approaches could all be positioned within a hermeneutic meta-framework because they all, either explicitly or implicitly, subscribed to the notion of people as knowing participants, learning what shaped their world and learning what they could do to adapt or change it (Friere, 1972; Mackie, 1980). Additionally, the adoption of this position could also be linked to the notion of a participatory worldview (Heron and Reason, 1997), and to the idea of forming a participatory methodology (Skowlimowski, 1994), as previously discussed in chapter one.

## 3.6 SUMMARY AND CONCLUSION

This chapter has presented the main aspects to be considered in the design and implementation of an evaluation, as well as the principal tenets of both traditional and hermeneutic research models. The LMFTs project involved assisting with the development of PHC, and challenged policy-implementors (managers) and health workers alike to work together for the benefit of the system as a whole. Evaluating the LMFTs project meant having to deal with many variables and its evolving, creative nature. A PAR approach was adopted, as opposed to a traditional research model, as it was thought to have the greater flexibility and power to evaluate this experimental model for change.

The evaluation of the LMFTs project was achieved by building a case study of the project. This approach was used to provide the stakeholders with an opportunity to learn both propositional and experiential knowledge and broaden their understanding from the narrative that would be generated (Polyani, 1962; Geertz, 1983; Stake, 1994). The case study approach was a strategy for doing research rather than a method and involved collecting evidence from multiple sources about a particular phenomena in a real life context (Robson, 1993). In the case study, the situation, the people and the methods used characterise the case. The evaluation was designed to understand the LMFTs project as an integrated and bounded system of purposes, parts and functions within a particular context rather than any generalisation beyond it (Stake, 1994).

The evaluation of the LMFTs project consisted of three phases of implementation, was eclectic in form, and followed a PAR approach which was situated within a meta-framework of a hermeneutic form of inquiry. The stakeholders involved in the LMFTs project were engaged in two different but inter-related elements of the PAR approach: participatory processes for establishing dialogue; and action research cycles for providing feedback and achieving critical reflection as the means of informing their future actions. The next chapter describes how the approach to the evaluation was developed and implemented.

# CHAPTER FOUR

# IMPLEMENTING THE EVALUATION APPROACH

## 4.1 INTRODUCTION

This chapter describes the process of implementing the evaluation approach based on a systematic reflection of that process. The implementation consisted of phases one, two and three, and there were five key elements common to all phases (table 17). A preliminary section will describe the general nature of these five key elements. The subsequent sections will give details of the three phases and describe them in terms of the specific activities relating to the five key elements. At the end of each phase there will be a short commentary highlighting the key points. Phase one is an exception in that the initial steps taken to develop the evaluation framework will be given before the description of the five key elements. The final summary of the chapter brings together the key points from each phase about which some general comments will be made.

**Table 17**

**Three Phases And Five Key Research Elements Of The Evaluation**

| Phase | Time Frame | Key Research Elements In Each Phase |
|---|---|---|
| One | February 1994 to January 1995 | Recruitment of a Research Sample<br>Data Gathering Activities<br>Data Management and Analysis<br>Data Feedback<br>Critical Reflection and Refinement of the Research Design |
| Two | February 1995 to January 1996 | |
| Three | February 1996 to January 1997 | |

It is important to remember that the implementing the evaluation approach was an emergent process and that the emerging evaluation framework was a product of a negotiation between the stakeholders. The researcher acted as an instrument of the evaluation and was responsible for initiating and implementing a PAR approach to the evaluation. The main components of the researcher's formal role are given in table 18.

**Table 18** **The Main Components Of The Researcher's Role Within The Evaluation**

| Phase | Who | When | Key Research Elements Undertaken In Each Phase |
|---|---|---|---|
| **Inception** | Founder | Sept. 93 - Mar. 94 | Put forward some initial ideas for the evaluation framework; Acted as LMFTs project leader (*left in March 1994);* |
| **Inception**<br>**One**<br>**Two/Thre.** | University<br>Research<br>Team | Sept. 93 - Jan. 94<br>Feb. 94 - Jan. 95<br>Feb. 95 - Jan 97 | Created the proposed evaluation framework that was accepted in the tender;<br>Guided the Researcher's initial steps in the development of the research process;<br>Supervised the Researcher via tutorials; |
| **One** | Researcher | Feb. 94 - Mar. 94<br>Mar. 94 - Nov. 94<br>Aug. 94 - Jul. 95<br>Mar. 94 - Dec. 94<br>Sept. 94 - Jan. 95<br>Dec. 94 - Jan. 95<br>Dec. 94 - Jan. 95 | Researcher appointed; met stakeholders; set up the Research Steering Group (RSG); established participatory workgroup activities;<br>Facilitated the collaborative creation of the evaluation framework by correlating the material and producing documents for discussion;<br>Recruited the first research sample: 7 Practices (I for pilot study);<br>Continuous cycle of data gathering from the LMFTs activities, and from the pilot study;<br>Created a data management system and made a preliminary analysis of first round of data collected;<br>Provided feedback to RSG, LMFTs and to the Practice in the pilot study;<br>Facilitated, and participated in, an RSG 'end of year' formal review, refinement of the research design & production of a report; |
| **Two** | Researcher | Feb. 95 - Jul. 95<br>Feb. 95 - Dec. 95<br>Sept. 95 - Jan. 96<br>Feb. 95 - Jan. 96<br>Feb. 95 - Jan. 96<br>Dec. 95 - Jan. 96 | Continued to recruit the first research sample;<br>Continuous cycle of data gathering from the LMFTs activities, and gathering of baseline data from 6 Practices and from LFHSA;<br>Correlated and made a preliminary analysis of the second round of data collected;<br>Ongoing provision of feedback to RSG and to individual LMFTs, and individually to the 6 'sample' Practices;<br>Facilitated, and participated in, an ongoing process of critical reflection of the data collected;<br>Facilitated, and participated in, an RSG 'end of year' formal review, refinement of the research design & production of a report; |
| **Three** | Researcher | Jan. 96 - Apr. 96<br>Jan. 96 - Sept. 96<br>Jan. 96 - Nov. 96<br>Jan. 96 - Dec. 96<br>Dec. 96. - Jan. 97 | Recruited second research sample of 20 Practices;<br>Continuous cycle of data gathering from the LMFTs activities, and data gathering from 20 Practices;<br>Correlated and made a preliminary analysis of the third round of data collected; ongoing provision of feedback to the RSG and the LMFTs;<br>Facilitated, and participated in, an ongoing process of critical reflection of the data collected;<br>Facilitated, and participated in, an RSG 'end of project ' formal review and the production of five 'end of project' reports. |

**KEY : Inception** Sept. 93 to Jan. 94 **Phase One** Feb. 94 to Jan. 95 **Phase Two** Feb. 95 to Jan. 96 **Phase Three** Feb. 96 to Jan. 97

**RSG:** In the main most of the RSG members did not become actively involved in the research process other than during the cyclical 'critical reflection' within their meetings;

**LMFTs** : The LMFT members became more involved over time and were actively participating in collecting data from their own activities and its analysis during phase three;

**Reports** : The Researcher produced all the reports, first as documents for discussion and subsequently refined them following the stakeholders critical reflections. The final LHA report bears all the Researcher's supervisors names as a matter of courtesy and adherence to protocol.

In addition, the PAR process needed to be sustained by the regular personal presence of the researcher who attended the LMFTs' meetings and their intervention activities, and who sought many 'ad-hoc' meetings with various individuals to smooth out the course of the PAR process. The 'ad-hoc' meetings were a necessary adjunct to the more formal pathways that the researcher created and formed part of the process of disseminating information, maintaining dialogue, diffusing tension and encouraging stakeholder participation.

## 4.2 FIVE KEY ELEMENTS

### 4.21 Recruitment Of A Research Sample

A purposive sampling strategy was used to select a research sample of Practices from which to learn and understand what development and change looked like in Practices in Primary Health Care (Patton, 1980). The research sample was selected by stakeholders using an adapted 'snowball' sampling scheme or nomination process (Sudman, 1976). An information sheet was circulated to the different stakeholder groups in preparation for undertaking this nomination process, for an elaboration of the snowball sampling scheme used see appendix 3.

### 4.22 Data Gathering Activities

In view of the number of different stakeholder groups involved it was decided that a multiple method strategy was the best option for achieving the various perspectives of the LMFTs project. table 19 below provides a summary of all the methods used for gathering data from a multiple of sources. The data was gathered from the LMFTs as a continuous process across all three phases and from the Practices in two separate data collection cycles in phases two and three.

**Table 19**

**Summary Of Data Gathering Methods And Tools Used Throughout The Evaluation**

| Data gathering from LMFTs | | Data gathering from Practices | |
|---|---|---|---|
| **Qualitative** | **Quantitative** | **Qualitative** | **Quantitative** |
| • Intervention Records: Plans, descriptions and self-evaluation forms; Diary sheets, Records of meetings;<br>• Mapping networks and informal team discussions;<br>• Self, peer and formal course assessments;<br>• Participant observation;<br>• End of project informal discussions; | • Intervention records: number of interventions; attendance figures; | • Participant Observation;<br>• Practice general checklist;<br>• Key informant semi-structured interview schedule;<br>• Mapping networks; | • LHA Annual Practice Reports, figures on: Health promotion banding figures; Immunisation; Vaccination; Cervical smears; |
| • In addition, three descriptive journals were used, by the researcher, to record details of the evaluation process:<br>1. substantive issues relating to the LMFTs and Practices, e.g. furtherance or constraints to progress;<br>2. methodological issues reporting progress and problems of the research process;<br>3. personal reflections of the researcher. | | | |

## 4.23 Data Management And Analysis

It was anticipated that a considerable amount of data would be generated during the course of the evaluation and consequently that a system for managing and analysing the data would need to be created. The following table 20 outlines the steps that were taken to establish an on-going data collection system throughout the evaluation.

**Table 20**

**Steps Taken To Create A System For Managing The Data**

**Step 1** All the data that was collected in the three phases was stored by Practice or LMFT;

**Step 2** Field notes, e.g. those taken at a Practice or LMFT visit, were re-organised around a set of themes which were relevant to the four key areas: personal, organisation, service and wider community in the evaluation. These themes were subject to on-going revision to accommodate data that did not fit the initial themes. This was a crude but effective process that helped to generate a basic coding system.

**Step 3** Each set of data, that is the hand-written notes, maps, and tape recordings were either typed out or drawn and collated to create a case record. This was to be a cumulative process which began as soon as possible following each Practice or LMFT visit. The creation of the case records helped to sensitise both researcher and other stakeholders to, and embed them in, the prevailing contextual issues of both the LMFTs project and its evaluation.

**Step 4** Additional details were provided in the researcher's descriptive journals which detailed the evaluation process.

The process of data analysis was considered to be an iterative activity and therefore did not occur at a specific phase in the research process. The process entailed three main activities: data reduction, data presentation and drawing conclusions and verification (Robson, 1993; Marshall and Rossman, 1995; Patton, 1997). In this study data reduction involved the reducing of data, by the researcher, into themed case records, data presentation involved exposition to the various different stakeholders and, drawing conclusions and verifying them was undertaken with the stakeholders via the action research cycle. These three activities proceeded concurrently, one taking precedence over others at various times. All three activities of data analysis were used in combination to provide a comprehensive and robust explanation of successes and challenges of the effectiveness of the LMFTs project (Yin, 1994; Marshall and Rossman, 1995). Thus, data analysis was an on-going, inter-related and circular process, each activity feeding into another and, in turn, this process feeding into the data feedback and critical reflection dimension of the PAR cycle in each of the three phases.

## 4.24 Data Feedback

The information feedback process did not occur at one specific time in the evaluation. It was an iterative activity which amounted to continuously feeding information into the participatory workgroups in each phase of the evaluation (Reason, 1988; Whyte, 1991; Zuber-Skerritt, 1991). The provision of regular feedback, in both verbal and written forms, was beneficial for furthering participation and critical reflection between stakeholders and for assisting them with future decision making (table 21).

**Table 21**

**Beneficial Aspects Of Providing Regular Feedback**

- engaging participants in the study;
- keeping the stakeholders aware of the research activities and emerging issues and concerns;
- serving as a tool for learning about political, technical and cultural issues as shapers of substantial change;
- guiding the future direction of the LMFTs and their evaluation;
- providing rich descriptive detail on specific Practice and LMFTs activities;
- forming the basis for reflection, critique and analysis for stakeholders reflecting-on-action undertaken;
- sharpening the analysis of the LMFTs and their evaluation through incorporation of multiple views;
- providing a check for gaps in data collected from Practices and LMFTs;
- providing checks on accuracy of data which increased its validity via 'member checking';
- instrumental to drawing conclusions and verifying emerging hypotheses;

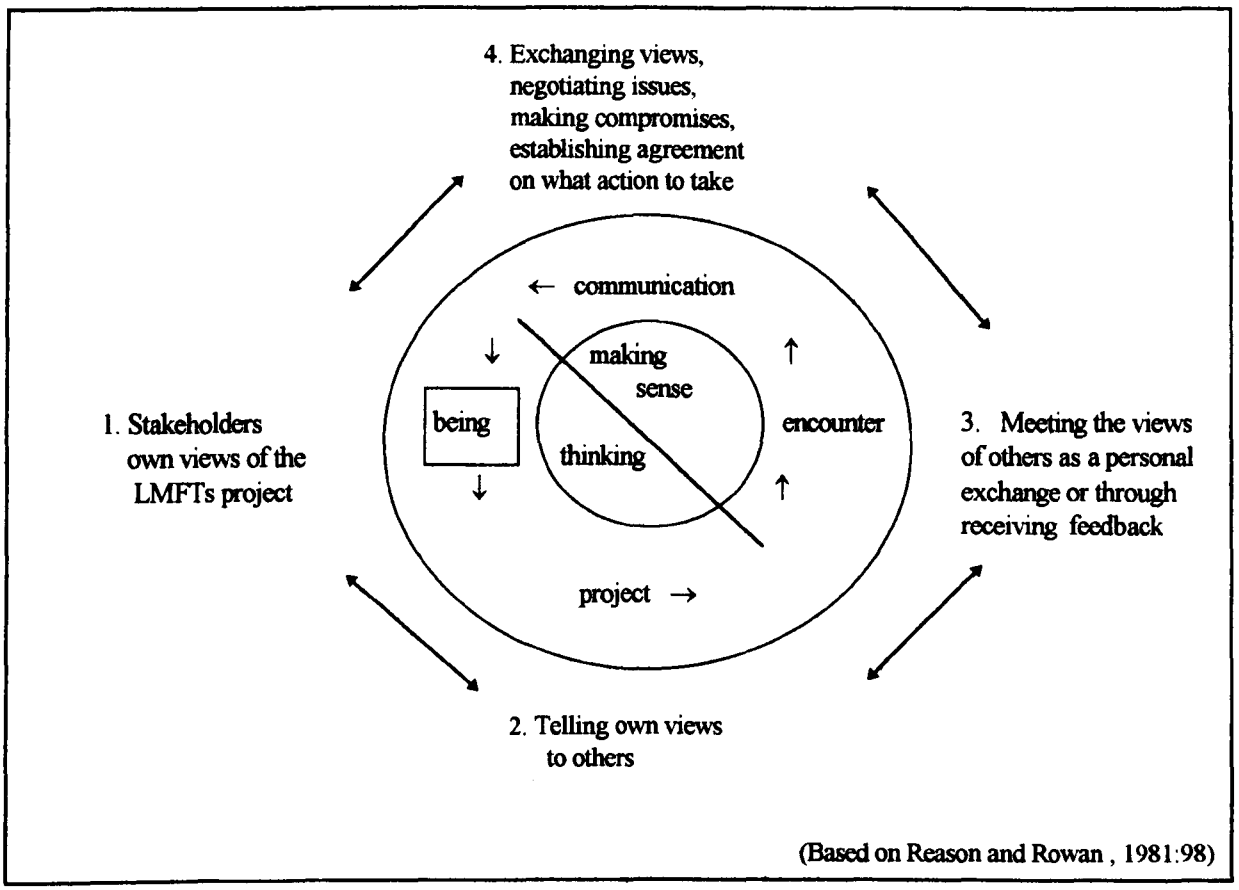
## 4.25 Critical Reflection And Refinement Of The Research Design

The research design was refined on the basis of the feedback and as a result of the process of critical reflection between stakeholders. The underlying assumption was that the LMFTs project was of such size and complexity that it would need regular rethinking and adjustment of both the LMFTs and the evaluation efforts to stay on course and answer the stakeholders questions. The means of achieving this was built into the evaluation through the researcher instigating the use of the action research cycles within the participatory workgroups. The participatory workgroups drew together representatives from the key stakeholders groups involved in the LMFTs project, as discussed later in figure 20. These provided structured opportunities for 'feeding in' the information and promoting critical reflection between the stakeholders in each phase. In this way the stakeholders monitored the implementation of the LMFTs project and the evaluation framework and made refinements as necessary at the end of each phase (Reason and Rowan, 1981; Whyte, 1991; Marshall and Rossman, 1995). The use of a cyclical process of feedback and critical reflection helps to explain how the research design was an emerging evolving system and that the whole process was a negotiation between stakeholders.

It was through involvement with this cyclical action research process that the stakeholders were encouraged to learn and develop their own knowledge (Revans, 1982) (figure 18). The expert or programmed knowledge of stakeholders was expanded by the researcher involving them in the reality of developing and implementing the evaluation framework. Their 'questioning insight' was increased by them having to work out, for themselves, the solutions to problems as the evaluation proceeded (Revans, 1982). Here, learning was an informal activity that came about through dialogue with others within the action research cycles (Zuber-Skerritt, 1991). It supported the process of change and development by generating knowledge from within the organisation. Local knowledge was produced as a result of collective learning between the stakeholders and, as intended, combined the development of understanding between stakeholders with the production of local information on which they could base further action (Whtye, 1991).

**Figure 18**

**Dialectical Research Cycle**




The purpose of engaging stakeholders in the hermeneutic, dialectical research cycles was to help them find out what meaning they gave to both the LMFTs project and its evaluation. This was a process of learning that involved stakeholders undertaking dialectical exchanges that eventually led them to developing a second 'collective' construction of the LMFTs project and evaluation. This secondary view was created from the sum of their first or primary constructions of the LMFTs project. Importantly to arrive at the second construction, the stakeholders had to negotiate their individual claims, concerns and issues as a key part of achieving an agreement. The exchange of views between stakeholders was used as a way to bridge the gap between theory and practice. The two were interdependent and therefore crucial to the creation of knowledge that they used to make decisions and plan future action (Schon, 1983; Kingsley, 1985).

What seemed to be happening in this process of dialogue was that the stakeholders personal theories-in-use, that is their assumptions, were challenged by learning about the theories-in-use of others (Argyris and Schon, 1974). As the stakeholders tried to find and agree on the way forward one person was not able to make decisions from their perspective alone, it had to be a joint decision that accommodated all their views. This amounted to a public inspection of their assumptions, e.g. stating their views to others, which was essential for developing information and leading stakeholders to reflect and re-appraise the assumptions underpinning their ideas and actions (Argyris and Schon, 1974). The consequences for learning was that each stakeholder was encouraged to move beyond single loop learning, that is maintaining the constancy of their own professional view, towards double loop learning whereby they made changes (modifications) to the governing variables of their own belief systems. Figure 19 illustrates schematically the process stakeholders went through within the dialectical research cycle.

**Figure 19**

**A Schematic Illustration Of The Learning Process Within The Dialectical Research Cycle**

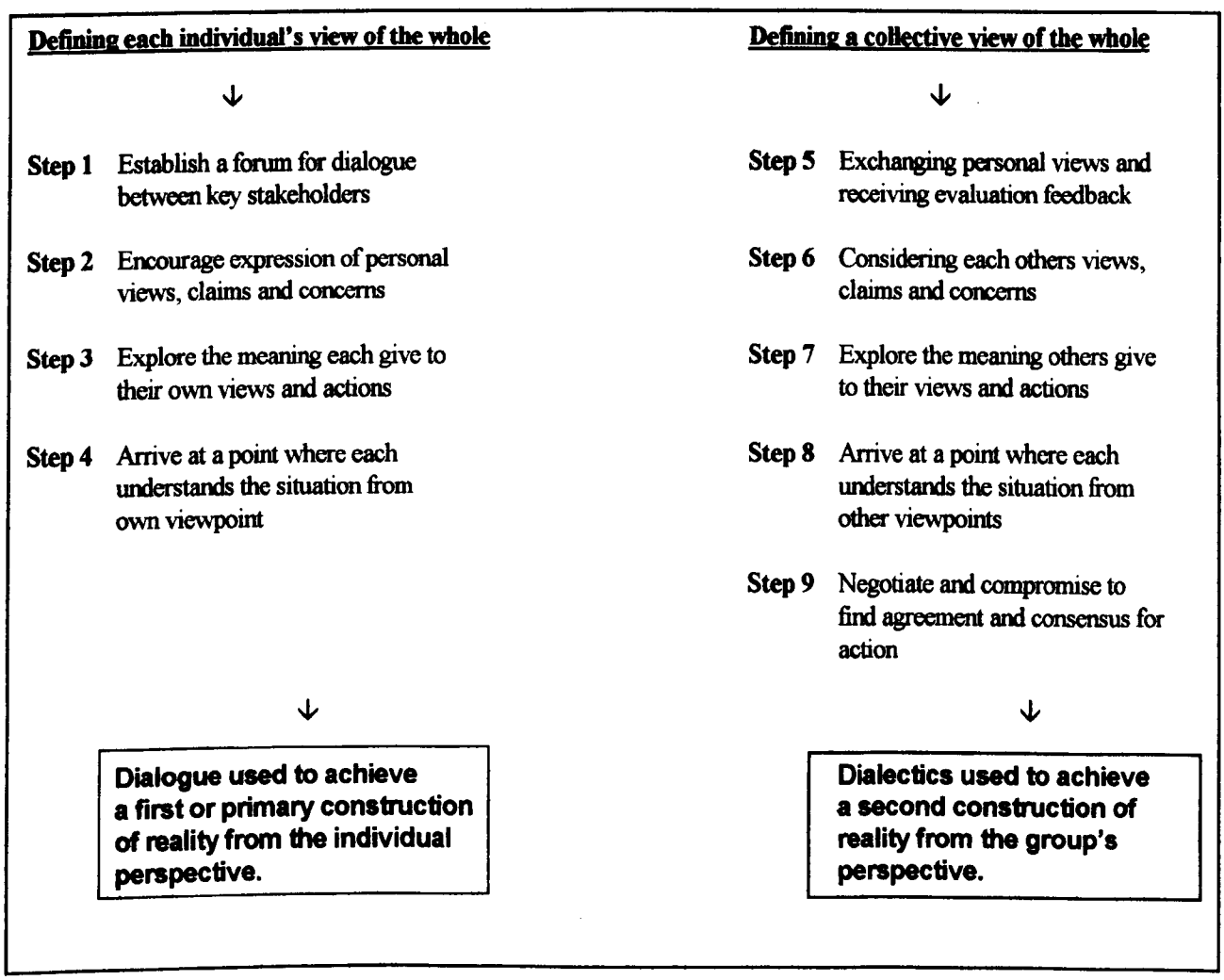


**Table 22**

**Establishing Confidence In The Findings Of The LMFTs Project Evaluation**

| Criteria | Mechanism | Application to Evaluation |
|---|---|---|
| **Credibility** | • prolonged engagement<br>• triangulation<br>• member checking | • LMFTs and Practices were subject to persistent observation throughout the evaluation.<br>• Different modes and sources of data were compared with each other to establish and verify the meaning of data.<br>• Data, analysis, interpretations and conclusions were 'checked' by various individuals and groups of stakeholders. |
| **Transferability** | • thick description | • Information was gathered to give a thick description of the participants, the context and their activities. The meaning of the data was interpreted in terms of the prevailing contextual issues, claims and concerns surrounding the LMFTs. |
| **Dependability** | • audit trails | • An 'audit trail' was established by the creation of LMFT and Practice case records in which original notes, documents and journals permit an assessment of the degree to which proceedings fall within generally accepted practice. |
| **Confirmability** | • reflexive journals | • Three reflexive journals were used to record details of the evaluation process. |
| **Authenticity** | • properly representative<br>• open & honest negotiation<br>• improvement of conscious experiences<br>• greater understanding other's views<br>• stimulated and facilitated action<br>• participation that increased the degree people empowered to act | • All key stakeholder groups were represented in the RSG and involved in the information feedback and PAR cycles.<br>• Stakeholders interests were openly acknowledged, discussed and negotiated.<br>• Stakeholders were brought together to engage in dialectical exchange for the purpose of improving their conscious experience of the world.<br>• Stakeholders were encouraged to talk with each other to gain greater understanding of each other's views.<br>• PAR cycles were concerned with reflection-on-action as a means to inform future action.<br>• Stakeholders were expected to act as a result of their reflection-on-action process.<br>(Based on Guba, 1981:75-92 and Lincoln and Guba, 1985:289-331) |

The manner in which each of the key elements outlined above was used in each phase combined to create a systematic approach to establishing confidence in the findings. Throughout the evaluation the criteria set out by Guba (1981) and Lincoln and Guba (1985), and discussed in section 3.31, were used as a guiding framework. Table 22 illustrates what mechanisms were used and how these were applied to achieve a credible process of evaluation.

## 4.3 PHASE 1: DEVELOPING THE EVALUATION APPROACH

The main components of phase one were establishing the participatory evaluation activities, designing the research framework for the evaluation and testing the feasibility of the design in a pilot study. Each of these will be described in turn. The description of the five key research elements are related within the context of the pilot study.

### 4.31 Establishing The Participatory Evaluation Activities

The agreement to use a PAR approach challenged the researcher to find ways to establish the two inter-related elements: the participatory processes and the action research cycles as part of the evaluation. An additional practical challenge was to organise participatory processes that not only involved stakeholders but also helped them to articulate their diverse interests. Of equal importance was also finding a way to handle the multiplexity of issues, events, and effects in such a way that aided stakeholders understanding of their significance in producing PHC development.

The researcher having used participatory workgroups in educational settings decided to use these as the means to establish the two inter-related elements of PAR into the evaluation. The stakeholders were brought together in a participatory working group to achieve the necessary interaction between them for designing and implementing an evaluation framework. The assumption was that participatory activity was essential for a collaborative construction of the evaluation wherein stakeholders designed their own research framework rather than following an externally prescribed traditional evaluation process (Guba and Lincoln, 1989; Skowlimoski, 1994; Kruger and King, 1998). Thus, participatory workgroups were used to increase stakeholders understanding of the processes, impacts and outcomes of the LMFTs and the evaluation as they became part of an information and communication exchanging process (Reason, 1988; Guba and Lincoln, 1989; Cornwall, 1996; Kruger and King, 1998). The participatory workgroups provided the forum in which action research cycles were set up and used to develop, monitor and refine both the LMFTs interventions and the research design.

The development of the framework for the LMFTs evaluation was, therefore, the result of a logical process (table 23), each part of which will now be described in turn.

**Table 23**

**Steps Taken To Develop The Framework For The LMFTs Project Evaluation**

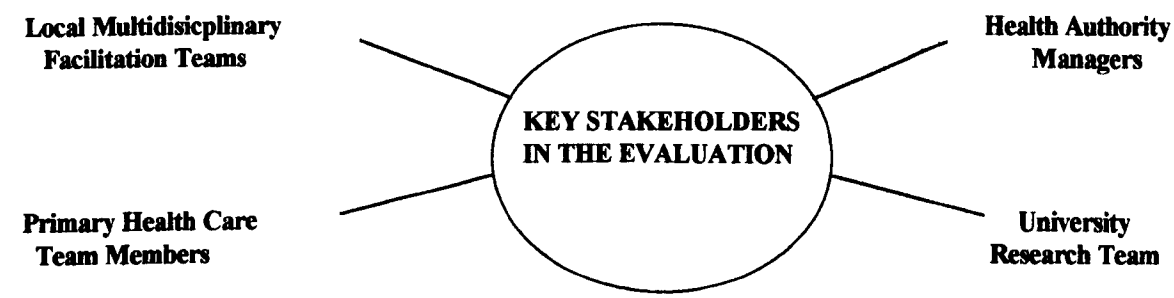
| Phase | Time Frame | Activity |
|---|---|---|
| One | February 1994 | **Establishing participatory activities:**<br>- forming the participatory workgroups |
| | February to October 1994 | **Developing the framework for the evaluation:**<br>- deciding the purpose of the LMFTs and the evaluation<br>- identifying the key issues and concerns<br>- designing the data gathering activities |
| | September 1994 to July 1995<br>November 1994 to January 1995<br>November 1994 to January 1995<br>December 1994 to January 1995<br>February 1995 | **Testing the feasibility of the design in a pilot study:**<br>- recruitment of a research sample<br>- data gathering activities<br>- data management and analysis<br>- data feedback<br>- critical reflection and making refinements |

## 4.32 Forming Participatory Workgroups

The first step was to organise the participatory work groups. It was agreed with the FHSA that a research steering group (RSG) be established, the membership of which had to be negotiated. This was a difficult process as health services managers were keen to direct and control the evaluation from a small steering group whereas the research team wanted to establish a PAR approach as originally proposed. After considerable negotiation, largely on a one to one basis with senior health authority managers, it was agreed that the RSG was to consist of eleven members, nominated by colleagues, and representative of the main stakeholder groups involved in the LMFTs (figure 20).

**Figure 20**

**Key Stakeholder Groups And Membership Of The Research Steering Group As Negotiated**




**Primary participatory workgroup, the Research Steering Group, membership:**

- 4 LMFTs: General Practitioner; Health Visitor; Practice Nurse; District Nurse;
- 1 LMFT Administrator;
- 2 Health Authority Managers: Director of Quality Assurance, Consultant in Public Health;
- 2 University Research Team: Director of Research, Dedicated researcher;
- 2 Non-involved Primary Health Care Team members: General Practitioners;

**Secondary participatory workgroups were formed by members from the four stakeholder groups.**

The main stakeholder groups were identified as those who had been involved in the LMFTs since its start and those whom the intervention was to effect. Each nominee undertook a commitment to feedback information to colleagues in the wider research community. Once nominees had agreed to join the RSG they were invited to attend a series of eight, two hour, participatory workgroups. This was the primary participatory workgroup in the evaluation. Secondary participatory workgroups were established later as it became recognised by the researcher that the RSG was providing an insufficient opportunity for stakeholder participation. The PHCTs that formed the research sample were not involved in developing the evaluation framework, their interests were considered to be represented by the two general practitioners, not-involved with the LMFTs project, and the LMFT members. The choice of using not-involved GPs came from the stakeholders medical model approach to 'objective' evaluation.

## 4.33 Developing The Framework For The Evaluation

The initial task of the RSG was to develop the LMFTs research framework for the evaluation. The stakeholders first met as a participatory research steering workgroup in March 1994. Before the stakeholders began the process of developing the evaluation framework the research team provided detailed guidance on the nature of the PAR approach and clarified the proposals as given in the tender for evaluation which is elaborated in appendix 2. After this, designing the framework for the evaluation was broken down into the following three parts,

- determine what was understood to be the purpose of the LMFTs and clarifying evaluation criteria;
- identifying and including key concerns;
- designing the data gathering activities, that is deciding most appropriate research methods to use and specifying the scope of the research.

These three parts were gradually worked through during the first eight of the RSG meetings. The participatory workgroups were all structured to encourage dialogical and dialectical exchanges between stakeholders in the effort to achieve agreement on the approach to the evaluation (the participatory process is explored in detail in appendix 4). After the first meeting the researcher, using the stakeholders' ideas, created the first tentative evaluation framework (table 24). This was circulated to all the RSG members for their reflection two weeks in advance of the next meeting.

At the second RSG the stakeholders, as part of the dialectical process, were brought together to encounter, communicate and try to make sense of each other's views (Guba and Lincoln, 1989). They undertook a critical examination of the nine themes in the first working document (table 24).

However, the stakeholders were not able to achieve working through the entire document in the time available. A secondary participatory workgroup was proposed and subsequently organised to complete the outstanding RSG work. After this the secondary workgroups became a regular feature of developing, and later implementing, the evaluation. They increased the level of participatory activity, ensured more stakeholder's views were heard and helped to sustain the momentum of the evaluation.

**Table 24**

**Three Successive Steps In Creating The Evaluation Framework**

| **First Working Document - a tentative evaluation framework** | | | |
|---|---|---|---|
| 1. Contextual setting of the LMFTs | | | |
| 2. Communication | 3. Networking | 4. Role Clarification | 5. Co-operation |
| 6. Development: facilitation skills | 7. Development: self | 8. Development: teams | 9. Development: organisations |

⇩

| **Second Working Document - a refined version that collapsed the nine key areas into three:** | | |
|---|---|---|
| 1.<br>• Improvement of the delivery of primary health care | 2.<br>Effective collaboration:<br>• making connections<br>• working together | 3.<br>Levels of Development:<br>• the ability to facilitate<br>• LMFT interventions<br>• organisational development |

⇩

| **Third Working Document - a refined version that expanded version two and identified four key areas:** | | | |
|---|---|---|---|
| **1. Personal:**<br>• self development<br>* personal growth<br>• the ability to facilitate<br>• role clarification | **2. Organisation**<br>• team development<br>• organisational development<br>• effective collaboration<br>* making connections<br>* working together | **3. Service:**<br>• the improvement in the delivery of primary health care<br>• meeting local health needs | **4. The Wider Setting:**<br>• changing political climate<br>• networking<br>• interventions |

The information from the secondary workgroup, together with that from the RSG, was used to produce the second working document (table 24). This was returned to the third RSG for discussion, reflection and critique. The second document was extended and modified a third time to encompass stakeholder's key concerns and take account of both human and political factors influencing the evaluation. The third modification was adopted as the working research framework for the evaluation (table 24). It was important to identify and include the key concerns of the different stakeholders as they came from very different backgrounds to each other and held different expectations of the LMFTs and the evaluation process. As the purpose of the LMFTs and the evaluation were explored their main differences were revealed in their expectations, the way they wanted to measure change and how they were going to use the information. The stakeholders views

are encapsulated in the case study example in figure 21 below, which uses some of their quotes and statements taken from flip-charts in the early RSG meetings to illustrate their different views.

**Figure 21**

**Views Of The Different Stakeholder Groups**

| | |
|---|---|
| ***LMFTs***<br>**Expectations:** "...improving the quality of PHC...," (LMFT Blue).<br>"told to do it in a variety of ways, helping to make Practices to work better as teams..." (LMFT Red).<br><br>**Measurement:** to find out what people think.<br><br>**Information use:** to provide feedback and support to LMFTs - verifying and affirming facilitation activities; | ***Health Authority Managers***<br>**Expectations:** "we're being asked to deliver as an organisation ... higher screening targets, better health promotion, they're (PHCTs) about delivering more effective health care" (HA Manager).<br><br>**Measurement:** to find out costs and measure improvements in Practices.<br><br>**Information use:** Determine if value for money; Needed, in time, to plan part of planning framework (for LHA overall development strategy); |
| ***PHCTs***<br>**Expectations:** "to reach the target in cervical smears and immunisation" (GP).<br>"...for them (LMFTs) to come in and stimulate (and) to be sort of like a seed that gets things going," (GP).<br><br>**Measurement:** to find out how the team has developed and what impact this has had on behaviour, practice and patient services and care;<br><br>**Information use:** to improve delivery of services to patients; | ***University Research Team***<br>**Expectations:** "to encourage teams (both and LMFTs and PHCTs) to adopt the principles of a learning organisation" (Researcher).<br><br>**Measurement:** an increased understanding on how the PAR approach can be used to promote development;<br><br>**Information use:** to give feedback to stakeholders to increase their level of understanding about change and development in PHC; |

The stakeholders different views naturally flowed through to influence the way they considered designing the data gathering process. The Managers and Doctors in particular favoured using a quasi-experimental model and comparing target LMFT Practices with non-LMFT Practices, whereas the research team considered the target Practices as a more appropriate sample. The LMFTs views were that they, "did not like the idea of comparing LMFTs," (LMFT Green) and they wanted to know, "what's in it for them [the Practices]?" (LMFT Blue). Furthermore, during

negotiating who was to take responsibility for certain parts of data gathering; the Managers offered themselves as a resource only and the LMFTs restricted time made them reluctant to consider it as part of their role, and more importantly they perceived it as the researcher's task, "its your research, your problem, you get on with it," (LMFT Blue).

These statements were typical of the different stakeholder's perspectives. The LMFTs viewed the evaluation as something that was able to provide them with on-going information about their progress, they were asking for a process approach but expected an outsider to collect the information. The Managers wanted information to help them make decisions, they focused more on outcomes and wanted evidence of the LMFTs effectiveness. They favoured the positivist research model and expected the researcher to undertake the data collection. The research team was concerned with meeting the different stakeholder's demands in the evaluation. They wanted to adhere to a hermeneutic, dialectical research model and make use of participation from design, through data collection, to producing the findings. The PHCTs were different again, they were interested in the way PHCTs developed and wanted an external evaluation that would produce findings useful to their own work.

The different ways the stakeholders looked at the LMFTs project gave an indication of the different 'mind-sets' they held and thus, a guide to the level of accommodation necessary for them to form an agreement on the approach to the evaluation. The development of the evaluation framework was a lengthy eight month process. The stakeholders agreed that the over-riding purpose of the LMFTs project was the improvement in the delivery of primary health care. Time, however, was needed to develop dialogue and the dialectical exchanges necessary to achieve negotiation and accommodation of their different perspectives. In addition, it was also necessary to contain the evaluation within tight time, financial, management and personnel resources. The foregoing is presented to illustrate the way in which the framework for the evaluation was a product of a negotiation between the stakeholders.

The framework for the evaluation identified four areas for consideration in the evaluation. These were: personal, organisation, service and the wider community setting as given in the third working document (table 24). Each of these key areas had a number of LMFTs objectives associated with it. As the stakeholders began to design the data gathering process attention was given as to how the meaning of development was going to be understood. The stakeholders returned to the LMFTs

objectives to work out the evaluation objectives per key area. The meaning of development in the Practices was not advanced any further until the data from the pilot study was analysed (see pilot section). The evaluation objectives directly reflected the stakeholder's views. Inevitably related factors started to appear in the key areas which was a reflection of the inter-relatedness of the factors in this complex intervention. It was possible to make distinctions between the different areas by considering that they formed different dimensions of a system of development. This made the application of the framework more practical. As the stakeholders identified each objective they, in turn, determined how the data was to be collected, by and from whom, and when this was to occur (table 25).

**Table 25**

**LMFTs Framework For The Evaluation Considering Four Key Areas**

**1 Personal**

**LMFTs Objectives:**
to facilitate an understanding of each other's PHCT role and development of regard for its associated worth and to help those involved share information and co-operate with each other.

**Evaluation Objectives:**

- *to seek examples:*
  - where an individual states he/she has been able to assert him/herself more confidently because of increased feelings of self-confidence and self-assurance;
  - that indicate instances where barriers to communication have been broken down;
  - that demonstrate a confidence in being proactive, as an individual, when making plans for future personal development;
  - that illustrate a capability of risk taking as an individual when faced with unanticipated occurrences;
- to establishes what understanding there is of each individual role;
- to discover the worth credited to each role and the associated skill by PHCT members;
- to determine what is understood to be the responsibility of each role;
- to establish what is understood by the phrase 'co-operating with each other';
- to determine what information sharing activities are taking place;
- to seek examples of 'visible teamwork' within and across Clusters.

| Specific Area | Indicator | Method | When | Where | Who |
|---|---|---|---|---|---|
| a) self development | Personal activity | Interviews | Phases 1, 2 and 3 | In and between LMFTs & PHCTs | Researcher |
| b) ability to facilitate | Personal activity | Self, peer and formal assessments | Phases 1, 2 and 3 | In and between LMFTs & PHCTs | Researcher, LMFTs & PHCTs |
| c) role clarification | Clarity of roles & responsibilities | Interviews | Phases 1, 2 and 3 | In and between LMFTs & PHCTs | Researcher |

**Table 25 continued.,**

## LMFTs Framework For The Evaluation Considering Four Key Areas

**2 Organisation**

**LMFTs Objectives:**

to assist individuals, teams and organisation in becoming self-directed and action orientated within the PHC setting;
to develop common values on sharing, healthy competition, development, honesty, openness, caring and co-operation among those involved as part of their becoming a learning organisation;
to develop effective communications within and between LMFTs and the PHCTs, in and across each Cluster.

**Evaluation Objectives:**

- to determine the extent to which the day to day organisation of the PHCT is a co-ordinated, integrated and participative activity;
- to define instances of mutual problem solving within the PHCT and within Cluster;
- to detail instances of collaborative working relationships (and of using Cluster solutions to Cluster problems in the longer term);
- to seek examples:
    - that demonstrate a confidence in being proactive, as a group or as a whole organisation, when making plans for future development;
    - that illustrate a capability of risk taking as a group or organisation when faced with unanticipated occurrences;
    - that describe and uphold a collective vision and strategy for change that is realistic given existing resources;
    - to identify the patterns of communication;
    - to determine what, if any, changes have occurred over time and establish the reasons behind them.

| Specific Area | Indicator | Method | When | Where | Who |
|---|---|---|---|---|---|
| a) team development | valuing team work<br>sharing roles<br>visible teamwork | observation<br>interviews | Phases 1, 2 and 3 | In and between LMFTs & PHCTs | Researcher and LMFTs |
| b) organisation development | co-ordinated and integrated PHCT activities | observation<br>interviews | Phases 1, 2 and 3 | In and between LMFTs & PHCTs | Researcher and LMFTs |
| c) effective collaboration | making connections | observation<br>mapping networks<br>interviews | Phases 1, 2 and 3 | In and between LMFTs & PHCTs | Researcher and LMFTs |

**Table 25 continued.,**

## LMFTs Framework For The Evaluation Considering Four Key Areas

**3 Service**

**LMFTs Objective:**
to make improvements in the delivery of the PHC service which appropriately meets the health needs of the local population.

**Evaluation Objectives:**

- to explore the way the needs of the local population are identified;
- to establish what health promotion activities are undertaken by each PHCT;
- to identify the rationale behind implementing particular PHC services;
- to discover what forms of audit are being used to monitor the PHC services provided by each PHCT;
- to identify what action has been initiated as a result of each audit cycle;
- to discover what the future plans are for meeting local health needs;
- to determine what measures are being considered for implementation in the future to ensure that PHC services meet an assured high standard of delivery.

| Specific Area | Indicator | Method | When | Where | Who |
|---|---|---|---|---|---|
| a) Improvement in the delivery of PHC | Rationale behind services provided<br>Types of services provided | Annual Practice Reports<br>Practice documents | Phases 1, 2 and 3 | PHCTs | PHCTs<br>LMFTs<br>LHA<br>Researcher |
| b) Meeting local needs | LHA Quality Standards document<br>Health Promotion Activities<br>Chronic disease management<br>Number of other agencies involved with | Annual Practice Reports<br>Practice documents<br>Interviews<br>Target figures | Phases 1, 2 and 3 | PHCTs | PHCTs<br>LMFTs<br>LHA<br>Researcher |

**Table 25 continued.,**

**LMFTs Framework For The Evaluation Considering Four Key Areas**

| 4 Wider Community Setting | | | | | |
|---|---|---|---|---|---|
| **LMFTs Objectives:**<br>to provide an organisational framework which allows teamwork to operate on a permanent basis.<br>to use both formal and informal interventions within primary health care in a cost effective way.<br>to facilitate the development of networks and collaboration within and across PHCTs in their Clusters. | | | | | |
| **Evaluation Objectives**:<br>• to identify the influence of current health care policy relevant to the development of primary health care;<br>• to identify the extent to which networking and collaboration is taking place through the examination of a range of activities;<br>• to undertake a network analysis:<br>- within and between PHCTs in the Clusters; between the LMFTs and the PHCTs; and within and between PHCTs and other health care agencies in the Clusters.<br>• to evaluate the formal and informal interventions, using both qualitative and quantitative methods;<br>• to assess cost effectiveness using basic information on use of monetary and other resources. | | | | | |
| **Specific Area** | **Indicator** | **Methods** | **When** | **Where** | **Who** |
| a) changing political climate | policy implementation | Health Policy Review | Phases 1, 2 and 3 | Within LHA | Researcher |
| b) networking | examples of collaboration | Network mapping | Phases 1, 2 and 3 | In and between LMFTs & PHCTs | Researcher |
| c) interventions | LMFTs activities | Activities reports | Phases 1, 2 and 3 | In and between LMFTs & PHCTs | Researcher and LMFTs |

At this stage the framework for the evaluation had reached a point when its components were ready for a feasibility test. The subsequent sections describe what occurred as the evaluation moved forward from design to action which is discussed in terms of the five key research elements outlined in the beginning of this chapter (table 17).

## 4.34 Testing The Feasibility Of The Design In A Pilot Study

The pilot study was undertaken among the four LMFTs and in one Practice. Those stakeholders that were following a medical and natural science model of evaluation assumed this to be an essential step, a view which the Research team did not share. The opportunity was however utilised to test the feasibility and usefulness of the data collection methods, and secondly, to enable the researcher to find ways of achieving action research cycles, dialogue and dialectical exchanges between LMFTs and between PHCT members within a Practice setting.

### 4.34.1 Recruitment Of Practices To Form A Research Sample

The decision to recruit a research sample of 8 Practices and one extra for the pilot study was the result of a negotiated process among the key stakeholders. One Practice was selected from each of the seven Clusters comprising PHC in Liverpool, the extra two required were chosen from non-LMFT Clusters. This gave a balanced sample of 8 Practices: 4 targets from LMFT involved Clusters and 4 comparisons, plus 1 pilot, from Non-LMFT involved Clusters, and followed a medical model approach to the evaluation. The recruitment strategy evolved from stakeholder activities in the participatory workgroups, see the case study example below.

**Case Study Example**

**The Stakeholders Development Of The Recruitment Strategy**

The stakeholders first tried to nominate Practices according to pre-set criteria which attempted to match like with like. This was unfeasible as no two Practices were found to be alike.

Initially a demographic approach was used to try to select a sample that would permit generalisations to all PHCTs involved in the LMFTs project, e.g. stakeholders tried to establish:

- the degree of Medical Audit Advisory Group involvement;
- the number of audit cycles undertaken;
- the proximity to LMFTs interventions;
- the attendance at teambuilding events;
- the number of clinical and non-clinical staff;
- fundholding or non-fundholding, and so on.

Finally, on finding wide dissimilarities between Practices, stakeholders recognised they would learn most about development and change by selecting Practices that were different. The criterion stakeholders were adamant about keeping was one that ensured selected Practices were as distant as possible from the LMFTs project. Subsequently, the set of criteria was replaced by one criterion which stressed 'distance' from the LMFTs activities, it was chosen to avoid 'contamination' of Practices in the sample. The assumption was that as the activities of the LMFTs rippled outwards across a cluster the sample Practices would be reached and influenced and thus, changes could be monitored in the sample from a basis of no prior contact.

Thus, Practices were subsequently selected according to their distance from the LMFTs. The key stakeholders groups were asked to nominate 27 Practices. The different lists were presented in the RSG and compiled to produce nine Practices: four comparison, four target and one pilot, to be approached. The remaining Practices provided second and third nominees should any decline to join in. This achieved a purposive sample of Practices (Patton, 1980, 1997; Lincoln and Guba, 1985).

**Recruitment** began in September 1994 and 7 Practices had tentatively agreed to join the evaluation by December 1994. 2 Practices subsequently withdrew and it took until July 1995 to secure 6 positive recruits. In view of these difficulties the RSG settled for a Practice sample of 4 Practices within LMFTs Clusters and 2 without. Key informants, from within the 6 Practices, were selected using the same adapted Sudman (1976) nomination process. The RSG agreed that interviewing 3 (and no more than 5) staff members, drawn from a cross-section of Practice staff, would constitute a purposive sample and provide sufficient information on personal, organisation, service and wider community activities within a Practice.

**Confidentiality** was discussed in outline with the stakeholders in the RSG and agreed in detail with the LMFTs and Practices. In principal information was to be used in an anonymised way and Practices were to provide, in writing, their individual consent. The finer details were worked out with the Practices and LMFTs as the evaluation process unfolded. In particular, the Practices were not agreeable to the LHA seeing what was considered to be a private account of their activities and, the key interviewees did not want other Practice members to know what they had said.

Subsequently, the following three levels of confidentiality was established to accommodate the participants views:

**Level 1** Personal confidentiality: interview transcripts were considered to be a personal account of the Practice or LMFTs activities and thus deemed to be the property of the interviewee.
The information was used, within the Practice or LMFTs, in a general anonymised way.

**Level 2** Practice or LMFTs confidentiality: Practice / LMFTs information was considered to be a private account of activities and thus deemed to be the property of the Practices or LMFTs.
The information was used openly within the Practice or LMFTs.

**Level 3** Public confidentiality: The Practice / LMFTs authorised what information was to be extracted from their case records to compile a public account of their activities.
The information was used, outside of the Practice or LMFTs, in a general anonymised way.

## 4.35 Data Gathering Activities

### 4.35.1 Data Gathering From The LMFTs

Data was gathered from the LMFTs to provide information on personal, organisation, service and wider community development within and between Practices in their Clusters. Since development in relation to the LMFTs concerned the implementation of the intervention programme, information on these were collected in detail. The LMFTs, together with the researcher, first created an intervention and self-assessment report. The report was structured in sections which systematically posed questions about the planning, implementing and evaluation of each intervention. The LMFTs, under guidance by the researcher, collected data on who was involved, what topics were discussed and what action plan was agreed in each cluster level intervention. The main purpose was to provide a clear overall picture of structure, process and self and participant evaluation of each LMFT intervention. Critical reflection with stakeholders on the usefulness of the data led to the report subsequently being expanded to include diary sheets and records of meetings. This was to gather additional information about the way LMFTs were developing teamwork and collaborative activity *within* Practices in their Clusters.

In addition, the researcher became fully engaged, whenever possible, in the interventions as a participant observer and undertook mapping of the LMFTs networks. This was to bring an 'external' perspective to the LMFTs 'internal' self description and evaluation activity and produce extra descriptive information of interventions which ensured the data provided sufficient detail to allow one to know what had occurred (Patton, 1980). The LMFTs networks were mapped, at the beginning and end of the evaluation, to show how the LMFTs networks expanded over time. Each LMFT made a drawing of their network on a portable magnetic board, which was subsequently photographed and reproduced as a hand drawing. Simultaneously, an informal team discussion took place to provide elaboration on each team's network map. The data was recorded in the researcher's reflective journals (table 19).

### 4.35.2 Data Gathering From Practices

Data was being gathered from Practices because the assumption from the RSG was that the sample Practices would represent local variability and demonstrate the different ways this profoundly influenced their capacity to respond to the LMFTs project. The data gathered was to provide evidence of how Practices, as small business organisations, functioned. It was to give information on how PHCTs worked together, how they envisioned and planned for their futures, and what they did to achieve their goals.

The researcher engaged in the Practice as a participant observer in order to produce sufficient descriptive details of their organisation and service activities to allow one to know how these activities occurred (Patton, 1980). A general checklist was generated which posed questions that systematically covered the four key areas considered in the evaluation (for an elaboration of the general checklist see appendix 5). The checklist was used to provide the researcher with some construction to the period of observation as well as help to legitimate the role of the researcher with the PHCTs members. It was discussed and used openly within the Practice and PHCT members were encouraged to contribute directly to it. This also helped to develop trust between researcher and PHCT members before the interviews were undertaken. The data from the general checklist assisted with compiling a baseline of knowledge on the organisation and function of the Practice.

In the Practice between three and five key informants were interviewed. A semi-structured interview schedule was used which followed Patton's (1980) example of a standardised open-ended interview. The schedule consisted of a set of open-ended questions, which systematically covered the four key areas considered in the evaluation framework (for an elaboration of the semi-structured interview schedule see appendix 5). The questions, worded carefully to avoid ambiguity, explored the way the Practices worked together. In addition, each key informants network was mapped to show who belonged to them. Before the interview proper, each key informant made a drawing of their Practice network. This activity was undertaken in the same manner as with the LMFTs and used as an icebreaker prior to each interview. It was introduced as a 'bit of fun' and used to help the person being interviewed relax and bring their focus onto Practice activities.

Finally, statistical data on the Practice was gathered from the Liverpool Health Authorities (LHA). The data on Practices was highly confidential as it was linked directly to their system of

remuneration. Written permission to use this information was gained from both the Practices and the LHA before undertaking data collection. The data provided information on a Practice's target level achievements in relation to the number of patients receiving smears, immunisation and vaccinations (two year olds), booster vaccinations (five year olds), and health promotion screening. An achievement of the high target levels relied upon a well developed administrative and health care delivery system being provided in each Practice. The Practice data was recorded in two forms in the LHA, either as a general statistic of patients receiving this type of care irrespective of where it was given or as a General Medical Services (GMS) statistic which recorded the number of patients receiving services from *within* a Practice. The latter GMS statistic was used as this recorded services directly provided by a Practice.

In addition to statistical information the LHA also provided general background information on the social demography of the population in each Cluster, and evidence of the implementation of their development strategy. This entailed: the Primary Health Care development aims and objectives for each Neighbourhood Objectives, profiles of each Neighbourhood ( a Cluster refers to a pair of neighbourhoods), various reports on activities of the Medical Audit Advisory Group, the Local Organising Teams and the LHA developmental initiatives as well as documentation on Purchasing, Neighbourhood planning and developing standards in PHC.

## 4.36 Data Analysis

It will be noticed at this stage that there was no particular theoretical framework. The study was more exploratory in nature which was in keeping with its emergent framework, correspondingly it was appropriate to develop a descriptive case study of the LMFTs project (Guba and Lincoln, 1989; Robson, 1993; Stake, 1995). To achieve this a set of themes or areas were looked for that were linked to the evaluation objectives and able to provide adequate coverage of the case (Robson, 1993). The case records were collated, over time, to provide the material for a descriptive case study of the LMFTs project.

The process of reducing the data into themes began as soon as there was any Practice and LMFTs data, this helped to bring information into a more manageable form. The case records, through what Robson (1993) called 'playing with the data', were manually reduced, by the researcher, into a set of themes relevant to the four key evaluation areas. Themes were defined as a view shared by two or

more people (Lincoln and Guba, 1985). This process sought to take the data apart in various ways and then reconstruct it to form a consolidated picture (Miles and Huberman, 1994). This process assisted with the generation of an initial descriptive framework of the Practices and LMFTs which was used to assist with defining the meaning of development in the Practices (Thomas and Graver, 1997) The steps the stakeholders undertook to clarify the meaning of development in relation to Practices are outlined in appendix 6.

The descriptive framework provided a picture of LMFT and Practice activities from which it was possible to derive some examples of development in relation to the four key areas. From this starting point the stakeholders revisited the evaluation objectives and devised criteria against which the examples could be examined and classified according to the dimension of development it was closely related to (table 26).

**Table 26**

**Four Dimensions Of Development And Associated Criteria**

| Dimensions of Development | Criteria |
|---|---|
| **1. Personal Development** | • Growth of people's skills and confidence;<br>• Clear definition of own and other's role;<br>• Recognition of own limitations;<br>• Accept skill's of others as complementary to own role; |
| **2. Organisational Development** | • Ensure the efficient use of each others skills;<br>• Use of personal development plans to identify training needs;<br>• Change of work practices to increase the level of efficiency;<br>• Change in work patterns to increase the level of communication and teamwork; |
| **3. Service Development** | • Meeting local population's health needs;<br>• Use of audit as a tool for review and reflection of current practice;<br>• Change or expansion of services to meet needs of population; |
| **4. Wider Community Setting** | • Undertaking mutual problem solving activity;<br>• Working together on local community initiatives; |

The process of data reduction was undertaken with stakeholders, as a series of iterations, which sought to eventually build a final explanation as to the effectiveness of the LMFTs (Yin, 1994). As a method of analysis it has been criticised for its tendency to drift away from the focus of study (Robson, 1993; Yin, 1994). The involvement of stakeholders, however, ensured that the evaluation maintained relevance to their interests, helped to guard against gaps in the descriptive framework and avoided missing the novel or unexpected emergent insights (Patton, 1980, 1997; Guba and Lincoln, 1989; Marshall and Rossman, 1995).

The presentation of data was established as an interactive process with stakeholders and concentrated on the progress of the LMFTs. A first draft evaluation report was produced as a document for discussion. The researcher presented the report verbally, aided by notes, acetates and handouts, to the RSG and to the secondary participatory workgroups in a manner that provided an opportunity for interaction and participation between the stakeholders. This helped to promote reflection-on-action taken, an essential stage of the action research cycle, as discussed earlier in this chapter. The draft report was designed to be interactive and included a section in which stakeholders were expected to offer their comments for inclusion in the final version. Only after receipt of their comments was the first annual report produced for general circulation. It contained early observations on the development of the LMFTs as they became teams and described the groundwork of developing the evaluation (Graver, 1995). Annexed to this report was the LMFTs intervention report which provided the guidelines for the LMFTs project (FHSA, 1993). The third activity, that of drawing conclusions and verifying them was seen to take place before, during and after gathering data (Miles and Huberman, 1994). At the beginning of the LMFTs 'drawing conclusions' amounted to stakeholders having vague unformed notions on the likely effectiveness of the LMFTs project. At the end of phase one these notions were not any clearer or better informed because this period had largely been concerned with the groundwork activities of developing the LMFTs intervention programme.

## 4.37 Data Feedback

The participatory workgroups provided the forum for giving feedback to the stakeholders. The first eight RSG meetings that were used to develop the evaluation framework represented the observe, reflect and plan stages, and the pilot study the action stage, of the action research cycle (Lewin, 1946 ; Kolb, 1984; Carr and Kemmis, 1986). This amounted to achieving one complete action research cycle. The evaluation framework was gradually drawn together by stakeholders looking at the material gathered from previous participatory workgroups and reworking it until a negotiated agreement on the design was achieved. The ensuing pilot study was useful in three ways. First, it provided information which gave a baseline of knowledge about one Practice's organisational activities. This was useful to stakeholders as an initial yardstick by which to assess the level of development encountered in Practices involved in the LMFTs. In addition, the Practice themselves received an account of the way their activities contributed to their management of change and process of organisational development. Each account gave an assessment of the Practice's activities

(an example of one Practice report is given in appendix 7). Second, the pilot study demonstrated the level of feasibility of the data collection methods and participatory activities. Third, the case records of the LMFTs showed the groundwork that they had undertaken to implement the intervention programme and directed stakeholders attention towards issues that were impeding their progress.

## 4.38 Critical Reflection And Refinement Of Research Design

As a result of critical reflection on the process outlined above a number of refinements were made to the data gathering activities and participatory activities in the LMFTs. The data gathering from the LMFTs was problematic. They had found it difficult to establish data gathering as a continuous activity within their practice and subsequently received assistance with data collection from the researcher and administrator whenever possible. In contrast, the data gathered from the Practices provided too much detail and had to be scaled down to reduce the depth of the data collection. The Practice data gathering instruments (table 19) were refined to reduce the amount of information collected whilst retaining an overall view of Practice activities. The participatory activities were such in the RSG that the process of action research was successfully established and set to continue within their quarterly meetings. This was not the case with either the LMFTs or in the pilot Practice. The use of participatory workgroups were to extend to become part of monthly LMFTs meeting and similarly in meetings in the six sample Practices. This effort was to try to bring the process of action research closer to the centre of LMFTs and Practice activities.

## 4.39 Commentary

Phase one was to establish the PAR approach and develop an evaluation framework for the LMFTs project which underwent a feasibility study in the latter part of the phase. The use of the process of PAR within the evaluation was not easy to establish among the different stakeholder groups. The different agendas of the stakeholders consistently pulled the process of negotiation back and forth across the central line of equilibrium or equality. The initial result was an evaluation framework with a quasi-experimental design which held more of a bias towards the positivist research model and thus objective evaluation. At the practical level the stakeholders were reluctant to be responsible for part of the collaborative data collection and analysis and presumed this to be the researcher's responsibility. This affected the quality of data gathering, and in particular from the LMFTs

interventions programme. The overall effect of design and practical difficulties was to place the burden of responsibility for achieving a 'good' evaluation onto the researcher rather than it being perceived as a shared and collaborative evaluation.

## 4.4 PHASE TWO: IMPLEMENTING THE EVALUATION APPROACH

This phase involved undertaking the first round of data collection from LMFTs and Practices, the subsequent analysis and an on-going process of information feedback to the stakeholders throughout. Phase two is described in terms of the key research elements outlined in the beginning (table 17). In addition, a review of national and local health policy and implementation practices was used to help identify the influential factors within the local context (see sections 1.5 and 2.42).

### 4.41 Data Gathering Activities

A summary of the data gathering activities is given in table 27 below.

**Table 27**

**Phase Two: Data Gathering Activities**

| **Qualitative Methods** | | |
|---|---|---|
| **Tool** | **Sample** | **Format of data** |
| **LMFTs:** | | |
| • Intervention records | • 23 Interventions | • 23 plans, descriptions and self / participant evaluation forms |
| • Mapping networks & informal team discussions | • 4 LMFTs | • 4 drawings on magnetic board, tape recordings & journal notes |
| • Participant Observation | • 13 Interventions | • 4 team journal notes |
| **Practices:** | | |
| • Participant Observation | • 6 Practices | • 6 Practice journal notes |
| • Practice general checklist | • 6 Practices | • 6 sets of hand-written notes and Practice documents |
| • Key informant semi-structured interview schedule | • 20 interviews | • 20 taped interviews |
| • Mapping networks | • 20 maps | • 20 drawings on magnetic board, tape recordings & journal notes |

**Table 27 continued,**

**Phase Two: Data Gathering Activities**

| Quantitative Methods | | |
|---|---|---|
| **Tool** | **Sample** | **Format of data** |
| **LMFTs:**<br>• Intervention records: attendance registers | • 23 Interventions | • 23 registration sheets signed by participants |
| **Practices:**<br>• LHA Annual Practice Reports, statistical data:<br>Health promotion banding;<br>Immunisation;<br>Vaccination;<br>Cervical smears | • 6 Practices | • 24 statistical tables: 4 tables, one on each topic, per Practice |

### 4.41.1 Data Gathering From The LMFTs

This was accomplished via a process of continuous data collection from the LMFTs intervention programme by the LMFTs and the researcher (table 27), as outlined in phase one.

### 4.41.2 Data Gathering From The Practices

Observational visits were made, by the researcher, to six sample Practices and authorised statistical information on the Practices was collected from the Liverpool Health Authorities (table 27).

## 4.42 Data Analysis

The process of reducing the data into themed case records continued as outlined in phase one. The data from the 4 LMFTs and 6 Practices was again manually coded into a set of themes relevant to the four key evaluation areas. The data from the LMFTs was amalgamated with their case record material begun in phase one. These 4 case records now held a diary of interventions implemented, attendance figures at interventions by denomination, specific reports on interventions and a map of the LMFTs communication network across their locality. The data from each Practice was collated into 6 individual case records. Each held an account of regular Practice activities, various Practice documents, e.g. policies, procedures, reports and leaflets and transcripts of the key informant interviews together with the maps of their individual communication networks.

One main tool of case study analysis is to make a comparison with other similar cases, this aims to deepen understanding and explanation (Miles and Huberman, 1994; Robson, 1993). The individual case records were compared with each other in a cross-Practice and cross-LMFTs analyses. The first step was to compare the interview data which provided a 'triangulation' of the different views gathered by the same data collection method. The second step was to compare this information with other 'themed' information gathered via different methods of data collection, e.g. diary sheets, intervention records, the general checklists and HA statistical records. This provided a 'triangulation' of information that was gathered from different information sources. These two different forms of triangulation were used to establish a first level of trustworthiness in the information (Lincoln and Guba, 1985). This preliminary analysis was fed back to the RSG, LMFTs and Practices for their reflection, analysis, critique and determination of the authenticity and accuracy of the analysis. This built a second level of trustworthiness about the findings (Lincoln and Guba, 1985).

The presentation of data was continued as an interactive process with the stakeholders. To achieve this specific information particular to the different stakeholder groups, e.g. LMFTs and Practices, was produced in a form that protected the relevant level of confidentiality and in a manner that tried to use their local language to describe settings, events and circumstances. The statistical information, e.g. LMFTs attendance numbers or Practice health promotion banding and target level figures was used, where relevant, to add a further perspective to the description. The interests of the stakeholder groups was met by producing 6 individual, Practice accounts of their own level of organisation development and 4 LMFTs 'intervention activity reports'. Once these 'private accounts' had been fed back, discussed and refined by the respective stakeholder groups the researcher pulled the various strands together to produce the second draft evaluation report. This was used for general discussion with key stakeholders in the RSG.

Following critical reflection and refinement within the RSG the second draft report was reconstructed to form an outline report and a supplementary discussion document. The report illustrated the interim results of the evaluation of the LMFTs project (Graver, 1996a). It described the implementation of the research framework for the evaluation and the on-going implementation of the LMFTs project. The outline report was submitted to the managers in the Health Authority. The supplementary discussion document provided a detailed description of the results and was used

by stakeholders as a reference text during the third and final phase of the evaluation (Graver, 1996b).

The process of drawing conclusions and verifying the vague and unformed notions about the LMFTs project proceeded as the analysis of data began to systematically test the ideas out for soundness. Secondly, feeding information back to the stakeholders broadened the analysis and interpretation of the data (Guba and Lincoln, 1989; Marshall and Rossman, 1995; Patton, 1997). Thus, the notions about the effectiveness of the LMFTs project gradually became clearer as they were verified in an increasingly grounded analysis undertaken with the stakeholders. This was a process of critical reflection which also served to identify emerging issues that needed further consideration by the stakeholders in order to improve the implementation of the LMFTs project and its evaluation in the third and final phase.

## 4.43 Data Feedback

The system for feeding information back to stakeholders gradually evolved beyond the initial RSG quarterly meetings. The system now extended to systematically feeding information back to the LMFTs, at their individual team or within the monthly multi-team meetings, and to Practices, via the key contact or within Practice meetings. This evolved for two reasons, firstly it helped to provide specific, relevant and potentially useful information in timely manner. Secondly, an appropriate level of confidentiality was able to be offered to particular stakeholders who were participants. In this way their accounts remained private and not publicly disclosed until they had been scrutinised and adapted for general viewing.

Each 'feedback' session was structured as a participatory workgroup as described in phase one. These served as a forum for undertaking the reflection-on-action dimension of the action research cycle. The groups were used as a source of information about the evaluation and as an information resource for the stakeholders so that they could learn from actions that had previously been taken. The completion of the second formal report signalled the achievement of one complete action research cycle within phase two. The results of the stakeholder's critical reflections were used to refine the implementation process in readiness for phase three.

## 4.44 Critical Reflection And Refinement Of Research Design

The critical reflection on the LMFTs project and research activities during phase two concentrated on whether data being collected was able to meet the evaluation objectives, whether the research approach was remaining true to a hermeneutic and participatory methodology, and whether the LMFTs project was achieving its objectives. This process was a time of learning as stakeholders identified aspects of the evaluation approach that was able to meet their objectives.

The result of this critical reflection led to a number of refinements to the research design and the LMFTs intervention programme. In terms of the research design the analyses of data from the six sample Practices had shown that a clearer meaning of the term development could now be advanced (as detailed in appendix 6), and secondly, that there was little connection between them and the LMFTs interventions. It had become evident that this use of a research sample distant from the LMFTs was unlikely to reveal how and in what ways the LMFTs project was being effective. The information gave a clear picture of several Practice's activities, and showed that the LMFTs interventions were not making any differences to these Practices who were either unconnected or only loosely connected to the LMFTs project. As a result data collection was to broaden and focus on those Practices identified by the LMFTs as having become responsive to their interventions. The six Practices that formed the 'control group' were now excluded from the evaluation. The comparison of LMFT and non-LMFT Practices was to be abandoned, the tools that were in current use were to be adapted to suit the broader focus and finally, the participatory activities were to be streamlined and primarily concentrate on the RSG and LMFTs.

In relation to the LMFTs intervention programme their 'activity reports' revealed a shift in their intervention work from a Cluster level orientation to a Practice level. Their experiences were such that they had felt it necessary to undertake facilitation activities in Practices before they could expect to see Practices attend Cluster level interventions. This change had begun as the result of their practice and experience but was now made explicit and openly supported as the way for the LMFTs to move forward. As a result of the above, the LMFTs were to focus their efforts on Practice level interventions whilst still contributing to Cluster level interventions, in collaboration with Neighbourhood Commissioning Managers, during the third and final implementation phase.

### 4.45 Commentary

Phase two involved continuous data gathering from the LMFTs and the first round of data collection from the Practices with a subsequent analysis. The resultant analysis of data, after using the quasi-experimental design, led stakeholders to recognise that the evaluation objectives could not be met by using this approach. Consequently the use of target and comparison Practices was abandoned in favour of gathering data from Practices involved in the LMFTs intervention programme. The use of the PAR approach was instrumental to the stakeholders making this decision. The other emerging issues were mainly practical and related to the continued difficulty of achieving systematic and comprehensive data collection from the LMFTs activities and the maintenance of participatory and collaborative activities within the evaluation. In this phase the researcher 'let go' of some of the felt responsibility for achieving a good evaluation and, raising this issue within the RSG, referred the responsibility back to the stakeholders. The effect was to seek ways of reducing the workload without compromising the evaluation process. Thus, the notion of achieving a collaborative evaluation process had moved slightly nearer this realisation.

## 4.5 PHASE THREE: IMPLEMENTING THE EVALUATION APPROACH

This phase involved undertaking the second round of data collection from LMFTs and Practices, the subsequent analysis and the continuous process of information feedback to the stakeholders. Phase three is described in terms of the five key research elements as outlined in the beginning (table 17). At the end of phase two the stakeholders had revised the 'reach' of the evaluation by increasing its scope and reducing its depth. The purpose was to track those changes that were taking place within a Practice as a result of a direct intervention of the LMFTs. This was distinct from the earlier data gathering process which concentrated on the six sample Practices most distant from the LMFTs project.

### 4.51 Recruitment Of Practices To Form A Research Sample

Practices were selected by drawing on the knowledge and experience of the LMFTs, this was a purposive sampling strategy (Patton, 1980). The LMFTs identified three different levels of response from the Practices involved in the LMFTs. From this information the LMFTs nominated 20 Practices (four from each cluster) from a total of 56 who were considered active or semi-active

responders and who were either undertaking or poised to undertake some form of change. The LMFTs also nominated a key person with whom they had been working in the Practice. The recruitment of Practices began immediately. Each Practice that was, following prior introduction by an LMFT member, verbally invited by the researcher to join the LMFTs evaluation process agreed to join in the evaluation.

## 4.52 Data Gathering Activities

### 4.52.1 Data Gathering From The LMFTs

The continuous process of gathering data from the LMFTs project continued as in phases one and two. However, as the focus of the evaluation had shifted to concentrate on the Practices involved with the LMFTs, the intervention records were modified for use at Practice level, e.g. the registration sheets became a record of those present.

### 4.52.2 Data Gathering From The Practices

Brief observational visits were made, by the researcher, to 20 Practices. At these visits specific information and documentation about changes occurring as a result of a direct intervention by the LMFTs was collected. In addition, each key contact person involved in an LMFT initiated change was asked if they would agree to a 25-30 minute semi-structured interview. Subsequently, each key contact person was asked to nominate for interview any other person involved the change process. The interview followed Patton's (1980) example of a standardised open-ended interview and explored the changes taking place in a Practice, (for an elaboration of the interview schedule see appendix 5). The data from the Practice was to provide information on how responsive to the LMFTs the Practices were, what ways they became involved in a process of change and the ways that they changed. A Practice provided any statistical data that was relevant to the change taking place. The summary of these and the LMFTs data gathering activities are given in table 28 below.

Table 28

**Phase Three: Data Gathering Activities**

| **Qualitative Methods** | | |
|---|---|---|
| **Tool** | **Sample** | **Format of data** |
| **LMFTs:**<br>• Receptiveness sheets<br>• Intervention records<br>• Mapping networks & informal team discussions<br>• Participant Observation | • 56 Practices<br>• 20 Practice Interventions<br>• 4 LMFTs<br>• 4 LMFTs activities | • 56 descriptions of responses to LMFTs by Practices<br>• 20 plans, descriptions and self evaluation forms<br>• 4 drawings on magnetic board, tape recordings & journal notes<br>• 4 team journal notes |
| **Practices:**<br>• Key informant semi-structured interview schedule & documents | • 47 interviews | • 47 taped interviews and relevant substantiating documents from the 20 sample Practices |
| **Quantitative Methods** | | |
| **Tool** | **Sample** | **Format of data** |
| **LMFTs:**<br>• Intervention records: Practice visits | • 56 Practices | • 56 sets of hand -written notes from LMFTs |
| **Practices:**<br>• Statistical data as relevant to Practice interventions:<br>Health promotion banding;<br>Immunisation;<br>Vaccination;<br>Cervical smears | • 5 Practices<br>• 3 Practices<br>• 3 Practices | • 11 statistical tables in total |

## 4.53 Data Analysis

The process of reducing data into a set of themes relevant to the four key evaluation areas continued as described in phase one and two. The data from the 20 Practices and 4 LMFTs was manually coded into a set of themes relevant to the four key evaluation areas. The data from the LMFTs was amalgamated with their individual case record material from phases one and two. This information provided a record of LMFT interventions undertaken in Practices in each cluster and thus added a 'Practice level' perspective of activities to their four case records. The data gathered from the Practices was collected together to create a record of LMFT associated change and development that had occurred in each of the eighteen Practices. This record showed, in relation to each Practice, the LMFTs prior relationship, their intervention objectives, the Practice's response, the LMFTs intervention activity, the agreed action plan and subsequent action undertaken by either the Practice or the LMFT. The appropriate Practice information was added to the related LMFTs case record and provided illustrations of particular effects LMFTs had had in Practices.

A cross comparison of case records was undertaken between the LMFTs and also between the Practices within and across the four Clusters. A similar process of triangulation of data as used in previous phases was undertaken to maintain the level of trustworthiness in the information (Lincoln and Guba, 1985). The final analysis was based on the descriptive framework and the set of criteria. The result was an account of the LMFTs impacts and outcomes which manifest from their activities and twenty examples of Practice change which were defined in terms of the four dimensions of development (table 26). This analysis was fed back to the stakeholders for their critical reflection, assessment of authenticity, and judgement of its accuracy.

The presentation of data was continued as an interactive and dialogical process. Four draft reports, one for each of the LMFTs, were produced prior to one generalised and anonymised draft report for consideration within the RSG. The LMFTs reports gave specific details of the work they had undertaken in each Cluster, a detailed account of one facilitation teams 'cluster level' activities is provided in appendix 8. The subsequent RSG report that was produced was a summarised amalgam of the LMFTs case records. After the discussions within the RSG a third and final evaluation report was produced for wider general circulation. The final report gave an outline of the LMFTs interventions, impacts, outcomes, barriers to progress and recommendations for the future (Graver et.al., 1997). This report was formally presented to the managers of the Liverpool Health Authorities at the end of the evaluation.

The process of drawing final conclusions and verifying the notions about the effectiveness of the LMFTs project was, as in previous phases, the result of an increasingly grounded analysis undertaken with the stakeholders. The key stakeholders in the RSG however were not the same people that the evaluation started with. Of significance here was that the two HA managers had left as they achieved promotion and their replacement was a manager directly concerned with implementing the LHA development strategy and co-ordinating initiatives through seven newly appointed Neighbourhood Commissioning Managers. In this third phase the LMFTs came under the direct influence of these Neighbourhood Commissioning Managers. Each Manager had devised specific primary care development objectives for their particular Cluster which the LMFTs were expected to contribute to. In drawing final conclusions about the effectiveness of the LMFTs project it was these super-ordinate LHA aims and objectives that were largely used as the yardstick against which to interpret and judge their level of effectiveness within the RSG rather than the earlier aims

and objectives that had been identified. The LMFTs, however, were to arrive at different conclusions. Their alternative interpretation and judgement was made using the objectives defined from within the Project and their own experiential and practical way of knowing. They described their interpretation as 'their internal view of development'. In each of these interpretations notions about the effectiveness of LMFTs project had undergone the necessary systematic challenge through using the action research approach and particularly the process of critical reflection. From these efforts stakeholders were able to draw sound conclusions from an empirically grounded analysis and make subsequent recommendations for future action (Guba and Lincoln, 1989; Patton, 1997). The two different interpretations were a reflection of two distinct and different perspectives held by different stakeholder groups.

## 4.54 Data Feedback

The system for information feedback remained the same as in phases one and two as far as the RSG and the LMFTs were concerned whereas the Practices received feedback via their key LMFTs member. The membership of the RSG had, by now, changed markedly by the beginning of phase three. The Public Health Consultant, LHA manager, one 'non-involved' GP and the Project administrator had left without replacements being appointed and the LMFTs representation had also tailed off. The depleted RSG noted that the Neighbourhood Commissioning Managers, now in post for three months, were having considerable influence on the LMFTs. It was decided to invite the leading Primary Care Development Manager to join the group as well as offer an open invitation to all LMFT members. This, having been accepted, produced a revitalised RSG in which interaction and participation was more prominent and meetings once again became a forum for critical reflection-on-action, learning and decision making. The completion of the third formal report signalled the end of the evaluation and an achievement of a third complete action research cycle within the evaluation. The results of the stakeholders' critical reflections were used to construct the final evaluation report.

## 4.55 Critical Reflection And Refinement Of Research Design

The focus of the stakeholders' critical reflection remained the same as in phase two. The stakeholders, having agreed to broaden the scope of the evaluation, were keen to ensure, in this final phase, that their objectives would be met. As the LMFTs concentrated their efforts on Practice level interventions the RSG constantly questioned how they were meeting their objectives. Thus the research effort was concentrated on gathering data that provided sufficient detail for a descriptive account of what was going on during this phase of implementation. The final report was to provide the manager stakeholders with information to use in planning their future strategy for the development of Practices and the LMFT stakeholders with information to use within their own home Practices as they furthered the development process from within.

## 4.56 Commentary

Phase three involved the continuous gathering of data from the LMFTs and the second round of data collection from the LMFT involved Practices. The stakeholder's critical reflections on the feedback was divided into two interpretations which reflected two different views of the stakeholders. One interpretation reflected a more internal perspective of the LMFTs intervention programme whereas the other interpretation was more external in perspective. This phase was characterised by the change of personnel in the RSG and, with the change of manager stakeholders, an introduction of different objectives against which the LMFTs project was to be assessed. The change of manager stakeholders, made little direct impact of the evaluation design other than asserting the need to assess the LMFTs against their own particular objectives. The practical issues surrounding the systematic and comprehensive data collection from the LMFTs activities was solved in part by the researcher's new focus of tracking actual change in the Practices, and in part by the LMFTs gradually valuing the evaluation process. The dwindling participatory and collaborative activities within the RSG were revitalised with the influx of newcomers, particularly the LMFTs members. The RSG, and the LMFTs own participatory workgroups, took on a new vigour as the LMFTs sought to establish their way forward alongside the NCMs and not as subordinates to them. In this new situation the LMFTs used the evaluation as a tool for helping them to support their case. The LMFTs recognised belatedly that the evaluation was as much their responsibility as the researcher's which moved them nearer to fully engaging in, as participant stakeholders, a collaborative evaluation process.

## 4.6 SUMMARY AND CONCLUSION

This chapter discussed the design and implementation of the framework for the evaluation of the LMFTs project. The design of the evaluation started as a quasi-experimental approach but finally emerged, following critical reflection and refinement by stakeholders, as a longitudinal case study in which a mixed-method design was used. The use of three participatory action research cycles were instrumental to achieving this and other refinements. As the LMFTs project was a very complex intervention the stakeholders opted to use multiple data collection methods to provide a multifaceted description of its implementation. This was a pragmatic choice that aimed to enhance the evaluation's usefulness to the stakeholders (Marshall and Rossman, 1995; Patton, 1997).

Throughout the implementation of the evaluation the researcher was concerned to establish and maintain the trustworthiness of the findings. In accordance with this intention the mixed-methods design was applied with an adherence to each method's particular form of verification. For example, the statistical material was collected and analysed according to the principles of objectivity and the interview and document data collection and analysis was in keeping with interpretive and subjectivist research principles. This aimed to add robustness and rigour to the evaluation design (Robson, 1993). In addition, the triangulation of different participants views and types of information, that is setting information from either different sources and / or different people's perspectives against one another to verify or refute findings, was used to provide further rigour to the findings of the research (Patton, 1980; Miles and Huberman, 1994; Stake, 1995).

Finally there was an intention to establish and utilise the PAR approach for the benefit of all stakeholders. In keeping with this the evaluation was characterised by an iterative feedback process and participatory, interactive methods encompassed within three action research cycles. The use of the iterative feedback process with stakeholders in the RSG ensured that a match was maintained between the approach and their objectives. The stakeholders deliberations grounded the evaluation, its approach and findings, in its contextual reality. Thus, the active involvement of stakeholders, in combination with sound method application and triangulation of data, was used to build trustworthiness, quality and authenticity throughout the implementation of evaluation (Lincoln and Guba, 1985). In the next chapter the findings from the three phases of the implementing the evaluation are presented in terms of processes, impacts and outcomes.

# CHAPTER FIVE

# THE CHANGES WITHIN THE LMFTs AND PHCTs INVOLVED IN THE LMFTs PROJECT

## 5.1 INTRODUCTION

This chapter presents the findings of the LMFTs project in terms of processes, impacts (immediate effects) and outcomes (longer term effects). The chapter will be divided into two parts (table 29). The first part will look at the formative evaluation stage. This consisted of phases one and two during which the crucial elements in understanding the way things emerged were the processes within the LMFTs project. At the end of phases one and two the emerging issues identified by the stakeholders were instrumental to advancing the processes within intervention programme. The second part will look at phase three which was a summative evaluation phase.

**Table 29**

**Three Phases Of Implementation Of The LMFTs Project**

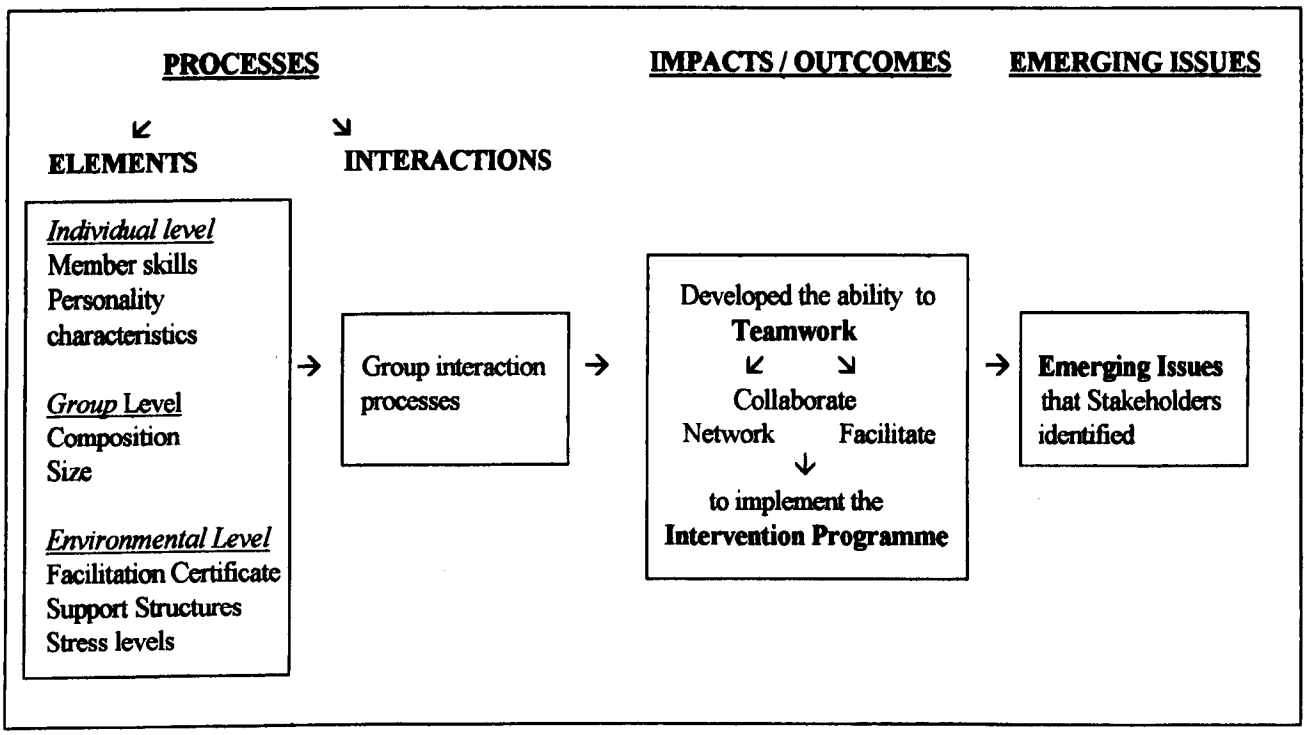
| Part | Phase | Time Frame | Findings |
|---|---|---|---|
| **One** | | | **Formative stage** |
| | One | February 1994 to January 1995 | Developing foundations for implementing the intervention programme. |
| | Two | February 1995 to January 1996 | On-going implementation of the intervention programme. |
| **Two** | | | **Summative stage** |
| | Three | February 1996 to January 1997 | Final phase of implementing the intervention programme. |

## 5.2 PHASE ONE: DEVELOPING THE FOUNDATIONS FOR IMPLEMENTING THE INTERVENTIONS

The findings from phase one are presented in terms of processes, impacts and emerging issues (figure 22).

**Figure 22**

**Phase One: Findings**




## 5.21 PROCESSES

The processes consisted of the LMFTs structural elements and their group interaction processes. The structural elements are divided into three levels: individual, group and environmental levels (figure 22).

### 5.21.1 Structural Elements

At the **individual level**, the different professional skills and dynamic personality characteristics were considered by the LMFTs as their prime assets as they developed the ability to teamwork, network

and facilitate. This was reflected in comments they made during informal discussions during their monthly team meetings:

> "I think one of the strengths of the whole thing is that we're all from different spheres of work and yet we can
>
> show that anyone can come from different spheres and link in."(LMFT Red).

> "They [LMFTs] are a very sort of go ahead, innovative, dynamic people in their own right." (LMFT Navy).

> "We saw ourselves as OK we don't know everything but we'll know a man who does type of thing so here you go get in touch with us if there's anything you need to know clinically or administratively or anything and we will find out because we have this multidisciplinary team. We have a GP we have a Nurse... and we have networks," (LMFT Blue).

However all did not run smoothly and the LMFTs encountered particular difficulties within their teams as they tried to develop teamwork. These difficulties may be characterised as inter-professional and interpersonal difficulties:

> "When Z. was part of the group we spent so long looking after Z and not concentrating on what we were doing... and that crashed dramatically. Then we had this horrendous evening meeting where it was supposed to be sorted out and it wasn't. I think there was definite development of the team through that process around Z ...we were a lot more comfortable with the four of us that were left... it took us from the February, so from September to February - got a lot of mess to work through, find our direction," (LMFT Red).

> "I mean we had a very unfortunate experience with Y ...very traumatic. [Y] wanted to be the team, ...the leader and we would do all the leg work but Y would be there on the day and take sort of credit but I like to think that we didn't allow that to happen ... I mean it had to finish," (LMFT Navy).

All four LMFTs experienced these type of struggles and each worked hard to find common ground within the group on which they could establish teamwork.

At the **group level** all the LMFTs started with five team members which mirrored, as closely as possible, the core membership of a primary health care team (table 30). The LMFT Navy differed in

that it neither had a practice manager or a health visitor in its initial composition. The LMFTs all commented positively on their multidisciplinary configuration:

> "So if you've got with five people, you've got the knowledge base to go out and see and you use your ability and knowledge to see. So that's the point of it all," (LMFT Green).

The LMFTs all developed very strong internal support structures which provided considerable and continual source of support in a constantly changing environment.

**Table 30**

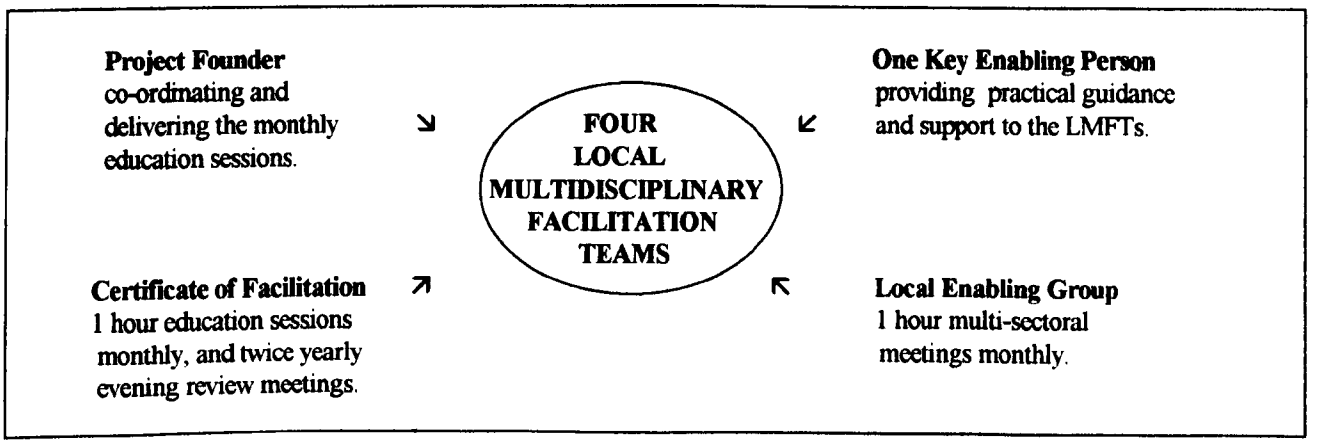
**Phase One: Composition Of The LMFTs**

| Team membership | LMFT - Blue | LMFT - Red | LMFT - Navy | LMFT - Green |
|---|---|---|---|---|
| ▪ Health Visitor | • | • ~ | • | • |
| ▪ District Nurse | | • | | • |
| ▪ Practice Nurse | • | • | • | • |
| ▪ Practice Manager | • | • * | | • |
| ▪ General Practitioner | • | • | • * | • |
| School Nurse | | | • | |
| Nurse Practitioner | | | • | |
| Psychiatric Community Nurse | • | • | | |
| *Total per team* | 5 | 5 | 4 | 5 |
| *Core PHCT members* ▪ | 0 | 1 | 1 | 0 |
| *Members left:* * | 0 | 1 | 0 | 0 |
| *Members replaced:* ~ | | | | |

At the **environmental level** the three key elements were the support structures, facilitation certificate and the stress levels within the teams. The four main support structures within the LMFTs project are given below in figure 23.

**Figure 23**

**LMFTs Support Structures**



The project founder initiated the launch of the LMFTs project and supported the LMFTs through their first six months after which time his appointment ceased. This departure meant that the project lost the founder's vision and leadership. This was reflected in comments made at a Local Enabling Group Business Meeting 8/9/94 where members expressed that they: "fear they [LMFTs] are in the doldrums," ; described the LMFTs work as a "summer of inactivity,"; wondered if the LMFTs "are they resting on their laurels?"; and, considered that the LMFTs were "missing X's (the founder's) leadership." The LMFTs themselves were similarly aware of the situation, and one team summed it up during the 1994 October evening review meeting by saying,

> "Summer - were we doing anything at all? We thought yes [but] there was a brick wall which was gradually caving in," (LMFT Red).

The three key persons from the local enabling group who were designated to support and guide the LMFTs, were the first to observe the falling level of the LMFTs activity, reporting that:

> "Number of interventions held had slowly fallen,"
> "LMFTs had lost touch with their key persons and enabling group,"
> "Role of the 'enablers' had become increasingly uncertain," (Local Enabling Group Meeting, 8/9/94).

The local enabling group and the LMFTs designated support members were, however, regarded by the LMFTs with some degree of uncertainty as to their role and distrust as to their intentions:

> "It all seemed to start with very very structured and this was how its going to be and then it went to the opposite then as soon as X [the founder] left. I didn't feel that [they] had an actual role," (LMFT Green).

> "No 'cos a lot of people had agendas and we would like to have known what in the areas (the LMFTs designated areas) their agendas [were] and then say where, is there anywhere we can work together I mean some of them were things we found out," (LMFT Green).

> "I think ... our enabling group has been under utilised partly our fault. I think er it could have been more useful er I think if it was as a resource which we could tap into that was the whole idea and practically that wasn't happening they were trying to push things around all their agendas. I particularly like the idea of them coming to our meetings once in a while not regularly and you know

something we had access to fairly quickly hmm and looking back you know we got [the LHA deputy executive's] confidence fairly well ahead with that enabling group then it stopped. And I was feeling, I don't know what the rest of the group felt it or not, that we were missing it out. But talking to other LMFTs they didn't particularly like the idea because they were looking at them as different from all of us you know you were saying before they coming in with their agenda's. So I don't know what everybody else feels I think that would have been a good resource if it was done properly," (LMFT Green).

In due course the support of the key persons and local enabling group gradually became redundant as the LMFTs drew more and more support from their own team members.

The LMFTs were supported by the Certificate of Facilitation in Primary Health Care. The course followed the notion of the LMFTs learning theory in parallel with practice. The effect of this was, however, considered by the teams to have been a factor in lowering the number of interventions they held initially:

"I mean were still on a learning curve but its not so steep as those things at the University every month were very hard and apart from all the stuff that hit you. There was that much," (LMFT Blue).

"I don't think the education should start for about twelve months because then you can address the things you really need. They shouldn't start either till you've actually gone and visited and got to know all your Practices," (LMFT Blue).

"I think the problem there was that [they] were not facilitators and they didn't have facilitator experience at all. I'd say it was too academic," (LMFT Green).

"We did think they had done some of it the wrong way round because we felt as we should have more practice experience prior to the education. The education would have perhaps followed on more naturally after we had encountered some difficulties and problems" (LMFT Blue).

During phase one, the LMFTs were subject to high levels of stress that was mainly induced by the uncertainty of undertaking the unfamiliar activity of facilitation among unknown Practices and staff. Their uncertainty was revealed by the descriptions they gave of the challenges they had faced:

"I feel we lack street level credibility," (LMFT Red).

"Being allowed into Practices," (LMFT Green).

"I think its acceptance really who's this person who think the're more knowledgeable than we are and what do they think they are going to tell us," (LMFT Green).

"I think swallowing the insults you know from Practices," (Green).

"People were very suspicious about anything that the LHA [were doing]," (LMFT Blue).

The experiences of the LMFTs highlighted the uncertain nature of facilitation work which underlined the need for developing positive ways of coping with their fluctuating levels of the stress this induced. In the main they overcame the debilitating effects of heightened stress levels by drawing on the internal group dynamics within their own teams as their support structures failed to meet their needs.

### 5.21.2 Group Interaction Processes

From the outset the founder was concerned to establish effective teams capable of delivering the intervention programme. Belbin's (1981) conception of the key team-roles that people needed to adopt to create an effective team were aimed for during the composing of the teams (table 11). The LMFTs were introduced to Belbin's ideas about key team-roles and encouraged to adopt them from their first team-building session onward. This team building event was held at the start of the LMFTs project specifically to initiate the team building process, break down communication barriers and help individuals adjust to their role as part of a facilitation team. The LMFTs were introduced to the vision, goals, objectives and expected outcomes of the facilitation work. Each LMFT engaged in problem solving processes to help them determine how they wished to work together and the nature of their working arrangements. This aimed to produce optimal results from their working together. These group processes served to help LMFT members set aside dominant professional loyalties and adjust their individual perspectives towards those of their team. Thus, the LMFTs entered the group life cycle at this team building event (figure 12) and began the process of mutually adjusting to each other, as discussed in section 2.41.

The five stages of the group life cycle: forming, storming, norming, performing and adjourning are useful for gauging what was happening to each LMFT in the team-building process (Tuckman and Jensen, 1977). Initially, in the forming stage, it was evident that team members were responding individually, mostly in keeping with their primary orientation, to the dilemmas caused by the mixed-motive nature of the multi-disciplinary group:

> In the early part of the team-building exercises the level of disclosure between team members was confined to professional homilies, a didactic discourse in which each defended their individual positions. After the table-tennis team tournament on the first evening the teams had begun to cross professional boundaries, reveal aspects of their work that concerned them and talk more openly about their hopes for the work of the LMFTs. By the end of the two day team-building event each team had begun to formulate ground rules for how they might work together and decide on a plan of action (Facilitator's notes, September 1993).

The LMFT members had taken the first steps in the process of mutual adjustment. This is an informal communication process that takes place in an unconnected group of individuals, via the use of various group processes, to achieve co-ordination of their work (Mintzberg, 1979). Each LMFT had different experiences of the adjustment process, three became more 'mutually adjusted' to each other, judged themselves to be moving in and out of the storming, norming and performing stages and viewed the future positively. The fourth team was, however, experiencing difficulties and felt themselves to be moving between the forming, storming and norming stage, they held a more of negative outlook.

Comments following reflections made by the affected LMFT during the Evening review meeting were:

> "Had not openly expressed ourselves, not spoken honestly,"
>
> "We were not sure what our common goal was,"
>
> " We were different from other teams,"
>
> "Ownership hard if not sure what you're doing,"
>
> "Team building difficult if not a team ourselves,"
>
> "Fallen back, regrouped and once more into the breach... ." (13/10/94).

Each LMFT member occupied a minimum of three roles and sometimes found these roles in conflict with each other. The way each member was locked into what Huntington (1981) called their own 'occupational consciousness' influenced the teams ability to work together and achieve its goals, see page 44. Their three main roles were:

- as an individual professional health worker with a primary loyalty to their own occupation,
- as a professional health worker with a remit and loyalty to their home general practice.
- as an LMFT primary health care facilitator.

The LMFT role was one that had different interests to either of their other role affiliations. Ultimately the failure of individual members to adjust to their team roles precipitated dysfunctional team work and led to an early departure of two members (table 30). The effect of these departures was described as having "a devastating effect, honesty, anger, frustration all bubbled up," (LMFTs Navy) on one LMFT, and as giving another a "bit of a shaky start, anxiety high as to whether we were a team or not,"(LMFT Red). Each member was selected after an assessment process that aimed to identify their potential or actual capabilities as facilitators. The prospective facilitators undertook a series of groupwork activities which were observed by the former LPHCFP team members. This was followed up by an individual interview with the LPHCFP team members. Additionally, there was consideration of how their various individual and team attributes would combine and contribute towards making an effective facilitation team. As the teams developed, the Belbin (1981) categories for assessing team roles was to be used by the LMFTs to make self-assessments of their contribution to their team. The LMFTs were, however, reluctant to make use of Belbin's categories to assess their roles in the team work and facilitation activities during phase one. This was because they, at first, found it difficult to relate the Belbin (1981) team roles to their own teamwork.

### 5.21.3 Impacts

The immediate effect of setting up the LMFTs project was the LMFTs progression towards the development of teamwork within each team. Teamwork is a concept that has been problematic to define and measure (Bond, et.al., 1985; Poulton, 1995) but one that has been characterised by the notion of collaboration (Davidson's 1976; Armitage, 1983), (tables 6 and 7 in section 2.41). Davidson's (1976) five tiered typology of interorganisational relationships was adapted to provide a useful way of assessing the level of collaboration between the LMFTs members. This model was used to assess how the LMFTs progressively developed their collaborative activity as they initiated, organised and implemented the intervention programme (table 31).

**Table 31**

## Phase One : The LMFTs Degree Of Collaboration

| Teams | | LMFT - Blue | | LMFT - Red | | LMFT - Navy | | LMFT - Green | |
|---|---|---|---|---|---|---|---|---|---|
| Time Frame - dates of the two evening review meetings | | Mar '94 | Oct. '94 | Mar '94 | Oct. '94 | Mar '94 | Oct. '94 | Mar '94 | Oct. '94 |
| | **Typology of Collaboration** | | | | | | | | |
| 1 | **Communication / consultation:** talking together, sharing information, ideas, feelings about the Interventions | ✓ | ✓ | ± | ± | ± | ± | ✓ | ✓ |
| 2 | **Co-operation:** when communication leads to working together; | ± | ✓ | ± | ± | × | ± | ± | ✓ |
| 3 | **Co-ordination:** formalised arrangements and tasks clearly defined; | × | ± | × | ± | × | ± | ± | ± |
| 4 | **Teamwork:** define goals and tasks precisely, structured planning and yielding some autonomy to the joint structure; | ± | ± | ± | ± | ± | ± | ± | ± |
| 5 | **Merger:** Structure formalised to the point where participants set aside dominant loyalties at least regarding the specific domain(s) in which co-operation has occurred, a new formal organisation emerges. e.g. a self organising team.. | × | × | × | × | × | × | × | × |

Key : ✓ : mostly developed; ± : partially developed; × : not developed;

(Based on Davidson, 1976:120)

The degree to which each team collaborated was used as an indicator of their ability to teamwork. This was self-assessed using the Davidson (1976) typologies. All LMFTs were demonstrating collaboration in varying degrees by the October 1994 evening meeting. Their activities were equating with levels one to four of the typology. LMFT Blue and Green were advancing particularly well in collaborative levels one and two whereas LMFT Red and Navy, who suffered early membership changes, had only partially developed their communication and co-operative activities.

The creation of information and communication networks and the ability to facilitate Practice development was central to the LMFTs project. At the start each LMFT member brought to the team their own professional information and communication networks. These were largely centred on the General Practice and Health Centre to which they were attached and rarely extended beyond this. On commencement of the intervention programme each LMFT regularly visited all the Practices in their area (table 32). In addition, their monthly meetings with the Local Enabling Group, helped them to make connections with other local health workers within their areas. An assessment of the degree of collaboration they achieved with their Practices showed this to be largely confined to Davidson's (1976) typology 1 and 2, (as described in table 31).

Alongside developing networks the LMFTs were involved in the practical work of facilitating Practice development via the implementation of the intervention programme. Their ability to facilitate was supervised by the Facilitation Course co-ordinators and assessed during the March and October 1994 evening review meetings. The LMFTs gave presentations which were assessed, using a score sheet, for content, organisation and quality of delivery by the Course co-ordinators and peers. Each team was judged, by the Course assessors, to have achieved an acceptable standard of competency by the October 1994 meeting.

### 5.21.4 Intervention Programme

The LMFTs intervention programme was comprised of five particular types of interventions, their networking activities, and the emergence of some specific facilitation activities for individual general practices (table 32). The details of what their intervention programme entailed was limited to providing a general overview in this phase. The reasons for this were twofold, the researcher joined the Project six months after it had begun and the LMFTs found it difficult to establish the habit of systematically evaluating their work. The interventions could, however, be described in terms of their structure, process and outcome.

**Table 32**

**Phase One: An Overview Of The LMFTs Intervention Programme**

| Interventions | LMFT - Blue | LMFT - Red | LMFT - Navy | LMFT - Green |
|---|---|---|---|---|
| Multidisciplinary forums | 1 | 2 | - | 1 |
| Multidisciplinary workshops | 1 | 2 | 1 | 4 |
| Interactive bulletins | 2 | 4 | 2 | 3 |
| Shared projects | 2 | 2 | 2 | 1 |
| Roadshows | 1 | - | 2 | 2 |
| Networking with Practices | 11 Practices visited, on average, one to two monthly; | 22 Practices visited, on average, one to two monthly; | 15 Practices visited, on average, one to two monthly; | 10 Practices visited, on average, monthly; |
| Extending original programme with:<br>Seminars;<br>Undisciplinary Mtg:<br>Practice awayday; | <br>1<br>2<br>1 | - | <br>1 | - |

Each intervention was structured as multidisciplinary group comprising of health professionals who were drawn from as many Practices as possible in a given Cluster, thus they were also 'multi-Practice' groups. In terms of process each had a general framework wherein they started with the

concerns of health professionals, used participative activities whenever possible and identified and prioritised local issues and concerns. Each was facilitated by an LMFT who were there to help people talk together, to share ideas and information and to come to an agreement about an action plan. The outcome was to make a plan for future action. The range of interventions and the topics addressed in phase one of the programme are given in table 33. The interventions provided the foundations for developing collaboration between Practices in each of the areas covered by the LMFTs. An assessment of the level of collaboration achieved between those Practices attending the interventions equated with Davidson's (1976) typology 1, as described in table 7. In an intervention the attending health professionals were communicative, talking readily together about their concerns, this however, rarely extended into collaborative activity beyond the intervention.

**Table 33** **Phase One: LMFTs Intervention Programme**

| Topic | LMFT - Blue | LMFT - Red | LMFT - Navy | LMFT - Green |
|---|---|---|---|---|
| Interactive bulletins | Introducing LMFTs;<br>Drug awareness report;<br>Reports on recent seminar and events; | Introducing LMFTs<br>Health Promotion Banding;<br>Drug awareness;<br>'Fag Ends' group; | Introducing LMFTs;<br>School Health project; | Introducing LMFTs;<br>Report: drug abuse - shared care;<br>Receptionists Needs; |
| Multidisciplinary forums | Introducing LMFTs; | Introducing LMFTs;<br>Elderly Care; | - | Abnormal vaginal bleeding guidelines; |
| Multidisciplinary workshops | Health Promotion Banding; | Health Promotion Banding;<br>Drug Awareness; | Health Promotion Banding; | Identifying Health Care Needs;<br>Health Promotion Banding;<br>Drug abuse/ shared care;<br>Receptionists needs; |
| Shared projects | Conference - Health Needs;<br>Mental Health issues; | Conference: Health Needs;<br>Exercise on Prescription | Conference - Health Needs;<br>School Health; | Conference - Health Needs; |
| Roadshows | Communication and job roles; | - | Teambuilding / nursing strategy;<br>Cervical cytology; | The Way Forward / Health Needs x 2 roadshows; |
| Practice visits | to establish rapport / develop networks | to establish rapport / develop networks | to establish rapport / develop networks | to establish rapport / develop networks |
| Extension of original prog.<br>Seminars;<br>Undisciplinary meetings x 2<br>Practice awayday; | Drug awareness;<br><br>Communication;<br>Communication / Practice Charter; | - | In-Practice brainstorming session; | - |

### 5.21.5 Emerging Issues

At the end of phase one the LMFTs and the evaluation processes were reviewed during the reflection-on-action dimension within the PAR approach. As a result various emerging issues were identified by the different stakeholders as impeding the progress of the LMFTs, appendix 9. Although much had been gained in terms of the LMFTs developing the ability to teamwork significant issues regarding the structural elements of the Project had arisen. These issues mainly revolved around three different aspects. First was the nature of LMFT management and the roles of the different stakeholders involved, second was the constitution and function of their support mechanisms and third was a concern about the accountability of the teams, for an elaboration see appendix 9. A detailed account of developing the groundwork of the LMFTs and their evaluation may be found in the first (formative) evaluation report (Graver, 1995).

## 5.3 PHASE TWO: ONGOING IMPLEMENTATION OF THE LMFTs PROJECT

Using the framework outlined at the beginning of this chapter the following processes, impacts and emerging issues were identified in phase two.

## 5.31 PROCESSES

### 5.31.2 Structural Elements

At the **individual level** the personal and professional development of the LMFTs was becoming evident. They had begun to notice differences in the way they conducted themselves at work:

> "Its given me such insights into a Health Authority and I've even got some clinical views now, ...I've been able to enhance my skills here as a Practice Manager... and its of benefit to this Practice," (LMFT Blue).

> "Well its give me confidence to go forward to my GP knowing what problems exist for GPs. Its helped me to put my opinions forward that I may not have even thought about doing because I didn't understand the GPs role in it all," (LMFT Red).

"Its done absolute wonders for my self-esteem... ,"(LMFT Red).

Each LMFT member, on developing the ability to facilitate the intervention programme, gained personally and professionally from this process, despite further changes to the composition of their teams and thus disruption of their internal dynamic processes (table 34).

At the **group level** the composition of each team changed in phase two. This was due to life changes, e.g. a district nurse visitor and psychiatric nurse left LMFT Red for job promotions, a member of LMFT Green went on maternity leave and absences occurred as a result of sickness(table 34). Although each team's composition changed the remaining 'core' of the team remained a strong enough unit to withstand the constant external environmental pressures and continue to implement the intervention programme.

**Table 34**

**Phase Two: Composition Of The LMFTs**

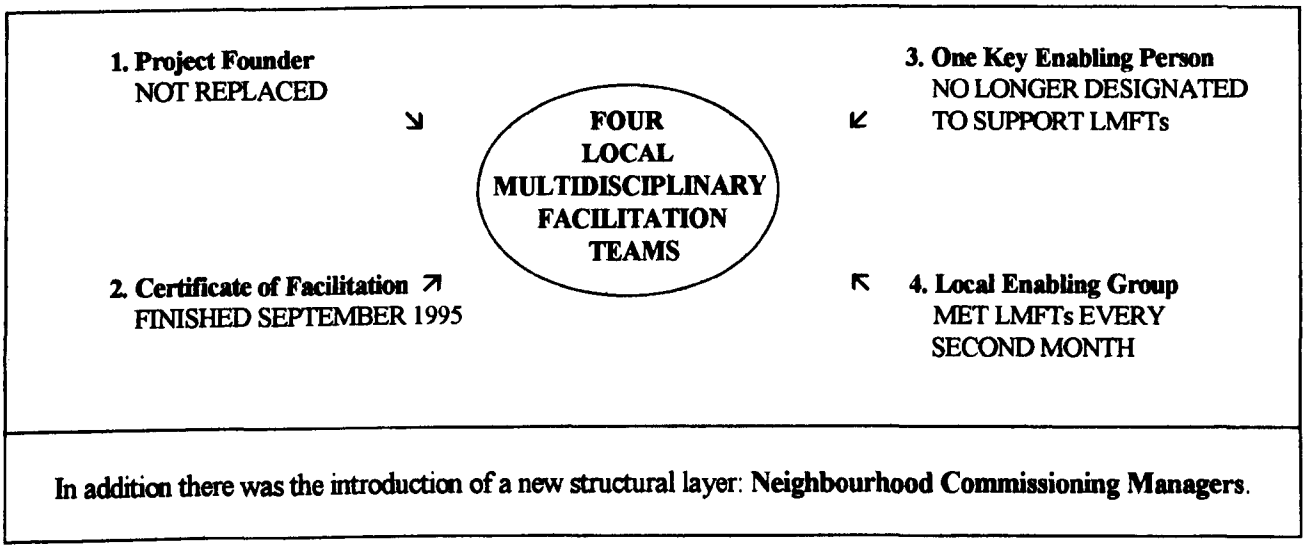
| Team membership | LMFT - Blue | LMFT - Red | LMFT - Navy | LMFT - Green |
|---|---|---|---|---|
| Health Visitor | • | • | • | • |
| District Nurse | | • * | | • ✚ |
| Practice Nurse | • | • | • | • |
| Practice Manager | • | | | • |
| General Practitioner | • * | • | • *<br>• ~ | • |
| School Nurse | | | • | |
| Nurse Practitioner | | | • | |
| Psychiatric Community Nurse | • *<br>• ~ | • * | | |
| Health Promotion Officer | | • ~ | | |
| *Total per team* | 4 | 4 | 4 | 5 |
| *Members left:* * | 2 | 2 | 1 | |
| *Members replaced:* ~ | 1 | 1 | 1 | |
| *Members - long term leave:* ✚ | | | | 1 |

At the **environmental level** there was a collapse of the original support structures (figure 24). This was because the members of the Local Enabling Group (LEG) were unclear about their role within the LMFT project and, were considered by the LMFTs, to not be 'local enough'. The LMFTs needed, particularly in the beginning, direct and active support from key people, e.g. managers and leading GPs, *within* their own local areas. The development of a support network between the two groups was not achieved. This was thought to be a result of formalising the LEGs connections with the LMFTs via a monthly meeting. This established a communication barrier between the two

groups which the LMFTs found difficult to overcome. Additionally, the project founder was not replaced, the Certificate of Facilitation in Primary Health Care ended, and the specific support role of designated LEG members was dropped. Thus, the LMFTs had to become self-reliant. A loose 'managerial / support' connection with the LMFTs was retained via meeting the LEG every second month. The LMFTs led this meeting and asked each LEG member, in turn, to give an account of their role / health organisation. This was requested by the LMFTs in order for them to further their understanding of health provision services within their areas.

**Figure 24**

**Changes To The LMFTs Support Structures**




The new management layer of Neighbourhood Commissioning Managers (NCMs), with a remit to implement NHS policy reforms (DHSS, 1983; Secretaries of State for Social Services, 1987 and 1989; DOH, 1990) locally, made a direct impact on the management of the LMFTs and the implementation of the intervention programme. Seven NCMs were appointed during 1995 to help make local health services more responsive to local needs. The four Clusters in which the LMFTs project was being implemented came under the management of four NCMs, and each LMFT was perceived as instrumental to the achievement of their objectives. The NCMs were uncomfortable with the level of independence and self organisation that manifest in the LMFTs. The teams however had, by this time, gained a considerable measure of confidence and thus began a defence against what they perceived as the NCMs inclination to manage and control them:

"They just literally want to throw something in and just say 'right do it," (LMFT Red).

"They just think they can use us and pass the message through which we've learnt now," (LMFT Green)

The LMFTs gain in confidence corresponded with their increasing ability to facilitate the intervention programme and cope with uncertainty. This was illustrated in their ability to make critical reflections about Facilitation Course.

When asked, as a group, 'What things did we do well?', they responded with:

"Got the Course going,"
"We have influenced and made contact with many people,"
"Despite the fact it was unknown we stayed the course,"
"Cross linked many different theories which was difficult, but we put it together."

(Evening review meeting, October 1995).

And, in response to the question, 'What things didn't go so well?', they replied that:

"The restrictive framework was set stopping creativity as we went along,"
"The practical work was not linked sufficiently well with the theory in the course,"
"They didn't feel it was explained clearly enough at the beginning"

(Evening review meeting, October 1995).

These were views that several LMFTs members had held at the end of phase one but had not been willing to make known. Their experiences had increased their confidence to such a degree that they now felt able to make critical comments for the betterment of the LMFTs project and future Facilitation courses.

### 5.31.3 Group Interaction Processes

The LMFTs remained mindful of the need to maintain positive team dynamics and accordingly organised their own 'awayday'. The serious work of the day they used to help them to reflect on 'where they were going' and the evening social event was arranged for them to have fun together as a group and promote positive group interactions. During the day each team expressed that they had

had times when they stormed rather than performed but had accepted this as part and parcel of teamwork. They commented that whilst it was uncomfortable when it happened they drew strength from their previous experiences, " we have got through it before," (LMFT Navy). The process of mutual adjustment was a continuous one. The teams had all had to make adjustments to their working agreement as members left a team and when they went through the process of re-appointing and integrating new members. They managed the adjustment process very well but felt vital time and energy was diverted away from facilitating the intervention programme:

> "We didn't do any sort of formal teambuilding. We didn't do, we promised to do it with A and we promised to do it with U and yet we have overcome it although there's times maybe if we'd done it at the beginning we'd have got a lot of things cleared out of the way," (LMFT Red).

> "With different members all the time doesn't add to your credibility. It was the changing personnel having to explain all the time 'oh this person come in place of this person," (LMFT Blue).

> "Its like being 'The Three Degrees' isn't it if they kept changing one degree each week or month or whatever it was then the three degrees all the three degrees is like all different people all the time you know what I mean?" (LMFT Blue).

As the teams strengthened their internal dynamic processes and their levels of confidence they became more able to adopt different roles during the implementation of an intervention. However the LMFTs were still not assessing their own roles but they had begun to see Belbin's (1981) key team roles as a formula for an ideal team, this point is returned to again in the third phase.

### 5.31.4 Impacts

The second assessment of the LMFTs collaborative pattern showed that all the teams were undertaking activities that were commensurate with all five categories in Davidson's (1976) typology, albeit the merger category was only partially developed at this time (table 35). The concept of 'merger' was likened to the concept of the LMFTs becoming self-organising teams, wherein their direction and activities were initiated from within the team and were not the result of external pressures from within the environment. The acknowledgement of their increasing abilities came via the Facilitation course where each member attained an acceptable standard of competency and, furthermore, through the successes of their practical work.

**Table 35**

**Phase Two: The LMFTs Degree Of Collaboration**

| Teams | | LMFT - Blue | | LMFT - Red | | LMFT - Navy | | LMFT - Green | |
|---|---|---|---|---|---|---|---|---|---|
| Time Frame - dates of the two evening review meetings | | Mar. '95 | Oct. '95 | Mar. '95 | Oct. '95 | Mar. '95 | Oct. '95 | Mar. '95 | Oct. '95 |
| | Typology of Collaboration | | | | | | | | |
| 1 | **Communication / consultation:** talking together, sharing information, ideas, feelings about the Interventions | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2 | **Co-operation:** when communication leads to working together; | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3 | **Co-ordination:** formalised arrangements and tasks clearly defined; | ± | ✓ | ± | ✓ | ± | ✓ | ± | ✓ |
| 4 | **Teamwork:** define goals and tasks precisely, structured planning and yielding some autonomy to the joint structure; | ± | ✓ | ± | ✓ | ± | ✓ | ✓ | ✓ |
| 5 | **Merger:** Structure formalised to the point where participants set aside dominant loyalties at least regarding the specific domain(s) in which co-operation has occurred, a new formal organisation emerges. e.g. self organising team. | × | ± | × | ± | × | ± | × | ± |

Key : ✓ : mostly developed; ± : partially developed; × : not developed; (Based on Davidson, 1976:120)

The LMFTs had, by now, established their networks with the majority of Practices in their Cluster and extended these to include other health involved people or organisations (when relevant to an intervention). Maps 3 and 4 shown in appendix 8 demonstrate the LMFTs developing networks. Their mastery of their position became clear when the LMFTs met, in a participatory workgroup, their newly appointed Neighbourhood Commissioning Managers to establish how they would work together in the future. This resulted in each LMFT devising their own set of aims and objectives which were complementary, but not subordinate, to those of the NCMs objectives. A set of each LMFTs' objectives are given in appendix 10. The impact of this action was twofold. First, the LMFTs gained far greater clarity of where they fitted into the overall PHC development strategy and second, they began to 'master their own destiny' by defining their own role boundaries, direction and facilitation activities for themselves. This step was seen as partial development towards the LMFTs becoming self-organised teams.

### 5.31.5 Intervention Programme

The LMFTs had extended the intervention programme by the end of phase two (table 36).

**Table 36**

**Phase Two: LMFTs Interventions Programme**

| Interventions | LMFT - Blue | LMFT - Red | LMFT - Navy | LMFT - Green |
|---|---|---|---|---|
| Multidisciplinary forums | 2 | 3 | 4 | 1 |
| Multidisciplinary workshops | 1 | 2 | 1 | 5 |
| Interactive bulletins | 1 | 1 | 2 | 2 |
| Shared projects | | 3 | | |
| Roadshows | | | | |
| Networking with Practices | 11 Practices visited, on average, one to two monthly; | 22 Practices visited, on average, one to two monthly; | 15 Practices visited, on average, one to two monthly; | 10 Practices visited, on average, monthly; |
| Extending original programme with:<br>Seminars;<br>Undisciplinary meeting;<br>Practice awayday; | <br>1<br><br>1 | - | - | - |
| This table demonstrates only part of the LMFTs activities, e.g. mainly their Cluster level facilitation activities. | | | | |

The intervention programme now consisted of two levels of facilitation activity. The same five interventions were still being implemented, although less often, at the Cluster level but these were now complemented by a second 'Practice' level of facilitation activity. This was in response to a 'felt need' by the LMFTs that was endorsed by stakeholders through the PAR process. The LMFTs had become aware that there was essential groundwork to be done in some Practices before they could get staff to attend the Cluster level intervention programme. However, no specific records had been kept by the LMFTs as to what these activities entailed but informal team discussions between the researcher and the LMFTs enabled them to create four short scenarios as examples of their early Practice level activity, for an elaboration see appendix 8.

The LMFTs continued to use the same process of facilitation in their interventions as described in phase one. The interventions were used as a mechanism for developing and maintaining collaboration between Practices. The degree of collaboration the LMFTs achieved with the

Practices in their Clusters was assessed as varying from type 1 to 3 of Davidson's typology (1976), (as outlined in table 7 in section 2.41), and depended on the responsiveness of each Practice. The degree to which Practices were establishing collaboration between each other (beyond the facilitated intervention) was judged lower at type 1. Many members of the Practices were attending and actively taking part in the interventions but they still did not actively take the ideas forward into action. This was not the case however with the Practices that were undertaking shared projects, they had undertaken collaborative activities that ranged from 1 to 4 of Davidson's typology.

### 5.31.6 Emerging Issues

The emerging issues were identified by stakeholders following a review of the preceding activities in phase two. These, in the main, concerned the continued lack of a clear management support structure, the unexpected direction the intervention programme was taking and the long term future of the LMFTs project, for further elaboration of the emerging issues in phase two see appendix 9. A more detailed account of activities and events of phase two may also be found in the second (formative) evaluation report (Graver, 1996a and b).

## 5.4 PHASE THREE: FINAL PHASE OF IMPLEMENTING LMFTs PROJECT

In keeping with the framework outlined at the beginning of this chapter phase three findings are presented as processes, impacts and outcomes, with an emphasis on the latter as this was the final implementation phase in which a more summative evaluation process was adopted.

## 5.41 PROCESSES

### 5.41.1 Structural Elements

The original conception of an LMFT was that it should emulate the core professional membership of the primary health care team within a Practice to promote team credibility and networking with Practice staff. A second notion was to encourage the LMFT members to adopt key team roles, as conceived by Belbin (1981) (table 11), and outlined in phase two. This was in order to become effective teams and deliver the intervention programme.

The professional membership of the LMFTs underwent several changes throughout the Project which meant that their composition was, at times, considerably different from the primary health care teams they were working with (table 37). Many members that left the LMFTs were either replaced by a health professional from a different discipline or not replaced at all. The most constant discipline represented, over the time period, were practice nurses and health visitors whereas district nurses followed by practice managers and general practitioners were under represented. The absence of certain disciplines was considered to have had a detrimental effect on networking and the LMFTs credibility levels within Practices:

> "It wasn't until very recently I've realised what we've lost in loosing a district nurse. We've not got the district nurses on board the same way as we have the practice nurses, the health visitors, the doctors...I still feel there is a huge gap," (LMFT Red).

> "I think it gives validity to the team to the GPs in the area doesn't it because we have got a GP so therefore somebody thinks its of value," (LMFT Blue).

> "... a practice manager could maybe have helped us see things more in the way that the FHSA see things, ...because they've got more of an idea of some things that are demanded of the Practice that as a health visitor I'm clueless about," (LMFT Red).

> "Essential to have a GP because a GP carries the strength. Well all take GPs quite seriously whereas a Practice mightn't take a practice nurse seriously they certainly don't take the practice manager seriously," (LMFT Blue).

> "...some of the difficulties we had with some individuals as where I would find it difficult but of the other members might find it easier to get into and its quite often because you're in the same profession," (LMFT Green).

Thus, the lack of certain professional disciplines was considered to have reduced the LMFTs ability to make connections, gain acceptance and develop collaborative activity within a Practice.

**Table 37**

**Changes In Team Composition Over Time**

| Team Membership | LMFT - Blue | | | LMFT - Red | | | LMFT - Navy | | | LMFT- Green | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Time Frame in Phases | 1 | 2 | 3 | 1 | 2 | 3 | 1 | 2 | 3 | 1 | 2 | 3 |
| Health Visitor | • | • | • * | • ~ | • | • | • | • | • * | • | • | • * |
| District Nurse | | | | • | • * | | | | | • | • ; | • |
| Practice Nurse | • | • | • | • | • | • | • | • | • * | • | • | • |
| Practice Manager | • | • | • | • * | | | | | | • | • | • |
| General Practitioner | • | • * | | • | • | • | • * | • * • ~ | | • | • | • |
| School Nurse | | | | | | | • | • | • | | | |
| Nurse Practitioner | | | | | | | • | • | • | | | |
| Psychiatric Nurses | • | • * • ~ | • * | • | • * | | | | | | | |
| Health Prom. Officer | | | | | | • ~ | | | | | | |
| Total per team | 5 | 4 | 2 | 5 | 3 | 4 | 4 | 4 | 2 | 5 | 5 | 4 |
| Members left team * | - | 2 * | 3 * | 1 * | 2 * | 0 * | 1 * | 1 * | 2 * | - | - | 1 * |
| Members replaced ~ | - | 1 ~ | 0 ~ | 1 ~ | 0 ~ | 1 ~ | 0 ~ | 1 ~ | 0 ~ | - | - | 0 ~ |
| Members - long leave ; | | | | | | | | | | | 1 ; | |

In addition to absent disciplines in the teams the LMFTs were constrained due to lack of time. Each member was appointed to provide five hours of facilitation activity per week, cumulatively if an LMFT had full membership this gave a total of 25 hours weekly. Serious problems arose as each LMFT found it was only possible to implement the simplest of Cluster level intervention inside twenty-five hours. Interventions that were more collaborative took much longer to set up, e.g. smoking cessation initiative discussed later in section 6.63. The LMFTs all considered the time inadequate and regularly worked overtime to get through the workload especially when they were working with reduced numbers in the team. Their views were summed up in the following quote,

> " Well that's a bit of a fallacy. To go into your surgeries, to do all the phoning, the networking, the connecting, the whole thing in five hours a week is silly," (LMFT Blue).

The notion of the need for LMFT members to adopt key team roles in order to effectively deliver the intervention programme was assessed using Belbin's (1981) key team role categories (table 11). The LMFTs used Belbin's (1981) key team roles to identify what roles they adopted and those they

felt they lacked within their team (table 38). The roles that they adopted were not specific to one person in the team rather they were adopted by different members as required by circumstance.

**Table 38**

**Roles In The LMFTs**

| ROLES | LMFT - Blue | LMFT- Red | LMFT - Navy | LMFT - Green |
|---|---|---|---|---|
| Company worker | × | ✓ | ✓ | ✓ |
| Chairman | ✓ | ✓ | ✓ | ✓ |
| Shaper | ✓ | × | × | ✓ |
| Plant | × | ✓ | × | × |
| Resource Investigator | × | ✓ | ✓ | ✓ |
| Monitor evaluator | ✓ | ✓ | ✓ | ✓ |
| Team worker | ✓ | ✓ | ✓ | ✓ |
| Completer / finisher | × | × | × | × |
| Key: ✓ = Primary role adopted in the team. × = Roles the team felt they lacked. | | | | |

Each team member regularly adopted more than one role during the course of an intervention. Each team was described as featuring a chairman, a teamworker and a monitor evaluator which brought, using Belbin's (1981) definitions, the following characteristics to all the teams:

- Chairman: an ability to welcome all contributions whilst retaining a sense of purpose,
- Teamworker: an ability to be responsive to people and promote team spirit;
- Monitor / evaluator: an ability to have discretion and judgement.

Only one LMFT noted that not having certain skills available within an LMFT impeded the organisation of their facilitation work:

> "When you use the Belbin and all the rest of it and you find out where there's a gap in the group... I would make sure they [the replacement] would fill in the piece... we had an area that none of us fitted into. So you know that practice manager that we had to start with...we didn't half miss her when she went because what she did was she was very quiet and she listened and what she did was collect any sort of keep us sort of tunnelled as well and also she could stand back...," (LMFT Red).

All the LMFTs stated they adopted several secondary roles during each intervention thus it has to be assumed that any remaining gaps in the teams were covered in this way. A further point to note was that none of the LMFTs claimed to have anyone that undertook the completer / finisher role as a primary role. This may be an error of self-assessment or refuted as each team had managed to implement an interventions programme. However, it may also reflect that it was a hidden role and, as with other secondary roles, assumed to be the responsibility of all members. This may, in part, provide one answer as to the reason the LMFTs failed to systematically evaluate their interventions as this was not achieved.

### 5.41.2 Group Interaction Processes

The third assessment of the LMFTs ability to collaborate is demonstrated in table 39 below.

**Table 39**

**Phase Three: The LMFTs Degree Of Collaboration**

| **Teams** | | **LMFT - Blue** | | **LMFT - Red** | | **LMFT - Navy** | | **LMFT - Green** | |
|---|---|---|---|---|---|---|---|---|---|
| **Time Frame:** | | Mar. '96 | Oct. '96 | Mar. '96 | Oct. '96 | Mar. '96 | Oct. '96 | Mar. '96 | Oct. '96 |
| | **Typology of Collaboration** | | | | | | | | |
| 1 | **Communication / consultation:** talking together, sharing information, ideas, feelings about the Interventions | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2 | **Co-operation:** when communication leads to working together; | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3 | **Co-ordination:** formalised arrangements and tasks clearly defined; | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4 | **Teamwork:** define goals and tasks precisely, structured planning and yielding some autonomy to the joint structure; | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 5 | **Merger / Self organisation:** Structure formalised to the point where participants set aside dominant loyalties at least regarding the specific domain(s) in which co-operation has occurred, a new formal organisation emerges, e.g. a self organising team. | ± | ± | ± | ± | ± | ± | ± | ± |

Key : ✓ : mostly developed; ± : partially developed; × : not developed; (Based on Davidson, 1976:120)

The LMFTs had, at this stage, become adept in categories 1 to 4 of Davidson's (1976) typology and were continuing to develop their ability to self-organise - category 5 (table 39). They established high levels of collaboration within their teams, and stable information and communication networks with their more responsive Practices (discussed in a later section). This was achieved despite the constant changes to team membership and the constraints of other contextual influences, e.g. the management support structures.

### 5.41.3 Intervention Programme

The efforts of the LMFTs largely concentrated on Practice level interventions, the reasons for this have been referred to earlier in phase two. In addition they, in collaboration with the NCMs, regularly facilitated specific events to promote PHC development at a Cluster level for the LHA.

Central to the LMFTs approach to facilitating interventions was a bottom-up, listening, problem solving approach. This they achieved by initiating local interventions to address local concerns and issues, whether in a Practice or across a Cluster. The interventions were multi-disciplinary unless focusing on issues particular to one discipline and participatory in mode. A general scheme of the way the intervention programme developed is presented in table 40, which is to be read from the bottom upwards. The LMFTs started with a city-wide conference and then moved onto working with locally based health care professionals from Practices to prioritise and address local health needs. The main elements of their intervention programme are described next.

The initial step was to hold a city wide conference in which the LMFTs introduced themselves and found out about key issues in each of their four areas. Local professional and non-professional health care workers were invited to participate in multi-disciplinary workshops. They were asked what they saw as the major obstacles to delivering, appropriate, quality primary health care services in their locality, e.g.

> A Health Visitor was concerned about duplicating the work of Practice Nurses in relation to the immunisation of children.

> The high local rate of smoking and its attendant health problems was of concern to a group of local Doctors.

These and all the other issues that were identified were recorded by the LMFTs and used as the focus of multidisciplinary meetings they initiated in each of their four areas.

**Table 40**

**An Overview Of The LMFT's Facilitation Activity**

**Achieving Various Forms Of Development: Personal, Organisational, Service, Community.**

↑

**Promoting Development Through Teamwork And Collaboration**

↑

**Organising PHCT/Practice Level Facilitation Activities**

↑

**Organising Cluster Level Facilitation Activities**

↑

**Making Local Networks**

↑

**Addressing Local Health Needs**

↑

**Identifying And Prioritising Local Health Needs**

↑

**A First Step: City Wide Conference**

The LMFTs facilitated multidisciplinary meetings in their local areas in which they helped participants to clarify and prioritise those local issues they were going to address. Once this was achieved they aimed to arrive at a consensus for action and make action plans to improve the situation. Underlying each of these facilitated interventions was the intention to promote teambuilding, encourage and support local health workers to become responsible for taking action, and give equal importance to all the participants. The overall purpose was to help local health workers make a collective effort to change things. The outcomes are illustrated by the following Cluster and Practice level examples:

**Cluster level**

The priority issue was the high number of patients needing support from local Mental Health services who were not receiving help early enough through lack of awareness of what was available. The participants decided to develop an initiative to introduce the local Mental Health Team members and its function to all local Practices. This collective action subsequently produced an increased number of 'early' patient referrals to the Mental Health Team.

**Practice level**

The key issue was the high number of General Practices not achieving the higher target levels for cytology screening. Further discussion revealed that many Practices did not have the administrative systems in place to enable them to achieve high cytology screening rates. As this was particular to each Practice the LMFTs agreed to develop a programme that involved staff from the Health Authority as well as themselves in intensive work to educate and establish effective and efficient clinical and administrative systems of work among the PHCT members. This intervention developed co-operative activities between staff members within specific Practices as it helped them to achieve higher target levels.

As the LMFTs worked on in their areas they gradually adapted the five original interventions to suit the needs of specific Practices. It was recognised during phase two that the same people were attending the Cluster level interventions and that some Practices were not being represented at all. The LMFTs response was to try to find out what, if any, the problems of the non-attending Practices were. Some of the reasons for non-attendance was attributed to the fact that many General Practitioners worked single-handedly and had very small numbers of staff making it impossible to release staff to attend interventions and others cited not having a practice manager to co-ordinate

their activities. From these comments and from the experiences of the LMFTs to date it was evident that there were very uneven levels of organisational development in the Practices. Those that were working together to achieve Practice aims and had established collaborative activities to this end, were more pre-disposed to promoting self-directed learning and becoming a learning organisation than those Practices that were under developed in an organisational sense. These were the Practices that were less responsive to the LMFTs intervention programme.

In the process of fact finding about non-attendance all the LMFTs found accessing Practices was a problem, the issue was largely one of trust as many of Practices were cautious about 'letting the LMFTs in':

> "I think one of the big challenges that we faced were that people were very suspicious about anything that the Health Authority or going in so we had to go in under our own steam not anyone else's banner in fact we had to deny all knowledge of anyone else as it were because we had to sort of make them aware that we're there we weren't there to glean information for people," (LMFT Blue).

The LMFTs used their own and other local health workers in depth local knowledge as a resource for accessing and promoting changes within Practices and avoided the use of any Health Authority staff unless essential or until a Practice requested such help. Once they had gained access the LMFTs tried to establish information and problem solving networks between themselves and their Practices and devise interventions that addressed a Practice's immediate concerns. As with the Cluster level interventions they intended to use their activities to promote teamwork and collaboration, this time it was between the individual members in a Practice. To achieve this various adaptions of the original intervention programme was made, e.g.

- one to one discussion between an LMFT and a Practice member about a specific issue, e.g. clinical standards;
- uni-disciplinary forums to provide 'safe climate' for the discussion of sensitive professional issues;
- social lunches to a gain access to receptionists in PHCTs after all other approaches failed;
- small sub-group discussion (unidisciplinary or multidisciplinary) to formulate a specific action plan;
- whole Practices multi-disciplinary workshops to work something out together, e.g. an individual Practice Charter;
- one day team-building sessions for a whole Practice;
- visiting other Practices to use as role models;

The LMFTs viewed the Practice level initiatives as a precursor to getting their Practices collaborating with other each other within a Cluster.

### 5.41.4 Impacts

The intervention programme became mainly focused on the development of individual Practices, that is helping people to work together, as opposed to concentrating on collaborative activities between groups of Practices. The range of impact the LMFTs had in Practices was assessed in terms of the response a Practice made to an intervention. Three broad categories of response emerged with the number of Practices in the least responsive category gradually reducing over time (table 41).

**Table 41**

**The Response From Practices**

| Categories | 1995 | 1997 |
|---|---|---|
| Active Responders | 2 | 15 |
| Semi-responders | 12 | 23 |
| Passive Responders | 42 | 18 |

**Key:**
- **Active responders**: The most responsive group. They positively and proactively met change;
- **Semi-responders**: A less responsive group that were much more passive and responded to change very slowly;
- **Passive responders**: The least responsive group that resisted change and remained passive to LMFTs activities.

The scope of the LMFTs' impact on development in Practices was assessed using a sample of 20 Practices. In this setting the meaning of development in Practices was conceived by the stakeholders as having four inter-related dimensions: personal; organisational; service and the wider community. Development was seen as context specific and identifiable by looking for changes occurring in any of the four dimensions in a Practice. The examples found in the Practices were compared with the criteria for evaluation (table 26) (see appendix 6 for a more detailed description). The evaluation criteria as defined by the key stakeholders were perceived, when achieved by a Practice, as an indicator of development and good practice. In the sample of twenty Practices all had achieved changes in the area of personal development, and fifteen of these had made changes in the areas of organisational and service development. Furthermore, four of these fifteen Practices had moved into undertaking collaborative activities in their wider community. Of the five Practices that had only achieved changes in the area of personal development, two were poised to make changes to their administrative systems and approach to service delivery. For examples of Practice level activities, see

appendix 11. Of significance, was that those Practices that had achieved the highest levels of change were Practices that had either a facilitator as a member of staff or had developed a close relationship with an LMFT.

### 5.41.5 Outcomes

The outcomes are categorised in terms of the four dimensions of development in Practices.

#### Personal Development

Examples of personal development were found to occur across the range of disciplines of PHCTs. Some were as a result of receptionists attending the Receptionist Course, ten said they increased their level of knowledge e.g. now able to state the importance of 'Items of Service' claims to the General Practice's income, nine described how they were able to use their increased skills to improve their own effectiveness, e.g. changing approaches to call and recall screening systems, and eight thought they had changed their attitude and behaviour towards colleagues and patients. In other examples, the administrative staff of two Practices changed their attitude towards 'attached' Health Professionals and subsequently permitted them to set up specific clinics on Practice premises, and several Practices nurses described an increase in their practical skills, e.g. they were enabled to establish patient 'disease' registers, develop clinical protocols and specialist clinics and reduce the amount of administrative work they did in their Practices. A final example involves a noted change in the attitude of the GPs, this was chiefly among those with a well established LMFT connection. These GPs had changed by becoming more 'open and receptive' to new ideas and were actively responding to suggestions, e.g. by allowing facilitators (audit and asthma facilitators as well as the LMFTs) onto General Practice premises, by agreeing to release employed staff for training days, and by adopting targets for improving screening levels: women for cytology, children for immunisation where there were none previously.

#### Organisational Development

In relation to organisation development the examples in the Practices ranged from improving mechanisms for talking to each other to providing on-going education sessions. For instance, six Practices established regular General Practice Staff meetings and semi-regular whole PHCT

meetings where there were none previously. Other Practices described how their meetings became more structured and participatory and as a result were thought more effective e.g. members were encouraged to put their ideas forward and plans for action were made with individuals being assigned specific responsibilities. In a different set of examples several Practices considered they had improved their capacity to solve problems together through working together with the LMFTs to implement their ideas, e.g. making of a Practice charter, devising a computerised appointment system, undertaking patient surveys and combining a mother and baby clinic into one clinical session. This brought together, for the patient's benefit, the expertise of several different PHCT members in one go. Some Practices specifically developed their own local communication networks to help them solve their immediate problems (which also included local Health Managers when they could not solve their problems themselves) and to increase the resource base of their Practice. And finally, in one or two Practices educational forums had been set up to address the training needs that they had identified and to foster the idea of learning together.

### Service Development

Improvements in the delivery of services to patients ranged from making profiles of the Practice population to concentrating on providing quality care. Some specific examples were the creation of an elderly patient register in one Practice and a specific disease register in another. Other Practices performed an audit of particular clinical activities they provided whilst another undertook a survey of their patients to determine their level of satisfaction and what problems occurred with particular services. A different example was where one Practice followed up the ideas of the Health Visitors, District Nurses and Health Promotion Officers and set about providing specific services for specific groups of patients, and another was where a Practice developed new clinical and administrative approaches to help them achieve the higher DOH target levels. Finally, several Practices were implementing specific clinical protocols after the Practice Nurse had devised them and some were choosing to do this by setting up particular disease management clinics.

### Development In The Wider Community

This was the least developed aspect of the four dimensions of development. Some Practices had begun to use others as role models, e.g. several Practice Managers were sharing problems relating to the development of the administrative or clinical services in their Practices, and some Receptionists

and Practice Nurses had visited other Practices to exchange ideas and solve particular problems. One clear example of collaborative activity was found where six Practices had established an on-going working group to address local health issues in their practice populations. The initial shared project had been a smoking cessation initiative which was subsequently followed by further initiatives focusing on diabetes, asthma and breast screening roadshows. An unexpected spin-off from these initiatives was a self-help support group called 'Fag Ends' which has since gained national recognition and sponsorship from the Roy Castle Foundation, and a Diabetes patients self-help group. Other examples were of specific one off shared projects, these brought members from several Practices together to focus on Cluster wide issues, e.g. a mental health strategy, an educational project for 5-16 Year Olds, an exercise for health programme, and a receptionist course.

**Table 42**

**Summary Of The LMFTs Input Into Development Of Primary Health Care In Liverpool**

| Primary Health Care Development Aims | | Primary Objectives | LMFT Blue | LMFT Red | LMFT Navy | LMFT Green |
|---|---|---|---|---|---|---|
| 1. | Primary Care Services: Improve: range, quality and access. | Increase knowledge of local health issues and promote service development. | • | • | • | • |
| 2. | Mental Health Services: develop & promote use of, | Promote strategy and service development and establish networks. | • | • | • | • |
| 3. | Women's Health Services: develop & promote use of, | Identify and address local needs. Develop local services. | • | • | • | • |
| 4. | Exercise Prescription Service: promote use of, | Raise level of awareness and re-establish service use. | • | • | • | • |
| 5. | Disease Management: develop services and promote use of, | Identify and address local needs. Develop specific services. | • | • | • | • |
| 6. | Healthy School Alliances: develop services and promote use of, | Establish and support developing relationships and support resulting development. | | • | • | |
| 7. | Ethnic Minorities: develop services and promote use of, | Raise awareness of race and ethnic issues; Support resulting development. | | | • | |
| 8. | General Practice Development : address specific issues | Promote, assist and support organisation development. | • | | | • |
| 9. | Advance General Practices as models of good practice | Develop to use as role models for others local Practices. | • | • | • | • |

The outcomes above concentrated on changes at the level of the Practices in each Cluster. The intervention programme was also evaluated at the level of the Cluster. The arrival of the NCMs meant that the LMFTs had to 'dance to another tune' and demonstrate their level of effectiveness to these managers. In the third phase the LMFTs suddenly found their intervention programme was

also being assessed for its contribution to the NCMs development strategies. The researcher and the LMFTs collated the NCMs different development strategies pertaining to the four LMFT Clusters and made a definitive list of their primary aims and objectives. This amounted to nine in total. The LMFTs interventions and the Practice examples of change were then assessed to determine which aims and objectives in the development strategies they had contributed to. Each LMFT contributed to at least seven of the nine primary objectives (table 42). A detailed example of one LMFTs' Practice level activity is provided in appendix 11.

## 5.5 CONSTRAINTS ON THE IMPLEMENTATION OF THE LMFTs INTERVENTION PROGRAMME

The LMFTs, despite achieving a high level of self-organisation with regard to the intervention programme were nevertheless part of and thus subject to the structures and strictures of the parent organisation, the LHA. They experienced several different forms of constraint which arose from the structures, e.g. management, and processes, the design of the LMFTs project, the environment of PHC, and the level of organisational development found within Practices. An outline of the different constraints is given below. A summary of all the issues that emerged is provided in appendix 9 and the third (summative) evaluation report that was submitted to the managers in the LHA provides an overview of the whole of the LMFTs project (Graver, 1997).

### 5.51 Structural Constraints

These arose from the poorly developed support structures during the early stages of the project and from a lack of clarity on goals and objectives. The main points that arose were:

- project leadership and direction was missing from March 1994 onwards;
- the LMFTs lost their focus of direction until they were able to determine their own way forward;
- the local enabling group was largely ineffective in helping the LMFTs to network and facilitate;
- there was an initial lack of a clear LHA 'development' strategy which increased confusion about the facilitator's role and objectives;
- the LHA and NCMs found the role of the LMFTs difficult to understand and some struggled to engage in truly collaborative activity;

- the uncertain nature of development work meant the LMFTs set fluid and flexible 'development' goals, this added to the Managers uncertainty about nature of the facilitator's role.

## 5.52 Constraints On The LMFTs Intervention Process

There were various different types of constraints on the intervention process which are given, in brief, in six sections:

1. **The initial programme of interventions, implemented at Cluster level, were found inappropriate for use with many Practices. The LMFTs found that,**

    - there was essential groundwork to be undertaken in Practices as a first step in their process of development;
    - they had to adapt the LMFTs project to be able to address individual Practice needs; and,
    - they had to work 'inside' Practices to facilitate and assist change from within.

2. **The LMFTs educational process was considered to have impeded progress initially, for they,**

    - learnt theory, practice and evaluation in parallel processes;
    - were taught facilitation processes too late in the educational course;
    - had too much in depth theory too early on;
    - had too few practical assessments of their facilitation activities and interventions.

3. **The NCMs attempted to manage rather than co-ordinate the LMFTs as 'self-organised' teams, which,**

    - made the LMFTs feel under threat from the Managers and reduced their momentum at the time;
    - meant the Managers agendas took precedence over the LMFTs agendas.

4. **There was a lack of integration and collaboration of the local planning teams in each Cluster area, which,**

- made it difficult for the LMFTs to establish information networks;
- led to a low involvement with Cluster level planning teams that was not constructive towards facilitating Practice / PHC development;
- impacted on the LMFTs in that they had to regularly exceed their specified hours to organise Cluster level interventions.

5. **The composition of each LMFT team influenced the way they were able to help Practices to develop, in that,**

- those without the original complement of disciplines made connections with a narrower range of disciplines in each Cluster;
- those without a Doctor faced greater difficulties gaining access to some General Practices;
- those without a Practice Manager concentrated less well on helping organisation development in Practices.

6. **The location of each facilitator was crucial to the degree of development a Practice achieved, in that LMFTs,**

- not linked or attached to a Practice were less able to establish a connection with a key person which was necessary for initiating the development of good relations with the Practice;
- not based on a Practice's premises were less able to establish the close relationship which was necessary for facilitating change across more than one dimension of development within a Practice.

## 5.53 Constraints Arising From The Practices / Environment In PHC

**The key constraint was that the majority of Practices were at a lower level of organisational development than was initially anticipated and most Practices tended to operate as a closed organisational system.**

It was found that,

- a very high proportion of Practices did not practice teamwork, hold meetings or undertake collaborative activity;
- many Practices viewed the LMFTs with suspicion and perceived them as threatening their privacy;
- 18 out of 56 PHCTs that continued to respond passively to the LMFTs' approaches, were considered to be operating "closed [organisational] systems" and " not aware of the benefits of facilitation work," LMFT Green.

The general lack of receptiveness in Practices made it difficult for the LMFTs to gain access and begin any form of 'development' work with them. The key points which made it particularly difficult and time consuming to promote change and development were,

- when a facilitator was not a member of the Practice concerned;
- when General Practitioners worked single-handedly when the opportunity to facilitate was solely dependent on chance encounters;
- when the Practice had not appointed any one to co-ordinate or manage the administrative activities;
- when no-one was designated to support or further change and development in the Practice;
- when the close relationship developed with one individual could not be extended further to others because that individual had limited power or influence within the Practice, e.g. a Receptionist or an externally based Health Professional. Thus, the capacity for organisational development was limited.

By the end of the LMFTs project many Practices were still unable to look beyond their own boundaries and develop cross-Practice or cross-sectoral teamwork and collaboration within their Cluster areas.

## 5.6 SUMMARY AND CONCLUSION

This chapter has presented the story of the LMFTs and how they implemented the intervention programme in three phases. It presented two formative evaluation phases (one and two) and a third and final summative evaluation phase. The key points were that despite the constant change in composition the LMFTs achieved a high degree of collaboration and were able become role models of teamworking and collaboration for the Practices involved in the project. They adapted the intervention programme from Cluster level to Practice level in response to the needs of the Practices. Although the Practices proved difficult to access and gain a response from, and the structural and environmental constraints influenced the LMFTs level of impact, fifteen Practices had made changes to organisational and service activities and all twenty Practices in the sample achieved changes in the area of personal development. An interpretation of these findings in terms of the contextual constraints will be made in the next chapter.

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# CHAPTER SIX

# THE LMFTs PROJECT - AS IMPLEMENTED

## 6.1 INTRODUCTION

This chapter will examine the way the LMFTs project was implemented and account for the reasons it did not work as intended, paying particular attention to the structural and processual constraints created by the implementation process. Following this an examination of the role of the evaluation will be made before the impact of the LMFTs project is discussed. The key points will be drawn together in the concluding section.

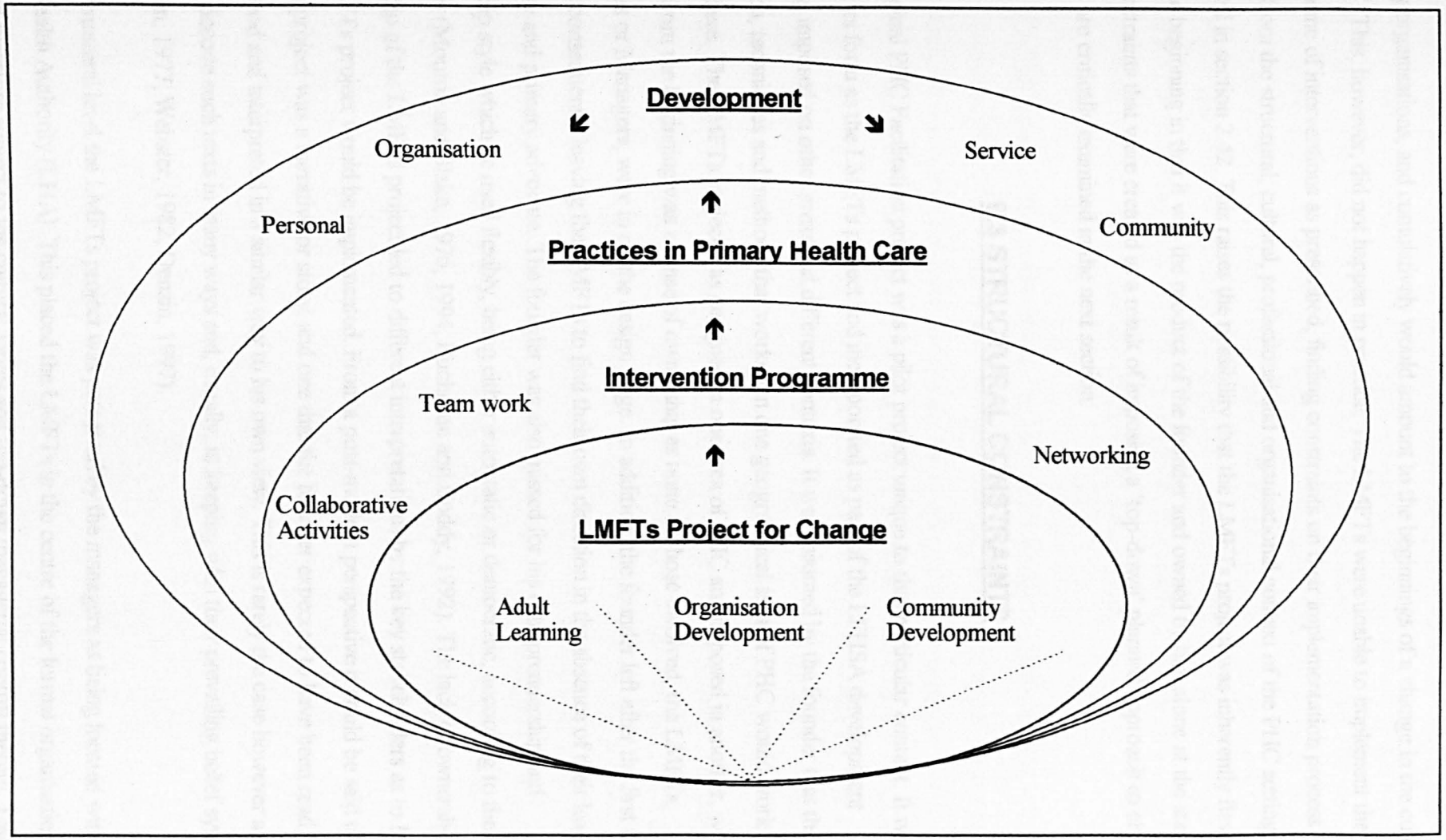
## 6.2 THE LMFTs PROJECT AS IMPLEMENTED - A CRITICAL REVIEW

At the outset the assumptions underpinning the LMFTs project was that it would assist Practices in becoming learning organisations through the use of interventions that fostered teamwork, networking and collaborative activities (figure 25). The project was founded on a combination of adult learning, organisation and community development principles and was purported to be a development model, as described in chapter one.

As implemented the LMFTs project resembled a prescriptive, top-down model for change. Its design was pre-determined and the intervention programme was prescribed as a step by step or rational-linear process that was imposed on four areas of PHC. As a planned approach to change it was to follow the normative-re-educative and problem solving approaches in organisation development, as discussed in section 2.2 (Beckhard, 1969; Bennis, et.al., 1976; Iles and Auluck, 1990). Its uniqueness lay in having four teams of facilitators, the LMFTs, who were already working within the setting, to facilitate the process of change. The LMFTs were expected to carry out a set programme of interventions during the course of each year and to concentrate on developing teamwork and collaborative activities between Practices. The idea was to use a problem solving approach as a catalytic process to help Practice staff recognise and resolve their problems together, as described in section 2.35 (Blake and Mouton, 1976; Buller and Bell, 1986). In this way the LMFTs were expected to achieve changes within their areas that helped individual Practices become

**Figure 25**

**The LMFTs Project**



learning organisations, and cumulatively would amount to the beginnings of a change in the culture of PHC. This, however, did not happen in practice. The LMFTs were unable to implement the programme of interventions as prescribed, finding constraints on their implementation process arising from the structural, cultural, professional and organisational context of the PHC setting, as described in section 2.42. This raises the possibility that the LMFTs project was inherently flawed from the beginning in that it was the product of the founder and owned by him alone at the start. The constraints that were created as a result of imposing a 'top-down' planned approach to change in PHC are critically examined in the next section.

## 6.3 STRUCTURAL CONSTRAINTS

The original PHC Facilitation project was a pilot project unique to that particular context. It was then, in its form as the LMFTs project and incorporated as part of the LFHSA development strategy, imposed on other areas and different contexts. It was assumed by the founder that the approach, techniques and methods that worked in one geographical area of PHC would work everywhere. The LMFTs project was designed in one area of PHC and imposed in another, what it lacked from the beginning was a sense of ownership as none of those involved, the LMFTs, Practices or Managers, were in on the design stage. In addition, the founder left after the first six months consequently leaving the LMFTs to find their own direction in the absence of their leader, visionary and primary advocate. The founder was also missed for his entreprenuership and leadership style which he used flexibly, being either autocratic or democratic, according to the situation (Mouton and Blake, 1976, 1994; Buchanan and Boddy, 1992). The lack of ownership and leadership of the LMFTs project led to different interpretations by the key stakeholders as to how the LMFTs project would be implemented. From a post-modern perspective it could be said that the LMFTs project was a narrative or story, and one that the founder expected to have been read, understood and interpreted in a similar way to his own view. This is rarely the case however as readers decode such texts in many ways and, usually, in keeping with their prevailing belief systems (Hoffman, 1977; Webster, 1982; Denzin, 1997).

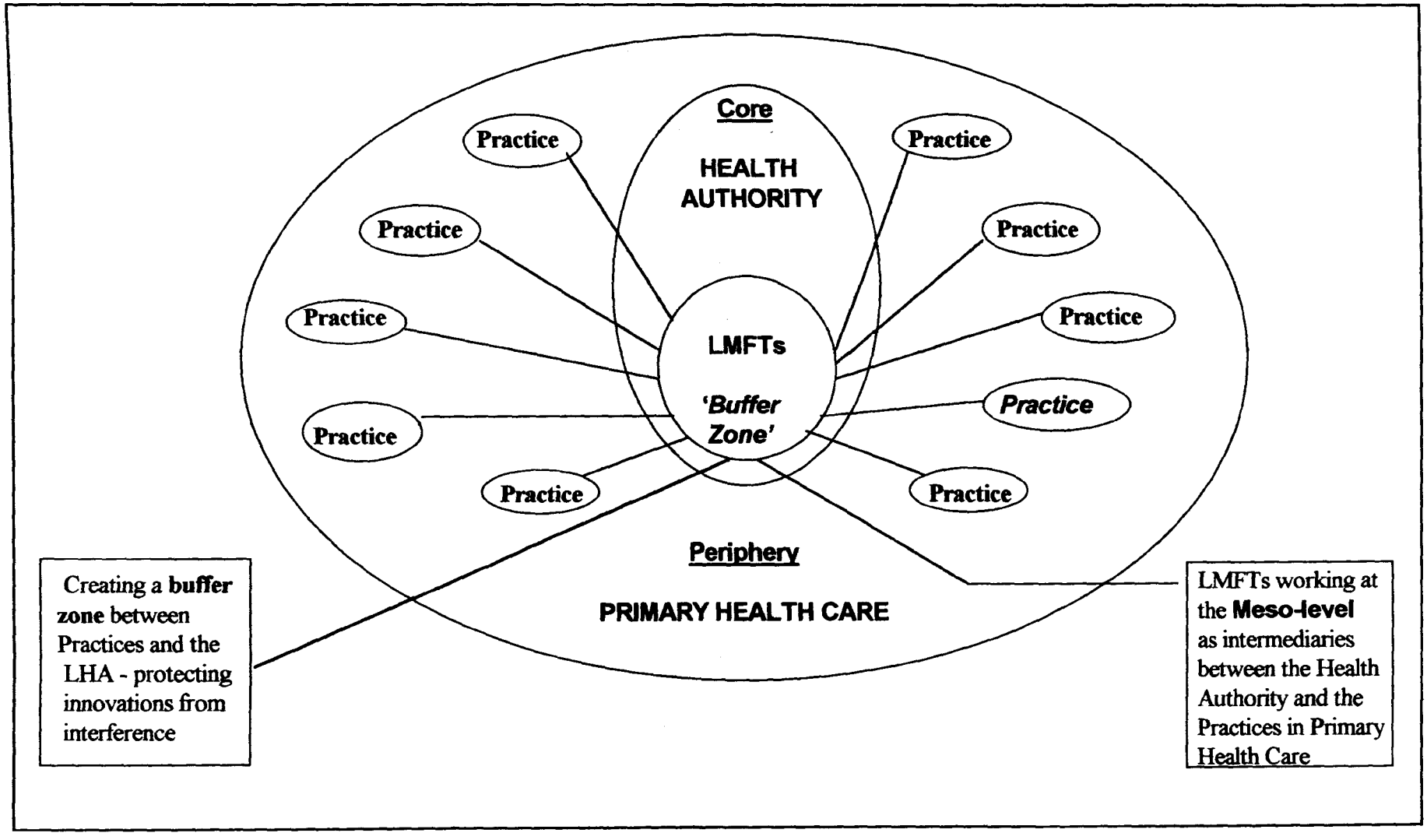
At the structural level the LMFTs project was perceived by the managers as being located within the Local Health Authority (LHA). This placed the LMFTs in the centre of the formal organisation of PHC and therefore subject to the cultural forces and top-down managerial control therein. This view was generally reinforced by the enabling group members and more particularly by the designated

key 'enablers'. This was not, however, the project founder or LMFTs viewpoint. The former stages of the PHC Facilitation project (LPHCFP, 1993) was located within the community and thus, this stage, the LMFTs project, was perceived by the LMFTs as being situated likewise. This view was encouraged by the community development bias of the Certificate of Facilitation course. In this view the LMFTs were unimpeded by the rules and regulations of the LHA. They perceived themselves as free to develop their ability to self-organise and pursue connections within the informal organisation that would lead to the development of networks, teamwork and collaborative activities within and between Practices (Kanter, 1983; Bushe and Shani, 1991; Stacey, 1995).

The LMFTs' perception of their activities was that they were working in parallel to the LHA but outside its managerial control. They were in Bushe and Shani's (1991) terms operating as a parallel learning structure that was designed for learning and building legitimacy for behaviours such as questioning, puzzling, experimenting and doubting which was needed for Practices to establish their own systems of learning and become learning organisations, as discussed in section 2.2. The LMFTs did, however, undertake activities that worked towards Practices achieving the quality standards for General Practice as set by the LHA. This helped to legitimise the facilitator's intervention programme in the eyes of the LHA managers but they were also placed in a position of tension from the beginning. They faced a pull towards the centre and formalisation on the one hand, and a pull towards the periphery and its informal organisation on the other. In practice the position they adopted could be described as a meso-level position, neither being cited permanently in one position or the other (figure 26). They worked as boundary agents: between LHA managers and Practices; between Practices in each area; between different health professionals in Practices, and finally, between the formal and informal structures of the organisation as they facilitated change in PHC (Kanter, 1983).

Figure 26

**Meso-Level Working Position Of The LMFTs**



This meso-level position created inherent tensions and was problematic at both management and Practice level. The LHA managers constantly attempted to regulate the activities of the LMFTs. They appeared to want to bind the LMFTs project to their own Practice development strategy and expected the LMFTs to adopt their values and beliefs about PHC development:

> "our agenda... should be the same," (NCM);
>
> "they just literally want to throw something in and just say 'right do it," (LMFT Red);
>
> "they just think they can use us and pass the message through," (LMFT Green).

The managers tried to use their managerial power to bring the LMFTs in line with their thinking. These actions were perceived by the LMFTs as trying to use the LMFTs activities to achieve their own agendas and consequently were fiercely resisted:

> "... you [addressing a colleague] actually stepped in and said that wasn't going to happen," (LMFT Red).

The managers approach to development in PHC ran counter to those of the LMFTs project, e.g. they focused more on technology to increase a Practice's efficiency and introduced computerised systems to achieve higher target levels. The LMFTs, on the other hand, concentrated on people as well as the systems (administrative and clinical) within the Practice, aiming to increase effectiveness by helping people 'do things right' and thus achieve efficiency (Sundstrom, et.al., 1990). Thus, the LMFTs experienced the resulting tension as a 'them and us' situation which became more visible when they joined the managers to facilitate an intervention together.

The Practices, on the other hand, perceived the LMFTs as part of the LHA and viewed them and their interventions with deep suspicion. Consequently it took a long time for the LMFTs to gain access to Practices make it clear that Practice level information was treated as confidential:

> "Getting into the Practices. That was a challenge really, sort of getting to first base with some GPs," (LMFT Blue).

The time between a Practice meeting the LMFTs and actively responding to their interventions was lengthy. Practices were invited to join and given time to 'opt in' to the LMFTs intervention

programme, and likewise they could also 'opt out' again. This several did - some rejoined later when circumstances had altered and they were ready to respond. Time was a crucial element of the LMFTs project, Practices could not and would not be rushed to join if they felt not ready or unprepared to participate in the intervention programme (see section 2.35). The LMFTs eventually established trust by demonstrating their helpfulness, e.g. as an information resource, and by creating a 'buffer zone' through which only information approved by the Practices travelled from them to the LHA (figure 26). They exchanged 'approved' information from Practices to Managers and vice versa. By doing this the LMFTs were moving the learning taking place inside a Practice outwards, across its boundary to other key stakeholders within PHC. Thus, what was being learned about the development of Practices was being made useful through its integration into the process of developing the LHA strategy at management level.

## 6.31 Structural Constraints On The Intervention Programme

Implementing the intervention programme proved problematic for the LMFTs. It was assumed that the five interventions that evolved within the first two stages of the Facilitation project would be effective in bringing Practices together, within a Cluster, to develop teamwork, networks and collaborative activities. The Practices involved in the earlier stages of the Facilitation project had each undergone a lead in period through which they had become ready to participate. In addition, personal contact with the 'charismatic' project founder was central to this process. This was not the case in the LMFTs project. The LMFTs were introduced to Practices at the first 'problem identifying' conference. Thereafter, Practices were invited to follow-up interventions at the Cluster level wherein little known LMFTs began to use the problem solving approach to help Practices resolve key health problems in their areas. During the first phase, the LMFTs became aware that they were not reaching Practices beyond a small 'regular' group in each Cluster. They were unable to build trust and commitment or develop support networks and mutual adjustment processes to overcome the social and environmental constraints on working in PHCTs. The LMFTs monthly visits to the Practices were revealing a wide variety of organisational, administrative and clinical problems. This presented a picture of the majority of Practices being at a lower than expected level of organisational development, this is discussed in more detail later.

The LMFTs realised that the Cluster level interventions were not reaching the Practices they thought needed them most:

> "the model wasn't in touch with Jo Bloggs if you know what I mean. ...I saw it as attacking from the wrong way..., the things [interventions] were not pertinent to what they wanted,"(LMFT Blue);
>
> "I don't feel the Practices are at a particular level that you could actually do those things with in that way," (LMFT Green).

So they surreptitiously began to adapt the interventions for use *within* Practices. This was the point where the participatory action research process became a crucial part of the LMFTs project. The information being fed back from the evaluation to the RSG meeting, at the end of phase one, pointed to the original LMFTs project failing to meet its objectives and therefore its intended outcomes. The evidence also made it clear that the LMFTs were being constrained by the original rational-linear design and unable to work with Practices in a manner they felt appropriate for meeting their particular needs. The result of critical reflection on the implementation of the LMFTs project led to the subsequent adaption of the intervention programme and to LMFTs undertaking interventions within Practices rather than between Practices in their Cluster. Thus, the LMFT project changed and departed from the original design but not the original intentions of its founder.

After phase one the LMFTs, once liberated from the original LMFTs project, were able to be more dynamic in their response to the needs of individual Practices. They adapted former interventions or created new ones to specifically suit Practice's needs whilst continuing to promote the principles of the LMFTs project. The interventions subsequently became crafted to suit the context in which they were being used. This was in contrast to the context being made to fit an intervention which had, up until the end of phase one, failed in the intent to promote development in many Practices. From this point onwards the LMFTs project started to evolve itself, becoming a part of and not apart from the environment in which it was being implemented. The LMFTs project shifted from being a technical approach to change to a practical one wherein those involved were treated as participants in a shared process of learning and development. And the evaluation, which had until now been distanced from the LMFTs, gradually became more firmly linked to their interventions. The effect was to integrate the evaluation with the LMFTs project and move the change process to within the

Practices. This potentially increased the LMFTs opportunity for promoting personal and organisational learning within Practices. However the impact of the LMFTs project was, as discussed in section 5.41.4, limited to those Practices that had either a facilitator as a member of staff or had developed a close link with a facilitator. The reasons underpinning this low level of impact in the Practices are examined in terms of the process constraints in the next section.

## 6.4 PROCESS CONSTRAINTS

This section first examines the process constraints that emanated from the environmental context, that is the structural, cultural and policy constraints and second, considers those that arose from the way the intervention process was undertaken by the LMFTs.

### 6.41 Environmental Context

The LMFTs project was implemented into PHC at a time when the NHS was under the influence of a number of politically driven institutional reforms (Pettigrew, et.al., 1992), as described in chapter one. The Griffith's reforms (DHSS, 1983), the first to include process and cultural changes in the restructuring of the NHS, were distinctive in that they were introducing management principles, reconfiguring the professional domains and instigating an action orientated institutional posture (Davies, 1987; Pettigrew, et.al., 1992). These reforms aimed at tilting the balance of power in favour of the management. This was to enable managers to drive forward financial controls in the form of efficiency and value for money strategies, reduce the potential for strategic drift and instate an 'excellence culture' by building up the capacity for organisation development and human resource management (Gunn, 1989). Although the impact has been described as patchy and variable as well as difficult to measure (Hunter and Williamson, 1989; Pettigrew, 1992) it has also been considered to have had an immense effect on the NHS (Best, 1987).

The impact in PHC has had the effect of reconfiguring the pattern of relations among health care professionals without any formal unification of the different services involved within the sector (Kilcoyne and Pietroni, 1996). The process of devolution has initiated the development of agency status among authorities and organisations involved in the provision of health care services (Pettigrew, et.al., 1992). Of particular significance in the LMFTs project was the change in role of the LHA, the GPs and the health professionals constituting the PHCT. At the level of the LHA, the

chief executive officers and managers were made accountable for defining clear strategies, operational objectives and financial controls and subsequently finding ways of achieving them. The LHA was to combine a corporate director type role with that of a regulatory body, and GPs had to provide evidence of activity in exchange for remuneration. This has placed the GP in a deferential position to the managers in the LHA. In the Practices, the GPs have had to grapple with a new role as a purchaser of care from provider agencies and institutions as well as face increasing pressure from the LHA to improve service delivery and meet their set of quality standards. The GPs role has broadened to incorporate managerial as well as financial and contractual issues. The purchaser / provider split led to a more competitive rather than co-operative environment with other Practices and agencies in the PHC (Pettigrew, et.al., 1992; Williams, et.al., 1993) and, within Practices, has accentuated the need for effective administrative systems and patterns of communication. The demand for improving the quality of service delivery and the inclusion of health promoting activities in Practices has stressed the need for an increased amount of teamwork and collaboration among the different health professionals attached to Practices. However, the competitive nature of the internal market is in conflict with the multidisciplinary teamwork model being espoused by the LHA. In addition, the health professionals, concerned about the erosion of their role, were less rather than more likely to collaborate with other disciplines in this changing culture of PHC (Bond, 1983; Goodwin, 1985; Glendinning, 1998)

The LMFTs project was introduced into this environment in which the delicately balanced relationships between the professional groups in PHC were being disturbed by the recent policy directives. This was an environment in which Practices had, until recently, largely operated with minimal managerial input (never mind control) and the GPs had held the dominant position. The receptiveness of this context for change would, using Pettigrew's et.al., (1992) model as a framework for assessment, be judged as possessing low levels of energy for driving the forces of change (table 43).

Using this assessment of the general context surrounding the LMFTs project it is clear that there was only one positive driver for change, that is key people were trying to lead the changes. Apart from this it was an environment in which everything and everyone was developing at the same time. Uncertainty was a key feature of this setting. Pettigrew et.al., (1992) stress that receptivity is a dynamic state and that it can be developed within a context. However, they also noted that the loss of key individuals or ill-conceived activity correspondingly reduced the level of receptivity. In the

case of the LMFTs project the resignation of the founder at an early stage, and the lack of support and guidance of the LMFTs in addition to the environmental factors outlined above decreased the levels of receptivity towards change in this context.

**Table 43**

**A General Assessment Of Receptiveness Of The Context Towards Change**

| | |
|---|---|
| **Change Agenda and Its Locale**<br>LHA strategy for development was at odds with the nature of Practices, the high proportion of single-handed GPs did not want to become fundholders or business orientated. | **Environmental Pressure**<br>High pressure for change was evident but seemed to be draining energy from many of the smaller Practices who were struggling to develop with the minimum of resources. |
| **Supportive Organisational Culture**<br>Conflict of ideologies - some LHA managers preserved hierarchies, whereas others encouraged innovation. | **Co-operative Inter-organisational Networks**<br>The Practices preserved their own boundaries very carefully. Their inter-organisational networks were barely developed at all. |
| **Quality and Coherence of Policy**<br>Conflicting policies were evident, e.g. espousing teamwork and competition simultaneously. | **Key People Leading Change**<br>Key people were leading change - facilitators were in post for Audit, Asthma, LMFTs project and Managers were using a hands on approach to developing PHC. |
| **Simplicity and Clarity of Goals and Priorities**<br>These were under development during the time of the implementing the LMFTs project. Therefore, it was a time of muddling through with a general purpose but little clarity as to the overall strategy for development. | **Managerial - Clinical Relations**<br>Managers relations with Practices varied depending on the time each Manager spent building an alliance with them. Alliance building seemed to be at an early stage of development |

(Based on Pettigrew, et.al., 1992:276)

By the end of phase one, the LMFTs were recognising the generally low level of receptivity towards them and the uneven levels of organisational development in Practices. In their view, the majority of Practices they visited had established only a minimal degree of collaboration within their daily work patterns and virtually no inter-organisational networks (Davidson, 1976; Armitage, 1983), (tables 6 and 7). The LMFTs noted that those Practices more receptive to their approach were characterised by having begun to work together as a whole team, by being more democratic and participative in terms of management style, by having better organised administrative systems in place and by being prepared to risk utilising the skills of the facilitator to help them solve a problem in the Practice. The structural and cultural environment of these Practices could, according to Kanter (1983), be described as integrative structures and classified as innovation stimulating. In these Practices there

was a desire and energy for change, and people were interested in receiving the LMFTs interventions.

By contrast, those Practices with a less receptive disposition were characterised by being smaller, often partnerships or single handed General Practitioners, by having a more autocratic management style and by having administrative systems that were less well organised and co-ordinated. In addition, these were Practices that often lacked someone designated to co-ordinate the various administrative systems. The environment in these Practices featured rule bound, compartmentalised activities, and were comparable to Kanter's (1983) classification of innovation stifling situations.

The prevailing environmental conditions led the LMFTs to the view that it was necessary to promote organisational development within individual Practices to enable them to undertake collaborative activities beyond their immediate boundary. The assumption was that a Practice needed to develop its internal environment before it could attend to a wider community outlook:

> "...we would do Practice based interventions first off to get the Practice working together before we even suggested using something for all the Cluster," (LMFT Blue).

The LMFTs reception within Practices was mixed, and acceptance was dependent on making connections with key members of staff who were in a position to influence others and who were interested in developing the Practice. In particular these were the doctors and practice managers and less often the practice nurses. Often LMFTs made connections with interested members of staff who were unable to further the developmental process because of their limited influence. In particular these were the receptionists, attached staff, e.g. health visitors, midwives, district nurses and, in certain situations, practice nurses. The different levels of influence of each member of staff reflected the hierarchy of professional dominance within a Practice. The way the Practices were managed and the way the different disciplines organised their work in the Practices reflected the struggles between different groups seeking to impose their own disciplinary focus and discourse (Ranade, 1998). Thus, some of the major obstacles to furthering change were, therefore, coming from the interdisciplinary struggles for professional dominance in PHC being played out in the Practices.

The interdisciplinary struggles evident within the Practices may be explained in terms of the four dimensions of PHC explored in section 2.42 (figure 11). The forces flowing from these four

dimensions become concentrated in Practices and manifest as particular patterns of activity. The particular characteristics in each Practice govern both its response to the LMFTs project and its capacity for establishing a system of learning and becoming a learning organisation. The activities in Practices that were less responsive to the LMFTs project mainly corresponded with type one of Davidson's (1976) typology (see table 7) and, in the main, were the least developed of Practices in PHC. In general, the management of these Practices was predisposed towards a hierarchical and authoritative structure and culture. The health professionals within them worked in relative isolation to each other, predominantly socialised with their own professional group and generally followed their own doctrine:

> "I think our roles are pretty set no matter who is here," (PHCT P.N.).

> "I think sometimes people feel threatened by nurses, community nurses, cos' their doing their own thing the majority of the time." (PHCT D.N.).

The patterns of communication were largely unstructured and reliant on 'ad hoc' meetings with other disciplines in the Practice which corresponded with stage 3 of Armitage's (1983) taxonomy of collaboration (table 6). Conversely, those Practices that actively responded to the LMFTs project, relating to type two and three of Davidson's (1976) typology (table 7). These were characterised by a less hierarchical and more democratic management culture. The staff were integrating their work activities and care was becoming a shared responsibility. Significant in these Practices was the move to try to collaborate with each other, it was the result of conscious effort and planning.

A further obstacle to teamwork and collaborative activity arose from the way services were organised in PHC. First, the different health workers in a Practice were accountable to different line managers based in other organisations in PHC. And second, their different roles were regulated according to their particular professional body. This made it difficult for individuals to agree to undertake teamwork and collaborative activities because it overstepped the clinical or managerial boundaries of their role:

> "[she] doesn't really know what our workload involves and because of that can't understand why we can't do A, B, C, or D" (PHCT D.N.).

The forces flowing from the four different dimensions of PHC had a strong negative effect on a Practice's capacity for teamwork and collaborative activity. The forces operated continually to draw each person back to their professional and social roots and promoted their individual 'occupational consciousness', as described in section 2.42.1 (Huntington, 1981; Poulton and West, 1993; Hey, et.al., 1996). This created a constant tension between the maintenance of differentiated bodies of expertise and the development of integrative and collaborative activities in Practices and in PHC. These tensions are part of the historical, political and social development of PHC that have been exacerbated by the introduction of managerial and market principles and the disruption of traditional role boundaries of clinical practice in the NHS reforms of the early 1990s, described in chapter one.

The LMFTs project made very little impact on the culture of PHC in Liverpool. The entrenched views born of the contrasting professional paradigms (Alford, 1975; Hey, et.al., 1996) did not yield particularly well to the original intervention programme and only in part to the adapted LMFTs project. The reluctance of health professionals to undertake collaborative activity may be interpreted using Lukes (1974) radical theories of power wherein professional groups are represented as 'mobilisations of bias' in PHC. Each professional group possesses a specialised professional discourse and have carved out a 'policy territory' for themselves which subsequently has enabled them to acquire an allocation of resources for the achievement of their own agenda. In addition, the doctrines of each profession has been enshrined in law and become manifest as particular methodologies (Lukes, 1974). Interpreting the professions in PHC as 'mobilisations of bias' it becomes clearer why each group seeks to maintain their differentiation and consequently why changing the culture of organisation was so difficult to achieve in the short, three year, life of the LMFTs project.

Where the LMFTs project had greater impact was at the Practice level. Practices have become central to the vision of a primary care led NHS but many Practices have found it difficult to meet the quality standards set by the LHA (1994). The LMFTs project emphasis on the development of teamwork, networks and collaborative activity was perceived, by some Practices, as an opportunity to help them improve. Practices, however, did not receive the LMFTs with open arms rather they had to earn their acceptance through the development of trust and demonstration of co-operative behaviours. This was achieved by the LMFTs learning how to create and utilise networks (discussed later on) and carry out the intervention process.

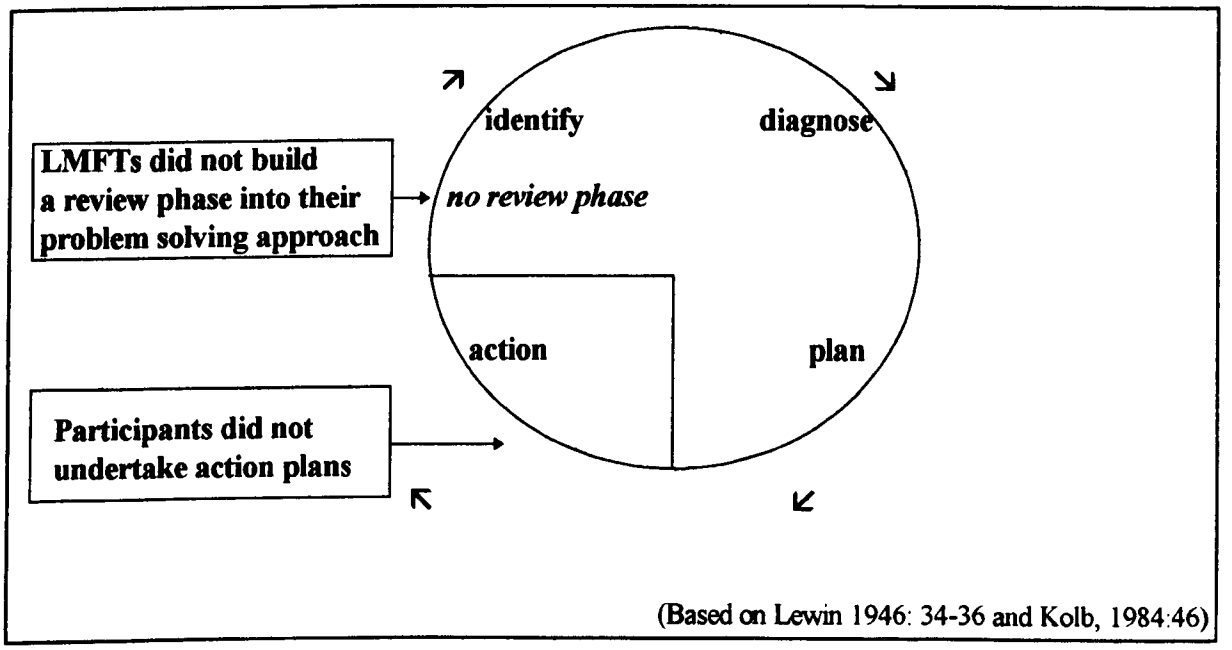
## 6.42 Intervention Process

In the early stages of implementing the LMFTs project the LMFTs were not teams and did not know how to facilitate the interventions together. The process of learning in action, that is learning how to apply theory and practice together, took time to assimilate and synthesise. The intervention process was built on a foundation of adult learning principles which emphasised participation in a learning process (Freire, 1972), and the use of community and organisation development approaches (Beckhard, 1969; Hope and Timmel, 1984; de Koning and Martin, 1996) as described in chapters one and two of this thesis. The key OD elements to be used were a problem solving approach and participation in groups (see section 2.34) (Lewin 1946, 1952; Kolb, 1984; Carr and Kemmis, 1986).

The way the LMFTs used the problem solving approach was to identify, diagnose and make plans with the participants but often the plans they made were not carried forward into action. Significantly the LMFTs did not systematically follow-up their interventions with a review phase (figure 27).

**Figure 27**

**Problem Solving Approach As Applied In The LMFTs Intervention Process**




(Based on Lewin 1946: 34-36 and Kolb, 1984:46)

The LMFTs were taught the phases of the problem solving approach in the Certificate of Facilitation Course but their activities were not supervised in practice. (An attempt was made, by the researcher, to encourage the LMFTs to follow-up and review all action plans with project participants during phase three of the evaluation). This meant the LMFT project participants rarely achieved one complete cycle of problem solving and were not enabled to move on to the next one with a revised plan of action. The experimental, emergent and ongoing nature of the developmental process became lost and the participants interest and enthusiasm for their changes faded away. Consequently, the participants process of learning and development was stalled and the dynamic energy created within an intervention ebbed away.

The failure to carry out action plans was particularly evident within the Cluster level interventions during phase one. Once one intervention finished the LMFTs became immediately immersed in the organisation of the next intervention. Their attention was deflected and they did not look back to see what had happened to previous action plans. During phases two and three this was less evident as a direct result of the LMFTs learning from reflection on their own activities via the process of evaluation. The LMFTs learned from their theory and practice how to perform the intervention process but had not grasped how important 'reflection-on-action' was for leading the developmental process onto the next round of experimental activity. The role the evaluation played in encouraging learning is considered in the next section.

## 6.5 THE ROLE OF THE EVALUATION

A key feature of the evaluation approach was to encourage learning. The way this was achieved is considered from three different views of the evaluation, 1) stakeholders, in the RSG, learning from the decision to evaluate the LMFTs project, 2) LMFTs learning from their involvement in the PAR approach and, 3) learning from the role of the researcher as an instrument of the evaluation.

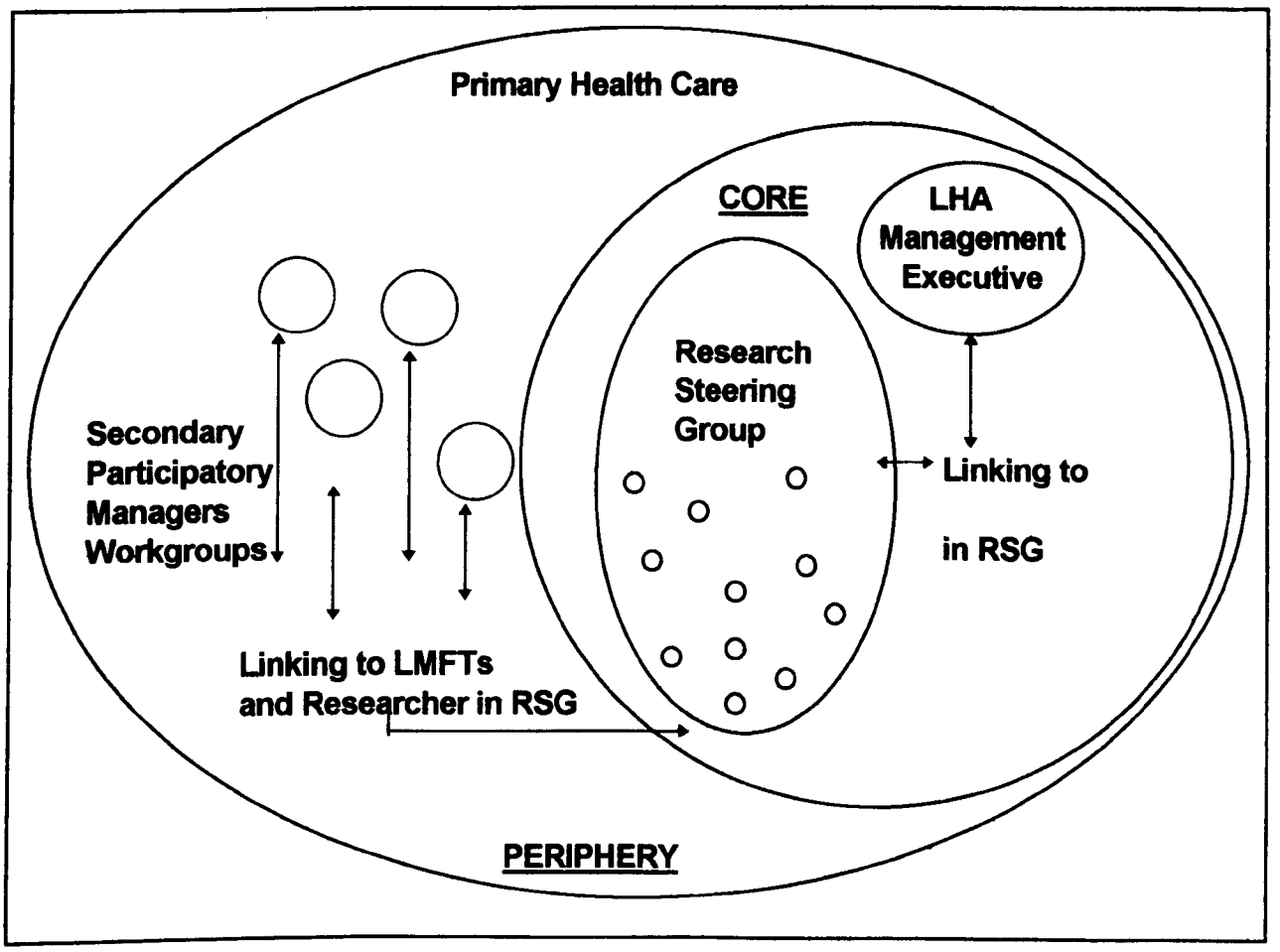
From the beginning the evaluation was considered as a tool for promoting learning and enhancing change among those involved in the LMFTs project. It can be conceived as a synthesising activity that brought together the different cultures involved in the development of PHC and by implication bridging the gulf between them. As the evaluation progressed the participants were not running side by side, rather their participatory activities were weaving them into one culture that was greater than the sum of the parts. The researcher was an instrument of the evaluation and played an active role as

a multipartisan who served the general interest (Locke, et.al., 1993). The interweaving of management, practice and research was accompanied by the integration of theory and practice during decision making, planning and taking future action (Argyris and Schon, 1974, 1978). Therefore it was genuine interdisciplinary synthesis that produced the framework for evaluation and the on-going guidance of the LMFTs project and the evaluation.

The evaluation was, in principle, 'steered' by the members of the RSG. In addition, there were other key people from the management executive who chose to remain outside the RSG but whose interests were constantly being represented by their colleagues within the group (figure 28). This was important for whoever became involved in the evaluation correspondingly affected the extent to which a culture of learning could be developed in the wider organisation.

**Figure 28**

**Expanding The Opportunity For Participation In The Evaluation**



The RSG was the main arena for dialogue and those who participated influenced what went on in the evaluation. In the RSG a dominant alliance formed between managers and GPs, and thus some clear boundary lines were drawn. This alliance effectively raised a barrier within the RSG that was difficult for other members to get past as they tried to make their own views heard. The researcher, having identified the stakeholders' structure of interests early on, moved to establish secondary participatory workgroups. These enlarged the influence of the research process beyond the confines of the RSG. In this way the level of participation and, therefore, the potential for learning was expanded beyond the boundaries of the RSG and moved out to those at the periphery in PHC.

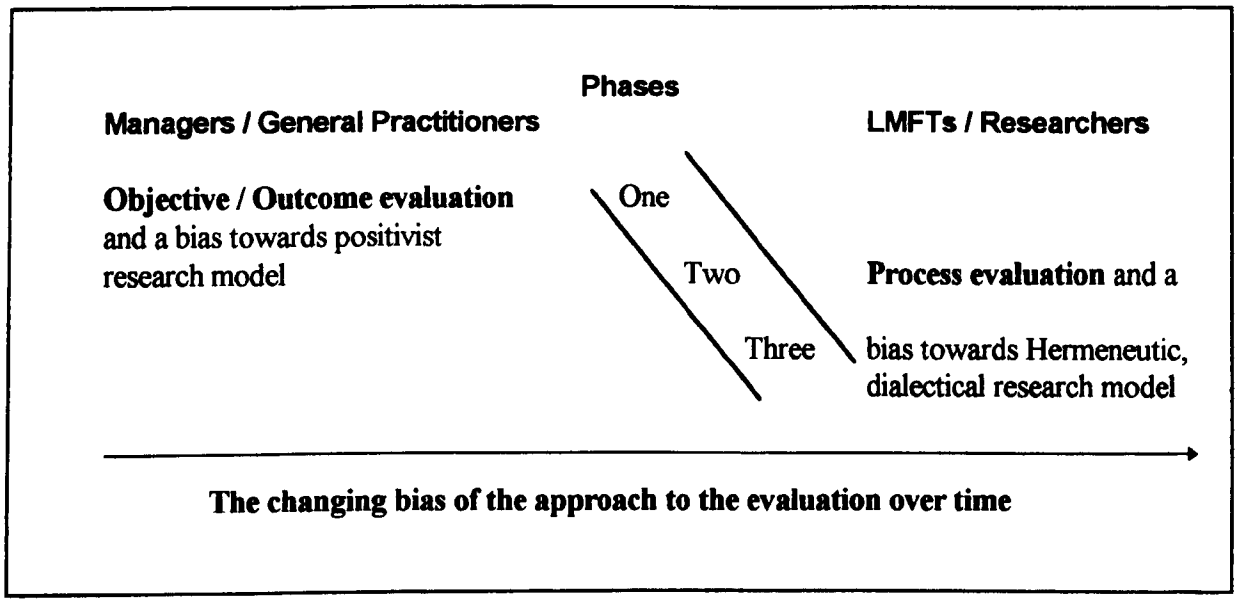
## 6.51 Stakeholders Learning From The Decision To Evaluate The LMFTs Project

The focus in this section is the learning that was encouraged among the key stakeholders in the RSG as they developed and implemented the evaluation. The role the evaluation played was to assist the stakeholders accommodate each others different perspectives within the evaluation framework. The decision to evaluate the LMFTs project brought a disparate group of people together, as key stakeholders, to design and implement an evaluation framework. The process of developing the framework provoked discussion of their diverse views. The stakeholders were learning, through collaboration and negotiation, to accommodate each others different perspectives in the evaluation framework. This was achieved only after a lengthy period of time.

In the beginning the stakeholders views on how the LMFTs project should be evaluated were diametrically opposed to each other (figure 29), as referred to earlier in section 4.33. The evaluation framework, as first implemented, demonstrated an initial bias towards the Manager / Practices preferment for using a positivist research model and initially led to the use of a quasi-experimental evaluation design. The early RSG meetings served to raise each individual's awareness of their own particular perspective but they were not taking into account how the others saw the situation. These early exchanges were dominated by the Managers and General Practitioners who swayed the remainder of the group towards using the quasi-experimental design, see section 4.33 - 4.39. At this time each stakeholder held on tight to their own views on how the evaluation should proceed and were not accommodating the views of others.

Figure 29

**The Shift From An Objective / Outcome To A Process Form Of Evaluation**




The receipt of information that the evaluation, as being implemented, would not meet stakeholders objectives forced the key stakeholders into a critical assessment of the whole approach to the evaluation, e.g. both their objectives and the overall framework. It was if those who were biased towards using the quasi-experimental design had grudgingly conceded to the use of a 'process oriented' approach to the evaluation. In retrospect the first two phases of the evaluation seemed rather like an experiment. It was as if the positivist research model was put to the test of evaluating the LMFTs project of change and found, following the stakeholders' critical reflections at the end of phase two, to be too limited to evaluate such a complex intervention process. It was if those who were biased towards using the quasi-experimental design grudgingly conceded that a 'process oriented' approach might provide

From participant observation it was noted that the balance in the dialogue between stakeholders had undergone a subtle shift during the end of the phase two reflection-on-action dimension of the action research process within the RSG meetings. The LMFTs had by this time gained considerable practical experience, were controlling their monthly meetings, and had begun to adapt their intervention programme. This had increased their confidence to the extent that they felt equipped to contribute their practical views to the critical reflections on feedback that were being made:

"we feel strong enough to say if we don't consider it is right what they want to do," (LMFT Green).

The LMFTs voluntarily gave their opinions without any prompting and thus contributions from the stakeholders were more evenly matched. The LMFTs behaviour had shifted from acting as a subordinate or minority group to achieving equal status with managers and doctors in the RSG. The change in relations between stakeholders encouraged more questioning of each other about the LMFTs project. These exchanges were part of the re-examination of the evaluation approach and led to a reduction of stakeholders expectations to a more realistic level and a refinement of the evaluation approach. At this point it became evident that the stakeholders were combining professional expert knowledge with practical knowledge, thus bridging the gap between theory and practice, as they made decisions about the next step in the evaluation process (Schon, 1983; Argyris, 1992; Hazen, 1994). The evaluation was instrumental in modifying the prevailing views of the evaluation approach, the objectives attainable, and the appropriate means of action.

The exchange of views was a learning experience for the stakeholders. The evaluation enabled each stakeholder to make their position clear in the public arena of the RSG meetings. As a result it was possible for each participant to discover the structure of all other stakeholder's interests. The value of this activity was its educative impact on each stakeholder as they learnt what was in their own minds, which eventually changed as they reflected on their priorities. The explorative process helped stakeholders to become aware of the implicit assumptions they held about both the process of organisational change and the evaluation. By the end of phase two the stakeholders, the managers and doctors in particular, had become aware of their own assumptions and begun to not only recognise but also value and accommodate the views of the other stakeholders in the RSG. The respect for each others views supported accommodation and in terms of learning represented, in individuals in the RSG, a shift from single to double loop learning (Argyris and Schon, 1974, 1978; Revans, 1982; Kolb, 1984; Swieringa and Wierdsma, 1992).

Further to this, the stakeholders involvement in the evaluation approach made them conscious of the contextual issues that influenced the process of change and, therefore, the likely impact of the LMFTs project. The evaluation brought as much into focus as possible about the complexity of the PHC situation. This was valuable for keeping everyone abridged of the constraints arising from the implementation process. The process of evaluation served to show how to overcome practical difficulties, how to mediate when contention arose between stakeholders, and how to face the uncertainty of indeterminate outcomes. In this way it broadened everyone's perspective and, in

particular, the LHA managers were provided with information on Practices and their development. This was useful for it contributed to the Managers understanding of Practice development and widened the range of interventions for inclusion in the PHC strategy under development at this time.

## 6.52 LMFTs Learning From Their Involvement In The PAR Approach

This section focuses on the way learning was encouraged among the LMFTs as they implemented the LMFTs project. Evaluation was conceived as part of the LMFTs project from the beginning but was not formally established until after the first six months. The LMFTs were involved from the start, e.g. during the development of the framework for evaluation but were reluctant to undertake a systematic process of evaluation of their activities, as referred to earlier in section 5.21.4. This situation improved from the middle of phase two onwards.

The turning point came when the researcher brought up for discussion the fact that the LMFTs were not implementing the LMFTs project as originally intended. Their initial reaction was one of hostility. However, they were also provoked to discuss this issue and started to provide reasons for their activities. The LMFTs were encouraged to note these down and discuss each in turn. By doing this they provided sound and supported reasoning for their actions which were later presented to RSG at the end of phase two. The LMFTs views were instrumental to making changes and adapting the LMFTs project. It seemed that the receipt of the researcher's support, the LMFTs active participation in the reflection-on-action dimension of the action research cycle, and the benefits gained changed their receptivity towards evaluation. It had become recognised as a useful tool for informing their decision making and actions. After this the LMFTs felt they owned the LMFTs project and started to make more use of the PAR approach within their own interventions.

Subsequently, the LMFTs learned how to use the evaluation process for themselves but continued to fail to systematically evaluate their interventions as a whole. The evaluation was therefore successful in that it assisted each LMFT to understand the contribution it could make to their activities but it was unable to generally establish an evaluative culture. This may have been a reflection of the way the researcher was able to encourage learning within the process of evaluation.

## 6.53 Researcher's Role In Encouraging Learning

In essence the researcher tried to establish a culture of learning between the stakeholders. The roots of failing to establish such a culture lie in initially following a quasi-experimental (positivist) research design (Cronbach and Associates, 1980; Smith, 1989; Robson, 1993). In this design the researcher was perceived as an objective outsider whose role it was to collect information from Practices and remain distant from the interventions.

For the first two phases of the LMFTs project the researcher was unable to maintain a sufficiently close relationship with the key stakeholders and in particular with LMFTs to develop an interactive role with them. On refinement of the evaluation approach at the end of phase two the researcher's role changed. As the evaluation began to integrate with the LMFTs project the distinction between other stakeholders and the researcher blurred as they co-developed the processes of evaluation and change. The researcher moved in and out of the LMFTs project, combining a mixture of external and internal evaluation positions, to facilitate the evaluation process. Initially there had been a strong emphasis on co-development and co-learning within the RSG meetings. This had faded during the early part of implementing the evaluation but re-emerged after the framework was refined. The interactive relationship between the stakeholders and the researcher was gradually re-built as connections were re-established. The opportunities for generating learning having regressed on adopting the quasi-experimental design were advanced again on changing to a more hermeneutic form of inquiry. The researcher acted as an instrument of the evaluation organising and facilitating activities that encouraged learning (Locke, et.al., 1993). Learning was explicitly encouraged through stakeholders experiencing a process of evaluation that used a PAR approach, e.g. stakeholders were guided through successive cycles of action research as they developed and implemented the evaluation. During the evaluation process the researcher adopted many different roles, e.g. facilitator, participant observer, advisor, mediator, advocate, protector (chiefly LMFTs from managerial pressures), project co-ordinator and educator to name the main ones. The researcher smoothed out the course of implementing the LMFTs project and its evaluation and the role became boundless in the interests of encouraging learning with the stakeholders.

The researcher, through assiduously applying the PAR approach to the evaluation, achieved three action research cycles which were the result of planning and constant effort. A culture of learning was created among key stakeholders in the RSG and more particularly between the LMFTs

implementing the LMFTs project. Without the PAR approach the evaluation would not have moved away from the original dualist perspective, the link between thinking and action would not have been forged and the LMFTs would not have been able to move the LMFTs project from the Cluster to Practice level interventions in PHC. Notwithstanding its shortcomings the LMFTs project did have certain impacts, these are examined in the next section.

## 6.6 THE OVERALL IMPACT OF THE LMFTs PROJECT

The LMFTs project finished at a point when the LMFTs had become confident in their role, and when the Practices they had created close relationships with were poised to actively respond to their interventions. The impacts of the LMFTs project on changing the culture in PHC was, therefore, minimal. In PHC it was very difficult to change things because the people and the organisation were at such a low level of organisational development. The impact was greatest on the LMFTs themselves and, in turn, on those Practices they were closely associated with. In a sense the LMFTs had to go through the whole process to learn what they did about themselves and about the way to facilitate change in Practices. The impact this learning had on the LMFTs enabled them to pass on their knowledge and skills to others in both upward (management level) and downward (Practice level) directions. This section examines the impact the LMFTs project had on the LMFTs, on their ability to develop teamwork, networks and collaborative activities, and how this learning was utilised to promote change in Practices.

### 6.61 LMFTs' Team Development

The LMFTs were an unconnected group of individuals brought together for the purpose of implementing the LMFTs project. They were not a team and did not know how to facilitate the intervention programme. They suffered causalities in the process of mutual adjustment, and became wiser for having experienced the difficulties of how to become teams and how to become effective at facilitating the interventions. These teams resembled Hey et.al.'s, (1996) classification of 'genuine' teams in that they originated from different disciplines and had a common purpose, they differed in respect of their changing group membership (tables 30, 34 and 37). As multidisciplinary teams the various different disciplines working in PHC were represented which brought multiple skills as well as interdisciplinary struggles for professional dominance into each team (see section 5.21.1).

The range of disciplines in each team provided vital resources, e.g. practical 'know how' and personal networks, which they used as a foundation for their facilitation activities. In addition, each member demonstrated great flexibility in learning to undertake several different team roles during an intervention (table 38). Their different professional roles also brought conflict to the process of mutual adjustment as some members were unable to relinquish their dominant positions and others could not transcend role boundaries in the team's effort to work as equals. In general, the health visitors, practice and community psychiatric nurses took to the teamwork process better than the general practitioners, practice managers, district nurses and midwives. The conflictual team relationships, their uncertain direction and lack of support had the initial effect of reducing each team's effectiveness in making decisions that were well informed and based on consensus. Each team, aware of these negative effects, limited their potential to suffer any lasting effects from process losses (West, 1996) by constantly attending to the development of strong internal support mechanisms. The growth in each team's ability to collaborate was a testimony to their success in learning to overcome their team development difficulties (tables 30, 34 and 38). It was also a testimony to the role the evaluation played in encouraging the LMFTs to learn from their experiences in the process of implementing the LMFTs project.

The lessons the LMFTs learned were how to work together without developing divisive horizontal or vertical hierarchies (Iles and Auluck, 1990) and how to become self-organising teams by side-stepping the constraints and normative social frameworks of the formal organisation of the LHA (Kanter, 1983; Stacey 1995). This was learning at the personal and group level which the LMFTs carried forward as individuals and as teams into Practices in their areas. They had learnt to be innovative when problem solving, had learnt to use networks to cut across the professional and cultural divides within the organisation of PHC, and had learnt to use collaborative activity as a tool for developing teamwork. This knowledge was a synthesis of the learning they had developed within the PAR process and gained from reflecting on their experience, practice and the theoretical propositions provided from the Certificate of Facilitation course. In essence, what the LMFTs had learnt first hand for themselves, and about themselves and their environment, they used as a project for developing networks and promoting teamwork and collaborative activities in Practices.

## 6.62 Developing Networks With Those Involved In The LMFTs Project

The LMFTs recognised, through the mapping activity (see examples in appendix 8), how the development of their networks had been instrumental to breaking down the barriers between the different constituent groups involved in the LMFTs project. Each facilitator brought to the LMFTs project a small personal network of contacts comprising professional and personal sets of relations (Mitchell, 1969). These they expanded to particularly include co-facilitators involved in the LMFTs project, managers from the LHA and the Practices in their Clusters. The LMFTs primarily concentrated on providing information for Practices and used this process to develop a network that was founded on trust between themselves and Practices.

The LMFTs relations with a Practice may be explained using the theory of transaction cost analysis (Williamson, 1975) which may be conceived as underpinning the concept of networking. The more common approach to this theory is to contrast markets with hierarchies but the relations between a Practice and the LMFTs resembled those found in a policy community where exchange was made possible because trust has developed between those involved (Hindmoor, 1998). The trust that developed between Practices and LMFTs was not the result of institutional safeguards, e.g. contracts or payments, but a response to their relations becoming embedded within an on-going system of mutual actions which benefited both alike (Granovetter, 1985).

The key to the networks between LMFTs and Practices was its embeddedness, the result of which developed the trust necessary for an exchange (Marsh and Rhodes, 1992). The number of participants in each Practice network was small and their focus of interest similar in that each wanted the Practice to develop. The relations between the participants were characterised by frequent and high quality interactions. The participants shared some basic values which provided a basis for achieving a consensus for action. During their interactions all participants were considered as equals and, although one person may have been considered as dominant, e.g. the GPs, the LMFTs aimed to establish a balance of power between them. The LMFTs were using the networks to cut across existing professional cleavages in the Practices. They were tapping into the informal organisation to generate energy for change within Practices. These networking activities were the forerunner to gaining access to Practices and facilitating the interventions and, subsequently, the means for sustaining the developmental process in those Practices positively responding to the LMFTs 'adapted' project.

## 6.63 Developing Teamwork And Collaborative Activities In Practices

By the end of phase two the evaluation style had become more process orientated, it converged with the LMFTs project and became a continuous process of communication with the key stakeholders and particularly with the LMFTs. At the same time, as a result of the feedback and critical reflection, a shift was made from the LMFTs implementing a broad intervention programme in Clusters to them undertaking specific activities in the more receptive Practices (see section 5.31.5). The LMFTs, through the use of PAR, were enabled to recognise how they had developed teamwork and collaboration for themselves and how to make use of their personal learning within their interventions:

> "I've learnt negotiating, diplomacy. I've learnt to step back." (LMFTs Navy .)

> "And as I say I have knowledge now of the Health Authority and the way it works. And I have a view of sort of clinical needs within this neighbourhood." (LMFTs Blue).

> "[I]ts actually realising how far you can take them. Being realistic all the time as well. I've had to enhance a lot of my skills... feeding back to them from what personal skills I'm getting here because and we're very aware that you do tend to be looked on as a role model." (LMFTs Red.)

As part of the second phase review process, the researcher and LMFTs together assessed each Practice's level of organisational development, their responsiveness and the interventions that had been undertaken with them. Subsequently, it became possible to postulate a general model of what seemed to be going on within Practices (table 44). The model was created by identifying what activities were taking place in Practices and comparing them with the principle activities within the organisation and community development perspective (figure 7). The descriptive framework, developed in phase one, was used to classify Practice activities in relation to the four key areas considered in the evaluation (for an elaboration see appendix 6).

The Practice activities were classified in terms of three broad categories, and development was conceived as a continuum along which Practices moved from one, the lowest level, to three, the higher level. These three categories correspond with the three levels of Practice response the LMFTs experienced (table 41). The Practices in level one were considered to be at an early stage of development and represented the least responsive group of Practices. The Practices in level two

were thought of as being in a state of transition moving from level one to three, and were representative of the semi-responsive Practices. Finally, those Practices in level three were perceived as moving beyond transition towards becoming learning organisations, these were Practices that equated with those who were actively responding to the LMFTs project.

From the beginning of phase three onwards, the LMFTs, working closely with the researcher, followed up all positive Practice responses and consolidated any interventions that they had already begun. As the LMFTs worked within Practices the evaluation moved in parallel and tracked changes that followed their interventions in a sample of twenty Practices. The changes varied and were classified according to how they fitted within any of the four dimensions of development (see section 5.41.4 - 5.41.5). A key feature in fifteen of the twenty Practices achieving changes within three of the four dimensions of development was their relationship with the LMFTs.

In each of these fifteen Practices one or more LMFT members were either employed by, or had developed a particularly close relationship with, the Practice. In all cases the facilitator(s) were highly influential in initiating and sustaining a process of development, they acted as champions of the change process (Kanter, 1983). These Practices were receptive towards the LMFTs who were able to initiate activities that brought people together for the purpose of promoting teamwork, e.g. in-house multi-educational training sessions, regular multidisciplinary Practice meetings, planning a new clinic, development of own Practice charter to name a few. At this point the LMFTs were following up most of their interventions and noted:

> "The biggest change is that getting people opening out and the more they open out the more we can work together. Working, and being behind closed doors, ...you tend to be very insular with what with [and] where you are going. I mean I'm talking from the inside now, I'm going into places and being on the inside of places... You can get a bigger picture about what's going on because they're being more open with you." (LMFTs Red).

Table 44

## The General Pattern Of Development In Practices In Primary Health Care

| AREA OF DEVELOPMENT | LEVEL OF DEVELOPMENT | | |
|---|---|---|---|
| **Personal** | **Level 1** | **Level 2** | **Level 3** |
| 1. Personal / professional development | regarded as an individual's responsibility and a personal gain;<br>minimally supported by Practice; | regarded as an individual's responsibility;<br>effort encouraged, appreciated and supported by Practice; | regarded as a shared responsibility;<br>effort encouraged, appreciated, prioritised, planned and supported by Practice; |
| 2. Role definition | narrowly defined with clear boundaries; | unclear definition with blurred boundaries; | clear, broad but flexible definition of boundaries; |
| 3. Role: understanding and valuing the role of others | not understood;<br>undervalued;<br>contribution to whole not recognised; | partially understood and valued;<br>partial recognition of contribution to whole; | clearly understood and valued;<br>full recognition of contribution to whole; |
| **Organisation** | | | |
| 1. Structure | hierarchical | hierarchical / flat | flat |
| 2. Management approach | authoritative | mixture of authoritative / democratic | mixture of democratic / participative |
| 3. Approach to policy, planning and decision making | GP | GP and specific others | Whole team |
| 4. Meetings | 'adhoc';<br>uni-disciplinary;<br>unstructured,<br>non-participatory; | 'adhoc';<br>uni-disciplinary;<br>irregular multi-disciplinary;<br>semi-structured and participative; | regular uni-disciplinary;<br>regular multi-disciplinary;<br>structured and participatory; |
| 5. Work pattern | not integrated;<br>separate groups; | partially integrated;<br>semi-connected groups; | fully integrated;<br>inter-connected groups; |
| 6. Team consciousness | low intra-group consciousness;<br>low inter-group consciousness; | moderate intra-group consciousness;<br>low to moderate inter-group consciousness; | high intra-group and moderate to high inter-group consciousness; |

Table 44 continued,

## The General Pattern Of Development In Practices In Primary Health Care

| AREA OF DEVELOPMENT | LEVEL OF DEVELOPMENT | | |
|---|---|---|---|
| **Organisation continued,** | | | |
| 7. Conflict | no specific mechanisms;<br>avoid conflict; | semi-formal mechanisms;<br>indirect / direct approach to conflict; | specific mechanisms;<br>direct approach to conflict; |
| 8. Monitoring progress | no specific review process; | informal review processes; | formal, regular review processes; |
| 9. Response to change | low response;<br>change is threatening;<br>reactive; | selectively responsive;<br>change as an opportunity;<br>reactive / proactive mix; | active response;<br>change as an opportunity;<br>proactive and *dynamic*; |
| **Service** | | | |
| 1. Identifying health needs | information from 'one to one' consultations;<br>use of local knowledge and experience of staff; | in addition, use of public and other local health reports; | in addition, developing profiles of Practice population's needs; |
| 2. Service development | opportunistic health promotion;<br>some specialist services offered;<br>very few protocols developed; | opportunistic health promotion;<br>specialist clinics offered;<br>several protocols developed; | opportunistic health promotion;<br>specialist clinics offered;<br>developing individual case management;<br>many protocols developed; |
| 3. Audit | Figures produced for annual report only; | Figures produced for annual report used to assess own clinical activities annually; | Figures produced for annual report and those from internal audits used to regularly assess own activities; |
| 4. Patients views | hearsay;<br>word of mouth;<br>complaint letters / see Practice Manager; | hearsay;<br>word of mouth;<br>formal complaint procedures; | hearsay;<br>word of mouth;<br>formal complaint procedures;<br>patient satisfaction survey; |
| **Wider Community** | | | |
| 1. Development of collaborative activities | developed with one or other members of the attached staff; | developed with several or all members of the attached staff; | developed with: whole PHCT, local health involved organisations, and other agencies across the city; |

The close relationship LMFTs developed with members of a Practice seemed key to sustaining the change processes within the Practices. A few Practices became involved in shared projects in the wider community. One particular noteworthy example of collaboration involved four of the fifteen Practices mentioned above who formed an inter-Practice group. This group of four Practices had no particular prior relationship but each was deeply concerned about stopping patients smoking. The LMFTs and Practices worked side by side, pooling their knowledge, skills and experience as they learnt how to develop and operationalise a smoking cessation initiative together. A number of mini-projects were spawned as a result, e.g. patient registers, staff and volunteer training programme, patient self-help group - 'Fag-Ends' and, within a local school, a 'stop smoking' group led by the school children. The degree of collaboration achieved between these Practices, during the shared project, spanned all five levels of the Davidson (1974) typology. This fell back to 'communication only' once everything was organised but was able to be increased again on the start of another inter-Practice shared activity, e.g. diabetes roadshows. Their first collaborative venture between these Practices had a snowball effect and they went on to try and create new projects. The investment each member made in the inter-Practice group had developed a 'social capital' for collaboration that they could draw on at the inception of a new shared project. As the LMFTs project was ending the LMFTs had integrated two more Practices into the original inter-Practice group and were in the process of building up another set of relationships to start a second inter-Practice group.

The way Practice members participated in these different collaborative activities raises the idea that the facilitation processes helped them to temporarily suspend their 'occupational consciousness' (Huntington, 1981) in the interests of achieving a shared project. In their own team development the LMFTs had learnt to utilise the informal aspects of the organisation to create an infrastructure of support around themselves as they implemented the LMFTs project. They went on to create a similar infrastructure around these Practices by developing a strong supportive and informative network with each of them.

Common to all collaborative activities was the exchange of knowledge, local information and practical skills between the participants (Benson, 1975). In both individual Practices and the inter-Practice group LMFTs were pivotal to the process of developing connections between Practice members. The LMFTs were instrumental to developing the Practice and inter-Practice group networks which were the first building blocks to creating an inter-organisational network in PHC.

Moving on from networks to the changes found in each of the fifteen Practices, the LMFTs were responsible for bringing some or all associated health professionals together to help them develop a Practice. Irrespective of the focus of the development process the underlying intent was to create teamwork and collaboration between the health professionals within a Practice. From their own experiences the LMFTs learnt they had to find ways to accommodate their professional differences. They found the effect of their different backgrounds was 'pulling them in different directions' during their planning and decision making processes. The LMFTs early attempts led to re-visiting the storming part of the group life cycle (Tuckman and Jenson, 1977) several times without actually resolving their conflicts. From the researcher's perspective the missing element was that they were not listening and talking to each other. They were talking to others and receiving advice but they did not address their problems directly, as one facilitator put it:

> "I'm sure we agree that we wouldn't let that situation go on for so long again that we should have tackled it earlier on," (LMFT Navy).

At the end of the first phase as part of the PAR approach the LMFTs were expected to report on their own progress in terms of successes and obstacles. This brought their professional differences out into the open and, subsequently, provided the material for discussion and resolution of their teamwork difficulties. The LMFTs learnt that talking their differences through, that is dialogical interchange, was a way to understand each others views and find sufficient compromise for working together. They used this knowledge, framed within a problem solving approach, within their interventions in Practices.

## 6.7 SUMMARY

The LMFTs efforts to promote teamwork and collaboration were characterised by adopting a bottom up, listening, solving problem approach within, whenever possible, a multidisciplinary group. They fostered collaborative activities that flowed from the concerns of the members of the Practice who were all expected to contribute as equals. The four stages of the problem solving approach were finally achieved in the latter phase as a result of the PAR process. This was not in a linear flow nor were the stages very distinct, e.g. action was a continuous process and the review stage was often 'ad-hoc' but it resulted in making gradual improvements to the LMFTs project. It was this process of critical 'reflection-on-action' that was key to the process of learning. It was through

critically reflecting on action taken that the stakeholders, predominantly the LMFTs, achieved personal change and thus, self-development. The subsequent effect of the LMFTs personal learning process was to generate energy for change in other PHCT members. They encouraged PHCTs to learn how to work together and, as a consequence, drive forward the development of their Practices. The LMFTs acted as catalysts for change in that they helped PHCT members to achieve a better understanding of themselves, of their problems and the ways they could resolve them together. What the LMFTs had learned about themselves in the PAR process, as individuals and as facilitation teams, they sought to put into action and achieve teamwork and collaborative activities between health professionals.

The levels of collaboration were not constant in any of the fifteen Practices. The high levels of collaboration achieved during a particular activity subsided once it was complete. However, it seemed as though a reservoir of goodwill remained which the LMFTs were able to tap into to re-energise the process of development. In these Practices the LMFTs had maintained a high level of interaction with the members which was a form of investment that contributed to the development of a 'social capital' for collaboration. In Practices where their contact was reduced the LMFTs found it harder to re-energise the development process as the development of a 'social capital' for collaboration was at a lower level.

Where a 'social capital' had been developed it seemed as though the LMFTs and Practices were held in a state of readiness for when the next opportunity for development emerged. The maintenance of the network kept the LMFTs alert to what was happening and the Practices stayed 'on the ball,' ready to utilise the LMFTs and exploit any opportunity for collaboration as it arose. Thus, networking and the facilitated 'bottom-up' interventions were essential elements in this developmental process. The network provided a support structure for each Practice and the LMFTs were the catalysts and often a source of energy for driving the change process. Additionally, the evaluation, moving in synchrony with the LMFTs project, produced the feedback and the PAR cycles necessary for them to learn about the process and make use of it in their future interventions. The consequences of interweaving the LMFTs project with its process of evaluation was that individuals were encouraged to move beyond single loop learning, that is maintaining the constancy of their own professional views, towards double loop learning whereby changes (modifications) occurred to the governing variables of their belief systems. The necessary condition was that

individuals had to become personally and actively involved to benefit from the process of participatory action research as a process of action learning (Revans, 1982).

## 6.8 CONCLUSION

The LMFTs project was a developmental model for change but one that tried to achieve too much. The potential for learning from experience and practice was impeded in the early stages by its rigid design, the emphasis on a rational-linear approach to problem solving and the adoption of a quasi-experimental design for the evaluation. The LMFTs were to learn the steps of a technical approach to change and the difficulties of implementing them in the unreceptive context of PHC but not how to learn from their experiences.

In the initial interpretation of the LMFTs project a classical science position was assumed as stakeholders looked for outcomes as a result of the interventions. In this sense everyone was looking at the LMFTs project and its evaluation as a means to an end and separate from its context. The stakeholders were failing to see it as a worthwhile process that becomes an integral part of the system and capable of generating learning of itself. This only came about once the PAR process within the evaluation became an additional component of the LMFTs project. Only then did the LMFTs project and the evaluation move in synchrony and the stakeholders were able to learn from their action, and their action facilitated learning.

As a model for change the LMFTs project falls into the personal development aspects of the learning organisation and thus, change was a personal process. By developing the people working in PHC both organisation and service developments automatically began to change. This raises issues around the notions of organisational change and goes to the heart of the learning organisational model in that organisations change through the personal development of the people that work within them. The implications are that once those people involved in a change project have become actively involved in a collaborative activity it is their personal learning and knowledge development that subsequently has the potential to cause ripples of change to radiate outwards over the whole system and augment the process of organisation transformation (Argyris and Schon, 1974, 1978; Stacey, 1995). The next chapter explores the researcher's experience of the evaluation process, and the conclusion drawn in this chapter that change was largely a personal process for those involved in the LMFTs project.

# CHAPTER SEVEN

# RESEARCHER AS A PARTICIPANT IN THE PROCESS - WHAT DID I LEARN?

## 7.1 INTRODUCTION

This chapter explores the researcher's experience of the evaluation process. It will explore, from the researcher's perspective, the conclusion drawn in the previous chapter that change was a personal change for those stakeholders involved in the evaluation. The research design was pre-determined in the research bid it was the researcher's responsibility to establish what the research process looked like and then implement it within the LMFTs project. This chapter is based on the researcher's personal diaries and a critical reflection on the research process. I have broken with the usual academic convention and used the 'first person' to give this account. It is the story of my experience as I see it now and how I frame it within the context of my reading.

In brief, in phase one of the evaluation I spent time becoming aware of my perspective (assumptions) with its built in interests, biases, opinions, and prejudices. I considered this an on-going task and documented the reflexive process using two diaries, one for personal views and the other for methodological issues. Over time, a theoretical and methodological orientation emerged which I was able to develop towards the evaluation. Some of the key issues have been abstracted to provide an abbreviated account of my own personal development as I journeyed through the research process.

## 7.2 MY PERSONAL DISPOSITION

In this study the PAR research framework for the evaluation, which was laid down before my arrival, was appealing as the interactive and participatory methods directly linked with the way I had developed 'learner-centred' group teaching sessions in classroom and practice settings. Key to this 'learner centred' approach was helping individuals become self-directed learners. As a nurse, counsellor and teacher I believed that the relationship between myself and the learner was a key constituent in their learning process. This relationship, based on the ideas of 'person centredness'

(Rogers, 1983), placed the learner and myself as equals as we worked together to find out how to resolve issues at hand. Issues were perceived as problems that had to be resolved by bringing both knowledge and practical experience to bear on them. The underlying motive for the approach that I adopted and developed lay in ensuring theory was applicable to the learner's practice. In essence this was my own version of action learning before I had discovered it as an academic concept (Revans, 1982). I was concerned to encourage learners to become both self-directed and autonomous, seeing learning as an ongoing process of development and, ultimately, empowerment.

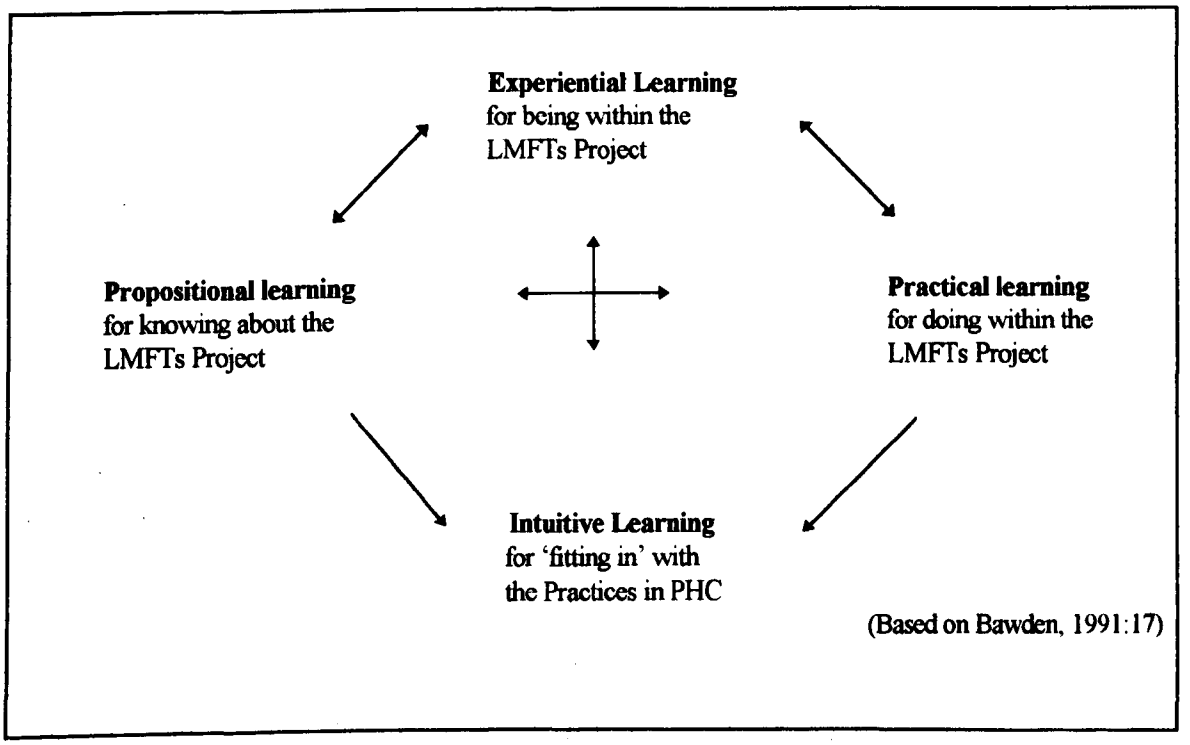
In the evaluation I envisioned that by using a PAR approach the stakeholders, including myself, would become involved in an ongoing process of learning as we moved through several action research cycles during the implementation of the evaluation approach. On reflection this conception was naive, whilst recognising research models were set within different philosophical frameworks, I conceived them as variations based on the same theme of the experiential process of learning. I had not realised that, despite agreeing to using a PAR approach, the other stakeholders involved did not view the research process in this way. It quickly became evident that their ways of knowing, their epistemological bases, were different to mine.

## 7.3 WAYS OF KNOWING

On perceiving the research process as an experiential process of learning I regarded the Lewinian/Kolbian cycle (Lewin, 1946; Kolb, 1984) capable of drawing together propositional, experiential, practical and tacit forms of knowing as a composite view of the evaluation. My view was that there was not one informed view or objective truth but multiple perspectives or truths about the world which individuals constructed subjectively. In other words these are social processes that are created by human interpretations, they do not construct reality per se' rather they develop concepts that describe it. The PAR approach provided me with a system of learning in which to incorporate the different ways of knowing (figure 30).

**Figure 30**

**Creating A System For Learning Within The LMFTs Project**




## 7.4 DEVELOPING THE METHODOLOGY

I envisaged the evaluation as having two distinct but inter-related methodological forms of inquiry: PAR and hermeneutic inquiry. PAR was perceived as being concerned with stakeholders generating knowledge in and for action. The hermeneutic, interpretive inquiry was perceived as being concerned with stakeholders gaining knowledge from understanding the way they were 'being' in the world and from the actions being undertaken. These two forms of inquiry were seen as feeding into each other during the action and reflection cycles of PAR. My understanding was that the stakeholders, which included myself, would become, through the development of dialogical exchanges, aware of their incongruities and cause each other to reflect on both their 'theories-in-use' (Schon, 1983) and the design and implementation of the LMFTs project and its evaluation. This was difficult to conceptualise until I made use of Rowan's (1981) research cycle (as described in section 4.25 and Appendix 4) to visualise how this process would unfold during the evaluation. I want to switch, at this point, from what was envisaged to what happened in reality.

## 7.5 IMPLEMENTING THE PROCESS OF EVALUATION

From the outset I struggled with balancing two parallel tensions, those of maintaining a valid methodology with those of meeting the different stakeholder's needs. Although these tensions may not necessarily be in conflict, in this case the principles of PAR were in constant danger of being subsumed beneath the interests of the stakeholders. Many stakeholders perceived the PAR approach not as a process for learning or for informing action but as the means for measuring, in terms of outcomes, the effectiveness of the LMFTs project. This generated a raw knot of anxiety in me which was to accompany me throughout the entire evaluation. I was constantly concerned with, and reflecting upon, whether the evaluation was achieving the principles of PAR, the criteria for a valid methodology and the stakeholders objectives.

Invoking the principles of PAR was concerned with involving stakeholders in the entire process of the research. By involving stakeholders in participatory workgroups I had hoped to gain a high level of ownership of, and commitment to, the evaluation. This was an ideal that I constantly strove, but found impossible, to achieve. The stakeholders were not a homogeneous group working towards a core vision or goal. The evaluation was not perceived as a team issue. It was difficult for them to accommodate each other's views or develop a close working relationship with each other. Most stakeholders made only a minimal investment in the process and thus a 'social capital' for developing collaboration was slow to develop.

In the process of developing the framework for the evaluation each stakeholder revealed their different view on the world. I recognised that their different set of objectives was shaped by their different psycho-social, cultural, professional and organisational experiences. I was puzzled as to how we would create unity out of difference and how we would establish trustworthiness and authenticity in the process of research. In other words, how we would develop, collaboratively, a framework for evaluation that encompassed, and subsequently met, our diverse vested interests whilst maintaining a valid methodology? My sense of how the process of research could achieve a valid methodology was based on using the trustworthiness and authenticity criteria set out by Guba, (1981) and Lincoln and Guba (1985) as a guide for achieving a credible evaluation process, as discussed in chapter 3. Chapter 4 describes what mechanisms were used and how these were applied to establish confidence in the research process and findings. Although the various case records and annual reports provided a 'product' against which the set of criteria could be applied, and the

bounded inquiry process enabled the process of triangulation, my concerns related to the extent to which stakeholders were participating in the research process. I questioned whether their lack of collaboration was invalidating the process particularly with regard to the criteria for authenticity.

The criteria for authenticity as suggested by Lincoln and Guba (1985) focus on: fairness of findings; and on ontological, educative, catalytic and tactical authenticity (see section 3.31). I start with looking at fairness of findings. Fairness was addressed by ensuring that all the key stakeholders were represented in the participatory workgroups. It was difficult to get them involved in, and committed to, the information feedback and PAR cycles, and particularly so once the framework for evaluation had been developed in phase one. I also felt that, during the early phases, the stakeholders were not being open and honest during the negotiations and that the dialectical process was being manipulated to serve the interests of the Managers and GPs. By phase three, however, the level of collaboration had increased as the stakeholders faced the possibility of not meeting their objectives and thus were more motivated to engage in constructive dialogue. In a different way I may not have been fair to those that figure in this story of the LMFTs project. I have felt anxious at times in this research that I have presented others in a negative way and wonder if fairness has given way to the interests of analysis and critique. Thus the 'fairness' criteria may not always have been honoured but I have tried to do my best in circumstances where the development of relationships was limited by the stakeholders willingness to collaborate and by the quasi-experimental design that was first adopted.

The extent to which the remaining: ontological, educative, tactical and catalytic criteria were achieved was difficult to determine, particularly in phases one and two. The stakeholders, through the dialectical process, appeared to create more sophisticated and elaborate constructions but this did not directly lead to action that was more empowering and emancipatory (the catalytic criterion). Gradually, however, I realised that there was a cumulative effect in the process and that the stakeholders needed time to develop a sufficient level of confidence before they felt empowered to act, e.g. the LMFTs voiced, at the end of phase two, the need to adapt the LMFTs project to meet the needs of the Practices. Thus, the PAR process needed a long period of time to allow the cumulative effect of the process to manifest as a change in an individual's 'seeing and doing'.

The criteria for tactical and catalytic authenticity, were met in various ways within the participatory workgroups. Each action research cycle culminated in a process of critical reflection that informed

and led on to the next phase of action. Of particular significance was the way the LMFTs were stimulated and facilitated by the evaluation process in phase three. Once the evaluation was able to move in synchrony with their activities the LMFTs began to recognise its usefulness, as these comments from the end of project team interviews affirm:

> "It told us when we were banging our heads against a brick wall with some of the interventions, ...[and] some of the Practices".
> "We didn't assess in the beginning all we did was go in and try and get everybody to work with us," (LMFT Red).

> "Well I think it highlights the positive things we do sometimes you don't recognise it and some things that need to be improved. I think it [the profile of each Practice undertaken in phase three] does make you think differently about Practices and think 'Oh yes this well you can leave those for a little bit and let them get on with it, yes and then go and concentrate on another [General] Practice," (LMFT Green).

> "Its a quicker way of finding out 'stop doing that or this' ".
> "It means you have time to sit and reflect on it and its quite interesting reflect on it as soon as it has been done but look at it again later on 'cos your ideas change".

> "I was like a rogue thing so you your evaluation has given me, 'Oh this is what I'm about!' 'This is what I should be doing,' so its given me direction ...its put a framework [round it]. I used to look on it as intrusive and a pain in the bum until, oh God this is terrible, ...[until] I said well I can't understand it [a discussion document] and I'm Jo Bloggs aren't I. It was amazing to me when she said your exactly right. I thought dear me amongst this table of academia or whatever you call yourselves, so I thought blooming hec that's why I'm here, ...[so] it was through going to the steering group that sort of twigged it for me," (LMFT Blue).

> "Well I think it got us to reflect and to review stuff and to evaluate ourselves..., it re-focuses again, ...that's been very useful," (LMFT Navy).

The educational and ontological criteria were not easily achieved in a research process that focused on developing knowledge in and for action and in which the researcher was also an active participant and a stakeholder. The emphasis of the PAR approach was on action and that of the hermeneutic dialectic process was on 'being'. I had conceived these two conjoining strands as

complementing each other. In reality the emphasis was on 'action' rather than 'being' and I constantly made efforts to balance the two in the interests of achieving both participatory activity and dialectical interchange. In retrospect I feel that I was too purist in my effort to maintain a valid research methodology based on the trustworthiness and authenticity criteria. It may have been better to allow the process to follow its own course and accept that stakeholders do not necessarily need to participate in every aspect of the evaluation. In this way the process is seen as a continuum of participation along which the stakeholders moved forward or back dependant on the degree to which the evaluation meets, at different times, their vested interests.

Notwithstanding some of the limitations of the research process mentioned above the experience of implementing the framework was for many stakeholders a case of,

> "...the blindfold shall help the blindfold to strip away the veils and bandages of custom and practice" (Revans, 1982:283).

Stripping our blindfolds away was not immediate nor readily evident but for many it was a gradual process of re-interpreting our own existing knowledge after meeting the views of 'self' and 'other'. I was unaware of these subtle and cumulative personal changes, all I perceived during phases one and two was that I had somehow failed because the stakeholders in the RSG had agreed to adopt a quasi-experimental approach to the evaluation.

The adoption of the quasi-experimental design with its emphasis on objectivity ran counter to the participatory nature of PAR and filled me with unease. Despite being viewed as an outside observer and positioned at a distance from the LMFTs (in the interests of objectivity) I persisted in trying to achieve participation and constantly sought opportunities for collaborating with the stakeholders. In phases one and two I felt I was in
the realm of mixing paradigms and urgently consulted literature to find my way forward in this predicament. After a time I was able to live with these contradictions as long as I personally continued to adhere to and apply the principles of PAR. I was conscious that the evaluation was perceived by the stakeholders as a systematic, rather than systemic, process and that many were not committed to developing it collaboratively or as a learning process. Furthermore, the key sponsors - the LHA - expected to receive, annually, an outline of progress and some tangible results. I felt we could not afford to fall short of these expectations through a failure to achieve 'good quality' evaluation. In view of this pressure I unconsciously expended much of my own effort and energy on encouraging learning and 'filling in the information gaps'. In doing this I had assumed, without being

aware, a total responsibility for the evaluation and consequently filled the role the other stakeholder's with a traditional view of evaluation expected of me.

By the end of phase two my suspicions, shared with the research director, that the quasi-experimental design was an inappropriate research model were confirmed. I had felt all along that the design, along with some of the stakeholder's objectives, were not appropriate for evaluating the LMFTs project. The difficulty I faced was telling this to the prestigious group of stakeholders in the RSG. At the time I still perceived this as my failure and one that I could have avoided if I had been able to convince the stakeholders, at the beginning, that we were using the wrong type of research model. I now realise, however, that we, as stakeholders, were probably not ready to understand that the traditional research model was inappropriate until it had been tried out. It was the receipt of this 'proof' that enforced the stakeholders to review the whole evaluation process. In the review I was able to raise my concerns about the research model as well as re-emphasise that the evaluation was everybody's responsibility.

Phase three was a time of liberation and change. Personally I liberated myself from holding the responsibility for the evaluation and was able to allow the process to take its own course. I was still viewed as an external evaluator but was able to work with the LMFTs at the centre of the LMFTs project. The refined research design led to me re-building interactive and dynamic relationships with the stakeholders, primarily the LMFTs, and encouraging learning both in action and through reflection. The LMFTs were themselves freed from the rigid framework of the original LMFTs project and openly pursued a course of change and development as dictated by the needs of the Practices in their areas. These positional shifts meant that our activities could now move in synchrony with each other. I retained reservations about the stakeholder's commitment but felt some confidence that they, particularly the LMFTs, had begun to recognise the value of the evaluation. I saw that they, with some help, would now attempt to systematically use the evaluation process. Although not articulated until this third phase I realised that I had had a vague and unclear vision of helping the stakeholders move beyond evaluating PHC systematically as a 'researched system'. Now it had become clear that the way I wanted to encourage learning was by helping the stakeholders become accustomed to using the PAR approach as the accepted way of going about their 'seeing and doing,' (Maturana and Varela, 1972). I wanted them to move towards a systemic process of evaluation and develop an 'action researching system' within PHC (Bawden, 1991)

(figure 31). This was not possible in the time permitted although the way the LMFTs were beginning to utilise the evaluation process showed it may be feasible over a longer time frame.

**Figure 31**

**Two Types Of Systems Researcher**

| **An Expert Researcher** | **A Systemic Action Researcher** |
|---|---|
| 'Hard' systems scientist | 'Soft' Systems Scientist |
| Positivist research model | Hermeneutic research model |
| Looking at the whole system | Looking at the whole system |
| Researcher as an objective observer | Researcher actively participating with others |
| Researcher outside of the system | Researcher as an integral part of the system |
| Researching on people | Researching with people |
| Conducted via systematic approach | Conducted via a systemic approach that taps into the underlying experiential learning process |
| **= A Researched System** | **= An Action Researching System** |

(Based on Bawden, 1991:24-31)

As I worked in the evaluation I increasingly saw it in terms of its power relationships. I sought to implement an evaluation process according to the principles of PAR wherein all stakeholders were to contribute as equals. In reality I felt much dis-empowered within the evaluation until events at the end of phase two led to other stakeholders recognising and valuing my role, knowledge and experience. The LMFTs also experienced a similar shift in their status with the other stakeholders once their local knowledge had proved relevant and useful for promoting change in Practices. The LMFTs and myself both felt subordinate to the Managers and GPs in the RSG, we perceived them as having power 'over' us. Thus, an asymmetrical relationship had formed between the stakeholders in the evaluation (Marshall, 1984; French, 1994).

The development of an asymmetrical relationship was not surprising given the traditional role Managers and GPs held in the NHS. Of importance was what happened to change the relationship from one of asymmetry to symmetry by the end of phase three. The asymmetry developed from the researcher's and facilitator's perception that the Managers and GPs had 'power over' them as a result of their status in the organisation. This was reinforced by the Managers and GPs initially, within the RSG, forming an alliance and proceeding to over-ride the views of other stakeholders on how the evaluation should progress. The 'power over' position was especially evident and exercised

when the Managers or GPs were unable to see a direct correlation between an intervention or evaluation process and an outcome, e.g. reaching a target or achieving an evaluation objective. As the researcher I was keen to find ways of fostering participatory activities based on mutual respect and thus, avoided rather than openly acknowledged the conflict of views. I had, however, misunderstood how mutual respect was fostered, and by failing to openly address the conflict of views through the use of 'constructive controversy' (West, 1994) I was also failing to advance open and honest relationships between the stakeholders.

During the process of critical reflection at the end of phase two I noticed a difference in the way I and the LMFTs were behaving towards the Managers and GPs. What was changing was how the LMFTs and I perceived ourselves. It seemed as though we, through the process of action and reflection-on-action, had found a different form of power. This power was developed in action and from the knowledge we had gained practically and experientially. The feedback and critical reflection process at the end of phase two brought the theoretical propositions of the Managers and GPs and the practical and experiential knowing of the LMFTs and myself together in the process of finding and deciding on our way forward in phase three. The combination of our different views led to a balancing of our relationships within the RSG. Our feelings about other stakeholders 'power over' us did not go away but we had discovered our 'power to' or the ability to make a difference. This increased our own personal power and provided the foundations for developing mutual respect between the different stakeholders. It was at this point, at the beginning of phase three, that I suddenly 'saw' how the PAR approach and the hermeneutic dialectical cycle were encouraging learning and how the dialectical research cycle was working inside the process of PAR.

What I suddenly saw was that my own learning had occurred through creating a dialectic between the stakeholder's different views of research, the literature and my personal experiences in the research. Once I had grasped this for myself I was more confident about how the dialectical process was encouraging learning and development. In my view it was as if the action learning cycle provided an outer conceptual and practical framework for the research process and that the dialectical research cycle provided a way to understand what was going on within, and between stakeholders, inside the PAR framework. In phase one, I had used Rowan's models (1981) model of the dialectical research cycle to try to conceptualise how the stakeholders would be able to engage in a dialectical process (see section 4.25 and Appendix 4). This was, however, only an abstract theoretical conception, one that suddenly became 'real' as I found I was able to trace my own

experience of moving through the four transient states of being, project, encounter and communication.

During studies of the literature in phase one the work of Guba (1981, 1990) Guba and Lincoln (1981, 1989, 1994), Guba and Moore (1991) and Lincoln and Guba (1985) in particular provided me with the means to understand the philosophical differences between the different research paradigms, the philosophical framework of constructivism and a general set of guidelines at a conceptual level. This gave a set of beliefs that 'fitted in' with the intentions underpinning the evaluation approach and a set of criteria as a framework for developing confidence in both the research and the findings, see chapter four. I, thus, satisfied my need to theoretically understand what I was doing but methodologically, although I understood that 'meaning de-construction and re-construction' could take place within a participatory workgroups, I was unclear how this would be achieved in practice.

As a result of constantly reflecting on my own experience I began to understand, by phase three, how the hermeneutic, dialectical research cycle led to knowledge gain. I felt able to make an explanation of this process by the using framework of Rowan's model (1981). What I had experienced for myself was that by clarifying my own way of 'being' in the world (uncovering my preconceived ideas) and projecting these into the public arena of the RSG, and then, through encountering the world-views of other stakeholders, I was enabled to adjust my own perspective of the evaluation and accommodate the stakeholders' perspectives as equally valid. On achieving this level of personal development I found that my concerns about some of the other stakeholders not perceiving the evaluation as an experiential process of learning were reduced.

## 7.6 SUMMARY AND CONCLUSION

In summary, I felt as a result of my own experiences that the other stakeholders, on being engaged in the PAR process and the dialectical research cycle, would learn and increase their level of personal development for themselves in their own time. It was not possible to determine the extent of our learning, this was both personal and unique and dependent on our individual starting point. However, without the PAR approach, the dialectical research cycle and the researcher's personal disposition the evaluation would not, in all probability, have been concerned to encourage learning. It would have met, to a limited extent, some of the outcomes but the stakeholders would not have benefited from being involved in a process orientated approach which helped them to understand the complexities of, and the contextual constraints upon, the LMFTs project. In a traditional evaluation the stakeholders, and researcher and LMFTs in particular, would not have been able to experience and learn from using the PAR process for themselves. The approach to the evaluation would have been bounded by the positivist model of research and thus participants would not have been able to cycle between the phases of reflection and action which, in my view, began to build the preliminary steps of an action researching system in PHC.

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# CHAPTER EIGHT

# TOWARDS A NEW MODEL FOR ACHIEVING ORGANISATIONAL CHANGE AND DEVELOPMENT IN PHC

## 8.1 INTRODUCTION

This final chapter argues that it is possible to bring about organisational change, in PHC, through action learning and PAR. The reasoning is that action learning and PAR fosters personal learning which, in turn, can lead to organisational development and the development of a learning organisation. First, this chapter will provide a summary of the context and the LMFTs project before looking at the most recent proposals for the future development of PHC. Following this a new model for organisational change in PHC is proposed by combining the process of PAR with the principles of organisation and community development and adult learning. This model adapts and extends the LMFTs model for organisational change.

## 8.2 CONTEXT

This study has explored the implementation of the LMFTs project in PHC, in Liverpool. The LMFTs project was developed by one person, a visionary, and was implemented in a rapidly changing context and unreceptive environment. The aims of the LMFTs project were to assist people involved in PHC develop teamwork, networking and collaborative action, via interventions based on a problem solving approach. The LMFTs targeted Practices within four of the poorest geographical areas in Liverpool. The LMFTs project was founded on a combination of adult learning, organisation and community development principles and was considered to be a developmental model for change, as described in chapter one. The approach to organisational change used in the LMFTs project differed from the conventional view presented in the literature. The LMFTs were to facilitate a 'bottom-up' process of change through using the problem solving approach, and participation was considered key to achieving sustainable change in PHC. The LMFTs project became part of the LHA's development strategy which aimed to help PHCTs deliver appropriate, effective and efficient PHC services in order to improve the health of the local population.

In the literature review, in chapter two, PHC was shown to be very difficult to develop. At the macro-organisational level PHC was acknowledged to consist of multiple structures, e.g. multiple power levels and lines of accountability, that militated against organisational change and development. PHC was shown to be subject to a range of contextual forces that emanated from the organisational environment to produce constant obstacles or triggers for change. These forces were of a political, socio-cultural and organisational nature, and were noted for their ability to produce reactive, rather than pro-active or managed, professional and organisational changes, and to invoke personal and group resistance to change in and between PHCTs.

At the micro-organisational level, developing effective teamwork in PHCTs was shown to be very difficult to achieve. The current level of teamwork and collaborative activity in PHC was identified as being very low. The problems of developing effective PHC teamwork were attributed to the environmental constraints and to the team's or group's dynamics. PHCTs were classed as unique in that they were found to differ considerably from their industrial and business counterparts. The PHCTs' uniqueness stemmed from their multi-professional constituency, their different professional orientations, their divergent agendas and objectives, and their multiple power levels. These multiple structures of accountability and management increased the potential for conflict, and reduced the likelihood of sharing objectives and teamworking in, and between, PHCTs in PHC. In addition, PHCTs were shown to lack clear objectives, co-ordination of their activities and regular feedback on their performance, all of which were considered key to developing effective teams and teamwork. These issues, as identified from the literature review, served to demonstrate the complex nature of PHC and the reasoning behind why it has been so difficult to achieve change and development in this setting. This was confirmed to be the case within this study. As described in chapter six, the LMFTs met similar obstacles, or contextual forces, from within the macro and micro-organisational levels of PHC. These contextual forces served to limit the impact of the LMFTs project and, thus, acted as barriers to implementing the process of organisational change in PHC.

## 8.3 CASE STUDY - THE LMFTs PROJECT

The LMFTs project was an example of a developmental model for change which was both successful and unsuccessful depending on the criteria used for its evaluation. The LMFTs project could be considered successful in that it met some of the objectives of the different stakeholder groups (figure 20), even though the progress, for some, was not as extensive as they had originally

expected. The meaning of success was different for each stakeholder group (see chapter five). The Practices that actively responded had started to change their administrative and clinical activities and had tentatively begun to develop teamwork and collaboration. Those Practices that had actively responded to the LMFTs interventions appreciated:

- having a skilled LMFT facilitator working with them;
- working closely with other PHCT members;
- working on important problems and practical issues relevant to their work;
- planning and taking action to resolve their own problems;
- gaining new knowledge, skills and insights about colleagues work activities;
- rekindling their interests, commitment and motivation.

Success for the LMFTs was being able to assist Practices develop once they had implemented interventions that responded to each Practice's specific needs, and the success of the LMFTs project was, for the LHA Managers, being able to recognise its contribution to the primary objectives of each Manager's localised PHC development strategy. Thus, the LMFTs project was deemed successful because the most responsive Practices were considered to have begun to develop and deliver more appropriate, effective and efficient PHC services to their local populations.

However, recalling that participation was considered key to achieving sustainable change, the LMFTs project could, in this respect, be considered unsuccessful - particularly during phases one and two. The LMFTs project was incorporated within the LHA's PHC development strategy and thus, became subjected to conventional managerial views on organisational change. In addition, the original mandate to deliver a set programme of interventions added further to the constraints on the LMFTs process of implementation. As the LMFTs tried to meet the objectives of the different stakeholders, the LMFTs project took on the shape and form of a 'top-down' conventional organisational change project. The implementation of the intervention programme and the problem-solving approach followed a linear path, participation was limited to a few committed individuals and Practices, and the change process was objectified as the emphasis was on outcomes - *the difference* - that could be achieved. Later, in section 8.5, a new model for achieving organisational change in PHC is postulated, one which attempts to address some of the shortcomings of the LMFTs model for change. Thus, the notion of all Practices participating in a facilitated process of change that would lead to sustained organisational change in PHC had not been realised by the end of phase two of the LMFTs project.

In parallel with the implementation of the LMFTs project was the PAR approach to its evaluation (chapter three). Here, key stakeholders actively participated in the creation and development of the framework for evaluation (chapter four). This involvement brought a lot of problems to the surface for the stakeholders, problems that were related to their expectations about the LMFTs project: its process and outcomes. What was revealed to stakeholders were their different personal worldviews and the way these governed their aims, values and attitudes towards the LMFTs project and its evaluation (figure 21). What PAR brought to the LMFTs evaluation was the involvement of the key stakeholders in a process of continuous learning through critical reflection-on-action. Each phase of the evaluation culminated in a review of, and reflection upon, the experience and action within the LMFTs project. The PAR approach consisted of two different but inter-related elements: participatory processes for establishing dialogue, and action research cycles for providing feedback and achieving critical reflection for informing further action. PAR was the means by which the stakeholders achieved personal learning concurrently with gaining information about the LMFTs project. It was evident that the stakeholders, through their involvement in the action research process, were finding their way forward in the evaluation process by 'learning through acting.' It was equally evident to the researcher, mid-way through phase two, that the problem solving approach in the LMFTs project was not involving those participants in a process of critical reflection and review. The LMFTs and the Practices were not involved in a process that helped them to learn from their experience and action. Thus, those involved in the change process were achieving small-c changes but this curtailed learning to the lowest level of single loop learning, where corrections to errors were made without making changes to any of the values or rules that governed the situation (Swieringa and Wierdsma, 1992).

In the third and final phase of the LMFTs project the PAR approach was synchronised with the intervention activities of the LMFTs. The researcher integrated the process of PAR with the problem solving approach of the LMFTs. Over the final year and a half the LMFTs were empowered, through involvement in the process of PAR, to adapt and extend the intervention programme so that it met the specific needs of individual Practices. A shift was made from implementing a rigid-linear planned approach to change *across* Practices in each Cluster to that of engaging in an emergent, dynamic and responsive change process *within* Practices. Subsequently, interventions were tailor-made to address problems specific to a Practice. Gradually the LMFTs, with the help of the researcher, began to undertake a critical review of each intervention they undertook and, eventually a 'review' process was built into each intervention.

The use of the PAR approach in this evaluation demonstrated its usefulness in that it involved participants, promoted learning, and simultaneously enhanced and evaluated the process of change in PHC. The tradition of following positivist research models in health care excludes all voices other than those of the experts. In this study, the PAR approach was characterised by inclusivity and, therefore, had a greater potential for recognising the needs of all stakeholders through hearing their different voices rather than one or two dominant voices, as discussed in sections 4.32 - 4.33, 6.5 and 7.5. In addition, the inclusivity of the PAR process helped health professionals overcome their constraints within difficult teamwork situations, as discussed in section 4.33. Integrating PAR with the LMFTs project moved away from the exclusivity of the expert professional model of research and towards a model of inclusivity, where everyone and everything moved forward together in the process of developing PHC.

In the final phase of the LMFTs project, most of those involved in the change process achieved small-c changes and continued to learn at the level of single loop learning. However, within the LMFTs, and among some of those Practices that had actively responded, there were individuals that had moved on from simply detecting and correcting errors (single loop learning) to displaying changes in their underlying insights and governing values (double loop learning) (Senge, 1990; Swieringa and Wierdsma, 1992). The process of PAR was not integrated with the LMFTs interventions long enough for the essential principles on which the organisation was founded to be challenged, and, therefore, triple loop learning was not achieved (Swieringa and Wierdsma, 1992; Zuber-Skerritt, 1996). The evidence for the way individuals were changing was found in the debates that they generated during problem-solving. Individuals, formerly reticent, were latterly prepared to engage in conflict and challenge the status quo and present insights into a situation. It was their involvement in the process of PAR, with its continuous cycle of learning through experience, action and reflection, that had encouraged individuals in the LMFTs and in Practices to make a shift from single to double loop learning. In addition, groups, e.g. the LMFTs and Practices (individually or several together) were assisted to move towards a collective knowledge and understanding of the organisation of Practices, and PHC as a whole.

These were the changes that made it possible to postulate that it was the process of PAR in combination with the principles underpinning the LMFTs project that had increased the level of impact of the LMFTs interventions in the final phase. The remit of the LMFTs project was extended

to include working *within* Practices, firm relationships were subsequently developed out of initially cautious and tentative meetings. PAR was considered instrumental in helping to overcome some of the prevailing contextual forces by introducing a process for self-learning and self-development to the individuals and Practices involved in the project. As a result of using the process of critical reflection-on-action the LMFTs were able to change and implement more appropriate interventions according to the specific needs of individuals and Practices. Subsequently, health professionals and Practices were encouraged to learn through their experience and action as they sought to implement their own action plans for self and Practice development.

The LMFTs project, in combination with PAR, primarily made an impact on the 'personal development' dimension of PHC organisation. Individuals in those PHCTs and Practices that had actively participated in the process of collaboration gained most at the personal level of learning and knowledge development (see section 5.41.4 and Appendix 11). As a result of the LMFTs helping people in PHC to develop they were subsequently able to develop the organisational and service activities that they were involved in. It seemed that once the Project participants became actively involved it was their personal learning and knowledge development that was key to furthering and sustaining organisational change in PHC.

An important part of learning for those involved in the LMFTs project was receiving feedback and critically reflecting on what they had been doing. A lack of information feedback and reflection was noted for raising people's levels of uncertainty and reducing their propensity for collaboration within the LMFTs project. Those health professionals that did not develop the ability to be reflexive with regard to task activities or social processes were not able to learn and benefit from being in the change process. The implication of this was that a process of reflection should become an integral part of the process of developing Practices and improving PHC.

A critical issue in the LMFTs project was that time was needed to allow for personal growth and spread of the developmental process. The original sponsorship money ended in September 1996 but the LHAs' were able to provide extra money for a further extension of six months. However, there was still not enough time to establish a system of 'learning through acting' as an infrastructure that could support and sustain a process of continual development and change in PHC. The use of the LMFTs project, in combination with PAR, produced a social capital for collaboration, change and development among the health professionals in the change process. It was the participation of the

health professionals that led to the sustainability of the change process in individual Practices. This was a developmental process that ran parallel to, and also worked within the framework of, the LHA's formal organisational structures. The ending of the LMFTs project meant the loss of the LMFTs as change agents to sustain the processes of change already begun in Practices, and the loss of an intervention process that produced a social capital for change within the PHC system as a whole.

It was concluded from this study that the LMFTs project as manifest, in phases one and two, was a conventional organisational change project with an emphasis on outcomes - *the difference* - that could be achieved. In this form the LMFTs project was not able to produce the level of organisational change that the stakeholders had hoped for. On following the conventional approach the LMFTs were unable to gain commitment, promote communication and achieve co-operation with Practices other than those few who were ready to participate in a change programme. Furthermore, among those willing to change, the LMFTs found it difficult to achieve organisational change that went beyond single loop learning. As a conventional approach to change it was found that the LMFTs project did not have the power to overcome the constraining contextual forces that kept the organisational policies, governing rules, values, attitudes and practices of PHC firmly in place. In its conventional state the LMFTs project was unable to use a process approach to foster a process of 'learning through acting' or to find constructive ways of utilising power and authority. The LMFTs were not able to develop a parallel learning structure that operated alongside the formal organisational mechanisms of the LHA (Bushe and Shani, 1991) and were not, therefore, able to alter or by-pass the norms and standards that adversely affected the effort to achieve organisational change in PHC (Kanter, 1985; West, 1994). Thus, the organisational structures of the PHC system were constraining the innovation of the LMFTs project.

However, in phase three the LMFTs project, in combination with PAR, became a more dynamic, process oriented approach with an emphasis on learning, on *becoming different*. The LMFTs reached many more individuals and Practices, many of whom gradually became committed to the process of development and started to initiate organisational changes that were the result of engaging in a process of learning. These organisational changes were not imposed but resulted from Practices learning about themselves from within, they looked at, and attempted to resolve, their own problems. The 'bottom up' problem solving approach, in combination with PAR, was used by Practices to determine their own process of development. Thus, when the PAR approach was

integrated with the LMFTs project second loop learning was shown to occur. The process of PAR was able to foster personal learning which enabled individuals and Practices to overcome some of the constraining contextual forces and, in turn, produced organisational change in Practices in PHC.

As argued in chapters one and two, and as a result of this study, PHC is acknowledged as being a poorly co-ordinated and integrated organisational system in which it is difficult to achieve organisational change. In the literature on organisational change there was very little information available to tell us about the process of organisational change within the system of PHC. It was concluded from this study that more attention needs to be paid to the fact that, as a result of its multi-dimensional structure, PHC is different. It is not directly comparable with organisations in the private sector and furthermore, PHCTs, as multidisciplinary teams, are unique and very different from conventional workteams in industry and business. It is argued, therefore, that the conventional approaches to organisational change, in common use in the NHS, are oriented towards business organisations and towards productivity, and as such may be inappropriate for use in health organisations with a service orientation. Unfortunately, the new health policies of the recent Labour Government do not propose new innovative ideas in this respect but advocate more of the same conventional approach to the development of PHC in the future, as commented on in the next section.

## 8.4 THE FUTURE DEVELOPMENT OF PRIMARY HEALTH CARE

In the two recent Labour Government health policy documents: 'The New NHS'(Secretary of State for Health, 1997) and 'Our Healthier Nation' (Department of Health, 1998), developing partnerships and the delivery of integrated primary health care services are prime aims. The development of partnerships between the NHS and local government have been identified as key to delivering better health and health care. In particular 'The new NHS' (Secretary of State for Health, 1997) identified the links between PHC and Social Services as important in the delivery of integrated services to the most vulnerable people in the community, and Primary Care Groups (PCGs) as the means of bringing GPs and other health professionals together to improve the health of local people.

The PCGs will be comprised of many different people each with particular vested interests who are expected to not only commission health care but also to work together to improve PHC itself

(DOH, 1998). It is surmised, however, that as GPs are the assumed leaders in PHC (West and Field, 1995), the balance of power in the PCGs may still be weighted towards GPs, and that the proposed involvement of patients will not actually be realised. In these proposals for organisational development the attention is focused on the structure of the PCGs with little thought being given to managing the process of helping people learn and work together. The health professionals that are involved are expected to collaborate and yet are acknowledged not to work together very well. In this latest vision for PHC the processual elements of achieving change in PHC are missing. There are no formally sanctioned mechanisms to generate, or tie together, a cyclical process of learning and development, there is no-one designated to facilitate the process of development, and further, there are no recognised processes for continuing the generation of a social capital for change within PHC. It can be argued that this is representative of yet another conventional organisation-wide 'top-down' strategy for change in PHC and thus, it is envisaged that sustained organisational change in PHC will be difficult to achieve.

In the light of the experience in this study what seems to be needed in PHC is a new way of understanding and promoting organisational change. It is argued that PHC needs to develop an infrastructure that is able to sustain a process of continuous learning, and one that acknowledges the value of critical reflection-on-action. An approach is needed that draws on, and utilises, the knowledge and experience of those involved in developing PHC, and one that concurrently promotes inclusivity, personal learning and organisational development. A new way of developing PHC could be based on establishing an action researching or action learning system (sections 2.23, 2.31 - 2.34, 7.3 -7.5.). This process oriented approach could provide the means for developing the person, the organisation, the service and the community and, in addition, the means for creating and sustaining a social capital for change among those involved in improving PHC.

In the view outlined above, the process oriented approach to the development of PHC is one that permeates the whole system, from policy, through strategy, to practice, in order to develop an ethos of continuous learning through reflection-on-action between different organisational members in PHC. It will however take time, it is not simply another model for change that is imposed on PHC but a new way of thinking about organisational change in PHC. It is an approach to change that involves everyone and where change is an emergent process which develops out of the knowledge and practice of those working within the organisational setting. The process of organisational development should, in time, become a self-driven and self-sustaining process wherein continuous

personal and organisational learning are a natural part of organisational life. Initially, however, key individuals will be needed, within all organisational levels, to encourage the development of self critical and critical reflection-on-action among members of the organisation. The development of this process-oriented change approach would be particularly costly in terms of time, the overall gain of achieving a more integrated, dynamic and responsive PHC system may, however, be considered a worthwhile investment. These are ideas that have led to a tentative proposal for a new model for achieving organisational development in PHC. The proposal is to combine PAR with the principles of adult learning, organisation and community development in a new model for achieving organisational change and development in PHC.

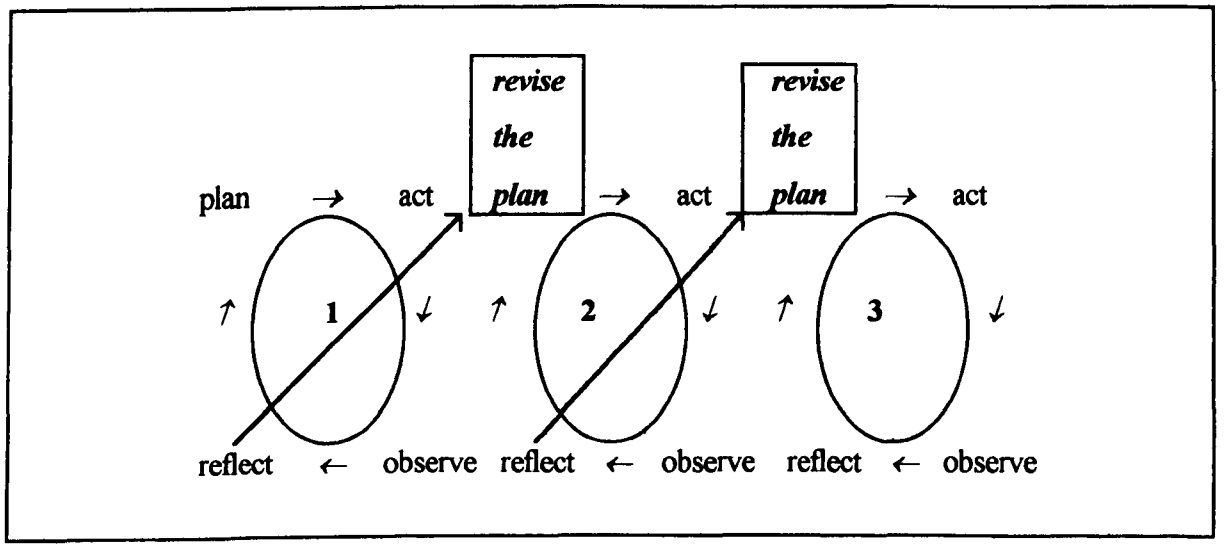
## 8.5 TOWARDS A NEW MODEL FOR ACHIEVING ORGANISATIONAL CHANGE AND DEVELOPMENT IN PHC

PAR, as stated earlier in chapter 3, provides an appropriate and complementary methodology to the LMFTs model for change. In PAR the intention is to promote learning as well as enhance and evaluate the process of change through the use of dialogue and timely feedback. In keeping with the LMFTs model based as it was on the problem solving model, the PAR model emphasises process over specific content and recognises change as a continuous, cyclical, lifelong learning process, rather than a series of change programmes. Furthermore, both PAR and the problem solving model are based on developing teamwork, collaboration, commitment and competence, and the need to foster critical, double-loop learning in order to effect real change and development, not only for participants themselves, but also for the organisation as a whole. Therefore, in the following section, the author will examine the inter-relatedness of the key processes of PAR and the problem solving model in the process of constructing a new model for achieving organisational change in PHC.

First, in the LMFTs project, the problem solving model was used in a linear manner, whereas the process of PAR was implemented cyclically. Figure 32 below represents the classical spiral of action research.

**Figure 32**

**The Spiral Of Action Research Cycles**



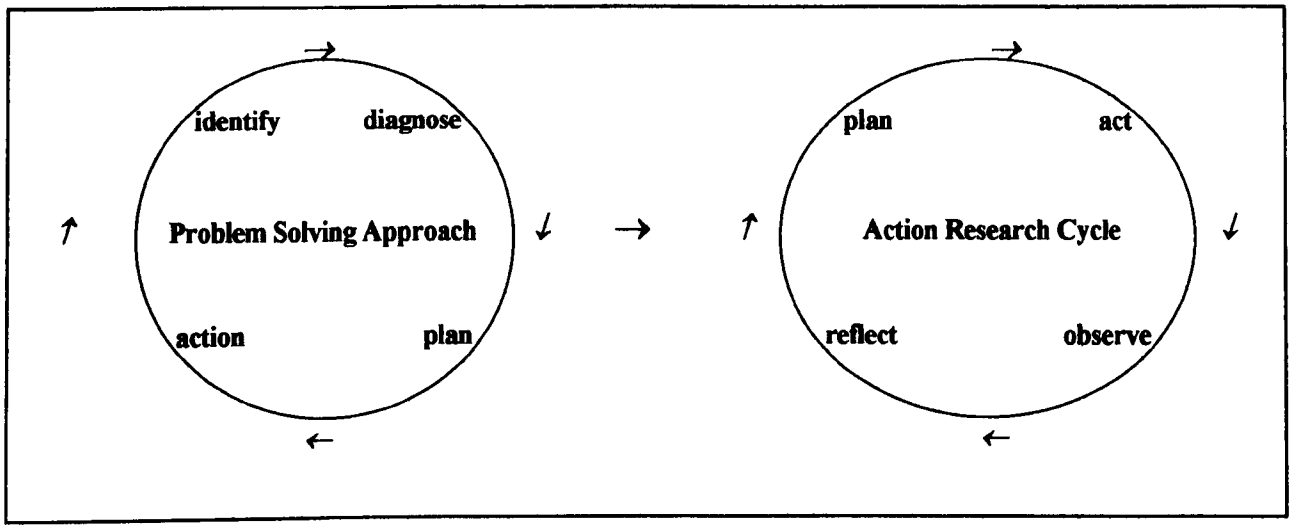

Each action research cycle consists of a plan: identifying and analysing the problems and designing an overall action plan; action: the implementation of the plan; observation: monitoring and evaluating the progress of both the plan and the action; and, reflection: critically reviewing the process as a whole: the plan, the action and the results of the evaluation (Kolb, 1984). The critical reflection process usually leads, in turn, to a revised or totally new plan and the continuation of the action research process in a second cycle.

Second, the conversion of the linear problem solving approach into a cyclical process is proposed, as shown alongside the action research cycle in figure 33. This conversion is made because it can be argued that change is not linear but a cyclical process in that it is evolving and ongoing and does not necessarily have a beginning, middle and end. Furthermore, problems cannot always be clearly defined at the beginning of the process. There is more often a vague sense of what needs to be addressed that may only be pinpointed after working through the issues several times in a cyclical process of trial and error.

Third, it is suggested that the key elements of the cyclical models of the problem solving approach and PAR are largely compatible and may be overlapped, see figure 33.

**Figure 33**

**The Key Elements Of The Problem Solving And PAR Models**

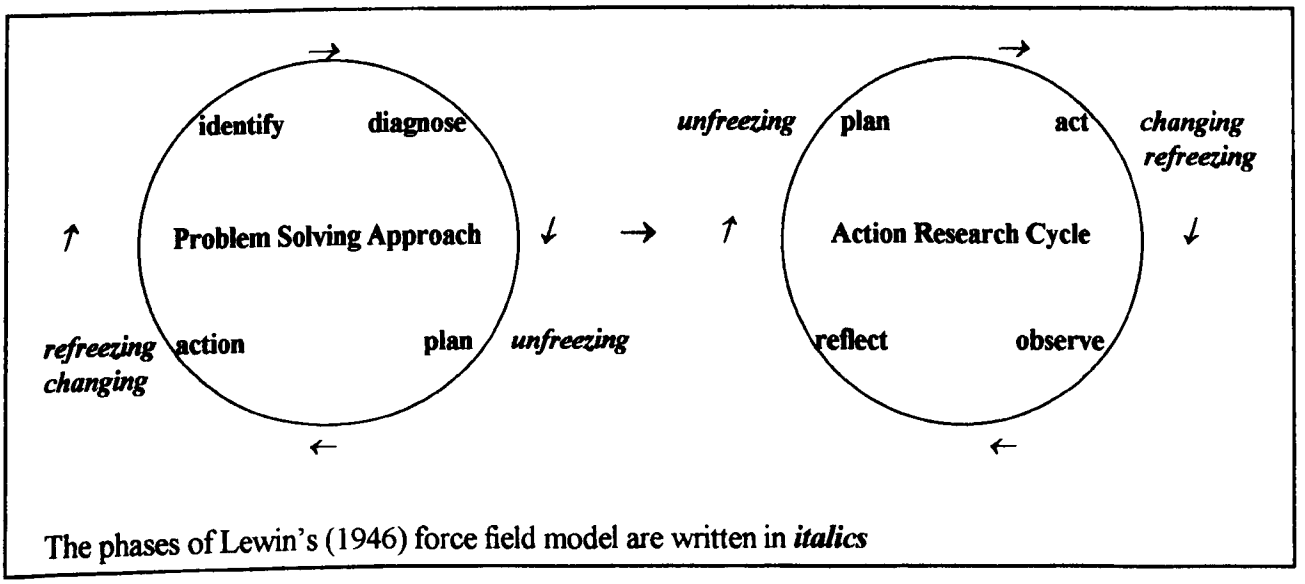



Interestingly, the comparison of these two models in figure 33 clearly shows that the problem solving approach lacks a key element of the action research process: reflection.

Fourth, a brief divergence is made to relate Lewin's force field model (1946) model of organisational change to the process of developing a new model for organisational change, see figure 34.

**Figure 34**

**Relating The Key Elements Of The Problem Solving, Lewin's And PAR Models**




The phases of Lewin's (1946) force field model are written in *italics*

In Lewin's (1946) model there are three stages of organisational change: unfreezing, changing and refreezing.. Unfreezing means providing the stimulus and motive to change in an organisation via the introduction of an intervention that disturbs it's equilibrium. Changing means altering values, beliefs, attitudes and behaviours on the basis of new knowledge and understanding about a situation. Refreezing means establishing and integrating the new views into the system so that they become permanent. Thus, a new equilibrium is established until there is a need for a new cycle of unfreezing, changing and refreezing.

Finally, an integration of these three models for organisational change is proposed. If the stages in the process of organisational change in each of the three models are laid out side by side it becomes clear that they could be integrated into one new model for organisational change (table 45).

**Table 45**

**Comparison Of Problem Solving, Force Field And PAR Models For Organisational Change**

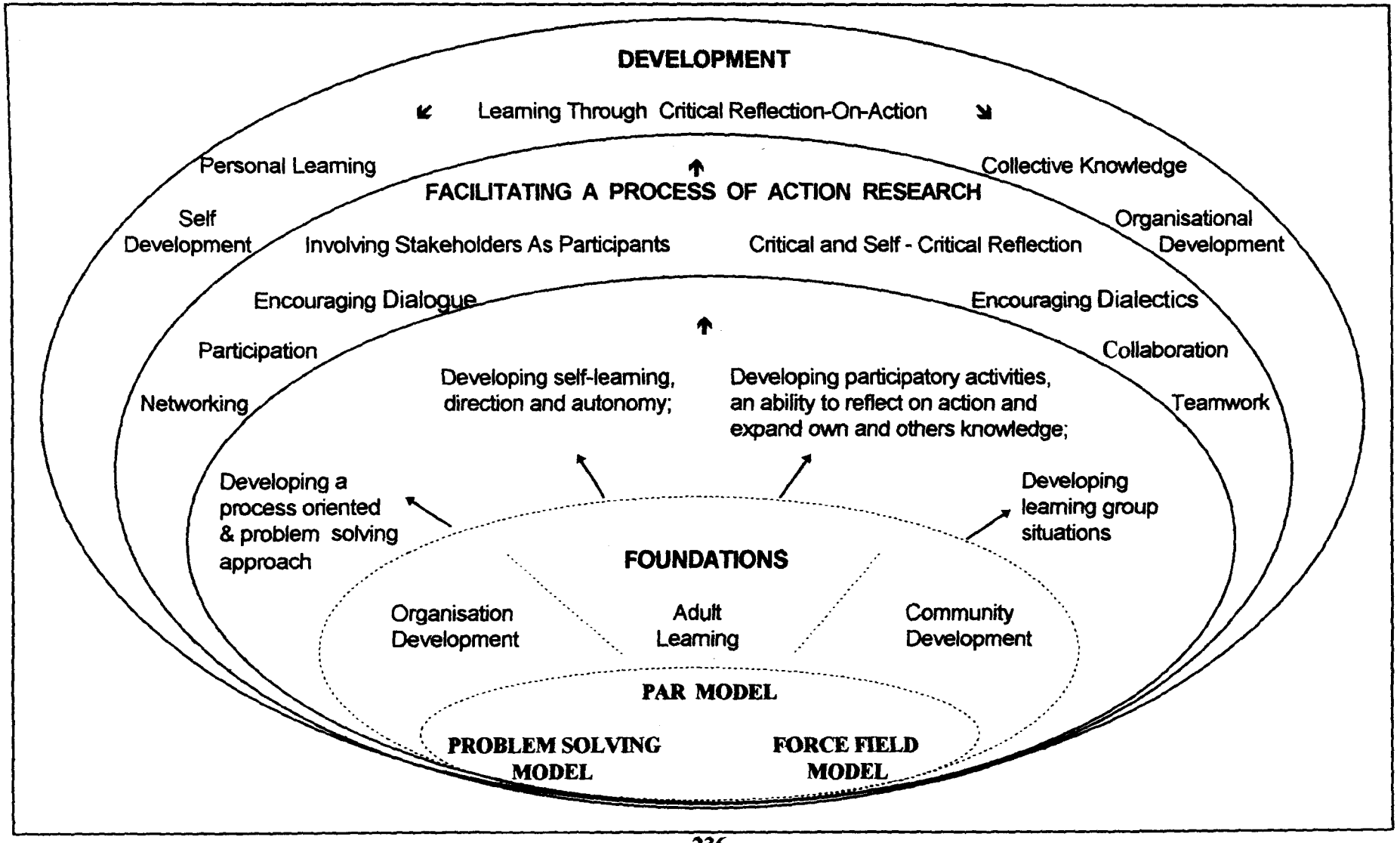
| Problem Solving Model | Lewin's Force Field Model | PAR Model |
|---|---|---|
| Identify | | Planning |
| Diagnose | | Planning |
| Plan | Unfreezing | Planning |
| Act | Changing | Acting |
| | Refreezing | Acting |
| | | Observing |
| | | Reflecting |

Importantly, the key element that was missing from the problem solving model used in the LMFTs project, particularly in phase one and two, was reflection. In table 45 it becomes clear that the process of reflection is not only missing in the problem solving model but also in Lewin's (1946) force field model. The process of critical reflection-on-action is of prime importance to the process of PAR, and crucial to fostering learning and, in turn, organisational change (Zuber-Skerritt, 1992). If a change process lacks critical and self-critical reflection there would not be any feedback, information gain or opportunity for stakeholders or participants to learn through their actions. A process of organisational change can only be effective if it fosters critical, double-loop learning. It is when an individual becomes sufficiently empowered and gains self-confidence that they are enabled to take steps to transform the system they are working in, and to make changes to those organisational and environmental constraints that impede real change and development of the whole

organisation. It is, therefore, necessary to adapt and extend both problem solving and Lewin's force field models by adding in the process of critical reflection, only then can a coherent model for organisational change be said to be achieved. As set out above in table 45 there is an inference that the process of organisational change is a structured, phasic process. This is not often the case particularly when using PAR as a model for organisational change. In PAR change develops as an emergent, dynamic and responsive process, and the change process does not necessarily start with planning / unfreezing but may begin in any of the four phases of the model. To sum up, by integrating the problem solving, force field and PAR models a new model for organisational change and development in PHC, is created, see figure 35 overleaf.

Figure 35

**A Model For Achieving Organisational Change In PHC**



## 8.51 Facilitating The Process For Achieving Organisation Change In PHC

The new model, discussed above, provides a general and broad framework for understanding organisational change in PHC. Theoretically it is based on the principles of adult learning, organisation and community development, as in the LMFTs project, but, in addition, those of PAR. In this new developmental model for change it is the processes that are used for creating change that are of prime importance and, furthermore, it is crucial that members of the organisation are involved as participants in initiating and implementing the process of change.

The aim is to develop processes that will encourage dialogue and dialectical exchanges between participants involved in a process of change. The action research cycle provides the starting point for conceptualising how personal learning and development may be encouraged in a process of change. The action research cycle is conceived as providing an outer conceptual and practical framework for an action research process, and the dialectical research cycle is used to conceptualise how PAR fosters personal learning and development. In this study the use of the action research process enabled health professionals to become involved in developing and implementing their own processes for change. Subsequently, the following framework has been created as a guideline for facilitating a process of organisational change in PHC, table 46. The table shows the relationships between the steps involved in developing an action research process and the phases in the action research cycle. It is stressed that the action research process is an ongoing, cyclical process and that the review process which follows implementing the action plan also signals the beginning of the next action research cycle. This reflects the notion that both learning and change is a continuous, cyclical, lifelong learning process and not just a series of externally developed and imposed training courses and change programmes.

**Table 46**

**Guidelines For Facilitating A Process For Organisational Change In PHC**

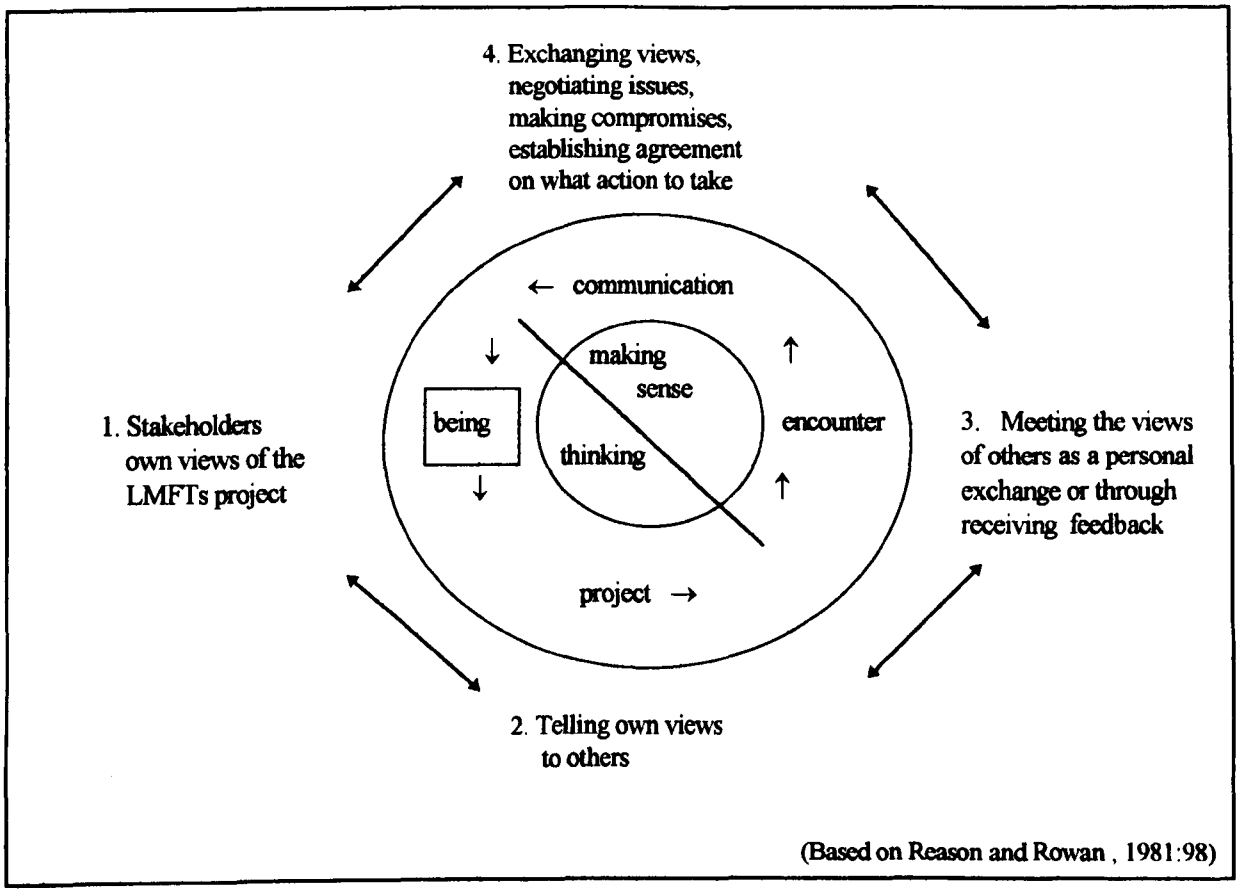
| Guidelines | Model Phases |
|---|---|
| • generate a genuine participatory process to involve everyone concerned;<br>• adopt a bottom up, listening, problem posing / solving approach;<br>• identify, clarify and prioritise the issues to be addressed;<br>• arrive at consent for action (whilst accepting non-agreement on other issues);<br>• formulate an action plan to improve the situation; | planning |
| • identify / specify those responsible for taking action;<br>• promote collaboration between those taking action;<br>• provide support and resources for the effort to change things; | acting |
| • specify a date for review of progress,<br>• review & critically reflect on usefulness of the changes made;<br>• refine the activities to eliminate negative aspects;<br>*this signals the completion of one action learning / action research cycle* | observing / reflecting |
| • revise or create a totally new action plan; | planning |
| • implement revised or new action plan:<br>*this signals the beginning of a second action research cycle* | acting |
| • specify a second date for review of progress. | observing / reflecting |

The guidelines, as outlined in table 46, describe how a process of PAR may be implemented within PHC and other similar organisational settings. The new model for organisational change advocates a developmental approach to change and development, one that starts at the periphery of PHC and includes all health professionals and allied personnel, e.g. Local Authorities, Social Services, Hospital Trusts etc., who will be involved in the process of change. This is how it is envisaged that the action research cycle provides an outer conceptual and practical framework for implementing a process of change inside of which the development of a dialectical process fosters learning.

To detail how PAR fosters learning, the author draws on the experiences and observations of the LMFTs project and uses Rowan's dialectical research cycle (Reason and Rowan, 1981) to explain what goes on within, and between, participants inside a process of PAR. Rowan's model (Reason and Rowan, 1981:98) helps us to conceptualise the different states stakeholders are expected to move through, individually and as a group, in order for them to learn personally from their experiences and actions in a change process (figure 36).

**Figure 36**

**Dialectical Research Cycle**




The dialectical research cycle is described by Rowan as a circular process that consists of four transient states: being, project, encounter and communication through which participants work, in turn, until each state is exhausted of all knowledge giving. In addition, there are also two other states underlying the four transient states, thinking: an inventive, creative and refining activity that becomes the sum of being and project, and making sense: an analytic and contemplative activity that creates a synthesis of experience and knowledge. In figure 36 the states of Rowan's dialectical research cycle (Reason and Rowan , 1981) are related to the way in which the stakeholders, as participants in the LMFTs project, experienced the process of learning inside the PAR process.

In PAR, as participants move through the process of action research a dialectic is created within it. This is a dialectic between the participants' different views of the setting, their claims, issues, concerns and problems, and their ideologies and personal experiences. What seems to happen to those involved in a dialectical process is that their personal theories-in-use, that is their assumptions, are challenged by learning about the theories-in-use of others (Argyris and Schon, 1974). Participants are encouraged to reveal the assumptions that lie behind their views and by doing so

allow a 'public inspection' of their private views. In figure 19, in chapter four, there is further illustration of this process and the way the stakeholders in the LMFTs project went through the dialectical research cycle. It is essential for fostering learning that participants are encouraged to reflect and re-appraise the assumptions that underpin their ideas and actions (Argyris and Schon, 1974). The consequences for learning are that participants are encouraged to move beyond single loop learning - maintaining the constancy of their own and the organisation's view, towards double loop learning where they make changes to the values and rules governing their own and the organisation's system of belief. It is the dialectical process that is believed to lead to personal learning and the development of a collective understanding of the organisation as a whole, and subsequently, can lead to organisational development and the development of a learning organisation.

## 8.52 Evaluating The Process Of Change In PHC

The proposed use of PAR within a model for organisational change can simultaneously provide the means for evaluating the process of change. Measuring the effectiveness of a change process and assuring the quality of service delivery are of major importance to those seeking to develop and improve effectiveness and efficiency in PHC. To this end, it is advocated that monitoring and evaluation become an integral part of an organisational change process. In this study the stakeholders were concerned to measure the effectiveness of the LMFTs project in PHC. The researcher created, as result of the literature review, a tentative scheme from which the stakeholders could develop their own framework for evaluating the LMFTs project, see the end of chapter three. From this starting point the stakeholders, using the process of PAR, developed their own criteria for evaluating the LMFTs project. The process of PAR was used as a vehicle for developing the framework for evaluation and for evaluating the LMFTs project. PAR made it possible for evaluation to become an integral part of process of change within the LMFTs project.

The experience of evaluating the LMFTs project has led to the creation of a framework for developing an effective process of evaluating organisational change, table 47. The framework can be seen to overlap the guidelines for facilitating a process of change, shown in table 46. This is inevitable since both frameworks are founded upon the PAR model, they are complementary to each other and each can be used in parallel within in a process of change. The focus in this framework is on creating a systematic process for evaluating the process of change, and on the negotiation of

criteria that include the interests of the many different stakeholders involved. Criteria may be developed, in tiers or layers, in order to be able to assess the different aspects of the change process, e.g. the progress of an implementation process - the practical setting; the level of development being achieved within a particular PHC setting - the local setting; and, across PHC in a city - the general or strategic setting. What matters is that stakeholders create and implement a framework for evaluation that includes their different needs. Of importance is that an emphasis on using a process of PAR is maintained as the basis for implementing an effective evaluation.

**Table 47**

**Developing An Effective Process Of Monitoring And Evaluating A Process Of Change**

| Process<br>**Key Stakeholders:** | **PAR Model Phases** |
|---|---|
| 1. work together to draw up the plan of action;<br>2. identify each stakeholder's issues, expectations and primary objectives;<br>3. determine what criteria meets these objectives;<br>4. identify what information to collect;<br>5. identify each individual's responsibility for the collection of data; | planning |
| 6. collect the information;<br>7. analyse the information together;<br>8. share out the findings; | acting |
| 9. critically review the findings; | observing |
| 10. use findings to revise and refine future actions;<br>11. move forward into the next PAR cycle of the evaluation. | reflecting |

## 8.6 CONCLUSION

In conclusion, a new model for achieving organisational change in PHC has been proposed. It combines the process of PAR with the principles of adult learning, organisation and community development to achieve a non-conventional, dynamic, process oriented approach to change with an emphasis on learning, on *becoming different*. It is a developmental model, one that tries to simultaneously address the needs of the individual and the organisation. It translates the empirically observed findings from the study of the LMFTs project into a model and a process for creating and supporting the future development of PHC. It is hoped that this developmental model for change may be useful to and adapted by others, for their own purposes, when concerned with change and development in PHC. More research work is needed to resolve the problems of dealing with people with different mind sets and their resistance to the notions of PAR and learning through acting. This new model presents a cyclical, ongoing process of change that helps those that become involved to develop their own system of action learning, and, by implication, organisational development and the development of PHC as a learning organisation.

# REFERENCES


Acheson Report (1981) **Primary Health Care In Inner London. Report Of A Study Group** Health Planning Consortium, London

Adorian, D., Silverberg, D. S., Tomer, D. and Wamosher, Z. (1990) **Group Discussions With The Health Care Team: A Method Of Improving Care Of Hypertension In General Practice** Journal of Hypertension Vol. 4 pp. 265-268

Aldrich, H. E. (1979) **Organisation And Environments** Prentice Hall Englewood Cliffs, New Jersey

Alford, R. (1975) **Health Care Politics: Ideological And Interest Group Barriers To Reform** University of Chicago Press, Chicago

Alkin, M. C., Daillak, R. and White, P. (1979) **Using Evaluations: Does It Make A Difference?** Sage Publications, Beverly Hills C.A.

Allen, D. and Lupton, T. (1988) **Contingency Theory, The Introduction Of General Management Into The Health Service** Management Education and Development Vol. 14 Part 1 pp. 47-50

Allsop, J. (1986) **Primary Health Care - The Politics Of Change** Journal of Social Policy Vol. 15 No. 4 pp. 489-496

Argyris, C. (1992) **On Organisational Learning** Blackwell Cambridge, Massachusetts

Argyris, C. and Schon, D. (1974) **Theory In Practice Increasing Professional Effectiveness** Jossey-Bass, San Francisco

Argyris, C. and Schon, D. (1978) **Organisational Learning: A Theory Of Action Perspective** Addison-Wesley, Reading Massachusetts

Armitage, P. (1983) **Joint Working In Primary Health Care** Nursing Times Occasional Paper 79 pp. 75-78

Armstrong, D., Taverbie, A. and Johnston, S. (1994) **Job Satisfaction Among Practice Nurses In A Health District** Health and Social Care in the community Vol. 2 pp. 279-282

Asch, S. E. (1956) **Studies Of Independence And Conformity: I. A. Minority Of One Against A Unanimous Majority** Psychological Monographs 70 (9, Whole No. 416)

Audit Commission (1992) **Homeward Bound: A New Course For Community Health** HMSO. London

Ayer, A. J. ed. (1968) **The Humanist Outlook** Pemberton Publishing Company, London

Bales, R. F. and Cohen, S. P. (1979) **SYMLOG: A System For Multiple Level Observations Of Groups** Free Press, New York

Barr, H. (1998) **Competent To Collaborate: Towards A Competency-based Model For Interprofessional Education** Journal of Interprofessional Care Vol. 12 No. 2 pp. 181-187

Bateson, G. (1972) **Steps To An Ecology Of The Mind** Chandler, San Francisco

Baum, F. (1992) **Research For Healthy Cities: Some Experiences From Down-Under** In: Leeuw, E.; O'Neill, M., Goumans, M. and de Brujin, F. (eds.) op. cit. pp. 18-25

Bawden, R. (1991) **Towards Action Research Systems** In: Zuber-Skerrit, O. (ed.) op. cit. pp. 10-35

Beattie, A. (1991) **Knowledge And Control In Health Promotion: A Test Case For Social Policy And Social Theory** In: Gabe, J., Calnan, M., and Bury, M. (eds.) op. cit. pp. 162-202

Becker, L. J. (1978) **Joint Effect Of Feedback And Goal Setting On Performance. A Field Study Of Residential Energy Conservation** Journal of Applied Psychology Vol. 63 pp. 428-433

Beckhard, R. (1969) **Organisation Development: Strategies And Models** Addison-Wesley, Reading Massachusetts

Beddome, G., Clarke, H. F. and Whyte, N. B. (1993) **Vision For The Future Of Public Health Nursing: A Case For Primary Health Care** Public Health Nursing Vol. 10 No. 1 pp. 13-18

Belbin, R. M. (1981) **Management Teams Why They Succeed Or Fail** Butterworth Heinemann, Oxford

Bennis, W. (1966) **Changing Organisations** McGraw Hill, New York

Bennis, W. G., Benne, K. D., Chin, R. and Corey, K. E. (1976) **The Planning Of Change** 3rd edition, Holt, Rinehart and Winston, New York

Benson, J. K. (1975) **The Interorganisational Network As A Political Economy** Administrative Science Quarterly Vol. 20 pp. 229-249

Bernhard, L. and Walsh, M. (1995) **Leadership The Key To The Professionalisation Of Nursing** Third edition, Mosby - Year Book Inc., Missouri

Best, G. (1987) **The Future Of General Management - Where Next?** King's Fund, London

Bertalanaffy von, L. (1968) **General System Theory Foundations, Development, Applications** Penguin Books, Middlesex

Blake, R. and Mouton, J. (1976) **Strategies Of Consultation** In Bennis, et.al., op. cit. pp. 48-68

Blake, R. and Mouton, J. (1988) **Comparing Strategies For Incremental And Transformational Change** In: Kilmann, R. A. and Covin, T. J. eds. op. cit. pp. 251-281

Blake, R. and Mouton, J. (1994) **The Managerial Grid** Gulf Publishing Company, Houston

Blaxter, M. (1990) **Health And Lifestyles** Tavistock / Routledge, London

Bleicher, J. (1980) **Contemporary Hermeneutics: Hermeneutics As Method, Philosophy And Critique** Routledge and Kegan Paul, London

Bond, M. (1997) **A Learning Team In The Making** Journal of Interprofessional Care Vol. 11 No. 1 pp. 89-98

Bond, M., Cartilidge, A. M., Gregson, B. A., Philips, P. R., Bolam, F. and Gill, K. M. (1985) **A Study of Interprofessional Collaboration In Primary Health Care Organisations** Report No. 27 Vol. 2 Health Care Research Unit, University of Newcastle upon Tyne, Newcastle upon Tyne

Boss, W. (1989) **Organisation Development In Health Care** Addison-Wesley Pub. Co., Massachusetts

Brass, D. J. and Burkhardt, M. E. (1992) **Centrality And Power In Organisations** In: Nohria, N. and Eccles, R. G. (eds.) op. cit. pp. 191-215

Brill, P. and Pierskalla, C. (1982) **Issues In The Application Of Organisation Development In Health Care Organisations** In Margulies, N and Adams, J. (eds.) op. cit. pp. 379-391

Brookfield, S. J. (1986) **Understanding And Facilitating Adult Learning** Open University Press, Buckingham

Brown, R. J. (1988) **Group Processes: Dynamics Within And Between Groups** Basil Blackwell London

Bruce, N. (1980) **Teamwork For Preventive Care** Research Studies Press, Chichester

Bruce, N., Springett, J., Hotchkiss, J. and Scott-Samuell, A. (1995) **Research And Change In Urban Community Health** Avebury, Aldershot

Brunsdon, E., Dean. H. and Woods, R. eds. (1998) **Social Policy Review 10** Social Policy Association, London

Bryar, R. and Bytheway, B. (1996) **Changing Primary Health Care. The Team Care Valleys Experience** Blackwell Science, Oxford

Buchanan, D. and Boddy, D. (1992) **The Expertise Of The Change Agent. Public Performance And Backstage Activity** Prentice Hall International UK Ltd., Hemel Hempstead

Buller, P. F. and Bell, C. H. (1986) **Effects Of Teambuilding And Goal Setting On Productivity: An Experiment** Academy of Management Journal Vol. 29 pp. 305-328

Burnard, P. (1991) **Experiential Learning In Action** Avebury Academic Publishing Group, Aldershot

Burrell, G. and Morgan, G. (1979) **Sociological Paradigms And Organisational Analysis** Heinemann, London

Bushe, G and Shani, A. (1991) **Parallel Learning Structures Increasing Innovation In Bureaucracies** O. D. Series Addison-Wesley, Wokingham

Campbell-Heider, N. and Pollock, D. (1987) **Barriers To Nurse Collegiality: An Anthropological Perspective** Social Science Medicine Vol. 25, No. 5 pp. 421-425

Cant, S. and Killoran, A. (1993) **Team Tactics: A Study Of Nurse Collaboration In General Practice** Health Education Journal Vol. 52 pp. 203-208

Carr, W. and Kemmis, S. (1986) **Becoming Critical: Education, Knowledge And Action Research** Falmer Press, London

Chen, L. C. (1988) **Ten Years After Alma Ata: Balancing Different Primary Health Care Strategies** Tropical and Geographical Medicine Vol. 40 Pt. 3 pp. S22-S27

Checkland, P. (1981) **Towards A Systems-Based Methodology For Real-World Problem Solving** In: Open Systems Group (eds.) op. cit. pp. 289-314

Chin, R. and Benne, K. D. (1976) In: Bennis, W. G., Benne, K. D., Chin, R. and Corey, K. E. (eds.) op. cit. pp. 22-45

Chisholm, R. and Ziegenfuss, J. T. (1986) **A Review Of Applications Of The Sociotechnical Systems Approach To Health Care Organisations** Journal of Applied Behavioural Science Vol. 22 No. 3 pp. 315-327

Coch, L. and French, J. R. P. (1948) **Overcoming Resistance To Change** Human Relations Vol. 1 pp. 512-532

Cohen, J. and Uphoff, N. T. (1980) **Participation's Place In Rural Development: Seeking Clarity Through Specificity** World Development Vol. 8 pp. 213-235

Coleman, J. S. (1978) **Relational Analysis: The Study Of Social Organisations With Survey Methods** In: Denzin, N. (ed.) op. cit. pp. 75-84

Connolly, M. (1995) **Commissioning Community Health Services** Health Visitor Vol. 68 No. 2 pp. 71-73

Consultative Council on Medical and Allied Services (CCMAS) (1920) **Report On The Future Provision Of Medical And Allied Services (The Dawson Report)** HMSO, London

Costongs, C. and Springett, J. (1997) **Joint Working And The Production Of A City Health Plan: The Liverpool Experience** Health Promotion International Vol. 12 No. 1 pp. 9-19

Cousins, C. (1987) **Controlling Social Welfare: A Sociology Of State Welfare And Organisations** Wheatsheaf Books, Brighton

Cornwall, A. (1996) **Participatory Research Methods: First Steps In A Participatory Process** In: de Koning, K. and Martin, M. (eds.) op. cit. pp. 94 -107

Cox, D. (1991) **Health Service Management - A Sociological View: Griffiths And The Non-negotiated Order Of Hospitals** In: Gabe, J.; Calnan, M. and Bury, M. (eds.) op. cit. pp. 89-114

Cronbach, L., Ambron, S. R., Hess, R. D., Hornik, R. C., Phillips, D. C., Walker, D. F. and Weiner, S. S. (1980) **Toward Reform Of Program Evaluation** Jossey Bass Publishers, San Francisco

Cummings, T. G. (1986) **A Concluding Note: Future Directions Of Sociotechnical Theory And Research** The Journal of Behavioural Science Vol. 22 No. 3 pp. 355-360

Dahlbom, B. and Mathiassen, L. (1993) **Computers In Context: The Philosophy And Practice Of Systems Design** Blackwell Publishers, Cambridge Massachusetts

Davidson, S. M. (1976) **Planning And Co-ordination Of Social Services In Multiorganisational Contexts** Social Service Review March pp. 117-137

Davies, C. (1987) **Viewpoint: Things To Come; The NHS The Next Decade** Sociology of Health and Illness Vol. 9 No. 3 pp. 302-304

Davies, J. K. and Kelly, M. P. eds. (1993) **Healthy Cities, Research And Practice** Routledge, London

Dawson, J. (1994) **Health And Lifestyle Surveys: Beyond Health Status Indicators** Health Educational Journal Vol. 53 pp. 300-308

Day, P. and Klein, R. (1997) **Steering But Not Rowing. The Transformation Of The Department Of Health** Policy Press, Bristol

de Koning, and Martin, M. (1996) **Participatory Research In Health Issues And Experiences** Zed Books Ltd, London

Delaney, F. (1994) **Muddling Through the Middle Ground: Theoretical Concerns In Intersectoral Collaboration And Health Promotion** Health Promotion International Vol. 9 No. 3 pp. 217-225

DeMeuse, K. P. and Liebowitz, S. J. (1981) **An Empirical Analysis Of Team-building Research** Group and Organisation Studies Vol. 6 pp. 357-378

Denzin, N. (1978) **Sociological Methods A Sourcebook** Second edition McGraw-Hill Book Company, New York

Denzin, N. and Lincoln, Y. eds. (1994) **Handbook Of Qualitative Research** Sage Publications, London

Denzin, N. K. (1997) **Interpretive Ethnography Ethnographic Practices For The 21st Century** Sage Publications Thousand Oaks, California

Department of Health (1990a) **NHS And The Community Care Act** HMSO, London

Department of Health (1990b) **General Practice In The NHS: A New Contract** HMSO, London

Department of Health (1993) **New World New Opportunities** National Health Service Management Executive HMSO, London

Department of Health (1994) **Developing NHS Purchasing And GP Fundholding Towards A Primary Care-led NHS** National Health Service Management Executive EL(94)79

Department of Health (1997) **The New NHS: Modern, Dependable.** Cmd. 3807 HMSO, London

Department of Health (1998) **The New NHS Modern And Dependable. Developing Primary Care Groups** National Health Service Executive HSC 1998 /139

Department of Health (1998) **Our Healthier Nation: A Contract For Health** HMSO Cm 3852 London

Department of Health and Social Security (1981) **The Primary Health Care Team (The Harding Report)** Report of a Joint Working Group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee HMSO, London

Department of Health And Social Security (1983) **NHS Management Inquiry (Griffiths Report)** DHSS, London

Department of Health and Social Security (1986) **Neighbourhood Nursing: A Focus For Care (The Cumberlege Report)** DHSS, London

Dockery, G. (1996) **Rhetoric or Reality? Participatory Research In The National Health Service, UK** In: de Koning, K. and Martin, M. op. cit. pp. 164- 176

Dolby, C. (1995) **Crossing Boundaries** Practice Nurse 5th May Vol. 9 pp. 355-358

Dunnette, M. D. and Hough, L. M. eds. (1992) **Handbook Of Industrial And Organisational Psychology** 2nd edition, Volume 3. Consulting Psychology Press Inc., Palo Alto California

Ebrahim, G. J. and Ranken, J. P. eds. (1988) **Primary Health Care Reorienting Organisational Support** Macmillan Education Ltd., London

Elden, M. and Chisholm, R. F. (1993) **Emerging Varieties Of Action Research: Introduction To The Special Issue** Human Relations Vol. 46 No. 2 pp. 121-141

Enabling Group Meeting (1994) **Deputy Chief Executive Presented An Overview Of The FHSA's Way Their Development Strategy Had Evolved To Date.** 5/10/95 @14.30 hours

Enthoven, A. (1985) **Reflections On The Management Of The NHS** Nuffield Provincial Hospital Trusts, London

Evaluation Research Society (1980) **Standards For Evaluation** Evaluation Research Society, Washington D. C.

Fetterman, D. M., Kaftarain, S. J. and Wandersman, A. eds. (1996) **Empowerment Evaluation: Knowledge And Tools For Self-Assessment And Accountability** Sage Publications Inc., Thousand Oaks California

Field, R. and West, M. (1995) **Teamwork in Primary Health Care. 2 Perspectives From Practices** Journal of Interprofessional Care Vol. 9 No. 2 pp. 123-130

Freire, P. (1972) **Pedagogy Of The Oppressed** Penguin Books Ltd., Harmondsworth

French, M. (1994) **Power/Sex** In: Radke, H. L. and Stam, H. J. (eds.) op. cit. pp. 15-35

French, W. L. and Bell, C. H. (1973) **Organisation Development: Behavioural Science Interventions For Organisation Improvement** Prentice Hall Englewood Cliffs, New Jersey

Freudenburg, N. (1990) **Developing A New Agenda For The Evaluation Of Aids Education** Health Education Research Vol. 5 pp. 295-298

Fricke, J. G. and Gill, R. (1989) **Participative Evaluations** The Canadian Journal of Program Evaluation Vol. 4 No. 1 pp. 11-25

Fromm, E. (1976) **To Have Or To Be** Abacus Sphere Books Ltd., London

Fry, J. (1986) **Primary Care 2000** Churchill Livingstone, Edinburgh

Gabe, J., Calnan, M., and Bury, M. eds. (1991) **The Sociology Of The Health Service** Routledge, London

Gadamer, H. (1975) **Truth And Method** Seabury Press, New York

Galaskiewicz, J. and Shatin, D. (1981) **Leadership And Networking Among Neighbourhood Human Service Organisations** Administrative Science Quarterly Vol. 26 pp. 434-448

Geertz, C. (1973) **The Interpretation Of Cultures: Selected Essays** Basic Books, New York

Geertz, C. (1983) **Local Knowledge: Further Essays In Interpretive Anthropology** Basic Books, New York

General Medical Services Committee (1965) **A Charter For The Family Doctor** General Medical Services Committee (GMSC) of the British Medical Association, London

Gilmore, M., Bruce, N. and Hunt, M. (1974) **The Work Of The Nursing Team In General Practice** Council for the Education and Training of Health Visitors

Glendinning, C. (1998) **From General Practice To Primary Care: Developments In Primary Health Services 1990-1998** In: Brunsdon, E. Dean, H. and Woods, R. (eds.) op. cit. pp. 137-164

Goodwin, S. (1995) **Commissioning For Health** Health Visitor Vol. 68 No. 1 pp. 16-18

Granovetter, M. (1973) **The Strength Of Weak Ties** American Journal of Sociology Vol. 78 No. 6 pp. 1360-1380

Granovetter, M. (1985) **Economic Action And Social Structure** American Journal of Sociology Vol. 91 pp. 481-510

Graver, L. D. (1995) **The Evaluation Of The Local Multidisciplinary Facilitation Teams. The First Report** Family Health Services Authority, Liverpool

Graver, L. D. (1996a) **The Evaluation Of The Local Multidisciplinary Facilitation Teams. The Second Report** Liverpool Health Authorities, Liverpool

Graver, L. D. (1996b) **The Evaluation Of The Local Multidisciplinary Facilitation Teams. A Discussion Document In Support Of The Second Report** Liverpool Health Authorities, Liverpool

Graver, L. D., Springett, J., Sands, R. and Reason, P. (1997) **The Evaluation Of The Local Multidisciplinary Facilitation Teams. The Final Report** Liverpool Health Authorities, Liverpool

Green, L. W. and Kreuter, M. W. (1991) **Health Promotion Planning. An Educational And Environmental Approach** 2nd edition, Mayfield Publishing Company, Mountain View CA

Greenwood, D. J.; Whyte, W.F. and Harkavy, I. (1993) **Participatory Action Research As A Process And As A Goal** Human Relations Vol. 46 No. 2 pp. 175-192

Guba, E. (1981) **Criteria For Assessing The Trustworthiness Of Naturalistic Inquiries** Educational Communication and Technology Journal Vol. 29 pp. 75-92

Guba, E. ed. (1990) **The Paradigm Dialogue** Sage Publications Inc. Newbury Park, Califorinai

Guba, E. and Lincoln, Y. (1981) **Effective Evaluation** Jossey-Bass Publishers, San Francisco

Guba, E. and Lincoln, Y. (1989) **Fourth Generation Evaluation** Sage Publications, Newbury Park California

Guba, E. and Lincoln, Y. (1994) **Competing Paradigms In Qualitative Research** In: Denzin and Lincoln, (eds.) op. cit. pp. 105, 109

Guba, E. and Moore, G. eds. (1991) **Advances In Environmental Behaviour And Design** Plenum P. Publishers, USA

Gunn, L. (1989) **A Public Management Approach To The NHS** Health Services Management Research Vol. 2 No. 1 pp. 10-19

Guzzo, R. A. and Shea, G. P. (1992) **Group Performance And Inter-group Relations In Organisations** In: Dunnette, M. D. and Hough L. M. (eds.) op. cit. pp. 269-313

Hackman, J. R. (1987) **The Design Of Work Teams** In: Lorsch, J. W. (ed.) op. cit. pp. 315-342

Hackman, J. R. (1990) **Groups That Work (And Those That Don't) Creating Conditions For Effective Teamwork** Jossey-Bass Inc., Oxford

Hackman, J. R. and Morris, C. G. (1975) **Group Tasks, Group Interaction Process And Group Performance Effectiveness: A Review And Proposed Integration** Advances in Experimental Social Psychology Vol. 9 Academic Press, New York

Hackman, J. R. and Oldham, G. R. (1980) **Work Redesign** Addison-Wesley Reading, Massachusetts

Hammersley, M. (1992) **Some Reflections On Ethnography And Validity** International Journal of Qualitative Studies in Education Vol. 5 pp. 195-203

Hammick, M. (1998) **Interprofessional Education: Concept, Theory and Application** Journal of Interprofessional Care Vol. 12 No. 3 pp. 323-332

Handy, C. (1993) **Understanding Organisations** 4th edition, Penguin Books Harmondsworth

Harrison, S. Hunter, D. and Pollitt, C. (1990) **The Dynamics Of British Health Policy** Unwin Hyman, London

Hasler, J. (1992) **The Primary Health Care Teams: History And Contractual Farces** British Medical Journal Vol. 305 pp. 232-234

Hazen, M. A. (1994) **A Radical Humanist Perspective Of Interorganisational Relationships** Human Relations Vol. 47 No. 2 pp. 171-191

Heimer, C. (1992) **Doing Your Job And Helping Your Friends: Universalistic Norms About Obligations To Particular Others In Networks** In: Nohria, N. and Eccles, R. G. (eds.) op. cit. pp. 143-166

Henkel, M. (1991) **The New Evaluative State** Public Administration Vol. 69 pp. 121-136

Heron, J. (1984) **Co-operative Inquiry Into Altered States Of Consciousness** Human Potential Research Project, University of Surrey

Heron, J. and Reason, P. (1997) **A Participatory Inquiry Paradigm** Qualitative Inquiry Vol. 3 No. 3. pp. 274-294

Hey, A., Minty, B. and Trowell, J. (1996) **Interprofessional And Interagency Work: Theory, Practice And Training For The Nineties** In: Pietroni, P. and Pietroni C. eds. op. cit. pp. 199-217

Hill, M. ed. (1993) **New Agendas In The Study Of The Policy Process** Harvester Wheatsheaf, New York

Hilton, R. W. (1995) **Fragmentation Within Interprofessional Work. A Result Of Isolationism In Health Care Professional Education Programmes And The Preparation Of Students To Function Only In The Confines Of Their Own Disciplines** Journal of Interprofessional Care Vol. 9 No. 1 pp. 33-40

Hindmoor, A. (1998) **The Importance Of Being Trusted: Transaction Costs And Policy Network Theory** Public Administration Vol. 76 Spring pp. 25-43

Hoffman, L. R. (1979) **The Group Problem Solving Process** Praeger Publishers, New York

Hooker, J. (1994) **Facilitating Primary Care** Journal of Advanced Nursing Vol. 19 pp. 1-3

Hope, A. and Timmel, S. (1984) **Training For Transformation A Handbook For Community Workers** Mambo Press, Zimbabwe

Hughes, L. and Lucas, J. (1997) **An Evaluation Of Problem Based Learning In The Multiprofessional Education Curriculum For The Health Professions** Journal Of Interprofessional Care Vol. 11 No. 1 pp. 77-88

Hunter, D. and Williamson, P. (1989) **Perspectives On General Management In The NHS** Health Services Management Research Vol. 2 No. 1 pp. 2-9

Huntington, J. (1981) **Social Work And General Medical Practice Collaboration Or Conflict** Allen and Unwin, London

Huse, E. F. and Cummings, T. eds. (1985) **Organisation Development And Change** West Pub. Co. New York

Huxham, C. and Vangen, S. (1996) **Working Together Key Themes In The Management Of Relationships Between Public And Non-Profit Organisations** International Journal of Public Sector Management Vol. 9 No. 7 pp. 5-17

Huxley, J. (1961) **The Humanist Frame** George Allen and Unwin, London

Iles, P.A. and Auluck, R. (1990) **From Organisational To Interorganisational Development In Nursing Practice: Improving The Effectiveness Of Interdisciplinary Teamwork And Collaboration** Journal of Advanced Nursing Vol. 15 pp. 50-58

Janis, I. L. (1982) **Groupthink** revised edition, Houghton Mifflin, Boston

Jarman, B. (1983) **Identification Of Underprivileged Areas** British Medical Journal Vol. 286 pp. 1705-1708

Jarrett, J. L. (1973) **The Humanities And Humanistic Education** Addison-Wesley Publishing Co., Reading Massachusetts

Jones, H. ed. (1975) **Towards A New Social Work** Routledge Kegan and Paul, London

Jones, J. (1983) **Community Development And Health Issues. A Review Of Existing Theory And Practice** Community Projects Foundation, Edinburgh

Jones, J. (1990) **Community Development And The Health Service** Winter School on Community Development and Health Paper A3, Health Education Authority/Open University, Milton Keynes

Kanter, R. M. (1985) **The Change Masters Corporate Entrepreneurs At Work** Routledge, New York

Kanter, R. M., Stein, B. A. and Jick, T. D. (1992) **The Challenge Of Organisational Change How Companies Experience It And Leaders Guide It** The Free Press, Macmillan, New York

Kapferer, B. (1969) **Norms And The Manifestation Of Relationships In A Work Context** In: Mitchell, J. (ed.) op. cit. pp. 181-244

Kaplan, R. E. (1979) **The Conspicuous Absence Of Evidence That Process Consultation Enhances Task Performance** Journal of Applied Behavioural Science Vol. 15 pp. 346-360

Katz, D., and Kahn, R. L. (1978) **The Social Psychology Of Organisations** J. Wiley and Sons, New York

Kelly, A. (1989) **The Enterprise Culture And The Welfare State, Restructuring The Management Of The Health And Social Personal Services** In Burrows, R. ed. (1991) op. cit. pp. 126-151

Kilcoyne, A. and Pietroni, P. (1996) **The History Of The Primary Health Care Team** In: Pietroni, P. and Pietroni, C. op. cit. pp. 194-198

Kilmann, R. A. and Covin, T. J. eds. (1988) **Corporate Transformation: Revitalising Organisations For A Competitive World** Jossey-Bass, San Francisco

Kingsley, S. (1985) **Action Research. Method Or Research** Occasional Paper No. 8 Association of Researchers in Voluntary Action and Community Involvement. Wivenhoe, Essex

Kirkpatrick, S. M. (1990) **Participatory Nursing Research A Promising Methodology In Third World Countries** Western Journal of Nursing Research Vol. 12 No. 3 pp. 282-292

Klein, R. (1995) **The Politics Of The National Health Service** Longman, London

Knowles, M. (1990 ) **The Adult Learner A Neglected Species** 4th edition Gulf Publishing Company, Houston

Koch, T. (1994) **Beyond Measurement: Fourth Generation Evaluation** Journal of Advanced Nursing Vol. 20 pp. 1148-1155

Kolb, D. A. (1984) **Experiential Learning. Experience As The Source Of Learning And Development** Prentice Hall, New Jersey

Komaki, J., Barwick, K. D. and Scott, L. R. (1978) **A Behavioural Approach To Occupational Safety. Pinpointing And Reinforcing Safe Performance In A Food Manufacturing Plant** Journal of Applied Psychology Vol. 63 No. 4 pp. 434-445

Krackhardt, D. (1992) **The Strength Of Strong Ties.** In: Nohria, N. and Eccles, R. G. (eds.) op. cit. pp .216-239

Kruger, R. A. and King, J. (1998) **Involving Community Members In Focus Groups** Sage Publications Thousand Oaks, California

Kuhn, T. S. (1962) **The Structure Of Scientific Revolutions** University of Chicago Press, Chicago

Kusher, M. B. (1989) **Use Of Evaluation To Improve Energy Conservation Programmes: A Review And Case Study** Journal of Social Issues Vol. 45 pp. 153-168

Latane, B., Williams, K. and Harkins, S. (1979) **Many Hands Make Light Work: The Causes And Consequences Of Social Loafing** Journal of Personality and Social Psychology Vol. 37, pp. 822-832

Lather, P. (1986) **Issues In Validity In Openly Ideological Research: Between A Rock And A Soft Place** Interchange Vol. 17 pp. 63-84

Lather, P. (1993) **Fertile Obsessions: Validity After Poststructralism** Sociological Quarterly Vol. 34 No. 4 pp. 673-693

Lawrence, M. (1992) **Caring For The Future** British Medical Journal Vol. 305 pp. 400-402

Leavitt, H. J. (1951) **Some Effects Of Certain Communication Patterns On Group Performance** Journal of Abnormal and Social Psychology Vol. 46 pp. 38-50

Ledford, G. E. and Mohrman, S. A. (1993) **Self-Design For High Involvement: A Large-Scale Organisational Change** Human Relations Vol. 46 No. 1 pp. 143-173

Leeuw, E., O'Neill, M.; Goumans, M. and de Brujin, F. eds. (1992) **Healthy Cities Research Agenda Proceedings Of An Expert Panel.** RHC Monograph Series No. 2 University of Limburg, Maastricht

Legge, K. (1984) **Evaluating Planned Organisational Change** Academic Press, London

Le Grand, J. (1991) **Quasi-markets And Social Policy** Economic Journal Vol. 11 pp. 1256-67

Lewin, K. (1946) **Action Research And Minority Problems** Journal of Social Issues Vol. 2 pp. 34-36

Lewin, K. (1952) **Field Theory In Social Science** Harper and Row Publishers, New York

Liebowitz, S. J. and DeMeuse, K. P. (1982) **The Application Of Teambuilding** Human Relations Vol. 35 pp. 1-18

Lightfoot, J., Baldwin, S. Wright, K. (1992) **Nursing By Numbers? Setting Staffing Levels For District Nursing And Health Visiting Services** York Social Policy Research Unit and Centre for Health Economics, University of York

Limerick, D., Cunnington, B. and Trevor-Roberts, B. (1984) **Frontiers Of Excellence** Australian Institute for Management, Queensland Division

Lincoln, Y. and Guba, E. (1985) **Naturalistic Inquiry** Sage Publications Newbury Park California

Lindblom, C. E. (1968) **The Policy-Making Process** Prentice Hall Englewood Cliffs, New Jersey

Lindblom, C. E. and Woodhouse, E. J. (1993) **The Policy-Making Process** Prentice Hall Englewood Cliffs, New Jersey

Liverpool Family Health Services Authority (1994) **Working Together To Raise Standards In Primary Care** Liverpool Family Health Services Authority in collaboration with Liverpool Medical Committee and the Liverpool Health Authority, Liverpool

Liverpool Health Authorities (1996) **Liverpool City Health Plan** Liverpool Health Authorities, Liverpool

Liverpool Primary Health Care Facilitation Project (1993) **Local Multidisciplinary Facilitation Teams For Primary Health Care In Liverpool 1993-1996 Interventions** Family Health Services Authority, Liverpool

Locke, E. A., Shaw, K. N. and Latham, G. T. (1982) **Goal Setting And Task Performance** Psychological Bulletin Vol. 90 pp. 125-152

Locke, L, F., Spirduso, W. W. and Silvermann, S. J. (1993) **Proposals That Work: A Guide For Planning And Dissertations And Grant Proposals** 3rd edition, Sage Newbury Park, CA

Long, S. (1996) **Primary Health Care Team Workshops: Team Members' Perspectives** Journal of Advanced Nursing Vol. 23 pp. 935-941

Lorsch, J. W. ed. (1987) **Handbook Of Organisational Behaviour** Prentice Hall, Inc., Englewood Cliffs, New Jersey

Lukes, S. (1974) **Power A Radical View** Macmillan Press Ltd., London

Luke, R. D. and Boss, R. W. (1981) **Barriers Limiting The Implementation Of Quality Assurance Programs** Health Services Research Vol. 16 Part 3 pp. 305-314

Macdonald, J. (1993) **Primary Health Care Medicine In Its Place** Earthscan Pubs. Ltd., London

Mackie, R. ed. (1980) **Literacy And Revolution: The Pedagogy Of Paulo Freire** Pluto Press Ltd., London

Macmillan, L. and Pringle, M. (1992) **Practice Managers And Practice Management** British Medical Journal Vol. 304 pp. 1672-1675

Manz, C. C. and Simms, H. P. (1982) **The Potential For 'Groupthink' In Autonomous Work Groups** Human Relations Vol. 35 pp. 773-784

March, J. G. (1981) **Footnotes To Organisational Change** Administrative Science Quarterly Vol. 26 pp. 563-577

Margulies, N and Adams, J. eds. (1982) **Organisation Development In Health Organisations** Addison-Wesley Reading, Massachusetts

Margulies, N. and Dundon, M. (1987) **Organisational Development And Health Organisations** Consultation Vol. 6 No. 4 pp. 221- 235

Marsden, D. and Oakley, P. eds.(1990) **Evaluating Social Development Projects** Development Guidelines No. 5 Oxfam, Oxford

Marsh, D. and Rhodes, R. eds. (1992) **Policy Networks In British Governments** Clarendon, Oxford

Marshall, J. (1984) **Women Managers: Travellers In A Male World** J. Wiley and Sons, Chichester

Marshall, C. and Rossman, G. B. (1995) **Designing Qualitative Research** 2nd edition Sage Publications Thousand Oaks, California

Marquand, J (1992) **Evaluation, Decentralisation And Accountability** Policy Studies Spring Vol. 13 No. 1 pp. 30-39

Maslow, A. (1968) **Toward A Psychology Of Being** 2nd edition, D Van Nostrand Company, New York

Maturana, H. R. and Varela, F. J. (1972) **Autopoesis And Cognition - The Realisation Of The Living** Reidel Publishing, Boston

Maxwell, R. (1988) **Reshaping The NHS** Policy Studies Transaction Books, Oxford

McCarthy, M. (1978) **Decreasing The Incidence Of High Bobbins In A Textile Spinning Department Through Group Feedback Procedure** Journal of Organisational Behaviour Vol. 1 pp. 150-154

McClure, L. M. (1984) **Teamwork, Myth Or Reality: Community Nurses' Experience With General Practice Attachment** Journal of Epidemiology and Community Health Vol. 31 pp. 68-74

McTaggart, R. (1987) **Pedagogical Principles for Aboriginal Teacher Education** The Aboriginal Child At School Vol. 15 Pt. 4 pp. 21-33

Metcalfe, D. (1992) **The Chains Of Education, Experience And Culture** British Medical Journal Vol. 305 pp. 33-34

Miles, M. and Huberman, A. M. (1994) **An Expanded Sourcebook Qualitative Data Analysis** Second edition Sage Publications Thousand Oaks California

Mintzberg, M. (1979) **The Structuring Of Organisations** Prentice Hall, New Jersey

Mirvis, P. (1988) **Organisation Development: Part 1 An Evolutionary Perspective** In: Pasmore, W. A. and Woodman, R. W. (eds.) op. cit. pp. 1-57

Mitchell, J. ed. (1969) **Social Networks In Urban Situations Analyses Of Personal Relationships In Central African Towns.** Manchester University Press, Manchester

Munghan, G. (1975) **Social Workers And Political Action** In: Jones, H. (ed.) op. cit. pp. 26-44

Mohr, L. B. (1982) **Explaining Organisational Behaviour** Jossey-Bass, San Fransisco

Morley, V., Danmers, J. and Pharoah, C. (1990) **Building A GP Platform** The Health Service Journal 23/8/90 pp. 1246-1247

National Health Service Management Executive (NHSME) (1992) **Charter Areas In Which The NHS Authorities, General Practices and Primary Health Care Teams Should Consider Setting Standards** NHSME EL (92) 88 Annex C

National Health Service Management Executive (NHSME) (1993) **Nursing In Primary Health Care - New World New Opportunities** NHSME, Leeds

Nohria, N. and Eccles, R. G. eds. (1992) **Networks And Organisations: Structure, Form And Action** Harvard Business School, USA

Nurse, J. (1993) **The Decline (And Fall?) Of Professional Influence In The NHS: The Coming Of Professional Management** Journal Of Interprofessional Care Vol. 7 No. 2 pp. 131-140

Nutbeam, D. (1994) **Intersectoral Action For Health: Making It Work** Health Promotion International Vol. 9 No. 3 pp. 143-144

Okurut, S., Odong, A., Imalingat, J., Okurut, A., Oloit, L. and Oloit, F. (1996) **Participatory Research Processes And Empowerment: The PACODET Community, Uganda** In: de Koning, K. and Martin, M. op. cit. pp. 72-81

Open Systems Group eds. (1981) **Systems Behaviour** 3rd Edition Paul Chapman Publishing Ltd in Association with the Open University Press, London

Ouchi, W. (1981) **Theory Z: How American Business Can Meet The Japanese Challenge** Addison-Wesley, Reading Massachusetts

Ovretveit, J. (1994) **All Together Now** Health Service Journal 1 December pp. 24-26

Ovretveit, J. (1996) **Five Ways To Describe A Multidisciplinary Team** Journal of Interprofessional Care Vol. 10 No. 2 pp. 163-171

Ovretveit, J., Mathias, P. and Thompson, T. eds. (1997) **Interprofessional Working For Health And Social Care** Macmillan Press Ltd., Basingstoke

Owens, P., Carrier, J. and Horder, J. eds. (1995) **Interprofessional Issues In Community And Primary Health Care** Macmillan Press Ltd., Basingstoke

Park, P., Brydon-Miller, M., Hall, B. and Jackson, T. eds. (1993) **Voices Of Change Participatory Research In The United States And Canada** Bergen and Garvey Westport, Connecticut

Parlett, M. and Hamilton, D. (1972) **Evaluation As Illumination: A New Approach To The Study Of Innovatory Programs** Centre for Research in the Educational Sciences Occasional Paper No. 9 (October) University of Edinburgh

Parston, G. (1988) **Evolution - General Management** In: Maxwell op. cit. pp. 17-33

Pasmore, W. A. and Woodman, R. W. eds. (1988) **Research In Organisational Change And Development** Volume 2 JAI Press Inc., London

Pasmore, W., Petee, J. and Bastian, R. (1986) **Sociotechnical Systems In Health Care: A Field Experiment** Journal of Applied Behavioural Science Vol. 22 No. 3 pp. 329-339

Patton, M. Q. (1980) **Qualitative Evaluation Methods** Sage Publications, London

Patton, M. Q. (1981) **Creative Evaluation** Sage Publications, London

Patton, M. Q. (1982) **Practical Evaluation** Sage Publications, London

Patton, M. Q. (1997) **Utilisation Focused Evaluation The New Century Text** 3rd edition Sage Publications, California

Pearson, P. (1994) **The Primary Health Care Non-Team?** British Medical Journal Vol. 309 pp. 1387-1388

Pearson, P. (1996) **Towards A Primary Care-led NHS** Health Visitor Vol. 69 No. 9 pp. 376-378

Pearson, P. and Spencer, J. (1995) **Pointers To Effective Teamwork: Exploring Primary Care** Journal of Interprofessional Care Vol. 9 No. 2 pp. 131-138

Pearson, P. and Spencer, J. eds. (1997) **Promoting Teamwork In Primary Care A Research Based Approach** Arnold - Hodder Headline Group, London

Pedlar, M., Burgogyne, J., Boydell, T. (1991) **The Learning Company A Strategy For Sustainable Development** McGraw-Hill Book Company, London

Peiro, J. M., Gonzalez-Roma, V. and Ramos, J. (1992) **The Influence Of Work Team Climate On Roles, Stress, Tension, Satisfaction and Leadership Perceptions** European Review Of Applied Psychology Vol. 42 pp. 49-56

Perrucci, R. and Potter, H. (1989) **Networks of Power, Organisational Actors At The National, Corporate And Community Levels** Aldine de Gruyter, New York

Personal Communication (1994) Medical Audit Advisory Group Member J. Webster 13/4/94.

Peters, T. J. and Waterman, R. H. (1982) **In Search Of Excellence Lessons From America's Best Run Companies** Harper Collins Publishers, New York

Pettigrew, A. (1985) **The Awakening Giant: Contingency and Change in ICI** Blackwell, London

Pettigrew, A., Ferlie, E. and McKee, L. (1992) **Shaping Strategic Change** Sage Publications Ltd., London

Pfeffer, N. and Coote, A (1991) **Is Quality Good For You** Institute for Public Policy Research Social Policy Paper No. 5, London

Pietroni, P. and Pietroni C. eds. (1996) **Innovation In Community Care The Marylebone Experience** Churchill Livingstone, Edinburgh

Plant, R. (1987) **Managing Change And Making It Stick** Fontana, London

Poland, B. (1996) **Frameworks For Knowledge Development And Evaluation In, Of and For Health Community Initiatives: Part 1 Guiding Principles** Health Promotion International Vol. 1 No. 3 pp. 237-247

Pollitt, C. (1989) **New Wave Public Service Reforms** The Health Service Journal Supplement, Managing Health in the 1990s pp. 4-5 27/4/89

Polyani, M. (1962) **Personal Knowledge: Towards A Post-critical Philosophy** Routledge, London

Porras, J. L. and Berg, P. O. (1978) **The Impact Of Organisational Development** Academy of Management Review Vol. 3 pp. 249-266

Porras, J. L. and Wilkins, A. (1980) **Organisation Development In A Large System: An Empirical Assessment** Journal of Applied Behavioural Science Vol. 16 pp. 505-534

Portykus, C.(1991) **Hidden Agenda** Health Visitor Vol. 64 No. 5 pp. 144-145

Poulton, B. and West, M. (1993) **Effective Multidisciplinary Teamwork In Primary Health Care** Journal of Advanced Nursing Vol. 18 No. 6 pp. 918-925

Poulton, B. and West, M. (1997) **Defining And Measuring The Effectiveness For Primary Health Care Teams** In: Pearson, P. and Spencer, J. (eds.) op. cit. pp. 146-161

Prigogine, I. and Stengers, I. (1984) **Order Out Of Chaos: Man's New Dialogue With Nature** Bantam, New York

Pringle, M. (1992a) **The Developing Primary Care Partnership** British Medical Journal Vol. 305 pp. 624-626

Pringle, M. (1992b) **Managing Change In General Practice: Introduction** British Medical Journal Vol. 304 pp. 1357-1358

Prochaska, J. O. and Di Clemente, C. C. (1982) **Transtheoretical Therapy: Towards A More Integrative Model Of Change** Psychotherapy: Theory, Research and Practice Vol. 3 No. 19 pp. 276-288

Quinn, J. B. (1980) **Strategies For Change: Logical Incrementalism** Richard D. Irwin, Homewood, Illinois

Rabinow, P. and Sullivan, M. eds. (1987) **Interpretive Social Science A Second Look** University of California Press, California

Radke, H. L. and Stam, H. J. eds. (1994) **Power/Gender: Social Relations In Theory and Practice** Sage, London

Ranade, W. (1998) **Governance And The New Public Health** International Healthy Cities Conference Athens, Greece 20-23 June, Paper No. 137

Raven, B. H. and Rubin, J. Z. (1983) **Social Psychology** Second edition J. Wiley and Sons, New York

Reason, P. ed. (1988) **Human Inquiry In Action Developments In New Paradigm Research** Sage Publications, London

Reason, P. (1996) **Power And Conflict In Multi-disciplinary Collaboration** In: Pietroni, P. and Pietroni, C. op. cit. pp. 237-246

Reason, P. and Rowan, J. eds. (1981) **Human Inquiry A Sourcebook Of New Paradigm Research** J. Wiley and Sons, Chichester

Reid, T. and David, A. (1994) **Community Nursing Practice Management And Teamwork** Nursing Times 21/28 Vol. 90 No. 51 pp. 42-45

Revans, R. (1982) **The Origins And Growth Of Action Learning** Chartwell Bratt Ltd., Sweden

Robinson, T. (1978) **In Worlds Apart Professionals And Their Clients In The Welfare State** Bedford Square Press, London

Robson, C. (1993) **Real World Research A Resource For Social Scientists And Practitioner-Researchers** Blackwell, Oxford

Roethlisberger, F. J. and Dickson, W. J. (1969) **Management And The Worker** J. Wiley and Sons, New York

Rogers, C. (1983) **Freedom To Learn For The 80s** C.E. Merrill Publishing Company, Columbus Ohio

Rootman, I., Goodstadt, M., Potvin, L., Springett, J. and Ziglio, E. eds. (in press) **Evaluation In Health Promotion: Principles and Perspectives** WHO European, Copenhagen

Rovers, R. (1986) **The Merging Of Participatory And Analytical Approaches To Evaluation: Applications For Nurses In Primary Health Care Programs** International Journal of Nursing Studies Vol. 23 No. 3 pp. 211-219

Rowan, J. (1981) **A Dialectical Research Paradigm For Research** In: Reason, P. and Rowan, J. (eds.) op. cit. pp. 93-112

Rowe, H. (1996) **Multidisciplinary Teamwork - Myth Or Reality?** Journal of Nursing Management Vol. 4 pp. 93-101

Rowland, K. M. and Ferris, G. R. eds. (1987) **Research In Personnel And Human Resources Management** JAI Press, Greenwich Connecticut

Royal Commission on the NHS (1979) **Report** HMSO, London

Rye, D. (1996) **All Change In The NHS** Nursing Management Vol. 3 No. 7 pp. 18-19

Saks, M. (1996) **Review Essay** Journal of Interprofessional Care Vol. 10 No. pp. 189-194

Schein, E. (1996) **Kurt Lewin's Change Theory In The Field And In The Classroom: Notes Towards A Model Of Managed Learning** Systems Practice Vol. 9 No. 1 pp. 27-47

Schutz, A. (1967) **Collected Papers 1. The Problem Of Social Reality** Martin Nijhoff, The Hague

Schwandt, T. A. (1994) **Constructivist, Interpretivist Approaches To Human Inquiry** In: Denzin, N. and Lincoln, Y. (eds.) op. cit. pp. 118-137

Schon, D. (1983) **The Reflective Practitioner How Professionals Think In Action** Harper Collins - Basic Books Division, New York

Schon, D. (1987) **Educating The Reflective Practitioner** Jossey-Bass Publishers, San Francisco

Sechrest, L. (1992) **Roots: Back To Our First Generations** Evaluation Research Vol. 13 No. 1 pp. 1-7

Secretary of State for Health (1992) **The Health of the Nation: A Strategy For Health In England** HMSO Cmnd. 1523, London

Secretary of State for Health (1997) **The New NHS. Modern Dependable** Cm 3807 HMSO, London

Secretaries of State for Social Services (1987) **Promoting Better Health: The Governments Programme For Improving Primary Care** HMSO Cmnd.249, London

Secretaries of State for Social Services (1989) **Working For Patients** Cmnd.555 HMSO, London

Senge, P. (1990) **The Fifth Discipline** Doubleday/Currency New York

Scott, G. B. and Marinker, M. (1992) **Imposed Change In General Practice** British Medical Journal Vol. 304 pp. 1548-1550

Sims, D. (1986) **Interorganisation: Some Problems Of Multi-organisational Teams** Personnel Review Vol. 15 No. 4 pp. 27-31

Shani, A. B. and Eberhadt, B. J. (1987) **Parallel Organisation In A Health Care Institution** Group and Organisation Studies Vol. 12 No. 2 pp. 147-173

Shea, G. P. and Guzzo, R. A. (1987) **Groups As Human Resources** In: Rowland, K. M. and Ferris, G. R. (eds.) op. cit. pp. 323-356

Sherif, M. (1967) **Social Interaction** Aldine Publishing Company, Chicago

Sherif, M. and Sherif, C. W. (1967) **Conformity-Deviation, Norms, And Group Relations** In: Sherif, M. (ed.) op. cit. pp. 164-189

Sherwood, J. J. (1971) **An Introduction To Organisation Development** In: Boss, W. (1989) op. cit. pp. 18

Skolimowski, H. (1994) **The Participatory Mind. A New Theory of Knowledge And The Universe** Arkana Penguin Books, London

Skinner, Q. ed. (1985) **The Return Of The Grand Theory In Human Sciences** Cambridge University Press, Cambridge

Smith, D. (1992) **Sociology From Women's Perspective: A Reaffirmation** Sociological Theory Vol. 10 pp. 88-97

Smith, J. K. (1989) **The Nature Of Social And Educational Inquiry: Empiricism Versus Interpretation** Ablex Publishing Corporation, Norwood New Jersey

Smithie, J. and Adams, L. (1993) **Walking The Tightrope. Issues In Evaluation And Community Participation For Health For All.** In: Davies, J. K. and Kelly, M. P. (eds.) op. cit. pp. 55-70

Soothill, K. Mackay, L. and Webb, C. eds. (1995) **Interprofessional Relations In Health Care** Arnold, London

Spratley, J. (1989) **Disease Prevention And Health Promotion in Primary Health Care Team Workshops Organised by the Health Education Authority** Evaluation Report H.E.A., London

Spratley, J (1990) **Joint Planning For The Development And Management Of Disease Prevention And Health Promotion Strategies In Primary Health Care. The Health Education Authority Worskhop Programme For The Development Of Local Organising Teams.** Evaluation Report H.E.A., London

Spratley, J. and Pietroni, M. (1996) **Creative Collaboration: Interprofessional Learning Priorities In Primary Health And Community Care** In: Pietroni, P. and Pietroni, C. op. cit. pp. 254-275

Springett, J. (1995) **Intersectoral Collaboration: Theory And Practice Lessons For The WHO Healthy Cities Project** Occasional Paper Series ISBN 1 900248 01 8 Journal of Contemporary Health Institute for Health John Moores University, Liverpool

Springett, J. and Leavey, C. (1995) **Participatory Action Research: The Development Of A Paradigm Dilemmas And Prospects** In: Bruce, N.; Springett, J. and Scott Samuel, A. (eds.) op. cit. pp. 57-66

Springett, J. (in press) **Participatory Approaches To Evaluation In Health Promotion** In: Rootman, I., Goodstadt, M., Potvin, L., Springett, J. and Ziglio, E.

Spurgeon, P. and Barwell, F. (1991) **Implementing Change In The NHS A Practical Guide For General Managers** Chapman Hall in Association with HSMC London

Stacey, R. (1995) **The Science Of Complexity: An Alternative Perspective For Strategic Change Processes** Strategic Management Journal Vol. 16, pp. 477-495

Stake, R. E. (1995) **The Art Of Case Study Research** Sage Publications Thousand Oaks, California

Standing Medical Advisory Committee (1963) **The Field Work Of The Family Doctor (The Gillie Report)** HMSO, London

Stansfield, J. H. (1994) **Ethnic Modelling In Qualitative Research** In: Denzin, N. and Lincoln, Y. (eds.) op. cit. pp. 175-188

Steiner, I. D. (1972) **Group Process And Productivity** Academic Press, New York

Stewart, M. (1990) **From Provider To Partner: A Conceptual Framework For Nursing Education Based On Primary Health Care Premises** Advances in Nursing Science Vol. 12 No. 2 pp. 9-27

Suchman, E. A. (1967) **Evaluative Research: Principles In Public Service And Action Programs** Russell Sage Foundation, New York

Sudman, S. (1976) **Applied Sampling**. Academic Publishers. London.

Sundstrom, E., DeMeuse K. P. and Futrell, D. (1990) **Work Teams: Application And Effectiveness** American Psychologist Vol. 45 pp. 120-133

Swieringa, J. and Wierdsma, A. (1992) **Becoming A Learning Organisation Beyond The Learning Curve** Addison-Wesley Publishing Company, Woking

Taylor, C. (1987) **Interpretation Of The Sciences And Man** In: Rabinow, P. and Sullivan, M. (eds.) op. cit. pp. 33-81

Taylor, D. (1991) **Developing Primary Care: Opportunities For The 1990s** The Kings Fund Institute and Nuffield Provincial Hospital Trust, London

Thomas, P. (1994) **The Liverpool Primary Health Care Facilitation Project 1989-1994** Family Health Services Authority, Liverpool

Thomas, P. and Graver, L. D. (1997) **The Liverpool Intervention To Promote Teamwork In General Practice : An Action Research Approach** In: Pearson, P. and Spencer, J. op. cit. pp. 174-191

Tichy, M. M. (1985) **Organisation Development In Health Care** In: Huse, E. F. and Cummings, T. (eds.) op. cit. pp. 432-437

Tjosvold, D. (1987) **Participation: A Close Look At Its Dynamics** Journal of Management Vol. 13 No. 4 pp. 739-750

Tones, K. (1989) **An Overview Of Health Promotion Services Within The NHS** Report of Conference 'Health Education / Health Promotion Within The Framework of the White Paper, *Whose Responsibility?*' pp. 15-24 Organisers: Halton Health Education Advisory Service, Cheshire 11/10/98

Torrance, E. P. (1959) **The Influence Of Experienced Members Of Small Groups On The Behaviour Of The Inexperienced** Journal of Social Psychology Vol. 49 pp. 249-257

Torrington, D., Weightman, J. and Johns, K. (1989) **Effective Management People And Organisation** Prentice Hall International UK Ltd., Hemel Hempstead

Traynor, M. and Wade, B. (1992) **I Wish I Had An Accountant** Health Service Journal Vol. 102 pp. 22-24

Trist, E. and Bamforth, K. W. (1951) **Some Social And Psychological Consequences Of The Longwall Method Of Coal Getting** Human Relations Vol. 4 pp. 3-38

Tuckman, B. and Jenson, N. (1977) **Stages Of Small Group Development Revisited** Group and Organisational Studies Vol. 2 No. 4 pp. 419-427

Turrell, E. A. (1993) **Change And Innovation. A Challenge For The NHS** IHSM, London

Tyler, R. W. ed. (1969) **Educational Evaluation: New Roles, New Means** University of Chicago Press, Chicago

Usherwood, T., Long, S. and Joesbury, H. (1997) **The Changing Composition Of Primary Health Care Team** In: Pearson, P. and Spencer, J. (eds.) op. cit. pp. 27-39

Vanderplaat, M. (1995) **Beyond Technique Issues In Evaluating For Empowerment** Evaluation Vol. 1 No. 1 pp. 81-96

Waddington, P. (1994) **The Integrated Care In Shropshire Project: Lessons From Experience** British Journal of Nursing Vol. 3 No. 13 pp. 685-689

Walton, H. J. (1983) **The Place Of Primary Health Care In Medical Education In The UK: A Survey** Medical Education Vol. 17 pp. 141-147

Webb, A. (1991) **Coordination: A Problem In Public Sector Management** Policy and Politics Vol. 19 pp. 229-241

Webster, S. (1982) **Dialogue And Fiction In Ethnography** Dialectical Anthropology Vol. 7 pp. 91-114

Weiss, C. H. ed. (1977) **Using Social Research In Policy Making** D. C. Heath Lexington, Massachusetts

Weiss, R. and Rein, M. (1970) **The Evaluation Of Broad-Aims Programs: A Cautionary Case And A Moral** Administrative Science Quarterly Vol. 15 pp. 97-109

Weisbord, M. R. (1976) **Why Organisation Development Hasn't Worked So Far In Medical Centres** Health Care Management Review Vol. 1 pp. 17-28

Welden, E. and Weingart, L. R. (1993) **Group Goals And Group Performance** British Journal of Social Psychology Vol. 32 pp. 307-334

West, M. A. (1994) **Effective Teamwork Personal And Professional Development** The British Psychological Society, Leicester

West, M. A. (1996) **The Handbook Of Work Group Psychology** Wiley, Chichester

West, M. A. and Farr, J. L. eds. (1989) **Innovation At Work, Psychological Perspectives** Social Behaviour Vol. 4 pp. 15-30

West, M. A. and Field, R. (1995) **Teamwork In Primary Health Care 1: Perspectives From Organisational Psychology** Journal of Interprofessional Care Vol. 9 pp. 117-122

West, M. A. and Poulton, B. (1997) **Primary Health Care Teams: In A League Of Their Own** In: Pearson, P. and Spencer, J. (eds.) op. cit. pp. 12-26

West, M. A. and Wallace, M. (1991) **Innovation In Health Care Teams** European Journal of Social Psychology Vol. 21, pp. 303-315

Whipp, R., Rosenfeld, R. and Pettigrew, A (1989) **Culture And Competitiveness: Evidence From Two Mature UK Industries** Journal of Management Studies Vol. 26 No. 6 pp. 561-568

Whyte, W. F. ed. (1991) **Participatory Action Research** Sage Publications, California

Wiles, R. and Robison, J. (1994) **Teamwork In Primary Care: The Views And Experiences Of Nurses, Midwives And Health Visitors** Journal of Advanced Nursing Vol. 20 pp. 324-330

Williams, S. J., Calnan, M., Cant, S. L. and Coyle, J. (1993) **All Change In The NHS? Implications Of The Reforms For Primary Care Prevention** Sociology of Health and Illness Vol. 15 No. 1 pp. 43-67

Wisner, B., Stea, D. and Kruks, S. (1991) **Participatory And Action Research Models** In: Guba, E. and Moore, G. op. cit. pp. 271-295

Wistow, G. and Hardy, B. (1996) **Competition, Collaboration And Markets** Journal of Interprofessional Care Vol. 10 No. 1 pp. 5-9

Wolfram, S. (1986) **Computer Software In Science And Mathematics** Scientific American pp. 19-26

Wood, N., Farrow, S. and Elliott, B. (1994) **A Review of Primary Health Care Organisation** Journal of Clinical Nursing Vol. 3 pp. 243-250

World Health Organisation (1978) **Report Of The International Conference On Primary Health Care, Alma Ata USSR.** 6-12 September WHO, Geneva

World Health Organisation (1985) **Targets For Health For All** WHO, Copenhagen

Yin, R. K. (1994) **Case Study Research Design And Methods** Second edition, Sage Publications, Thousand Oaks

Young, K. (1994) **An Evaluative Study Of A Community Health Service Development** Journal of Advanced Nursing Vol. 19 pp. 58-65

Yuchtman, E. and Seashore, S. E. (1967) **A System Resource Approach To Organisational Effectiveness** American Sociological Review Vol. 32 pp. 891-903

Zajac, E. J. and Kraatz, M. S. (1993) **A Diametric Forces Model Of Strategic Change: Assessing The Antecedents And Consequences Of Restructuring In The Higher Education Industry.** Strategic Management Journal Summer Special Issue Vol. 14 pp. 83-103

Zuber-Skerritt, O. ed. (1991) **Action Research For Change And Development** Avebury Aldershot, England

Zuber-Skerritt, O. ed. (1992) **New Directions In Action Research** Falmer Press, London

# APPENDIX 1

## LMFTs PROJECT PROPOSAL

These aims are taken from the Local Multidisciplinary Facilitation Teams For Primary Health Care In Liverpool 1993 -1996, Interventions (Liverpool Primary Health Care Facilitation Project, 1993:4-6).

## AIMS

The underlying and long term aim is: ***To Create And Support Integrated Primary Health Care With A Broad Definition And Proven Effect And Efficiency***.

In the effect the LMFTs aim to assist and hasten the change from Primary Health Care from an isolated, reactive, fragmented, disease-focused service, towards a planned, holistic, supported, health-oriented service with efficient use of different skills and driven by the health needs of the local population. It also provides a model for sustaining the new state. This means that individuals will be *self-directed learners* and organisations will be *learning organisations* because then they will posses the skills of reflection, audit, organisational vision and strategic planning necessary to detect and respond effectively to the health needs of the population served.

It also means that there will exist an infrastructure - an established network - of facilitation to allow debate of, the formation of consensus on, and effective response to local health needs that is agreed by people from widely different backgrounds. It will mean that there will exist efficient networking systems for learning about and from other people and organisations with a view to effectively sharing skills, knowledge and resources as well as understanding management priorities. This will make activity more sensitive and efficient. It will mean that there will be effective links with education providers to ensure appropriate opportunities to learn relevant skills, e.g. teamwork and organisational development. Relevant shared action will be develop at the same time as debate, networking and learning.

These are aims for all involved in Primary Health Care. The specific role of the LMFTs will be to ease the interface between people, groups, world views and priorities, by applying interventions likely to bring about spontaneous positive cross boundary activity. They will use interventions that: motivate people and groups by appealing to their priorities; highlight local opportunities and resources; provide *safe environments* for exploration of new ideas; create a *climate of confidence* to help people feel confident about doing things for

themselves. They will base these interventions on proven theory of how to cause change and maintain change and will use interventions of proven worth. They will have as their starting point the aim of improving the health of the people of Liverpool with both long and short term perspectives.

In order to ensure that the most effective combination of interventions is used, an analysis follows of the principles underpinning the achievement of the aims and an understanding of where the theory and expertise can be found to translate these principles into reality.

## PRINCIPLES UNDERPINNING THE ACHIEVEMENT OF THE AIMS AND THE SOURCE OF RELEVANT THEORY AND EXPERTISE.

1. The LMFTs aim to **change the culture** of many groups so that collaboration, reflection, audit, organisational vision and strategic planning become the norm. Changing the culture of any group requires interventions which involve the target group in the process of change. Interventions used must therefore appeal to the priorities of those involved and use existing forces.

*We can draw on the experience of **community development** and **anthropology** to understand cultures and learn how to effectively change them and **marketing** principles to help create a 'climate of confidence' in which people will more readily accept change.*

2. The LMFTs wish to **motivate** all Health Care workers to develop their **own vision** of the future and to **learn** the knowledge, skills and attitudes necessary for its attainment and maintenance. The impetus to develop personal aspirations must come from within and allow people to move from dependency to autonomy (with responsibility).

***Psychology** can inform us of how to motivate people to change. We can draw on the principles of **Adult Education** to understand how adults learn and from **Management of Change** and **Organisational Development** to advise on developing Shared Vision.*

3. The LMFTs wish to **make it easy for people to learn from,** and to **work well with,** others - people with whom they may not share beliefs or aspirations. Out of this comes teamwork and intersectoral collaboration. Easing the interface between different people, disciplines, organisations and culture is the specific uniqueness of the facilitation role and requires skills that help people of different backgrounds, world views and priorities to understand and use each other better.

*The theory of* ***Group Work*** *and* ***Teambuilding*** *teaches us that this is a risky, threatening process because it may challenge people's sense of identity. Neutral 'Safe Environments' are needed if people are to embark on this process. 'Institutionalising safe environments - making them the norm and valued - makes it more likely that the process of collaboration will be widespread and not reliant on a few committed individuals.* ***Community Organising*** *theory*

*teaches us that everyone must be able to personally get something out of this activity in a short and long term way, if action is to be sustained - interventions must target people's self interest.*

**The interventions used by the LMFTs must therefore: draw on the principles and expertise of the above disciplines to empower others to act for themselves and with each other; be sufficiently diverse and flexible to involve people at different stages; promote shared vision and ownership by local people in 'safe environments'; focus on practical problems of the target groups; have a long term view but promote short term achievements that will encourage longer term commitment; have the elements of partnership, reflection, audit and action underpinning every stage; help people develop widespread availability of relevant skills to maintain the process.**

## THE SPECIFIC OBJECTIVES OF THE LMFTs WILL BE:

- To effectively link with the relevant education establishments and to know of the education needs of the individuals in their area.
  *This will access expertise and sensitively target education.*

- To effectively link with the relevant health policy making establishments.
  *This will ensure that developments are realistic in the context of political priorities and resources as well as help make sure other city activities complement local developments.*

- To help develop teamwork, shared Practice and Neighbourhood strategies, improved Practice and Neighbourhood systems, and local collaborative projects.
  *This will help with specific practical problems related to service delivery and use local resources. This will at the same time develop skills locally for further more ambitious work.*

- To assist individuals to be *self-directed* learners and Practices to be *learning organisations.*
  *This is the most effective way of helping people address the health agenda.*

- To assist the involvement of local voices (professional and lay) to articulate local health needs.
  *This should be of direct relevance to the purchasing process.*

## THE INTERVENTIONS PROGRAMME

The interventions and responsibilities chosen to be used by the LMFTs have been devised with the above principles, aims and objectives in mind. None of the interventions should be seen in isolation but together they amount to an intervention programme to promote and maintain desired changes. In-built in every intervention are ways of helping individuals and groups to learn the skills necessary for developing shared vision, strategic planning and collective action, taking people from where they are and producing short term success in the context of their own aspirations and external agendas. To a large extent they use an educational approach to solve service development and health needs assessment problems. The LMFTs and their *Local Enabling Groups* (LEGs) need to be imaginative about the combination and timing of interventions used to produce the maximum effect.

**A likely list of interventions used in one year will be: .....**

1. One cross Practice development workshop per month, alternately exploring new initiatives or topics and auditing aspects of work or health needs (*Multidisciplinary Forum)*;
2. One *Interactive Bulletin* per three months;
3. One cross Practice Workshop per three months;
4. Stimulating and supporting two or three *Shared Projects* per year, e.g. a shared Health Promotion Strategy, developing a shared care system relating to the care of the elderly; the co-ordination of self-help groups, piloting a multidisciplinary training attachment for doctors;
5. Maintaining an updated register of workers of the area and regular personal presence in all General Practice premises of their target area monthly;
6. Three in-Practice management workshops (*Roadshows*) per year.
7. In addition, they would effectively link with the established education and policy making organisations and learn of the education needs of workers of the area. They would recruit Practices to cross-city *Residential Teambuilding Workshops*, city-wide research and other centrally organised training.

# APPENDIX 2

## TENDER FOR THE EVALUATION OF THE LOCAL MULTIDISCIPLINARY FACILITATION TEAMS PROJECT

### RATIONALE

The purpose of any evaluation is to provide useful information to the stakeholders and participants. As such it should form an integral part of activity and involve an internal and external element. The questions asked should directly be related to the aims and objectives of the Project as understood by the stakeholders and participants. Thus the first stage in the evaluation will be to clarify with the stakeholders what their perceptions of the aims are and what questions on effectiveness they would like to have explored and whether questions identified in the following framework are acceptable.

The American Association of Evaluators recognises over a hundred different types of evaluation. This proposal has chosen a type of evaluation that reflects the philosophy of the LMFTs Project and one that is being increasingly used to assess innovative projects under the Health for All umbrella. It is an approach which emphasises evaluation as a tool for learning and draws on the approaches used in quality assurance management, namely a focus on the measurement of change. The results of the evaluation will make a substantial contribution to understanding new approaches to development of primary health care and will acknowledge the lead Liverpool is taking in this area. The framework proposed here takes its lead from the declared aims and objectives of the Project as laid out in the report *Local Multidisciplinary Facilitation Teams for Primary Health Care in Liverpool 1993-1996: Interventions* as well as those outlined in the *Invitation to Tender*. It assumes:

1. The aim of the LMFTs as defined in both these documents is to encourage a culture of self development and create within and across the organisational structure the attributes and values of what has become understood as a learning organisation (Objectives 1 and 2 in Invitation to Tender.
2. That the expected consequences include improvement in the quality of the delivery of General Practice; increased consensus and greater collaboration with regard to decision-making and action in service development; greater awareness and understanding of the issues by participants in the process, in particular the facilitation workers and an increased level of innovation and response to change amongst those practices and individuals involved in the Project. This will manifest itself in team work, networking and a facilitation infrastructure (Objectives 3 - 9 Invitation to Tender).

   This is taking place in a policy environment where the trend is the active encouragement of the reorientation of health service delivery towards primary health care, the existing service is being forced into rapid cultural change but a cultural change that involves a complex network of small organisations and

stakeholders all at different stages of development. Many of the health professionals involved, who traditionally have focused on individual patient care, are not equipped with the skills demanded by the changing environment and are having difficulty in understanding the importance of their new role in the health of the local community.

3. Cultural change is not a rapid process. It is estimated that it takes ten years before a new culture has fully emerged. The project has an initial life of three years so only small signs of any cultural change are likely to be apparent in such a small space of time.

## PRINCIPLES OF PROPOSED FRAMEWORK

1. The Project will be evaluated in a number of ways using both internal and external evaluation criteria.
2. A participatory action research framework and a combination of qualitative and quantitative assessment tools, both internally and externally derived will be followed. The former from the aims and objectives of the Project and the latter from theoretical frameworks derived from the notions of the learning organisation and quality assurance that form the theoretical basis of the Project's aims.
3. It is particularly important to gain acceptance of criteria from stakeholders in the Project since this will enhance the possibility of the continued implementation of the elements of the Project to ensure long term cultural change.
4. Both process and impact as well as outcome evaluation will be addressed but the emphasis will be on evaluating change.
5. An area of similar size and population characteristics, not subject to the activities of the LMFT project, will be chosen to operate as an independent control.

**Within these parameters a number of key questions need to be addressed:**

1. Are the aims and objectives of the Project understood by the stakeholders and the participants?
2. Who are the stakeholders in the project and what are their expectations? Have those expectations been achieved?
3. What are the beliefs, attitudes and behaviours of the participants of those who are to be involved in the Project?
4. What are the activities created by the Project and what is the impact?
5. Has the quality of service delivery within general practice improved? If so, on what basis and by what criteria?
6. Is Primary Health Care more responsive to the needs of the community?

7. What unforeseen consequences have emerged?
8. To what extent is continued self-development through learning an accepted mode of operation and what skills and characteristics have the participants in the Project acquired that could not have been acquired elsewhere?
9. To what extent has the culture of Primary Health Care changed as a result of the Project and to what extent has it changed because of other external factors?
10. Has networking increased and if so in what form? Has the increased networking contributed to greater consensus regarding priorities for service development, more joint working and better use of human and other resources?

## METHODOLOGY AND TOOLS FOR ASSESSMENT

The relationship between tools and evaluation criteria are set out, attached, in tabulated form.

The following should be noted:

1. The study will rely largely on qualitative methodological framework with outcome and impact data collected in three stages: at the beginning, in the middle and at the end of the Project's life using a combination of interviews of key informants and semi-structured questionnaires by an independent researcher and a quasi-experimental design.
2. Process data will be collected by the Project participants. This will include a record of the activities undertaken together with agreed evaluation sheets and regular diary keeping.
3. Markers of improved quality in general practice will be agreed with the stakeholders and collected in both control area and the Project area in co-operation with the FHSA, with data collection and analysis undertaken at regular intervals.
4. The level of learning activity of the Project workers will be measured by achievement of the learning outcomes of the Primary Health Care Facilitation Certificate.

## WORKPLAN

| | |
|---|---|
| 0 - 3 months | Verify the framework for evaluation with stakeholders and establish mechanisms for |
| regular | data collection in an acceptable form by participants. Establish steering group. |
| 3 - 12 months | Undertake initial interviews in target and control areas and collect network data. |
| 12 - 18 months | Analyse first set of continual and interview data. |
| 18 - 30 months | Collect second round of interview and networking data and analyse second set of continual data. |
| 30 - 36 months | Analyse data a produce report. |

## REFERENCES


Hastings, C. (1993) **The New Organisation, Growing the Culture of Organisational Networking** McGraw-Hill

Patton, M. Q. (1978) **Utilisation Focused Evaluation** Sage Publications

Schein, E. H. (1985) **Organisational Culture and Leadership** Jossey-Bass

Swieringa, J. and Wierdsma, A. (1992) **Becoming A Learning Organisation** Addison-Wesley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## FRAMEWORK FOR ANALYSIS AND DATA COLLECTION

| Area of Investigation | Tool | When applied | Where |
|---|---|---|---|
| Culture: Beliefs, perceptions, attitudes and behaviours | Key informant, semi- structured interview followed by content analysis. | In the early stages of the project and towards the end | Purposive sampling of participants in project, target and control areas |
| Networking | Network analysis of qualitative and quantitative data. Comparing interpretation with participants perceptions. | At beginning, middle and end to allow evolutionary characteristics to be captured in snap shots | Target Area and Control Area |
| Innovation and creativity | Record keeping of new initiatives within GP Practices and PHCTs, within agreed categories according agreed to criteria. | Continual | Target Area and Control Area |
| Quality of GP practice | Quality assurance tools used by FHSA and agreed by practices | Yearly | All areas |
| Outcomes of individual interventions | Evaluation questionnaires and descriptions by project workers according to agreed criteria | Continual | Project area only |
| Levels of self development of project workers | Self assessment questionnaires and satisfactory completion of 'Facilitation Course' | At the end of the Facilitation course | Project area only |

| MAIN ACTIONS | ASSOCIATED ACTIONS | COMMENTS |
|---|---|---|
| **Step 1:**<br>Clarify aims and objectives. | Get people on board.<br>Set up evaluation group.<br>Check out what the real problem is.<br>Establish baseline information. | The importance of spending time on this groundwork cannot be over emphasised; Involvement of the right people will ensure commitment and use of information generated and a good response to any questionnaires. The evaluation group (min.3) should reflect the range of interests. Proper clarification makes the evaluation straight forward. |
| **Step 2:**<br>Design the framework for the evaluation and decide what questions to ask. | Decide what the purpose of the evaluation is and who is going to use the information.<br>Decide what useful questions to ask in relation to achieving aims and objectives.<br>Decide for whom are you going to collect it.<br>Decide if you want process as well as outcome information. | Do this before you decide what measures to use. If the objectives have been stated clearly this should be relatively easy. Make sure you are clear who the evaluation is for. This affects what questions are asked. The main aim is to see whether the activities in the programme resulted in the stated objectives. Try to look at process as well as outcome. |
| **Step 3:**<br>Design the framework for evaluation and decide how you are going to measure change. | Decide what you are going to measure and which methods you are going to use.<br>Decide sample size and target population.<br>Decide when you are going to collect information. | Good measurement depends of being clear on the issues. Method should be appropriate to the questions and need not be numbers. Be realistic and honest about limitations of time and money. |
| **Step 4:**<br>Collect the data. | Make sure data collection is unobtrusive and does not add to peoples workload or if it does can they see the value of doing it.<br>Make sure people are still on board.<br>Keep people informed by regular feedback.<br>Remember data is not information. | There will be problems of confidentiality and bias. Most common bias is in self-reported behaviours. Problems are less if everyone has been involved. Participation is the key. |
| **Step 5:**<br>Evaluate the results to determine effectiveness of programme. | Interpret data in association with the evaluation group.<br>Comparing what actually happened with what you expected.<br>Remember numbers are only indicators of what the world is like. | Data is not information until it has been interpreted. This is best done as a collaborative process so people are clear how the results were obtained. Do not forget the value of 'soft' information and remember some health changes take time to be revealed. |
| **Step 6:**<br>Make recommendations. | Clarify what is useful.<br>Cover practical changes that call for immediate implementation.<br>Include costs and benefits of not implementing as well as implementing.<br>Challenge existing beliefs.<br>Look at longer term changes that may not yet be visible. | If people have been involved in the process they will already be committed to acting on the findings and be receptive to results. |

# APPENDIX 3

## STAKEHOLDER'S INFORMATION SHEET FOR THE PROPOSED SNOWBALL OR NOMINATION SAMPLING SCHEME.

A sampling frame is the name given to the mechanism by which individuals/teams are selected for inclusion in a research project. To ensure clarity as to the scope of the research the **sample area** is outlined as follows:

Liverpool is divided into 7 Clusters, 4 of which are involved with the LMFTs project.

**LMFT AREAS**

4 PHCTs to be selected from the 'LMFT' involved Clusters

**NON-LMFT AREAS**

4 PHCTs teams to be selected from non-LMFT involved Cluster;

**The key areas of the evaluation are:**

| 1. Personal: | 2. Organisation | 3. Service: | 4. The wider setting: |
|---|---|---|---|
| • self development<br>* personal growth<br>• the ability to facilitate<br>• role clarification | • team development<br>• organisational development<br>• effective collaboration<br>* making connections<br>* working together | • the improvement in the delivery of primary health care<br>• meeting local health needs | • changing political climate<br>• networking<br>• interventions |

The framework for evaluation is being developed through participation and collaboration, termed participatory action research (PAR) with stakeholders. A purposive sampling strategy is proposed as the way to select a research sample because it draws on the local knowledge of stakeholders to identify particular Practices from which to learn and understand what development and change looked like (Patton, 1980). The research sample is selected by stakeholders using an adapted 'snowball' sampling scheme or nomination process (Sudman, 1976).

### Theory To Support The Use Of A Purposive Sampling Scheme

In the traditional form of interview and subsequent analysis in social science, the interview and the information collected are treated as independent of the others, as a single entity where the information is not considered in reference to the whole structure or in this case the LMFTs project.

In the evaluation of the LMFTs project the intention is to develop as comprehensive a picture as possible, to see the interviewee as an individual but also as part of the wider organisation. The evaluation of the LMFTs project is looking for examples of effective collaboration and the analysis as Coleman suggests, "must somehow tie together and interrelate the attributes of these different parts of the structure," (1978:76).

This indicates a need for stakeholders to meet regularly for critical reflection and clarification of the data to attain the fullest picture of the LMFTs project.

Similarly, looking to the Participatory Action Research (PAR) mode of collaborative inquiry to inform us in the selection of individuals for interview, the word participatory stands out. This suggest that the interview candidate should not be selected by the traditional strategies i.e. randomised or stratified methods but in a collaborative way through using local knowledge, being identified by those working in the setting. The nomination of key people who are able to speak for their community in this way follows the principles of selecting 'key informants' as outlined by Green and Kreuter (1991) when identifying key people to assist with needs assessment in the community. The individuals can be selected from one of two approaches, or as recommended by Green and Kreuter (1991), using a combination of the two, a purposeful sampling method.

There are two different approaches for selecting key individuals in an organisation. The first approach, the positional, looks at hierarchical banding and identifies individuals on grounds of position within the structure, i.e. one from each level. This could be translated in the LMFTs project evaluation to considering different types of people involved in the delivery of primary health care, from it's narrowest to broadest meaning. The second approach, the reputational, identifies those who are socially active, those prepared to give their candid views on the topic. The combination of the two approaches seems a way of achieving the best of both worlds and reaping the benefits of the distinct and different angles and either could be used in a snowball method of sampling.

### Method Of Achieving A Sample

Snowball sampling is a method whereby interviewee number one nominates interviewee number two, who subsequently names interview candidate number three and so on. Snowball samples have been used:

1. in sociometric studies, the focus here is on determining the connections made between networks, typically in small groups or teams;
2. in studies of elite groups where initial interviewees are selected by their formal role but the informal members are subsequently found through snowballing;
3. to determine the effects of participation in some programmes where no perfect control group can be found. The asking for the name of the next interviewee can be done according to predetermined criteria e.g. one who has been involved in a specific situation.

### Sample Biases Of The Snowball Sampling Method

The snowball sampling method is, like all selection methods, subject to some sample biases. The first bias is a lack of sampling variance, which can be overcome through the use of the stakeholders collaborative nominations. In a lack of variance there is perceived to be a low independence between sample members and thus clustering effects tend to show up. As the LMFTs project evaluation is looking at teams, networks, working together etc., the Cluster effect is being observed and thus should not present any problems (Sudman, 1976). The second bias is that a person who has a high profile is likely to be nominated several times over, leading to a sample bias.

This in the LMFTs project could however be used to advantage in that the most prominent named person is likely to be in Green and Kreuter's ( 1991) terms a key informant and therefore, someone who can speak for a particular Practice or PHCT.

### Adopting A 'Screening Scheme' To Avoid Biases

If the stakeholders were concerned about either of the above biases a screening procedure could be employed to address sample bias. For example, ask all the individual members of a Practice to nominate, in order of preference, three individuals they feel would be a suitable key informant. Then a comparison of their nominations would identify those names most prominent and one could either screen IN or OUT those individual names, particularly, if comparing with a list of previously greed criteria.

### Criteria Based Selection Of Nominees In Proposed Sample

Stakeholders, in the research steering group (RSG), raised various examples of criterion that they considered useful for selecting the sample of Practices. The evaluation is looking at different sets of relations, e.g. horizontal and vertical networks, collaborations, communication systems and two distinct areas: LMFT and Non-LMFT. The basis for identifying criteria can spring from these dimensions. In addition, using PAR means that developing the criteria and making the selection involves all stakeholders in the process. The following examples for developing criteria from were raised in the RSG discussions:

- select those Practices that have similar social demographics in surrounding areas;
- use the number of audit cycles each PHC Team has undertaken;
- select those with either a greater or lesser degree of Medical Audit Advisory Group involvement;
- select those that have or have not attended Local Organising Teambuillding workshops;
- select Practices with a similar number of clinical and non-clinical personnel;
- select those with health worker / voluntary workers involved in the Practice;
- select equal number of Practices from LMFT and Non-LMFT areas;

- select those in close proximity in each LMFT and non LMFTs involved Cluster, or the reverse;
- select those Practices that are as far away as possible from the LMFTs, geographically and professionally;

These criteria may relate to both LMFT and the Non-LMFT PHC Team selection and to the nomination of interview candidates from each Practice. If you have further suggestions for criterion once you have had time to consider these issues for yourselves please ensure they are received at the next RSG meeting.

## Issues Involved In Selecting A Purposeful Research Sample For The LMFTs project Evaluation

1. **Issue: disproportionate number of teams**

   The first issue to address is the fact that we have what Sudman (1976) describes as a disproportionate number, 4 LMFT areas and 3 non-LMFT areas. It is proposed that 4 non-LMFT Practices and 4 LMFTs Practices be selected and subject to any criteria we establish. This gives 8 Practices in total.

2. **Issue: number of interviews**

   The number of key informant interviews it would be realistic for the researcher to undertake was agreed as 20. It is proposed that 3 interviews per Practice, that is 24 in total, would provide reasonable coverage of the different perspectives in the Practice, e.g. administration, medical, health professional. There remains an option to undertake a fourth key informant interview if time constraints permit or circumstances suggest this is required.

3. **Issue: how to select key people for interview from the Practices**

   The process of participation and collaboration is extended to the Practices once they have agreed to become involved with the LMFTs project evaluation. In keeping with this approach and utilising it in the Practices can be encouraged to nominate, using the snowball sampling scheme, their own key informants for interview and set their own criteria against which to assess their nominations. For example, a cross disciplinary representation of key informants.

4. **Issue: develop a scheme for regularly feeding information back to stakeholders.**

In order to obtain a full CLEAR picture of what is happening there needs to be an agreed way whereby those stakeholders involved meet and discuss what is going on and what is being found out. This need not be too rigid a scheme but it is particularly important that we meet to critically reflect on the data gathered. Integral to the PAR approach is the need to establish regular feedback sessions, this maybe on 'one to one', or with a LMFT, Practice, community group, or group of managers or within the RSG, as appropriate. The purpose is to share information, critically reflect on data gathered, verify the conclusions drawn and promote the use of the information gathered. As the evaluation progresses the researcher moves cyclically between periods of data collection and periods of reflection on the data. The feedback and critical reflection sessions with stakeholders is essential for understanding the meaning and accuracy of the data, for generating new interpretations derived from different stakeholders views, and for revealing emerging issues surrounding the LMFTs project and its evaluation.

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# APPENDIX 4

## THE PARTICIPATORY PROCESS FOR DEVELOPING THE FRAMEWORK FOR EVALUATION IN THE RESEARCH STEERING GROUP AND IN THE SECONDARY PARTICIPATORY WORKGROUPS

The PAR approach that was used permitted stakeholders to create and make on-going refinements of the framework for evaluation. It was an emergent research design. Key to the process was for representatives of the different stakeholders, forming the research community, to understand, find meaning and mutually learn by establishing participation and dialogue. Participatory methods were used to develop interactive and dynamic relationships among participants for the exchange of claims, issues and concerns. The emphasis was on local knowledge creation. Bringing stakeholders together in this way was, thereby, to develop the research framework using a hermeneutic dialectical methodology (Guba and Lincoln, 1989, 1994).

The use of participatory processes was founded on the idea that people were considered to be self-determining - given some help - and that working together in a group that fostered truly open communication processes could both facilitate an individual's ability to 'grow' and self develop (Heron, 1984) and an organisation's capacity to learn through posing and solving its own immediate problems (Friere, 1972; Pedlar, et.al., 1991; Swieringa and Wierdsma, 1992). To this end the stakeholders were invited to form participatory workgroups which aimed to provide a setting in which to:

- explicitly develop an opportunity for dialogue between the different stakeholders;
- find ways to work with contextual issues influencing the evaluation;
- create a dialectical exchange of views between stakeholders;
- progress through the 'reflection phase' of a series of action research cycles;
- regularly feedback to the stakeholders;
- develop mutual learning;
- produce collective knowledge as a basis for action and decision making.

**The first participatory workgroup held with the RSG.**

The first step was for the researchers to introduce, in detail, the nature of the PAR approach and the proposals as given in the tender for evaluation, appendix 2. The group was then divided into two to undertake the groupwork.

The groupwork was divided into two halves:

1. thirty minutes was spent exploring what was understood to be the purpose of the LMFTs, and,
2. thirty minutes was used to identify the aim and clarify the criteria for evaluation.

Two sets of trigger questions were used to initiate participation and access stakeholders views, e.g.

Set I: what is the LMFTs trying to do? what changes do you expect to see?..., and,

Set 2: what do you want to find out?; who is the information for?; what sort of change? when do you need the information? ...,

Each group was facilitated by one researcher. The development of the evaluation approach was broken down into these three parts:

- determine what was understood to be the purpose of the LMFTs and clarifying evaluation criteria;
- identifying and including key concerns;
- designing the data gathering activities, that is deciding most appropriate research methods to use and specifying the scope of the research.

The stakeholders, working in pairs and using the trigger questions, talked through their ideas with each other before comparing views in their half groups. The half groups recorded their views on flip-charts. After one hour the stakeholders met as a whole group to exchange and explore each others views and find out where their ideas corresponded and differed. The first two parts given above were discussed in the first RSG meeting.

After this meeting the researcher, using the stakeholders' ideas, created the first tentative evaluation framework. The flip-chart statements were categorised into nine themes to produce the first working document which was separated into two parts: LMFTs and PHCTs (table 23). The first framework was circulated to all the RSG members two weeks in advance of their next meeting to allow for pre-meeting reading and thinking. This was preparatory to the next RSG in which stakeholders, as part of the dialectical process, were brought together to encounter, communicate and try to make sense of each other's views (Reason and Rowan, 1981; Guba and Lincoln, 1989) (figure 23).

**Second and subsequent participatory group work.** This was continued in a similar manner to the above. However, whenever pairs were used stakeholders were asked to seek different partners to further the development of relationships and achieve a better understanding of each other's views. The second RSG workgroup undertook a critical examination of the nine themes in the first working document. The second RSG closed after two hours without discussing the operational objectives specific to the LMFTs. In order to maintain the momentum the researcher proposed, and the RSG agreed, that a secondary participatory

workgroup should be organised. This was formed by willing members from the four different stakeholder groups. They were appraised beforehand, by their key representatives, on progress to date. The group was facilitated by the researcher as they worked through the unfinished section. The information from this secondary participatory workgroup was combined with that from the RSG, to produce the second working document. This process of critical reflection on the work of previous meetings continued in this participatory and cyclical fashion until a third document was produced and adopted as the working research framework for the evaluation.

Rowan's model (Reason and Rowan, 1981:98) helps to conceptualise the different states stakeholders were expected to move through, individually and as a group, to produce results in Phases 1, 2 and 3 of the evaluation. The dialectical research cycle was described by Rowan as a circular process made up of four transient states: being, project, encounter and communication through which research participants work, in turn, until each state is exhausted of all knowledge giving. There were also two other states underlying the four transient states, thinking: an inventive, creative and refining activity that becomes the sum of being and project; and, making sense: an analytic and contemplative activity that creates a synthesis of experience and knowledge (figure 23 in section 4.25).

Each stakeholder arrived at the first participatory workgroup with their particular 'primary' construction of reality. This was their way of being-in-the-world that they would 'project' as their understanding of reality to other stakeholders. In the participatory workgroups each stakeholder encountered the views of others views, either as a personal exchange or as a receipt of feedback from the evaluation. To develop a secondary or collective construction of reality of the LMFTs model the stakeholders had to become involved in a situation that helped them to prepare for, and undergo, a re-construction of their own world view. The stakeholders in the LMFTs model engaged in and moved through a process which permitted them to experience conflict and contradiction of their own beliefs as they were confronted by the perspectives of the other stakeholders. The dialogical exchange was the process by which stakeholder's encountered and, subsequently, modified their primary construction of the LMFTs model as they developed and implemented the framework for evaluation. Ultimately the participatory and interactive methods of the PAR approach aimed to produce a framework for evaluation that met the needs of all the stakeholders involved and to implement the framework for evaluation in a collaborative manner.

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# APPENDIX 5

## GENERAL CHECKLIST AND SEMI-STRUCTURED INTERVIEW SCHEDULE

### PART ONE : GATHERING INFORMATION ON DAILY ACTIVITIES IN THE PRACTICE

**Introduction** These questions are being addressed by the researcher during the visit to the Practice. The answers to the general questions provides some of the background information to the Practice profile. You are welcome to add in your comments or details in any of the sections as relevant.

*(The checklist was available for all personnel to read and used in the Practice as an explicit data collection process. In practice the actual checklist offered a page per question to allow for note taking during participant observation and the addition of Practice member contributions).*

#### Personal, Team And Organisation Development

**G.1. General Practice Information Systems**

**G1.1 In the day to day work of the Practice what ways are used to provide people with the information they need to do their jobs.**

Prompts:

diaries; appointments; telephones; computers; meetings & format; noticeboards; communication boards; memo systems; tagging- medical records; messages; post in/out;

**Meetings:**

Prompts:

organising meetings; types of; how often; who attends; use of: chair, agendas; minutes; action points; where: environment and atmosphere of; general working pattern of - describe / draw the scene to tell the story of the meeting(s);

**G1.2 What do you do when making a decision on the care a patient is to receive.**

Prompts:

autonomous; chain of discussion; guidelines/protocols; referring a patient, organising a home visit; recording particular illness factors; repeat prescriptions; respite care; emergency appointments; adding to medical records / manually or via computer;

**G1.3 What do you do when putting together:**

Prompts:

The information for the FHSA annual report;

The age/sex; disease or other registers, The recall systems; An audit;

## G2. Role Clarification

**G2.1 Are there job descriptions for everyone's specific position?**

Documents:

**G2.2 Have the job descriptions been brought up to date recently?**

Prompts:

If so, who was involved with this:

**G2.3 Are the management / administration / clinical tasks shared out?**

Examples:

**G2.4 Are any tasks seen to be duplicated?**

Examples:

**G2.5 Are there any particular activities observed aimed at developing the personal or professional capabilities of any PHCT members:**

Prompts:

Whose takes responsibility for this? Who is it for? Who does what? Any links with others: educational or local people - voluntary? e.g. environment or waiting room projects, any connections with individual health workers, local groups...

## G3 Working Together

**G3.1 What policies and plans does the Practice have to guide it's day to day work?**

Prompts:

overall statement of the aims; specific objectives; plans showing the way the GP/PHCT are to work; any special ways (procedures) of dealing with particular things: case notes, special diseases, clinics, management or educational /training points; an annual Practice plan; a business plan produced ?

**G3.2 Who writes the annual plan?**

Prompts:

who else gets consulted or involved:

**G3.3 What ways of undertaking an audit of Practices activities are evident?**

Prompts:

written standards to match selves against: listed Practice priorities and periodic reviews: any other ways?

**G3.4 Who writes any of these documents: standards, protocols etc.**

Prompts: how decided upon; examples of; when written: / updates;

**G3.5 What day to day difficulties are observed?**

Prompts:

administration; professional; clinical; patient issues; personal issues;

**G3.6 How were the difficulties handled?**

Prompts:

what mechanisms; by whom;

## G4. Service: Meeting Health Needs

Looking at the types of primary health care services the Practice provides.

**G4.1 Is there a list of what services are currently provided by this Practice?**

List:

**G4.2 What evidence of change over the past year (s)?**

Prompts:

changes to earlier routines; new approaches to, e.g. recall systems; new systems developed;

**G4.3 In changing any services who becomes most involved?**

List:

**G4.4 Who gets involved in running the new or improved services?**

Prompts:

if there are any, list:

**G4.5 What ways are being used to show how well the new approaches are working?**

Examples:

**G4.6 How does the Practice identify any vulnerable groups in your Practice population?**

Prompts:

who was involved; how; were local people asked?

**G4.7 Who chiefly makes these decisions?**

Prompts:

list / rank / order:

**G4.8 What plans are there for the future development of the Practice?**

Prompts:

documents:

## PART TWO PHASE ONE AND TWO: THE SEMI-STRUCTURED INTERVIEW SCHEDULE

This interview schedule was used with key informants from the 4 sample Practices distanced from the LMFTs intervention programme. (The use of capital letters in the interview questions was to provide the researcher with a prompt that could be grasped at a glance). A preliminary Information Sheet this was given to the Practice at the time of nominating key informants for interview, point out that:

- The purpose of the interviews is to collect standard data from the Practices involved.
- The questions examine, further, the four areas explored in the general data collection sheet used earlier in the Practice.
- The task of the interview is to allow the researcher to be brought into the world of the interviewee through the use of the framework provided by the questions.
- The researcher holds the responsibility to get the right responses from the interviewee.
- The focus of the questions is looking at change to working practices. This will be adding a qualitative dimension to the FHSA quantitative data already gathered within each Practice.
- The findings in the longer term will be used to help the Practice develop their own profile which can be used as a tool for monitoring their own work practices.
- The content analysis is looking for themes that emerge as change takes place. The areas considered in the evaluation are: personal development; organisational development; the services provided to meet local health needs and the wider setting, particularly networking and collaborating activities.

### Introductory Sheet For The Key Person Being Interviewed

(This sheet was worked through with the interviewee immediately prior to the interview).

- Thank you for agreeing to be interviewed by me.
- This interview is my opportunity to get to know, in more detail, how the Practice organises its day to day work. I used to work as a nurse in a Practice myself so I understand something of the daily events.
- The interview is divided into five parts. Each is intended to take no longer than 15 minutes. These can be split up into different sessions if you don't have the time to go through it all at one time.

- With your permission I would like to record the session. This may, at first, put you off but as you get into the interview I hope you find that you forget all about it.
- If you feel you there is something you want to say that is particularly sensitive and don't want recorded please switch the recorder off yourself.
- This interview is confidential. Your name will not appear on it anywhere and the information will be used in an anonymised way.
- When I have transcribed the taped interview I will ask you to meet me again to check that I have understood correctly what you had said.
- The findings of the research will be given back to the Practice in a general way with no specific identification as to 'who said what'.
- Finally, as time is precious, would you accept me bringing you back to the point during the interview if you become side-tracked?
- Are you comfortable and ready to do this?
- What time do you have available today, how do you want to do this?

## PERSONAL, ORGANISATION, SERVICE & COMMUNITY DEVELOPMENT

### Part 1 Mapping Exercise

We begin with a bit of fun by the mapping 'connections' board activity.

**K1. Mapping communication patterns**

*This aims to show the communication patterns that most commonly occur within the Practice.*

- Please MAKE A LIST of the names, in the journal, of the people you think of as part of your Practice.
- Have you used a magnetic board before? *If not, I will talk you through how to use it.*

**WILL YOU PLEASE:**

K1.1 Plot on the board, using the names you have written on the hexagons, how you view the formal patterns of communication within the Practice.

K1.2 Using a coloured pen indicate the links made between the people involved. As you do this describe to me the purpose of these links.

K1.3 What are the contacts you make with others outside the Practice in relation to your role?
***Please add these to the first board.***

K1.4 Please list the different ways you contact these people.

K1.5 Are there certain people that you are more likely to approach when trying to solve problems of your own? ***Please plot these on the second board.***

*e.g. administrative; clinical; patient; role; personal issues;*

K1.6 What strength would you give to the link that you have made with the people you have identified?

*Number 10 indicates the strongest connection.*

## Part 2 Personal Development

K2. **Role** - that is the type of work that you and others do in the Practice.

K2.1 How well do you feel you are PREPARED for your ROLE?

*e.g. opportunities for training / further education are?*

K2.2 What OPPORTUNITIES are there for PERSONAL DEVELOPMENT?

K2.3 What are your PERSONAL AMBITIONS?

K2.4 What kind of DIFFICULTIES do you EXPERIENCE in relation to your ROLE in the work situation?

K2.5 How do you DEAL WITH CONFLICT in your position?

K2.6 What HELPS YOU THROUGH the DIFFICULTIES you have just described?

K2.7 How well does the WORK you do in this Practice MATCH your JOB TITLE?

K2.8 ... and MATCHES your EXPECTATIONS?

K2.9 ... and MATCHES your JOB DESCRIPTION?

## Part 3 Organisation Development

K3. **Working together** - this part is looking at how you work together.

K3.1 Are there COMMON IDEAS on what you are all aiming for?

K3.2 What have YOU DECIDED to do to help the Practice REACH its AIMS?

*e.g. common agreements; ways to work, to meet, to make decisions?*

K3.3 When do you ALL MEET TOGETHER TO DISCUSS HOW WELL you are PROGRESSING?

K3.4 What part have YOU played in helping to MAKE these DECISIONS?

*prompt: the key decision makers are ?*

K3.5 How do YOU get INVOLVED with the practical side of ORGANISING Practice work?

*e.g. general organisation / management of the work; writing guides; rota planning; specific management tasks; ? like more or less involvement;*

K3.6 When does WORK get DONE TWICE?

K3.7 How do you THINK the way you all WORK AFFECTS RUNNING of the PRACTICE?

K3.8 How do you FEEL about the STAFFING LEVELS here?

K3.9 How do you FEEL about the way INFORMATION is SHARED?

K3.10 What would YOU like to SEE CHANGE?

K3.11 How do you FEEL about the WAY all WORK TOGETHER?

K3.12 What PHRASES would you use TO DESCRIBE how you and your colleagues WORK in this practice? *Write or say.*

**Part 4** **Service And Community Development**

**K4** **Meeting health needs** - that is the primary health care services provided by the Practice.

K4.1 How have YOU been INVOLVED in IMPROVING any SERVICES?

*e.g. thinking up - ideas, putting service together, running service?*

K4.2 How do you feel the SERVICES provided by the Practice MEET what the LOCAL PEOPLE NEED?

*e.g. were you asked for your opinion?*

K4.3 How do the VIEWS OF LOCAL PEOPLE become known?

K4.4 How does the Practice INVOLVE OTHER HEALTH PROFESSIONALS in decisions about service provision?

*e.g. invited to talk, plan, shared projects / work;*

*- whose views? multi-disciplinary or multi-agency meetings?*

K4.5 What can you SAY about the Local Multidisciplinary Facilitation Teams (LMFTs)?

*e.g. met them, been to the Practice, attended neighbourhood meeting?*

K4.6 How do you feel about the WAY SERVICES are ORGANISED?

K4.7 How do you feel about the STANDARD of services provided?

K4.8 Are there ways of MONITORING your services?

*e.g. protocols; audit; number of patients seen;*

K4.9 How would you IMPROVE service delivery?

K4.10 Where did you GET these IDEAS from?

K4.11 What Practice PLANS are there in the future?

K4.12 How will YOU be INVOLVED?

**Part 5** **Closing The Key Person Interview**

- Thank you for giving your time and your views.

K5.1 Is there anything that you think I have not covered?

*e.g. any more that you would like to say; any issues you want to raise; or anything else at all?*

K5.2 Is there anything that has left you feeling uncomfortable?

*NB. on / off record*

K5.3 Before we finish would you mind filling in your personal profile sheet?

K5.4 Will it be all right to get in touch with you later on?

*- after transcribing - for checking understanding and accuracy*

- *Thank you. It was very important to hear your views for both the Practice and for LMFTs evaluation.*

**Part 6** **Key Person Profile Sheet**

**K6**

Practice code:

Group code:

Male/female

**(delete as appropriate)**

Occupation:

Time in current occupation:

Previous occupation:

Time in previous occupation:

Length of time in this Practice:

Length of time in any other Practice:

Contact telephone number(s):

(if different from the Practice)

Thank you very much.

Lynne D. Graver

# PART THREE - PHASE THREE :ADAPTED VERSION OF THE ORIGINAL SEMI-STRUCTURED INTERVIEW SCHEDULE

This interview schedule was used with key informants from 20 sample Practices directly involved with the LMFTs intervention programme

## Introductory Sheet For The Key Person Being Interviewed

(This sheet was worked through with the interviewee immediately prior to the interview).

- Thank you for agreeing to be interviewed by me.
- This interview is my opportunity to get to know, in more detail, what Practice changes have occurred as a result of the LMFTs intervention programme. I used to work as a nurse in a Practice myself so I understand something of the Practice activities.
- The interview is divided into five parts. Each is intended to take no longer than 5 minutes making the interview approximately 25 - 30 minutes long. Do you have this amount of time available right now? With your permission I would like to record the session. This may, at first, put you off but as you get into the interview I hope you find that you forget all about it.
- If you feel you there is something you want to say that is particularly sensitive and don't want recorded please switch the recorder off yourself.
- This interview is confidential. Your name will not appear on it anywhere and the information will be used in an anonymised way.
- When I have transcribed the taped interview I will ask you to meet me again to check that I have understood correctly what you had said.
- The findings of the research will be given back to the Practice in a general way with no specific identification as to 'who said what'.
- Finally, as time is precious, would you accept me bringing you back to the point during the interview if you become side-tracked?
- Are you comfortable and ready to do this?

## Part 1 Personal Development

C1.1 Tell me how the Practice got involved with the LMFTs [facilitators]?

**ROLE**

C1.2 What changes have you observed as a result of the LMFTs intervention programme?

C1.3 What role have you played in the changes?

C1.4 How have you benefited from the LMFTs interventions?

**Part 2** **Organisation Development**

**WORKING TOGETHER**

C2.1 What activities have altered as a result of the changes?

e.g. administrative / clinical / new procedures

C2.2 Who else has become involved?

**Part 3** **Service Development**

C3.1 What service development has the changes led to?

C3.2 How will the changes be monitored?

**Part 4** **Wider Community Setting**

C4.1 How have relationships changed with other Practices in the area?

C4.2 How has the Practice become involved in working with other health agencies in the local area?

**Part 5** **Closing The Key Person Interview**

- Thank you for giving your time and your views.

C5.1 Is there anything that you think I have not covered?

*e.g. any more that you would like to say;*

- *any issues you want to raise; or anything else at all?*

C5.2 Is there anything that has left you feeling uncomfortable?

*NB. on / off record*

C5.3 Before we finish would you mind filling in your personal profile sheet?

C5.4 Will it be all right to get in touch with you later on?

- *after transcribing; - for checking understanding and accuracy.*

- *Thank You. It was very important to hear your views for both the Practice and for the LMFTs evaluation.*

(A key person profile sheet, as described earlier, was used following each the interviews).

# APPENDIX 6

## STAKEHOLDERS CLARIFYING THEIR MEANING OF DEVELOPMENT IN RELATION TO PRACTICES

### First Step

A descriptive framework was created, by the stakeholders, from looking at the data from the Practice in the Pilot study. The themes of the descriptive framework for analysing Practice data is given below.

| | |
|---|---|
| **1. Personal**<br>1. How individual development needs were defined and met;<br>2. Clarity with regard to own role;<br>3. Clarity with regard to each others role;<br>4. Attitudes displayed towards each others PHCT roles;<br>5. Levels of responsibility accepted by individuals for their own work;<br>6. Use made of personal appraisals;<br>7. Levels of commitment shown towards achieving aims of PHCT. | **2. Organisation**<br>**Teams**<br>1. Levels of team consciousness shown towards supporting team work;<br>2. Levels of integration of team members;<br>3. Development of working relationships;<br>4. Ways conflict was handled;<br>5. Degree of shared planning and problem solving.<br>**Organisation**<br>1. Organisational structure of the PHCT;<br>2. Daily patterns of activity in the PHCT;<br>3. Ways PHCTs developed Practice aims / objectives, policies … .<br>4. Methods of working as a group;<br>5. Systems of communication used for handling information;<br>6. Systems of communication used for sharing communication;<br>7. Ways the Practice monitored activities;<br>8. Review of progress towards reaching Practice aims. |
| **4. The Wider Setting**<br>1. External activities that influenced Practice development. | **3. Service**<br>1. Methods of identifying local health needs;<br>2. Service developments made recently;<br>3. Development of collaborative activities with other people;<br>4. Audit of the services provided and its subsequent uses;<br>5. Patient's views of services. |

## Second Step

As the data from Practices accumulated a clearer picture of the process of development in Practices began to emerge. As a result of their critical reflections, the stakeholders were able to begin to define their meaning of development in relation to the Practices. Development was deemed as a process that took time to achieve. It was related to the four areas considered in the evaluation. In keeping with the four areas considered in the evaluation development was looked upon as having four different dimensions within a Practice. Development was seen as context specific and identifiable by looking at or for changes occurring in the personal, organisation, service or wider community associated with a Practice. The criteria agreed between stakeholders in phase one were used, in conjunction with information from sample Practices in phase two, as the basis on which to define a 'working' meaning of the four dimensions of development as applicable to a Practice, see outline below.

| Dimensions Of Development | Criteria |
|---|---|
| **Personal Development** | • Growth of people's skills and confidence;<br>• Clear definition of own and other's role;<br>• Recognition of own limitations;<br>• Accept skill's of others as complementary to own role; |
| **Organisational Development** | • Explore and ensure the efficient use of each others skills;<br>• Use of personal development plans to identify training needs;<br>• Change of work practices to increase the level of efficiency;<br>• Change in work patterns to improve the level of communication and teamwork; |
| **Service Development** | • Explore the needs of the local population;<br>• Use audit as a tool for review and reflection of current practice;<br>• Change or expand services to meet needs of population; |
| **Wider Community Setting** | • Undertaking mutual problem solving activity;<br>• Working together on local community initiatives; |

The development in relation to the Practices was defined in terms of the changes that occurred as a result of the LMFTs interventions. Stakeholders looked at each Practice individually to gauge their level of development.

### Personal Development

Personal development was related to the idea of self development of an individual. It was proposed to occur when the LMFTs facilitation methods: assisted the growth of people's skills and confidence in the job they were doing; helped those involved to define their own professional role more clearly; helped those participating to learn to recognise the limit of their own skills; and finally, helped participants to discover where the skills of others were complimentary to their own role and utilise them accordingly.

**Organisation Development**

Organisation development was thought of in terms of administrative and team development, and effective collaboration, e.g. making connections with other health professionals and working together as a Practice team. This was said to become visible when people had learnt, through the LMFTs interventions, to explore the efficient use of their different skills to resolve local problems and plan joint action. For example, a result may be the changes made to the current administrative patterns to improve the way the Practice functions. Organisational development was considered to be happening when people began to co-operate with each other to make the whole PHCT more effective.

**Service Development**

Service development was related to the improvement in the delivery of PHC and meeting local health needs. This was said to be taking place when changes to service delivery were made based on the health needs of the majority of the local population. An example would be when people were working as a team or developing local information networks or when they had learnt how to step over their traditional role barriers to tackle local health issues together. A subsequent effect may be demonstrated when a Practice seeks to audit their own service provision or question the quality and appropriateness of current services. These were changes that helped to constitute the shift towards providing a service that was driven by the health needs of the local population and which used local resources to a maximum effect.

**Development in the Wider Community**

This was related to Practices working together on particular local health issues. This was when examples of problem solving demonstrated a combined effort between different Practices and showed them to be building information networks and good working relations between each other. It was considered to be happening when there was a move away from individual's and individual Practices solving problems towards more collective and collaborative action. A further effect may be the inclusion of other health workers from the local community in the effort to address a local health need.

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# APPENDIX 7

## A PRACTICE REPORT

## INTRODUCTION

This report is developed within an organisation development framework. The Practice is viewed as a small organisation and as having four dimensions, see below. The activities of the Practice were assessed according to those which were occurring within these four dimensions. This report provides a baseline which the Practice can use in later reviews to assess its further development. It is intended to be supplementary to the annual report the Practice produced in 1995.

**The activities of the Practice were examined as follows:**

| **Part 1 Personal** | **Part 2 Organisation** | **Part 3 Service** | **Part 4 Wider Community Setting:** |
|---|---|---|---|
| • self development<br>* personal growth<br>• the ability to facilitate<br>• role clarification | • team development<br>• organisational development<br>• effective collaboration<br>* making connections<br>* working together | • the improvement in the delivery of primary health care<br>• meeting local health needs | • changing political climate<br>• interventions<br>• collaboration |

The assessment provides a baseline on how the Practice was working towards meeting its aims. The document is written in a form that provides suggestions on how the Practice can improve its development processes and not simply as an analytical report, it is a learning tool. It highlights those activities which promote Practice development in each of the four areas as well as those more likely to do the reverse. Development is viewed as a dynamic process and some of the activities that promote growth today may become inappropriate at later date. Thus, for development to continue activities need reviewing at regular intervals. They may need adapting or discarding depending on particular circumstances in the Practice. The Practice develops a 'learning cycle' through a repeated process of planning, experimenting, auditing and review or reflection. The assessment therefore provides the Practice with a yardstick against which to review current activities. Remember this was looking your Practice in terms of organisational development. There were no right or wrong answers but certain activities that were more or less likely to promote Practice development. This assessment includes some suggestions for helping to create more united, proactive and co-operative ways of working towards developing your Practice. These suggestions are made in keeping with using an organisational development approach that simultaneously helps people, organisations and service improve their patterns of working together. This is so that people can learn from each other as they cope with the ever constant change present in PHC today.

This assessment was created from information gathered from June 1995 - May 1996 and is divided into four parts: personal, organisation, service and the wider community setting. Each part includes recommendations (abbreviated to R. in the text) for improving Practice development, following which the recommendations are put together in one section for ready reference. Finally, the attached sheets (set 2) contain a set of charts the Practice may find useful for recording the assessment of change and development.

## PART ONE

## PERSONAL DEVELOPMENT

| The assessment looked at: | |
|---|---|
| 1 | How individual development needs were defined and met; |
| 2 | Clarity with regard to own role; |
| 3 | Clarity with regard to each others role; |
| 4 | Attitudes displayed towards each others PHCT roles; |
| 5 | Levels of responsibility accepted by an individual for their own work; |
| 6 | Use of personal appraisals; |
| 7 | Levels of commitment shown towards reaching the aims of the PHCT; |

### 1 How Individual Development Needs Were Defined and Met

The Practice members were largely responsible for determining their needs for themselves. These were discussed on an ad-hoc basis and mainly addressed by using the tailor-made courses supplied by the drug companies or those provided by the FHSA. It was evident from several comments that the management of the Practice fell mainly to one doctor and the practice manager who had recently been promoted from a receptionist role. The doctor commented that he had had "no formal training" and felt that his "administrative skills were lacking" as had the practice manger who was aiming to complete the FHSA's Practice Managers Course later in the year. The attached staff looked to the Trusts that employed them and the requirements of their professional governing bodies to guide their personal development. In general, those employed by the doctors felt that they were prepared to meet their development needs whenever possible, however, some members were not clear what was needed by or expected of them as the Practice went forward to become fundholding.

**R1.1 Management needs to formalise its current approach by setting up a system of staff appraisal through which to identify and prioritise personal development e.g. education and training needs of those in their PHCT.**

### 1.2 Clarity With Regard To Own Roles

Each person gave a fairly clear view of their current role within the Practice but were concerned to know how fundholding would affect their work in the future. Comments from some Practice staff

showed that they felt unclear about where their role ended and another person's began, this has, on occasions, caused friction when someone seemingly 'oversteps the mark'. Whether related to the move to become fundholding or to some other cause, tensions were seen to increase and spill over into conflict as each person tried to cope with the fraught situation. This resulted in some staff narrowing down their activities in order to avoid anymore friction. Over the longer term this type of work pattern limits the scope for working together for the benefit of both patients and the Practice.

**R1.2** **A conscious effort needs to be made to determine the boundaries of individual roles.**

**1.3** **Clarity With Regard To Each Others Roles**

The extent to which there was knowledge and understanding of roles within the different groups in the Practice was varied e.g. when making use of skills appropriately. On one occasion the same request was made to three people, irrespective of their different disciplines. This showed that the different roles, knowledge and skills were not fully understood and therefore people were more likely to be inappropriately 'used'.

**R1.3** **A conscious effort needs to be made so that each member of the PHCT may understand each others role.**

**1.4** **Attitudes Displayed Towards Each Others PHCT Roles**

The attitudes displayed towards the value of each others roles in the Practice varied. Generally, it was recognised that each person made a specific contribution to the Practice as a whole. In practice, every day activities were fraught with the tension of trying to cope with difficult and changing circumstances. This intermittently resulted in individuals pulling in opposite directions. In this situation a person may become judged on the activity presenting on the surface without colleagues understanding the wider reasons for the activity shown.

In some instances it was evident that an individual 'danced to two tunes' one belonging to their particular profession and function within primary health care and the other relating to Practice activities. The working practices of each may not necessarily amount to the same thing. The overall effect of this sometimes meant individuals were not always pre-disposed to give their best in either direction.

**R1.4** **An overall view of the Practice needs to be developed so that each person sees where their contribution, and those of others, fits into Practice as a whole.**

**1.5** **Levels Of Responsibility Accepted By An Individual For Their Own Work**

Each person readily accepted responsibility for their own job. There was a difference where health professionals accepted responsibility for developing their work within broad guidelines, whereas those employed by the Practice were largely bound to tasks based on their job description or past practice. This difference, in practice, meant the health professionals were more able to take up a 'developmental' approach to their work practices than the employed Practice staff. Over time, this may hamper a Practice that was trying to develop different ways of working for the benefit of the Practice as a whole.

**R1.5** **The Practice needs to develop a more experimental attitude to avoid creating rigid working practices and to promote co-operation across the whole PHCT.**

**1.6** **Use Of Personal Appraisals**

Personal appraisals were undertaken informally, each person identified their own particular needs and made their own approach to the practice manager or doctors. For some however this was a difficult thing to do, the lack of a recognised route to discuss education or training needs was considered as asking 'favours' rather than being seen as being beneficial to the Practice as well as the individual. Similarly the lack of a recognised way of discussing progress or problems at work may have caused a rise in the tensions present in the Practice.

**R1.6** **There is a need to provide a method where praise, acknowledgement, criticism and solving problems is regularly used. This provides a meeting point where progress and development can be discussed openly.**

**1.7** **Levels Of Commitment Shown Towards Reaching The Aims Of The PHCT**

The aim of the Practice was not written in any report as a specific intention but as a result of the team-building weekend was described as working to " provide a good and efficient service to the patients."

Individually PHCT members held a personal level of commitment to their own specific work. Secondly, most if not all members of the specific groups identified (map 1) showed their commitment by doing their own work and avoided leaving it for anyone else to do within their immediate group. Across the Practice, however, commitment, and therefore co-operative working between groups, appeared to decrease. There was evidence that developing a shared system of work between clinical and administrative activities had not yet reached a smooth working pattern. The effect of failing to co-

operate may lead to a further reduction of commitment in some and, in others, lead to 'burnout' given the plan to take up fundholding activities in the near future. Both results affect the PHC team and works against rather than towards reaching the Practice aims.

**R1.7** **The continued development of a shared system of work between clinical and administrative activities must be achieved to maintain commitment and effective use of everyone's time and skills.**

## PART TWO

## ORGANISATION DEVELOPMENT

| **The assessment looked at:** | |
|---|---|
| **Primary Health Care Team** | |
| 1 | Levels of team consciousness shown; |
| 2 | Levels of integration shown; |
| 3 | Development of working relationships between members of the PHCT; |
| 4 | Ways conflict was handled; |
| 5 | Degree of shared planning and problem solving evident; |
| **Organisation** | |
| 6 | Organisational structure of the PHCT; |
| 7 | Daily pattern of activity in the PHCT; |
| 8 | Ways the PHCT developed the aims, policies and procedures; |
| 9 | Methods of working as a group; |
| 10 | Systems the PHCT used for handling information; |
| 11 | Systems the PHCT used for sharing information; |
| 12 | Ways the Practice monitored activities; |
| 13 | Review of progress towards reaching Practice aims; |

### Primary Health Care Team (PHCT)

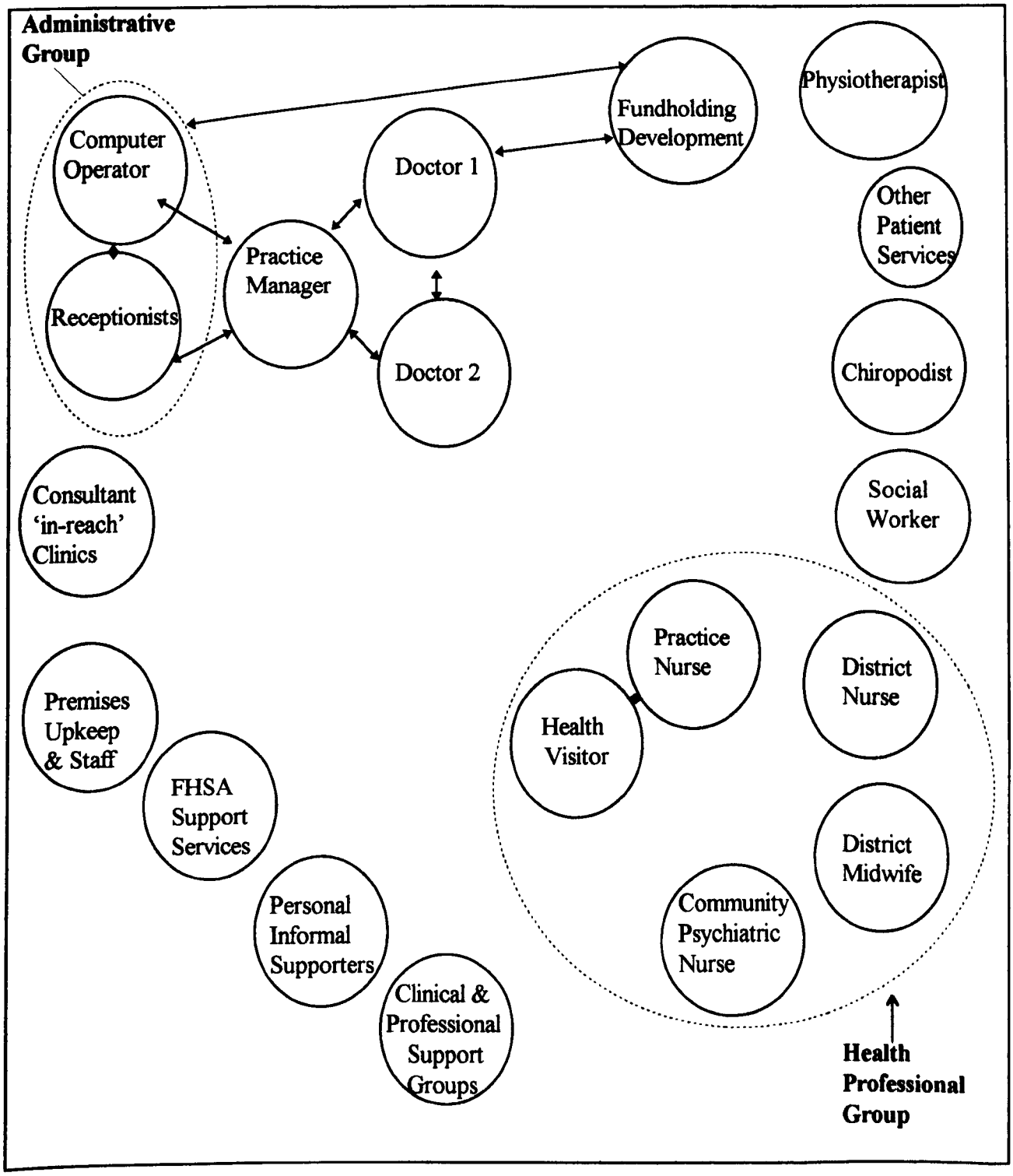
**2.1** **Levels Of Team Consciousness Shown By Members In The PHCT i.e. the activity which supported or undermined team effort**

Individually, within their home groups e.g. reception/administration and across allied disciplines e.g. the health visitor and practice nurse, members showed a fairly high level of team consciousness and mostly acted to encourage, develop and sustain team work between each other. This approach to team work occurred with specific activities and was not a general way the Practice members worked together. Although the amount of co-operative activity was increasing the lack of a generally agreed 'team work approach' tended to undermine the development of good working relationships in the team.

**R2.1** **The effort to encourage, develop and sustain team work needs to be consciously developed and extended to include all members of the PHCT.**

**Map 1**

**Showing The Way PHCT Members Felt They Associated With Each Other**




An explanation of this map is given in the two paragraphs below.

**2.2** **Levels Of Integration Between Members Of The PHCT i.e. the unity individuals felt with the whole PHCT**

The mapping activity, map 1, showed that the Practice defined itself as having distinct and separate groups.

On viewing the map as a whole, the groups can be divided into the clinical group and the administrative group with sub-groups internal to each division. A close union was not found between all the sub-groups or within one or two sub-groups, one person felt that, "[colleagues] could provide me more help" when undertaking management and administrative issues. The organisation maps were combined to provide a total view of the situation as given in map 1. The map shows the separateness and alliances of the main groups: a) health professionals and b) administration, which is indicated by the boundary lines drawn around them. The health professional and administrative groups felt that there was some co-operation growing between them. The doctors stood apart from either group. The senior doctor and the Practice manager worked as co-ordinators and mediators between the two groups as they managed the Practice.

The connections made beyond the immediate PHCT members were drawn as a separate groups on the periphery of the Practice boundary. They were linked to the Practice through the various services or help they provided as and when necessary. The doctors were regarded as overseeing the Practice as a whole, however the senior partner shouldered most of the responsibility. The health professionals located on-site considered themselves reasonably well connected to all other groups and used individual approaches to make their links. Those health professionals based off-site were more distant and not well integrated with the Practice. The receptionists and administrators formed a self contained group and related individually to all other PHCT members through their work.

**R2.2** **To continue to make efforts to increase the unity of PHCT members.**

**2.3** **Development of Working Relationships Between Members In The PHCT i.e. working together, in unity, to reach the aims of the PHCT**

The unity across the PHCT, as reflected in map 1 above, showed that the groups largely worked together very well inside their own specific groupings. This did not, however, happen between all groups in the Practice. These phrases, "low interaction", "I can give more help from an administrative point of view" and "friendly, hard working", were used to describe 'how the team works'. The words provide clues as to the climate and attitudes of some within the Practice as well as pointing to the need to develop better working practices in order to have both administrative and clinical work as if they were cogs in a single wheel.

**R2.3** **as R2.2.**

## 2.4 Ways Conflict Was Handled In The PHCT

Conflict was handled in several ways, firstly a semi-formal approach was described, where PHCT members went to the practice manager. This route had been used by several members from different groups, perhaps more so by those employed by the doctors. An issue, was then taken further by the practice manager, as necessary, in the attempt to resolve it speedily. In this situation the practice manager was used as a first line of approach before the senior doctor was approached.

The second approach described was where some of the health professionals preferred to go directly to those involved to sort the issue out as early as possible, attempting to resolve the issue by using a face to face approach. This could be between members of their own group or between others, e.g. doctors or reception staff and themselves.

The third approach observed and described was when the tensions were 'held in' and kept within the individual or specific groups. This situation was leading to frustration building up, there was also a potential for it to boil over if it remained unresolved. The following examples add weight to this statement, to quote, "it doesn't really get dealt with," or "I had two or three on one side, then others on the left...," "there is still a bit of a gap between the reception staff and the professional staff communication wise," and finally in relation to solving the conflict, it was said that, "we haven't found a real solution to that." The attempt to resolve conflict by either non-confrontation or in-experienced handling may result in the issues becoming escalated or prolonged and, in the longer term undermine the development of processes set up to resolve conflict. Conflicts left unresolved may be regarded as ignoring the needs of those team members involved and become the source of increasing job dissatisfaction.

**R2.4** **A specific and recognised approach to deal with conflict needs to be created.**

## 2.5 Degree Of Shared Planning And Problem Solving In The PHCT

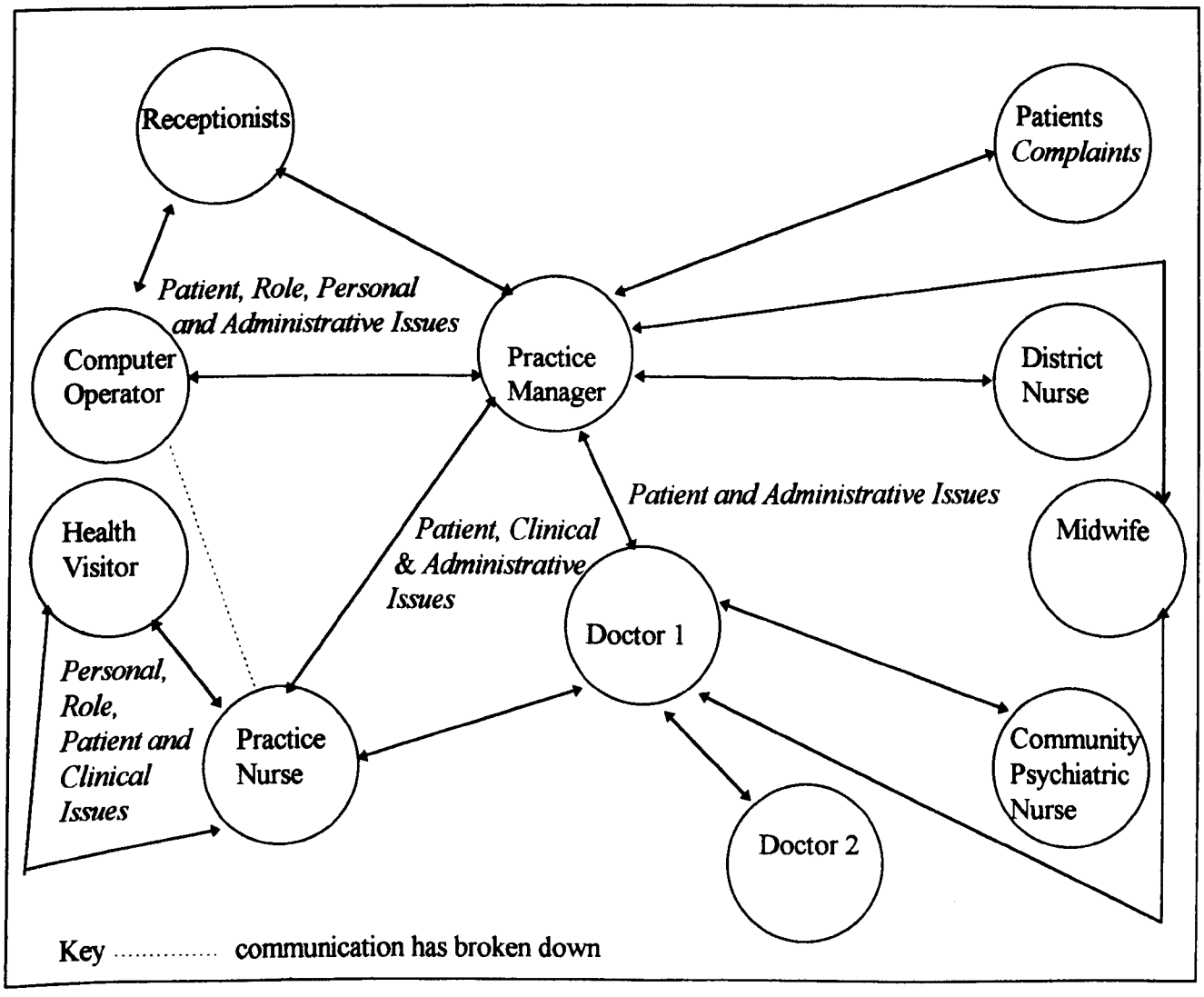
The degree of shared planning and problem solving varied and was dependent on the nature of the issues and the group it was likely to affect. A team-building exercise had been undertaken the previous year however much of that was now put on one side as the Practice tried to prepare for fundholding. At the time of this visit all Practice members, particularly the senior doctor and practice manager were trying 'to get to grips' with the meaning and implications of fund-holding. For example, in the words of one PHCT member, "I think the fundholding is taking over that much of

everybody's time ..., all this (organising the Practice) is taking a little bit of a back seat, it had to.., because there's so much going on you know." On the whole there was an intention to share the planning and problem solving around both administrative and clinical issues however this, as yet, had not become a cross-Practice activity and remained a way of working within particular sub-groups only (map 2).

**R2.5** **In the future, issues concerning managerial, administrative and clinical matters need to be shared with the rest of the PHCT to promote better systems of work and create a better understanding of each others contribution to the whole. Those decisions that affect other PHCT members should ideally include them, early on, in the decision making process.**

**Map 2**

**The Problem Solving Pathways Used In The PHCT**



## Organisation

### 2.6 Organisational Structure Of The PHCT

The Practice had a recognised senior partner who was regarded as the leader and the practice manager filled the next level of management. The structure of the Practice then moved away from this traditional or hierarchical structure as reception, administrative and health professional staff were ranked equally alongside of the practice manager, this created a 'flat structure' at a second level. This change provided a more democratic structure to the second level of organisation.

At the second level there seemed to be a clear move towards people becoming more equal, each having their individual role to play in the day to day working of the Practice. The managerial and administrative responsibilities although shared between doctors and the administrative staff were, at this time, largely carried by the senior doctor. It was recognised that everybody was either new to the Practice or in a new role, each having to learn their job as they did it. There were hopes that once everyone had settled down the Practice would take up further activities to promote the development of the Practice towards becoming a better organised system.

**R2.6 The initial steps towards recognising everyone as being equal have been made and needs to be continued to promote an integrated system e.g. one that the whole PHCT works inside of.**

### 2.7 Daily Pattern Of Activity In The PHCT

Each day the pattern of activity came across as busy almost frantic at times and great efforts were made to keep everything under control. The level of organisation was directly related to the numbers of staff being present at work - holiday or sickness exerted strong work pressures onto the rest of the staff. There was no spare time for anyone and the capacity for individuals and groups to have a wider view on how each person's job dove-tailed into the next person's e.g. practice nurse clinics and related administration systems or synchronising the work of midwives and doctors in relation to post-natal and baby checks, was at times limited. The inter-locking of work was vital to the Practice which had little spare capacity. This was an aspect that was in need of assessment and review, once fundholding was under way, to see where the organisation was working smoothly and where further work needed to be done.

The daily work described as being mostly under control, was also said to have developed 'isolated practices' e.g. some activities were developed in isolation from the rest of the Practice. In the current

situation, personal and organisational development could occur but was more likely to be stalling due to the lack of direction and the pressure of 'going fundholding'. For example, if each person was working to their own goals, no-one would be particularly concerned with working towards commonly defined and agreed aims. Personal and organisational development, in this setting, may become secondary to getting through the daily work. The process of development through experimentation becoming set aside for fear of 'not getting the tasks done' or through the lack of energy or drive towards finding better ways of doing things.

The Practice appeared to be primarily focused on the tasks of fundholding which was straining the ability of people to teamwork. The processes or internal workings of the Practice, e.g. two-way communication flows, information exchange and the sharing and resolving of problems together were increasingly difficult to achieve where there were no sustained methods for promoting team work.

R2.7 **A review of working practices in the organisation needs to be undertaken to assess the way individual goals 'fit' in with aim of the Practice as a whole. An adaption of either personal or Practice (organisational and service) goals may need to be made to ensure steady progress is sustained in all dimensions of Practice activity.**

**Secondly, the methods used to review working practices, make decisions or change working patterns etc., can at the same time help people, organisation and service develop through promoting team work, see example in 2.8.**

## 2.8 Ways The PHCT Developed The Aims, Policies And Procedures

### The Annual Reports

The annual report, was primarily put together by the practice manager and computer operator. The information was gathered from the relevant clinics and other, mostly computerised, information lists. This was a considerable task for one or two individuals to do each year. In the future it may be worth considering putting the report together as a team contribution e.g. various members of the PHCT becoming responsible for learning how to put the details together and providing the information by a given date. The report, therefore becomes dual purpose, it provides the authorities with the essential information and has a use as a tool for developing team activity.

The objectives outlined in each report, understood to have been defined by the doctors, focused upon immediate requirements e.g. the earlier reported objectives were general and aimed at cytology,

cancer and smoking reduction whereas those objectives in the last submitted report (93/94) broadened out to include premises, new appointments and specifying what was to be achieved in each targeted clinical area e.g. increase uptake of immunisation to 80%.

The broadening focus of the objectives reflected the change of interests in the Practice. However, they remained outside a general 'all embracing' statement that specified what the Practice was aiming for in the immediate and longer term. The aim of the Practice was generally said to be about providing good services for the patient. This was a good intention but one that left individual people to interpret for themselves rather than the Practice working out, as a whole, exactly what this meant for each person involved. This left room for uncertainty and misunderstanding as each person did not necessarily become aware of what the next person thought or was aiming for.

**Policies and Procedures**

A small number of protocols were in use as guidelines to the work in the Practice, some were clinical but not in full use and others were administrative policy guidelines. The development of these, so far has not been a shared activity. As with creating the aims and objectives, all those in the Practice whom it would affect should ideally become involved in making policy documents, protocols, guides or whatever. This helps everyone become more in tune with each other and work together to reach Practice aims and objectives. The principle followed is that to include people in the creation of something helps them to feel part of it and therefore the procedure or policy is more likely to become part of every day practice.

**R2.8** **In this Practice, as in any organisation small or large, to provide the best for the patient the 'workers' need to know where it is they are going, next year and five years on, only then can they 'see' where they fit into the whole. The PHCT needs to develop, together, protocols and procedures that guide the different dimensions of Practice activity. This aims to promote good teamwork and increase clarity and understanding of each others roles and activities.**

## 2.9 Methods Of Working As A Group

For the past year the Practice had instituted monthly multidisciplinary meetings which have recently lapsed to make way for fundholding work. Some members of the PHCT were unable to attend the meetings due either to the time it was held or the lack of enough forward notice. The meetings were seen as benefiting team-building by helping the Practice 'bond' as they discussed issues in a multi-disciplinary way and tried to develop better ways of working together.

More recently, 'mini-meetings' were being held early each morning of the week. A rotational pattern was adopted where the health professionals attended one morning and the practice manger on another. These were to try to ensure the Practice management stayed 'on top of things' and addressed issues as soon they arose.

Meetings may be seen as the spearhead of developing Practice co-operation. The pattern and organisation of the meetings needs regular review in order to ensure they are an effective tool for helping the PHCT reach their aims. Meetings that are well structured and made to be effective become useful for people to resolve administrative or clinical issues, and therefore, help to move the Practice forward together.

R2.9 **The Practice needs to reinstate the monthly multidisciplinary Practice meetings at a regular time and place to which the whole PHCT is invited. It is advised that attendance be made representational and rotational if meeting times cannot be agreed to suit everyone, with the agreement that particular people be invited when the subject of discussion directly relates to them.**

**Each meeting needs to be structured to ensure it is effective. That is, it meets everyone's requirements, highlights problems, discusses and determines what action is to be taken and identifies who is to be responsible for the action. A follow up date should be set at the meeting, to assess progress of the action agreed. All meetings should have minutes taken for both information giving and later reference or review.**

2.10 <u>Systems The PHCT Used For Handling Information</u>

There was a wide range of systems in use some more formalised than others e.g. diaries or appointments books, filing, notice boards, 'stick on' notes, postal system, hand written notes, computerised repeat prescriptions and most of the patient's medical records.

A computerised system for handling patient information was beginning to be used across the Practice. This was to gradually replace some of the manual ways of recording patient information e.g. new registrations, prescription writing, test results and updating patient files.

Overall the Practice operates a large number of systems for handling information which in the main worked well but it was noted that computerisation had initially introduced more work in Practice administration.

**R2.10 To undertake a regular review of systems to ensure work was streamlined and duplication of work was minimised.**

**2.11 Systems The PHCT Used For Sharing Information**

The formal Practice meetings assisted with sharing information but this only worked for those able to attend. Others unable to attend found it quite difficult to know what was going on and had to approach individuals in order to find out information. It was mentioned that minutes were not readily available or circulated to keep those involved up to date. This created barriers to sharing information.

Some managerial activities e.g. those of the direction of the Practice remained unclear for some PHCT members. In terms of leadership and management style the doctors and practice manager needed to agree on their given approach and provide this information for the rest of the staff. This way divided views about the type of leadership, the need for team work and the degree to which members of the PHCT should be involved in decision making becomes known. This type of 'open information' system reduces inconsistency which serves to undermine working co-operatively together.

**R2.11 A clear outline of the way the Practice is organised is needed.**
**A method for circulating information to all members of the PHCT needs to be organised.**

**2.12 Ways The Practice Monitored Activity**

The monitoring of general working activity was largely done through judging the way an existing or new service development was functioning e.g. number of patients attending, how long they waited before getting appointments etc.

Clinically, the information collected for the health promotion banding levels served to guide the Practice as to the number of Practice population that had been seen during the preceding year. This data provided the basis for future objectives e.g. increasing the percentage of patients to be seen in the coming year with regard specific forms of health care. More recently the Practice had become involved in two particular clinical audits, aspirin use and diabetic profiling, both were under the guidance of the local Primary Care Audit Group (formerly the MAAG).

**R2.12 Continue to use the annual statistics to provide one regular yardstick for assessment of progress and develop internal forms of audit to serve internal reviews of working practice.**

**2.13 Review Of Progress Towards Reaching Practice Aims**

A review of how well the Practice was doing generally did not appear to happen as a 'cross PHCT' activity on a regular or formal basis. From the report figures it was apparent that certain aspects of Practice activities had improved steadily e.g. 'cytology target levels,' this was therefore one source of review.

What was less clear, however, was when the PHCT sat down regularly to review their role and how their working patterns were helping (or otherwise) the Practice reach its aims. On presuming this occurred infrequently or not at all, it was unlikely that everyone was able to share in and acknowledge achievements (others and their own) or adjust their working patterns by being able to look at, from several different points of views, how their work fitted in with the activity of the PHCT as a whole.

**R2.13 If, in the future, better management and working relations were part of the Practice's drive towards its aims, it would be advisable to start up a process in which all PHCT sat down together to hear and discuss how the Practice was doing. This would act as a form of assessment and serve to enthuse people to work towards the direction the Practice was wanting to move in. It would be advisable to undertake an annual Practice review to assess progress in not only clinical but administrative and service areas as well, this is viewing the whole Practice as one integrated system.**

## PART THREE

## SERVICE DEVELOPMENT

| The assessment looked at: | |
|---|---|
| 1 | Methods of identifying local health needs; |
| 2 | Service developments made recently; |
| 3 | Development of collaborative activities with other people; |
| 4 | Audit of services provided and its subsequent uses; |
| 5 | Patient's views of services; |

**3.1 Methods Of Identifying Local Health Needs**

The opinion in the Practice was that the PHCT had a good understanding of the health needs of the local people. This was derived from hearing what was said in 'one to one' consultations and on generally knowing the Practice population. It was felt that the Practice met local people's more usual needs. The doctors and nurses expressed their awareness of the high incidence of elderly people, the unemployed and a higher than usual percentage of Diabetic patients (4% as opposed to 2% average) within the Practice population. Over the past year the practice nurse has adjusted her clinic times until

they suited the people attending and has progressed with developing a menopause 'education and information' group. A specific reference was made to the additional benefits that 'in-house' services e.g. minor surgery, physiotherapy and chiropody brought to the patients.

**R3.1** **It is advisable to gain the views of the Practice population in a more formalised way. This offers valuable insight to the quality of service the Practice provides , highlights gaps and can be considered as another form of audit.**

**3.2** **Service Developments Made Recently**

Over the past three to four years many changes to service provision has occurred in the Practice following the change in the 'GP Contract'. As a result various forms of opportunistic health promotion has become an established part of the services and more recently specialist clinics have begun to be developed which focus on the management of particular diseases e.g. asthma and diabetes among others. The increase in service provision

has, in part, been due to the development of the practice nurse role and the result of having other health professionals 'attached' permanently to the Practice. In addition to the specialist clinics held regularly by the practice nurse, there were specialist 'in-reach' clinics provided where the Practice population had, with minimal waiting time, access to a consultant on Practice premises e.g. orthopaedics.

**R3.2** **In the immediate future it is advisable to continue developing the current services provided. In the longer term, however, it is advisable to look at the local community and link into other 'health related' activities or projects that aim to improve the health and well-being of local people. This broadens the meaning of primary health care and integrates the PHCT with other local health care agencies.**

**3.3** **Development Of Collaborative Activities With Other People**

Working links have begun to be made with the health visitor and the district nursing team, in order to improve services to the Practice population. The clinical services, those developed in the Practice and those offered by the health authority within this shared building, have provided a point of contact and in some cases the means for collaborative activity with the associated health care workers. Outside of the Practice, the PHCT makes use of any 'health prevention' activities going on e.g. the practice nurse and the health visitor actively sought to make links with the local health promotion unit, and the

doctors regularly refer patients to the exercise prescription service in the local leisure centre. In general, the PHCT recognised and where possible tried to use other activities in the local community as complementary to the services the Practice provided.

**R3.3** **as R3.2.**

**3.4** **Approaches To Auditing The Services Provided**

The annual report formed the basis of the more formal audit processes used in the Practice. Each year attendance and referral figures were collected alongside information on cytology and immunisation rates *, see sheet attached. In addition, various different statistics have been gathered to provide evidence of activity in association with the health promotion banding for level three. In the last report the data gathered and sent to the FHSA, was used by the Practice as the basis for setting specific Practice objectives for the coming year.

Internal to the Practice, the figures were collected to monitor the use of the clinics provided. Similarly figures were collected for the daily consultations patients made with the doctors. More recently patient profiling had begun with regard to diabetic patients and an audit of patients taking aspirin had been performed. At this stage the administrative activity had not been formally reviewed as part of the system of providing patient services and the chronic disease management protocols were currently in draft form only. These protocols, however, have the potential to be developed as a tool for audit.

For example, a practice nurse may develop and set standards which s/he can meet inside the protocol. To explain, the next step would be to make criteria against which clinical activities could be assessed to find out how effective the clinical work was. It must be stressed that this is a developmental process. The first steps may not work but lead to 'seeing' a way in which different criterion could be formulated to help determine how useful or effective clinical practice was. Over time, the Practice would end up with some self-generated specific standards and criterion that the staff would be able to use for a regular review of their work.

The use of audit is invaluable to understanding how the Practice is doing but if used unwisely could be considered as a weapon which would have long-lasting repercussions on those involved. The system of audit, is more likely to be successful if it has been developed by those it affects.

**R3.4** **The Practice, as it undergoes the change to fundholding, has an opportunity to implement a systematic approach for reviewing all former Practice activities. At this changeover time all work practices could be reviewed, over a period of time, in order to determine if the pattern of work achieves the best quality of service that the PHCT can provide for the Practice population.**

** statistical rates were only available as far as 1995, Quarter 1.*

**3.5** **Patient's View Of Services**

The views of the patients were generally gained from the PHCT members during their daily activities. All members of the PHCT undertook the responsibility of feeding back patient comments, good and bad, as part of their role. A complaints / suggestion box was to be placed in the waiting area, there was not a specific 'complaints' procedure at the time of the visit. Most often any patient with a complaint was seen immediately by the practice manager who worked to resolve the issue, whenever possible, there and then.

The number of formal complaints received in the past year was stated as nil, some informal ones were received and attended to immediately by the practice manager. These were mainly about the manner in which patients were spoken to by a member of the PHCT. Overall, all members of the PHCT were aware of their accountability to the patient and responded positively to resolve the issues as they arose.

**R3.5** **It is recommended that a formal mechanism for patient complaints becomes established. This provides the PHCT members and the patients with a recognised process in which issues can be legitimately discussed.**

## PART FOUR

## THE WIDER COMMUNITY SETTING

| **The assessment looked at:** |
|---|
| 1. External activities that have influenced Practice development |
| 2. Collaborative activities |

**4.1** **External Activities That Have Influenced The Practice Development**

External influence to develop has largely come from the FHSA and become forced by the recent

implementation of health policy reforms e.g. the change to provide health promotion services in the Practice. The PHCT undertook a weekend on communication to assist the development of team building prior to their preparations for becoming a fundholding Practice.

**4.2 Collaborative Activities**

Locally the Practice uses agencies - Health Promotion Unit for information and projects e.g. 'Fag Ends' - the smoking cessation support group (initiated and supported by the LMFTs) to refer patients to. The connection with local activities were minimal at present as the Practice concentrated on preparations for implementing fundholding.

**R4.1/2 The intention to provide a good service for patients has resulted in the Practice being able to accept particular changes as opportunity. It is advisable to adopt a proactive and dynamic approach to meeting future change. By this it is meant that the Practice should anticipate what changes are going to occur and decide and prepare an action plan on how to meet the event before the change arrives. This dynamic approach reduces the surprise and chaos aspect of change. If change is managed, forces are in place to allow Practice activities to adapt and respond.**

## SUMMARY

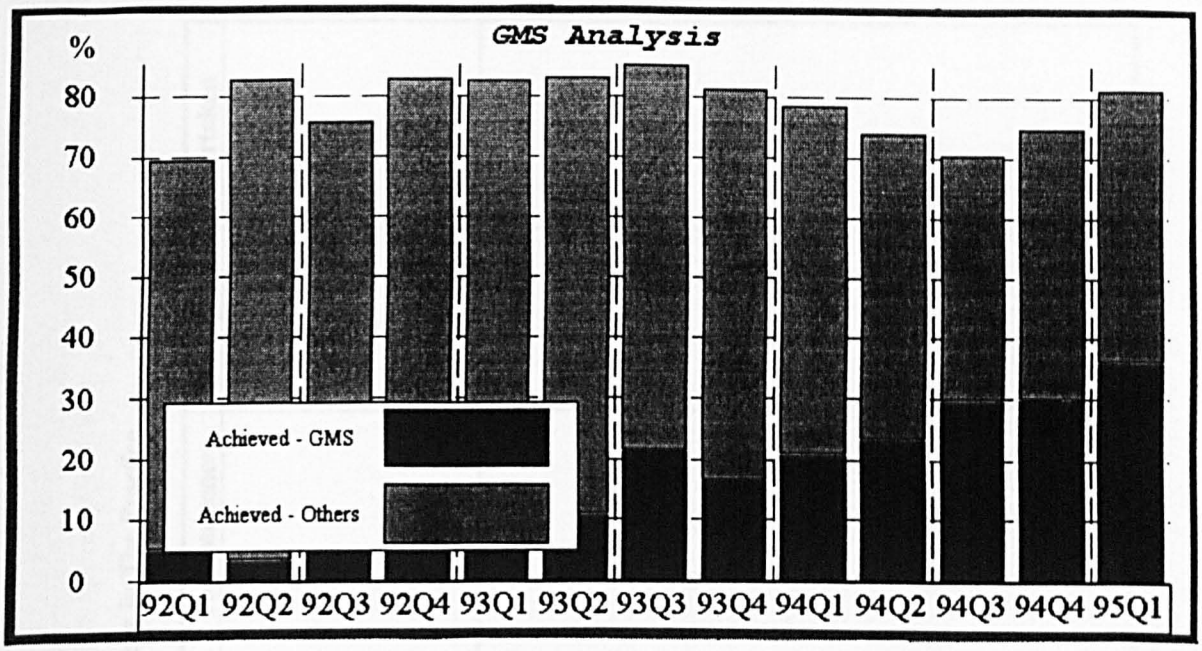
The changes undertaken have been absorbed into the Practice as each person has tried to grasp what the implications of fundholding means. This has led, sometimes painfully, to significant development of individual's skills, created some integration of organisational activity and a service provision that meets the Practice population's immediate health needs. It is advisable to continue working towards creating greater collaboration and team work to sustain the changes already made and draw on as a strength when meeting change in the future.

**ATTACHED SHEET 1**

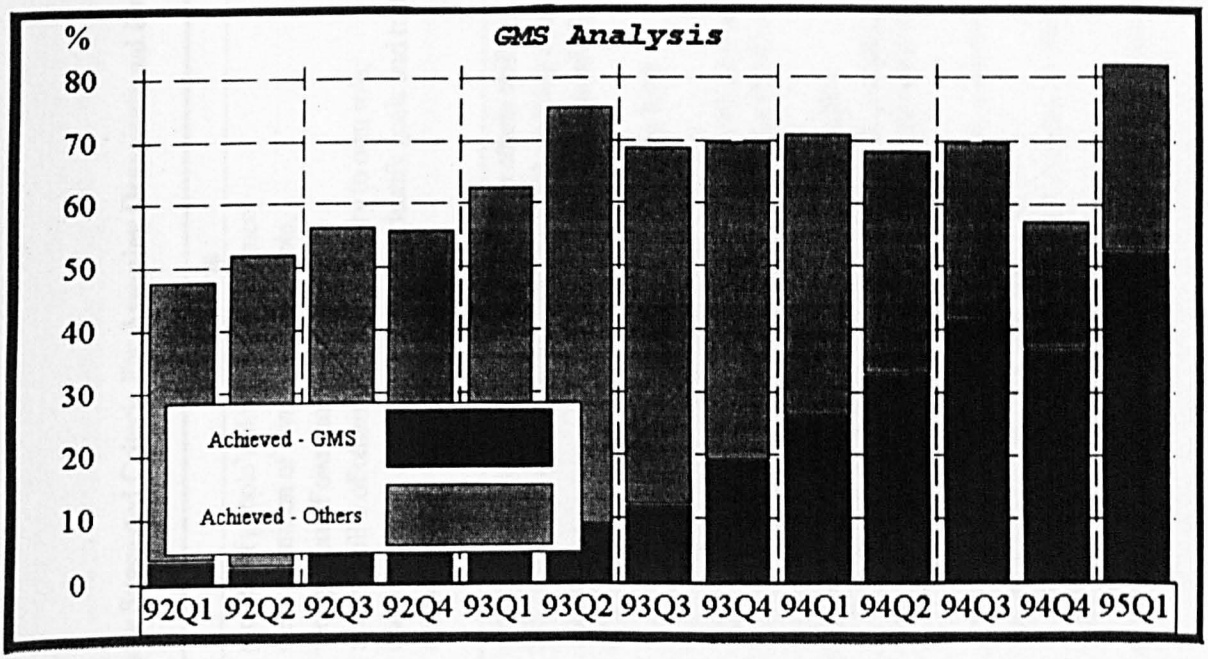
**Three Graphs Showing The Practice's Gradual Improvement In Immunisation And Cytology Screening.**

These GMS figures indicate work undertaken by members of the PHCT for the Practice.

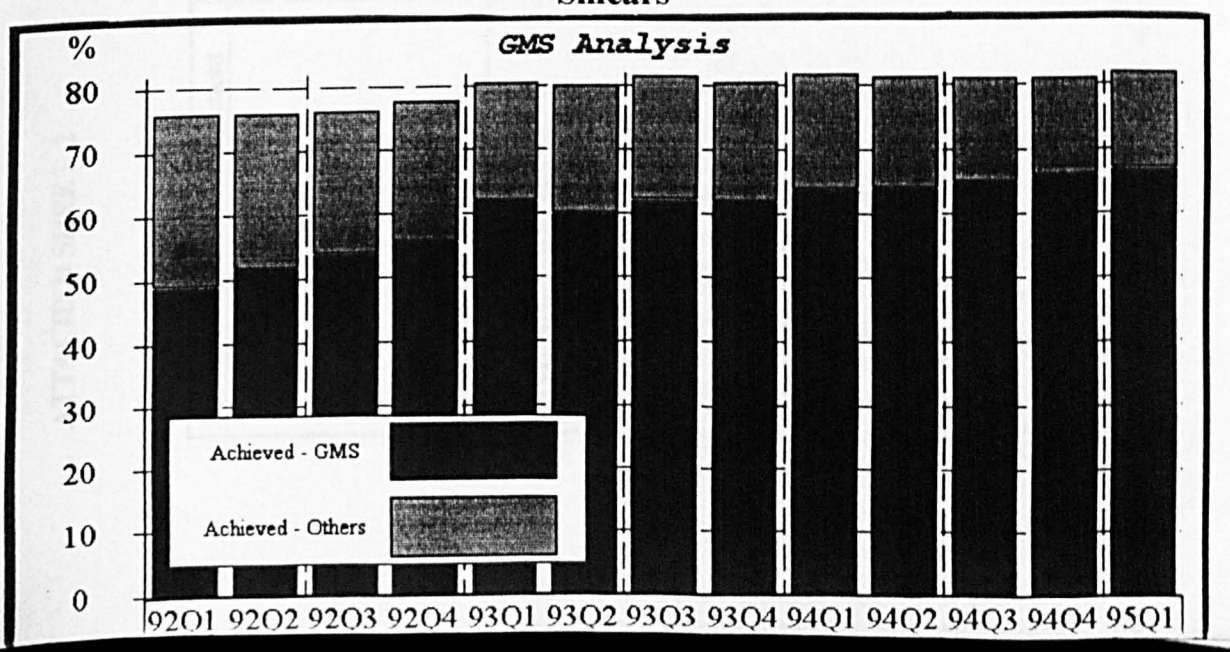
## Immunisation and Vaccinations




## Boosters




## Smears



**ATTACHED SHEET 2**

**Some Suggested Criteria For Assessing Organisational Development In The Practice**

| Dimensions Of Development | Criteria | To Commence | In Progress | Undertaken |
|---|---|---|---|---|
| **Part One**<br>**Personal Development** | • growth of people's skills and confidence;<br>• clear definition of own and other's role;<br>• recognition of own limitations;<br>• accept skill's of others as complimentary to own role;<br>• use of personal development plans to identify goals and training needs of staff; | | | |
| **Part Two**<br>**Organisational Development** | • explore and ensure the efficient use of each others skills;<br>• use of personal development plans to identify training needs;<br>• review and change work practices to increase the level of efficiency;<br>• review and change work patterns to improve the level of communication and teamwork;<br>• define and implement, together in the PHCT, Practice objectives;<br>• have policies that state the clear responsibilities and activities of team;<br>• have a comprehensive approach to employing staff:<br>• clearly defined job descriptions that are fair and unambiguous;<br>• contracts of employment that comply with employment regulations for all Practice staff;<br>• provide support for any additional training needs identified;<br>• undertake regular Practice meetings;<br>• review, revise and improve administrative systems in relation to achieving Practice objectives; | | | |

**ATTACHED SHEET 2 continued,**

**Some Suggested Criteria For Assessing Organisational Development In The Practice Continued,**

| Dimensions Of Development | Criteria | To Commence | In Progress | Undertaken |
|---|---|---|---|---|
| **Part Three**<br>**Service Development** | • undertake activities that explore the needs of the local population;<br>• change or expand services to meet needs of population;<br>• change administrative or clinical systems to try to achieve Practice objectives;<br>• make use of audit as a tool for review, reflection and review as, necessary, of Practice activities; | | | |
| **Part Four**<br>**Wider Community Setting** | • make and maintain relationships that foster communication and learning among own PHCT;<br>• make and maintain relationships that foster communication and learning with staff from other Practices in the locality;<br>• undertake mutual problem solving activity with other local key health workers;<br>• work together on local community initiatives; | | | |

In addition a set of Practice Assessment Sheets were created with each Practice. These noted the number of the relevant point from the report which was set against a date for its achievement. On these sheets there was space for the members of the Practice to describe and make a review of the activities that they had undertaken.

# APPENDIX 8

## AN EXAMPLE OF ONE FACILITATION TEAM'S CLUSTER LEVEL ACTIVITY

The case records demonstrated how the team utilised their facilitation role to suit the Cluster in which they were active. Their interventions followed a problem solving approach. Each team developed and adapted their role to accommodate the different views of the people they were working with. None of the case records looked the same because the many different people inside the Practices had very different ways of doing things. This, in addition to a team's own personal characteristics, dictated the way each team undertook the facilitation activities. The case records at this time had a primary focus on Cluster level interventions and offered a general view of what happened in each area as a result of the facilitators activities.

This case record provides an example of the activities the facilitation team and contains the following material:

- a table that provides evidence of interventions facilitated by the team;
- a table that categorises the people attendant at interventions;
- a diagrammatic representation of the development of one specific intervention;
- an activities report to substantiate the diagrammatic outline of the specific intervention.
- two maps to demonstrate the growth the development of the team's network.

**Interventions Facilitated by the Team were:**

| Date | Type of Intervention | Topic | Time Taken | Attendance | Clusters Represented |
|---|---|---|---|---|---|
| 18/9/93 | Multidisciplinary forum | Introduction to Team entitled, 'We know a man who can'. | 2 .30 hrs | 55 | N/A |
| 13/1/93 | Workshop | Health Promotion Banding: Team working with MAAG and LPHCFP at the event. | 2.0 hrs | 171 * | Clusters A-G |
| 1/94 | Bulletin No. 1 | Introduction to team | - | - | - |
| 23/2/94 | Conference Facilitators for LPHCFP | Health Needs: Team acting as facilitators for LPHCFP | 2.30 hrs | 8 for group work from own Cluster area | Clusters A-G |
| 25/3/94 | Seminar | Drug Awareness | 2.30 hrs | 28 | N/A |
| 5/94 | Bulletin No. 2 | Drug Awareness Report | - | - | - |
| 1/7/94 | Unidisciplinary Meeting - Health Visitors | 'Lets Communicate' | 2.30 hrs | - | - |

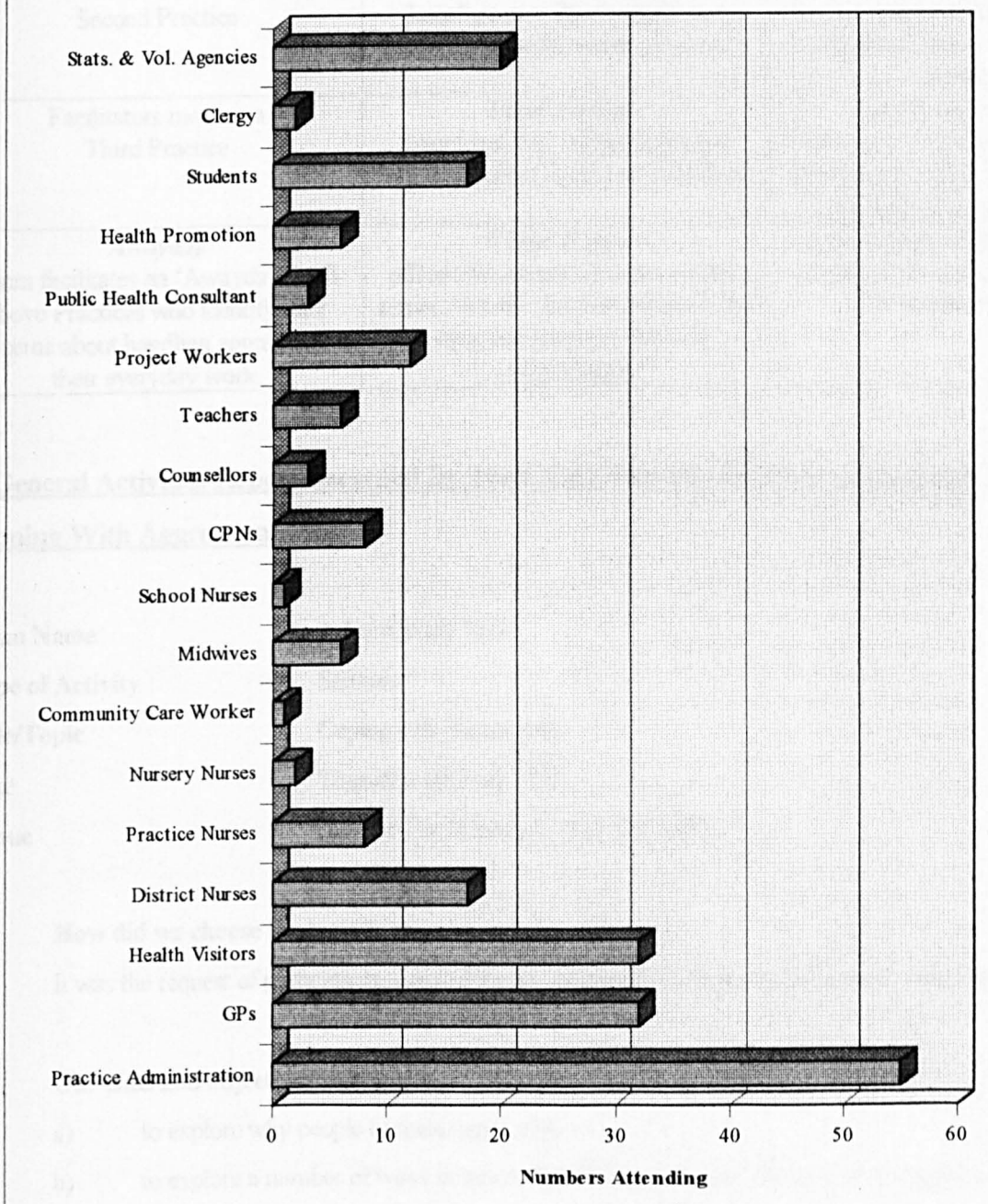
**Summary of the Teams interventions continued,**

| Date | Type of Intervention | Topic | Time Taken | Attendance | Clusters Represented |
|---|---|---|---|---|---|
| 5/11/94 | Shared Project | Mental Health in Local Area | 1. 30 hrs | 29 | N/A |
| 3/11/94 | Roadshow: A Medical Centre | Communication<br>Job Roles | 3. 30 hrs | 12 | N/A |
| 25/11/94 | Practice Awayday | Communication<br>Patients Charter | N/A | 16 | N/A |
| 5/95 | Bulletin No. 3 | Reports on recent events | - | - | - |
| 4/5/95 | Seminar | Aggression | 6 hrs per person to prepare<br>3 hrs to give | 31 | Cluster A and B |
| 19/9/95 | LMFT Evening Meeting with NCMs | The Way Ahead | 3 hrs | LHA Chief Executive<br>All Facilitators<br>Administrator<br>Researcher<br>MAAG<br>E.G. members | Clusters A, C, D and G |
| 21/9/95 | Multidisciplinary Forum<br>Facilitators for MAAG event | Use of aspirin | 3 hrs | 103 * | Clusters A - G |
| 8/11/95 | A Practice Awayday | How to run a smooth surgery | 8 hrs to prepare<br>6 hrs to give | 25 | Cluster A |
| 17/11/95 | Multidisciplinary Forum | Change in LMFTs model and role of facilitators | 2 hrs to prepare<br>1 hr to give | 7 | Cluster A |

**KEY** * Figures could not be included in the next chart to demonstrate the full extent of network connections as they were not all recorded.
N/A no records of this information.
All abbreviations are explained in the glossary.

**Table 48**

**An Example of the Network Connections made by this Team of Facilitators in their cluster from June 1994 to December 1995**



A summary of the development of the 'Coping with Aggression' Intervention held 4/5/95 was as follows:

| Inception | Developing /Mobilising Networks | Forward Action Following Intervention |
|---|---|---|
| *Meetings:* Facilitators Meeting with First Practice | *Networking* Facilitators visited all Practices in their Cluster to publicise the forthcoming seminar | *Further Interventions Planned:* Practical Anger Management workshops to be designed specifically for individual Practices |
| Facilitators meeting a Second Practice | *Local Expertise Utilised* Locally based Psychologist and Police agreed to speak at event | *Future Plans:* To hold more Unidisciplinary and Multidisciplinary in-Practice events |
| Facilitators meeting a Third Practice | *Local Students* from local F.E. college and from Nursing School invited to participate | *Mail Shots continue:* Flyers sent to local people, groups and health workers in the Cluster to promote future events. |
| *Awayday* Team facilitates an 'Awayday' with above Practices who identify their concerns about handling aggression in their everyday work. | *Wider Support* offered from local GP tutor, college tutors, MAAG, Enabling Group, and a drug company provided the refreshments. | *Continuing to help Practices develop by focusing on specific Practice issues* |

## A General Activities Report Recorded By The LMFT Relating To Their Intervention 'Coping With Aggression'.

| | |
|---|---|
| **Team Name** | A Facilitation Team |
| **Type of Activity** | Seminar |
| **Title/Topic** | Coping with Aggression |
| **Date** | Thursday 4th May 1994 |
| **Venue** | A Local Post Graduate Medical Centre |

1. **How did we choose the topic?**

   It was the request of participants, particularly the receptionists, attending a Practice 'awayday'.

2. **Our aims and objectives were:**

   a) to explore why people become aggressive;

   b) to explore a number of ways in which PHCTs can minimise the amount of aggression presented to them and to deal with situations effectively.

3. **How did we organise the session?**

GP asked local Chief Clinical Psychologist to give a presentation.

PM invited participants to attend, particularly targeting the receptionists.

PM and PN sent out flyers to all Practices in the Cluster.

GP set up the PGEA element of the session.

HV and PM met the participants and attended to registration.

CPN chaired the seminar.

4. **Team roles adopted during the development and implementation of this intervention were:**

| Category | Primary role | Secondary role | Tertiary role |
|---|---|---|---|
| **Company worker** | - | - | - |
| **Chair** | Community Psychiatric Nurse | - | - |
| **Shaper** | Practice Nurse | | - |
| **Plant** | - | - | - |
| **Resource Investigator** | - | - | - |
| **Monitor / Evaluator** | - | Practice Manager | |
| **Team worker** | General Practitioner<br>Practice Manager<br>Health Visitor | Community Psychiatric Nurse | - |
| **Completer / Finisher** | - | Health Visitor | Community Psychiatric Nurse |
| **Other** | - | - | - |

5. **List the different types of facilitation methods used:**

Networking

Communication

Interaction with Practice members

Audience participation

6. **Would other facilitation methods have been more suitable? If so why?**

It would have been so much better with small group work and role play as originally planned.

7. **Programme details**

Clinical Psychologist talked about the reasons for aggression. Time for audience participation after the talk. Chair brainstormed with audience about systems/interpersonal reasons for aggression and ways of coping with it. Unfortunately the Police could not attend. They were supposed to round up the session.

8. **Who attended**: 31 people in total, by disciplines these were as follows:

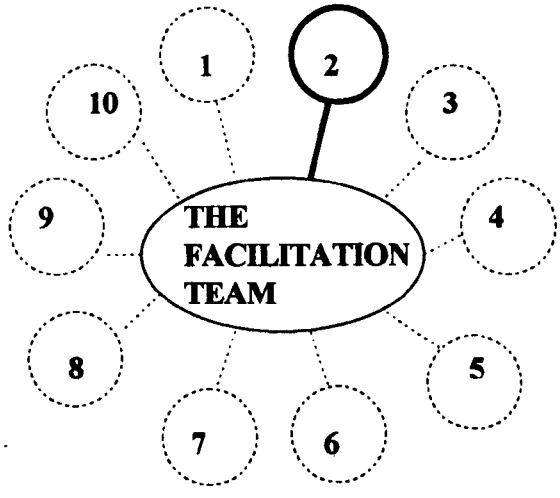
Practice Manager, 1; Hospital Administration staff, 1; Practice Receptionists/Administration staff, 11; Local students on Receptionist course, 15; Practice Nurses, 2; Community Auxiliary Nurse, 1.

## MAPPING NETWORKS

**Map 3**

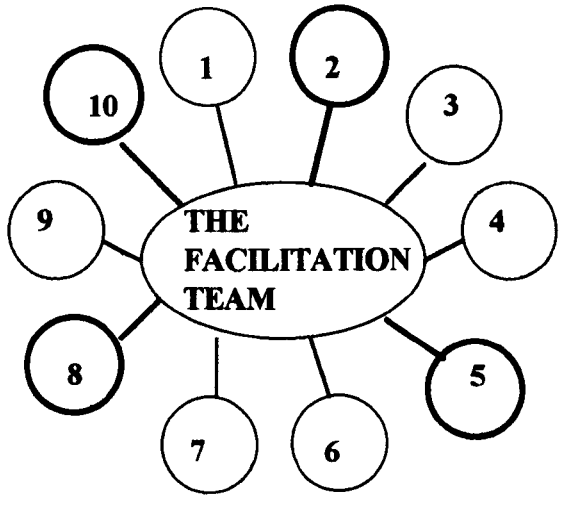
**A Segment Of The Network Developed By A LMFT With Their Practices**

A) Connections with Practices at the beginning of the LMFTs model for change.




Passive responders: .....
Active responders: ———

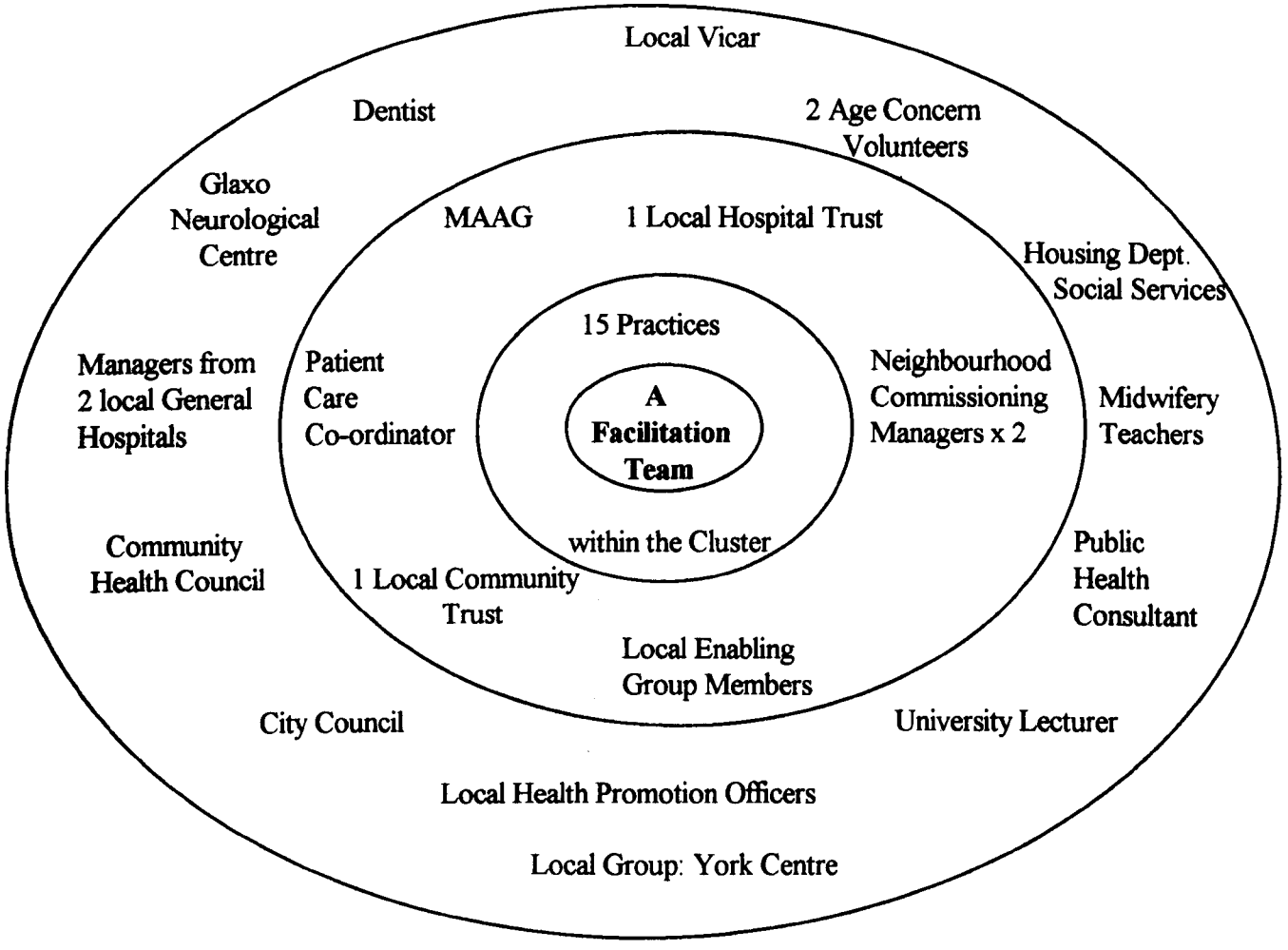
B) Connections made with Practices towards the end of the LMFTs model for change.




Semi-responders: ———
Active responders: ———

**Map 4**

**A Segment Of The Network Developed By A LMFT In Connection With The City Health Plan 2000 Intervention**




**KEY**

**Centre ring:** A Facilitation Team.

**Second ring:** Individual facilitators personally approached all local Practices.

**Third ring:** Connections used to organise the intervention and connect them with other interested parties.

**Outer ring:** demonstrating the extension of their connections to other people within 'health involved' organisations.

**Abbreviations** please see glossary

## CLUSTER SCENARIOS

Four short scenarios were produced to provide an illustration of each Facilitation Team's Practice level activity during Phases One and Two.

### Blue Facilitation Team's Scenario

The team have worked at addressing issues of some Practices by organising unidisciplinary meetings. The team worked to create a non-threatening atmosphere in which those present were able to voice their concerns. The issues raised, and the connections made by using a problem solving approach, later led the team to organise multidisciplinary Practice meetings with individual Practices. Each of these meetings addressed particular topics relevant to that Practice. For example, one Practice looked at how to achieve the smooth running of the Practice - they looked at administrative issues and redesigned their appointment system. A second Practice, considered their communication problems and how to create their own patients charter. They produced a patient charter that was specific to the Practice. The facilitators used the creation of a Practice 'patients charter' to get the PHCT members to work together to devise their own criteria for the charter.

### Red Facilitation Team's Scenario

The team in this Cluster developed an approach whereby they linked GPs, who were located near to each other, into a particular initiative e.g. smoking cessation. The team having achieved success in the first round have now moved on to target four more, geographically proximal, GPs to try and help them to get together and link into the local smoking cessation initiative. This team assisted collaboration by supporting the development of a working sub-group comprised of GPs and other local people (health workers and lay), who subsequently produced a 'smoking cessation' initiative and agreed a plan of action to take their ideas forward. The four GPs in the original group were not known to speak to each other apart from pleasantries. After one year of working together on this initiative they were observed, at another intervention, choosing to sit together to eat their lunch before the event started.

### Navy Facilitation Team's Scenario

After a series of meetings within a local Practice, which started with a brain storming session about their issues and concerns, this team organised a specific session for this Practice on cervical cytology. Since that time the Practice concerned has gradually re-organised the way it worked to improve both its system of administration and the services provided to patients who require cervical smears. This was seemingly a small step for this general practice to take but, at the same time, also a stride forward in terms of their own personal and organisational development. Previously they had failed to the respond to several approaches made to them by this local facilitation team.

## Green Facilitation Team's Scenario

Perseverance was one of the hallmarks of this team's approach to bringing about change in a local Practice. After using a considerable number of different facilitation approaches, this team broke through the barriers and reached a Practice by organising a simple get together over an informal lunch to which they had a favourable response. During the lunch the team gleaned that the receptionist's had many issues that have remained unanswered despite their attempts to discuss their case. The team set up an evening workshop, at which both a FHSA personnel officer and an education and training officer were present, to discuss contractual and other employment issues. All the local Practice administrative staff were invited to attend. From this beginning, the team went on to create a Receptionist's Course. Local receptionists and those from other small Practices across the city were invited to attend for training and development. Subsequently, the team have revisited the Practices involved and noted a considerable change in attitudes of the reception staff both towards themselves when they enter the premises, and in the way the reception staff now apply themselves to their work.

## SUMMARY

These scenarios provide insight into the lengthy and time consuming process of development work in PHC. For example: over one month the preparation and facilitation of one shared intervention was detailed as taking up to 25 hours; an 'LMFTs' intervention took about 25 hours of activity and the time spent on Practice level activity was detailed as taking 20 hours. This, although an approximation of time spent, amounts to 70 hours of a team's time each month. What was interesting to note from the LMFTs' reports was that those interventions requiring collaboration with several agencies e.g. the receptionist's course; the smoking cessation initiative and so on, took much longer to set up. Furthermore, those action plans that followed the initial Cluster level intervention inevitably led to the team's extending their networks as more local people and more agencies were drawn into subsequent Cluster level interventions. For example, the secondary intervention activity the 'Fag Ends Re-launch' took 76 hours of work, and similarly, the work involved in planning, organising and facilitating the Receptionist Course although not specified exactly took well in excess of this time for the team involved. The evidence was that to undertake both visits to individual Practices and to set up interventions across Clusters takes, in some weeks, considerably more time than the five hours each team member is allocated to work on local facilitation activity.

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# APPENDIX 9

## EMERGING ISSUES

## EMERGING ISSUES FROM PHASE ONE - FEBRUARY 1994 TO JANUARY 1995

All the emerging issues from the Phase One are collated in this section. The issues were divided in four parts to correspond with the four key areas identified in the evaluation framework. A final, fifth section, addressed evaluation issues.

### Part One - Personal:

- Some of the LMFTs feel unsupported;
- The LMFTs would like feedback on 'how they are doing';
- Few personal appraisals for staff development are complete;
- The parallel learning of theory and practice is unfamiliar;
- Some feel the uncertainty of development work is uncomfortable.

### Part Two - Organisation:

- Uncertainty has made some teams unclear of what they are trying to achieve;
- Some of the LMFTs are inward looking and inner directed (operating as a closed system);
- Some still feel they lack 'street level credibility';
- The management structure of the LMFTs is no longer clear;
- The style of management for the LMFTs is uncertain;
- The accountability of each team is vague;
- One team remains in constant flux about their composition;
- The local enabling group is not comfortable about its role;
- The 'key person' for each team lacks clear role definition;
- The enabling meetings are not conducive to sharing ideas.

### Part Three - Service:

- Access to Practices is very difficult to engineer;
- A strategic perspective to facilitation activity is not observable;
- Developing an appropriate intervention programme is a difficult process;
- The interventions held are not evaluated by participants;
- The pace of the facilitation activity is slowing down.

**Part Four - Wider Community Development:**

- The formal intervention programme is being challenged;
- Facilitation work needs developing further to meet Practice needs;
- Some LMFT bulletins are not interactive any more;
- Some LMFT bulletins are just a 'what's on' leaflets for their Cluster;
- Some bulletins do not project LMFT events to come.

**Part Five - Developing The Evaluation:**

- It is time consuming to create an evaluation framework;
- The process is constrained by a lack of resources;
- There is a limited amount of collaborative data collection;
- It is difficult to meet all needs of stakeholders all of the time;
- The boundaries of the research role is easily overreached;
- Connections with the steering group are difficult to maintain;
- Access to Practices is a very particular and complex process;
- Ensuring the confidentiality of participants is a difficult task;
- The participatory nature of the methods makes them vulnerable to misuse;
- It is difficult to ensure a favourable climate for interviewing;
- The participatory methods induce a complicated and cyclical process of evaluation;
- The interventions are not clearly evaluated by the LMFTs;
- The data collected from the LMFTs is very patchy and not standardised;
- A system for 'mapping connections' of the LMFTs is not yet achieved.

## EMERGING ISSUES FROM PHASE TWO - FEBRUARY 1995 TO JANUARY 1996

The section is divided into two parts, A) provides examples of comments made during critical reflection of the emerging issues from phase one, and B) provides a list of the questions the stakeholders made following reflection of the implementation of the LMFTs model during phase two.

## A) CRITICAL REFLECTIONS ON RESOLUTION OF ISSUES FROM PHASE ONE

The critical reflections of the facilitators and the researcher on the degree to which the Phase One issues were resolved in Phase Two are given before the emerging issues from Phase Two are outlined.

At the end of Phase Two, the Facilitators were asked, 'what has changed/developed since Phase One'? Their comments are collated in the tables below.

### Part One - Personal:

- **Some of the LMFTs feel unsupported.**

  "Good support from within our team. Support from outside agencies available when required. Team would have

  liked to have made more use of Enabling Group."

  "We feel supported."

  "No more support but we've matured and don't rely on support."

  "More affinity with other LMFTs. We're more confident and more focused therefore need less support."

- **The LMFTs would like feedback on 'how they are doing'.**

  "We're getting feedback from Practices and the people we are networking with."

  "This remains unchanged.

  "We would like to be aware of positives and negatives."

  "Feel quite confident and don't need feedback. Reflective practice."

- **Few personal appraisal for staff development are complete.**

  "Available as an option as part of the job."

  "Not relevant."

  "Remains unchanged."

  "True."

- **The parallel learning of theory and practice is unfamiliar.**

  "Mis-timing."

  "As reviewed in the Certificate of Facilitation meeting."

  "Still true."

  "Some basic education at commencement of contract."

- **Some feel the uncertainty of development work is uncomfortable.**

  "We feel comfortable - people know who we are. Change of team members enforced re-allocation of practices."

  "Still true."

  "LMFTs should be educated to project work and development."

  "Not any more. Adventurous at times."

## Part Two - Organisation:

- **Uncertainty has made some teams unclear of what they are trying to achieve.**

  "[We] have never felt uncertain about our aims. It would help if we knew the future of the LMFTs."

  "[This has] not interfered with our programme."

  "Took a step back and changed tack. Ownership of the team."

  "We know what we're trying to achieve for 1996 - [we've] a forward plan."

- **Some of the LMFTs are inward looking and inner directed.**

  "We go back to it [the team] re-group and re-build - then we work with different agencies / groups (networking) autonomously and then share with the group again."

  "Disagree. Feel open as a team."

  "Not now, have to meet needs of your locality."

- **Some still feel they lack 'street level credibility'.**

  "No, e.g. more involved in planning process."

  "No, credibility on the up."

  "Not now."

- **The management structure of the LMFTs is no longer clear.**

  "Still unclear but doesn't matter - more autonomy."

  "True."

  "Still true."

  "True."

- **The style of management for the LMFTs is uncertain.**

  "Isn't a manager that could fit the bill."

  "Do not agree," and finally, "True."

- **The accountability of each team is vague.**

  "Feel accountable to each other as a team and to Christine Wall - accountable to the community which we service (we're in a better position to be accountable [now]."

  "Accountable to self and peers."

  "We are accountable to NCMs and ultimately to the FHSA."

  "It is debatable whether it should be structured."

- **The local enabling group is not comfortable about its role.**

  "Yes - same - less important now."

  "True, LEGs were not a group."

  "What is the LEG or who are they?"

  "Never has been."

- **The 'key person' for each team lacks clear role definition.**

  "We value her role - she is here when we need her e.g. to help us focus and provide information and reassurance. We just need to ask her less now."

  "Our key enabling person has gone."

  "Do not agree."

  "A big compliment to ours that we're still together."

- **The enabling meetings are not conducive to sharing ideas.**

  "We feel more able to contact them as individual team about specific things."

  "No problem. Feel comfy with this."

  "Not many enabling group meetings."

  "Not changed."

## Part Three - Service:

- **Access to Practices is very difficult to engineer.**
- "Very varied - in general it's improving see our ranking [sheet]."
- "Sometimes."
- "Not as difficult more easily accessible."
- "Much better than when we started."
- **A strategic perspective to facilitation process is not observable.**

  "It is now - we link/connect in with other groups/initiatives e.g. health promotion while still having our own agenda - willingness to share expertise across the board."

  "What does this mean."

  "Moved on now more outward looking."

- **Developing an appropriate intervention programme is a difficult process.**

  "Not difficult now - have our own strategies."

  "Until intervention is decided we do not know how difficult to see."

  "Yes agree, but still managed to develop a few."

  "We're now able to look at appropriate interventions for our neighbourhood."

- **The interventions held are not evaluated by participants.**

  "We evaluate now - all. There is room for improvement here."

  "At 100% now."

  "Not given out."

  "This has been done on some occasions but not all the time."

- **The pace of the facilitation activity is slowing down.**

  "Do not agree."

  "Wrong - hotting up now."

  "Started as per model. Then reassessed. Went more individually, now hurtling along: health needs; Practice needs; neighbourhood needs and tapping in [to networks wherever]."

  "It's picked up again. We've made it our own."

## Part Four - Wider Community Development:

- **The formal intervention programme is being challenged.**

  "Yes definitely."

  "We still use the interventions but we've adapted them to the needs of the locality e.g. more shared projects, less big forums. We needed the structure originally."

- **Facilitation work needs developing further to meet Practice needs.**

  "Still true,"

  "Developed still further, an on-going process."

  "It is a dynamic process. So change is inevitable e.g. inter-practice meeting with 4 Practices once a month to plan is more helpful than big forums."

- **Some LMFT bulletins are not interactive any more.**

  "Correct,"

  "No," "we've pulled back on track."

  "Though this would be an ideal, encouraging Practices [to complete them] would be time consuming. Also this would not be cost effective."

- **Some LMFT bulletins are just a 'what's on' leaflets for their neighbourhood.**

  "Yes."

  "No."

  "This does not apply to us."

  "Interactive and what's on and what's coming."

- **Some bulletins do not project LMFT events to come.**

  "No."

  "You may think that but we do."

  "This does not apply to us."

  "Do now."

## Part Five - Developing The Evaluation: The Researcher's Reflections:

- **It is time consuming to create an evaluation framework.**

  The PAR activity has expanded beyond the steering group to include participants from the four different groups, e.g. the LMFTs; the PHCTs, the RSG, and the LEGs in secondary workgroups. The 'LEG' members tend to be seen individually now that the formal LEG has all but dissolved.

- **The process is constrained by a lack of resources.**

  This remains unchanged.

- **There is a limited amount of collaborative data collection.**

  Although there has been some improvement the data collection it is still an uphill task.

- **It is difficult to meet all needs of stakeholders all of the time.**

  The different interest groups pull the researcher in different directions constantly.

- **The boundaries of the research role are easily overreached.**

  This is still the case.

- **Connections with the steering group are difficult to maintain.**

  This difficulty is constant and increasing due to the expansion of the evaluation to include stakeholders from the different groups.

- **Access to Practices is a very particular and complex process.**

  The access has to be sensitively maintained but there seems to be acceptance of the researcher once the data collection gets under way.

- **Ensuring the confidentiality of participants is a difficult task.**

  This remains difficult. Some Practices want to know about the others involved but the other Practices do not all feel this way. It was impossible to conceal the identity of those involved from the LMFTs model.

- **The participatory nature of the methods makes them vulnerable to misuse.**

  The degree of pressure exerted from the different stakeholders is difficult to proactively manage. The uncertainty and spontaneity of the process creates multiple paths to follow in order to ensure a holistic view.

- **It is difficult to ensure a favourable climate in Practices for interviewing people.**

  All the interviews in the first round were completed with a great deal of ingenuity!

- **The participatory methods induce a complicated and cyclical process of evaluation.**

  This has escalated now all the participants in the research are involved.

- **The interventions are not clearly evaluated by the Facilitators.**

  This is under constant development and review in the attempt to provide a true reflection of the facilitation activity.

- **The data collected from the LMFTs is very patchy and not standardised.**

  This has improved but not sufficiently to create a system of good practice in terms of evaluation.

- **A system for the mapping connections of the LMFTs is not yet achieved.**

  This has been achieved along with other advances that try to capture the essences of facilitation activity, networks and collaboration.

## B) EMERGING ISSUES ARISING FROM PHASE TWO - FEBRUARY 1995 TO JANUARY 1996

The emerging issues from phase two were converted into a question format by the stakeholders. This was to make it easier for stakeholders to consider what responses they needed to make in phase three.

*These questions were complied, by the stakeholders, from the comments they made during their critical reflections in the RSG meeting at the end of phase two.*

### Facilitation Teams:

- Do the teams need further team building with their 'reshaped' teams?;
- Do the teams need to re-examine their team profiles to note any change or limits in their teamwork?

### Facilitation Work:

- How can we make facilitation work more visible?
- Will the need for individual Practice intervention before participation at Cluster level become recognised and accepted?

- Will the Facilitators be able to say No as more and more persons and organisations come to see them as an easy access conduit to primary health care and its PHCTs?
- Is the creation of 'Neighbourhood and Cluster systems' the way forward, e.g. continuing and extending inter-Practice meetings to interlink surgeries within neighbourhoods or supporting inter-practice health needs development?
- Do the Facilitators need to develop future facilitation activity around: cytology / women's health; diabetes awareness and asthma education?
- Do the Facilitators continue supporting the projects already initiated: Fag Ends; Exercise for health; Everton Road Clinic - service development; maintain links with Women's Health Group?
- When do the Facilitators let go of locally developed projects?

### Time Issues:

- Is there a need to acknowledge the Facilitators are committing more time than they are paid?
- Can it be accepted that the 5 hour post makes it very difficult to maintain everything i.e. documentation?

**Management And Support For The Facilitators Teams:**

- Can it be established through discussion what kind of management structure do the Facilitators now need?;
- What opportunities for on-going support / advice / training is available to the Facilitators to continue working with Practice teams?
- What help is available to help Facilitators devise their own aims and objectives for the future?
- What ways can the Facilitators be assisted to establish an equal relationship with commissioning managers (NCMs)?

**Future Of The Project:**

- Will the project exist after September 1996?;
- Will the structure of change after September 1996?
- Will ownership change after September 1996?
- Do the Facilitators continue unchanged, post September 1996, or will contracts be revised?
- What is the long term future of a project like this?;
- What information can be given to the Facilitators to help them plan ahead, e.g. up to and beyond September 1996?
- Can the Facilitators be offered security for the future i.e. a binding commitment from the 'powers' to continue funding?
- What is going to happen with the clusters in Liverpool without Facilitators Teams?

**Linking With Commissioning Managers (NCMs):**

The way forward is to forge links with LMFT and NCMs to identify and meet the clusters needs.

- What help is there to assist both parties:

  enhance their communication?

  work in close collaboration with each other?

  align agendas?

  share objectives?

  share Practice and Neighbourhood level activity/information?

  be equals in the role of PHC development?

- It has to be questioned whether it is the role of the Facilitators to organise public meetings or to set up courses or to facilitate them?
- Do the Facilitators recognise the need to improve their networking generally?

**Evaluation Process:**

- Do the Facilitators recognise that much closer connections will now be made between the LMFTs model and the evaluation process?
- Do the Facilitators know how to improve their evaluation ability?
- Do the Facilitators need enhanced support for evaluation of their events?
- Do the Facilitators accept the crucial importance of record keeping to establish the fullest picture possible about their activities?
- Can the format of the Practice analysis be used as a more widely as a tool for Practice development?

**Other General Comments Made Following This Review:**

- The LMFTs have only just become 'embedded' in their Clusters;
- They now seem to be accepted and to have 'street credibility';
- In the case of the receptionists training course it has to be acknowledged that there was special expertise in that Facilitation Team. This sort of opportunity is at the expense of the local Cluster facilitation work.

## EMERGING ISSUES FROM PHASE THREE - JANUARY 1997

As this was the end of the evaluation of the LMFTs model, the emerging issues from phase three were converted into a **summary of findings, key issues and recommendations for the future.**

### Summary Of Findings:

- The environmental challenges were considerable.
- The LMFTs were very responsive to the needs of the situation.
- Development / impact was most evident in those Practices that had either a LMFT facilitator as a member of staff or when a member of the Practice had established a close connection with a LMFT member.
- Facilitation activity had its greatest impact when it happened as personal development for a Facilitator or PHCT member;
- The Facilitator, given the constraints they have faced did a very good job. They were very productive. They were an impelling local force for change capable of achieving development across three to four dimensions in those Practices with whom they had established a strong relationship.
- The Facilitators form vital grassroots element for assisting change in any future PHC developmental tool kit.

### Key Issues Were:

- The structure of the setting changed considerably during the period of time the Facilitators were active;
- The inherited model of change, from the earlier stages of the Project, was inappropriate for the low level of organisational development found in the Practices;
- The model was being implemented by people inexperienced in facilitation work;
- The facilitation teams were comprised of people unused to team work themselves;
- The teams varied in their composition which influenced their focus of facilitation;
- The greatest impact was when a facilitator was a member of the Practice or had established a close relationship with the team.

## RECOMMENDATIONS FOR THE FUTURE

### Goals - Make The Overarching Strategy And Goals Clear:

- Determine what development can realistically be achieved in individual settings in Primary Health Care;
- Identify the focus points for the facilitation activities in each Cluster;
- Define, collaboratively if working with a PHCT, the specific developmental goals to be achieved;
- Provide a 'development' lead from the Liverpool Health Authority, e.g. explicitly define strategy for development and specify what principles are to be upheld.

### Revise The Structure Of The LMFTs Model:

- Provide co-ordination of the 'development' activities from the Liverpool Health Authority;
- Create an administrative infrastructure for the facilitators;
- Provide a practically orientated educational programme for the facilitators;
- Networking and communication needs promoting for the facilitators by:
    - forming an enabling group from key 'enabling' people in each Cluster;
    - integrating the facilitators with local Cluster level planning groups;
    - collaborating with local key people and organisations to promote development;
- Cluster level facilitation activities should become the shared responsibility of the key 'enablers';
- Facilitators should be representative of the administrative, medical, practice nursing, community nursing and health visiting disciplines within PHC to achieve the broadest forms of development in Practices in a Cluster;
- Facilitators need to be based, on-site, in a Primary Health Care Team;
- Facilitation work should become part of a contractual arrangement within each PHCT;
- PHCTs should be encouraged to commit themselves to a process of development in return for intervention;
- Time spent on facilitation work should be part of a contractual arrangement for designated PHCT members;

### Revise The Process Of Intervention:

- Facilitators should first undertake steps to establish relationships with each PHCT based on goodwill / trust;
- A S.W.O.T. analysis, or similar, should be undertaken in each PHCT to identify and prioritise issues and organisational development needs;

- PHCTs should be encouraged to create their own Practice development plans;
- Facilitators should assist PHCTs achieve their development plans;
- Each facilitator, in addition to his or her own PHCT, should provide facilitation work in three other PHCTs. The home PHCT, in time, becoming used as a role model;
- Activities to promote team work and collaboration should be facilitated using the following framework:
    - adopt a bottom up, listening, problem solving approach;
    - identify, clarify and prioritise the issues to be addressed;
    - arrive at consensus for action;
    - formulate an action plan to improve the situation;
    - specify a review date,
    - promote collaborative activity;
    - support the effort to change things;
    - on review, reflect on usefulness of change, revise to erase bad points and implement again;
    - specify a further date for review;

**Make Evaluation An Integral Part Of A Change Process As It Leads To Personal Development And Learning, And Organisational Change Begins To Automatically Follow.**

- The following framework for an effective evaluation based on a PAR approach is suggested:
    1. Work together to draw up a plan of action;
    2. Determine what criteria meet the objectives;
    3. Identify what information to collect;
    4. Collect the information;
    5. Analyse the information together ;
    6. Share out the findings;
    7. Review the findings;
    8. Revise and refine future work as necessary;
    9. Move forward into the next participatory cycle of evaluation;
    10. In this evaluation model development is recognised when examples found match the evaluation criteria devised by the stakeholders. The evaluation criteria become representative of markers of good practice.

# APPENDIX 10

## THE AIMS AND OBJECTIVES OF EACH FACILITATION TEAM

The Facilitation Teams wrote these objectives towards the end of phase two of the LMFTs model for change. Each example provides an abridged and anonymised version taken from more detailed documents.

### BLUE FACILITATION TEAM'S OBJECTIVES

#### General:

1. Getting into the eleven Practices on our patch at grassroots level.
2. Networking.
3. Developing relationships with Primary Health Care Team members.
4. Doing what is relevant to Practice development.
5. Acting as a resource for our local Practices in all areas. If we cannot we will find someone who can.
6. Facilitating change.
7. Continuing involvement in the Primary Care Mental Health Project.
8. Two of our Practices are already involved in negotiations about Diabetic services and our interest continues.
9. Welfare benefit advice 'in-Practice' is being piloted in one of our Practices and we hope to maintain an interest here.
10. We hope to enable all eleven Practices to have their own teambuilding awaydays.

#### Future Practice PHCT Development Plans:

1. To continue to support the development of inter-Practice groups and extend it within the area.
2. To develop the learning potential in this group, e.g. Practices identifying learning gaps and joining to learn together possibly at small lunch time forums.
3. Looking at individual disciplines learning/training needs, e.g. practice managers and receptionists.
4. To maintain and develop interventions for identified health needs of the Practice population. Some of these will be in relation to Health of the Nation targets and some to the Practices perceived needs, e.g. asthma information and awareness campaign.
5. The Practices need to make sure that effective communication is taking place between Practices.

## NAVY FACILITATION TEAM'S OBJECTIVES

### Neighbourhood Level

1. To support the neighbourhood development strategies by working collaboratively with the NCMs and other relevant agencies:
2. Health needs assessment project
3. To continue to support the Nurse Practitioner project
4. Develop a school health initiative
5. To continue to build a close link already established with local organisations
6. To collaborate with local people and organisations to promote healthier lifestyles
7. Development of projects as a response to the local health needs assessment, to promote:
    - breast awareness;
    - men's health;
    - alcohol detoxification;
    - community resuscitation project;
    - elderly depression and mental health.

### Practice Level

1. Facilitate Practice meetings focusing on key issues for that Practice and also for the Cluster itself.
2. To work with PHCTs to raise targets.
3. Support for 5 Practices to continue development as a group Practice moving into fundholding and new premises.
4. Support Practices in their work to develop patient charters.
5. Support and facilitate training and projects within the PHCTs in order to fulfil the aims of the Neighbourhood planning strategy.
6. One of neighbourhood pairs in Cluster to be specifically targeted due to the nature of its Practice structure, i.e. very old fashioned, single handed Practices, large ethnic population, poor health promotion targets. A specific aim is help to develop cross-Practice collaboration.

## RED FACILITATION TEAM'S OBJECTIVES

| Aim | Objectives |
|---|---|
| To continue to communicate with PHC teams and other agencies at local level. | • Produce two bulletins<br>• Encourage PHCT to attend the educational events<br>• Develop relationships between staff in surgeries<br>• To maintain regular contact with surgeries |
| Sustain inter-Practice meetings founded in Phase one and support any new initiatives they generate. | • To facilitate regular meetings<br>• To help identify an agenda<br>• To improve information on cytology, asthma, diabetes, and smoking |
| Develop inter-Practice group further. | • To encourage more Practices to join the inter-Practice meetings or start their own meetings |
| Improve the quality of cytology services in this Cluster. | • To produce a questionnaire for use in Practices<br>• Facilitate the production of a Practice protocol that can be used by Practices in the inter-Practice group |
| On-going support for 'Fag-Ends' smoking cessation group. | • To provide an effective management team to utilise financial resources |
| Promotion of women's health within the Cluster. | • To identify women's health needs and network with other agencies to establish relationships |
| The organisation of a Mental Health Fair in conjunction with other agencies. | • To provide information on positive mental health<br>• To facilitate the event through the liaison with other agencies |
| Organisation of a new asthma initiative for children and parents. | • To facilitate a one day event for the under 12 years asthmatic children<br>• To encourage the asthmatic children to exercise through liaison with leisure services<br>• Establish self-help initiatives |
| Promotion of the 'Exercise for Health' scheme. | • To attend monthly sub committee meetings at the local sports centre |
| Contribute to and evaluate the LMFTs model for change. | • To provide relevant evaluation information |

## GREEN FACILITATION TEAM'S OBJECTIVES

1. Consolidation of our unique relationship with the Practice and attached staff in our cluster, i.e. the multidisciplinary approach has enabled us to become accepted and gain co-operation from all levels of the PHCTs.
2. Maintain networking with community and voluntary links.
3. Facilitate and support the individual Practices in identifying their health education needs.
4. December 1995 - produce bulletin and visit all Practices.
5. Neighbourhood Commissioning Managers - ensure a two way process of communication to maintain and develop our relationship with the Neighbourhood Commissioning Team.

**Green Facilitation Team's Joint Objectives With Their NCM** (an extract from a letter sent to NCM 25/6/96)

The areas we feel we can contribute are as follows:

| | |
|---|---|
| **Practice Development** | Interventions to be discussed regarding targeting one Practice and looking at Receptionists training, communication and staff development within the Practice. |
| **Social Services** | We plan to liaise with Social Services and other agencies, i.e. Age Concern, to tackle a local strategy for the long term care of the elderly. |
| **Mental Health** | We will assist with any new initiatives involving Mental Health Services. |
| **Primary Health Care Stroke Strategy** (Early 1997) | To facilitate workshop to invite PHCT to improve knowledge about management of stroke patients after discharge into the community. |
| **Neighbourhood Profile** | To help arrange a workshop to feedback NCM's work about neighbourhood profiling for the PHCTs making it an interactive meeting. |

# APPENDIX 11

## SUMMARY OF PRACTICE DEVELOPMENT IN ONE CLUSTER

P. = Practice

| P. | Activity | Action Plan | Follow Up | Impact / Outcome |
|---|---|---|---|---|
| 1 | To support the Practice as they establish their working relationships. | Adopt a more hands off approach; Promote regular meetings; | Maintain close relationship to continue promoting the changes. | Personal, Organisational and Service; |
| 2 | Try to establish trusting relationships to promote development. | Visit regularly to try to get Practice involved in facilitation activities; | Maintain relationship and keep them up to date with local events. | No known impact; |
| 3 | Try to establish trusting relationships to promote development. | Visit regularly to gain access, establish links and deliver bulletins; | Continue visits to encourage & hasten change. | No known impact; |
| 4 | Try to establish trusting relationships to promote development. | Visit regularly to gain access, establish links and deliver bulletins; | Continue visits to encourage & hasten change. | Personal; |
| 5 | Try to establish trusting relationships to promote development. | Visit regularly to gain access, establish links and deliver bulletins; | Continue visits to encourage & hasten change. | No known impact; |
| 6 | To maintain relationships to promote development. | Visit regularly to continue support and deliver bulletins; | Continue to support specific people and organise a Roadshow. | Personal, Organisational and Service; |
| 7 | One to one meetings to promote developments. | Arrange a discussion on how skills would be useful to Practice in the future; | Encourage to hold regular Practice meetings and develop an 'action plan'. | Personal, Organisational and Service; |
| 8 | Support individuals in the PHCT to promote development. | Develop role and services through support of Practice Nurse; | Nudge current changes along. | Personal, Organisational and Service; |
| 9 | Try to establish trusting relationships to promote development. | Visit regularly to gain access, establish links and deliver bulletins; | Continue visits to try to establish a link. | No known impact; |
| 10 | Try to establish trusting relationships to promote development. | Visit regularly to gain access, establish links and deliver bulletins; | Continue visits to try to establish a link. | No known impact; |
| 11 | Try to establish trusting relationships to promote development. | Visit regularly to gain access, establish links and deliver bulletins; | Continue visits to try to establish a link; | No known impact; |
| 12 | Try to establish trusting relationships to promote development. | To continue to develop communication in the Practice; | Offer support to any team development objective. | Personal and Organisational; |
| 13 | Try to establish trusting relationships to promote development. | Visit regularly to gain access, establish links and deliver bulletins; | Continue visits to try to establish a link; | No known impact; |
| 14 | Try to establish trusting relationships to promote development. | Visit regularly to gain access, establish links and deliver bulletins; | Help to meet DOH targets for Imms. & Cervical Cytology. | Personal; |
| 15 | To support Practice as they develop themselves from 'scratch'. | Organise in-Practice events to help all the staff work together; | To have a more hands off approach whilst maintaining support. | Personal, Organisational, Service; and the beginnings of community development; |

# INDIVIDUAL PROFILES OF EACH PRACTICE IN THE CLUSTER

## 1. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 1 | 3 Doctor Group | Practice Nurse |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Semi-responsive** | **Active** | **Active** |

**Facilitation Activity**

**Background**: the LMFT / Nurse Practitioner works in the Health Centre in the Primary Care Treatment Centre. The Practice was in much difficulty at the beginning of the Project. There was a considerable amount of friction between the Staff members appointed to the different Doctors.

**Response to facilitation activity:** A request for help came from the newly appointed consortium manager who was thrown in at the deep end with a disunited group of single handed Practices. She was expected to help form a consortium with and later to assist to 'go fundholding' and asked the facilitators to assist her.

**Specific facilitation activity:** A Roadshow was held to clarify roles in June 1994 and Staff subsequently attended local workshops. This began a period of enormous input from the facilitation teams. Things finally began to settle as the Doctors formed a partnership and went fundholding in April 1996.

**Objectives of Practice level facilitation activity:**

- To establish a relationship based on trust with the different groups of staff;
- To support and assist the changes as the Practice Doctors take on a formal relationship and take up fundholding status.

**Personal Development**

Examples include:

- Individual appreciation and respect of each other's role in the PHCT has grown among staff members;
- A Receptionist was now able to discuss cytology screening with patients having learnt this was acceptable as part of her role during the team building sessions.

**Organisation Development**

Examples include:

- Members of the team seek to find ways of solving problems together,
- As different clinics have been set up the staff have planned and organised them together;
- They now co-operate with each other much better, e.g. hold a 'combined' baby clinic in which different Health Professionals make their services available to patients at the same time;
- Practice Nurses having clarified their role were able to make a case for the administrative work to be undertaken by clerical staff;

- Team building had provided the forum to discuss the issues , implications, planning and organising to 'go fundholding'.

**Service Development**

Examples include:

- Increased range of and access to services available;
- Increased efficiency and effectiveness as a result of shared clinical activities in the Baby clinic.

**Development in the Wider Community**

Examples include:

- none known.

**Future development objective:**

- Continue to support the Practice but at more of a distance than before;
- Identify areas, together with the PHCT, where improvement is required;
- Encourage to hold more regular team meetings.

## 2. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 2 | Partnership | Practice Nurse and others |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Passive** | **Passive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice. A very self reliant Practice that do not feel they require any support from the facilitators.

**Response to facilitation activity:** to date no response apart from being keen to receive feedback from Neighbourhood events.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish and maintain a good relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events;
- To provide feedback regularly on Neighbourhood events.

**Personal Development**

Examples include:

- None known.

**Organisation Development**

Examples include:

- None known.

**Service Development**

Examples include:

- None known.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- To maintain relationship and keep up to date with Neighbourhood events.

## 3. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 3 | Group | Attached District Nurse |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Semi-responsive** | **Semi-responsive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice. A self-reliant Practice that is reluctant to admit any problems, gives the impression of being a team but some members infer that there is not equity among its members.

**Response to facilitation activity:** Receptive, will listen and attend Cluster level events.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events.

**Personal Development**

Examples include:

- None known.

**Organisation Development**

Examples include:

- None known.

**Service Development**

Examples include:

- None known.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Continue to visit;
- Give support and help on request.

## 4. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 4 | 3 Dr partnership | Practice Nurse |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Passive** | **Passive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice.

**Response to facilitation activity:** to date shown interest but no active response, in part due to workload, immanent move to new premises and appointing a new partner.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events;
- To support during their current difficulties and be on hand to help with Practice development at the appropriate time.

**Personal Development**

Examples include:

- Receptionist developed additional knowledge and skills as a result of attending the Receptionist's course.

**Organisation Development**

Examples include:

- None yet.

**Service Development**

Examples include:

- None yet.

**Development in the Wider Community**

Examples include:

- None yet.

**Future development objective:**

- To support during their current difficulties and be on hand to help with Practice development at the appropriate time.

## 5. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 5 | Single handed | District Nurse & Health Visitor |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Passive** | **Passive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice; GP to retire shortly and does not consider change necessary.

**Response to facilitation activity:** to date no response apart from receiving the bulletins.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events.

**Personal Development**

Examples include:

- None known.

**Organisation Development**

Examples include:

- None known.

**Service Development**

Examples include:

- None known.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Maintain relationships.

## 6. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 6 | 6 GP Group | Practice Manager |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Semi-responsive** | **Semi-responsive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice.

**Response to facilitation activity:** Practice ethos changed from being a 'closed shop' to more responsive, e.g. Dr chaired an intervention on Mental Illness recently. 8 family planning clinical sessions held in-Practice by the facilitator helped to establish a relationship.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events;
- Individual support to different personnel in the face of personality problems (clashes) and concerns around current practice.

**Specific Facilitation Activity;**

- Monthly visits to 'till the soil' and use the 8 Family Planning sessions to establish relationships.

**Personal Development**

Examples include:

- GP - opening out, "he is just about to go onto the Liverpool Medical Committee";
- Individual's gained knowledge about supervisory role and expectations about clinical practice.

**Organisation Development**

Examples include:

- A change to the organisation and administration of the cytology screening system to make it more efficient.

**Service Development**

Examples include:

- An improvement of service delivered to the patients given the change to the call and recall system.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Maintain relationships and support specific members of staff as and when they need it;
- To hold a roadshow on 'pre-school boosters'.

## 7. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 7 | Partnership | **Attached District Nurse & Health Visitor** |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Semi-responsive** | **Semi-responsive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice.

**Response to facilitation activity:** begun to respond to facilitators more in this last year.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events.

**Facilitation Activity:**

- One to one meetings with D.N. on delivery of the bulletin, general chats;
- Members of PHCT attended cluster interventions;
- Mediation between Practice Staff and Health Professionals providing local community health services;
- Facilitation of communication process to establish a co-operative working relationship between Health Professionals and the Practice.

**Personal Development**

Examples include:

- A change of attitude and behaviour from hostile, through indifference, to finally accepting the presence of attached staff.

**Organisation Development**

Examples include:

- Setting up, via the use of multidisciplinary meetings, the different clinics on-site organised by the different attached Health Professionals.

**Service Development**

Examples include:

- Improved the range of services available to the Practice population;
- Increased services for the elderly patients as the District Nurse undertakes home Health Checks for those patients that do not want to come to the Practice.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Encourage Practice to hold regular meetings;
- Discuss how facilitators skills and support would be useful;
- Develop, together with the Staff, an action plan;
- Take up request to organise a roadshow on Diabetes - aiming to target non-attendees.

## 8. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 8 | Partnership | Practice Nurse |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Semi-responsive** | **Semi-responsive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice. A 'closed Practice' the facilitators were not able to gain access for most of the project but Neighbourhood orientated and attends pertinent Cluster Interventions.

**Response to facilitation activity:** becoming more responsive over time.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events.

**Facilitation Activity:**

- Supporting the Practice Nurse as she tried to develop her role and define its boundaries;
- Doing some groundwork with the Practice to enable them to apply for 'Health Promotion Banding, level 3';
- Helped to write some preliminary protocols which build safe measures into the Practice Nurse's clinical role;
- Helped Practice to write a bid and make a case for extra work hours in relation to the Practice Nurse role.

**Personal Development**

Examples include:

- Development of the Practice Nurse, e.g. she developed her role and Practice services whilst in receipt of support and advocacy from the facilitators.

**Organisation Development**

Examples include:

- Writing protocols to guide newly developed clinical practices;
- Writing a bid for more Practice Nurse hours.

**Service Development**

Examples include:

- The range of services has increased as the Practice Nurse has developed her role and set up clinics accordingly.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Nudge these developments along further.

## 9. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 9 | Group | Practice Nurse<br>GP |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Passive** | **Passive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice. A very hierarchically structured Practice that is friendly and receptive to facilitators when you can manage to get beyond the 'waiting room'. An extremely difficult Practice to access that presents a very self-reliant air.

**Response to facilitation activity:** to date no response apart from receiving the bulletins and listening passively.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events.

**Personal Development**

Examples include:

- None known.

**Organisation Development**

Examples include:

- None known.

**Service Development**

Examples include:

- None known.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Appears to not want any help.

## 10. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 10 | Single handed | Practice Manager |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Passive** | **Passive** |

**Facilitation Activity**

**Background**: the LMFT Practice Nurse is employed as the Practice Nurse in the Practice. The original partnership split up recently but the Doctor still shares the Administrative Staff and Practice Nurses with the other Doctors on the premises. GP not a 'team player' and doesn't have Practice meetings. Easy Practice to access, staff are friendly. The GP doesn't attend any Cluster interventions.

**Response to facilitation activity:** to date no response apart from receiving the bulletins.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events;
- To be available to offer support if requested.

**Personal Development**

Examples include:

- None known.

**Organisation Development**

Examples include:

- None known.

**Service Development**

Examples include:

- None known.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- To be available to offer support if requested.

## 11. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 11 | 3 partners | Health Visitor |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Passive** | **Passive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice; Fair reception to facilitators.

**Response to facilitation activity:** to date no response apart from receiving the bulletins. Improvements have been made since NCM came into post - the facilitators kept up to date via this route.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of team and other local events.

**Personal Development**

Examples include:

- None known.

**Organisation Development**

Examples include:

- None known.

**Service Development**

Examples include:

- None known.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Be available to support Practice as when ready for or requests help.

## 12. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 12 | 2 Doctor Partnership | Practice Manager<br>Practice Nurse |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Semi-responsive** | **Semi-responsive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice.

**Response to facilitation activity:** Staff more receptive to facilitators involvement over time of the Project.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events;
- To hold regular Practice meetings.

**Personal Development**

Examples include:

- Practice staff say they now feel 'more motivated'.

**Organisation Development**

Examples include:

- Practice generally improved its organisation and administration but nothing specifically;
- Practice meetings held irregularly but the meetings do include whole PHCT when held.

**Service Development**

Examples include:

- None specifically.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Continue to develop communication with the Practice;
- To offer support to any team development objectives of the Practice;
- To encourage participation in facilitation activity - Practice or Cluster level.

## 13. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 13 | Single handed | Dr and Receptionist |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Passive** | **Passive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice.

**Response to facilitation activity:** to date Dr very receptive but limited by the lack of resources she has. The Dr attends Cluster Level activities when able to.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish and maintain relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events.

**Personal Development**

Examples include:

- None known.

**Organisation Development**

Examples include:

- None known.

**Service Development**

Examples include:

- None known.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Continue to maintain the close connection now made with the Practice;
- Doctor says she will be delighted to receive the facilitators support if Practice move takes place.

## 14. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 14 | Single handed | Receptionist & Health Visitor |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Passive** | **Semi-responsive** | **Semi-responsive** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice.

**Response to facilitation activity:** Not attended anything before the day found in a 'crisis' - 10/94 when one of the facilitators happened to visit. Attendance at two cluster level interventions recently, currently there is a good reception towards facilitators who think the Practice members are better talked to on a one to one basis at the moment.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events.

**Personal Development**

Examples include:

- A Receptionist developed additional knowledge and skills as a result of the Receptionist course;
- Attitudes of Practice Staff changed towards facilitators - they now accept them.

**Organisation Development**

Examples include:

- None known.

**Service Development**

Examples include:

- None known.

**Development in the Wider Community**

Examples include:

- None known.

**Future development objective:**

- Support application for community fundholding;
- Help to meet DOH targets for Immunisations and Cervical cytology;
- Developing the link with the new Health Visitor.

## 15. GENERAL PRACTICE

| Date of First Review | General Practice | Type of Practice | Link Person |
|---|---|---|---|
| March 1996 | 15 | Single handed | Dr |
| **RESPONSE** | **1995** | **1996** | **1997** |
| | **Semi-responsive** | **Active** | **Active** |

**Facilitation Activity**

**Background**: the team has no prior relationship with the Practice. The Practice came into being at the same time as the LMFTs model. The Practice had asked for help from the MAAG who couldn't make it on one occasion so the facilitators stepped in. After this introduction to them the Practice regularly asked for further help.

**Response record:** Requests for help on fairly frequent basis at first, less so now. Active response to facilitator's ideas and suggestions.

**Objectives of Practice level facilitation activity:**

- To visit regularly to gain access;
- To establish a relationship based on trust;
- To deliver bulletins in order to raise level of awareness of facilitators and other local events;
- To help establish and develop services in this new Practice.

**Facilitation Activity**

- Practice roadshow 1994 relating to cervical cytology;
- Assessment of Practice resources and identification of their immediate requirements;
- Setting up an administrative system for cytology screening;
- Encouraged release of Receptionist to attend the Receptionists course.

**Personal Development**

Examples include:

- The Practice Staff feel they have each individually benefited from the facilitators input, e.g. the Receptionist has increased her knowledge, the Practice nurse was assisted in her effort to develop the cytology recall system, and the GP has become more inclined to inform staff of the progress of the Practice.

**Organisation Development**

Examples include:

- Setting up a cytology recall system;
- Target levels were raised as far as they could be within the constraints of Practice resources;
- Assisting the GP bid for the services of the Nurse Practitioner to continue to improve the cytology screening levels;

- Inclusion of all different members of staff in the cytology screening approach;
- Potentially increased Practice income as cytology screening levels increased under the 'GMS scheme'.

**Service Development**

Examples include:

- Range of services available to patients increased;
- Nearly all patients from the different ethnic groups had received cytology screening by the time the Nurse Practitioner was appointed.

**Development in the Wider Community**

Examples include:

- GP makes himself aware of local needs and is trying to establish a liaison with local ethnic minority leaders.

**Future development objectives:**

- To have a more hands off approach now to allow Practice to establish its own way forward;
- To continue to promote the improvement of cytology target levels;
- To establish and support the next appointed Practice Nurse;
- Keep encouraging the Practice to be involved with the local Neighbourhood.

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