Document 5 – A Thesis

Understanding Networks

An examination of doctor engagement in a clinical network: the case of Mid Trent Critical Care Network

**Susan Claire Shepherd
Doctorate in Business Administration**

July 2015

ABSTRACT

Within the field of health care, this study has addressed a lack of current research exploring social aspects of a clinical network. In presenting the final stage of this study, this document focusses on the engagement experience from a medical viewpoint. This is topical and of interest, as doctor engagement in the NHS is associated with enhanced organisational performance and improved patient care.

There is little previous empirical research exploring the engagement experience from the perspective of doctors working in a clinical network. The final stage of this research study therefore presents a new theoretical understanding of this subject area. Throughout the study, the author has demonstrated that clinical engagement is at the heart of a successful clinical network.

The study is qualitative in nature and takes an interpretive epistemological orientation. Data is gathered through a number of research methods and doctors' perceptions of engagement are explored through emerging narrative accounts.

Findings from this research study indicate that choice of engagement leads to both the engaged doctor, and the reluctant manager, and has highlighted that choice of engagement is influenced by a perceived internal and external conflict. Outcomes confirm that doctors will choose to engage when they have a personal interest and commitment, feel that they are listened to and have a voice, perceive that they are valued and respected, are involved and able to influence, have power and respect and where the environment that they work in fosters collaboration, facilitates the sharing of expertise and specialised knowledge and offers both personal and professional support leading to improved patient care.

Exploring why doctors choose to engage in a clinical network has confirmed the requirement to create a culture for engagement and identified that successful engagement leads to improved patient care, a factor that has been constant throughout this research study.

ACKNOWLEDGEMENTS

The author acknowledges Professor Colin Fisher and Dr Donald Harradine for their professional support and guidance throughout the duration of this study. Their academic wisdom and genuine interest in the research area has assisted the author in gaining a greater insight into the research subject ensuring that the topic has remained relevant throughout the study period. The author realises the benefits of expert supervision and appreciates the time and professionalism afforded her by her supervisors, all of which has contributed to her development as a researcher and as a health care professional.

The author also recognises Professor Malcolm Prowle and Professor Susanne Tietze for their supervisory support and guidance early in the research journey, which contributed to the development of this study.

The author acknowledges her friends and colleagues in the Mid Trent Critical Care Network for their continuous support, advice and salvation during the years of this study and for their willingness to participate in the research. Their openness and honesty has made this study what it is and the author hopes that she has succeeded in presenting their views in an exacting way. Without the financial support of the Network and the enthusiasm and inclusion of participant members, this study would not have been possible. Additionally, the author acknowledges her friends outside of the Network for giving their time and for generously sharing their insight and intellect.

Finally and most importantly, the author acknowledges her family for allowing time away from them to study and for their unfailing love and support; always.

TABLE OF CONTENTS

TABLES AND FIGURES:

APPENDICES:

LIST OF ABBREVIATIONS

AoM	Academy of Management
BLSS	Business Law and Social Sciences
CQC	Care Quality Commission
CEO	Chief Executive Officer
CCG	Clinical Commissioning Group
CD	Clinical Director
CCU	Coronary Care Unit
DoH	Department of Health
DBA	Doctorate in Business Administration
EBSCO	Elton Bryson Stephens Company
GP	General Practitioner
GAfREC	Governance Arrangements for Research Ethics Committees
HRA	Health Research Authority
HDU	High Dependency Unit
IRAS	Integrated Research Application System
ICS	Intensive Care Society
ICU	Intensive Care Unit
ITU	Intensive Therapy Unit
LQF	Leadership Qualities Framework
MES	Medical Engagement Scale
MLCF	Medical Leadership Competency Framework
MSFT	Mid Staffordshire NHS Foundation Trust
NHS	National Health Service
NIHR SDO	National Institute for Health Research Service Delivery and Organisation
NRES	National Research Ethics Service
NTU	Nottingham Trent University
ODN	Operational Delivery Network
PA	Programmed Activities
R&D	Research and Development
REC	Research Ethics Committee
SHA	Strategic Health Authority
SPA	Supporting Professional Activities
UK	United Kingdom

INTRODUCTION TO THE STUDY

Within the field of health care, this study in its entirety has addressed a lack of current research exploring the social aspects of a clinical network. The Mid Trent Critical Care Network (the Network) forms the case study for this research. The intention of this final stage of research is to build on work done in previous documentation. Earlier qualitative research (Shepherd, 2012) examined participants' perceptions of network effectiveness and identified clinical engagement as a key factor that contributes to the success of the Network. The aim of this research is to examine why doctors choose to engage in the Network in order to explain and make sense of their engagement to inform an effective strategy for engaging doctors in the management and leadership of the NHS. The author has easy access to senior doctors in the Network, and this research takes an interpretive approach to examine doctors' perceptions of the engagement experience, explored through narrative analysis. This research offers a new theoretical understanding of factors that contribute to the successful engagement of doctors in the NHS, thereby adding to the body of knowledge on doctor engagement.

Chapter 1 frames the research topic in the context of the NHS and identifies the purpose, importance and scope of the study. It introduces the key questions for research and provides a brief summary of the research journey. Chapter 2 examines literature pertinent to this study and introduces the conceptual framework. Chapter 3 presents the research philosophy and methodology adopted to answer the research questions and provides a brief overview of the ethical issues and considerations for this study, making reference to the process of ethical approval in the NHS. Chapter 4 offers a discussion of the research methods and their application to this study. Chapter 5 presents the research findings and analysis of results and includes a revised conceptual framework. In the final chapter, Chapter 6, key outcomes from the study are compared to recent literature and conclusions are drawn from these outcomes. The final chapter concludes with a number of recommendations based on key elements arising from the study.

CHAPTER 1

This Chapter presents the research subject and outlines the purpose of the study. It identifies the research questions and reviews the importance of the topic in the context of a health care environment. A summary of the research journey is included and the limitations of the study are recognised. The final part of the Chapter defines a number of key terms for the reader.

1.1   Setting the Scene

> *"... every man, every civilisation, has gone forward because of its engagement with what it has set itself to do. The personal commitment of a man to his skill, the intellectual commitment and the emotional commitment working together as one, ..."* (Bronowski, 2011, p.330).

Research for this study has been undertaken with participant members of the Mid Trent Critical Care Network (The Network), a mature managed clinical network that operates as a non-statutory networked organisation in the United Kingdom (UK) National Health Service (NHS). The Network was established in April 2000 to ensure equitable access and care for all critically ill patients within the Mid Trent Region and no critical care unit in the Region operates independent of the Network. The Network facilitates a greater understanding of the clinical context of critical care, and membership of the Network includes relevant provider and commissioner organisations as outlined in Appendix 1. Since its inception, member organisations have evolved in line with changes in the architecture of the health service (i.e. Commissioning organisations have evolved from Primary Care Trusts to Clinical Commissioning Groups). Clinical networks are vibrant systems designed around connections and partnerships rather than isolation and self-reliance and provide a more flexible, relationship-based model of health care delivery. The Mid Trent Critical Care Network was established as a managed clinical network (Scottish Office, 2000; Scottish Executive, 2002; NHS Scotland 2002a; 2002b) but functions as an Operational Delivery Network (ODN) in the current structure of the NHS (NHS Commissioning Board, 2012a). Whilst it is suggested that clinical networks differ from managed networks because they lack a formalised service delivery function involving the organisation and co-ordination of clinical services (McInnes *et al.*, 2012), throughout this document the author uses the term "clinical network" to describe a network form constructed of clinical members, working together to improve clinical care and service delivery. Clinical

networks are explored in more detail in earlier research (Shepherd, 2009; 2010; 2012) and the ODN model is further described in Chapter 2. Likewise, critical care is defined in more detail in earlier research (Shepherd, 2009; 2010; 2013) although for the purposes of this document, a brief definition is included at section 1.8.2. Critical care is a high cost, low volume specialty and critical care services are therefore well organised into a networked model of care.

Since first becoming involved in a clinical network in 2001, the author has developed a particular interest in the network model of service delivery in a health care environment and has been fortunate enough to be able to pursue this interest through this study. The overall aim of this research study is to gain a better understanding of the social aspects of a clinical network through a process of examination and analysis. Early in this study, the author searched the literature on networks and identified a number of associated benefits (Shepherd, 2010; 2012). Whilst there is a large body of evidence to support the effectiveness of clinical networks (Scottish Office, 2000; Scottish Executive, 2002; 2007; Goodwin *et al.*, 2004a; 2006; Kennedy, 2007; Baker, 2002; Pedler, 2001; Cavill, 2006; 6, *et al.*, 2006; Ferlie *et al.*, 2010; Guthrie *et al.*, 2010), it became clear to the author that much of the literature focusses on the more tangible structural aspects and that elements relating to the organisation and success of networks are easily categorised into a number of key areas. These include; structure and scope, accountability and governance, funding and resources, stakeholder support and ownership, leadership and management, workforce, knowledge and information management, service development and quality and benefits.

During the earlier stages of this study (Shepherd, 2012) the author found little empirical evidence on the value and effectiveness of network models, or of known outcomes and impact on patient care, a point that was later echoed by Malby and Kieran (2012), although behaviours and trust were recognised as important indicators of network success (6, *et al.*, 2006; Currie *et al.*, 2010). Whilst some of the earlier literature on the development and implementation of managed clinical networks recognises the need to focus on patient care and experience (Scottish Office, 2000; Baker, 2002), the author identified a gap in the literature in respect of the social aspects of clinical networks. As this study has progressed to this stage, the author has revisited relevant literature and has discovered a growing interest in the social factors associated with clinical networks. A review commissioned by The Health Foundation (2014) to better

understand how networks can support health care improvement, recognises the importance of social factors in networks. It examines different network types and identifies the power of social and professional connections synonymous with the collaborative network model as an effective vehicle for quality improvement. The review identified five core features of effective networks that are akin to the findings from earlier qualitative research undertaken for this study around co-operation, collaboration and collective intelligence. Throughout the earlier stages of the study, the concept of engagement arose as a key factor contributing to the success of the Network and this research examines engagement in the context of the Network as outlined in the following section.

1.2 Purpose of the Study

Clinical networks, as non-statutory organisations, rely heavily on the engagement of member organisations and participant members to deliver the work of the network. The term 'engagement' does however imply a commitment; an inclination to become involved, and in respect of the NHS, this infers that clinicians choose whether to engage or not in the organisations they work in.

Earlier qualitative and quantitative research (Shepherd, 2012; 2013) provides evidence of good clinical engagement in the Mid Trent Critical Care Network, but why is this; why do clinicians choose to engage in the work of the Network and what is it about the Network that influences this engagement? In progressing this study on the social aspects of clinical networks, this stage of the research therefore explores clinical engagement in a network environment. The value of the Network is embedded in social factors and these values are lived and accepted by the people in the Network; this is what gives the Network its culture. The author considers that she is in a privileged position of working with clinical staff on a daily basis and of being able to witness first-hand, some of the benefits associated with clinical engagement in a networked environment. The nature of the Network facilitates multi-professional working and staff from a number of professions and organisations participate in the work of the Network. It is to be noted however, that whilst earlier qualitative research undertaken for this study (Shepherd, 2012) recognises the contribution of multi-professional clinical staff in the operation and success of the Network, in order to bring a clear focus to this stage of the study, this final piece of research is undertaken solely with doctors.

Much is written about the importance of doctor engagement in the NHS (House of Commons, 2013; Department of Health, 2013; Darzi, 2008; UK Coalition Government, 2012; Ellins and Ham, 2009) and this is covered in more detail in Chapter 2. This research however is not concerned with the practise of engaging doctors, as earlier research for this study demonstrates that doctors are already engaged in the work of the Network (Shepherd, 2012). This research therefore provides a unique perspective of the engagement experience, exploring specifically why doctors choose to engage in a clinical network. The author considers that much of the literature on clinical engagement identifies the process for engagement, and in seeking to describe the actual engagement experience, suggests that this research explores engagement *"through the other end of the telescope"*. In fact, it is acknowledged that many of the studies exploring doctor engagement have focused on structural changes and on the required skills and leadership styles for engagement and that these studies have had less impact than anticipated (Bohmer, 2012). Much less attention has been paid to the behavioural aspects of medical engagement, and this study observes social and organisational issues associated with doctor engagement in a clinical network to inform a strategy for engaging doctors in the management and leadership of the NHS. In the context of this study, the author has reviewed literature on employee engagement, which also addresses the social and organisational aspects of engagement. Whilst it is suggested that there is no obvious difference between the dynamics of engagement in the public and private sectors (Scottish Executive Social Research, 2007), Kahn (1990) advises that employees present varying degrees of themselves in the roles that they perform at a physical, cognitive and emotional level.

The author suggests that doctor engagement is likely to have a bearing on a number of levels, be this on a personal, professional or organisational level, particularly where doctors might perceive a benefit either for themselves as individuals or collectively as a group, and these different levels of engagement are explored in this study. Within the context of this study, doctors have a dual role in terms of the role that they undertake in the Network and the role that they perform in their employing Trust, that is, the role of clinician and of clinical manager. At an organisational level, doctors can choose to be engaged, or not, in the management and leadership of the organisation, whether this is the Network, their employing Trust or the wider NHS, and their choice of engagement in these settings is examined in this study. Recent literature relating to doctor

engagement is applied to the key outcomes from this study and conclusions are drawn from the outcomes.

The author suggests that there could be many reasons why doctors might choose to be involved and engaged in the management of the NHS particularly as it is suggested that clinical leaders continue to play an important role in the management of health services, predominantly in respect of maintaining quality and patient safety in today's financially challenged NHS (Montoute, 2013). Clinical engagement is recognised as a key factor for improved organisational performance in the NHS (Clark, 2012a; 2012b; Bohmer, 2012; Broome *et al*., 2013; Silversin and Kornacki; 2000, Australian Medical Association, 2010; Mountford and Webb, 2008; 2009; Buchanan *et al*., 1997; Atkinson *et al*., 2011; Hamilton *et al*., 2008; Dickinson and Ham, 2008, Ham and Dickinson, 2008; MacLeod and Clarke, 2009) and as a key factor for networks to thrive (Malby and Kieran, 2012). In terms of engagement in Networks, Malby and Kieran (2012) assert that the engagement of participant members is vital in any networked organisation in order not only to preserve the network environment, but also to achieve the network's objectives. As indicated, early qualitative research has demonstrated that the Network has good clinical engagement and this third and final piece of research examines doctor engagement in the context of a clinical network.

This stage of the research therefore reports an interpretive research approach to ethnographic research and the following section illustrates the framing of the research questions within the qualitative research methodology.

1.3   The Research Questions

At this stage of the research process, the author is interested in exploring how doctors explain and make sense of their engagement with the Network and whether these meanings change according to situation or context, audience or time. As already determined, doctor engagement is vital to improve quality and efficiency in the NHS (Lewis, 2012) and research identifying why doctors choose to engage, from the perspective of doctors involved in a clinical network, provides useful data for organisations seeking to engage doctors in the future and an insight into effective strategies for engaging doctors.

At each stage of the research process, the author has generated several iterations of the research questions and through re-visiting and redefining these has come to realise the benefit of simplicity. The key questions for this research are outlined in Table 1 and relate specifically to participant member senior doctors identified as being engaged in the Network.

TABLE 1 - RESEARCH QUESTIONS – DOCUMENT 5

Key Questions	Sub Questions	Research findings *to ascertain:*
How do doctors explain and make sense of their engagement with the Network? Do these meanings change according to context or situation, audience or time?	*Why do doctors choose to engage in a clinical network?* *What can we learn from doctor engagement in a clinical network?* *What is it about the Network that has engaged doctors?* *What are the triggers and cues that we need in an organisation to get doctors involved and engaged?* *Do doctors engage more readily with a clinical network than with their employing organisation and if so, why?* *Do doctors behave differently in a networked organisation?*	How doctors give meaning and make sense of engagement in a Network Effective strategies for engaging doctors in the management and leadership of the NHS How doctors give meaning and make sense of organisational culture and engagement Effective strategies to encourage particular behaviour

Simplifying the questions in this way has enabled the author to utilise qualitative research techniques to dig for detail and probe for richness. The findings from these questions are explored in Chapter 5.

In order to provide some context to the study, the following section briefly outlines the background to this research.

1.4 The Research Context

The UK National Health Service is the largest and most complex health care system in the world. With an annual budget of around £106 billion and employing over 1.7 million people, the NHS treats 1 million people every 36 hours, spending nearly £2 billion a week and touches the lives of virtually every person living in the UK (The King's Fund, 2011). The NHS has changed dramatically since its inception in 1948 and changes in administration and policy present continual and often new challenges for those managing and delivering patient care (House of Commons, 2013). Just under half of the NHS workforce are clinically qualified

and all staff in the NHS have a duty of care to operate within a common set of principles and values to ensure fair and effective delivery of health care for all patients (Department of Health, 2013). The NHS is a progressive multifarious organisation and whilst the NHS could be perceived as a single organisation, the author suggests that it is more a system made up of multiple organisations. New advances in economic, technological, social and medical conditions influence the planning and provision of health care and present an ever-changing environment into which different models of service delivery are introduced (Department of Health, NHS Modernisation Board, 2003). Additionally, advancing technology means that more patients are better informed of their condition and treatment options, which in many instances could raise expectations and influence decisions. The ever increasing demand for limited health care resources and greater choice for patients introduces an element of contestability in to the system requiring providers of health care to offer more responsive, innovative and efficient high quality services for all (Department of Health, 2004).

It is suggested that the continual development of the NHS has created new problems, while not always solving old ones and that striking a balance between cost, quality, equity and the timeliness of care is an ever increasing problem in the NHS (Rivett, 1998). Today, quality patient care and safety are the key drivers of the NHS and staff are encouraged to work in partnership to lead change and improve the quality of care that patients receive (Darzi, 2007). Patient pathways are often complex and span a number of different health specialities and organisations. Joined up working arrangements are therefore important to ensure that patients receive seamless care. In some areas of the health service, patients really benefit from partnership working, especially in areas of care where costly health care resources are limited, for example critical care. Throughout England, Wales and Northern Ireland, critical care services are organised into clinical networks within defined geographical boundaries based on patient flows. Following the recent reorganisation of Clinical Networks in the NHS, there are currently 15 critical care ODNs in England.

Informal networks have existed in areas of the NHS since its inception and cancer networks can be traced back to the 1970s (Sheaff *et al.*, 2011). Following the recommendations of the Calman-Hine Report (1995), managed clinical networks for cancer services were formally introduced into the NHS in the late 1990s. At that time, the network model was a radical proposal and a novel approach for the reorganisation of cancer services (Ferlie, Hawkins and Kewell,

2002) and these networks were a precursor for managed professional and clinical networks. As networks started to gain popularity in the NHS, Ferlie and Pettigrew (1996) suggested that the networked model offered a more flexible approach to organisational structure and redirected attention away from formal structure and policy to the importance of patterns of social relationships within organisations with the concepts of trust, reciprocity and reputation gaining prominence.

The networked model of care was widely welcomed by health care professionals who shared similar work and interests especially where it was anticipated that networks would facilitate the development of standardised care and the sharing of best practice across a whole health economy (Addicott, McGivern and Ferlie, 2006). New NHS policy introduced in 2000 placed the patient at the heart of the health service and heralded a move away from a competitive market form to a more collaborative partnership based model of health care (Secretary of State for Health, 2000). The network model places greater emphasis on collaboration, co-operation and partnership working and, over the years, the numbers and types of networks in the NHS has increased dramatically. Clinical networks vary in form and function and have differing needs in terms of management, engagement, design and authority (Malby and Kieran, 2012). Members come together in a clinical network voluntarily and the success of networks depends on member involvement and engagement.   Norris *et al.*, (2005) propose that network members require a set of non-clinical competencies including interpersonal and analytical skills to facilitate effective collaborative working. Whilst the value and impact of clinical networks continues to be debated, it is encouraging to note that more recently, it has been suggested that networks are perceived as a basic concept of social analysis (Sheaff *et al.*, 2011).

As already described in previous documents for this study (Shepherd, 2009; 2010; 2012), clinical networks offer a model of care that is more closely linked to the patient's pathway and experience of care and in today's NHS, a number of services are organised into a network model of care. Following the most recent review of clinical networks in the NHS (McLean, 2011), networks are presently classified into three categories; NHS England supported Strategic Clinical Networks, Clinical Commissioning Group supported ODNs and Professional Local Networks.   Many of the original managed clinical networks are now organised into Strategic Clinical or ODN models and are accountable to a commissioning organisation (NHS Commissioning Board, 2012a; 2012b; 2012d). There is no single model for clinical networks and whilst each prescribed model

suggests a set of operating principles, their purpose and design often depends on local circumstances, boundaries and the population served. Networked organisations offer the potential to improve efficiency and effectiveness, and the rationale for networking, along with some of the potential benefits, are well recognised (Ferlie *et al.*, 2010; Kanter, 1994; NHS Commissioning Board, 2012a; Goodwin *et al.*, 2004b). Likewise, the importance of doctor engagement in the NHS is widely acknowledged (Clark, 2012a; 2012b; Bohmer, 2012; Broome *et al.*, 2013, Silversin and Kornacki, 2000; Australian Medical Association, 2010; Mountford and Webb, 2008; 2009; Snell, Briscoe and Dickson, 2001; Buchanan *et al.*, 1997; Atkinson *et al.*, 2011; Hamilton *et al.*, 2008, Dickinson and Ham, 2008; Ham and Dickinson, 2008) and some of the benefits associated with doctor engagement in the Network are recognised through earlier stages of this research (Shepherd, 2012; 2013). At the heart of the argument for clinical engagement is the proposition that doctors hold a position of power and the concept of power emerges within this research.

The NHS is not free of political involvement or interference and the author often bears witness to the effects of politics in the NHS. In the authors' experience, this comes in two different forms, the "big P" politics where services and developments are influenced by Government decisions and directives; and the "little p" politics where services and developments are influenced by decisions and directives undertaken by doctors in the NHS. Doctors form a powerful body in the NHS and the author has sat with a number of doctors and listened to them discuss the power of medical politics. Words used to describe medical politics by the doctors themselves are; "parochial", "protectionism" and "power". There is no doubt in the author's mind that doctors are strong political players in the NHS and that, with the right connections, they can make or break strategic and operational decisions. A fine example of this is in respect of some of the decisions around the reconfiguration of specialist services to regional centres of excellence where the interference of powerful clinical leaders, in objection to the proposals (often due to disagreements in respect of territory, power or control), have the power to stall the process for a considerable length of time. It is therefore vitally important that doctors are engaged at all levels in the decision making processes of the NHS; particularly as doctors themselves are likely to have an awareness of the veiled power that they can exercise should the need arise. Early research (Shepherd, 2012) has demonstrated effective clinical engagement in the Network and this study specifically explores why doctors choose to engage in the work of the Network.

The NHS faces an almost constant challenge to deliver patient care of the highest standard and clinical engagement is recognised as an important factor that contributes to improving the performance of NHS organisations (Lewis, 2012). Clinical engagement however cannot be assumed for all aspects of the NHS, and this research identifies some of the triggers for engagement. Clinical engagement is perhaps more important now than at any other time in the history of the NHS as the NHS faces a protracted period of imposed austerity and a requirement to deliver improved quality care for all patients. The following section therefore addresses the significance of this study in what is currently a topical area of debate.

1.5 Importance of the Study

A number of independent and public enquiries have identified both organisational and cultural factors that contribute to deficiencies in the quality of health care. Many of the problems that have arisen from the recent inquiry into care provided by Mid Staffordshire NHS Foundation Trust (MSFT), termed 'The Francis Inquiry', suggest a disconnect between the organisation and clinical staff, with notable disengagement of medical professional staff from managerial and leadership responsibilities (House of Commons, 2013) and disengagement from the MSFT governance process. Early in 2001, concerns were raised about the management of the MSFT with lack of engagement and leadership of clinicians being identified as a contributing factor (House of Commons, 2013). The report uncovered failings in leadership and in the care of patients and advised that a change in the culture of the NHS is needed to improve the safety and quality of care for patients. Engaging clinicians in the work of the MSFT was identified as a problem in 2005 by the interim Shropshire and Staffordshire Strategic Health Authority (SHA) Chief Executive (the SHA responsible for the MSFT at that time), but there was also a recognition that clinical engagement and buy-in was essential for the delivery of the MSFT strategy. A key theme in the recommendations of The Francis Inquiry requires greater cohesion and unity of culture throughout the health care system brought about by the engagement of every person attending patients to ensure a safer and more caring service (House of Commons, 2013). The theme of clinical engagement is prevalent throughout this recent NHS inquiry report, which highlights the importance of clinical engagement as a prerequisite for any NHS organisation to succeed. Indeed the report contains the Health Care Commission's principle aims which

include a requirement to "*engage clinicians to identify what they consider to be the most useful measures of clinical practice*" so that in any health care organisation an agreed set of measures include both clinically created and government determined measures (House of Commons, 2013, p.795).

The Department of Health is responsible for the promotion and provision of a comprehensive health service in England, and the NHS Constitution outlines the purpose and principles of the NHS and the values and behaviours expected of NHS staff (Department of Health, 2013). In a passage of evidence presented to The Francis Enquiry, the Director General of NHS Finance, Performance and Operations describes the NHS Constitution as a key driver for the development of a positive NHS culture and states that "*effective interaction, relationship, engagement requires systems and processes that enable it to happen and behaviours that can then make it happen*" (House of Commons, 2013, p.1337). Staff engagement shows in the way that people think and behave at work. It is asserted that effective clinical leadership lifts the performance of health care organisations (Mountford and Webb, 2009) and that people with high levels of engagement think and behave positively, which in turn results in high levels of performance at work (Department of Health, NHS Employers, 2013). A study undertaken with NHS secondary care trusts using the Medical Engagement Scale (Spurgeon, Clark and Ham, 2011) reveals a relationship between the concept of medical engagement and organisational performance and demonstrates that Trusts that score highly on the overall Medical Engagement Scale index fare as "good" or "excellent" in terms of overall organisational performance. Staff engagement in the NHS is recognised as essential in order to meet the challenges facing the NHS and it is suggested that effective staff engagement "*is achieved by the overall way staff are treated at work, including their degree of involvement in decision making*" (NHS Employers, 2010, p.1). Clinical engagement is therefore linked with improved clinical and organisational performance and with improved quality of care for patients, and health care organisations and the Government are keen to engage doctors in health service management and leadership (Darzi, 2008). In recent years, there has been a real drive in the NHS to improve clinical engagement and leadership in the NHS and to actively engage all staff in decisions that affect them and the services they provide (Darzi, 2008). The author determines that no decisions that affect patient care are made in the Network without the involvement of clinicians, which could influence their engagement. Indeed, this perception was confirmed in earlier

qualitative research as one participant, in describing why the Network is successful suggested that:

> *"…I think it is a very clinically led network I can't really think of anything we do in the Network that has been management driven, you know, I think really the management structure of the Network is there to support the clinical work the Network does, and make the things that the clinicians want to happen... And maybe that's one of the reasons it's successful" (Shepherd, 2012, p.69)*

It is possible that many doctors are disinterested in the management structures of the NHS and evidence from the literature on doctor engagement explored in Chapter 2 highlights issues around engagement and disengagement. Abstract politicians are however desperate to engage doctors in health service management and leadership. Doctors who become managers might find themselves in unfamiliar territory and disengaged from other doctors, their corporate population. As determined by earlier research (Shepherd, 2012), doctors are engaged and work collaboratively in the Network.

In seeking to gain a greater understanding of clinical networks, this research study has explored a number of elements specifically relating to the social aspects of a clinical network which has led to the identification of this research topic as outlined in the following section.

1.6   The Research Journey

In line with the professional academic programme of learning, (Nottingham Trent University, 2009) the research for this study has been undertaken in three phases, and findings and outcomes at each stage of the study have been used to inform the next stage of the research. This approach to the research has afforded the author a degree of fluidity in the design of the study and the opportunity to identify specific areas linked around a core theme for further in-depth research, adding to the richness of the study as a whole, and to the body of knowledge on clinical networks. Findings from earlier qualitative and quantitative research have been shared regionally and nationally and the author has applied specific elements in practice in the critical care and major trauma network environment. Additionally, the ODN Governance Framework and Toolkit developed at Document 3 (Shepherd, 2012; 2013) is currently in use in the adult critical care, neonatal, major trauma and paediatric cardiac ODNs nationally.

Each phase of this study has explored an area of the Network to enable the author to gain a greater understanding of the social aspects of clinical networks and the study has developed with each phase of the process. The following sections provide a summary of the purpose and key outcomes of earlier qualitative and quantitative research undertaken at Documents 3 and 4 (Shepherd, 2012; 2013) and an indication of where the research has added to the body of knowledge on clinical networks.

1.6.1 Document 3

This document reported the first stage of an evolving research study to explore the social aspects of a clinical network. Qualitative research undertaken at Document 3 examined participants' perceptions of the Mid Trent Critical Care Network and gave meaning to how they make sense of the Network and of belonging (Shepherd, 2012). Key questions at this stage of the research are illustrated in Table 2.

TABLE 2 - RESEARCH QUESTIONS – DOCUMENT 3 (SHEPHERD, 2012)

Key Questions	Sub Questions	Research findings *to ascertain:*
How do participants make sense of the Network?	*What is the Network? Does it work? What makes it work?*	How participants give meaning and make sense of the Network How participants work together in the Network
How do participants make sense of belonging to the Network?	*Why belong? What does belonging mean? What do they get out of it?*	How participants give meaning of the success of the Network

The target group of multi-professional clinical staff participated openly in this study and through ethnographic interviewing; the author gained a rich insight into the beliefs and perceptions of members participating in this study. Findings from this study are suggestive of why the Network is effective and recognises improved outcomes for critically ill patients as a key indicator of success. The study provided insight into a clinical network and participants' accounts suggested that the organisation and delivery of critical care services works effectively through a network model. The study revealed that networks facilitate joint working and foster an environment where relationships flourish and members are respected and valued and that in many instances, collaborative working and the sharing of knowledge and best practice, leads to improvements in patient

care. The study demonstrated the strengths associated with the social aspects of a clinical network and confirms some of the benefits of clinical networks in a health care environment. Outcomes from the research are suggestive of a network model where relationships are built on mutual trust and respect and where participant members come together to share best practice, expertise and knowledge. Through their engagement and commitment, members support each other and, through a networked model of health care, deliver an improved experience and outcomes for patients.

Outcomes from this stage of the study confirmed to the author that networks evolve over time and that the relationships forged between network members and member organisations contributes to their success. Networks are maintained through these relationships. They provide an environment for collaborative working combining the efforts and expertise of members. It is through working together and sharing best practice and knowledge, and through joint decision-making, that these organisations really succeed. Networks nurture information sharing and facilitate cross-organisational co-operation and collaboration often addressing difficult decisions and solving problems that are not always easily solved in isolation. This initial stage of the research study offers a unique perspective of a critical care network from the perspective of Network participant members. The findings have added to the body of knowledge on clinical networks and have been shared nationally and regionally.

Malby and Kieran (2012) ascertain that the overall impact and potential of networks in the NHS landscape is untested in terms of impact on patients, and governance. This stage of the research set out to examine participants' perceptions of a clinical network and throughout this stage of the research, participants identified a number of successes of the Network. In order therefore to provide some evidence of the effectiveness of the Network as a model of service delivery and to test the impact of a networked system on patient outcome, quantitative research undertaken at Document 4 examined an element of the Network that participants perceived to be successful; namely the Network Transfer System (Shepherd, 2013).

1.6.2   Document 4

As already specified, findings from the earlier qualitative research indicated that Network participants perceived that the Network is successful where it demonstrates improved outcomes for patients. In stating the transfer system as a success of the Network, there is a suggestion that a systematic networked approach to managing the transfer of critically ill patients improves outcomes for patients and as such, provides evidence that the Network operates successfully. Research at this stage of the study was therefore designed to examine an element of the Network success through a number of proxy measures identified in the Network transfer system. Given the professional context of this study, the author explored a number of elements of the Network transfer system utilising secondary data already contained within the Network Transfer Audit Database (Mid Trent Critical Care Network, 2002). Key questions at this stage of the research are illustrated in Table 3.

TABLE 3 - RESEARCH QUESTIONS – DOCUMENT 4 (SHEPHERD, 2013)

Key Questions	Sub Questions	Research findings *to ascertain:*
Does a systematic networked approach to managing the transfer of critically ill patients improve outcomes for patients?	*Is there a difference in the incidence and type of transfer incidents in a Network transfer system compared with historical data?* *Does a Network transfer system provide evidence that a Network works?*	That applying a systematic networked approach to managing the transfer of critically ill patients improves outcomes for patients thus providing evidence that the Network works

Within the Network, there are approximately 490 critical care patient transfers (clinical and non-clinical) per annum and these transfers are not without risk. The Network audits all transfers and currently holds over 5,500 patient transfer data. Applying a longitudinal research design, this study explored secondary Network critical care transfer data, collected over a 10-year period. Using a number of proxy measures the study explored whether a systematic networked approach to managing the transfer of critically ill patients does reduce some of the risks associated with transfer and improve outcomes for patients, thus providing evidence of Network success. The author developed a Network effectiveness

timeline to enable comparison of a number of key variables, in order to provide a mechanism of attributing improvement in patient outcomes to a networked system (Shepherd, 2013). Through further descriptive analysis, this quantitative research study identified clear benefits for patients cared for in a network environment. Figure 1 shows the Network timeline mapped with an element of the data in order to provide an illustrative example of representative proxy measures.

FIGURE 1 - NETWORK EFFECTIVENESS TIMELINE MAPPED WITH AN ELEMENT OF NETWORK DATA
(FOR ILLUSTRATIVE PURPOSES – FULL DOCUMENT AVAILABLE (Shepherd, 2013)
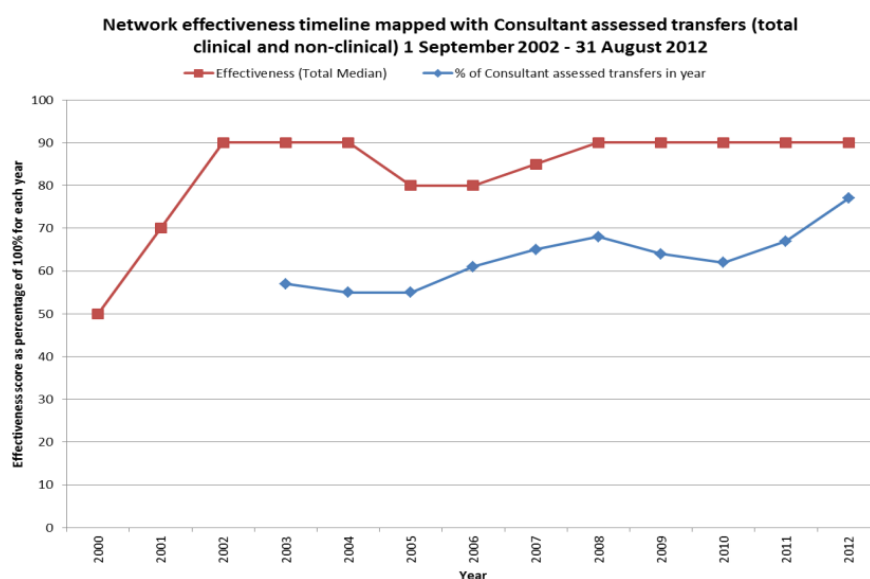
In taking a realist approach to quantitative research, the author objectively observed and assessed Network data and a number of issues and hypotheses arose in the context of this study. In recognising that many compounding factors could influence patient outcomes, the author organised the research to enable a comparison and correlation of key variables and an analysis of Network performance.

This stage of the research demonstrated that across the Network, staff and patient safety has improved and a number of clinical risk factors have reduced as a result of a Networked transfer system. Compared to historical controls, the number of serious transfer incidents in the Network is remarkably low (1%). This study has contributed to the body of knowledge on critical incidents during the inter-hospital transfer of critically ill patients and to the literature on clinical networks, specifically in respect of attributing improved patient outcomes to a networked system. The findings from this study are also suggestive that shared learning through a

network environment does, in certain instances, reduce the number of transfer incidents.

Evidence demonstrating the effectiveness of clinical networks is rare and this research revealed that it is possible to relate elements of a network system to clear quantifiable improvements.

Clinical Networks are an NHS success story (NHS Commissioning Board, 2012a; 2012d) and much of this earlier research has revealed a number of key themes linking the positive contribution of clinical staff to the effectiveness and success of the Network. Several participants suggested the need for engagement to make the Network effective and findings from early qualitative research are indicative that participants recognise the benefits and value of engaging in a network environment and of working collaboratively, particularly where this contributes to an improved experience and outcome for critically ill patients in the Network region (Shepherd, 2012). Participants suggest that working collaboratively is a good thing. Previous research has revealed that clinicians engage in the Network for a number of reasons and that working collaboratively contributes to the success of the Network and this stage of the study explores doctor engagement in the context of the Network.

Whilst the importance of clinical engagement in the NHS is widely acknowledged, particularly within the current health care climate, as indicated, this study is limited to doctor engagement in a critical care ODN. The following section therefore addresses some of the limitations of the study.

1.7   Scope of the Study and Limitations

The term 'clinical engagement' is widely used in the NHS. Clinical engagement might describe the engagement of clinicians where 'clinician' is defined as a health care practitioner working in a clinical environment for example a nurse, paramedic, therapist, psychologist, doctor, physiotherapist, dentist etc. It might also describe the engagement of clinicians where 'clinician' is defined as a doctor (Forbes, Hallier and Kelly, 2004). Throughout this study, the author has acknowledged the contribution of clinical staff in the work of the Network and uses the term 'clinician' to describe multi-professional health care staff working in the clinical environment. In the author's experience of working in a clinical network, doctors are often the tacticians, the visionary leaders and nurses are

often the change agents, the implementers. That is not to say however that these roles are not interchangeable. As already mentioned, it is well recognised that the engagement of doctors in health care organisations contributes to improved organisational performance (Hamilton, *et al.*, 2008) and in order to present this study within the bounds of the academic requirements, this research study solely examines doctor engagement.

The research for this study is conducted by a non-clinical senior health care manager who has over a decade of experience of working within a clinical network adding to the uniqueness of the study. Research is undertaken with senior doctors, influential in the Network and their employing organisation, identified as being engaged in a clinical network environment in order to gain a participant perspective of doctor engagement in the NHS. In holding a senior position as an employed member of the Network, the author recognises the effect that her position could have on participant involvement in the study. All research participants are known to the author and the author is known to all research participants. A number of researchers consider this a probable benefit suggesting that participants tend to be more "*honest and willing to divulge personal information to researchers who have been validated by someone they know*" enabling the researcher to gather more accurate data (Lamont and White 2005, p.12). Potential risks could present where senior doctors might say things to be pleasing to the author as a senior manager. Participant members know the researcher and therefore might not wish to divulge information when answering some of the research questions for fear of embarrassing themselves, or the researcher. The author proposes that this might pose a higher risk where the research participant is junior to the interviewer, and that in respect of the participants for this research, all recruited members are senior doctors in the Network, which should reduce any potential risk of embarrassment and non-disclosure of information. This was in fact found to be the case as all participants contributed freely and enthusiastically to the research process.

This study has undergone rigorous ethical approval as outlined in Chapter 3 of this report. In order to fulfil the requirements of the NHS and University ethical process, the author produced a letter of invitation to participants (Appendix 2), a participant information sheet for each participant member (Appendix 3), and gained consent prior to commencement of the research interviews (Appendix 4), which should provide some reassurance to research participants in respect of confidentiality and disclosure of information. Research participants were advised

that no information offered would be attributable to any identified individual and participants offered information freely and openly. On one occasion during interview, it became apparent to the interviewer that the participant would be identifiable by the uniqueness of the information supplied. The author acknowledged this to the research participant at the time of the interview and the participant confirmed their willingness to be identified for this aspect of the research if appropriate.

It is to be noted that whilst this research study addresses elements of the social aspects of a clinical network, the research is conducted in a single critical care network. Whilst this provides an opportunity for similar research to be undertaken in other specialty networks (either as a single network study or a multiple network study), or with a number of other critical care networks, it does limit the scope of this study in terms of comparative network analysis. Additionally, the Mid Trent Critical Care Network has been proven to be a successful clinical network (Shepherd, 2013) with evidence of good clinical engagement (Shepherd, 2012) and it should be recognised that not all clinical networks are successful in the same way, in much the same way as not all organisations are successful for the same reasons. This does however provide further opportunity for future research into doctor engagement in other organisational models including other clinical networks.

This study specifically examines the perceptions of a number of senior doctors, all of whom are Consultants in the field of critical care medicine. It does not include the perceptions of doctor engagement from doctors in other health care specialities or the perceptions of other clinical staff working in other clinical networks or the wider NHS, which again provides an opportunity for further future research.

The author considers that it is worth mentioning that the research questions drafted at the outset of this study did not relate specifically to doctor engagement, but rather that the theme of 'doctor/medical engagement' has emerged as a result of the research undertaken for Documents 3 and 4 (Shepherd, 2012; 2013). This demonstrates the evolvement of research for further inquiry and the adaptability of the researcher and the subject area.

In order to assist the reader in their understanding of some of the key terms used throughout this document, the author has briefly defined these in the context of this study as clarified in the following section.

1.8 Definitions of Terms

1.8.1 Operational Delivery Network (ODN)

Following a review of clinical networks in the NHS, a number of specialist services were categorised into the Operational Delivery Network form. This includes adult critical care services. ODNs focus on operational delivery for improved patient outcomes and co-ordinate patient pathways between provider organisations within an agreed geographical area to ensure access to specialist support (NHS Commissioning Board, 2012a). Whilst these networks are not mandated as organisational structures in the NHS, there is a requirement for health care organisations providing the services that fall within the remit of these networks to formally belong to the relevant regional ODN for quality improvement (NHS England, 2013). ODN membership is therefore mandatory for all commissioned providers of adult and neonatal critical care, paediatric neurosciences, burns and major trauma with a requirement for compliance with the relevant service specifications (NHS England, 2014).

1.8.2 Critical Care

'Critical care' is a global term that covers a diverse set of services and patients defined as requiring critical care are at risk of actual or potential life-threatening illness or injury with one or more failing organs which require continuous monitoring and support (The Audit Commission, 1999). Patients in hospital are classified into four Levels of care (Level 0-3) as indicated in Table 4 (Department of Health, 2000).

TABLE 4 - CLASSIFICATION OF LEVELS OF CARE FOR CRITICAL CARE

Level 0	Patients whose needs can be met through normal ward care in an acute hospital.
Level 1	Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.
Level 2	Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.
Level 3	Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

Patients with a requirement for high dependency are usually at Level 1 or 2 and patients with a critical care requirement are usually at Level 2 or 3 although patient care can intensify or lessen in acuity throughout the episode of critical care. The specialty of intensive care medicine has developed largely in response to advances in medicine and surgery (Department of Health, 2000) and critically ill patients are cared for in Intensive Care Units (ICU) or Intensive Therapy Units (ITU), High Dependency Units (HDU) and in specialist areas like Renal Units or Coronary Care Units (CCU). Most acute hospitals with critical care services also provide critical care outreach support to the ward areas. These teams of highly skilled multi-professional, multi-disciplinary staff work closely with ward staff to identify any patients that have become critically ill, or are at risk of becoming critically ill, in the ward areas. Early intervention by these specialist outreach teams prevents further deterioration and facilitates the timely transfer of the patient to a critical care environment as appropriate.

1.8.3 Doctor/Medical Engagement

The terms 'medical engagement' and 'doctor engagement' are used interchangeably to describe the engagement of doctors, and engagement in this context is examined in more detail in Chapter 2. In a paper commissioned by the King's Fund (Clark, 2012a), it is suggested that the term 'engagement' has acquired a range of meanings and that no universal definition exists. Medical engagement is defined as:

> *"the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this*

> *commitment in supporting and encouraging high-quality*
> *care"* (Spurgeon, Barwell and Mazelan, 2008, p.214).

Throughout this stage of the research, doctors presented their perception of engagement and this is examined in more detail in Chapter 5. The author has however selected the following definition of what engagement means to one research participant as an example of doctor engagement in the context of this study:

> *"Engagement means active involvement and conscious contribution to moving a situation/specialty forward, it involves communication and information sharing with shared governance and responsibility."*

This document presents the final stage of this research study that seeks to explain doctor engagement in a clinical network from the participants' perspective. The author has utilised different research methodology and methods throughout this study and considers that the theoretical perspective and methodology chosen at Document 3 (Shepherd, 2012) worked well in terms of expressing the philosophical assumptions underpinning the research and has therefore adopted the same approach for this study.

SUMMARY OF CHAPTER 1

This Chapter outlined the importance of this study in a modern day UK National Health Service and identified the purpose of the study. It set the scene for the research and provided a summary of each stage of the research process recognising key outcomes from earlier qualitative and quantitative research, and how these outcomes relate to the final stage of this study. Clinical Networks have a place in the current NHS and clinical engagement is recognised as an important component for improved organisational performance. This Chapter explored these key research elements in the context of the NHS and briefly summarised the importance of this study for both the academic and health care environments.

This Chapter recognised the key concepts of operational delivery networks, critical care and doctor engagement as relevant terms for the purposes of this study and defined these in the context of the study. The following Chapter examines specific areas of the literature selected for the final stage of this research study in more detail.

CHAPTER 2

CRITICAL LITERATURE REVIEW

This Chapter examines the literature reviewed in the subject areas considered relevant by the author in the context of this study. It begins by re-visiting literature on clinical networks to explore areas relevant to participant member engagement, a distinct area that has not previously been explored in this study. Literature pertaining to doctor engagement is reviewed to determine the significance of medical engagement in the management and leadership of health care (Importance of engaging doctors, section 2.3.2) and issues of engagement and disengagement (Engaging doctors, section 2.3.3). The final part of this Chapter revisits the conceptual framework that has evolved throughout the duration of this study, giving structure to the research process.

2.1   Introduction

This research study is concerned with the social aspects of clinical networks. The author conducted an initial literature review in advance of all research for this study in order to give context to the subject area (Shepherd, 2010) and assist with the generation of research questions. Review of the literature is an on-going process and, throughout the research journey, the author has explored literature on networks and any relevant new studies have been cited in the context of each stage of the study (Shepherd, 2012; 2013). As outlined, in Chapter 1, at earlier stages of this study, the author found little evidence of research exploring the social aspects of networked organisations and identified that much of the literature on network effectiveness relates to the more tangible elements of networks. A number of recent studies of networks (Ferlie *et al.*, 2010; Guthrie *et al.*, 2010; Currie *et al.*, 2010; Sheaff *et al.*, 2011) do however address some of the social elements. Whilst Chapter 1 explores the more recent literature on clinical networks to give context to this study, at this section, literature on networks is included specifically to examine participant member engagement.

Working in a clinical network in an ever-changing health service, the author is aware of the growing interest in clinical networks in the NHS and has observed a rise in prominence of networks in the NHS architecture over the last few years with the introduction of strategic clinical and operational delivery network forms. This study is concerned with a critical care ODN. This is not a newly established

network, but is a mature managed clinical network that has evolved over the last few years to the ODN form. As these networks become embedded in the NHS, the main changes have been in respect of the governance arrangements and in some areas of the country, critical care networks are now operating within an integrated network management model. In the East Midlands region, the ODNs for adult and neonatal critical care have seen little change to their organisational structure, although with the new funding mechanism, the adult critical care network management team has assumed management responsibility for the major trauma network in the region with no increase in resource allocation. A number of key success factors have been identified for ODNs for improved patient care and ODN work programmes are perhaps now more than ever subject to scrutiny to ensure appropriate use of resources (NHS England, 2014).

Clinical networks provide a successful model of service delivery in the NHS (NHS Commissioning Board, 2012c) for delivering quality improvement and better outcomes for patients and over the last year, ODN membership has become mandatory for commissioned providers of a number of services including critical care. This has raised the profile of these networks in the NHS structure. Recognising clinical networks as an NHS success story, the NHS Medical Director and Chief Nursing Officer state that by *"combining the experience of clinicians, the input of patients and the organisational vision of NHS staff, they have supported and improved the way we deliver care to patients in distinct areas, delivering true integration across primary, secondary and often tertiary care"* (NHS Commissioning Board, 2012c, p.3). This confirms the importance of clinical networks in the NHS architecture and endorses the significance of member engagement in delivering quality improvement and co-ordinated patient care.

As this research study has evolved, engagement has emerged as a key concept. The author has not viewed the extant literature on clinical networks in respect of participant engagement in previous stages of this study. This Chapter therefore provides the opportunity to re-visit literature on clinical networks in order to explore elements of member engagement as well as literature relating specifically to the importance of engaging doctors in the management and leadership of the NHS. Gaining an understanding of how doctors make sense of their engagement in a Network will help inform a strategy for future engagement.

2.2   Overview of Literature

This research study is an iterative process and as the study has advanced, new questions have arisen which have prompted the author to explore additional literature relevant to each stage of the study. Previously, literature on clinical networks was critiqued in the context of network development and structure (Shepherd, 2009; 2010; 2012), in order to determine some of the factors that contribute to the success of these organisational forms. As the study has progressed to this final stage, the author has re-examined some of this early literature to look specifically for evidence of participant engagement to confirm engagement as a key factor for Network success and to ascertain the significance of engagement in networks and the wider NHS. Consistent search terms for this study were initially derived from experiential knowledge, but subsequently from the literature itself. Whilst the search for "operational delivery networks" harvested a small number of documents, these are NHS documents which describe the introduction and development of these networks into the current architecture of the NHS and yielded nothing further in terms of any research papers or studies on these network forms. This is perhaps not surprising given that these networks were formally introduced in to the NHS in December 2012 (NHS Commissioning Board, 2012).

The author utilised a number of search engines and databases via the Nottingham Trent University (NTU) on-line library facility to extract the literature; primarily EBSCOhost Online Research Databases (EBSCOhost, 2014) and Emerald Insight (Emerald, 2014). Access was gained via NTU institutional log in. A Boolean operator was used to combine searches, for example "clinical networks" *and* "engagement" although singular searches garnered more results. Additionally the author searched the Department of Health website (Department of Health, 2015) for relevant health related documents and explored external web pages via Google search engine. Documents were initially organised into three categories; "Network", "Engagement" and "Doctor/Medical engagement", although as the study progressed, further categories arose; namely "Leadership" and "Doctor/Manager relationships".

This research adds to the earlier qualitative and quantitative research exploring critical care networks from a number of perspectives. The author is therefore cognisant of the fact that research bias is an unavoidable part of the research process, a point made by Elliott and Timulak (2005), and would not intend to be

naïve in terms of the effect that previously acquired knowledge, particularly in applying a constructionist orientation, has on the research. The author identified the key research questions and explored these through application of the research methods. This inductive approach to research involves drawing common assumptions out of observations and findings and enables the generation of theory from the research (Bryman and Bell, 2007). It is suggested that the strength of qualitative methods is in the process of induction as data emerges to provide the theory, rather than the reverse (Morse, 1991). The author applied this approach to allow ideas and concepts to flow from the research in an attempt to explore the engagement experience from the unique perspective of senior doctors working in a clinical network. The author proposes that there is an element of inductive and deductive reasoning in most research projects and this study is influenced by the earlier stages of the research where ideas and theories have been generated by deductive and inductive approaches.

As indicated, some of the extant literature has been re-examined from a different perspective and the following section provides a brief evaluation of literature relevant for the final phase of this research study.

2.3 Revisiting the Literature

2.3.1 Clinical Networks

Clinical networks comprise interrelating systems and complex relationships. They are formed when participant organisations join together for a common purpose and participant members with a shared interest, work collaboratively for that purpose (Jackson and Stainsby, 2000). This is certainly the case with the Network where participant organisations come together and work collaboratively for a shared purpose; that is to improve the experience and outcomes for critically ill patients in the Network region. Clinical engagement and a history of strong relationships between participant members are amongst some of the positive aspects associated with early clinical networks (Edwards and Fraser, 2001). Likewise, engagement is identified as a key characteristic of well-established and well-functioning networks and recent studies recognise the value of building relationships, both within and external to networks (McInnes *et al.*, 2012). Clinical networks transcend traditional organisational boundaries giving rise to a multitude of different

relationships. Hudson (2000) suggests that inter-organisational relationships are largely built on human relationships and that the challenge is to create the right climate for collaboration recognising the diverse contributions that participants make. According to Hudson, effective partnerships are based on stable and trusting relationships between two or more independent parties. Within a networked system, members adopt shared rules of engagement, and any change in the behaviour of members has the potential to affect the outcomes and performance of the networked organisation as a whole.

Whilst the complexity of the NHS and clinical networks is widely acknowledged, (Plsek and Greenhalgh, 2001; Plsek and Wilson, 2001; Lubitsh, Doyle and Valentine, 2005; Proudlove, Moxham and Boaden, 2008; Plsek, 1999; Wilson and Holt, 2001; Fraser and Greenhalgh, 2001; Addicott, McGivern and Ferlie, 2007; Hunter, 2001) clinical networks are now also recognised for their success in the wider health care system (NHS Commissioning Board, 2012d, NHS Commissioning Board – A special health authority, 2012). Such is the growing recognition of the importance of clinical networks in the NHS architecture, that in 2006 the National Institute for Health Research Service Delivery and Organisation Programme (NIHR SDO) commissioned an independent network research programme to further explore these networks. The research identified a number of research themes under the broad headings of network origins, processes and impacts, with a view to informing future strategy and implementation. Research was conducted between 2006 and 2011 and the cost of the research programme totalled in the region of £1.3 million. Following the research, a number of reports were published (Guthrie *et al.*, 2012; Ferlie *et al.*, 2010; Currie *et al.*, 2010, Sheaff *et al.*, 2011) and whilst these have been explored in relation to earlier stages of this research study, (Shepherd, 2012) the author has re-examined the outcomes from these studies in the context of network member engagement.

In their study, Ferlie *et al.* (2010) examine the key characteristics of networks and success factors and describe the origin and development of different types of networks. This comparative network study focusses on organisational behaviours and comprises a series of case studies observing two networks from each of the following specialties; clinical

genetics, cancer, sexual health and older people. An element of the study explores the performance management of networks and the authors introduced a model of performance assessment comprising inclusiveness and engagement of stakeholders, shared learning, innovation and change and unintended outcomes (Ferlie *et al.*, 2010). This comparative assessment of networks produced little evidence of inter-organisational learning and, in terms of clinical level effectiveness, the authors report that they found it impossible to gather reliable and valid clinical outcome data for network clients. The importance of engaging constituent member organisations and of engaging clinicians and managers in order to achieve the aims of the Network was however recognised by one of the cancer networks as vital *"…because unless you have got clinical engagement nothing else could happen…."* (Ferlie *et al.*, 2010, p.76). The study proposed that some groups of doctors were difficult to engage within one of the sexual health networks and several of the networks considered that some groups of doctors were more dominant than others, making doctor engagement more variable. The study identifies a number of common factors in networks acknowledged as high performing networks, including the strong involvement of clinicians, and at the time, proposed that the changing architecture of the NHS might provide new network based forms as subjects for further empirical research.

In the context of the structure of the organisation, Cavill (2006) suggests that networks have clear rules of engagement and are inclusive of individuals and organisations who will gain benefit from and contribute to the network and mentions clinical engagement as a requirement for network self-assurance. Likewise, Ferlie *et al.* (2010) identified perceptions of engagement both in terms of stakeholder and member engagement and suggested inclusiveness and engagement of stakeholders as a necessary requirement when assessing network performance.

A study undertaken by Guthrie *et al.* (2010) draws on the Scottish experience of networks and explores professional and patient perceptions to assess the impact of networks. The study suggests that participant engagement is a prerequisite of an effective clinical network, but recognises that engagement in different networks varies. It highlights the importance of identifying a common purpose for otherwise disparate

groups to coalesce. Managerial networking behaviour is highlighted as an indicator of network success and it is suggested that network member behaviour is influenced by situation and environment (Guthrie *et al.*, 2010). As membership of clinical networks in the NHS is mandated for specific services, collaboration might not be an option. It is suggested however that this may not be undertaken with any degree of commitment (Sowa, 2008). Uncertainty around member engagement highlights some of the tensions and dilemmas of inter-organisational relationships in networks. A key focus of the study undertaken by Guthrie *et al.* (2010) addressed the management of relationships and emphasised the importance of informal relationships based on a desire and willingness to participate rather than on authority and control. Whilst these more informal relationships support the development of trust, understanding and commitment, participants suggest that some degree of formality is necessary to achieve network success (Guthrie *et al.*, 2010). Building trusting relationships and engagement was acknowledged as time consuming but valuable for the future success of networks and it was noted that "*engagement is optional*" and that some members will "*certainly engage more than others*" (Guthrie *et al.*, 2010, p.34). Engagement is crucial in clinical networks, but the relational nature of networks means that it cannot be forced.

Currie *et al.* (2010) undertook a study as part of the NIHR SDO programme to explore children's services networks. This comparative evaluation describes how the vulnerable nature of networks and power differentials between members has influenced previous research on clinical networks and identifies that networks are susceptible to institutional influences. The study is based on the premise that networks need to be networked if they are to deal with difficult health and social care problems and focuses on leadership and knowledge exchange. The importance of relationships and of network leadership is recognised, although the concentration of formal leadership does highlight that the "*collective input and engagement of network members from every profession is vital to facilitate collaborative working*" (Currie *et al.*, 2010, p.55). The study however does not address what makes doctors engage in the Networks.

Sheaff *et al.* (2011) conducted a systematic comparison of a number of cardiac care, children's health and mental health networks and applied case study analysis and social network analysis to examine outputs. This final study commissioned by the NIHR SDO programme on clinical networks suggests that member engagement is dependent in part on outcomes, both personal and organisational, and explores engagement in terms of innovation. The findings suggest that members engage with networks where it appears to help them meet targets and other incentives generated outside the networks and revealed a vulnerability of some networks to the constant reorganisation of the NHS, although this was lessened with firm membership. The authors undertook an analysis of the strength of links between network members and hypothesised that the more specialised occupations, i.e. doctors, were more likely than other professions to have contacts outside of the network, meaning that they were less likely to be engaged in the network. The findings from the study however did not support this hypothesis as they revealed that the links within the network were more numerous than the links to bodies outside the network. Additionally, previous research undertaken by the author (Shepherd, 2012) has revealed that doctors engage in the Network, and this research therefore seeks to explore the engagement experience from a medical perspective. This would suggest an element of clannish behaviour as described by the author in earlier qualitative research undertaken at Document 3 (Shepherd, 2012). Ferlie *et al.* (2010, p.13) acknowledge that network coordination is achieved when members come together in informal groups and learn to negotiate and make adjustments within their professional community or "*clan*". They further purport that within the field of medicine, professions are "*clannish*" and that individual professionals identify more with an "*invisible*" group of peers than with their employing organisation. They suggest that such professionals "*escape*" their employing organisation by joining external professional networks (Ferlie *et al.*, 2010, p.25). But why is this, and what makes doctors choose to join these Networks?

What these studies do not address is why doctors choose to engage in these Networks or indeed explore the engagement experience from a medical perspective, which is the purpose of this research.

In congruence with the outcomes of the earlier qualitative research undertaken by the author (Shepherd, 2012), McInnes *et al.* (2012), in their study of a collegial clinical network, identified connecting and engaging as a desirable outcome of successful networks representative of the collaboration of network stakeholders. Goodwin *et al.* (2004b) undertook a review of clinical networks in the NHS and recognised the need for managers to actively engage professionals within networks. The study identified that professional leaders are required to promote networks to their peers and advise differing leadership styles dependent on the type of network. Interestingly Goodwin *et al.* (2004b) also warn of the dangers of network capture through elitism or gaming, or domination by individuals or organisations.

As indicated, early literature on clinical networks is concerned with the structure and outcomes of these non-statutory organisations. As the author has revisited the literature on networks, it has become evident that elements of the success of networks is dependent on network members and participant member organisations working together to share knowledge (explicit and tacit) to support the spread of best practice (Addicott, McGivern and Ferlie, 2006, Bate and Robert, 2002). This is suggestive of a requirement for members to be engaged in the work of networks with a willingness to work collaboratively for knowledge sharing.

Bate and Robert (2002) make a distinction between explicit and tacit knowledge and offer support for the constructivist view of knowledge; "*knowledge is not objective but exists subjectively and inter-subjectively through people's interactions, through working together, sharing knowledge, respect and trust*" (Bate and Robert, 2002, p.10). Ferlie *et al.* (2005) argue that knowledge sharing is often dependent on social and cognitive or epistemological boundaries between and within the professions and suggest that networks provide a solid foundation for face-to-face interaction for information and experience exchange and learning, albeit usually for members of the same profession. Furthermore, it is suggested that bureaucratic structures affect the transfer of knowledge and learning which is so often reliant upon sound relationships and collaboration as found in the network structure (Bate and Robert, 2002). Goodwin *et al.* (2004b) advise that the secondary care sector is well placed to engage in collaborative knowledge transfer and that this might

best be achieved through the networked model of care. While Goodwin *et al.* (2004b) recognise the benefits of coterminous boundaries in respect of accountability, they also suggest that complex boundaries between partner agencies could pose difficulties of engagement for health care organisations, particularly where they have multiple requests for involvement. This is more likely to occur in multi-agency networks where the demands for partnership working spans the health and social care sectors, and has not been the experience of the critical care network.

In the early stages of the development of the cancer networks in London, it was suggested that inter-organisational competition following structural reconfiguration undermined the socialisation and trust necessary for knowledge sharing and learning due to the competitive nature of the environment which, in some instances, impaired pre-existing informal networks (Addicott, McGivern and Ferlie, 2006). This indicates that networks, like all organisations, need time to mature and the right environment to flourish. As some of the later cancer networks formed in a less competitive environment, the network approach was thought to encourage the engagement of network members and facilitate better education, training, learning and knowledge-sharing (Addicott, McGivern and Ferlie, 2006). Networks are innovative and creative structures focussing on the production and sharing of knowledge. They provide a foundation for the exchange of ideas and are distinctive in their adaptability to survive and thrive and [managed] networks are reported to be successful where authority is balanced with member engagement (Randall, 2013).

Outside of the UK NHS, clinical networks are taking shape and in the Australian health system, it is suggested that the networked organisation is replacing the more traditional organisational forms as a vehicle for engaging clinicians in improving patient care (Cunningham, *et al.*, 2012). A number of studies have been undertaken to ascertain the effectiveness and determinants of successful clinical networks in the Australian health system and Haines *et al.* (2012) identify the engagement of members as a key criteria for success. They define engagement as a success factor as "*the extent of engagement by network members in network activities*" (Haines *et al.*, 2012, p.3) and conclude that few studies have identified critical factors that determine network effectiveness. Additionally Haines

et al. (2012) suggest that some clinical networks are more effective than others and recognise the importance of engaging clinicians in aspects of redesign, implementation, knowledge sharing and quality improvement. An element of their study sought to ascertain the extent of engagement by network members in network activity.

Whilst networks have been considered to be relatively poorly understood in the NHS in the past, there is a growing body of knowledge in respect of networks and their effectiveness (Randall, 2013). In April 2011, the Chief Executive of the NHS in England wrote a series of transition letters to plan for the future of the NHS. This introduces an engagement exercise which recognises clinical networks in the new system:

> *"As part of this broader engagement work, I have asked Sir Bruce Keogh, the NHS Medical Director, and the national clinical directors to begin longer term work to strengthen our multi-professional clinical networks and to engage with the networks to understand how best to improve outcomes for patients. There is a central role for networks in the new system as the place where clinicians from different sectors come together to improve the quality of care across integrated pathways. So I want to put these networks at the heart of our efforts to renew and strengthen engagement."*
> (Nicholson, 2011)

This heralded the start of a renewed interest in clinical networks and, following a review, led to the introduction of clinical networks in their current form.

In the autumn of 2011, the Health Foundation launched a programme to support networks in health care for the continuous improvement of health care services. The programme recognised the huge increase in networks in recent years and proposed that a network is a "*powerful way of sharing learning and ideas, building a sense of community and purpose, shaping new solutions to entrenched problems, tapping into hidden talent and knowledge, and providing space to innovate and embed change.*" (Randall, 2013, p.3). Research undertaken for this network support programme identifies networks as cooperative structures where members coalesce around a shared purpose and where relationships of members are based on trust, respect and mutuality. The social aspects of networks is more clearly identified in relation to network effectiveness and impact, which suggests a growing recognition of the intangible, social elements of

networks. Furthermore, membership, leadership and impact are identified as critical for networks to succeed (Malby and Anderson-Wallace, 2014). These studies are encouraging because, in identifying the influence of the social aspects on network success and effectiveness, they reflect the very essence of this study thereby adding credence to this study.

Recent research has emphasised differences between leadership of networks and of hierarchical organisations primarily related to the co-operative relationship based structures of networks (Randall, 2013). Moreover, it is recognised (Malby and Anderson-Wallace, 2014) that within a network structure, leadership is often facilitative and inclusive and is more likely to be distributed amongst participant members, leading from within and across the network and the author wonders if this could explain in part why doctors choose to engage in networks. For some leaders this collaborative approach requires a shift in leadership style and a greater focus on developing and maintaining relationships. Within the health care environment however, clinical leaders are likely to find themselves leading within and across organisations often with different cultural norms. This could present a dichotomy in terms of leadership style and preference and might therefore explain why some clinicians choose to engage or not in management and leadership roles within different organisations, including networked relationship based organisations.

In congruence with earlier research undertaken for this study (Shepherd, 2012), a revisit of the extant literature clearly demonstrates evidence for effective clinical engagement in networks. Moreover, a number of recent studies address the social aspects of networks and many of the findings are in accordance with outcomes from earlier qualitative research (Shepherd, 2012). Previous stages of the research for this study revealed the tangible elements of a successful network. Outcomes from earlier qualitative research also provided a fresh perspective on a number of intangible elements of success, something that has rarely been explored in the past. As with any evolving study, the review of literature is an important part of the process, and the author has re-visited the literature on networks at this stage of the study to explore the concept of engagement as a determining factor of success and to further explore what it is that makes doctors choose to engage in these virtual organisations.

Clinical networks rely on the engagement of participant members. Without the members, there is no network. In terms of the Network, members are in the main multi-professional health care staff working at all levels of the organisation and in specialities with an affiliation to critical care services. Members are representatives of the different Network stakeholder organisations. Clinical and management staff attend Network meetings and events and engage in the work of the Network to improve the outcomes and experience for all critically ill patients in the region and to ensure delivery of the Network objectives through a collaborative network model. The ODN Governance Framework (Shepherd, 2013b) suggests a Network membership model and staff members are identified to represent their organisation and/or profession.

Earlier qualitative research (Shepherd, 2012) demonstrates that the Network is founded on solid relationships, which are valued by participants and engagement is identified as a key factor contributing to the success of the Network, which has prompted this final piece of research. Understanding why doctors choose to engage is important not only for clinical networks, but also for organisations that rely on clinical engagement for improved patient care. The author has easy access to senior doctors through their membership and engagement in the Network. The theme of doctor engagement is relevant to academia and to the health care environment and the following section outlines the importance of doctor engagement in the management and leadership of the NHS. In seeking to understand how doctors make sense of their engagement, this section develops the argument for doctor engagement, identifying the requirement and some of the concepts for engagement that are explored in Chapter 6.

2.3.2 Importance of Doctor Engagement

There is a body of literature in respect of doctor engagement in the health care setting, and the importance of clinical engagement and medical leadership in policy decisions affecting health care is widely recognised (Bohmer, 2012; Darzi, 2007; 2008; Rosen and Dewar, 2004; Levenson, Dewar and Shepherd, 2008; Greening, 2012). The principal duty of a doctor is to safeguard the wellbeing of patients and to protect them from harm and, in an evolving NHS, doctor engagement is central to ensuring

that the service is patient directed. Health care in its own is not a difficult concept in that patients present with a problem and caregivers administer the most appropriate care and treatment. It is clear from recent inquiries however that incidents do occur in the care and treatment administered to patients (House of Commons, 2013) and it is therefore crucial that doctors engage with the wider health care team, including policy makers, for the design and delivery of safe quality services to protect patients from unnecessary harm.

There is no doubt therefore that there is a clear consensus for doctors to engage in the management and leadership of the NHS. Levenson, Dewar and Shepherd (2008) argue that the terms "*management*" and "*leadership*" are often used interchangeably. They therefore offer a definition of each term as follows; management is defined as "*working with people and processes to produce predictable results*" and leadership is defined as "*focussing on establishing the conditions for more radical change, or representing the collective profession as a whole*" (Levenson, Dewar and Shepherd, 2008, p.31). The author suggests that research participants undertake both a management and leadership role in the Network.

At the heart of the argument for clinical engagement is the proposition that doctors hold a position of power (Reinertsen *et al*. (2007) and Berwick (1994, p.797) observes that "*if clinical front-line staff decide they do not want to make changes then no one outside the healthcare system can be powerful or clever enough to make them do so*". With the creation of the NHS, doctors were expected to maintain clinical standards, whilst delivering care in a resource limited environment, and in return, they were granted significant clinical freedom and minimal accountability (Rosen and Dewar, 2004). This notion of clinical freedom is recognised by Ham and Dickinson (2008, p.4), who propose that doctors have, "*enjoyed a large measure of clinical autonomy since the inception of the NHS*" and is further reinforced by Clark (2012a, p.4) who suggests, "*securing greater engagement of doctors will almost certainly create the sort of organisational culture where all staff feel valued and involved*". Whilst the author supports these concepts, this research will explore the significance of this perceived power and the impact of value and involvement in influencing doctors' choice of engagement.

A review of the NHS undertaken in 2007 set out a vision for a safe and effective health service, designed around the patient, and actively sought to engage local clinicians in working together to drive and improve patient care (Darzi, 2008). In today's NHS, senior clinicians in the acute hospital setting are responsible for the quality and safety of patient care and doctors are taking on full-time management roles, both in the acute and primary health care setting (Clark, 2012a), although it is suggested that the effectiveness of these arrangements is variable (Ham and Dickinson, 2008). Indeed the introduction of clinical commissioning groups into the NHS during 2012 and 2013 places doctors at the forefront of purchasing care, which again focusses attention on the need for clinical engagement and leadership (Bohmer, 2012). As already stated however, the health care environment is both multifaceted and multidimensional and according to Bohmer, (2012) leadership of the NHS requires management skills and leadership styles with which many doctors are unfamiliar. There is a possibility that this unfamiliarity and unpreparedness will lead to further confusion, which could ultimately affect the engagement of doctors in leading their own health care system. Moreover, Bohmer (2012) addresses a number of issues concerning the engagement of doctors in the leadership of health care and, in considering the actual requirement for medical leadership, determines that, in understanding both the medical science and the organisational requirements, doctors are well placed to influence the level and types of care patients receive to determine the best outcomes, and argues therefore that doctors play a vital role in shaping clinical services. In a similar vein, Atkinson *et al.* (2011, p3) consider that "*the need for medical engagement in the leadership of and involvement in the planning, design and delivery of NHS services is now widely recognised*". Bohmer (2012) argues that this, together with a whole system, multi-professional approach to the design and delivery of health care, leads to improved outcomes for patients. In a similar vein, Clark (2012a) claims that engaging doctors in management, leadership and service improvement is critical to improve organisational performance and suggests that engagement therefore requires a cultural rather than a structural change. Likewise, Hamilton *et al.* (2008, p.4) propose that medical engagement is a priority throughout the NHS and maintain that "*if doctors are engaged in management and leadership then organisational performance will improve and if there is good organisational performance there is likely to be high levels of medical engagement*". Hamilton *et al.*

(2008, p.5) further suggest that doctors have the "*most influence when it comes to implementing operational changes that can lead to improved performance.*" Following an in-depth review of employee engagement, MacLeod and Clarke (2009) highlighted examples where organisational performance has been transformed by employee engagement and suggest that in understanding the principles that underpin employee engagement more widely, organisational performance and employee well-being is enhanced. Furthermore, they propose that it is how the workforce performs that determines organisational success and that there is a clear correlation between improving engagement and improving performance. Kirkhaug (2010) recognises that performance is enhanced when employees work collectively due to the influence of social interaction and adaptability of members.

In recognising the need to engage doctors in the leadership of the NHS, a UK-wide initiative, undertaken jointly by the Academy of Royal Colleges and the NHS Institute for Innovation and Improvement, introduced a project to encourage doctors to become more actively involved in the design and implementation of services, and better engaged in the health care system (Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement, 2013). Evidence reviewed to inform this initiative again demonstrated that doctors hold a position of power and suggested that they are therefore able to impede or confuse the efforts of others to impose change. An output from the project was the Medical Leadership Competency Framework (MLCF), which, it is argued, will have a "*long-term impact on the culture of medical engagement and influence the next generation of doctors to view engagement and leadership as part of their working lives*" (Hamilton, *et al.*, 2008). This framework is explored more in Chapter 5 in the context of the findings from this study. Atkinson *et al.* (2011, p.3) claim that through integration into medical education and training, the Medical Leadership Competency Framework "*will ensure that doctors acquire appropriate management and leadership skills at all stages of their careers*". The author considers that this is a bold statement, and would argue that for this to happen, doctors will need to take some responsibility to ensure that they identify their required skills, and have a willingness to gain the necessary skills and competencies, and that leaders within employing organisations will need to take responsibility, firstly to endorse the use of the tool, and secondly, to allow

doctors the time and space to develop the necessary skills and competencies, ensuring that they have the necessary leadership support. Additionally support will need to be given at a higher level to embed the framework into relevant College curricula although the author recognises that this is being achieved through the Medical Royal Colleges and Faculties.

The health care environment is constantly changing and so is the role of doctors and their relationship with patients. This is in a large part due to advances in social, technological, political and environmental factors which, it is suggested, makes it even more important for doctors to be actively engaged in the leadership and improvement of health services (Atkinson *et al.*, 2011). With regards to this, between May 2006 and April 2007 the Royal College of Physicians and The King's Fund organised a series of ten consultation events to give doctors an opportunity to discuss their changing roles as clinicians. Participants accepted that "*collectively doctors needed to engage with management to a greater extent than in the past*" (Levenson, Dewar and Shepherd, 2008, p.xi). Additionally there was a recognition that medical training, undergraduate and postgraduate, needs to better prepare doctors to manage professionally, and whilst the author recognises the value of this for doctors new to management, she considers that something more needs to be done to support existing senior clinical managers. Levenson, Dewar and Shepherd (2008) collated doctors perceptions of professionalism and advise that, whilst doctors collectively recognise the requirement for them to engage in management, most were unclear in respect of how and when to engage. This suggests a formal process of engaging and the author would argue that doctors will choose to engage in management where they see a compelling reason to do so, a point that is reinforced by Hussey, Silversin and Kornacki, (2013).

An evolving health service requires change at a macro and micro level and doctors should be engaged in service transformation. Clinical information is more readily accessible to patients, which in many instances raises expectations for the management of their care and treatment options. It is suggested that in some respects, these changes are challenging doctors and not surprisingly causing them to rethink their roles (Rosen and Dewar, 2004; Levenson, Dewar and Shepherd, 2008; Royal College of Physicians, 2005). It is acknowledged that the

doctor/patient contract has changed over time without any real discussion between those involved and, as the service continues to develop and that a more sustainable and realistic compact is required, not just between doctors and patients, but also between doctors and the organisation (Edwards, Kornacki and Silversin, 2002).

The argument presented here is that clinical engagement is a necessary requisite to ensure the continuous development of effective clinical services and Rosen and Dewar (2004) argue that the disengagement of doctors is not an option in today's NHS. As already determined, doctors do not always choose to engage in the management and leadership of the NHS and it is important to explore some of the reasons why doctor engagement might not have occurred.

2.3.3 Engaging Doctors

A core concept that has already been cited for doctor engagement relates to a perceived power and autonomy associated with the role of doctors in health care. A number of changes however have been introduced in to the NHS over the years, which are likely to have affected this authority and introduced an element of tension and conflict into the clinical and management arena and Ross Baker and Denis (2011) propose that the NHS needs to appoint clinical leaders capable of representing their profession and take responsibility for managing clinical services.

The engagement of doctors needs to be sustained in an ever-changing environment to ensure the continual delivery of safe patient care and organisations need to adjust their cultures and behaviours to accommodate doctor engagement. It is proposed that doctors have a "*duty to engage in health management …*" but it is suggested that this duty for doctors is "*one of the most difficult challenges they face in the modern era*" (Royal College of Physicians, 2005, p.9). The notion of engaging doctors in the management and leadership of the NHS is therefore important in health care to improve organisational performance and achieve change (Ham, 2003). Whilst it is argued that doctor engagement improves patient outcomes and leads to improved organisational performance, the author suggests that in many respects, this does not happen as doctors choose not to engage in the

management and leadership of the NHS. This view is supported by Greening (2012) who confirms that attempts to engage clinicians in an effective way across the NHS has not occurred. Additionally, it is suggested that over the years doctors have become demonstrably disengaged from the health care system of which they are a key part and that clinicians' dissatisfaction with non-clinical management, strained doctor-manager relationships and an associated sense of disenfranchisement all contribute to this disengagement (Bohmer, 2012). But why is this, and what influences doctors choice of engagement?

Earlier qualitative research undertaken by the author (Shepherd, 2012) suggests that whilst doctors choose to engage of their own accord, they are more likely to engage when they see an associated benefit, particularly where this is linked to improved patient care. According to Clark (2012a), doctor engagement requires a high degree of inclusivity and a different set of behaviours from executives. Levenson, Dewar and Shepherd (2008), recognise that there is a perception that the NHS is continually reorganised without adequate clinical engagement, which they suggest does little to convince doctors that their views are taken in to account. The author proposes that doctors are less likely to engage if they perceive that they do not have a voice and this research will explore this concept.

Buchanan *et al.* (1997) confirm that doctors have been engaged in the management of hospitals in one form or another since the inception of the NHS. Following an inquiry into the management of the NHS in 1983, general management was introduced in to the system, which marked a transitional moment in the history of the NHS (Gorsky, 2013). A key recommendation from the 1983 management review was for clinicians to be more closely involved in management decisions within the hospital setting (Rivett, 1998). Following this inquiry, clinical directorates were established in acute hospitals led by a senior management team (clinical and administrative) which introduced a new dynamic into the organisational hierarchy of hospitals and into the relationships of clinicians and managers in the NHS. It is suggested that the development of these clinical directorates has been only partially successful and that "*doctors who occupy hybrid roles such as clinical and medical directors face the challenge of bridging these two disparate cultures.*" (Hamilton *et al.*, 2008,

p.5). Llewellyn (2001, p.594) asserts that medical management "*imposes new roles, responsibilities and relationships on clinical directors*" and suggests that medical managers are expected to make tough and contentious decisions in a difficult environment. The introduction of clinicians into management brought with it an expectation that they would take responsibility for the expenditure of clinical care whilst, at the same time, take responsibility for the delivery of patient care introducing a degree of contestability in to the system. Although this afforded clinicians more autonomy in decisions affecting resources, at this time Rivett (1998) suggested that divisive conflict was likely where decisions were challenged by management. Moreover, in recognising that clinicians deliver care directly to patients and have an inevitable influence over the design and delivery of patient care, the author contends that conflict is inevitable where doctors perceive that their power and autonomy is being eroded by managers who make the decisions and, in doing so, gain greater control of the health service. This view is supported by Rivett (1998) who suggests that clinicians would not take kindly to managers making decisions in isolation that could be harmful to patients. Furthermore, decisions and actions that clinicians take have a direct impact on the patient and on the organisation and, whilst clinicians have a responsibility to their employing organisation, it is proposed that this often comes secondary to their professional responsibilities and may, in some instances, be a cause of internalised conflict (NHS Institute for Innovation and Improvement, 2008). Additionally the author would argue that whilst doctors and managers should have the same priority (patient care), that there is often a perceived conflict between doctors and managers in terms of patient care versus resource management and that this tension causes doctors to disengage in the management process. Montoute (2013) in attempting to recognise the challenges faced by clinical directors in the NHS, identified the order in which these clinical managers view their responsibilities as to their discipline, then to their hospital, then to the NHS, in that order. This would suggest an inevitable conflict between the clinical and management environments, which might then, not unsurprisingly, lead to a lack of clinical engagement in the management process. Relationships between doctors and managers is somewhat uncertain and it is suggested (Reasbeck (2008) that there is a requirement to create more effective working relationships between doctors and managers. Nicol (2012) recognises the requirement to

improve the doctor-manager relationship and proposes a number of strategies for improvement including increased clinician and manager collaboration as part of clinical networks.

The NHS Confederation (2007) identifies a number of challenges faced by senior managers in the management of the NHS and, whilst clinical engagement and managerial engagement with clinicians is identified as key to achieving many of the aims of the NHS, it is suggested that this "*often falls short at every level*" (The NHS Confederation, 2007, p.3). Furthermore it is argued that doctors in the UK have become "*demonstrably disengaged from the system of which they are a key part*" (Bohmer 2012, p.8). According to Bohmer (2012), this disengagement is attributable to a number of factors including clinicians' dissatisfaction with non-clinical managers and the inevitable effect on the doctor-manager relationship, as well as an associated perceived alienation and focus on government targets and requirement for improved efficiency. Additionally, from her perspective as a practising NHS doctor, Greening (2012) further suggests, a lack of appreciation of the NHS operating as a professional bureaucracy, unrealistic expectations of clinical directors and the generally poor management training of doctors as further contributing factors for this disengagement. It is interesting to note that the perceptions of the practising doctor focus more on the social aspects of engagement and the author will draw on the social aspects when reviewing the findings of this research in Chapter 5. It is also interesting to note that despite the Government's attempts to engage doctors in the management and leadership of the NHS, it appears that this has not happened. This study has however confirmed that doctors choose to engage in the management of the Network, which suggests that there is something about the clinical network model that influences their choice of engagement. This provides a unique opportunity to explore the positive engagement of doctors in a clinical network, in order to understand how doctors make sense of their engagement experience and of the clinical manager role, to identify effective strategies for engaging doctors in the management of health care.

Early in the research process, the author identified a lack of literature in respect of the social aspects of clinical networks and recognised that much of the literature in respect of networks focused on the structural

aspects of success (Shepherd, 2012). A brief review of the literature in respect of doctor engagement has highlighted a focus on the organisational and structural aspects of medical engagement. Spurgeon *et al.* (2008) reinforce this viewpoint by suggesting that organisational systems and strategies play a crucial role in creating the cultural conditions under which doctors will choose to engage or not. Additionally it is recognised that some doctors consider it a requirement to integrate their managerial and clinical duties whilst others view medical management as a separate specialty suggesting that, in the main, doctors move into management later in their medical career. According to the doctors who took part in the consultation events organised by the Royal College of Physicians and The King's Fund, medical leadership was "*conspicuous by its absence*" (Levenson, Dewar and Shepherd, 2008, p.xii).

Bohmer (2012) suggests that little attention has been paid to the behaviours required for effective medical leadership and in exploring medical engagement, Clark (2012a), recognises that there are few studies that signify what good engagement looks and feels like and how this impacts on the delivery of health care. In contrast, when exploring employee engagement, MacLeod and Clark (2009) refer to engagement within a number of categories; that is attitude, behaviour and outcomes and these aspects will be explored in this study.

Lemer, Allwood and Foley, (2012) present a case exploring how to create the right environment to support clinical leaders and engage doctors and cite clinical leadership, improved doctor and manager relationships, greater understanding of the doctor role in the organisation and health system, measuring engagement and empowering clinicians to identify and lead change as key factors for engagement. Lemer (Lemer, Allwood and Foley, 2012) offers a personal perspective of engaging clinicians and suggests that creating the right environment, investing in training at all levels within the organisation and promoting a culture where clinical leadership matters are important to her as a practising doctor. Additionally she suggests that organisations should be allowed to make mistakes in order to learn and grow. Brown, Ahmed-Little and Stanton (2012) identify the clinical-managerial divide as a reason why doctors might choose to disengage and indicate that increased workload and low

morale impacts engagement. Likewise, Bohmer (2012) indicates that financial and status disincentives and a lack of training support act as barriers to engagement and also recognises that leadership and management requires tools and leadership styles with which most doctors are unfamiliar.

In the main, much of the literature refers to engagement in terms of clinical leadership and identifies factors required for engagement. In seeking to explore why doctors choose to engage from the perspective of senior doctors working in a clinical network environment, this study offers a unique perspective of medical engagement "*through the other end of the telescope*" as it explores the engagement experience as outlined in Section 1.2; Purpose of the Study.

In undertaking a review of the literature for this stage of the study, the author briefly explored literature relating to employee engagement in order to compare and contrast common themes arising from the literature to further inform this study. This search revealed three commonly identified levels of engagement suggesting that employees are either "engaged", "not engaged" or "disengaged" (Scottish Executive Social Research, 2007) and the author suspects that, in examining choice of engagement, different levels of engagement and disengagement are likely to be revealed. This study explores doctor engagement in the NHS and outcomes from a review of the employee engagement literature undertaken on behalf of the Scottish Executive (2007) suggest that there is no apparent difference between aspects of engagement within the public and private sectors, although findings do suggest differences in engagement levels resulting from organisational characteristics apparent within each of the sectors. This review also suggests that employees are motivated by a number of factors which differ from person to person.

The author has identified a number of common themes that have arisen from both sets of literature relating to personal and work engagement and factors for engagement and disengagement. These include being involved and valued, pride and commitment, trust and respect, creating a culture for engagement and improved organisational performance. A point to note is that whilst commitment is considered to be an important element of engagement, it is suggested that organisations should look beyond

commitment and strive to improve engagement in order to promote organisational success (Scottish Executive Social Research, 2007). Earlier qualitative research (Shepherd, 2012) distinguished the concepts of engagement and commitment as key factors that contribute to the success of the Network as an organisation and, as already determined, this research explores the concept of engagement from the perspective of doctors in order to determine a strategy for engagement.

A review of the literature relating to doctor engagement has revealed that it is well recognised that the positive engagement of doctors contributes to enhanced patient care and improved organisational performance (Ham, 2003; Lewis, 2012; Mountford and Webb, 2009; Department of Health, NHS Employers, 2013; Spurgeon, Clark and Ham, 2011). It is encouraging therefore, to realise that this is in congruence with employee engagement literature, which also recognises instances where organisational performance has been transformed by employee engagement (MacLeod and Clarke, 2009; Scottish Executive Social Research, 2007). This is further supported by Sambrook, Jones and Doloriert, (2014) who suggest that "*engagement is a positive and desirable state for employees with positive results for organisations*".

Comparing the literature in this way has also revealed that whilst literature on doctor engagement identifies factors that relate to doctor engagement on a personal and professional level, these are often separated and there is a suggestion that little attention has been paid to the behaviours required for effective medical engagement (Bohmer, 2012). In contrast, literature in respect of employee engagement reveals that engagement can be influenced by aspects in the workplace as well as by what the individual brings to the workplace and it is suggested that when personal engagement occurs, the notions of self and work are often intertwined and difficult to distinguish from each other (Kahn, 1990). Moreover, Kahn (1990) describes how when individuals become personally engaged at work, they can experience a sense of connection (engagement) or disconnection (disengagement) from their role.

Literature in respect of doctor engagement identified a number of barriers to engagement and revealed factors that are likely to cause doctors to disengage from the management and leadership of the NHS. In the main,

these relate to issues of clinical/management/doctor/manager conflict, unwarranted bureaucracy, unrealistic expectations and lack of management training. Employee engagement literature recognises burnout as a key factor of over-engagement and the conceptual opposite of engagement and, whilst this does not appear in the literature on medical engagement, there is evidence of cynicism in disengagement, which is considered a key factor of burnout (González-Romá *et al*, 2006).

Key themes emerging from the overview of literature have informed the research questions specifically in respect of choice of engagement and disengagement, perceived doctor/manager conflict, lack of preparation for management and, creating the right environment for engagement. The prime aim of this research is to explore choice of engagement from the perception of senior doctors and this study is designed to reveal factors associated with engagement and disengagement (with potential re-engagement) in order to inform a strategy for engagement.

It is clear from the review of the literature that engaging doctors in the management and leadership of organisations is an important factor for improved performance and better outcomes for patients. This links to the elements identified in the conceptual framework designed to guide the research for this study as illustrated in the following section.

2.4   Conceptual Framework

The author has developed a conceptual framework to guide this study. The framework provides a visual representation of key concepts, deemed significant by the author, and outlines perceived relationships between the concepts. It provides a structure for the organisation of ideas and observations and sets out the focus and content of the research. In describing the relationships between the concepts, the framework represents a movement from confusion to certainty and in many instances simplifies the research task as it provides some structure to the research (Fisher, 2007). An initial conceptual framework was developed to guide earlier qualitative research and the purpose and development of this framework is described in some detail in Document 3 (Shepherd, 2012). The conceptual framework has been through several iterations during the research process, particularly as the author has advanced the study and developed greater competence through critical discussion and learning. The framework

contains concepts identified from the literature pertaining to the structural aspects of a network. The Doctorate in Business Administration (DBA) is a professional doctorate aimed at the development and application of knowledge in the professional setting (Nottingham Trent University, 2009) and so the framework also contains concepts identified by the author as relevant from her knowledge and experience of working within a clinical network. These concepts relate to the social aspects of the Network and the overall impact on function and outcome. It could be argued that this includes an element of bias, which may result in some elements being seen as more important than others. Any such bias can however be overcome by regular review of the framework. Management research is about both knowledge and action and has both an academic and practical purpose. It is suggested that "*theory without practice is barren, but practice without theory is blind*" (Hammick, 1996, p.22), and this framework is developed from both theory and practice.

In taking an inductive approach to earlier qualitative research, the author re-designed the conceptual framework to reflect research participants' perceptions and emergent findings. The process of induction involves drawing common assumptions out of observations and findings to inform theory (Bryman and Bell, 2007). This approach is not unusual as often researchers have an idea of what might feature in their study and draft an initial conceptual framework, which evolves over the lifetime of the study as ideas and concepts change (Miles and Huberman, 1994). Quantitative research undertaken at Document 4 (Shepherd, 2013) measured a number of the key concepts in order to test the effectiveness of the Network. According to Bryman and Bell (2007, p158), measurement in quantitative research provides the basis for "*more precise estimates of the degree of relationship between concepts*" and the author was able to demonstrate the strength of the relationships to improve outcomes for patients.

This later version of the conceptual framework was developed on completion of the initial qualitative research (Shepherd, 2013) and signifies the Network as a symbiotic, agile organisation. The cogs represent the mechanisms of the Network, illustrating the organisational culture and identifying the connections between the concepts. The whole framework identifies a collaborative system that ultimately improves the experience and outcomes for patients. As advised, a benefit of the DBA process is the opportunity that it affords the researcher to continually refine the research process and, throughout this study, the author has revised the framework to reflect findings from the research. According to Fisher (2007) students should be prepared to modify, adapt and even replace a

conceptual framework as the study progresses. Re-development of the conceptual framework following early qualitative research has enabled the author to re-visit the initial conceptual framework and revise this in line with findings. Table 5 provides an updated outline of this framework and Figure 2 provides an illustration of how the initial and revised frameworks connect to inform this final stage of the research. This identifies "engagement" as a vital cog in the mechanism of the Network as identified by the orange lines, and is the area of the Network that will be explored in more detail at this stage of the study. Key themes informing engagement at this stage of the study are involvement, value, power, relationships, conflict, culture, training. The revised (and final) conceptual framework included at Figure 17 illustrates how the key concepts arising from this study inform the engagement debate.

TABLE 5 - RE-EXAMINATION AND EXPLANATION OF THE REVISED INITIAL CONCEPTUAL FRAMEWORK (ILLUSTRATED AT FIGURE 2)

Exploring [understanding]:	Provides insight into:	Evidenced by:	Impact on Function and Outcome:
People elements [*network members*]	member [*network*] behaviour and organisational performance	Engagement & Involvement	Improved patient experience and outcome
Structure [*organisation*]	organisational [*network*] culture	Support & Collaboration	
Culture [*organisation*]	member and organisational [*network*] behaviour	Commitment & Respect	
Process [*organisation*]	organisational [*network*] performance	Productivity & Efficiency	

FIGURE 2 - REVISED CONCEPTUAL FRAMEWORK TO GUIDE THIS STAGE OF THE RESEARCH
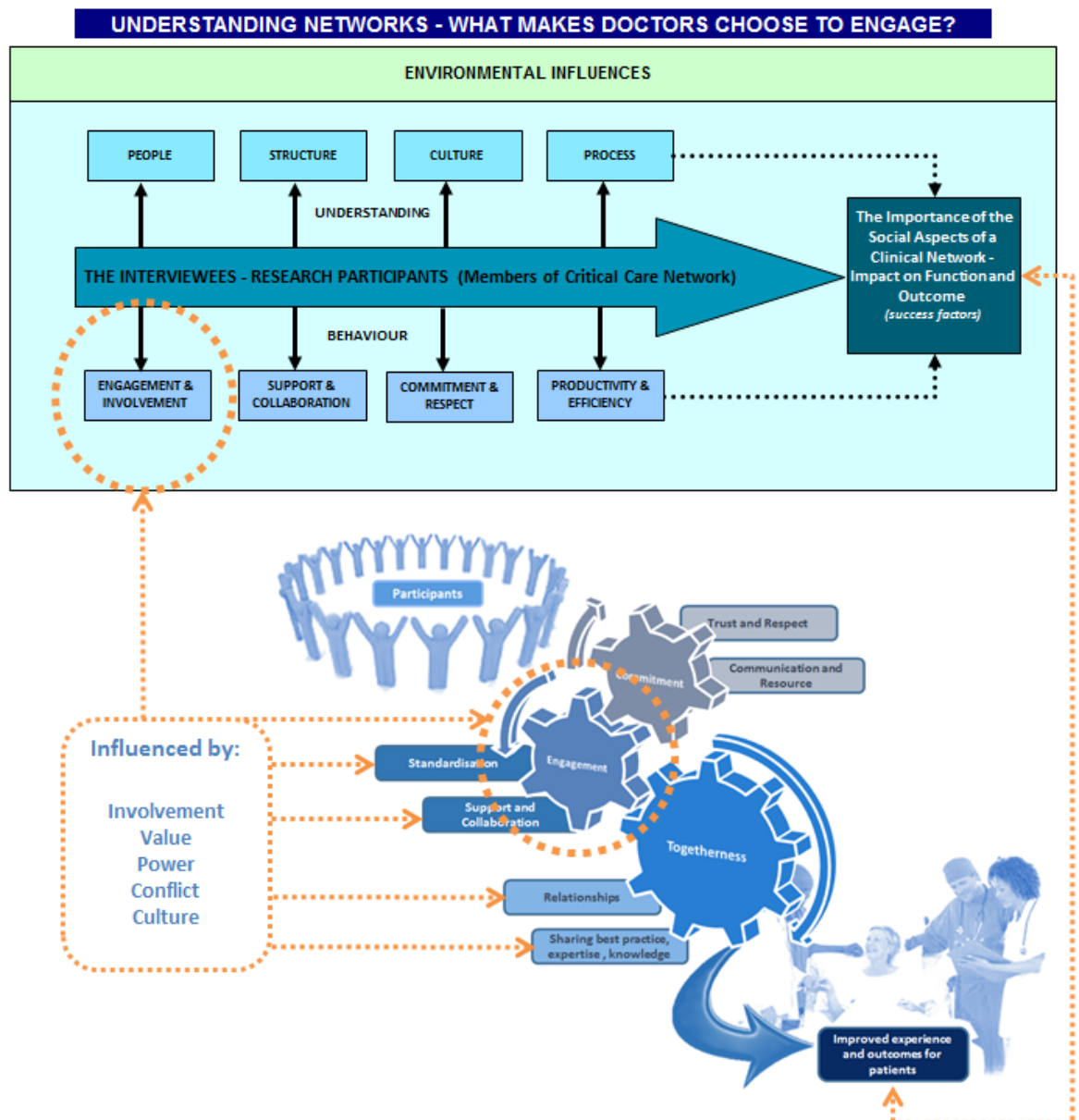
For the final stage of this study, the author takes an inductive generation of theory with an interpretive epistemological orientation and a constructionist ontological orientation. With an inductive stance, theory is therefore the outcome of research. In taking an interpretive approach to research, it is suggested that the researcher is able to see the link between understanding and action as an indirect one mediated through people's thinking, values and relationships with each other (Fisher, 2007).

The author has selected the research approach and methods for this study based on the fundamental research questions outlined in Table 4 to address how doctors explain and make sense of their engagement with the Network. The research methodology is explored further in Chapter 3.

SUMMARY OF CHAPTER 2

This Chapter outlined literature relevant to the final stage of this research. It described the vulnerable nature of networks and explored literature on clinical networks in terms of member engagement. It highlighted the complexity of clinical networks and identified a requirement for effective partnership working based on trusting relationships between participant members and member organisations.

This Chapter recognised the importance of clinical engagement and advised that engaging doctors in the management and leadership of the NHS is critical to improve organisational performance for the delivery of safe patient care. It highlighted that much of the literature in respect of doctor/medical engagement proposes different models of engagement, but does not address reasons why doctors might choose to engage in an organisation.

This Chapter provided an opportunity to further explore the underpinning conceptual framework that has been used both to guide this study and to develop theories explaining the patterns and connections that have emerged from the research. The following Chapter explores the research methodology adopted for this study.

CHAPTER 3

RESEARCH PHILOSOPHY AND METHODOLOGY

"He who would search for pearls must dive below" (Dryden, 2001, p.106).

This Chapter presents the epistemological position and methodological approach undertaken to answer the research questions identified at the final stage of this research study. Behind the methodology and methods employed for this study lies the philosophical assumptions of the researcher and the theoretical perspective behind this methodology. This Chapter explores the philosophical assumptions underpinning the research approach.

This Chapter explores the qualitative research methodology and constructionist viewpoint and describes the interpretivist approach adopted by the author to explain how doctors make sense of their engagement in a network environment.

Most research raises ethical issues and the final part of this Chapter provides an overview of ethical issues associated with the collection and management of the research data for this study and the impact of the NHS research process on this study.

3.1   Introduction

The purpose of this research is to discover and give meaning to factors that explain why doctors choose to engage in a clinical network. This study is therefore concerned with finding out how engagement is perceived from a medical perspective, although interpretation of the research material is undertaken by a senior manager working in the research environment. The author recognises that whilst this introduces a unique perspective to the research process, it could also introduce an element of bias, particularly where the researcher might choose to influence the research findings by conveying the narrative in a way that is unrepresentative of the doctor voice. The author has interacted with doctors in a health care environment for over 30 years and through this study seeks to understand how they describe and give meaning to engagement in an effort to explain this to others. In applying an ethnographic research methodology, the author therefore attempts to represent the views of the doctors and engage with those views. According to Watson (2001, p. 6) a

good ethnography will "*add to the general body of knowledge about the human social world and, at the same time, inform the practical understanding of all those involved in the activities it examines*". As Director of the Network, the author has both a professional and personal perspective of doctor engagement in the Network and is aware that elements of her own voice will inevitably come through in the study and that her viewpoint could influence the findings of this study. Watson (2001, p. 223) recognises that management is a "*human social craft that requires the ability to interpret the thoughts and wants of others….to shape meanings*" and, in taking an interpretive view of the research data, the author has interpreted the doctor perspective of the engagement experience and has used her own voice, as a senior manager, to present her version of this.

Having applied the interpretive perspective earlier in this research study, the author already has an awareness of the impact that her own preconceptions could have on the research process and therefore, in order to confirm accuracy of the interpretation and overcome any research bias, has applied a number of techniques to check her understanding of the narrative. Throughout the interviews, the author questioned the research participants and sought to understand their meaning as the interviews progressed, cross-checking her interpretation throughout and clarifying her understanding of what the doctors were saying in an effort to try and understand the engagement experience from their perspective. Watson (2001) advises that it is through these conversations that researchers start to make sense of the different worlds they are observing and to consequently act on their interpretation of what is being said, thereby imposing a meaningful order upon their perceived reality and, as the interviews progressed and common themes started to emerge, the author discussed her findings with the research participants to get as close to their meanings as possible. Additionally, the author discussed her findings and interpretations with her academic supervisors, both of whom have many years' experience of working with doctors and of applying the research methodology, and with other doctors, to confirm that her version of the doctor story was accurate.

Earlier qualitative research undertaken for this study suggests that clinicians (doctors and others) are engaged in the work of the Network and that the Network provides an opportunity for clinical engagement (Shepherd, 2012). Research participants spoke of the value of having highly committed, skilled clinicians engaged in a common purpose, working together to improve patient care, and recognised the need for engagement to make the Network work.

Chapter 2 acknowledged that a high level of clinical engagement is identified as a key advantage in the management and leadership of the NHS and in the networked model of health care to improve organisational performance and inform policy making in the NHS. From the author's perspective, clinicians engage in the work of the Network and it through this engagement that the performance of the Network is improved and previous research (Shepherd, 2013) has confirmed that this contributes to an improved experience and outcomes for patients.

Research at this stage of the study uses the same research methodology and methods employed for earlier qualitative research. The methodology was debated at length in Document 3 (Shepherd, 2012, p.14-27) and so this Chapter does not repeat the argument, but rather provides a summary relevant for this stage of the research. This Chapter therefore builds on the author's knowledge of the methodology and adds to the previous debate. For this stage of the study, the author applies the qualitative research methodology and takes an inductive generation of theory with an interpretive theoretical perspective and constructionist epistemological orientation. There is however an element of deduction as earlier research informs this stage of the study as well as a previously developed conceptual framework. Whilst literature pertaining to the subject of engagement informed the generation of the research questions, this was reviewed in greater detail following the analysis process. Outcomes are compared to this literature and conclusions are drawn from the outcomes.

Qualitative research seeks to understand an aspect of social life and usually emphasises words (Bryman and Bell, 2007). Researchers gather narrative data to gain insight into the area of interest. Qualitative research is often conducted via different unstructured methods relevant to the study context in order to capture detailed, rich and complex data using mainly an inductive process to develop explanations at the level of meaning (Spencer, *et al.*, 2003). This is reflective of this research study.

Qualitative research enables the researcher to interact with the research participants to explore the subject and develop an understanding of the issues from a number of different perspectives. It affords the researcher the opportunity to ask questions about everyday life and experiences and to explore further meanings associated with the realities of these experiences. As already explained, the author is engaged in the work of the Network through her role as

Director and interacts with clinical staff in the Network on an almost daily basis which has helped her gain her own understanding and appreciation of their role in the Network. This research is concerned with the study of clinical networks and at this stage of the study is designed to find the answers to a number of research questions that begin with How?, Why? and What? (*what can?, what is?, what are?*) rather than How many?, How much? which are questions that fit better with the quantitative research paradigm. Due to the challenging data requirements that this type of research demands, methods exploring clinical networks has almost exclusively been qualitative based on case studies (Raab, Lemaire and Provan, 2013). This is not surprising given the complex nature of networks. This stage of the study explores how doctors explain and make sense of their engagement with the Network. Therefore, in seeking to understand the perspectives of participants and explore the meaning that they give to the phenomena, this study lends itself to the qualitative research methodology. Research is however about more than the choice of approach.

Studies involving people raise questions about the nature of human beings and knowledge; particularly in respect of determining what is knowledge and how it is obtained and interpreted. People have different perspectives, and so do researchers, and consideration needs to be given to the philosophical assumptions of the researcher which underpin the different approaches to research.

3.2   Philosophical Assumptions and Constructionism

By the nature of very existence and of being, researchers as human beings have their own predisposed view of the world and of reality (*ontology*), which impacts their understanding of knowledge and of how this is obtained (*epistemology*). Epistemology is therefore concerned with the nature of knowledge and signifies an understanding of what is involved in knowing, in other words, "*how we know what we know*" (Crotty, 1998, p.8). Ontology is concerned with the study of the nature of being and of reality (Guba and Lincoln, 1994). In looking at the nature of research paradigms, Guba and Lincoln (1994) identify three key interconnecting questions in terms of ontology, epistemology and methodology. The ontological question addresses the *nature* of reality and of the world; the epistemological question addresses the nature of the *relationship* between that which is known by the *knower* (or would-be knower) and that which can be known, and the methodological question addresses how the would-be knower

sets about finding out what he or she *believes* can be known. Furthermore, Guba and Lincoln (1994) suggest that the methodological question cannot be reduced to a question of methods, but rather that the methods must fit the predetermined methodology. This highlights to the researcher that there is much more behind the practice of research than merely conducting an enquiry, and provides a structured approach to assist with the development of the research framework. As this study has progressed through the different stages of the research, the author has gained a greater understanding of the research process, and of the impact that her own theoretical perspective has on the study, as she herself has developed as a researcher. In a similar vein, Crotty (1998) also recognises the importance of epistemological issues both for the researcher conducting the research and for the observers of the research.

In recognising the intrinsic value that the epistemological position has on the researcher's theoretical perspective and consequently on the chosen research methodology, Crotty (1998) introduces a model to facilitate the generation of a research framework. This framework identifies four elements; epistemology, theoretical perspective, methodology and methods. The author has used Crotty's model to construct a framework to illustrate the methods, methodology, theoretical perspective and epistemology adopted at each stage of this study. Figure 3 outlines the framework for this final piece of research. The author has introduced arrows into the framework to demonstrate the fluid relationship between each of the four elements.

FIGURE 3 - RESEARCH FRAMEWORK

Research Framework - Document 5 - Qualitative
Research Question - Why do doctors choose to engage in the work of a clinical network?

Epistemology	Constructionism
Theoretical perspective	Interpretivism
Methodology	Ethnographic research
Methods	Survey/Questionnaire, Semi-Structured Interviews, Participant observation
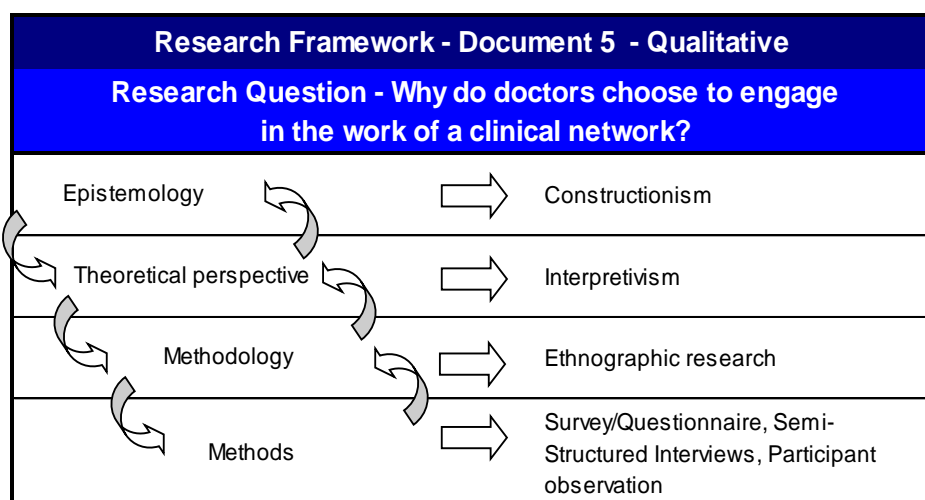
It is important to understand the ontological and epistemological approach of the researcher in terms of their set of beliefs, how they view the world, and how they know about it, to determine how this influences the research study. Whilst this

framework confirms the author's preferred viewpoint and approach for this ethnographic research, it also provides a clear structure to the research process. Setting out the framework in this way has enabled the author to view the impact of all elements on the whole process and maintain a focus on the research perspectives to facilitate meaningful enquiry.

In recounting her view of the world and social life within that world, the author believes that knowledge is constructed from interactions with human beings and with realities [*that she perceives*] exist in the world and therefore takes the constructionist perspective. In considering her epistemological orientation for earlier qualitative research (Shepherd, 2012), and again at this stage of the study, the author has gained a much greater appreciation of the assumptions of reality that influence both her research and work, which helped her realise her constructionist viewpoint. The constructionist view recognises that people may construct meaning in different ways, even in relation to the same phenomenon and recognises therefore that multiple realities are present in any social context. According to Blaikie (1993), these multiple realities are the consequence of different groups having either inherited, and or created, different ways of viewing and understanding their world.

In Document 3 (Shepherd, 2012), the author advised the reader that the terms "*constructivism*" and "*constructionism*" have distinct meanings but are often interchanged and so, for ease of reference, the explanatory text is reproduced herewith.

> Constructivism is concerned with the individual making meaning of knowledge; constructionism refers to the development of phenomena relative to social contexts (Vygotsky, 1978). In other words constructivism is knowledge constructed by the learner through a series of complex knowledge structures based on prior knowledge and experience. The learner consciously thinks about trying to derive meaning and consequently meaning is constructed. In contrast, constructionism is more concerned with learning through collaborative construction of socially and culturally defined knowledge and values. Crotty (1998, p.42) describes constructionism as; "the view that *all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings*

> *and their world, and developed and transmitted within an essentially social context... In the constructionist view, as the word suggests, meaning is not discovered but constructed. Meaning does not inhere in the object, merely waiting for someone to come upon it.*" (reproduced from Shepherd, 2012, p.16-17).

A key part of the author's role as Director of the Network is to construct from enquiry and, in essence, this is reflected through this research. The Network offers a solid construct from which to elicit the expertise and knowledge from its members and, taking account of different viewpoints, facilitates the generation and implementation of theory and practice. Indeed the author is described as a "servant of the Network" in this research study. The author works with multi-professional staff at all levels and believes that knowledge is formed from experience and from interactions with others and the environment. From interaction, people build their own picture of the world. The author also appreciates however that everyone is an individual and that in individuality; people have their own thoughts and their own understanding and knowing of knowledge and of the world. The Network provides the setting and opportunity to share this knowledge. Nonetheless, whilst this can be shared, everyone interprets what they see and hear in their own unique way and as a consequence there is no one true knowledge about things. Anderson (1991, p.29) quotes Schutz (1967) in terms of meaning making in the social construct; "*every act of mine through which I endow the world with meaning refers back to the same meaning endowing act… of yours with respect to the same world.*"

Constructionism offers an interesting perspective for this study as, even though research participants are from the same clinical profession and specialty of intensive care medicine, each will perceive different situations in a different way relating to, and as a consequence of, their own experiences and view of the world. This adds to the richness of this study which seeks to give meaning to the research phenomenon. In conducting the different stages of research for this study, the author has considered whether she can remain independent from the phenomena being observed, or whether this would be hard to sustain given the nature of the work environment. It is fair to say that at Document 3 (Shepherd, 2012); she recognised that as Director of the Network it would be impossible to assume a totally neutral stance given the phenomena being studied. This stage of the research is however different in that, although the research explores doctor engagement in the Network, the author has no influence over any of the research

participants in terms of their primary substantive job role or position. Additionally, the author is a non-clinician and, whilst she works closely with clinical staff, she has no a priori experience of working as a clinician in the NHS. At this stage of the research, and in recognising that doctors are engaged in the Network, the Network provides a mechanism to explore the phenomenon. The author therefore considers that it is unlikely that the responses of the research participants will be influenced by her position and perceives their contribution to the research to be impartial and honest. The author is also recognisant of the fact that she has a predisposition towards the Networked model of health care and, in acknowledging this predilection, is conscious to represent the participants' viewpoints in an honest and exacting way.

Throughout this research study, the author has come to appreciate the importance and justification of the choice of research methodology and methods to answer the research questions. Not only do the design of the study and the refining of the research questions influence the research process, but the theoretical perspective that the researcher brings to the study also influences this choice. This is explored in the following section, however, as this has already been covered extensively in Document 3 (Shepherd, 2012); at this stage, a synopsis is included to explore how this influences the choice of research design.

3.3 Theoretical Perspective and Interpretivism

This research employs an interpretivist approach to explore how doctors make sense of their engagement in a clinical network environment. Undertaking an interpretive stance has enabled the author to explore meanings and interpretations and to form structures out of these interpretations. According to Crotty (1998, p67), the interpretivist approach "*looks for culturally derived and historically situated interpretations of the social life-world*". Interpretive researchers believe that meaningful reality is not objectively determined but is socially constructed (Fisher, 2007; Kelliher, 2005). An understanding of reality is formed both from an individual's interpretation of reality, which is influenced by their perceptions and understanding of the world, and by other people's interpretations. Geertz (1973, p.9) describes this interpretive view of data as "*what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to*". This captures the reality of how research data emerges from multiple descriptions and opinions and

it is through negotiation, that compromises and agreements are reached (Fisher, 2007).

Interpretive researchers are concerned with the detail of a situation and study different descriptions that people give of situations and issues. They are also keen to discover the process by which people make sense of the world and seek to form structures out of interpretations. As individuals, research participants live within their own social context, but interlink with many other more complex frameworks in both the home and the work environment. Medicine is a science, and doctors therefore are likely to look for objective meaning in research. Interpretivism is however concerned with the subjective evaluation of realities and interpretivist researchers look at the different interpretations that people give of the subject matter and the different explanations of the process by which the people they study make sense of the world. Interpretive research attempts to understand the processes by which people gain knowledge and builds on the foundations of theories concerning reality. "*The real world has to be seen through human thought and not seen as separate from it*" (Fisher, 2007, p.15).

It is proposed that the roots of interpretivism lies in the work of Max Weber who suggests that the human sciences are concerned with "*Verstehen*" (understanding) in contrast to the explicative approach of the natural sciences (Crotty, 1998). Bryman and Bell (2007) support this view and advise that it is this "*understanding"* of human behaviour which is central to the interpretive approach as opposed to an emphasis on the "*explanation"* of human behaviour which is more akin to the positivist approach to social sciences. This tradition of interpretivism and notion of *Verstehen* describes sociology as "*a science which attempts the interpretive understanding of social action in order thereby to arrive at a causal explanation of its course and effects*" (Weber, 1947, p.88 in Bryman and Bell, 2007, p.18). This definition embraces both explanation and understanding. Furthermore, Bryman and Bell (2007, p.18) suggest that the crucial point is that the "*task of 'causal explanation' is undertaken with reference to the 'interpretive understanding of social action' rather than to external forces that have no meaning for those involved in that social action*", in other words, that reality emerges from the subjective meanings of social action. In taking an interpretive approach, the author recognises the different levels of interpretation and perspectives taking place in the research process. The author has a perspective; research participants have a perspective and the author has a perspective of what the research participants are telling her which she then

interprets by identifying specific themes and concepts in an attempt to give meaning to and make sense of doctors perceptions of engagement in the Network. These different perceptions present a fascinating concept, mainly in respect of expectations, emotions, beliefs, values and judgements conveyed by participants. Managing these societal aspects is key to collaborative working and many of these characteristics contribute to the culture of the Network in that as a virtual organisation, it is the people who make it happen. Interpretivism promotes the value of qualitative data in pursuit of knowledge (Kelliher, 2005) and, in applying the interpretive perspective, the author adopts an empathetic stance to enter the world of the research subjects in an attempt to understand the world of engagement from their point of view adding to the knowledge and understanding of why doctors choose to engage in a clinical network, something which has been little explored.

Being a participant of the Network that provides the basis for this study has enabled the author to adopt an ethnographic study design. This study obviously builds on previous qualitative research which provided an ethnographic account of a piece of qualitative, interpretive research. Ethnography as a research methodology is therefore described in Document 3 (Shepherd, 2012). The following section highlights salient points relevant to this stage of the study.

3.4   Ethnographic Research

This ethnographic study seeks to explore how doctors interpret and make sense of their engagement with the Network. In exploring the lived experience of doctor engagement, this research methodology enables doctors engaged in the Network to express their views in their own language.

Ethnography is a qualitative research strategy designed to study people in their natural settings. It provides a methodology for "*collecting describing and analysing the ways in which human beings categorise the meaning of their world*" (Aamodt, 1991, p.41) and involves documenting people's beliefs and understandings from their own perspectives (Riemer, 2012). Earlier qualitative research however taught the author that ethnography often goes beyond this to explore more how people interpret and make sense of their world, a point which Spradley (1980) makes when he suggests that the core of ethnography is in the '*meanings*' of actions and events the ethnographer is seeking to understand. Exploring these meanings enables the researcher to really begin to

understanding how people interpret and make sense of their world and, in taking an interpretive approach to this research, the author is looking to discover how doctors understand and make sense of engagement in a network setting. This research study is designed to enable the author to explore meanings through conversation as, according to Crotty (1998, p.75), *"only through dialogue can one become aware of the perceptions, feelings and attitudes of others and interpret their meanings and intent"*.

Although ethnographic research has a long history in the social sciences, it continues to play a significant part in the development of many areas of management research (Gill and Johnson, 2005), and is often undertaken by researchers working in professional and applied fields (Bryman and Bell, 2007). According to Watson (2001), ethnography is an extension of the processes used in everyday life and, according to Streubert and Carpenter (1999), as a method of enquiry, ethnography enables the researcher to become a part of the culture being studied. In management and business, ethnographers study organisations and the people within the organisations and are particularly concerned with the way that people interact. In this respect, in ethnography there is a "*coming together of the 'everyday' thinking of the 'subjects' of the research and the body of academic knowledge to which the researcher has access*" (Watson, 2001, p.6.)

According to Streubert and Carpenter (1999, p.148), ethnography requires an "*intimacy with the participants who are part of the culture".* Whilst the author has a sound relationship with the research participants, which certainly proved to be advantageous in terms of recruitment to the study where doctors "*offered*" to be interviewed, the author recognises that it is not always possible to have a truly "*emic*" (insider) view as the language, beliefs and experiences belong to those being researched. So, whilst the author works with clinicians, including doctors, she is not a clinician and therefore has no idea of knowing what it is like to be engaged in the Network from a clinical or medical perspective. The author has always held the view that she frequently undertakes the role of translator in the Network, translating clinical expertise and knowledge into tangible and deliverable outputs. This role of translator is equally important in ethnographic research as according to Fetterman (1989) the ethnographer's role is to translate insiders' meanings into concepts that can be understood by people outside of the society. Furthermore, Fetterman (1989, p.22) suggests that the ethnographer should remain "*open and non-judgemental about the actions and beliefs of the*

social group under study, while making these understandings and practices intelligible to outsiders."

In health care, ethnographic research often focusses on improving aspects of service delivery or organisation, and explores the impact of cultural beliefs and practices on specific concepts of health, for example illness and treatment (Hustler, 2005). Whilst ethnography is an effective method to explore issues surrounding clinical networks, this study is short-term and looks at doctor engagement in an identified critical care clinical network. The time and scope of this study does not allow for a full ethnographic study and this research might therefore more correctly be described as micro-ethnography (Streubert and Carpenter, 1999).

All research approaches are not without risk, and the risks associated with this stage of the research study relate to the small number of research participants, interpretation of meaning due to interviewer's bias and in relationships formed between the researcher and those being researched. Having previously undertaken ethnographic research, the author has already considered these risks, but the author is ever mindful of any influence or bias that this might introduce into the study, and considers that the relationship issue has proved to be of benefit both in terms of participant recruitment and in terms of generating meaningful data.

This study lends itself to ethnography because of the opportunity to collect stories and to explore thoughts, meanings and feelings that doctors attribute to why they choose to engage, or not, in the Network and in the management and leadership of the NHS. The research is designed to explore the social aspects of a clinical network and takes an inductive approach to generating theory using an interpretive model, recognising the presence of multiple perspectives from which to construct knowledge.

As this study has progressed, the author has used different research methodology and methods in order to answer the research questions and has come to realise the importance of choosing the appropriate research design for the organisation of research activity, including data collection. The author appreciates the relationship between the research methodology and research methods and Chapter 4 outlines the research methods adopted for this study.

This study obviously requires the participation of NHS staff and in order to ensure that the research study is morally and ethically sound, ethical and confidentiality issues were considered prior to the research being undertaken. Ethical approval is a huge issue for staff working in the NHS and the following section provides an overview of the ethical approval process undertaken for this study.

3.5 Ethical Reflection and Considerations

The author has previously recognised the significance of the ethical considerations for the research process, and the ethical process undertaken for this study is described in detail in the earlier qualitative research report submitted at Document 3 (Shepherd, 2012, p.33-40).

Research studies should be both morally and ethically sound. Ethical issues affect both the professional practice of employees and the design and delivery of research projects. Study participants have a right to be treated fairly and to suffer no harm because of their participation in research. The Academy of Management (AoM) Code of Ethical Conduct states that it is the researcher's responsibility to assess the possibility of harm and to take reasonable precautions to ensure the safety of research participants (Bryman and Bell, 2007). In the context of this study, ethical issues are concerned with behaviour in the relationships formed, data management, and ethical safeguards including participation, consent, risks, confidentiality, and anonymity. Ethical issues therefore have an impact on a personal and professional level. Hammick (1996) makes this point when she identifies the impact of personal and professional knowledge and experience on ethical practice and suggests that moral reasoning is a question of balance and judgements between knowledge and experience.

Students conducting research as part of an academic programme are required to gain ethical approval prior to the undertaking of any primary research. The author completed the NTU College of Business Law and Social Sciences (BLSS) Graduate School Ethical Clearance Checklist Form A (Nottingham Trent University, 2010), which was approved by the Course Director. The author is however employed by the NHS and is therefore bounded by more rigorous ethical procedures. Demonstrating rigor throughout the phases of a research study is considered an essential component for excellent research and the author has been thorough in her approach to adhere to a core set of recommended standards (Lamont and White, 2005).

NHS based research is considered to be an important part of the UK economy, vital for providing new knowledge to inform the service and improve the health of the population (NHS Health Research Authority, 2013). The NHS Constitution confirms the commitment of the NHS to the "*promotion, conduct and use of research to improve the current and future health and care of the population*" (Department of Health, 2013, p.3). The NHS has very stringent rules to govern research projects in order to protect the rights, safety, dignity and well-being of research participants and research in the NHS is governed by an ethical framework. The NHS Health Research Authority (HRA) is an ethical body established in 2011 to "*protect and promote the interests of patients and the public in health research, and to streamline the regulation of research*" (NHS, Health Research Authority 2015).

All research projects in the NHS are submitted via the Integrated Research Application System (IRAS) which is a single system for applying for the permissions and approvals for health and social care/community care research in the UK (Integrated Research Application System (IRAS) Version 3.4, 27 October 2011). IRAS is designed to cover all types of NHS research studies and captures all information required for approval from the relevant review bodies. Researchers must gain permission from organisations where the research will be undertaken and, whilst IRAS enables submission of information through a central resource, researchers must manage their research applications through the relevant regional and local research committees. The design of this study required the inclusion of NHS staff as research participants and so the author sought research ethical approval from five acute hospital trusts within the Network region and her host employing organisation.

The ethical process for this study took 22 months from start to finish and the confirmatory ethical approval letter is included at Appendix 12. In order to fulfil the requirements of the ethical approval granted for this research study, the author is required to submit on-going progress reports to local Trust R&D committees and the regional Research Ethics Committee (REC). Table 6 provides an illustration of documents generated for ethical submission and Table 7 gives an indication of the on-going requirement for the submission of progress reports.

TABLE 6 - INTEGRATED RESEARCH APPLICATION SYSTEM – SUBMISSION CHECKLIST

Document	Enclosed	Date	Version	Number submitted		
				IRAS	REC	R&D/SSI
Covering letter on headed paper (signed)	Yes	22/07/2011		1	1	6 (localised)
IRAS Application (signed/authorised copy)	Mandatory	21/07/2011	Version 1	1	1	6
R&D Application (IRAS Parts A-D) (signed/authorised copy)	Mandatory	21/7/2011	Version 1	0	0	6
Research Protocol or project proposal (6 copies)	Mandatory	01/07/2011	Version 1	1	6	6
Summary CV for Chief Investigator (CI) (signed and dated)	Mandatory	21/07/2011		1	1	6
Summary CV for supervisor (student research) (signed and dated)	Yes	21/07/2011		1	1	6
Research participant information sheet (PIS) – local version	Yes	01/07/2011	Version 1 & 2	1	2	12 (localised)
Letters of invitation to participant – local versions	Yes	01/07/2011	Version 1	1	1	6 (localised)
Written final confirmation from the organisation(s) acting as sponsor (letter signed)	Yes	01/07/2011	Version 1	1	1	6
Research participant consent form – local version	Yes	01/07/2011	Version 1 & 2	1	2	12 (localised)
Referee's or other scientific critique report	Yes	01/07/2011	Version 1	1	1	6
Interview schedules or topic guides for participants	Yes	01/07/2011	Version 1	1	1	6 (localised)
Site-Specific Information Form (signed/authorised copy – Trust CD/MD signature required)	Yes			1	1	6 (localised)
REC favourable opinion letter and all correspondence	Yes			0	0	6
*Risk Assessment and Monitoring Plan	n/a	9/1/12	Version 2	0	0	1
*Investigator Site File	n/a	9/1/12	Version 1	0	0	6
*NHS Employment form for Letter of Access	n/a	5/8/11	Version 1	0	0	6
Total number of documents submitted/created (146)				**12**	**19**	**115**
*Documents submitted/created for Sponsor Organisation						

TABLE 7 - ETHICAL PROCESS – REQUIREMENT FOR ON-GOING PROGRESS REPORTS

Revised Documentation	Date	Version	Ethical body	No. Submitted
Annual Research Update Report	December 2012	Dec 2012	R&D	6
	December 2013	Dec 2013	R&D	6
Annual Progress Report	15/11/13	November 2013	Derby NRES	1
Letters of invitation to participant – local versions	19/12/13	Version 1.1	Trusts	7 (localised)
Research participant information sheet (PIS) – local version	19/12/13	Version 1.1	Trusts	7 (localised)
Research participant consent form – local version	19/12/13	Version 1.1	Trusts	7 (localised)
Quarterly Progress Report	18/4/13	Jan-March 2013	ULHT R&D	1
Annual Progress Report	8/4/13	April 2013	R&D	6
Quarterly Progress Report	18/10/13	April-June 2013	ULHT R&D	1
Quarterly Progress Report	18/10/13	July-Sept 2013	ULHT R&D	1
Quarterly Progress Report	3/3/14	Oct-Dec 2013	ULHT R&D	1
Quarterly Progress Report	3/4/14	Jan-March 2014	ULHT R&D	1
Quarterly Progress Report	16/7/14	April-June 2014	ULHT R&D	1
Annual Progress Report	4/6/14	June 2014	ULHT R&D	1
Quarterly Progress Report	1/10/14	July-Sept 2014	ULHT R&D	1
Quarterly Progress Report	12/12/14	Oct-Dec 2014	ULHT R&D	1
Annual Progress Report	12/12/14	December 2014	Derby NRES	1
Total number of revised documents/progress reports submitted/created (50)				**50**

The issue of NHS staff as research participants has since been addressed with the introduction of a new version of Governance Arrangements for Research Ethics Committees (GAfREC) (Department of Health, 2011), introduced in September 2011. This document specifies that "*research involving staff …who are recruited by virtue of their professional role, does not therefore require REC review …*" (Department of Health, 2011, p.13). The exception to this is where there is a legal requirement for REC review or where the research also involves patients or service users as research participants. There is still a requirement however to gain management permission for research involving NHS staff members.

All researchers have an obligation to ensure the application of appropriate standards in respect of the research process and, being employed in the NHS, the author is required to conform to NHS Research Governance processes. This study takes place in a clinical network and research participants are senior doctors working in the field of critical care medicine. The NHS Research Governance Framework (Department of Health, 2005) outlines the principles of good governance of which informed consent is a key element. Research participants were given a written Participant Information Sheet (Appendix 3) outlining the detail of the study in advance of their involvement. This comprehensive document describes the purpose and objectives of the study and outlines ethical issues in terms of data handling, confidentiality and anonymity. Prior to interview, participants gave permission for the interview to be tape recorded for the purposes of the research, and completed and signed a consent form (Appendix 4) which was then counter-signed by the researcher. In this instance, consent is implicit. Additionally the author attended three different Hospital Trust Executive Group meetings and undertook covert participant observation. Permission for attendance was sought from the Hospital Chief Executive and Medical Director/Clinical Director, who were advised of the research study and agreed for the researcher to attend in a shadowing role. In granting permission, the Executives demonstrated an awareness of the role of a participant observer in being able to observe without risking a change in group member behaviour. Fisher (2007) reminds us that in such circumstances there are codes of research ethics, for example the British Sociological Association (2002) for research undertaken without prior informed consent.

The author has been meticulous in recording and storing the research data. Paper and electronic files are stored according to the Nottingham Trent University

Research Data Management Policy as part of the University's commitment to research excellence (Nottingham Trent University, 2014). As Principle Investigator, the author assumes responsibility for the research data management for this study. Interviews have been electronically recorded and data transcripts have been typed verbatim. Some of the content of the interviews has been disclosed only to the author's academic supervisors. The author has attributed a code to research participants' place of work and has protected the identity of research participants by the use of a reference code. In some instances, a participant revealed distinct information during interview, which could potentially expose their identity and, where this occurred, the author alerted participants to the potential disclosure and gained consent to allow the use of the information.

As outlined above, the author undertook a rigorous ethical process prior to commencement of the research for this study. Completion of the ethical process afforded the author the opportunity to re-shape the research study in order to ensure that the research process would facilitate exploration of the key research questions. Whilst the author did not anticipate the rigor of the process, this did influence the study as outlined below.

At the start of the NHS ethical process, the author had only a vague idea of the research study in its entirety, although the key subject area (clinical networks) remained constant throughout. Having to undertake the research ethical process involved the author in a complete re-write of the project proposal, which afforded the author the opportunity to re-review the research study and re-examine the key stages of the research at Documents 3, 4 and 5. Refocusing of the research study led to the identification of clearer research questions and confirmation of the research methodology for each stage of the study, which ultimately led to the research findings and outcomes. Had the author not had to follow the NHS ethical process, it is possible that the study would not have been so well rehearsed and would not therefore have progressed through the identified stages, which might have led to difficulties further into the process in terms of clarity and significance. In this instance, the author considers that the rigorous ethical process therefore played a pivotal role in shaping this study within the context of the DBA process.

SUMMARY OF CHAPTER 3

This Chapter outlined the philosophical assumptions and theoretical perspectives underpinning the methodology for this research study. It described the constructionist viewpoint and interpretive perspective and explored how the epistemological and ontological assumptions of the researcher might impact or influence the research study.

This Chapter introduced the Research Framework for this stage of the study and demonstrated the relationship between the epistemology, theoretical perspective, methodology and methods. It explored the qualitative research methodology as an approach for this study and the final part of the Chapter provided a brief overview of ethnographic research. The qualitative paradigm is appropriate for this research study as the author is keen to explore dimensions of the social aspects of a clinical network and examine the experiences and perceptions of research participants and the significance of the meanings that emerge from the findings.

Finally, this Chapter defined key ethical considerations and principles to ensure the safety of research participants and the appropriate management of the research material and explored the impact of this on the research study.

The following Chapter explores the research methods applied to answer the research questions.

CHAPTER 4

RESEARCH METHODS

"I have no data yet. It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts" (Doyle, 2015, p.4).

This Chapter outlines the research methods selected to answer the research questions. It presents the argument for the choice of methods and provides a summary of their application to this study.

In outlining the various techniques adopted to gather the data, this Chapter describes the data collection and analysis procedures applied to this research including the generation of themes and concepts. An overview of the research participants is included.

4.1   Introduction

As this research study has progressed, the author has become more confident in applying different research methods in order to answer the specific research questions. Additionally the author has come to appreciate that the research methods are usually dictated by the methodology and that the choice of methods usually occurs during the research design phase. Reading the relevant academic literature has also highlighted to the author that the terms "methodology" and "methods" are often used interchangeably, and in certain respects the author believes the terms are used incorrectly, particularly where the term "method" is used to describe ethnography and action research. For the purposes of clarity, a research method is a technique for collecting data and can involve a number of different research instruments (Bryman and Bell, 2007). Although this provides a simple definition, according to Silverman (2006), researchers need to resist treating research methods as mere techniques as the research method will take on a specific meaning according to the methodology in which they are used and the methodological preferences of the researcher. Whilst this relates to the previous Chapter, it indicates a relationship between the different research methods. The relationship between qualitative and quantitative methods can often be complementary rather than exclusive and it is possible to use any of the research methods in any of the approaches (Fisher, 2007; Silverman, 2006;

Mays and Pope, 1996). The research methods used for this study are discussed in the following section.

4.2   Discussion of the Research Methods

Whilst it is acknowledged that different research methods are associated with different kinds of research design, it is through the use of a research method that data is collected. Research methods do not have to be used in isolation as several methods can be used to inform a single study. Although the application of the different methods used in qualitative research has been widely debated (Hammick, 1996; Silverman, 2006; Mays and Pope, 1996; Brewer, 2000), Streubert and Carpenter (1999), confirm that the choice of method depends on the research questions being asked.

Ethnographic research undertaken for this study explores engagement from the perspective of senior doctors in the field of intensive care medicine. Therefore, in order to answer the research questions, the author gathered data using a number of techniques, some of which are new to the researcher. Initially, and in order to identify research participants, the author conducted a short survey questionnaire (Appendix 5). The terms '*survey'* and '*questionnaire'* are used interchangeably in the literature and the author has chosen the term "*survey questionnaire*" to mean; survey – to gather the information from the respondents; questionnaire – the form designed to gather the data. Whilst the survey questionnaire is normally attributed to quantitative research, the author designed this with a series of open-ended questions principally to obtain a viewpoint on what engagement means to doctors and why they choose to engage in the work of the Network. The survey specifically asked participants to score their level of engagement in the Network on a five point Likert scale (Buglear, 2007). The answer to this question enabled the author to identify engaged doctors and served as a precursor to more in depth face-to-face interviews, to provide greater insight into the subject area. From previous research, the author is aware that the process of writing the survey questionnaire can limit the extent to which descriptive data is obtained compared to data obtained orally (Morse, 1991) and that combining the research methods enables the collection of more descriptive data.

Undertaking face-to-face interviews has proved to be an effective method of data collection for this study, particularly as the researcher has taken an interpretive perspective. Indeed it is suggested that interviews are a part of most interpretive

studies as they provide a "*key way of accessing the interpretations of informants in the field*" (Walsham, 2006, p.323) and aim to *"discover the interviewee's own framework of meanings"* (Britten, 1996, p.28). According to Fetterman (1989, p.50) "*ethnographers use interviews to help classify and organize an individual's perception of reality*". The author used a spine of questions to design a series of face-to-face interviews, which sat somewhere between semi-structured and unstructured and allowed participants the freedom to tell their story and to express opinion and thought. According to Britten (1996) the term "*unstructured*" is misleading in that no interview is completely devoid of structure and certainly in this process, key questions were used to guide the interviews.

The author set out to identify a number of critical incidents from the interviews. In research, a critical incident is defined as *"any observable human activity where the consequences are sufficiently clear as to leave the observer with a definite idea as to their likely effects"* (Bryman and Bell, 2007, p.227). According to Bryman and Bell (2007) the most common use of the critical incident method involves interviewing participants about a certain type of event or behaviour in order to develop an understanding of their sequence and importance to the individual. The term "critical incident" however has a different connotation in health care and defines "*an event which led to harm or could have led to harm if it had been allowed to progress*" (Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland, 2006, p.24). Therefore, the research participants, as doctors, would define a critical incident as an event which either caused real or potential harm. For this reason, the author termed a critical incident as a "narrative account" for the purposes of this study when talking to research participants. Although the author set out to identify specific narrative accounts, when probing for these, participants were not as forthcoming in recounting events as the author had hoped as they recited more objective rather than subjective accounts of events. Nevertheless, throughout the interview process, narratives emerged and the author was able to extract these for analysis as described further in Chapter 5.

Finally, the author observed three different Acute Hospital Trust Directors' Group meetings as a participant observer, although only the Chair of the meeting and Sponsor were aware of the author's attendance as an observer. In all meetings, the author was referred to in her capacity as Director of the Networks and as such considers that she was a "*researcher-participant*" (Bryman and Bell, 2007,

p.456) whereby she was able to participate in the meeting but was only semi-involved and therefore able to function fully as a researcher throughout.

Interpretive researchers are often participants in the process they are studying. The author has a keen interest in networks, which has inspired this research study. As Director of the Network, the author is aware that her position could introduce an element of bias into the research process, which in turn could affect the study findings. As already mentioned, the existence of the researcher in the study raises issues of reflexivity where the researcher's "*own interpretative processes and authorial position need to be taken account of*" (Hustler, 2005, p17). This is in respect of both the research process and in the reporting of outcomes.

The NTU Code of Practice for Research advises that *"Research requires a commitment to the careful, reflective process of discovery and interpretation"* (Nottingham Trent University, 2009, p.3). The author acknowledges the potential for bias relating to her previous experience, knowledge and preconceptions (Walsham, 2006) but in having an awareness of this, has attempted to present participants' views in an exacting way. The author also recognises a benefit of undertaking interviews with colleagues with whom she already has a relationship as this might mean that participants "*will reveal their 'true' inner feelings, attitudes and behaviour"* (Bowling, 1997, p.337) something which the author considers did in fact happen throughout the interview process. In undertaking interpretive research, the author also acknowledges that she had a choice in terms of writing style and made a conscious decision to write this report in the 'third person' for two reasons. Firstly, to the author, use of the 'third person' distinguishes an academic, rather than a professional style of writing. Secondly, as a key member of the Network, the author is involved and interested in the research phenomena and writing in the 'third person' has enabled her to distance herself from the events to maintain a level of impartiality.

Having selected the research methods and considered issues of reflexivity relating to the involvement of the researcher in the study, the research participants were selected and the methods applied as outlined in the following section.

4.3   Application of Research Methods

As already indicated, in order to answer the research questions and probe for richness, the author applied a number of methods to collect data. The research questions for this study relate to the qualitative approach and are designed to enable the researcher to seek to explore meaning from the research participants' experiences and observations. This study is therefore interpretive and qualitative in design. Such a design is well suited to explore doctor engagement and the meanings that participants attach to their actions. The author applied a number of different data collection methods to this study, namely, a survey questionnaire, semi-structured interviews (and emergent narrative accounts) and participant observation. Whilst the survey questionnaire and semi-structured interviews were designed to enable the author to gather evidence to answer the research questions, the in-depth interviews were more concerned with why doctors choose to engage and the meanings that they describe as emerging from engaging in the management processes of the NHS. The survey questionnaire was designed around the key concept of engagement as illustrated in Appendix 5. The author undertook the opportunity to pilot the survey questionnaire with the Network Medical Lead to ensure that the information gleaned would inform the research questions and assist with the identification of research participants for the next stage of the research process. Survey questionnaires were distributed to doctors attending the Network annual conference via delegate packs to provoke responses from this specific professional group. A total of 22 doctors attended the Network Conference and of this group 59% (n=12) returned a completed questionnaire. Following the Conference, a further 9 survey questionnaires were handed to doctors attending the Network Service Improvement and Clinical Group meetings and of this group 78% (n=7) returned completed questionnaires. Finally, 3 survey questionnaires were posted to Clinical Leads in the Network and of this group 100% (n=3) returned completed questionnaires. Therefore the overall number of completed questionnaires represents a 65% (n=22) response rate.

The author found the process of deciding a series of questions to guide the face-to-face interviews challenging, both in terms of time and detail and undertook a mock interview with her lead academic supervisor to assist with the refining of the interview questions. This demonstrates the author's growth as a researcher, particularly in appreciating the benefits associated with ensuring that the whole research process is suitable for the topic under examination. The generation of

the research questions was not done in isolation of any previous knowledge or findings, as outcomes from earlier qualitative and quantitative research influenced the research design.   Applying the inductive method of theory generation proved to be effective in earlier stages of the research, where the findings really gave meaning to participant members' perceptions of the Network.

Following the generation of the interview questions, a pilot interview was undertaken with a senior doctor in the Network, which confirmed the final spine of questions as illustrated in Appendix 6.   Individual face-to-face semi-structured interviews were then conducted using this outline of questions.   All interviews were between 1 and 2 hours duration and all were digitally tape-recorded. Interviews were sorted, allocated a reference code and transcribed verbatim to produce detailed transcripts of text for analysis. The author repeatedly listened to the interview recordings and read and re-read the transcripts for accuracy and inserted line numbers to enable a more efficient process of extraction of narratives and quotes during the analysis process. At this stage of the research, a reference code was applied to each interviewee to preserve their anonymity and the author began the process of coding of the data.

Research participants were engaged in this study as outlined in the following section.

4.4   Identification of Research Participants

As already described, the survey questionnaire was distributed to doctors via the Network Annual Conference and Network Meetings, and the overall response rate represents two-thirds (65%) of the target group.

The survey questionnaire asked a number of direct and descriptive questions. Question number 2 was designed to identify the level at which doctors perceive that they are engaged in the Network as illustrated in Figure 4. This question was designed to inform a score using a five point Likert scale as illustrated and completion of this question enabled the author to identify doctors who scored 4 or 5, indicating a high level of engagement.

FIGURE 4 - SURVEY QUESTIONNAIRE – QUESTION NUMBER 2

2	On a scale of 1-5 how engaged are you in the work of the Network?

1	2	3	4	5
not at all engaged	want to be engaged but don't know how	mildly engaged	moderately engaged	considerably/ fully engaged

Tick symbol to copy to cells ✓

Respondents were invited to include their contact details on the survey questionnaire although this was not a requisite for completing the survey. Seventy-two per cent of respondents (n=16) included their contact details and this, together with the score from Question 2, enabled the researcher to select the research participants to partake in the face-to-face semi-structured interviews. A purposive sampling approach was therefore used to recruit participants for the face-to-face interviews. Whilst a more in-depth analysis of the data is provided in Chapter 5, Table 8 illustrates the research sample. The author allocated a reference code to all research participants and to the 5 Acute Hospital Trusts in order to preserve anonymity and confidentiality. Appendix 7 provides a more detailed illustration of the timings of interviews, size of sound files and transcription word counts.

TABLE 8 - SAMPLE RESEARCH PARTICIPANTS

Tape number	Tape File reference	Time in Critical Care (years)	Time in Network (years)	Grade	Gender	Age	Date of Interview
1	D1-24-n-14 CC02	24	14	Senior Consultant	M	52	28.4.14
2	D2-28-n-14 CC05	27	14	Senior Consultant	M	55	1.5.14
3	D3-25-n-14 CC01	24	14	Senior Consultant	M	49	21.5.14
4	D4-10-n-7 CC03	10	7	Senior Consultant	F	46	28.5.14
5	D5-12-n-6 CC03	12	6	Senior Consultant	M	41	29.5.14
6	D6-11-n-5 CC03	11	5	Senior Consultant	M	37	29.5.14
7	D7-14-n-5 CC02	14	5	Senior Consultant	M	40	30.5.14
8	D8-16-n-14 CC02	16	14	Senior Consultant	M	48	30.5.14
9	D9-25-n-14 CC05	26	14	Senior Consultant	M	52	2.6.14
10	D10-12-n-9 CC05	12	9	Senior Consultant	M	43	9.6.14
11	D11-16-n-6 CC05	16	6	Senior Consultant	F	40	10.7.14
12	D12-18-n-11 CC04	18	11	Senior Consultant	M	46	5.12.14

Interviews were undertaken with senior consultants practising in the field of intensive care medicine. All interviews were conducted in either the research participant's place of work, or the researcher's office. A total of 12 interviews were conducted.

Case selection and sample size is important in any research study, particularly to ensure that the study produces enough data for analysis. This sample size yielded 76,000 kilobytes of data, which when transcribed equated to over 141,558 words. Smaller sample sizes can be applicable in qualitative research, importantly when participants or cases are chosen appropriately and yield unique insights by revealing consistencies between categories that may escape larger sample sizes. It is proposed that by thoroughly examining a small number of cases, the researcher may actually explore in more detail the contextual dimensions that influence smaller groups or patterns of interaction that can have a greater significance for understanding social processes (Lamont and White, 2005). As the interviews progressed, the author began to identify a number of common emerging themes and, whilst the author appreciates that each participant has a unique perspective of their engagement experience, it became evident to the author that these common themes were recurring and would therefore form the basis of the analysis. It could be suggested therefore that the author managed to achieve a level of data saturation through the interview process (Saldaña, 2012) It is suggested that there is a greater use of qualitative research methods to research human sciences in health care and that "*observation and interviews are used as ways of providing information that is detailed and usually related to few rather than many participants*" (Hammick, 1996, p.29). Face-to-face interviews allowed the author to probe for detail through both the questioning and the responses.

Prior to the interview, participants were given a letter of invitation to partake in the research, (Appendix 2) and a research participant information sheet (Appendix 3). Prior to the commencement of each interview, participants were advised that their involvement in the study was voluntary and were informed of the purpose of the research. They were advised approximately how long the interview would last and of their right to anonymity in the study. Permission was sought from each participant to tape record the interviews and participants were advised that the tape recording could be stopped at any time during the interview. All participants are of consenting age and each signed a research participant consent form (Appendix 4) indicating their willingness to be involved in the study

and giving permission for the author to use direct quotes in any research documents. At the end of each interview, participants were asked for additional comments and thanked for their time.

The interview questions were designed to gain an in-depth understanding of doctors' perceptions of the engagement experience.   Additionally the author introduced critical incident enquiry (termed as narrative accounts to participants) in order to gain an understanding of what is important about the topic. Fisher (2007) advises that the critical incident technique is a useful method that aims to understand participants' interpretation of their lived experience. In this instance, participants were asked to describe four quadrants as follows:

- An example that represents engagement working well in the Network
- An example that represents engagement working well in the participant's Trust
- An example that represents engagement working not so well in the Network
- An example that represents engagement working not so well in the participant's Trust

Whilst this element of the interviews generated data in respect of engagement and particularly in relation to the Network and the Trusts, the technique did not yield narratives in the way that the author had hoped it might, which it is suggested is not totally uncommon in this type of research (Elliott , 2006). Some participants struggled to identify examples to discuss and others gave only the briefest description of events. In general, doctors appeared to more easily be able to recount instances of where things have gone well in the Network and less well in their Trust.   As doctors talked freely during the interviews, they spontaneously provided narratives accounts of their experiences, which the author was then able to extract for analysis as outlined in Chapter 5.

In an attempt to gain insight into some of the cultural and behavioural issues within the Trusts, and to add richness to the study, the author attended three different Acute Hospital Trust senior clinical/executive meetings as a participant observer. Observation provided the opportunity for the author to witness group dynamics and behaviours, which could potentially be different to behaviour observed in Network meetings as well as during face-to-face interviews.

4.5   Data collection and analysis

It is suggested that qualitative data cannot be collected in the standardised way that quantitative data is collected, and that there is no standard approach to the way the data can be analysed (Saunders, Lewis and Thornhill, 2000). Having

applied the qualitative research method at Document 3 (Shepherd, 2012), the author already appreciated the value of organising the research data to better facilitate the sorting and coding process. As the interviews progressed, the author began to notice a number of common themes arising from the data, and further handing of the data during the transcription process confirmed these. Furthermore, the richness of the data really started to become evident during the formal coding process as the author began the process of generating theoretical ideas in relation to the codes and data, which is a key component of the coding process (Bryman and Bell, 2007). The initial coding process was undertaken manually as the author coded in pencil in the right hand margin of hard-copy print-outs of the interviews, a process which Saldaña (2012, p.22) suggests enables the researcher to gain "*more control over and ownership of the work*". During previous stages of the research study, the author utilised a word processing package to better facilitate the physical cutting and pasting of the data in order to categorise the data according to key themes. Following the initial manual coding exercise, the author imported the interview transcripts to a qualitative data analysis electronic software package – NVivo 10 for Windows (QSR International Pty Ltd, 2015) and thereafter coded electronically. The author had not used an electronic system previously and so this choice of coding method necessitated the learning of the software package to a level of competency to allow for the coding, sorting and interrogation of the data for analysis. Following electronic coding of the first interview, the author extracted several pages of the interview text and asked an academic colleague to independently code the text. This was then compared with the original coding and many of the themes matched, which assured the author of her coding technique.

The process of generating themes was inductive and themes were identified, coded and recorded by investigating regularities, convergences and divergences in the data. Coding is an interpretive act in itself (Saldaña, 2012) and the emerging themes represent the language used by participants. The descriptive coding process led to the identification of a number of emerging themes and key concepts which has informed the research findings and analysis for this study as illustrated in Chapter 5. The following section briefly describes the method undertaken to identify key themes and concepts.

4.6 The Generation of Themes and Concepts

On first reading, the author highlighted a great number of descriptive codes and amongst the most common of these is support, relationships, power and respect, being listened to, being involved, being valued, management preparation and conflict. This investigative process is organised, comprehensive and transparent. It is also labour intensive, both in terms of time and effort and so the author was careful to ensure that the process remained outcome focussed, whilst allowing for an element of creativity, spontaneity and significance. On further reading the data, the author identified a number of emerging themes including collaborative advantage, power and politics, choosing to engage, preparing doctors for management, conflict and competitiveness. On completion of the coding process, the author categorised these themes into key concepts and linked these to the Research Questions as illustrated in Table 9.

TABLE 9 - QUALITATIVE DATA CODES, THEMES AND CONCEPTS

RESEARCH QUESTIONS:
1. Why do doctors choose to engage in a clinical Network?
2. What can we learn from doctor engagement in a clinical network?
3. What is it about the Network that has engaged doctors?
4. What are the triggers and cues that we need in an organisation to get doctors involved and engaged?
5. Do doctors engage more readily with a clinical network than with their employing organisation and if so, why?
6. Do doctors behave differently in a networked organisation?

Descriptive code	Emerging Themes/ Categories	Final Themes/ Concepts	Research Question
• Working together • Support • Relationships • Belonging • Sharing • Power • Respect • Personal interest and commitment • Patient care/Patient safety	**Togetherness Collaborative Advantage Power and Respect Clinical Engagement Choosing to Engage**	**CHOOSING TO ENGAGE**	1,2
• Being listened to and having a voice • Being valued and respected • Being involved and influencing • Pride and enthusiasm • Leadership and insight • Status as a position of power • Patient care/Patient safety	**Doctor Engagement in the NHS Engaging Doctors in Management Choosing to Engage Triggers and Cues for Engagement**	**THE ENGAGED DOCTOR**	2,4
• Doctors unprepared for management • Exposure to management • Management training for doctors • Management skills • Learning from others • Vulnerability • Feeling frustrated • Being isolated and judged • Hidden agendas and conflict	**Preparing Doctors for Management Management Training and Skills Doctors as Managers Conflict**	**THE RELUCTANT MANAGER**	2,4
• Doctor/Manager conflict • Doctor/Doctor conflict • Doctors as managers conflict • Lack of power and control • Politics • Clinical vs management • Behaviours and use of language • Feeling valued and respected • Competition • Lack of involvement and support • Engaging/Disengaging • Patient care/Patient safety	**Conflict Power and Politics Doctor and Manager Conflict Doctor and Doctor Conflict Doctors as Managers Conflict Competitiveness**	**INTERNAL AND EXTERNAL CONFLICT**	5,6
• Network culture • Trust culture • NHS culture • Engaging in a network • Gender issues • Patient care/Patient safety	**Cultural Issues Clinically Led NHS Network vs Employer**	**CREATING A CULTURE FOR ENGAGEMENT**	1,3,5,6
• Being involved and valued • Teamworking and sharing expertise • Influencing management • Commitment • Opportunity • Being safe	**Clinical Expertise Working Together Patient care/Patient safety**	**IMPROVING PATIENT CARE**	1,2,3,4,5,6

Whilst the coding process creates a list of themes, these are random and it is in the connection and connecting of these themes that the key concepts start to emerge and that the interpretive analysis starts to take shape. In taking an interpretive perspective, the author read and re-read the data to formulate thoughts about meaning for analysis and to identify patterns of meaningful connection, in other words she undertook a process of interpretive reading (Ricoeur, 1981) which has led to the re-drafting of the conceptual framework, illustrated at Figure 17. These concepts form the basis of this analysis. The final step, interpretation of the whole, involved reflecting on the initial reading along with the interpretive reading to develop a comprehensive understanding of the findings. As the author read and re-read the interview transcripts she discovered a number of narratives emerging from the texts, through which research participants portray themselves and their experience of engagement to themselves and to others in the NHS, and devised a narrative framework (Appendix 8) to facilitate the collection of these. The author utilised Labov's model (Routledge, 2005) of natural narrative as a guide to develop the narrative framework, but crafted a framework to capture information considered relevant to inform this study. This framework enabled the author to view the research material with new insight in order to move from theming to interpreting. It is suggested that a great deal of "*openness and trust*" between the participant and the researcher is required in order to gain full participation in the telling of a narrative, (Marshall and Rossman, 2006) and that this is acquired through the development of a caring relationship over time. The author is fortunate to be in the position of having a relationship with all participants ranging from a professional to a personal [*friendship*] relationship. Elliott (2006), in recognising the importance of the narrative among qualitative researchers as a means of presenting the social world, suggests that the use of the narrative has spread through a wide range of areas and certainly in the NHS, it is not uncommon for patients to tell stories of their experiences of health events from their perspective. The author however has found little evidence of the use of narratives to tell doctors' stories of the engagement experience adding to the uniqueness of this study. In the concept of this research a narrative is a story that doctors tell during the course of the interview that "*connect events in a meaningful way….and thus offer insights about the world and/or [their] experiences of it*" (Hinchman and Hinchman, 1997, p.xvi).

A total of 42 narratives were extracted from the 12 interview transcripts and these were coded according to the key concepts as illustrated in Appendices 9 and 10.

A sample completed Narrative Framework is included at Appendix 11 to illustrate the method of data extraction. In order to confirm the coding of the narratives, the author extracted the selected text from the original interviews and uploaded this to NVivo to enable cross-referencing of the conceptual analysis as illustrated in Figure 5.

FIGURE 5 - CROSS REFERENCING EMERGENT THEMES
*(**Alex** is a pseudonym)*
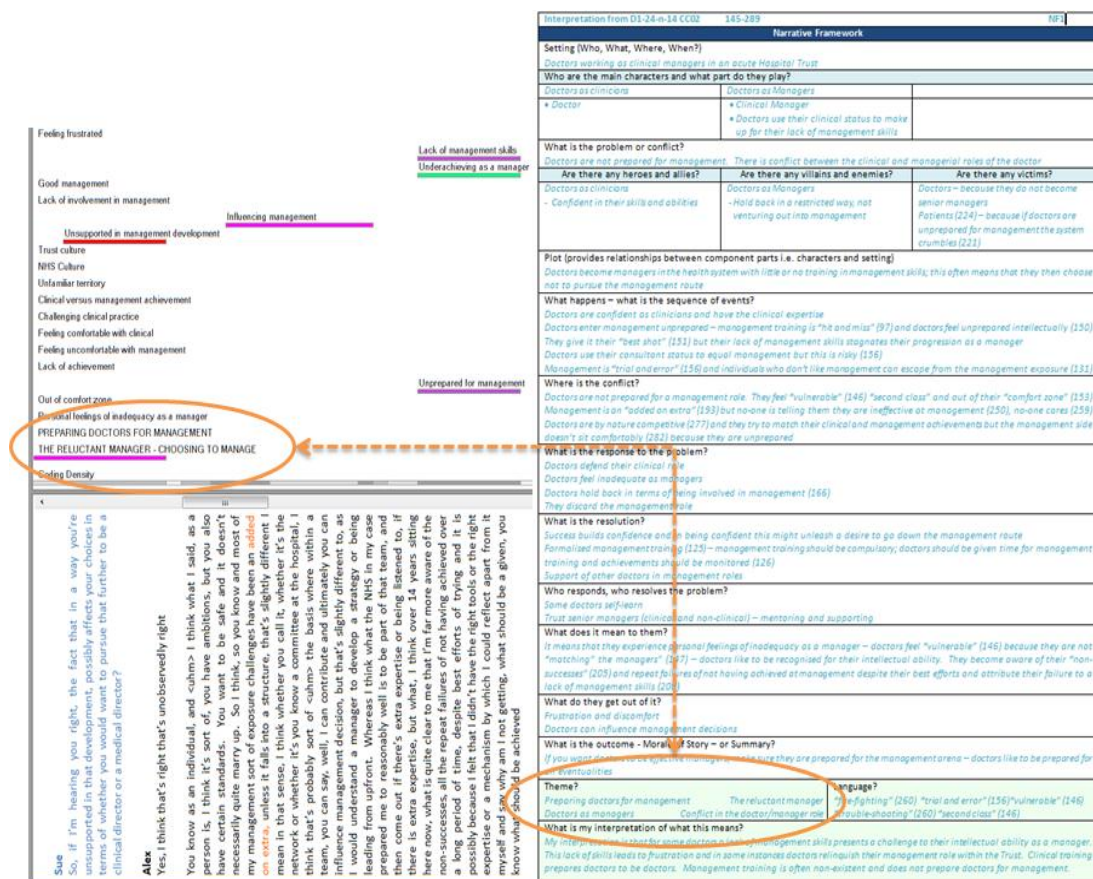
To explain and understand how doctors choose to engage, the function of the narrative is to convert the static codes into dynamic narrative. This narrative framework therefore became the explanatory and exploratory structure and mechanism for this research. As a final step in this process, and to better facilitate the analytical process, the 42 narratives were grouped according to the key concepts as illustrated in Figure 6 and these provided the final structure for analysis.

FIGURE 6 - CONCEPTUALISING THE NARRATIVES

Throughout the whole process of this research, participants identified improving patient care as a key indicator of success and this theme therefore runs throughout all the research.

The data collection methods allowed for the sorting of data in accordance with the key research questions. Data was therefore organised as follows:

- How doctors give meaning and make sense of engaging in the Network
  Research Questions - Why do doctors choose to engage in a clinical network? - What can we learn from doctor engagement in a clinical network? - What is it about the Network that has engaged doctors?
  Key concept: **Choosing to Engage; The Engaged Doctor**

- Effective strategies for engaging doctors in the management and leadership of the NHS
  Research Question - What are the triggers and cues that we need in an organisation to get doctors involved and engaged?
  Key concept: **The Reluctant Manager**

- How doctors give meaning and make sense of organisational culture and engagement
  Research Questions - Do doctors engage more readily with a clinical network than with their employing organisation and if so, why? - Do doctors behave differently in a networked organisation?
  Key concept: **Internal and External Conflict**; **Creating a Culture for Engagement**

As identified in Table 9, the key concepts for this research are:

- **Choosing to Engage** – The Engaged Doctor; being involved and influencing, being valued and respected, sense of pride and enthusiasm, having a personal interest and commitment and sense of togetherness (includes the importance of relationships and of support and sharing)

- **The Reluctant Manager** – doctors unprepared for management, preparing doctors for management (includes management training and skills), feeling frustrated, being isolated and judged, hidden agendas and conflict

- **Internal and External Conflict** – lack of power and control, competitiveness, doctor and manager conflict, doctor and doctor conflict and doctors as managers conflict

- **Creating a Culture for Engagement** – cultural issues, gender issues, network versus employer

- [*Success factor*] **Improving Patient Care** – clinical expertise, working together, being involved and valued, sharing experiences, influencing management, commitment, opportunity, being safe

Gathering data from a number of sources has added to the reliability of the findings through a process of triangulation whereby the observed findings are examined and validated. Additionally, the study has a strong ecological validity as the author has easy access to senior doctors in the NHS and particularly within the clinical network identified for this study.

Figure 7 illustrates the process applied to the data collection and analysis (adapted from Jones, 2013, p.19).

FIGURE 7 - PROCESS OF DATA COLLECTION AND ANALYSIS
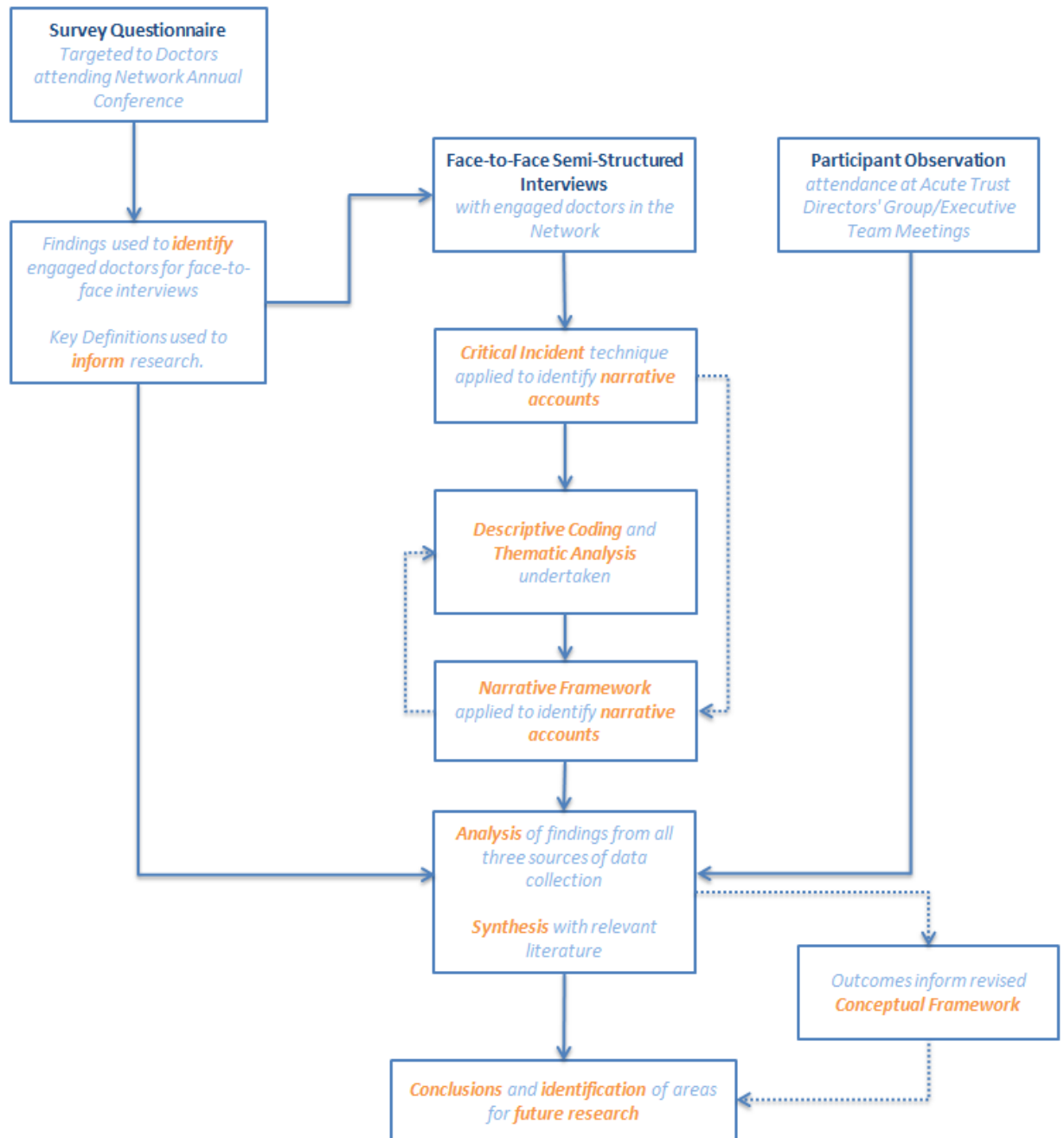
Whilst coding methods were adopted during the initial stages of the analysis, ultimately it is the interpretation and explanation of the data that generates the outcomes of the study. The author has used thematic and narrative analysis to facilitate this interpretation. Thematic analysis was used in the early stages of examination to sort the data and identify patterns and themes within the data and then latterly to inform the analysis of findings.

Qualitative research includes an element of discovery, and Chapter 5 outlines the findings from this research.

SUMMARY OF CHAPTER 4

This Chapter outlined the research methods adopted for this research study. It established that the research questions are framed within the relevant context of this study and that they are appropriate for the methodology employed.

This Chapter provided an overview of the data collection and analysis process which confirmed that purposive methods of participant selection have ensured recruitment of appropriate research participants to enable the author to explore doctors' perceptions of the engagement experience. Additionally this Chapter explored the process of participant selection and established that face-to-face interviewing has garnered detailed knowledge on the subject area, particularly through the identification of narrative accounts.

Qualitative data has been gathered for the final stage of this study and the following Chapter explores the research findings and provides an analysis of the data.

CHAPTER 5

RESEARCH FINDINGS AND ANALYSIS OF RESULTS

"For this is the first key to wisdom, assiduous and frequent interrogation. …By doubting we come to inquiry; by inquiry we perceive the truth" (Maurice, 1870, p.138).

Through the use of thematic and narrative analysis, this Chapter describes the research findings from the perspective of the research participants as interpreted by the author. The findings represent the medical viewpoint of senior consultants working in a clinical network within the field of intensive care medicine and are not representative of the medical profession as a whole. The stories therefore are as told by the doctors and the interpretations are entirely the authors. The use of narratives allows a focus on the participants' subjective interpretations and the meanings that they make of the research topic.

5.1 Introduction

This research study is designed to give meaning and make sense of the engagement experience from the perspective of doctors. Whilst it is suggested that much of the literature on doctor engagement is based on opinion and experiences (Kaissi, 2012), this tends to concentrate on strategies for improving medical engagement. This research study, in seeking to identify why doctors choose to engage, concentrates more on the doctor experience of engagement. Research subjects are therefore practising doctors all of whom have identified themselves as being engaged in the work of the Network.

As already indicated, data was gathered initially by use of a survey questionnaire and then latterly through face-to-face interviews. Observational enquiry informs cultural aspects of the analysis. Whilst informing the research process, a key purpose of the survey questionnaire was to identify participants for the face-to-face interviews. There are five acute hospital trusts in the Network region and survey questionnaires were distributed to doctors across these Trusts. In total, 22 completed questionnaires were returned and 72% (n=16) of respondents voluntarily included their contact details. Figure 8 illustrates the distribution of responses by Trust. In order to retain anonymity throughout the research process, the author has allocated a code to each acute hospital Trust.

FIGURE 8 - SURVEY QUESTIONNAIRE RESULTS BY ACUTE HOSPITAL TRUST
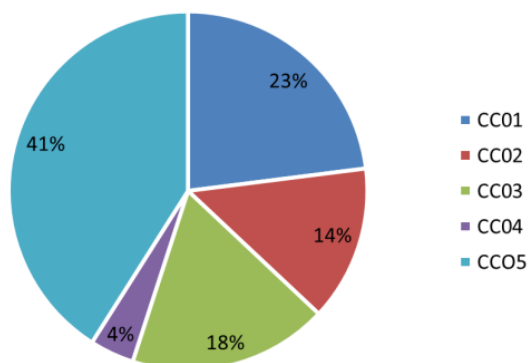
All respondents indicated that they are at Consultant level; 18% are female and 82% are male. Figures 9 and 10 illustrate the distribution of years' experience in the specialty of critical care medicine and years' experience in the Network for doctors completing the survey questionnaire.

FIGURE 9 - EXPERIENCE IN SPECIALTY   **FIGURE 10 – EXPERIENCE IN NETWORK**
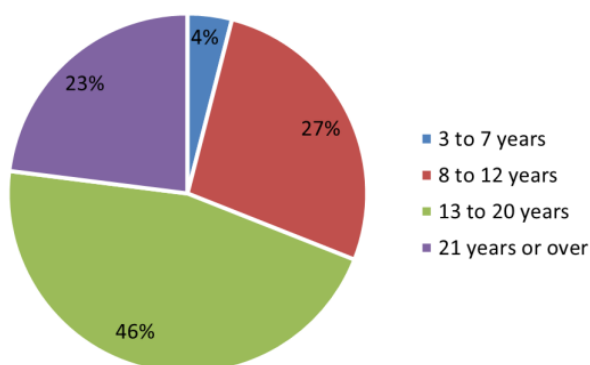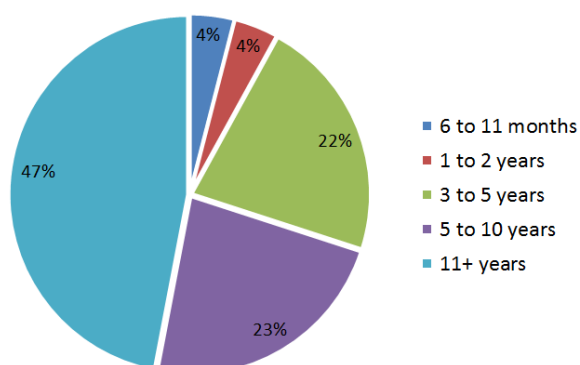
Question 2 specifically asked participants "*On a scale of 1-5, how engaged are you in the work of the Network?*" and Figure 11 illustrates the responses to this question, which indicates that 83% of respondents considered that they are moderately or considerably/fully engaged in the work of the Network.

FIGURE 11 - RESPONSES TO QUESTION 2

Legend:
- 1 - Not at all engaged
- 2 - Want to be engaged but don't know how
- 3 - Mildly engaged
- 4 - Moderately engaged
- 5 - Considerably/fully engaged
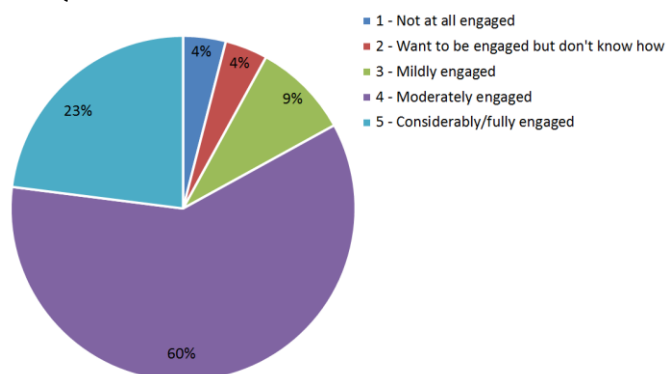
This question is intrinsic to the research process as, in order to examine doctors' perceptions of engagement, the author needed to ensure that interview participants were selected based on their level of engagement. The answers provided, along with the identifiable information, enabled the author to purposively select participants to take part in the face-to-face interviews. From this group, 12 doctors were selected for the next stage of the research.

Twelve face-to-face interviews were undertaken; 10 participants were male, 2 female. In total, participants advised that they had worked for a total of 210 years in the critical care environment within the range of 10-27 years, representing a mean of 17.5 years and a median of 16.5 years. At the time that the interviews were undertaken, the Network had been in existence for 14 years. Participants suggested that they had been involved in the work of the Network for a total of 119 years with 5 participants advising that they had been in the Network for the full 14 years, 1 participant for 11 years and the remaining 6 within the range of 5-9 years.

The research findings and analysis are presented within the key themes identified in Table 9 and are illustrated by a series of narratives, as told by the participants but interpreted by the author, in an attempt to represent the doctor viewpoint in a logical and meaningful way. The survey questionnaire contained a number of open-ended questions, and direct quotes are included from these to describe doctor perceptions of engagement. These are illustrated in grey text (shown as indented paragraphs) and are not related to any research participants, as at this stage of the study, the survey questionnaires were anonymous. Verbatim quotes extracted from the face-to-face research interviews are identified in blue (shown as indented paragraphs) and verbatim quotes extracted from the narrative accounts that arose from the face-to-face interviews are identified in blue within a boxed frame. In taking an interpretive approach to this study, the author

considered assigning a pseudonym to each research participant. During the analysis phase however, the author grouped the narrative accounts according to the key concepts and the narrative is interpreted through this collection of stories. The author assigned a code to each research participant and to their employing Trust and the codes are included within the boxed frame.

This research is concerned with seeking doctors' views of their reality and is therefore subjective in nature. To ascertain a certain truth would require the examination of the same narratives as told from a number of different perspectives, which is beyond the remit of this study. In some instances, a single narrative is used for analysis, however, where thematic analysis of the narratives led the author to identify interlinking themes across a number of narratives, these have been grouped, as indicated, to inform the discussion. Actual quotes from the research material are included and are typed verbatim with attendant punctuation and expression. The narrative accounts, are included within the body of the Chapter to facilitate ease of reading. The author has taken what she considers is a practical approach to the analysis of the data such that at this stage, the findings solely present the author's interpretation of the narrative. Whilst the author recognises the benefits associated with comparing the findings to the literature at the analysis stage, this has been done at Chapter 6, the conclusion stage, so as not to influence the author's interpretations of the narratives during analysis. The following sections outline findings from the thematic and narrative analysis of the data. Participants are identified by use of a reference code to retain their anonymity in the study. Each section includes analysis of salient points and narratives and concludes with the author's interpretation of the narrative.

5.2   Choosing to Engage

This study is concerned with the concept of engaging and the survey questionnaire asked a number of direct questions relating to doctor engagement in the Network. Respondents were asked to describe what the term engagement means to them, specifically in respect of the Network, and describe active involvement, sharing and commitment, a sense of belonging and of being valued as key descriptors;

> *"Engagement means active involvement and conscious contribution to moving a situation/specialty forward, it involves*

> *communication and information sharing with shared governance and responsibility."*

> *"Being involved with and consulted by a body with responsibility for a particular area. Being aware that your views are considered."*

> *"…engagement means involvement with and commitment to a group, process or organisation. It provides a sense of belonging and of being valued, and the opportunity of working with colleagues who will often have shared values and beliefs, and of having the opportunity to collectively have a greater influence and positive benefit than would be possible as an individual."*

At the interview stage, participants were specifically asked about the term engagement and were given the opportunity to describe what it means to them personally to be engaged. Participants identified being involved and being able to influence, being listened to, being respected and supported, and having a personal interest and commitment as key factors.

5.2.1 Doctors describing being engaged

During face-to-face interview, research participants suggest that engagement has both a personal and organisational connotation. The personal aspects relate to the benefits that they as individuals consider they gain from being engaged and the organisational aspects relate to the benefits that they perceive that they, and others, gain from [*them*] being engaged.

Participants indicate that in being engaged, they need to feel that they are listened to, that they have a voice and that they are valued;

> *"Engagement means that I'm wanted there, that I'm valued, that I'm taken seriously in the sense that you know that I can contribute something…"*

> *"I think it is about being listened to, it is about being heard, it's about having a voice."*

> *"…you need to think that actually what you're thinking will be listened to and respected…"*

> *"I think to be engaged makes you feel valuable"*

Participants suggest that engagement should be enjoyable and one participant likened engagement to being on a journey of discovery. A number of benefits to being engaged in the Network were identified, not

least of which is a perceived sense of togetherness and participants indicate that through the Network, they gain support from colleagues. Additionally, participants suggest that the Network seeks their viewpoint, listens to what they have to say and that they have the confidence that the Network will enact business for the benefit of patients. Participants indicate that the Network is a collaborative organisation that provides them with new opportunities. All participants are engaged in the work of the Network and are employed by Network member organisations, which sit within the wider NHS. As already determined, clinical engagement is a key priority for the current health care administration as outlined in the Health and Social Care Act 2012, and the benefits associated with engaging doctors in the management and leadership of the NHS is well recognised (Bohmer, 2012; Atkinson *et al*., 2011; Hamilton *et al*., 2008; Dickinson and Ham, 2008; UK Coalition Government, 2012). Participants were asked for their views in respect of clinical engagement in the NHS in order to ascertain to what extent senior doctors consider that the NHS that they work in is clinically led, and the following section explores their perspectives of this.

5.2.2   Doctors perceptions of a clinically-led NHS – *external to the Trust*

The following narratives relate to the Government ambition for a clinically led NHS that delivers the best possible care for patients (UK Coalition Government, 2012; Lansley, 2012a; 2012b; 2012c; 2012d). The accounts highlight the views of participants working as senior clinicians in the current NHS and relate to their views of clinical engagement within the wider NHS.

D1-CC02 NF3	*"It's about, <uhm> absolutely scathing, it's utter and complete lip service to my mind… a tick box exercise… …my perspective is that there are some very capable national directors … to describe where we want to be and then I think once that report has been achieved, then I think most national directors have fallen over and I think are firmly in the camp under the DoH. I don't think that they, yeah, <uhm> because I think the pressures, yeah, I think politics is more powerful and dangerous…*
	I think it's a lot talked about, but I don't think it's a reality, and I think it's becoming increasingly difficult because of where the NHS is heading. …I think doctor engagement, if it goes down the

	privatized route… You know and it's not a matter of money, so it's a matter of clinical engagement… I think in the NHS, it's much easier to be brushed aside… a lot of management decisions are based on ultimate patient needs and patient safety and it will be hard to imagine that without the engagement that those aspects can be fully addressed… "
D9-CC05 NF33	*"so there are areas, of clinical engagement and think groups and all those sort of things. The reason it is not clinically led. I think it's still very Whitehall based, very Whitehall driven… the concept of what the very management, business-type people have is really not in touch with actually, what happens out in the world…so Andrew Lansley's changes. Are they any closer to the <uhm> patient? No. The complexity is probably worse than it's ever been. At least with strategic health, we knew who to go to and moan to, now, now it's probably worse."*
D6-CC03 NF24	*"I don't necessarily think it is <uhm> I think it's financially led <uhm> and I think that <uhm> the idea is nice, isn't it, that you've got NHS England and you've got CCGs … I don't think it ought to be fully clinician led. I think clinicians have an awareness of what is required and the service that they provide on a day-to-day basis…I think clinician-led NHS, they like to think they are but it isn't really, that's the bottom line."*
D2-CC05 NF6	*"It's more clinically led than; well it's been through phases - it was very clinically led when I started off as a junior trainee and then with the sort of business/management with the general manager, it became much less clinically led and now it's sort of swinging back."*
D3-CC01 NF15	*"I think it's more clinically led now than it was. <uhm> I don't know, it's difficult because sitting in secondary care, it feels very much like the power is…, for want of a better word, is being taken away from secondary care and because I don't sit in primary care, it's difficult to know how much of that is actually just passing to clinicians in primary care and how much of it is passing to non-clinical managers in primary care <uhm>".*
D9-CC05 NF33	*"… there isn't any more money and at the moment we still have this disconnect between primary care and secondary care. We fight against each other and the commissioners encourage that… They've got to not be primary care fighting against secondary care, they've got to be together, that's the only way we'll save the money, the only way the health services will survive. The commissioners need to stop [expletive] around in the same way that health care*

> *and social care have and they have got to come together because actually, they impact so massively on each other… So that is the future I think of the health service, NHS, but they haven't quite got that. They're tinkering around the edges… So for the NHS to be really clinically led, we've got to get more people clinicians, up there, but of course then is that what I want to do, do I want to go and live in London?... But of course the opportunity – it's also about the opportunities."*

These narrative accounts clearly indicate that participants observe that the direction that the NHS is headed makes it more difficult for doctors to be clinically engaged. For the author these accounts suggest a level of fear expressed by doctors working in a system where they perceive they have little influence in respect of the future direction of the organisation that they work in. Fear therefore is expressed through a perceived loss of control. Many of the participants are likely to have entered the medical profession at a time when doctors had a recognised professional standing in society and, over the years, they have watched this be eroded away. It is possible that participants might feel that they have earned their position and status as senior health care professionals, particularly if they progressed their medical career at a time when gruelling on-call schedules and less flexible working arrangements impacted their personal and professional lives. The narratives suggest that participants consider that they are not as involved, or indeed as influential, in the decision-making process of the NHS as they would like to be, which is likely to impact their view of NHS management per se.

Over the years, the NHS has undergone enormous change, which demands a constant re-evaluation of the relationships between health care professionals and patients. It appears that this continual re-drawing of the landscape, where clinical practice is the core business and improved patient care is an overriding principle, introduces an element of frustration for participants. Additionally, the narratives suggest that participants perceive that they are not included in the decision-making processes, which in turn might influence their choice of engagement.

These accounts suggest a heightened level of bureaucracy that makes it more difficult for them, as doctors, to navigate their way through, or indeed to understand, the 'new' system. It appears that doctors have lost

sight within the complexity of the organisation of the NHS and that they no longer know where the decision-makers sit within the structure. The extracts indicate that doctors are suspicious of decisions that affect their patients, and of the decision makers who are making those decisions without involving them, and that this is a particular problem when they perceive that the decision makers are not in touch with what really happens in the clinical environment. Additionally, these narratives reveal a conflict between a perceived "them" and "us" (managers/doctors), heightened with the suggestion that the very people that are making the decisions in respect of patient care are "*not in touch*" with what really happens. Whilst this might imply an air of arrogance on the part of the doctor, to the author it highlights further the very real frustration expressed by clinicians where they consider that they have not been consulted with in respect of their clinical expertise or their professionalism. For doctors who are used to being in charge and who are used to making decisions that affect patients, the mere hint of them being excluded from this process might explain some of the implied dissonance with management and ultimate lack of engagement.

The extracts reveal some hope and optimism in the National Clinical Directors to deliver the clinical vision. Furthermore, they also indicate an element of infidelity on the part of these very clinical leaders, as they come under pressure and switch allegiance, positioning themselves firmly within the management camp where it is alleged *"politics is more powerful and dangerous",* (perceived by the author to mean, in respect of the effect that centrally driven policy has on doctors as the policies affect them and their patients). This clearly suggests a divide between the managers managing at the centre and doctors managing at the interface with patients.

The final three narratives present a more positive picture of clinical engagement and it is of interest to note that the three doctors telling the stories have the most years' experience in the NHS and work at a level of senior clinical management. This appears to suggest that not only have these doctors been in the NHS long enough to observe a rotational pattern of change, but that they have a greater level of exposure to higher clinical management and so perhaps better appreciate the complexities and challenges of the management profession and environment. The

narratives make clear reference to the Government's vision of a clinically led NHS with a power shift to the primary care sector, although there is an indication that participants are uncertain where the current power base of the NHS rests and whether this is in management or in primary care. All participants sit in the secondary care sector and it is interesting to note that they perceive a loss of power within this sector and a disconnect between primary and secondary care, a divide that, it is suggested, is encouraged by commissioners, indicating a villainous characteristic representative of the commissioners.

There is a curious use of language as participants describe clinical engagement as a *"tick-box exercise"* proposing that the NHS pays *"lip-service"* to clinical engagement and that in an attempt to engage clinicians, the NHS is *"tinkering around the edges"*. It appears therefore that whilst there is much talk of clinical engagement in the NHS, doctors consider that they are not fully engaged in the decision-making processes and advise the inclusion of more credible clinical leaders and joined up working as a solution for the survival of the NHS. To the author this indicates a shift in the balance of power back to front-line clinicians.

When asked about their perception of clinical engagement, several participants associated this with clinical engagement within the management structures of their Acute Hospital Trusts and the following section examines this in more detail.

5.2.3   Doctors perceptions of a clinically-led NHS – *internal to the Trust*

The following narratives provide a collective summary of doctors' perceptions of their involvement as senior clinicians working within the management structure of their employing Trusts. All participants were asked the same question in respect of whether or not they think that the NHS is clinically led, and the following accounts relate to clinical engagement in an acute Trust rather than in the wider NHS. It is interesting to note that of the 3 extracts, 2 are from doctors working within the same Trust, which either suggests that the Trust management has a particular issue with engaging doctors, or that the doctors perceive that they are not involved in the decision making processes and that they are therefore not engaged with.

D4-CC03 NF21	*"I mean, I think, in theory, it's a great idea, and I think you know the people that work in the NHS are probably in the best position to be able to say, how it should be run and I'm not sure that that's the experience of people who've worked in the NHS for a long time… and I've certainly seen a lot of managers come through that don't come from a medical background and they stay for a year or two and then they move on and yet they're making decisions about how the hospital should be run. But sometimes you know they're not very good at asking us about what we think. I think they're trying to improve it but I think it's a slow process, but at the same time, doctors can't do everything, you can't run the hospital and do the clinical work… it can be very frustrating when they're making decisions that you don't agree with <uhm> or we certainly in this Trust had a lot of change, a lot of managers come and go, and you see one group come in, they make some decisions and then they leave and a new lot come in, but they make the similar sorts of decisions, things that we think are mistakes and time after time you see that <uhm>. …* *<uhm> there's a lot of doctors engaged in management-type activity but I'm not sure that that necessarily filters down to the people actually working in, you know, in their day-to-day clinical roles... I think that is because the doctors that move into management roles, I think that some of them lose sight of what their colleagues are doing clinically and they get so focused on their management job…"*
D5-CC03 NF22	*"<uhm> clinicians have been left out of a lot of the management <uhm> you know kind of tiers shall we say, and certainly out of a lot of more far-reaching decision making that has happened in the past <uhm> …but, you know, kind of the process problems is because the people that are making the decisions and are making up these processes, are not the people that are actually on the shop floor delivering them … <uhm> and their hope is that – is to get clinicians much more involved and taking a much more active role and, importantly, I think, to paraphrase the medical director, said "I'm going to give you the teeth to be able to make the changes that you think are appropriate" because in the past, of course, although we had a bit of a voice, it was fairly disjointed and it was also lacking in any real kind of weight or power to be able to force change… clinicians aren't involved as much as they should be in important high-level management decision-making… at the end of the day, as with all of my colleagues, I suspect I want what's best for the patients, and where I see at best inefficiencies and at worst almost dangerous practice because of decisions that have been made by non-clinicians, <uhm> you know frustration is probably too weak a*

	word to use, but at times it can be damn right infuriating that people who have no concept of what we do, or people who have no idea about, you know, clinical factors, are making such far-reaching decisions, so it is very, very frustrating. …without people buying into this concept of clinician led management, and without people making suggestions and plans for strategy and all the rest of it, then it's not going to work, and it has to be the clinicians that do that."
D7-CC02	*"No, it's not clinically-led but it's financially driven, it's target driven, it's about payment by results – <uhm> tariff, it's about bums on the seats, it's becoming less, my experience of this, and it might be quite warped working here, is that it actually doesn't matter who does the work or even what the quality of the work is, it's about productivity, it's about how many cases you can get done, how many patients you can get seen, how much money you can claim for, that's all that matters…"*

There is an indication that doctors feel excluded from the management process in their Trust. There appears to be an issue in Trust CC03 in terms of permanency and credibility of the senior management team where non-clinical managers make decisions that affect patient care without any clinical involvement, and then move on. It is implied that, whilst the managers might change, new management make the same management decisions over and again, which the doctors consider are a mistake, so to the doctors, the same mistakes are being made over and over again. This behaviour appears to cause frustration for the doctors, particularly when they do not agree with, or have any influence over, the decisions. The narratives suggest that a lack of doctor engagement is to blame for a lot of the problems within Trust CC03 as the decision-makers are far removed from the clinical environment which, participants perceive, introduces a real element of danger into the process. It is suggested that doctor engagement is not used to best effect and participants identify respect as a lever for change. They expose a connect between respect and doctors having a voice and highlight the importance of doctors forming relationships to gain respect amongst their colleagues which gives an insight in to some of the observed behaviours. Worryingly the narratives reveal that, where doctors perceive that they are not recognised in the Trust and do not have a voice, they have been active bystanders of the bad decisions made by management. The narratives indicate an issue with internal communication advising of a disconnect between the management and clinical aspects of the Trust.

This appears to lead to confusion and frustration as doctors try to navigate their way through systems and processes with which they have had no input or influence, but which affect them and their patients. Participants recommend that greater integration of managers and clinicians on a day-to-day basis would improve this. There is a suggestion of a disconnect between clinical managers and the doctors in the Trust such that management decisions made by the clinical managers do not filter down effectively, and participants suggest that clinical managers lose sight of clinical priorities as they conform to management, a point that was made earlier in the external narrative accounts. There is a hint of elitism as participants suggest that doctors are best placed to make high-level management decisions and that the system will not work without the involvement of the clinicians. The appointment of a new medical director in Trust CC03 seems to give promise of a transformed, more inclusive culture where clinicians will make the changes that they think are appropriate. There is strong use of language as one participant suggests that the clinicians had previously lacked the "*power*" to "*force*" change giving rise to the power debate.

The extract relating to CC02 illustrates a picture of a financially, target driven culture where quality of work gives way to efficiency gains and where clinicians are engaged to improve productivity. There is a hint of frustration in this narrative as the perception of the participant is that quality is compromised in favour of quantity, which to him, explains the lack of clinical engagement. This is reminiscent of the doctor/manager conflict mentioned earlier where there is a perception that managers are only interested in resource management and doctors are interested in patient care.

An interesting narrative that emerged when doctors talked about clinical engagement suggests that doctors are engaged with at a superficial level.

5.2.4 Clinical engagement is done at a superficial level

The author considers that doctors are highly intelligent, and sometimes opportunist individuals and suggests therefore that any pretence at clinical engagement by management, has the potential to cause doctors to

disengage with the management process as indicated in the following narrative.

D3-CC01 NF11	*"I still get the impression sometimes it's being done at a relatively superficial level <uhm> that people are engaging with clinical staff, in the decision-making process because they have been told they think they should, … I think now, the organisation I work for actually is genuinely engaged, trying to engage with medical staff to drive forward things like its clinical strategy <uhm> but dealings with some of our partner organisations, I get the impression that they want somebody who sat in the room so they can say "yes, you sat in the room when we made the decision",.. quite clearly, sometimes you go to an engagement meeting, whatever that is, to discuss X and Y, and it's quite clear pretty much from the moment you walk in that actually the outcome has already been decided…*
	Now, sometimes actually it's the right decision or actually it's the only practical decision, well in that case, "why did you bother doing the clinical engagement bit?" …I think that some of that isn't it, it's about identifying where that engagement is useful and maybe one of the things that's happened is because there's been this drive to have clinical engagement, we have tried to clinically engage about everything and you don't necessarily need always to do that… Perhaps some of the feeling of "it's a tick box exercise" is because you're actually being asked to engage in stuff where actually engagement isn't really that relevant.
	– I think there is a risk that people become disillusioned because they invest time in attending meetings, whatever, and actually don't feel that either, that it was relevant or actually, that they were ever going to influence the decision that was being made and I think the danger then is that they won't engage in stuff where actually they would make a real difference to the decision, <uhm> you know people sort of get engagement overload…
	I think we should stop trying to force every single consultant to be engaged because I don't think we'll ever succeed and I think what you do is [expletive] people off. If people have decided they don't want to be engaged…If they want to be engaged, we should give them the opportunity, but not everybody wants to spend 2 hours in an evening sitting in a meeting, talking about whether we should move this service from this hospital to this hospital or whatever the issue is because actually, that's just not what their interest is. If we've got people who really want to do that, we should support them. If we've got people who don't, well, why do we feel we've got to force them to be?"

This account describes a situation where the participant perceives doctors are engaged with, just to satisfy management and reveals that doctors suffer from an element of engagement overload. The participant makes a fair point when he suggests that not all of the doctors need to be engaged with about everything all of the time, and the author suggests that an astute manager will be one who realises this, and engages the right doctors in the right discussions, so that the best decisions can be reached. This narrative illustrates a risk where doctors are 'engaged with' so often that it becomes a "*tick-box*" exercise leading to disillusionment, disappointment, and consequently future disengagement from discussions where doctors will genuinely have a valid and valued opinion to contribute. Additionally, there is a suggestion that the medical voice is not heard in discussions where the outcome has already been decided, leading to further cynicism in the medical fraternity and disengagement in the management processes. There is a perception that clinician time is a precious commodity to be used wisely, and that wasteful use of this valuable resource could therefore be costly for both the doctor and the Trust. Doctors are considered to have the clinical insight to inform management decisions and improve patient care. This participant also makes a point later in his interview where he suggest that, in his Trust, doctors are given ample opportunity to be engaged and questions where the blame lies when doctors, in choosing not to engage, suddenly find that a decision has been made that they do not agree with.

| D3-CC01 | *"I mean, I would add to that a proviso that would sort of say, you were given the opportunity, if you chose not to take it that sort of takes away the right to moan about the decision and that's one of the problems, isn't it, is we allow people to choose not to be engaged at the beginning and then worry about their engagement further down the line when they go, "well I don't like that decision" - well if you don't like the decision, why weren't you in the room when we made it because you know, actually you might not have been persuaded by the arguments, but you might have been, so actually, you might have realized it is the right decision, but even if you hadn't, you wouldn't be able to say, "oh, and you've made the decision completely without me", well, we only made it without you because you chose not to be there. And I think organisations do sometimes get unfairly criticised over their, apparent lack of medical engagement when actually - where does the blame for that lie?, does the blame for that lie with the organisation, or does it lie with* |

> *the individuals who choose not to be engaged? …because you can provide people with all the opportunity. In my Trust, there is no lack of opportunity to being engaged."*

This extract presents a new area of frustration expressed by this participant, which is frustration with his medical colleagues. Previously any frustration on the part of the doctor has been aimed at management. This narrative however indicates a level of frustration, from a clinical manager on the part of medical colleagues who choose not to engage in the management decisions, and then choose to complain about their perceived lack of having being engaged with. Similarly, a fascinating aspect arising out of the interviews relates to a clinical manager recounting a perceived immaturity of doctors who consider that they have not been engaged with if they have not got their own way, or the outcome that they expected from their engagement, as demonstrated in the following account.

D3-CC01 NF12	*"I think the other thing, I've certainly experienced among some colleagues is, I don't always think that there's much maturity in some members of clinical staff and I think for that, probably more medical staff <uhm> who I think still see engagement as "I've told you what I think, therefore you should do that and if you don't do exactly that, then I haven't really been engaged."*
	… I guess it's behaviours. I mean it's almost deeper than just the way you behave, though isn't it, it's almost a belief isn't it, and I think that's one of the dangers is that as a group, it's a huge generalization isn't it, but I think there is a feeling amongst medical staff, consultants, GPs, I think, to a degree as well that when people say we want this service, we want this to be clinical engagement, we want this to be clinically led, they think that means they're going to be able to go, "well we're going to do a, b and c then" but even though a, b and c may be completely stupid and if a, b and c doesn't happen, then they go, "well, we weren't really engaged and so there's no point in us going next time" and I don't quite know how you overcome that…"

This suggests an element of clinical versus managerial differences resulting in doctors choosing not to engage in the management process. It also indicates a requirement for a behaviour and ultimately a culture change, as doctors become a part of the decision making process rather than the absolute decision maker, a role that they undertake on a daily

basis in the clinical setting. It highlights a childlike behaviour amongst doctors where, because they have not got their own way, they no longer want to be involved and, in fact, the participant suggests that there is a belief amongst his colleagues that clinical engagement means doing what they [doctors] want, even when this might not lead to the best outcome for patients; the very thing that they profess they care about. This narrative provides an insight into doctor behaviour for engagement, or lack of engagement. It suggests that whilst doctors are taught how to behave, and survive, in a clinical setting, that their medical training does not always prepare them for the management environment and that as clinical managers, doctors therefore have a whole set of different expectations and responsibilities placed on them that they are often ill prepared for.

Several participants indicate that the current climate of the NHS impacts the engagement of doctors and their choice of engagement, and that it is much harder to engage doctors in the management and leadership within the current climate of the NHS. There is no doubt that participants perceive that doctors need to be engaged in the NHS and recognise that doctors are more likely to engage where there is a patient benefit.

This study explores why doctors choose to engage in a clinical network and all participants confirmed that they are engaged in the work of the Network. Participants were asked to describe what makes them choose to engage and they revealed several different reasons for engagement. Analysis of the interviews revealed a number of key themes which the author suggests are positive motivators. Doctors identify that in choosing to engage in the Network they gain a sense of togetherness and collaborative advantage and the opportunity for sharing and building relationships. They also specify that in the Network they appreciate that they are listened to, that they have a voice, that they consider that they are valued and respected and are involved and able to influence management decisions for patient care. This research highlights that engaged doctors feel pride and are enthusiastic, that they gain insight into the management processes and through being involved and having the opportunity to influence, are able to do the very thing that they care about; to improve patient care and safety. Through the use of thematic analysis, the following section explores some of these key concepts.

5.2.5   The engaged doctor

A number of key concepts arose out of the data that relate to why doctors choose to engage. Participants revealed the importance of being heard and of being listened to, and indicated that this influences their choice of engagement or disengagement. Several participants revealed that at times they feel that the "listening to" is insincere, resulting in frustration and disengagement from the management process. This provides an indication of the importance that participants place on this concept for engagement.

> *"…it was a bit pointless when you don't actually feel like you're part, … I think also…. not just sort of listen to as in, yeah, we listen to, so we've got the classical example of meetings once a month, when a manager comes and listens to 50 anaesthetist consultants all spouting off basically. But it's totally unconstructive. So you know it's of no use to the person who listens to it and is no use to the 50 there because it's lip service in a sense ..."*

> *"…from our point of view that's been quite upsetting - the lack of err, the lack of listening I think has been quite upsetting ..."*

> *"…look for engagement, certainly embrace <uhm> ideas and implement them, more importantly, so listening in the first instance…"*

> *"when you've got no engagement, it doesn't matter what else someone is doing, you just feel like you're not listened to"*

Being listened to therefore is a positive aspect that affects doctors' choice of engagement, particularly when this enables them to influence the management process.

> *"..actually, we were like children, so we just needed a bit of attention and then we felt much happier once we were being listened to."*

> *"…just to be listened to was what was required."*

> *"I felt that was a really powerful engagement. … it certainly allowed us to voice and then to feel we had some influence over the things we could control."*

> *"I still feel as though we're being listened to, and so we have the voice and that's the thing…"*

> *"I think it is about being listened to, it is about being heard, it's about having a voice."*

When describing why they choose to engage in the Network, participants acknowledged the importance of being valued and respected by their clinical colleagues. The Network provides a collaborative environment where clinicians from the same specialty come together to share best practice and, in working together, clinicians demonstrate a mutual respect for each other. They also attribute some importance to recognition for the work that they and colleagues do in the Network and ascertain that the Network environment provides a focus for their expertise, which appears to satisfy their sense of importance.

"It's nice to be appreciated, isn't it? And we don't do that very well, very often you can put an awful lot of hard work in and not get a lot back and I think in the Network people do recognize what other people do. I think we're quite good about recognizing other's achievements and input and hard work, aren't we? so I think you know that does make it a nice place to work."

"…when you're properly engaged, <uhm> yeah, it's quite rewarding because I think, you know you do get a sense that you are contributing, you do get a sense that your knowledge and expertise, whatever it is, is being heard and is being respected, and is being put to good use. It feels useful, it doesn't feel like you're wasting your time."

"…we know each other very well, we have a relationship, don't we? So it's a mutual respect, it's a mutual understanding that we're all trying to work together, supportive …"

Throughout the interviews, it became evident to the author that this need for respect stretches beyond the Network and plays a part in participants' choice of engagement in the management of the NHS. Participants suggest that they feel a positive regard when they consider that they are respected for the job that they do, particularly when this is undertaken in difficult circumstances. Within the Trust, participants recognise the need for doctors to respect each other's skills and knowledge and to demonstrate mutual respect for each other. Whilst there is a suggestion that this does not always happen, participants also revealed a benefit in everyone working together and respecting the different professions and the contribution to improving patient care. The author determines that there appears to be a firm link between being respected and doctors choosing to engage in the management and leadership of the NHS, particularly where participants suggested that clinicians needed to be credible managers in order to gain the respect of their colleagues.

Participants indicate that they recognise the value of the Network and of being involved in the Network and assign a personal and general significance to being valued, wherein they feel valued as individuals, but also see a value in being engaged. There is also an indication that where doctors do not see a value in management, that they are less likely to choose to engage.

"that's probably a failing of other organisations, isn't it? They don't make people feel valued enough <uhm> and again, maybe that's one of the things why a lot of doctors don't want to engage in management, because they don't see a lot of value in it."

"I think the clinicians engage with the Network and see the value in it. I think we've probably got one of the stronger..est networks in critical care in the UK, and certainly for me, I'm always quite grateful because I think for me personally and for [county] it serves us well."

"…because you feel like it belongs to you and that gives you….gives its value."

"<uhm> I think there is a feeling that you are contributing a bit more and I think it certainly goes back to being valued, doesn't it, if you feel you're contributing, if you feel what you're doing is being valued, you're probably more likely to carry on doing it."

When talking about what makes them choose to engage, several participants identified involvement as a key aspect of engagement, both in terms of choice and influence. Whilst being involved and influencing emerged as a key aspect of choice, this is linked to a positive outcome both for the doctor, in gaining insight and in being listened to and respected, and also for the patient in terms of influencing for change.

*"There are so many reasons why I think the Network is the right way forward <uhm> and for that reason I **want** to be actively involved in it."*

"it's about influence to me, if you engage with something, then you can influence it for good or bad"

"I think that being involved in it can help me to run a better service here because of, you know, the things that the Network has to offer us as a hospital."

"I think it's valuable work, I think it does a lot of good, I think it does a lot of good for patients. I think it does a lot of good for the staff in the critical care units in the Network…I think you know, if you don't believe in the work that whatever it is that you are involved in is doing, then you probably aren't going to stay engaged in it so, I think so that's probably a sort of key prerequisite almost, isn't it, it's got to be, whatever you're

> *engaged in has got to be going, or at least tying to do the right thing. You won't be doing the right thing all the time."*
>
> *"…it's about influence to me, if you engage with something, then you can influence it for good or bad…"*
>
> *"I just think, I feel like I've got influence and therefore that helps you feel like you've got an engagement and I felt that probably early on in the Network."*
>
> *"…once the doctors got **involved** and **engaged** and saw that it was applicable and appropriate, the change is much quicker and easier to drive…"*
>
> *"I guess, you'd almost turn it on its head and say why wouldn't you want to be engaged? you know for me, I struggle a bit with the idea of people who don't want to get involved in something, because I sort of think, well why wouldn't you want to be involved?"*

Several participants indicated that they recognised a link between them as individuals being involved and the impact that this has on the organisation (be this the Network or the Trust) and crucially seemed to consider engagement to be a collective act and a two-way process. In being engaged, participants identified a requirement for hearing others, as well as being heard themselves and explained this such that in choosing to engage, they actively seek to understand the views, perspectives and beliefs of other people who are involved. This suggests that not only does engagement in the Network offer the opportunity for individuals to have a voice, but it also offers the opportunity for the collective voice to be heard.

A key aspect that participants identified for engaging in the Network is that the Network clearly demonstrates achievement of the Network aims and objectives. Analysis of the findings suggests that participants perceive that the work of the Network is transacted with much more ease than the business within their Trusts, although there has to be a recognition here that the Network is a collaborative organisation where critical care clinicians discuss and debate issues and are more often than not able to come to a consensus opinion for progressing the work of the Network. The Acute Hospital Trusts seem to present a much more target driven culture with many more layers of administration, described by participants as "*layers of treacle*", "*layers of bureaucracy*", "*tiers of management*". Although cultural aspects of the Network and Trusts is discussed in more detail in section 6.5, at this stage participants identified a sense of pride and enthusiasm through their engagement in the Network.

"I think it's very satisfying in a sense or it's <uhm> – yeah, I think there is a sort of element of pride in that we managed to do this as a network…"

"…you have this enthusiasm and that dynamic approach that you can see it is almost staking out the aims, but that journey is an enjoyable journey…"

"…if the Network is enthusiastic and changes things, it makes you want to be part of it because it gives you a tool to change something. Because if you're in an area where you feel disempowered, then you don't want to engage in that area anymore, you want to go somewhere else, whereas the Network gives you that opportunity."

A key aspect that arose out of earlier qualitative research (Shepherd, 2012) was in respect of a sense of togetherness and a recognition of the strength of the relationships that doctors formed with colleagues in the Network. Likewise, when asked to explain why they choose to engage in the work of the Network, participants spoke of the value of the relationships and of a sense of togetherness and of belonging and that through this they gain both professional and personal support. Participants suggest that the benefits that they realise from forming strong relationships with like-minded colleagues in the Network is felt at both a personal and an organisational level.

"So <uhm> you want to engage for the relationships and I think that concept of those circles of a sense of belonging or community of intensive care, you want to engage, because you want to be part of that. You want something slightly bigger than your own Trust, for the relationships because you need – you are dependent on those relationships for transfers, but you also depend on it for colleague-ship, those meetings, you can feel, you're not just in your own little hospital suffering…"

"I always think of the individuals and I have good relationships with all the individuals in the Network because of the relationships you build."

"But what the Network is, is it's that support to do your local job, … and those relationships with transfers and feeling that comradeship and you're feeling like you're part of an intensive care community – I guess feeling like you're part of an intensive care community is to feel valued, but it also feels like you've got more of a sense of belonging."

"You know and I think that's a very good forum to have, so people can see each other, have a discussion, it's the social part of the Network that I think is very important. If you don't have that, I think you lose quite a lot as a whole."

"…something is different about the non-clinical and clinical relationships in the Network – they work."

> *"I think it does go back to the relationships between people, you know, I think it's something about the interactions that go on isn't it?"*

> *"It's kind of a forum at which to see other friends and colleagues from around the region, but more importantly than that, of course, is that the whole purpose of the Network really is to have all of us aligned."*

> *"…what I'm really trying to say is that we kind of sort of stand and fall together…"*

These extracts indicate that a key to the success of the Network is in respect of the firm relationships that are formed within the Network-type organisation. Whilst all participants appear to recognise the importance of relationships in the Network, when a doctor describes it as "*we stand and fall together*" this suggests a very powerful collaborative. One participant proposed that if the relationships are right, that all the other aspects around the organisational structure come from that, but then proffered that a firm structure might be the thing that helps people build better relationships. Participants perceived that, although the Network operates within a firm governance framework, that the Network is a much less governed, and more fluid organisation than the hospital Trusts and advocate that through this agility and fluidity, the Network achieves a lot more. This raised an interesting point for future debate, as one participant suggested that it could be argued that the governance structures of a Networked organisation are not strong enough. He further suggested however that by nature of the fluidity of the Network, the Networked organisation is successful, and that by introducing a tighter authoritative structure, there could be a loss of agility and ability to operate as a network. It was suggested that the risk to this would be the creation of an artificial clinical/managerial split.

> *"I think if you impose very strong governance and managerial role rules on the Network, you might lose some of the relationships … maybe the key is to, particularly with clinicians, is to manage them without them feeling that they're being managed. In a network you glean the expertise and put structures into place from that, so, you've got to have some way of coordinating…the Network needs some structure but it needs to be fluid…"*

The author has long recognised the benefits associated with the agility and fluidity of the network model and throughout the many reviews of clinical networks that she has been involved with, has always proffered a view that no one model fits all networks and that networks should be

responsive. Participants suggested that their choice of engagement is influenced by personal choice and interest and indicated that they want to see tangible results for the time that they invest. Time is a precious commodity for doctors and throughout this study the author has realised that an efficient use of their time is important to them. This suggests that doctors choose to engage when they see a benefit and choose to disengage when they perceive, either that they are not truly being engaged with, as suggested in earlier narrative accounts, or that they are not interested in influencing the topic of engagement. Several of the participants spoke of their engagement in the Network in terms of the wider perspective that they gain from their engagement. Additionally, a number of participants revealed a comfort in the safety that the Network affords them, both as an individual doctor practising in the field of critical care medicine, but also as a clinician operating within a critical care service in an Acute Hospital Trust wherein the Network provides a safety-net for the delivery of safer patient care

"…the Network gives me that sense of security…"

"…you have a lot of sense of security, belonging to the Network because it's bigger than yourself and bigger than your trust and I think that's a very powerful motivator for engagement,…"

"…it's that support to do your local job, so the protection it can bring you in clinical decision-making so that you feel safer and more supported."

"Yeah, it is self-gratification, but it's self-gratification because you don't get it in everyday life in the NHS which I think is why Sue, it's so pleasant to be involved in the Network, and actually it's sort of an arena where the end objective is always about improving patient outcome, patient care, patient safety, quality of care. Even you know it's just not about finance, it's not about targets and tariffs and other things. It's purely about providing a better service …there is self-fulfilment but it's also about just being in a room of people."

These findings corroborate earlier qualitative research (Shepherd, 2012) as participants suggest that the Network provides a collaborative environment where clinicians come together and share best practice and offer each other support. Support and sharing underpin the concept of a sense of togetherness and at Document 3 (Shepherd, 2012) participants recognised this as an element that contributes to the success of the Network. Likewise, at this stage of the study, participants revealed the importance of support and sharing relating to their choice of engagement. A key factor that arose relates to doctor time, in that participants suggest

that the sharing of information often prevents doctors repeating work already undertaken by others in the Network. Additionally participants reveal an advantage in the support that they gain and in knowing that other colleagues recognise the environment that they work in and appreciate the stresses and pressures that they face in the clinical environment. Whilst this suggests an element of elitism in respect of critical care as a specialty, it also offers an insight into the important role that the Network provides as a collaborative in bringing clinicians together in this specialised area of health care.

"I think if we can engage in the Network to share, because you don't have to reinvent the wheel, you know so, like [name] <uhm> cooling protocol - he's done a fantastic job and why shouldn't it be a Network met guideline, why should we now write our own ... I think it's a very good place to share ideas, meet people and you know share our experiences ..."

"I think I will have to say support. It's that backup of a group of other clinicians in other Trusts, and clinicians is the word in point I think that they are all ITU colleagues out there. They all know the pressure on the ground floor and what everybody else is facing, and they are not any different to me to be honest they may have different ways of managing it than we have, but it's having that facility to be able to pick up a phone or send an e-mail to somebody that understands your plight that from a critical care point of view, is very important I think."

"We are treated as equals, which is nice considering we are not equal in terms of the, I suppose the size and power of our hospital is limited, <uhm> but I know from the Network the way the Network runs, particularly for people like [name] who has always been very supportive of the smaller hospital in the Network, and sees the value of those smaller hospitals in the Network and that makes you feel part of a team if you like of hospitals, as opposed to being out on a limb, and I think only from rumour but the Mid Trent Network is exceptional in that respect as opposed to other networks locally."

"It's an open <uhm> forum really, isn't it, the Network for anything that you want to discuss or bring to the table and I like that."

"… it's that support network, it's that mine of information that I don't get at my desk in the hospital, that I can get more in the Network that I can perhaps get from the Trust. …It's like my predecessor said, it's that level of support that we get from the Network is invaluable given that we are who we are and where we are."

"A level of support and reassurance really."

This research has already demonstrated that doctors are considered to have a level of power and autonomy, although this study has revealed

that participants perceive that this is being eroded as doctors become less involved and engaged in the management and leadership of the NHS. Earlier narratives make mention of a shift in the balance of power from the secondary to the primary care setting. A concept that arose out of this research however, is in respect of the positive power of the Network and the effect that this has in terms of doctors choosing to engage in the Network. Participants describe a perceived power in terms of the relative power of the individual members of the Network, and of the collective power of the Network as a whole. In terms of the benefit that the perceived power of the Network brings to individuals, participants suggest that in the Network everyone has equal power, which fosters a collaborative working environment and the development and maintenance of solid relationships. Participants reveal that they will use the power of the Network to their advantage.

> *"The Network tends to foster much more of the view that in order for you win, somebody doesn't have to lose, whereas a lot of the mentality in other branches of medicine is, I can't win unless you lose…"*
>
> *"We have equal power in the Network – as relevant power, because they come - and if I say to everyone what about this and everyone say's "that's [expletive] useless" and we all go "okay that's useless – we'll forget it" but if say someone comes and says "how about this as an idea" and everyone goes "yes, that's a really good idea" then that's equal. Everyone is then empowered by the Network - so although I'm the [position] in the Network, I'm first amongst equals – but everyone else is equally as powerful…"*
>
> *"when the Network said, "don't change yet", that was very powerful. So even though I would like to change, and I feel the evidence is there, I haven't changed because… I want to stay in keeping with the Network because there's power in working together in being bigger than just your Trust…"*
>
> *"… they go back as part of the corporate Gestalt from the Network and say "this is not me saying this, this is the Network saying this" and it's that collective voice – it's the Gestalt – the Network brings the Gestalt that allows the whole thing to operate as a collective……"*
> *[Gestalt – German – essence or shape of an entity's complete form – "concept of wholeness" (Barber, 2015)]*

These accounts reveal an insight into the competitive world of medicine and suggest that participants perceive that they gain equality in the Network indicating that the Network fosters a more non-competitive environment which empowers engagement. Furthermore, the findings indicate that participants perceive that the Network has a collective power

and decision-making authority, which they propose benefits them as individuals within their Trust, particularly when decisions made in the Network are implemented at Trust level. These extracts suggest a networked organisation that has the power and respect to effect change at a local level, which is curious given that the Network as a non-statutory organisation has no formal decision-making powers. This indicates to the author that participants use this perceived power as a lever for change for their benefit.

> *"…the management authority when they go back to the Trust comes from the Network…"*

> *"I think the fact that the Critical Care Network is seen to be very fair, very much an honest broker means that people know that if the Network were to come and say, "actually we're really concerned about this in this Unit", that most people probably would listen even though the Network necessarily doesn't have the statutory power, but I think most people would know that actually if the Network starts to say that, people are going to sit up and listen …"*

> *"<uhm> I think that's where the Network, yeah, it feels like it's for us, whereas the hospital, it feels like we're employees of the hospital and you know, I think there is something in that management model as well between the doctor and the managers and the way we make decisions, I think that's powerful"*

> *"It gave us back control and it felt like you had some control over what you had no control over beforehand and then you also felt that sense of community, that you weren't alone."*

> *"the Network is, although it's very powerful and it's kind of I suppose an umbrella for more than one Trust and sort of more than one group of clinicians, <uhm> it is very heavily – in fact, I know there are one or two managers around, but even the managers <uhm> yourself, I suppose included are clinicians by background or certainly have clinical insight, that a lot of the managers that I've met do not have. So it doesn't feel the same, it feels more clinically led…"*

An interesting use of Network power was disclosed as one participant advised of his manipulative use of the power of the Network as an influencer and lever for change:

> *"And there is no doubt you know, that I know I do it, and I'm sure there are other people in the Network who do it, who perhaps slightly abuse the Network in that we use it as a lever to get stuff, …I'm sure, other lead clinicians and heads of service do it, you almost abuse the fact that the Network is there and use it as a lever and an influencer to get stuff done."*

To conclude this section, the findings from this study have identified many reasons why doctors choose to engage in the work of the Network. One participant used the analogy of a Swiss army knife to describe why he chooses to engage in the Network and the author has included this at this point to demonstrate the alleged versatility of the Network;

"I feel much more secure in my ability to, you know, manage clinical issues on the frontline <uhm> and having all of that you know kind of weight, if you like, of the Network behind me. having all of that kind of if you like, and all of those resources, it's almost like – the Network's almost like a Swiss army knife and that you can flick out the bit that you need and whichever blade you flick out or whichever <uhm> kind of application you flick out, <uhm> you know it's going to be useful and fit for purpose, because it's been designed by people just like you, does that make sense?"

This offers a powerful suggestion that the Network is useful because it is designed by the right people, who know and understand the business. During the interviews, several participants advised that doctors become managers for different reasons, and that the "*right doctors*" need to be engaged in management roles.

5.2.6 Engaging the right doctors in leadership and management roles

Participants appear to be quite clear and honest in their interpretation of the different types of doctors who choose to engage in management and leadership roles as defined in the following narrative accounts:

D8-CC02 NF29	*"I think there are different types of doctors you see; you've got the clinicians and the ones that are the doers and you've got another set, the ones that think they know how to do things and tell everyone else how to do it, and they may not really know, but then you've got hopefully some people that can do both. I think you've got to ensure that you engage with clinicians, but the right clinicians…How do you engage them into – <uhm> and not always change; sometimes doing the same thing but doing it properly is what you need to do. It's not always about change, is it? Sometimes you've already got a process and it's sticking to it or bringing it back in."*
D3-CC01	*"I must admit what I tend to see actually is, we've got a significant body of consultants who want to be doctors, but don't really want to do anything else at all, and you've got another group of doctors who*

	want to be doctors and are prepared to do other stuff and often they do lots of the other stuff, so you will get the same people who are being the managers delivering the education, etc... Then, we've got another bunch of people who turn up at work, do their job, go home again and really don't do very much else at all... but maybe the reason we got those group of people is they felt they've got to do everything they didn't want to, whereas actually if you said to them, "okay, we don't expect you to do everything, but what is it that interests you, maybe if you really like numbers and statistics, yeah, we do need doctors who're engaged in clinical audit…"
D3-CC01 NF10	*"I know my colleagues have gone into clinical management roles for a whole variety of reasons, some of which I would think of being good reasons some of which I would think of being less good reasons. <uhm> and I think that the motivation of clinicians to get involved in management <uhm> could come from a whole host of things you know at one extreme, I've worked with colleagues whose largely sole role for doing it has been self-interest. Either for the kudos, the influence they feel it brings often because <uhm> they've got a vested interest in whatever it is that they're managing and want to ensure that the status quo is maintained, to the other extreme, I've worked with some colleagues who really aren't doing it for self-interest at all, they're doing it because they generally think it's the right thing to do because they generally want to be involved and engaged and they want to make sure that the organisation tries and does the right thing for patients and a lot of people sit somewhere in between, I think it's a variety but, yeah, I don't think we necessarily get the best people into the roles at all."*
D9-CC05	*"I think there are very different people then, you can always spot them….people that are in it for…personal gain. Yeah, people that go into it because they believe in it and can see that actually being in it is the place to be, otherwise you don't influence, and then other people that are in there just purely for personal gains."*
D11-CC05	*"there are some people who are natural managers and there are others who just don't want to do it, for whatever reason, and not everyone can be a manager you know, and I think it is wrong in the doctoring model anyway, not all doctors can be consultants that's the other thing you know so, that's being addressed through workforce change things but there needs to be a way, and their needs to be enough time to recognise the doctors that will be good managers…."*

There is a suggestion that doctors enter the management field through a number of different avenues and that consequently there are different types of doctors engaged in the management of the NHS. It appears that doctors choose to engage in management for different reasons and participants categorise clinical managers into a number of different groups. There are managers who are clinicians first and foremost. Participants perceive that this group of doctors undertake their clinical role and avoid doing anything else, conceivably because they are fearful that they might end up being coerced into a management role that they dislike. The narratives do however imply that all doctors should engage in a management role of some sort, be this in education, clinical audit, or information technology and that in doing so, this offers the potential for clinicians to influence other areas of the health care environment where their input could be of value. Participants identify another group of doctors who, in engaging in the management and leadership of the NHS, believe that they know the best course of action to take, and go about telling others what they need to do. This suggests to the author that doctors do not like to be told what to do by other doctors who they do not respect either for their management or clinical skills, or lack of management and clinical skills. This leads on to a further group of doctors who it is suggested engage in management purely for their own self-interest and personal gain, possibly for the kudos and influence that they feel the position affords them. Whilst there is a suggestion that within these groups of doctors there is a negative connotation attached to their choice of engaging in the management of the NHS, the author is encouraged by the identification of a final group of doctors who, it is suggested, become clinical managers, because they genuinely believe that that is the right thing to do in order to ensure the best care for their patients. There might of course also be an element of self-interest here as this enables these doctors to influence, and possibly manipulate, the system.

Whilst this section describes the attributes of the engaged doctor, throughout the interviews, participants identified a number of obstacles that makes it more difficult for them to be effective managers, not least of which they perceive is a lack of preparedness for management. In many respects, this places doctors in what they propose is a foreign environment and although some doctors appear to adapt to their clinical

management role with relevant ease, for others this lack of preparedness seems to influence their choice of engagement in the management and leadership of the NHS.

5.3 The Reluctant Manager

These findings revealed that of the 12 participants, 11 considered themselves to be clinical managers. Several participants described their management role as being facilitative, or clinical management, and others considered that they undertook more of a leadership role. One participant revealed that he does not consider that he is a "manager", in the sense that he would determine a manager as someone with manpower responsibilities and financial accountability. As a consultant, the author would argue that this participant is a manager as the consultant role has an element of management and leadership, and as the interview progressed, the participant recognised elements of management within his consultant role. This offers a unique perspective of medical consultants in management. These clinicians are not paid for the additional management elements of their role, and, whilst they may enact management tasks, this research revealed that they do not always have control or autonomy in a management capacity.

D12-CC04 NF40	*"I am not a manager. I have to state that from the start, I'm a clinician. I am Clinical Lead for intensive care. I do not have any manpower role; I don't have any control over finances. I'm nobody's <uhm> manager I suppose you'd say. I run the unit only in a clinical sense and that means decision-making based on clinical needs, and setting up the policies and procedures. I manage patients every day of the week. I don't manage staff, I'm not a man manager… I think I should state straightaway I am not paid any more for the role I undertake as Lead. There is no recognition for that role at all in the Trust, and so I'm a bit averse to taking on that level of responsibility of a man manager when I am not paid for the flak.*
	…I'm a bit of a toothless tiger really in that respect, I can stamp my feet and shout and stuff but nothing will change, because I'm not in control of it. I don't have any overall power in that respect, if you see what I mean. I could suggest things, and I am often left to do things because I'm the only one that will do them, so in that respect I am managing it on my own but, I don't have overall responsibility for the service, that's somebody else… I am a facilitator. I am not in charge of anybody I let everybody work together and that's the art of leadership really; let people do what they're good at …"

As a consultant, this participant acknowledges that he does manage patient care and that he takes the lead for a clinical service. He describes himself as a "*toothless tiger*" in terms of his management power and control advising that he does not "*have any overall power and is not in control of it*". This particular consultant reports to an Associate Clinical Director who has overall accountability for the service and who enacts any "*management*" business on behalf of the service and the Clinical Lead. This offers a sole perspective of a clinical manager who does not perceive himself as a manager, possibly because he does not represent his Critical Care Unit on any Trust management groups, but rather all decisions go through the Associate Clinical Director. This management model was not highlighted by any of the other participants, who all confirmed that they are clinical managers. This account suggests a disconnect between consultants having management responsibility and accountability. As the interview progressed, the participant suggested that aspects of his role have a management connotation commensurate with the Consultant role.

In terms of why doctors choose to engage, the author considers that choice implies an inclination to be involved or not, and that, whilst doctors might choose to be engaged in the management and leadership of the NHS, all participants revealed that, in their opinion, the NHS does not prepare doctors for management. Lack of preparedness for management arose as a key concept throughout this research and this is explored in the following section.

5.3.1 Doctors are unprepared for management

Participants confirmed to the author that not all doctors choose to engage in the management and leadership of the NHS. Some participants advise that this is because they consider that they do not have the necessary skills for management and are therefore unprepared for a management role and/or for the management environment. The following accounts identify where doctors perceive that they are not prepared for management and defines some of the initial consequences of their perception of this unpreparedness.

D2-CC05 NF5	*"I did the managing health services course off my own back, but that was not really designed at doctors in management. … for instance, it used Handy a lot which is fine for things like styles of leadership, but not really for operating in the health service, and as*

	a junior consultant your exposure to management is haphazard and often hostile … <pause> A lot of the doctors that I see in management seem to learn on the job …they don't prepare them, they get a lot more support than they did in terms of time - and also they get more support from other doctors in management, whereas before you sort of sink or swim really."
D4-CC03 NF20	*"…it's a completely different world. You know <uhm> I'd say you're not prepared for it, even simple things like how meetings are structured, and things like that. I was not aware of any of that before I started to get involved with this type of thing. <uhm> A lot of things about how hospitals function and run, you know a lot of the finance-type side of things, I had no idea about that. I've had to just pick up and learn it as I go along. …you know it does affect your confidence and <uhm> it can make doing simple things take much longer because you don't know the processes to go through, or the people to contact <uhm>…I suppose it makes it very stressful…I think most people are quite disillusioned."*
D3-CC01 NF10	*"… I think the only preparation I'd had really was through the stuff I'd done in the Network <uhm> because of you know … some of the training, education we had running in the Network around things like human factors and incident investigation and things… Actually, I don't think I had any idea what I was letting myself in for … I'd done a management training course, which was 3 days I think in Sheffield as a senior trainee because you are expected to do that before you went on to get a consultant job. But I mean that wasn't really anything particularly, practically – it was a tick box exercise …there didn't seem then to be any sort of <uhm> progression planning, there didn't seem to be any preparing people for clinical leadership positions… there was no clear progression through sort of head of service, CD roles or other clinical management roles. It was just, and to a large degree they still do, they just send out expressions of interest and a lot of the time there's any one person who expresses any interest if anybody does, so they get given the job.*
D8-CC02 NF30	*"…hopefully you learn from other leaders or other people you admire or you think, "well you know they have got that worked out", and then you develop your own style, don't you, on doing things I think… a lot of these management skills you can learn. Well you have either got it, or you haven't? …I think you can train people to use those skills better, but I think lot of the courses and the management programmes you know, it's too contrived sometimes."*

These narratives illustrate a landscape where doctors enter management without the necessary skill set. They hint at a naivety on the part of the

doctors as they go into management with little idea of what to expect in a clinical management role. There is a suggestion that doctors self-select for management and that the NHS clinical model allows for this, as the NHS acquires a broad base of senior clinicians each of whom gets to make pretty much independent decisions about the clinical care that they give. These extracts suggest that doctors get very little preparation for management and that often management training is self-funded and that skills are obtained through learning on the job. Participants suggest that some of the skills come from observing colleagues and from experience and imply that management courses for clinicians do not always deliver the practical skills required. There is a suggestion of a perceived "other" who are responsible for not preparing doctors for management. To the author, these narratives suggest an element of a lack of responsibility on the part of the doctor at several levels. Participants describe management as a foreign environment and yet doctors appear to enter it unprepared, although they do seem to acknowledge that not only does this affect their performance as a manager, but that it also impacts their confidence and creates a heightened level of stress. This is unlikely to happen in a clinical environment where doctors would make sure that they are prepared and have the necessary skills and knowledge before undertaking clinical tasks. Where doctors recall that they have had some management training, they concede that they do not remember much about it. This suggests that the management training is either offered at the wrong time in their careers, such that they do not then have the opportunity to operationalise their learning, or that it is delivered at the wrong level and needs to be more practical, or that in fact doctors attach little importance to the management training that they receive. This seems to be backed up by the suggestion that management training is too contrived and that doctors can learn their management skills by observing other people that they admire (presumably other clinical managers). This demeans management as a profession where there is a perception that the management role can be undertaken without due preparation and that management skills can easily be learnt through an informal route.

There is an undertone of discontent expressed in respect of the importance that one Trust attributes to their clinical management structure indicated in the speed at which the formal management training was delivered and a suggestion that this was delivered as a "*tick box*

exercise". Moreover, this highlights a lack of value on the part of the Trust to the clinical manager role where anyone can be given the job.

There is an indication that not only do doctors enter the management environment unprepared, but that this is a haphazard and often hostile environment where doctors will either "*sink or swim*". The narratives reveal a lack of succession planning for the appointment of clinical managers with little preparation for future clinical leadership positions. The findings suggest that this lack of preparation for clinical management inevitably has an effect on the doctors who find themselves ill prepared for management as specified in the following narrative accounts.

D1-CC02 NF1	*"I think personally it makes you feel vulnerable or second-class because you're not matching, the managers in a sense and, and potentially it is also an awkward position to be in because your clinical expertise acquired already over a 6, 7 plus year exposure, you can't intellectually sort of match that with 2 days, so you think, well, I'll give it my best shot and clearly you have, you know, got abilities to develop in something which is slightly more unfamiliar, but it doesn't have the comfort zone, …It's a bit like trial and error. You clearly almost use your consultant status, which equals, or if I make a project plan or a management decision that's sort of almost backed up by who I am as a clinician, but clearly that wouldn't hold watertight, if you're were in industry or something else… for me personally, I think it's more likely that I'm very <uhm> conservative, holding myself back and in terms of being involved in management, …and probably it stagnates you in your progression because you're sort of, yeah…* *You know as an individual, and <uhm> I think what I said, as a person is, I think it's sort of, you have ambitions, but you also have certain standards. You want to be safe and it doesn't necessarily quite marry up. So I think, so you know and most of my management sort of exposure, challenges, have been an added on extra, …* *… you know if you're reasonably good at your day in day out job, that's your yardstick, so you know you can be at the level, but the management side, or this exposure, hangs behind and that doesn't sit comfortably…"*
D7-CC03 NF26	*"I think when you come to your final exit interview prior to being a consultant, one thing was, that you had to go onto a decent management course which was usually a prescribed one, which*

> *was a couple of days, and I went on a 3 day course, in Birmingham actually which was all very good and very useful, but all I can remember is being given 15 bits of paper and trying to work out personality types – I can't remember anything else about the whole thing, and something about Maslow's hierarchy of needs and teaching, and that was about it and about all I can remember. The rest of it was all very useful, and very interesting at the time, but essentially it was a tick box exercise, …you pick up the skills as you go by default ...I wouldn't feel equipped to apply to become a CD…I could do it, I would do it in my own way and my own style and I would just do it in the way that I thought it should be done, but whether or not I was actually doing it in the way that was accepted or evidence based, or reasonable, or backed up with anything other than my gut instinct in terms of clinical judgement and fairness and a balance between corporate financial and clinical lead, but that's not really the way it should be done, you can't become a manager in any other part of the hospital or any other business in fact without having some sort of pedigree in terms of some sort of qualification some sort of background …"*

These narratives suggest a disconnect between doctors being prepared for their clinical role and being prepared for a management role and indicate that doctors do not feel comfortable operating as clinical managers when they feel ill prepared for the role. There is an indication that doctors are resistant to management because either they do not consider that the management path is right for them, or they do not feel that they have got the experience and skills to bring to a management role and perhaps find it difficult to see how they could get those skills. Whilst some doctors might enter management with all good intentions, in circumstances where they might perhaps feel unprepared for management, some are likely to become disillusioned and walk away, either because of their own abilities or inability or because of the way they deal with others. Throughout the interviews, the author appreciated the importance that doctors place on their knowledge and skills and realised that doctors like to be prepared for all eventualities. Medical training ensures that doctors have the clinical expertise which in turn seems to give them the confidence to operate in the clinical environment. Whilst some doctors are prepared to enter management without the appropriate skill set, it appears that the perceived lack of intellectual preparation often hinders their progression within clinical management. Additionally, there is a suggestion that this lack of preparation makes some doctors

experience feelings of inadequacy and vulnerability and makes them feel "*second class*" to managers who have the appropriate skills and knowledge to progress in the management arena. The clinical environment is tightly governed, and doctors are accountable for their actions, they operate within a high risk environment where any incident is scrutinised. This creates a culture of governance and so, where doctors feel unprepared for management, they question their standards and level of protection.

Participants indicate that doctors are competitive by nature and are in fact used to being trained for the job that they do, and it appears that a sense of unpreparedness does, in some instances, dissuade them from remaining in clinical management positions. In this respect, whilst doctors appear to be reluctant managers, the author proposes that the perceived lack of preparedness is in some respects the cause of this indifference to management.

Participants reveal that they might be inclined to use their consultant status as an instrument of power to preserve their standing with managers. There is a recognition however of the fragility of this strategy and when doctors perceive that they are not succeeding in their management role, they appear to abandon all ambitions of progressing a career in clinical management attributing their lack of progression to the absence of any formal management training. Additionally one participant suggests that some clinical managers "*prop up their slightly dubious management ability with a good clinical knowledge of the area they are managing*" which again is a risky strategy to adopt as the participant further suggests that if you "*threw them into an area they have no clinical knowledge of… you'd see rapidly how bad they were as managers*".

These accounts reveal that, where doctors receive formal management training, that whilst this is deemed to have been interesting at the time, it is often referred to as a "*tick box exercise*" and becomes irrelevant over time. Additionally there is a recognition that in any other aspect of management, managers are trained for the role that they undertake whereas there is a suggestion that the lack of any recognised management training for doctors leaves them exposed and vulnerable. What is not clear is how much of this unpreparedness is due to the

doctors themselves not taking responsibility to gain the necessary skills and knowledge for management, in other words, taking ownership for this. The narratives suggest that participants perceive that management skills can be learnt and it is possible therefore that where doctors enter a clinical management role and come unstuck due to a lack of preparation for the role, that they look to others to blame for their lack of preparation rather than to themselves. The author suggests that in the clinical environment, doctors would take responsibility to learn a new clinical skill, but the same does not seem to apply to the learning of new skills for management. In some respects, it appears that the management environment is more complex and difficult than is perhaps perceived by some doctors entering the field of clinical management without the necessary skills or knowledge to undertake some of the complexities of the role.

The following extract, whilst still signifying that doctors are not prepared for management, presents an interesting viewpoint as this participant indicates that he does not find the lack of management training frustrating because doctors *"don't know what you don't know"* and in fact suggests that doctors are quite cynical about management training.

D10-CC05 NF34	*"<uhm> I didn't get any training, zero <uhm> I don't find it as frustrating as you might, because you don't know what you don't know… a lot of doctors are quite cynical about management training, so it's very hard to engage us. Like the thought of someone saying in medical school, we're going to give you 3 months of, you know …. get rid of anatomy and we're going to give you 3 months of management training, would have us all up in arms for that and it's often not taught very well <uhm> I've been to a few really interesting things, a management course or a personality development course, <uhm> which I found really helpful and surprised me because I'm so cynical about those things, so I don't think I've had any preparation. It's only apprenticeship, of watching other people, watching people lead <uhm> a ward round, watching people interact, but you don't have any…in my training, there was nothing…if you had more preparation, you might have done things differently, but <uhm> doctors aren't trained to think corporately. Doctors are trained to think much more about themselves and their patient, …but they've not necessarily got the best skills for management and in some things you can't actually be trained for, in some ways, <uhm> doctors by nature but we're generalizing are*

> *quite hierarchical <uhm> and there's many hoops that they've gone through, there is this exam to go through, then there is this, and you've got to do this, and they're very good at that, and they take, whereas <uhm> management doesn't always lend itself to that. It's not always as hierarchical and someone's got to take a lot more initiative to step outside and just do things or to – and to circumvent <uhm> individuals to get things done. That's not medical training to do any circumventing. There's a very clear hierarchy of responsibility for that patient's care, so it's when they – they're not very good at, they're not very agile. Doctors I don't think are very agile people which actually can make them quite black-and-white and that can be quite helpful for some sort of, some things in the hospital and <uhm> then the whole relationship between nurses and doctors makes hospitals incredibly strange…but you see doctors … that get attracted to management …I think their key effectiveness is they know the model and also they bring the engagement of their colleagues, because without a doctor involved, then you have a disengaged workforce and so the most, they bring respect to <uhm> the management, that basically has such a low respect, maybe because a lot of the management – the general regard of managers in the NHS is so low which is a bit unfair. They are very much – that's the stereotype."*

Whilst this narrative indicates that it is difficult to engage doctors in any formal management training, it does reveal that when the participant has engaged in management training, he found it quite helpful. This narrative highlights the corporate aspects of management and exposes a difference between medical and management training in that medical training is much more insular in respect of delivering patient focussed care. The participant suggests that doctors are much less agile than managers, and that the clinical environment is more hierarchical with clear lines of responsibility and accountability. This narrative highlights a difference in training structures for doctors and managers and clearly suggests that management as a profession has a low regard, which could explain why many doctors choose not to engage in management of the NHS. The lack of regard for management as a profession however is not clarified in terms of origin and it is possible that some of this is fuelled by the perceived lack of regard that doctors attribute to management as a profession.

Throughout the interviews, participants advised that doctors are taught to make a diagnosis, to give treatment and to make decisions, often rapid

decisions. Moreover, they indicated that in the clinical environment doctors do not always have the facts, and that often they do not have the time to wait for the facts, or indeed for the right set of circumstances, and so they carry a lot of responsibility and have a level of confidence to deal with uncertainty. The layers between the patient and the doctor are very narrow and doctors are not used to multiple layers, they are used to just making a decision, which could account for their frustration with management.

Participants advocate that doctors bring rapid decision-making skills and a willingness to make a decision to management, which they suggest is in conflict with a more inflexible bureaucratic management model. This alludes to a conflict between the two different models and an expectation for doctors to traverse the different models. Throughout the interviews, participants identified areas of internal and external conflict as identified in the following section.

5.4 Internal and External Conflict

In respect of this study, internal conflict relates to doctor behaviour and external conflict relates to conflict that is perceived by the participants to occur between them as doctors and other people i.e. doctors and managers, doctors and doctors. Doctors spend a lot of time working in an environment that is fashioned by the organisations in which they work. They therefore work in a system that they did not design and often over which they have little control. Lack of power and control arose as a key theme throughout the analysis process.

5.4.1 Lack of power and control

The concept of power arose throughout the interviews and the author noticed that this related to either external power, imposed on participants as doctors, or internal/personal power that participants as doctors perceive that they, or other doctors possess. The first set of narratives relate to the perceived external power and the second set to the perceived internal/personal power.

Perceived external power:

D11-CC05 NF38	*"I think we're clinically led with our hands tied behind our back because they say we've got the doctors that are the leaders, but we don't have any of the power so you can't say, <uhm> this is my directorate, give me that much money, this is my budget, that's what I'm going to do, and I will hire and fire people, and I will make this better or not, that doesn't happen so it's not a real management structure. I think the power sits in the politics. … you've got responsibility and accountability, but no power to change it. …"*
D7-CC02 NF27	*"…there are certain people around here who, everything is scrutinized. Your leave is scrutinized, your PAs are scrutinized, your job plan's scrutinized, and your SPA is scrutinized and you have to justify every minute of every day and it is - after a while it is really quite wearing, and then if you do upset a few people, you start getting instructor course leave and things cancelled and other bits and bobs for purely no reason than pettiness and there's no recourse, there's no come back. But it doesn't matter but they're the – it's that sort of thing, it's about internal power and job plans…"*
D7-CC02	*"…if they decide to make life very difficult for us they will play it – the thing is that they can make life difficult for us, or just start cutting funds, making things difficult so you've got to kind of play it both ways - that is just the policy and power …"*
D9-CC05	*"…this is one of the challenges that we face as doctors, particularly all these senior consultants, they all are you know very powerful, very motivated. They have achieved and trying to get them to do, you know people talk about herding cats, trying to get them to do what you want them to do is very difficult."*

These narratives indicate that whilst doctors have the responsibility, they do not have the power to change anything, so in other words, they have the responsibility but no authority. There is an indication of doctor/manager conflict as participants advocate that they are told what to do on a daily basis by management with no support which results in increased pressure and staff absence. There is also an indication of frustration as the clinical managers assert that they operate within an artificial management system. These accounts reveal that doctors perceive that much of the power sits in the politics of Trust administration which they perceive impacts both them personally and professionally, and suggest a disconnect between management and clinicians which influences doctors' choice of engagement. Additionally, they indicate an element of egotism on the part

of clinical managers who use their internal power to punish medical colleagues who cause dissent. One participant advised that the doctors in his Trust are "*starting to rebel – a bit like the ents out of Lord of the Rings*". There is a suggestion that, whilst some doctors might want to be more involved in clinical management, the nepotistic culture of Trust management does not enable other doctors to gain access to management roles. The narratives also highlight the challenge that clinical managers face in managing groups of other doctors who are perceived to be both motivated and powerful.

Perceived internal/personal power:

D11-CC05 NF37	*"I think a lot of time it is about power, that's the first thing <uhm> and moving up the chain of command"*
D12-CC04 NF40	*"I can stamp my feet and shout and stuff but nothing will change, because I'm not in control of it. I don't have any overall power"*
D12-CC04 NF42	*"Part of me wants to teach them a lesson, and say, "Right okay we'll just shut the doors and it's up to you to sort this out then.""*
D3-CC01	*"I've got a quote. I don't know whether it's a quote, whether it's a quote, quote, or whether it's… but there's something about the fact that doctors either don't realize how powerful potentially they are, or think they should be much more powerful than they should be. I think you get that dichotomy again, don't you? You've got a group of doctors, I think who think they should have all of the power and all of the decision-making, which to me clearly is wrong because they'll just make crap decisions, and you've got a whole other group of doctors who perhaps are the ones who aren't engaged. I think that group are actively disengaged almost because they try and have more influence and more power than would ever be right to give to them, and you've got another group of doctors who really don't think they've got any power at all, who don't realize actually how much power potentially they can have, and I think the people who are actively usefully engaged probably sit somewhere in the middle…I know that if I sit in Trust Board and go, "that's a really stupid idea, it would be clinically unsafe and it would be clinically unsafe for these reasons", and put up a good cogent argument, that is hugely powerful and actually, it's very difficult for the managers to then go down that track without very good reason."*
D8-CC02	*"I think all doctors have power."*

D8-CC02	*"You see <pause> doctors forget, because most of the time you're acting as a patient's advocate or for the patient's interest that you have power…but I think <uhm> doctors have power because if they feel … there is a safety issue or something that's not being done right increasingly by bringing <uhm> it to the attention of senior managers, it's **hard** for them to ignore and sometimes people will try and side-line you and try not to acknowledge, but if you know which buttons to press and you press the right ones you can't be ignored."*
D8-CC02	*"They've got a different agenda and for that reason they'll get nowhere because I for one will not cooperate. And I'll not go out of my way, but I'll make it known that that isn't the way to do things. There is positive engagement there is negative. You can engage me and I'll be positive and contribute, but if I don't share the vision then I'm just going to put spanners in the works aren't I? so it's about whether I share the vision. If I share a vision then you'll engage me and I'll be as positive and I'll contribute all I can, and I'll do what I can, but if it's something that I really don't believe in then other than being negative, and probably a negative force, then I'm the wrong person <laughs>…"*

These narrative accounts reveal an interesting viewpoint in respect of the power that doctors suggest that they have as a professional body and as individuals. Doctors have the monopoly over managers in terms of their clinical knowledge and these narratives indicate that doctors not only recognise this, but that they manipulate this to their advantage. What is interesting to the author is the realisation that doctors are sometimes disparaging of their colleagues and that this often presents as frustration, particularly where doctors perceive that their medical colleagues make what they consider to be the wrong decisions in management. The accounts reveal a perception that the clinical argument will triumph over the management argument, which suggests that clinicians and managers recognise the value of improving patient care. This is a step forward from the perception offered earlier which suggests that management often neglects to remember the patient in the process. The final narrative indicates the power of the uncooperative doctor for personal gain and reveals that doctors will choose to engage or disengage according to the value that they place on the issue. Throughout the interviews, participants indicated that doctors are not always in favour of other doctors having power over them and revealed a competitive nature.

> *"It's like the hidden joker ….whenever there's a conversation it's like the hidden joker but part of the reason that doctors don't operate well in management in a Trust is that doctors don't like other doctors having power over them ….because it's a very competitive profession ..."*

This competitiveness manifests in a number of different guises and phases as illustrated in the following section.

5.4.2 Competitiveness

Participants spoke about doctors being competitive as individuals and as a profession and suggested that it is in a doctor's make-up to be competitive due to the nature of the environment that they find themselves in from a relatively young age. The following narratives tease out some of this competitiveness from a personal perspective in order to explore some of the internal conflict experienced by doctors.

D1-CC02	*"…we are by nature competitive"*
D2-CC05 NF8	*"It's like the hidden joker ….whenever there's a conversation it's like the hidden joker, but part of the reason that doctors don't operate well in management in a Trust is that doctors don't like other doctors having power over them ….because it's a very competitive profession …Well it's like you and the manager or you or the politician are playing a game of cards which doesn't involve jokers but you have got one anyway – so suppose you have both got a hand of cards and you both have 4 aces, the hidden joker is if the doctor wants, he can have 5 aces….. it's very competitive every doctor wants to be the best doctor and be better than other doctors and if a doctor is in a position of management authority and given power over doctors particularly if other doctors consider themselves more clinically competent than the other …..they might resent it.* *…well it starts as soon as you get to medical school ...most doctors were in the top 1 or 2% of their school intake, then they get to medical school and all of a sudden everybody else was in the top 1 or 2% and so immediately in order to regain your position of self-worth which for a lot of us was around that we were in the top 1 to 2% of school, you **immediately** start competing because you want to be back in the top 1 or 2% …. and that just translates all the way up …and for some of them …they can't win unless somebody else loses and that increases the ….not just the level of competition, but the perceived intensity of competition… chairing a group of doctors*

	is a skill <laughs> different to chairing a group of managers …because you have to manage competition much more …"
D3-CC01	*"…generally most people who've got to be doctors have gone to school where they will generally have been among the brightest at that school, they would have been successful in their exams, because if you don't, you don't get to medical school. Medical schools is be a bit different because everybody is pretty much on an even footing, but for most doctors, feeling that you're not very good at something is quite uncomfortable and if you can't overcome that, then moving into areas like clinical management, I think can be quite difficult and I think some people do walk away from it… We're not really very good at giving them the skills they need, they feel they're rubbish at it, and they don't like being rubbish at stuff so they give up. …it's generally in their nature for doctors to be competitive.* *Clearly, if you aren't relatively competitive, you probably don't achieve what you need to achieve, to get in to medicine in the first place <uhm> I think it depends how you're competitive, doesn't it? because there are different – you can be competitive as in, I like to know that I've always done my best, I wouldn't say I'm happy that if I have to go, "yes, somebody else who's best is better than my best because I might just try and make my best better". But is there – you can feel you've done your best without necessarily being the number one and be content with that and there's the, "no, I have to be always number one" type of competitiveness and I think probably the people who are the better clinical managers that I've worked with, sit in the former rather than the latter group."*
D9-CC05 NF32	*"…by and large they're bright, so they're the bright boys in the school …doctors are so competitive, so competitive, and you put them into anything and that's to some degree, the advantage of having, if you can get them involved in leadership management, then they'll strive to perform …as doctors you normally are at top of your class, top of your class at school, brightest there, you're the high achiever, you go into medical school, you're there with lots of high achievers, it becomes competitive…"*

Participants recognise the competitive nature of medicine and suggest that in order to regain a position of self-worth, doctors compete with other doctors. These narratives imply that every doctor wants to be the best doctor, and to be better than other doctors and reveal that competitiveness amongst doctors starts as early as Medical School. The

author suggests however that this competitiveness is likely to start in the pre-Medical School phase as doctors compete to gain a place at Medical School in order to commence their medical career. Places at Medical Schools are limited and there is a high level of competition for places. The inference is that doctors do not operate well within the management of Trusts because they do not like other doctors having power and influence over them. The metaphor of the "*hidden joker*" gives an indication of the power that doctors perceive they have over other professions in that they hold the ultimate "trump card". These narratives suggest that doctors compete with other doctors in order to be the "*best*" doctor. As doctors become clinical managers, this places doctors in charge of other doctors and participants indicate that doctors do not like this, particularly where clinical managers do not have the clinical credibility or respect of other doctors. The accounts give an indication into the nature of competitiveness in the field of medicine as several participants suggest that generally people that go in to medicine are amongst the "*brightest*" students at school and that they continually have to succeed in order to progress their career. Additionally these narratives reveal a cause for doctor/manager conflict, as doctors in management are not always going to be the best managers, particularly if they are not prepared for management. The challenge is to harness this competitiveness for the benefits of patients and the service as a whole. In recognising their competitive nature, doctors do appear to reveal a reason for not wanting to be involved or engaged in the management of the NHS where they are not "the best" any more. For doctors to realise the benefits of managers and doctors working together requires a cultural shift so that the best bits of each profession can be selected to deliver the best service for patients in a more non-competitive environment, akin to the Network.   The Network has this joined-up model and participants indicate that the Network works for them as doctors, which is why they choose to engage in the Network.

Participants revealed an element of competition in terms of the work environment and the following narrative account gives an indication of why doctors might choose to engage in the Network:

D3-CC01 NF18	*"I think the other thing about the critical care network is it generally doesn't feel in any way competitive. I think it feels supportive and*

> *cooperative <uhm> whereas I think you know, even moving into the [different specialty] network I think you see elements of competition coming in there, don't you? And in the Trust, I think there are always competing elements, there is only a given pot of money and there are only so many beds and you know so that, that competition is always there and I think the way we organise a lot of NHS acute provider organisations reinforces that because we break people up into groups and silos, don't we?, you know and we have emergency care or elective care, we have medicine and surgery you know and actually those groups are competing, they're competing for different resources, they're competing with each other for finance and they're doing that all the time <uhm> so it is a much more competitive environment, I think.*
>
> *…I can certainly think of some people who I think probably will be quite happy engaging in the Network because it is non-competitive and they are a bit less confrontational if you like, who probably would be quite uncomfortable engaging in a more competitive Trust environment.*
>
> *"…when people in the Network share, you go "thank you", yeah, because the first thing I'm going to do when I get back to work is make sure that never happens in our Unit and I think that is really refreshing and there isn't that competitive scoring points thing."*

This account indicates that a competitive environment does have an influence on doctors' choice of engagement. It is suggestive that the way that a lot of provider organisations are organised reinforces competition but that the Network is a non-competitive, supportive and co-operative environment offering doctors the opportunity to be involved in things that they would perhaps not be involved in in their Trust, which in part will be due to the single specialty nature of the Network. This narrative suggests that the Network is useful to doctors individually and collectively as it gives critical care a voice in the wider health community. There is no doubt that the organisational structure and size of the Trust and the Network has a part to play in terms of creating a competitive environment, as the Trust culture is more likely to create competition due to the complexity and competing elements of the environment. This suggests that doctors who are less confrontational in nature, are more likely to engage with the collaborative culture of the Network rather than in a Trust which demonstrates a more competitive, hostile environment.

As participants talked about why they choose to engage, a common narrative that emerged was in relation to external conflict. The emerging themes are categorised into "Doctor and Manager conflict", "Doctor and Doctor conflict" and "Doctors as Managers conflict" and the following extracts illustrate participants' observations of each of these areas of perceived conflict.

5.4.3 Doctor and manager conflict

D2-CC05 NF6	*"…a lot of the doctors are very well engaged with the Network and they are less engaged within their Acute Trusts…I think sometimes the engagement with management within the Acute Trusts is punitive <pause> or less sharing shall we say, less inclusive. There is much more of a manager/doctor split … <uhm> I think the Network comes together for a common purpose. Whereas sometimes the Trust managers in general they have a slightly different ….the Network is about critical care, and everybody who is in critical care sees <pause> that the Network is focused on what they are interested in ….whereas if you are in critical care and you are interested in your ability to cope with emergencies, but the managers are interested in elective throughput, then there is a disconnect between what your objectives are …so doctors play a variety of roles… being a Medical Director is not a job that most doctors want, it is a job that you end up with …and also you've got to remember that most of the doctors are more intelligent than the managers who are managing them, so will find a way round them if they need to.* *… generally and I wouldn't just say doctors, clinicians generally…we have a better idea of how the service ought to operate <pause> and therefore we may not have all the management skills to allow the service to operate in the way that we see it needing to operate, but we bring the clinical view that informs management in its broadest sense… it depends whether the managers have got the management skills <pause> so it's like you wouldn't take your car to be repaired by a motorcycle engineer. There are some shared skills but there are some different skills. So I think a health service or a hospital or an organisation that was completely managed by doctors is a recipe for complete disaster because most doctors don't have the level of management skills that are involved <pause> but similarly as we saw with exclusive general management, a hospital that is entirely managed by general managers without clinical input is also a recipe for disaster <pause>… so you need a mixed model, you need managers with*

> *some medical knowledge or at least the ability to understand medical knowledge and you need doctors who come with medical knowledge with enough management insight to frame the issues in a way that lends itself to a management solution…*
>
> *You get conflict and you get this artificial manager/doctor divide where you know the management are seen as the deniers of technology <pause> …the doctors especially in critical care always want the newest toys the best ventilators, managers are constrained by finance and so your desire to get the latest technology is actually constrained by finance and other competing things on a budget, but it can be seen as you are being constrained by management and, because a lot of doctors don't have a manager head, they find it hard to balance their demands with those of the wider organisation, so, a goalkeeper comes to a football match with different skills to a centre forward but you couldn't put the team on without both of them…"*

This narrative suggests that doctors bring the clinical view to management but that they do not have the necessary skills to manage the resources, which often leads to doctor/manager conflict. Whilst there are some shared skills amongst clinical and non-clinical managers, this account reveals that each also has a set of different skills. It also, however implies that managers do not always have the management skills or the clinical insight and that doctors working as clinical managers, does not always work well for the doctors or for the organisation. It also reveals a level of conflict in terms of competing priorities and suggests some manipulation on the part of doctors who, it is proposed, are more intelligent than the managers who are managing them and who will therefore find a way of circumnavigating the system if they can. This goes against the earlier account where it was suggested that doctors are not proficient at circumventing the system. To the author this reveals that an element of power sits with doctors at a number of levels. Doctors can choose to engage or not, and both disengagement and engagement gives the doctors a level of perceived power. Doctors are able to manipulate situations and circumnavigate the system either for personal or professional gain. Doctors will bypass clinical managers where they have little regard for their ability as a manager in order to get what they want. This level of manipulation and circumnavigating is likely to be frustrating

for both doctors and managers and the professions need to find a balance to facilitate effective collaborative engagement.

This narrative exposes an artificial doctor/manager divide where doctors are not understanding of the management arena and discloses that a health service that is run entirely by clinical managers or non-clinical managers is a recipe for disaster, revealing a solution in the form of a mixed model of management where doctors and managers work together as in the clinical network model. This participant perceives conflict in the form of a doctor/manager divide and further describes an implicit and explicit contract with medicine and management and the public:

D2-CC05 NF6	*"So I think in some areas the doctor/manager conflict is real… there is this thing about the implicit and explicit contract with medicine and management and the public in that the implicit contract is different from the explicit contract <pause> when you're trained as a doctor the implicit understanding is that you are in charge of health care and that's the implicit contract that you have, that you come into the profession with - as a medical community - whereas the explicit contract is you work for the hospital and therefore are employed by the Chief Executive and therefore should do what he says which is the explicit contract, so there is this tension between the implicit and explicit contract… there are a **huge** body of doctors working in the health care system who contribute nothing to management - they come in they look after their patients they see the one patient in front of them. They don't bother to take the wider view because there is no need for them to take a wider view. They try and advance **their** service and they won't have an opinion on an issue about whether there are impacts for the wider service from changes in their service. There are other doctors who are some would say have gone over to the dark side and they can **only** see the whole system and then there is a range in-between."*

This narrative possibly goes some way to explain some of the fundamentals as to why doctors choose to engage in the management and leadership of the NHS or not. It implies that doctors perceive that, throughout their training, they are led to believe that doctors are in charge of health care, however, the reality is that, in the current organisation of the NHS, doctors are accountable to a clinical manager through the hierarchical structure of the organisation they are employed in which, it is suggested, is where a lot of the doctor/manager conflict arises from. The

author perceives that there is a historical legacy in medicine where doctors were in charge, and that this, coupled with the competitive nature of the profession, and of doctors as individuals, fuels some of the doctor/manager conflict described by participants, particularly where the conflict is felt between the more mature clinical managers (who are likely to have inherited this legacy) and the non-clinical managers. Whilst doctors are employed by hospital Trusts and are therefore accountable to senior management, the author suspects that the perceived power of the medical profession alters this leadership model and positional power. Doctors and managers might therefore view each other with suspicion and indifference although the professions have an obligation to work together to facilitate the delivery of improved patient care. One participant suggested that doctors might need to be helped to see that they are not always the "*ultimate boss*", and that, in being valued for their clinical expertise and specialist skills and knowledge, they are part of a bigger multi-professional team as identified in the following narrative account:

D3-CC01 NF14	*"But it is different and actually, within departments, the clinical leaders aren't always the clinical managers, <uhm> so it's yeah it's how you, and it's almost taking people back a step, isn't it?, saying actually, you aren't just the ultimate boss anymore, you are part of a team and you've got a specialist set of skills and knowledge that that team wants and needs, but there will be other people around that table, who will have other skills and knowledge that you won't have or that will be better than the skills and knowledge that you have in that area and there is something about mutual respect as well, isn't there? It is actually, you know, the nonclinical managers respecting the input of the clinical managers which I think in my experience by and large does happen, but you see much less I think the clinical managers respecting the managerial expertise of the non-clinical …* *I suspect, getting people in medical training engaged in management, not just by attending a management course, but actually getting them working with managers and seeing what skills and expertise managers do have earlier, when they don't feel they've already got to the top, as it were. <uhm> and I think, a lot of the junior doctors in training would probably be much more receptive… but you know, certainly, for more senior consultants you almost think, well actually have you gone past the point, you*

> *can't teach old dogs new tricks and sometimes that's what we try and do you know we almost wait until people have got to be at the top of their clinical profession before you give them the opportunity to go into management and is that the right time?"*

Through this narrative, there is a perceived recognition that doctors and managers each have a specialist skill set and an inference of a level of disrespect of non-clinical managers by the doctors. Whilst doctors are valued for their clinical expertise and specialist skills and knowledge, there is a suggestion that clinical managers need to have a greater appreciation of the non-clinical manager role and that as clinical managers, doctors are a part of the management team and should therefore practise mutual respect for the different professions. This account reveals a perception that only doctors can do the job of a doctor, but that anyone can do the job of a manager, which does rather undermine management as a profession. There is an implication of an inherent disregard for management by doctors who are at the top of their profession and a recommendation that doctors be exposed to management earlier in their careers in order to better engagement them in management practice. Participants recognised the importance of team engagement to effect change, both in terms of clinicians and non-clinicians, but also in respect of engaging the whole multi-disciplinary team as illustrated in the following narrative account:

D11-CC05 NF38	*"… you've got responsibility and accountability, but no power to change it. You get slapped because we don't – so the four hour wait is an example. Every day you get an email about how bad the waitings are, every day you get told to do the ward rounds, every day you get told to discharge people early, but you know, because that's what happens. But you don't get, you know when we don't have any nurses, when we don't have beds, when we don't have the resources to do what we should be doing, we've got people then cluttering in recovery, nothing changes.* *– there is no slack at all. When you're working there continuously, we've had people go off, stressed, stressed, leaving most departments you know it's not frowned upon anymore because it happens, that's just what happens. …why would they want to, why would they want to go through all that grief. They don't get any extra, it's only because you get grief, you don't get the good things…We have to fight even for simple things. You know and*

> *you think why does it have to be so difficult? …I don't think you can change anything if you don't get the clinicians engaged. And I think you need, you can't just have the doctors engaged, you need to have the whole multi-disciplinary team engaged… you need everybody engaged, otherwise you can't change things and you can't, if you don't change, if you're not changing, then you're standing still, and if you're standing still, you're going backwards. Do you know what I mean?"*

There is a perception that doctors as managers need to have the authority to manage, and the autonomy to operate as managers, although there is a suggestion that the management structure within Trust CC05 does not allow doctors the management freedom to undertake their management roles. This narrative highlights a strong sense of conflict as the participant reveals that doctors are "*slapped*" by hospital management for poor performance and that they are "*told*" what to do by managers on a daily basis. There is a further indication that doctors are unsupported in their clinical management roles and that they have to "*fight for the simple things*". Through this account, the author observes an environment in which doctors are given a position of management, but because there is a perception that they do not have the power to change anything, this "management" element is in fact taken away from them. There is a strong perception that the power base sits in the politics of the wider Trust administration and that doctors are excluded from this. The lack of support appears to be reinforced by the suggestion that clinicians go off with stress and that nothing is done about this. Through the narrative the participant describes a clear picture of doctor/manager conflict in an acute hospital environment and there is a risk that they system breaks down as clinical staff become less willing to take on management roles which in turn will influence their choice of engagement.

One participant, in recognising where he can influence management, identified a lack of understanding of the management infrastructure.

D12-CC04 NF42	*"… we don't understand the infrastructure that feeds into our clinical services very well, unless we have being trained in that respect. We are not financiers, we don't run the business side of the hospital. We only know what we need on the ground floor, and I think that's <uhm> where I can help I suppose, assist*

> *management of the NHS, that we can feed into the management system what we require, but I wouldn't understand the terms in which to put it, for example, like to produce a business case for example. …nobody has come and asked us if we're okay… That's my issue with it all, that's where the communication issue has broken down. …only the other day I had a meeting with finance who were saying, "Well, you need to make sure that you understand this that and the other, because they may take you on this particular point and that particular point, and a particular point", but hang on a minute, we haven't got enough beds it's simple as that, that's all I understand, I mean we need another 11.6 nursing staff to man those beds if we get this approved. How much more complicated does this need to be made? I don't understand. So, I think as a clinician working on the ground floor the solutions to that problem are clear, but I am not entirely sure that the Executive Committee are aware of the problem in our Unit at all …It's something as simple as that; a quick phone call even a visit, that'd be exceptional wouldn't it from the Chief Executive and say, "Can I help. Is there something that we can do up there that will help you?" …Yeah, I suppose. I don't know how well we do that. I am not retracting from their abilities as if you like as business managers, they understand that process I don't, so to put the lunatics in charge of the asylum I'm not sure is the answer, but I think it'll be nice to know that they were aware of the clinical problems that we were having. <uhm> Forever, we've been having these problems, forever it isn't just now, before we reach a crisis."*

Much of the conflict described in this narrative seems to be in respect of a break-down in communication between clinical and non-clinical managers in the Trust. It appears to describe a culture in which doctors do not understand the management environment and the infrastructure that feeds in to the clinical services and, as a consequence, doctors find themselves in unfamiliar territory. There appears to be a disconnect between the clinical and management environment with clinical managers looking to the non-clinical managers for support. There is also a suggestion that hospital management is not in touch with the clinical issues at the interface with patients and that they are not interested in the problems faced by the clinical managers, which the author suggests contributes to doctor/manager conflict. There is however also a recognition that doctors should not be put in charge of the administration of the business of the NHS. A key message coming through a number of these narratives is in terms of the complexity of management, as

participants frequently wonder how difficult management needs to be. This account confirms a perception that for the participant the health service is simply about patient care, and from his perception, the solution to the problems are clear and simple.

These narratives have described a perceived conflict between doctors and managers, but participants recount examples of where clinical managers experience conflict with their medical colleagues, and the following section explores this perceived doctor and doctor conflict.

5.4.4 Doctor and doctor conflict

A key area of conflict arising out of the findings that participants perceive as a potential barrier to doctors choosing to engage is in respect of doctor and doctor conflict. Participants indicate that in some aspects, this is likely to dissuade doctors from choosing to engage in clinical management roles as they advise that they are likely to experience grief, but little reward for their efforts.

D3-CC01 NF15	*"I think in the view of a lot of clinicians towards management, you know you still get that, "oh, you've gone over to the dark side" comments, or "you are a clinical manager"…. inevitably as a manager, you are going to make decisions that aren't going to be popular with all of your colleagues you know, and in clinical management, some of those decisions are going to directly affect your clinical colleagues, and you're going to be job planning people and potentially altering their job plans, potentially altering the financial remuneration they get for doing their work, the hours in which they have to do it, and I guess the tendency is that most of those decisions tend to the clinicians, to feel like they're negative for them, …you are seen as being the people who are implementing the things that they don't really want to do. You just have to have a thick skin.* *I think there is a risk you can end up being disliked by managers and doctors and I think it's really quite a struggle sometimes not to be <uhm> and I mean, it is hard work. I mean, I think trying to be fair and reasonable and balanced in both directions all of the time is actually quite a big thing <uhm> and I think it's very easy to, you don't have to step very far off that absolute, you know narrow middle path as it were to be seen as, well, you've either stepped too*

	far into the management camp or you've stepped too far in to the clinical camp depending on who you're dealing with. *It is a bit of a tightrope, <uhm> because if you go too far, down the "no, no we couldn't possibly do that bit of organisational restructure because it would affect the patients", you know your non-clinical management colleagues and going to turn round and say of you "now you're just going back to being a doctor" and if you go the other way, with your clinical colleagues, they'll go, "oh yeah, but that's got nothing to do - you're not concerned about patient care anymore, you're just making that decision because it's going to save the Trust some money" and you are constantly balancing between the two and you don't necessarily, because you don't really fit well into either, do you?"*
D10-CC05 NF36	*"So … quite a number of years ago… because of all the need for big decisions, there was a sense of a power vacuum for the more closer to the ground decision making… feeling totally disengaged and having no influence on decisions… I don't want to sort of say anything against [name] decision-making at the time because he was under different pressures... But then we weren't really aware of them as much so therefore it was really hard for us to care. The old adages of management was that as doctors, our focus was on the clinical circumstances…* *For big reasons I understand why [name] focus was not on [hospital], had to be, there's only so many hours – he broke himself for years and he's still breaking himself.* *… but the conflict's more personal because <uhm> you expect someone like [name] to be on your side …and so some people take that as a sense of betrayal ….our core duty is always to the patients and the two philosophies of medicine is I think, is that patient focus and then to the profession of doctors, so it's sort of, very narrow, but also very broad. But the broadness isn't to the public, I think the broadness is to your colleagues, that's why people hate doctors because they all… Well, the managers hate us because we just don't ever think, see the big picture, but also the public don't like us because we sort of come in a group and we cover-up for each other or whatever the public feel we do. But there is the colleague-ship is very strong…Camaraderie, colleague-ship and I think part of that, it's the only way you can cope with the decision-making in uncertainty and the consequences of some of those decisions are life and death for some people and so you depend on your colleagues so much unless you've got too much arrogance…"*

D2-CC05 NF8	*"…there is conflict between doctors and doctors as well …but if you look at the Chinese there are what …40 billion of them. They will fight each other all the time yeah, until somebody attacks them, and then they will unite, and it's the same with doctors."*

These narratives suggest that being a clinical manager is hard work, often made harder by colleagues who view the clinical manager as having defected to the "*management camp*". It is perhaps inevitable that clinical managers will make decisions that prove to be unpopular in the clinical environment and it appears that many clinical managers tread a fine path between management and clinicians in an attempt to be fair and reasonable, and balanced in all directions. There is a suggestion that clinical managers are seen as implementing things that doctors do not always want, or agree with, and that at times they run the risk of upsetting either their clinical colleagues or management colleagues, or both. The consequence for the clinical manager is that they are not liked by their medical colleagues and this recognition of the unpopularity of the clinical manager role, could dissuade some doctors from engaging in clinical management.

There is an indication that, whilst doctors appreciate the pressures that their clinical managers are under, they are not always aware of the exact pressures and admit that at times they find it hard to care. There is a suggestion of some childlike behaviours, as the narratives describe a situation where doctors perceive that they are not getting the attention of their leaders, and a suggestion that conflict feels more personal when it is doctor/doctor conflict as there appears to be an unspoken, but expected, bond between members of the medical profession. These accounts reveal a heightened sense of betrayal as there is a suggestion that a doctor's core duty is to the patient and so, where clinical managers are making decisions without the doctors that affect their patients, there is an indication that the feeling of disloyalty is greater. These narratives describe conflict between the doctors making the decisions and the doctors at the interface with patients. They also highlight an interesting dichotomy as one participant suggests that there is conflict between doctors and doctors until someone "*attacks them*" at which point they will "*unite in battle*". This gives rise to a further area of conflict where doctors as clinical managers perceive a degree of internalised conflict between

their role as a doctor and as a clinical manager, as explored in the following section.

5.4.5 Doctors as managers conflict

Several participants acknowledged that the right doctors need to be engaged in the management of the NHS as illustrated in the following narrative accounts:

D11-CC05 NF37	*"… you can't make all doctors be managers because I don't think all doctors should be managers, and I do think you need to select your management traits, and the other thing you need to have enough time to do it because otherwise you don't do it well... I don't think you should be doing other stuff because I think if you do, serving two masters doesn't work <uhm> not unless you are equipped properly… The ones who put themselves forward are very often, those aren't the good managers, …succession planning, I think, is done really badly… I think you need to have a few so that you can choose who you think is the best person…*
	I think a lot of time it is about power, that's the first thing <uhm> and moving up the chain of command, you know so to speak. I think some people would do it because they don't want to do as much clinical, I think that's another way to get out, isn't it, a get out clause. <uhm> so I don't think there's, like everything in life, there isn't just one answer. I don't know whether people do it because they want to gloat at other people, I don't know. I've seen it happen, I don't know if that's the intention they had but…you don't make friends and you're not there to make friends ..."
D9-CC05 NF32	*"…so I've gone over to the dark side or whatever I used to call it. So you've trained all your life to do that role that you do, look after patients, all that thing and you concentrate on doing that and someone's trying to tempt you away from that to go and do something completely different. And you see no benefit for that, and it's just meetings and all of that sort of rubbish and it's just not appealing.*
	You have to be quite secure in yourself <uhm> your self-belief, quite secure in your, not your position, but how others perceive you..."
D3-CC01 NF16	*"…sometimes as a clinical manager, you have to accept that you probably haven't done stuff as well as you'd have liked to do, now,*

> *in a clinical setting, that's really difficult because there's immediately a patient at the end of that, but I think you have to be able to overcome that, okay, I didn't run that meeting as well as I could. … I had to go and speak to that person about that thing and maybe I could have done it better, but actually I can learn from that and do better next time… it's a completely different set of skills, isn't it? I think the other thing is, for a lot of my colleagues, it doesn't sit comfortably with sitting around the table, having your say and then having the Chief Exec. say to you, "great, thank you very much, but actually I understand that, but because of this, this, and this, we've all got to have to do that". Accepting sometimes that actually, yes, you may be at the top of your profession in a clinical sense, but in a non-clinical managerial sense, you do have – you will have the medical director or the Chief Exec. or whatever, who is effectively now your boss."*

These narratives identify some of the pitfalls of being a clinical manager, particularly where doctors suggest that being in clinical management is perceived by colleagues as having "*gone over to the dark side*". Participants identify their lack of management skills and reveal that they have to apply a different coping mechanism when they do not perform at their best in the management environment as opposed to the clinical environment. Doctors appear to recognise that making a mistake in the clinical setting impacts patient care, whereas there does not seem to be the same recognition if they make a mistake in the management setting where decisions could potentially impact whole patient groups. The point that the participant seems to be making however in recognising the internal struggle, is that medical training demands a different cultural norm to management, hence giving rise to doctors as managers conflict.

One participant offered a fascinating insight into his perception of doctors as managers which could go some way to explaining why some doctors struggle to adapt to a clinical management role:

> *"…some doctors who are in management roles aren't managers ….and I would say the majority of them aren't managers <pause> they are administrators with clinical skills <pause> because an administrator delivers a set of deliverables and a manager takes a strategic view about what's the next step of deliverables and how you go about achieving them. …You've gone to proper management, <pause> so you are taking a different view than the pure medical view …..so a lot of medical managers still take a medical view …not a management view with a clinical spin…. which is different…"*

This study explores why doctors choose to engage in a clinical network in order to identify factors that influence engagement in the management and leadership of the NHS. The author therefore explored cultural issues with participants and a key concept that emerged was a requirement to create a culture for engagement as explored in the following section.

5.5   Creating a Culture for Engagement

Participants spoke of the culture of the Network and how this compares to the culture within their Trusts. The following section includes areas relevant to this study to inform a strategy for engagement.

5.5.1   Network and Trust culture

Within the survey questionnaire, a number of questions were designed to elicit information on the cultural influences of the Network and of the respondents' employing organisations and allowed space for comments. The comments from these questions have been used to inform the analysis undertaken for this study. At Question 6, respondents were asked to list words that they would use to describe the culture of the Network and of their Trust and Figure 12 illustrates the responses. These are sorted according to the respondents' Trusts and responses highlighted in yellow indicate participants who were later included in the face-to-face interviews.

FIGURE 12 - LIST OF WORDS USED TO DESCRIBE THE CULTURE OF THE NETWORK AND OF THE TRUSTS

	Network	Trust
CC01	Supportive / Sharing / Educational / Approachable	Disorganised / Constant change / Disjointed
	Committed / Focussed / Determined / Serious / Reliable	Reliable / Committed / Wants to improve / Focussed on patients / Listens to staff
	Supportive / Community	Troubled / Poorly structured / Trying hard! / Increasing engagement
	Open and inclusive / Supportive / Unified / Solution based / Simple and bureaucratic	Top down / Internally divided / Resistant to change / Problem based / Complex and bureaucratic
	Supportive / Open / Non-blaming / Vigilante / Learning from mistakes	Organisation without memory / Overwhelming bureaucratic / Lack of staff engagement / Lack of strong leadership at every level / Lack of information sharing
CC02	Well established / Clarity / Approachable / Helpful	A mess! / Financially driven / Disparate
	Engaging/reactive / Approachable / Listening / Proactive / Enthusiastic	
	Strategic / Community / Quality / Co-operation / Optimisation	Managerial / Targets / Fiscal / Productivity / Budgets
CC03	Sometimes a "club" only accessible by the nominated reps/leads	Improving / Listening / Engaging
	Positive / Quality-focussed / United	Improving / Striving
	Proactive / Forward thinking / Professional	Adaptive / Reactive
	Inclusive / Supportive / Good Leadership / Well organised / Fun!	Weak leadership (though improving!) / Reactive / Chaotic at times / Trying hard to improve! / Good team working

	Network	Trust
CC04	Active / Progressive / Informed / Influential / Teaching hospital	Recovering / Proud / Vulnerable / "usual" / Becoming open
CC05		Reactive / High handed
	Co-operative / Positive / Well-led / Patient Centred	Well managed / Busy / Change / Open
	Stable	Centralised
	Open / Sharing / Opportunity	Top-down / Controlling / Abusive
	Small / Quick / Powerless / Limited resource	Large / Slow / Powerful
	Open / Fun / Sharing	Dedicated / Large
	Involved / Active (pro-active) / Forward thinking / Supra-Trust	Protective / Defensive / Ambitious / Large / Well-led
	Hard working / Enterprising / Useful	Busy / Overstretched resources
	Engaged / Helpful / Tightly Knit / Useful / Proactive	Variable / Clinician centred, sometimes / Organisational treacle / Forgotten how to make things happen

The above illustration highlights a contrast in the language that doctors use to describe the culture of the Network and of their employing Trusts. When describing the culture of the Network, doctors use a more positive frame than when describing the culture of their Trusts. Many of the descriptors used to define the Network culture suggest a more collaborative culture that is proactive, supportive, co-operative, progressive and well led, allowing for the sharing of information in an open and honest way. Research participants suggest that the culture of the Network influences their engagement:

"The culture of the Network is, and always has been, supportive and open."

"The Network is welcoming and clearly believes it can improve region-wide co-ordination and patient care."

"The Network tries hard to be inclusive to all types of staff and has a good multidisciplinary feel to its operation."

"The culture of the Network is a very positive factor in encouraging and maintaining my involvement and engagement, it is a culture that focuses on producing solutions and positive outcomes…"

"If colleagues are active in the Network, it inspires engagement."

"Enthusiastic, motivated members of the Network inspire and motivate me…"

This is in congruence with the outcomes from earlier qualitative research (Shepherd, 2012) where participants identified a sense of togetherness, engagement and commitment as key factors that contribute to the success of the Network. In contrast, language used to describe the culture of respondents own employing organisations is less positive and describes organisations that are more complex and bureaucratic in their structure indicating a culture that is based around more centralised, top-down, controlling structures. These organisations are described as being more reactive rather than proactive and disorganised and chaotic. Some of the language however identifies that these are much larger organisations that are busy and over-stretched in terms of resources and certainly respondents within CC01, CC03 and CC04 recognise a progressive culture that suggests a commitment to change and to deliver improvements for patients. It is interesting to note that doctors working within the culture of CC02 suggest a financially, target driven culture whereas doctors in CC05 consider size to be an important factor that contributes to the culture of their organisation.

Respondents to the survey questionnaire were asked to score the level of medical engagement in the Network and their Trust and Figure 13 illustrates the perceived levels of engagement:

FIGURE 13 - LEVEL OF DOCTOR/MEDICAL ENGAGEMENT IN THE NETWORK AND IN PARTICIPANT TRUSTS
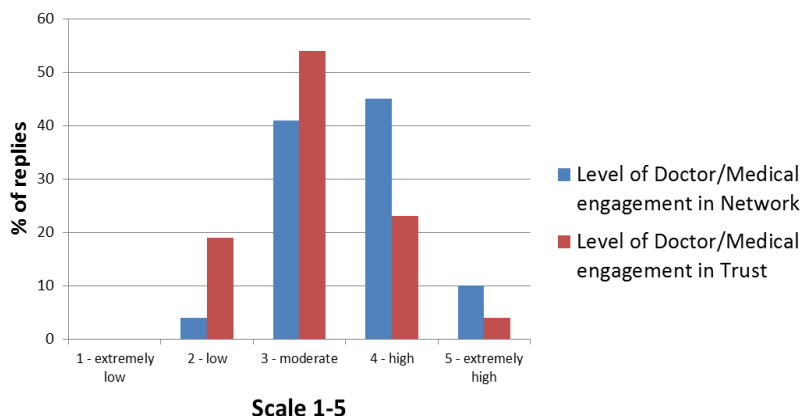
Whilst Figure 13 indicates that the level of engagement is perceived to be higher in the Network than in the employing Trusts, this gives a collective view of all five Trusts, and the author noticed that in some Trusts, the level of engagement was perceived to be higher than in others. Figure 14 therefore illustrates the suggested levels of engagement in each of the five Trusts within the Network:

FIGURE 14 - LEVEL OF DOCTOR/MEDICAL ENGAGEMENT BY EACH PARTICIPANT TRUST
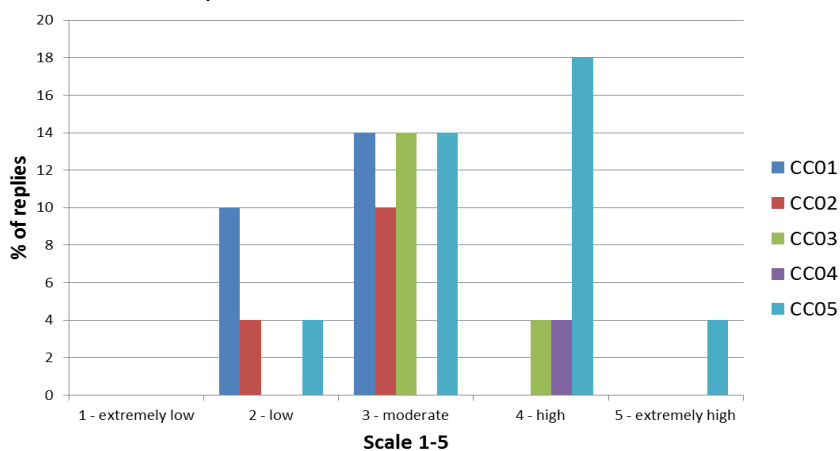
The author attended a Trust Director/Executive Group meeting in Trusts CC01, CC03 and CC05 as a participant observer, and considers that Figure 13 is representative of the levels of medical engagement that she observed during these meetings, particularly in Trust CC01 where she observed a supportive, but management led culture, and in Trust CC05, where the author witnessed a higher level of medical engagement. Observing the Trust meetings gave the author a brief insight into some of the cultures and behaviours of the three hospital trusts and key observations are included:

Trust CC01 – Trust Executive Committee, Members - Executive Directors and Senior Clinical and Non-Clinical Managers

Members were introduced at the start of the meeting. The author observed an informal meeting atmosphere, in respect of the fact that members appeared to come and go throughout the meeting with no regard or apology made to the Chair (CEO) and suspected that this was an accepted behaviour. No refreshments were provided for the meeting and not enough seats were provided for attendees such that members formed two rows, one around the meeting table and the other around the edge of the room, which meant that throughout the meeting, members were sitting with their backs to other members. Interestingly the author met a member of the group prior to the meeting who advised early arrival at the meeting in order to get a seat, and perceived this lack of seating to be a common issue. Members of the Trust Executive Team were all positioned around the meeting table. Points of interest to the author during this meeting were that the meeting appeared to be non-threatening and informal. Members demonstrated kindness and understanding of difficult issues and were polite and respectful to colleagues. The author did not witness any conflict. All members were dressed in formal business attire, which made it difficult to differentiate clinicians and non-clinicians, but did suggest to the author that the clinicians were distinguishing themselves as clinical managers by their attire, for the purposes of this meeting. Non-clinical managers interjected at will, however, clinical managers requested the attention of the meeting Chair to interject. There was use of humour as the Trust "*prepared for battle against the bigger beast (CQC)*" and in looking for evidence of the ordinary, the author perceived that all members gained a sense of togetherness in dealing with the challenges of the wider NHS. A financial presentation came late in the meeting and the author observed a shift in behaviour as people started looking at watches and yawning as well as an increase in activity by members using laptop computers and small group chats.

Trust CC03 – Trust Divisional and Service Team Heads of Service Group Meeting, Members - Medical Director and Clinical Leads

The author observed an informal meeting atmosphere as members were not introduced to each other at the start of the meeting, and the meeting

took on a workshop format. No refreshments were provided at the meeting. Members were asked for input to a series of questions and were engaged in the work of the meeting. An element of the meeting was providing peer support and members shared their thoughts and experiences on the subject under discussion. The Medical Director led the discussions and allowed members the freedom to speak. The author witnessed a supportive environment and did not observe any conflict.

Trust CC01 – Trust Directors' Group, Members - Executive Directors and Senior Clinical and Non-Clinical Managers

At the start of the meeting, the meeting Chair (CEO) personally greeted members as they arrived for the meeting. The meeting room was big enough to accommodate members and no refreshments were served. Members wore smart formal attire and addressed each other on first name terms. Humour was used throughout the meeting with one clinical manager referring to himself and his clinical colleagues as the "*moguls of management*". The author noticed that doctors were supportive of other doctors and offered advice to strengthen cases of need. When questioning medical colleagues, each question was introduced with a positive, complimentary and supportive comment. All clinicians were respectful of the Chair and any latecomers or early leavers noted apologies to the Chair. The CEO as Chair, orchestrated the meeting and following each item, made the time to acknowledge the work, to offer thanks to the team and to sum up the salient points, keeping the meeting on track. The author observed some non-verbal body language of non-clinical managers toward clinical managers (eye-rolling) and noticed that the doctors held court throughout the meeting. Members were involved and were attentive, polite and respectful of others throughout. The author witnessed a supportive environment and did not observe any conflict.

Attendance at these meetings enabled the author to observe group behaviour outside of the Network to gain a cultural perspective, albeit on a very small scale. Further observation would be required to provide a truly emic view of the cultures prevailing within the acute hospital Trusts in the Network.

Throughout the interview process, participants spoke of the culture of the Network. Several narratives arose which suggest that doctors engage more readily in the Network than in their Trust as outlined in the following section.

5.5.2   Engaging in a network culture

D1-CC02 NF2	*"I think the Network, the Network to me, well for starters, it's detached from your employer, so to speak, in that sense so you are there as a representative but I think the Network, to my mind much clearer, can show the stepwise progression to whatever the set aim is.* *… It needs, in a sense, the Network Director equivalent to ultimately make certain things happen with using completely different tools, language, law, whatever advice which has nothing to do with the expert clinician manager and I think that's where the Network has got that fairly unique interface."*
D1-CC02 NF4	*"I think it's, it's a forum where I think that is the right mixture between being informal enough to be able to express what you want to express so it's not intimidating. I think it does – well, it's almost sort of I would say, it's got its unique style to conduct business, so it's a constructive way and to <uhm> certainly look for engagement, certainly embrace <uhm> ideas and implement them, more importantly so listening in the first instance, but then I think actioning them, I think that's the most important thing is the principle that something gets identified and you can be very, very confident that it will be embraced.* *Are you treated the same as that elsewhere?* *No. I don't think so. I think the Network, as I said, that's sort of behind that word unique, in that it's that formal-informal structure, the way it runs so it's the – I think it's the thoroughness, it's the preparedness, it's the reliability of meetings, minutes. It's all of those aspects. But then sort of married to another aspect of probably reflected in the Network conference, where it is – <uhm> there is a human side, there is an appreciation side to that which I think very often in any of the other sort of exposure in the Trust doesn't come into it. I don't quite know. It comes very much from high up. … it comes sort of, but it's not tangible, it's not experience-able.* *It's there, maybe because it's a different size organisation and so*

	forth. I think there are some attempt. to do that. But I think in the Network, it's there for real. And I think it has developed, I think that's the other, that it is a dynamic <uhm> institution ....<uhm> I think also, I think it's, it's more truly multidisciplinary in that sense as well."
D2-CC05 NF7	*"...The Network is useful, because I think it's quite, patient focussed, but equality of access focussed and it's a useful lever for me so that I'm fairly comfortable that if you go to [hospital] you get the same level of care if you go into [hospital] if you're going to [hospital] if you go into [hospital] if you go into [hospital] …* *…so personally …sharing work, sharing ideas, bouncing ideas, shared operating procedures <pause> I think it's good for the trainees because they rotate round and the same things are happening everywhere…* *[in the Trust] People play their cards close their chest and keep stuff to themselves, so surgery for instance, …..so people behave that way because they want to be top dog but whereas in the Network it's more about everybody wants to be top dog… the Network tends to foster much more of the view that in order for you win somebody doesn't have to lose.* *So do you actually feel you learn anything when you come to the Network then?* *<uhm> well, I mean it depends on the context …. you learn different ways of doing things … <uhm> You learn that there are opportunities that you hadn't thought of hitherto ….you learn that you can simultaneously disempower and empower in a positive way …* *So by the same token, then what do you learn in your Trust?* *Mostly I would say doctors within a Trust learn to keep their heads down because you don't want to put your head over the parapet because someone will take a shot at it…"*
D2-CC05 NF9	*"… a lot of the doctors are very well engaged with the Network and they are less engaged within their acute trusts* *Can you expand on that please?* *There is much more of a manager/doctor split …* *<uhm> I think the Network comes together for a common purpose. Whereas sometimes the Trust managers in general they have a slightly different agenda…*

	*So I will engage if I can see a patient benefit …within the Network, that had been the driver from the word go. So the first thing that really engaged people in the Network was the transfer trolleys ….and the transfer protocols and the transfer training because we all knew that we were [expletive] at transfers and we had all this stuff from the ICS saying how [expletive] we were at transfers and everyone saw here was a sublime opportunity to improve our transfer capacity capability to the benefit of patients, but also for staff benefit and so everyone **immediately** engaged and all the other engagement that we have had in the Network has kind of fed off that… if there is stuff within the Trust that has a clear patient benefit, then I will engage with it…"*
D3-CC01 NF19	*"I think the culture of the Network encourages people to be engaged because I think it provides people with the opportunity to be involved, if they want to be. I think it's not a culture that puts people off, it isn't hierarchical. I don't think it does place unfair or unreasonable demands on people who are engaged and want to do stuff <uhm> and I think, you know, it's difficult to quantify it, but it's almost like, it's almost it's actually quite good fun. And I don't know how you sort of quantify that as a behavioural or a cultural thing. But actually, I quite enjoy coming to Network meetings and you almost think actually, I'd miss that sort of camaraderie and sort of humour, and I guess some of it is about being with like-minded people as well, isn't it. You sit in a room and actually most of the people who come to Network meetings, are there because they do want to do the right thing, they want to do the right thing for patients and sometimes it's quite nice to just get a chance to spend a couple of hours with other people who sort of feel the same as you do. And you're not having to constantly have those battles because you talk about stuff that's actually useful and meaningful …* *So Yeah, I think culturally, but again, it's difficult, isn't it because when you're very engaged in something, I guess your view of it does change and whether, I don't know, whether everybody would see it that way or they're going to see it differently. I mean, I guess as a complete outsider you could come into one of our meetings and go "actually, that's a bit intimidating" because clearly everybody knows each other and if you're used to meetings that were much more formal, you might go, "oh, it's all a bit", you know, and there's lots of in-jokes and, nobody seems, everybody is quite prepared to have a bit of a go at each other and if you didn't understand the culture and the behaviours, coming in as a complete outsider, you could go, "oh, my God, what's going on in this room?".*

D10-CC05 NF35	*"The thing is in the Network, the difference somehow is the Network feels like it's for us <uhm> and it's for the doctors and the nurses and you're in your role, so as more of a servant of that, rather than the boss who we are your servants and therefore, that changes everything, <uhm> so that brings engagement because the Network is what, we can get out of it, it's a good thing, but what it can give to us and working together synergistically can bring <uhm> and your role is to facilitate <uhm> us doing our job better, not whether there is some sort of, it often feels in other, it's also you're small and you can be lean and you can be responsive... Within the Trust, nothing feels very responsive, you get a good idea, you have every confidence that if we came to you with a good idea, we'd have a chat and then it would happen. Whereas there is no confidence in that and because – and you don't even know, you don't even know who can make a decision in the hospital <uhm> … it's very difficult to get decisions made because there's many competing factors, I think that's where the Networks – but I think it's a big thing about who's serving who and that perception.* *<uhm> I think that's where the Network, yeah, it feels like it's for us, whereas the hospital, it feels like we're employees of the hospital and you know, I think there is something in that management model as well between the doctor and the managers and the way we make decisions, I think that's powerful."*
D11-CC05 NF39	*"…There's lot of cloak and dagger in the Trust, there is a lot of feeling of hidden agendas, things that they are planning, you know that you've got no say or voice in. <uhm> with the Network, it seems to be transparent, helpful, open, and honest… but I'm nervous just because of the size, because we have a very large Trust ... So I don't know if it's just because of the size and that's why we feel that we don't know we don't have power <uhm> whereas the Network, we know most of the people in the Network …* *I think it's the, it's not about the learning, it's about we see other consultants from other Trusts, even if it's once a year that we see them at the Network conference and if you see people, the more we see them, most of the time the more you trust them, the more you trust them, and the more you work well with them… You know and I think that's a very good forum to have, so people can see each other, have a discussion, it's the social part of the Network that I think is very important. If you don't have that, I think you lose quite a lot as a whole."*

These narratives suggest that participants engage in the Network because it demonstrates achievement. There is a suggestion that the discussions in the Network are helpful, transparent, honest and frank. The Network appears to offer a safe environment for doctors to share their expertise and knowledge and operates within a collaborative culture with shared leadership and responsibility.

There is a suggestion that the Network offers a unique interface between garnering the expert clinical opinion and implementing ideas, and the narratives indicate that the Network Director acts as a translator between the clinical and management settings. These accounts suggest that participants perceive that the Network provides the right balance between a formal and informal culture, allowing members the opportunity to share ideas and express opinion without intimidation, and thus providing them with the confidence that their ideas will be embraced and implemented.

The narratives indicate that the leadership of the Network facilitates debate in a non-confrontational manner giving credibility to the value of the Network and there is a suggestion that the administrative structures add to the reliability of the Network as an organisation. There is a perception that there is a total lack of leadership in aspects of some of the Trusts where issues remain unresolved and people run out of energy. One participant describes the role of the Network Director as a "*servant of*" the Network which they suggest changes everything and influences the culture and brings about engagement.

These accounts reveal that participants consider that they are treated differently in the Network to the way they are treated in other organisations. They suggest that the Network is a multidisciplinary, organic, dynamic organisation with clear tangible elements and several of the narratives recognise a perceived importance of the social aspects of the Network. Additionally the Network is perceived to be patient focussed, providing equity of care for critically ill patients in the region. These accounts suggest that the Network embraces engagement, that it is an empowering and listening organisation and participants reveal that they feel valued in the Network. Additionally, there is a suggestion that participants perceive that there is something powerful between the doctor/manager relationships in the Network in the way that decisions are

made and enacted to deliver improved patient care. These narratives indicate that The Network is made up of like-minded individuals and that it is focussed on critical care, which appears to impact the engagement of critical care clinicians who are all basically doing the same thing with the same endpoint. There is however a perception that, by the very nature of the Network, members form a close group which to some people, might make the Network appear cliquey.

There is an indication that the culture of some of the Trusts is less inclusive and less transparent and the narratives suggest that people keep things to themselves and there is a hint of rivalry and of hidden agendas within the Trusts. There is a suggestion that the culture within some of the Trusts is not as constructive, innovative or creative as the Network culture, although there is a recognition that there are far more competing factors within the Trusts, which it is proposed makes it more difficult to get things done. A few participants indicate that doctors are more cautious in their Trusts because the Trust is their employer and advise that they learn to keep their heads down for fear of being "*shot at*".

The collection of narratives describe a Network that is cohesive and focussed with a clear aim and reveal that there is more of a disconnect in the Trusts with different and competing agendas. Whilst these narratives are suggestive of why doctors choose to engage in the Network, doctors clearly indicate that they choose to engage in the Network when they see a benefit for themselves and their patients.

The essence of this research is to gain a doctor perspective of the engagement experience in order to ascertain why doctors choose to engage in the management and leadership of the NHS. In indicating that they are engaged in the work of the Network, participants were given the opportunity to describe what the engagement experience feels like for them as senior doctors working in the Network and in the NHS.

5.5.3 Doctors describing what engagement feels like

D1-CC02	*"Well, it makes me feel, <uhm> well, <uhm> happy so a bit… but what it doesn't make me feel is less frustrated as in the NHS, so it*

	is constructive, it gives me to some degree a buzz <uhm> you know it's a sort of positive power…I think it's very satisfying in a sense or it's <uhm> – yeah, I think there is a sort of element of pride … I think it's not a chore, it's something you, yeah, you want to do."
D2-CC05	*"If you talk about it with a sort of Rogerian [Carl Rogers] person centred thing, the thing that motivates people is unconditional positive regard. Okay so you make them feel good about themselves and **engagement** makes them feel good about themselves because they get feedback they give feedback and they feel part of the process…. We all want to be on the winning team…. We all want to belong…"*
D3-CC01	*"…<uhm> when you're properly engaged, <uhm> yeah, it's quite rewarding because I think, you know you do get a sense that you are contributing, you do get a sense that your knowledge and expertise, whatever it is, is being heard and is being respected, and is being put to good use. It feels useful, it doesn't feel like you're wasting your time…<uhm> it's not a quite warm and fuzzy feeling, is it?, but it's a, you know, I think, if you've been involved in something at where you've been well engaged, you can walk away from that and say "I think that was a useful use of my time, a useful use of my knowledge and expertise"*
D7-CC02	*"It's kind of, it's an opportunity to actually be involved with a group of people who are similarly as involved as you are and are as keen and enthusiastic as you are and it's a feeling of sort of mutually working towards a slightly nebulous aim which is the betterment of all the hospitals and the units, but also the betterment of the hospital that you work in**…**, it is self-gratification, but it's self-gratification because you don't get it in everyday life in the NHS which I think is why Sue, it's so pleasant to be involved in and actually it's sort of an arena where the end objective is always about improving patient outcome, patient care, patient safety, quality of care."*
D8-CC02	*"I think to be engaged makes you feel valuable. To be engaged - in fact, turning around if I wasn't engaged I'd feel insulted, to go that far, because, well, I would feel that that my experience – <uhm> that I like many others would like to share experiences of what I think has gone well or what things haven't gone well and I'd like to learn from others on what they feel has gone well and what hasn't gone well, and I think as a clinician when you're established you need to do that - that is the next step, isn't it? …so, it makes you feel involved, it invigorates your passion for what you're doing …*

	So, I think it gives you that feeling of professionalism, value, involvement yeah."
D9-CC05	*"Good, good, positive. That's if you like, the sense of being engaged makes everyone feel better and, whether or not it would make a difference, I don't know, but it's worth us trying, worth putting a bit of effort into it and doing that…"*
D10-CC05	*"… it feels like community and it feels like influence <uhm> and it feels yeah belonging as part of community, that's what those words that may give when you're engaged, feels like family. It's part of, you to take that even stronger than the word community and feel this is where you belong, this is your family, and this is what you are part of."*
D11-CC05	*"It's good. If engagement works well, I think it decreases stress, increases productivity, …it also benchmarks you and I think that's quite important so and you don't feel as isolated and I think that you can drive standards up and if you can drive standards up, it's good for the patients."*

Through these narratives, participants perceive that positive engagement gives them a sense of satisfaction and pride and that engaging is something that they choose to do. There is a suggestion that to be engaged makes participants feel valued, and that it decreases stress and increases productivity. Participants talk of "positive power" and "positive regard" and suggest that engagement makes people feel good about themselves, particularly when they are involved and are able to influence. There is a suggestion that engagement is rewarding, especially when doctors consider that their expertise is being heard and that they are being respected as a result, which links back to the positive regard. This appears to be important for senior doctors, who consider that they have reached the top of their profession, and who therefore gain a perceived benefit in sharing their own expertise and in learning from other similar colleagues. This level of personal and professional support is suggestive of why doctors choose to engage in the Network.

Several of the narratives indicate that engagement offers participants the opportunity to be involved and reveal that they choose to engage often with groups of like-minded people. Participants suggest that in choosing to engage in the Network, that they gain self-gratification, particularly

when their involvement leads to improved patient care. The Network appears to provide a collaborative engagement where participants perceive that in belonging they gain a sense of community and there is even a suggestion that the Network "*feels like family*". This is a very powerful descriptor for a work environment, which reveals a shift from a professional to a personal benefit. Participants provide many descriptors to define what the engagement experience feels like and indicate that they gain a sense of pride and a sense of belonging, that they feel respected and valued and that in being involved they gain a sense of contributing to improve patient outcomes, safety and care.

Figure 15 illustrates the author's perceived cycle of engagement where involvement often leads to engagement and empowerment. The model illustrates that disengagement may occur at any time during the cycle as doctors need to continually see a compelling reason to choose to be involved and engaged. The narrative accounts suggest that doctors are more likely to choose to engage where they see a perceived benefit in terms of improved patient care.

FIGURE 15 - CYCLE OF ENGAGEMENT
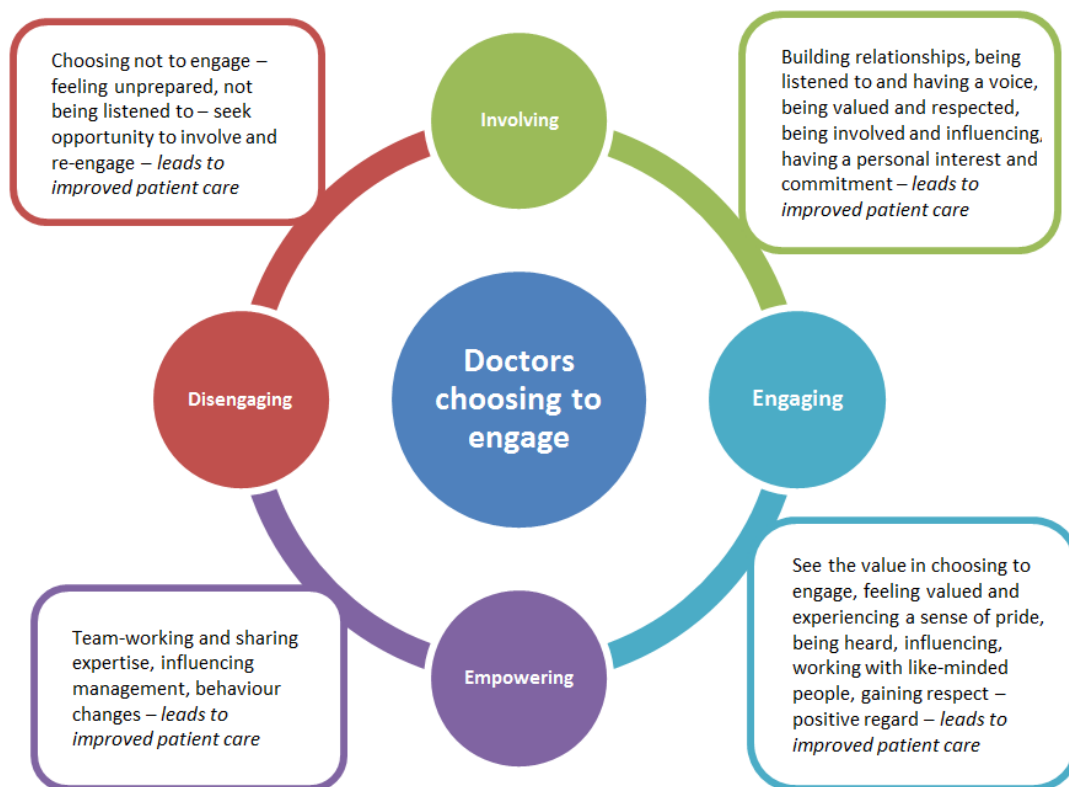
Throughout this research study, participants identified improved patient care as a prime reason that influences their choice of engagement and this is explored further in the following section.

5.6   Improving Patient Care

Improving patient care was a theme that was prevalent in earlier qualitative and quantitative research (Shepherd, 2013) where participants suggested that the Network is deemed to work if it improves the experience and outcomes for patients. Similarly, at this stage of the research, participants revealed that they are more likely to engage in the management and leadership of the NHS if they are able to influence and improve patient care:

"... you won't change the clinical services unless you engage doctors."

"...because the doctors were engaged…it is doctors' behaviour that changes patients' outcomes ….largely…"

"I mean I don't think you can run – you can't run the NHS well, and the NHS won't deliver the good services to patients if it doesn't have clinicians, doctors, nurses, all the sorts of clinicians involved in the way the organisations are being run and managed."

"If I can see there is a patient benefit I'll be engaged, if I can't, I'll just tune out …"

"If I can see a patient benefit …that had been the driver from the word go."

This to a large extent explains why doctors more readily choose to engage in the work of the Network. The aim of the Network is to provide equal access to the same level of care for all critically ill patients in the Region in order to improve the experience and outcomes for patients. The network model facilitates the bringing together of multi-professional, multi-disciplinary staff working within the field of critical care to decide the best pathway of care for the agreed patient population. Clinicians come together and agree a set of key objectives, benchmarking measures and outcomes for patients and, through the Network, are able to influence the development of patient care and the improvement of clinical services. The Network promotes an honest and open culture and provides an environment for clinicians to work collaboratively fostering a sense of

togetherness and sense of belonging, encouraging comradeship and the formation of sound relationships. Previous qualitative research (Shepherd, 2012) revealed that the Network achieves the desired outcome for participants as the Network demonstrates clear evidence of improved patient care and safety. At this stage of the study, participants indicate that they are more likely to choose to engage when they can see clear benefits for patients. During the interview process, the author asked participants to share an example of when engagement has worked well and not so well in both the Network and the participants' Trusts. The purpose of this line of enquiry was to generate narrative accounts for analysis although, as previously explained, during this line of enquiry, participants gave a more objective account of events, which did not easily facilitate the generation of narrative. What did arise from analysis of these accounts however, was the identification of descriptive codes generated from the examples offered as illustrated in Figure 16.

FIGURE 16 - DESCRIPTIVE CODE TO DESCRIBE ENGAGEMENT WORKING WELL AND NOT SO WELL

EXAMPLE ENGAGEMENT WORKING WELL		
PARTICIPANT'S TRUST	**THE NETWORK**	
Adopts Network Ethos	Achieving	Listening
Being enthused	Added Value	Multi-disciplinary
Being interested	Adptable	Network as a living breathing thing
Being involved	Benchmarking	Network has an Overview
Evolution of engagement	Caring	Non-competitive
Fighting for a common cause	Choice	Non-threatening
Having control	Cohesion	Positive
Having influence	Collaborative	Power
Leadership	Decreases stress	Pride
Multidisciplinary	Delivering	Promoting good practice
Patient Benefit	Development	Reaffirnment of knowledge
Power-vacuum	Dynamic	Reassurance
Teamwork	Encouraging	Relationships
	Engaging	Respectful
	Enthusiasm	Responsive
	Expertise	Satisfying
	Facilitative	Shared Common Purpose
	"Flagship"	Sharing
	Honest	Summative
	Improved Patient Care	Support
	Increases productivity	Team Working
	Influencing	Translator
	Informative	Trust
	Involved	Uniqueness
	It's fabulous	Unite
	Knowing what you are doing is right	Usefulness
	Leadership	Valuable
	Lean	Working Together

EXAMPLE ENGAGEMENT WORKING NOT SO WELL		
PARTICIPANT'S TRUST		**THE NETWORK**
Absolute shambles	Lack of education	Competition
Agnostic	Lack of influence	Disappointed
Antagonistic	Lack of Respect	Disengaged
Anti-organisation	Lack of service development	Feeling embarrassed
Bearing a grudge	Management are taking over	Feeling of regret
Being ignored	Not having a voice	Fighting
Breakdown in communication	"not invented here"	Intertia
Change in behaviours	Not involved	Just adopt Network Policy
Costly	Not listened to	Lack of collaboration
Cultural change	Not positive	Lack of compromise
Denial	Not worried about patient risk	Missed opportunity
Disengaging	Nothing has changed	No shared view
Disrespectful	On-going battle	Not as engaged as could be
Don't want the hassle	People don't bother	Prejudiced opinions
Effect on patient care	Pointless	Time restraints
Engagement doesn't work well	Pressurised	Wanting to do better
Externally imposed solution	Resentment	
Fear	Supportive	
Frustration	System failure	
Issues difficult to address	The organisation is dreadful	
It makes no difference	Things became unpleasant	
It's endemic	Utilitarian	
It's more confused	Working in silos	

Through these examples, the author was able to, firstly identify descriptive codes and secondly sort the codes by those most frequently used. These are highlighted in orange in Figure 16 and reflect the themes that arose out of the interviews and narratives described in the previous section in terms of factors for positive engagement. The coding demonstrates that doctors perceive that engagement works well when there is evidence of their involvement and of teamwork. Participants gave examples of where they perceived that engagement works well in the Network and identified, collaboration, engagement, involvement, pride, relationships, sharing, support, benchmarking, value and working together as key factors of good engagement, leading to promoting good practice and improved patient care, which is in congruence with the factors that arose from the narrative accounts described in earlier sections of this study. In terms of sharing an example where engagement works less well, participants mentioned frustration, not being involved and not being listened to as key factors in the Trust examples, but interestingly cited feeling embarrassed as the most prominent factor where engagement has worked less well in a Network which suggests a personal and shared ownership of the problem. It is interesting to note that, in the examples given, participants easily identified more examples of where engagement worked well in a Network environment and where it worked less well in a Trust environment.

During the analysis process, the author identified several triggers and cues for positive engagement as outlined in the following section.

5.7   Triggers and Cues for Engagement

Not surprisingly, many of the triggers and cues for engagement identified by participants fall within the concepts already described in terms of value, choice, involvement, pride, excitement, listening, giving and receiving feedback and patient benefit. Participants identified that they want to be able to see tangible results for their engagement and that they need to feel that they are being engaged for genuine reasons.   It is suggested that clinical managers need to have the time for their management role and that there needs to be a recognition by clinicians and managers for adequate preparation in readiness for a role in NHS management. Participants highlighted a lack of knowledge in terms of how the NHS is structured at a local and national level and indicated that they might

choose to engage more readily if they understood some of the fundamentals of the business and had a better understanding of how to navigate the system.

One participant suggested that the best engagement from Consultants that he had observed arose when the Consultants perceived that a decision that was going to be made was something that posed a personal threat to them or potentially to their service. This is clarified in the following extract;

"If you wanted to fill a room with every single consultant, make an announcement about consultant car parking. That was probably the best engagement in terms of numbers of people and level of debate that we ever had, was when our previous Director of Facilities said he was going to close all the consultant car parks and that the consultants could park in the other car parks with the rest of the staff.

And actually, interestingly, all the consultants went "it's dreadful, we'll never be able to find anywhere to park", actually, there wasn't enough consultant car parking for all the consultants, so the consultant car parks were often full. So [name] had either got to make more consultant car parking and take car parking off the rest of the staff to do that, or just go, "I tell you what, you're just going to have….", and actually, you know, they said, "look, we're going to redo all the barriers, we're going to make sure everybody who should have a card has one, but make sure that people who shouldn't have cards don't" and actually now you can always get parked. Car parking is a 100 times better than it was when we had separate consultant car parks. But it caused absolute outrage. You could have a meeting that said we're going to close the hospital and you wouldn't get that many people in the room."

To the author, this reinforces choice of engagement for personal effect. Throughout this stage of the research study, a number of key themes have emerged in respect of why doctors choose to engage. Previous qualitative research identified engagement as a key concept outlined in the conceptual framework and, in undertaking this stage of the study, the author has refined this aspect of the conceptual framework as outlined in the following section.

5.8   The Conceptual Framework – Choosing to Engage

An explanation of the various stages of the development of the conceptual framework has already been described in Section 2.4 and the revised framework illustrated at Figure 17 relates to the research questions identified at this stage of the research (Section 1.3). This gives meaning to research participants' perspectives of why they choose to engage. It identifies the key concepts that have emerged from the data analysis and draws the relationships between these.

The framework illustrates that in choosing to engage, doctors either engage in management (The engaged doctor) or choose not to engage in management (The reluctant manager) and recognises the impact of external factors, which in this instance relate to internal and external conflict and creating a culture for engagement. A number of emergent themes as already outlined underpins each of these key concepts. This study has demonstrated that doctors choose to engage when their engagement leads to an improvement in the experience and outcomes for critically ill patients which gives meaning to their engagement. This links to the key outcomes from earlier qualitative and quantitative research and an arrow demonstrates the relationship between engagement and improved patient care.

FIGURE 17 - REVISED CONCEPTUAL FRAMEWORK FOLLOWING RESEARCH PROCESS
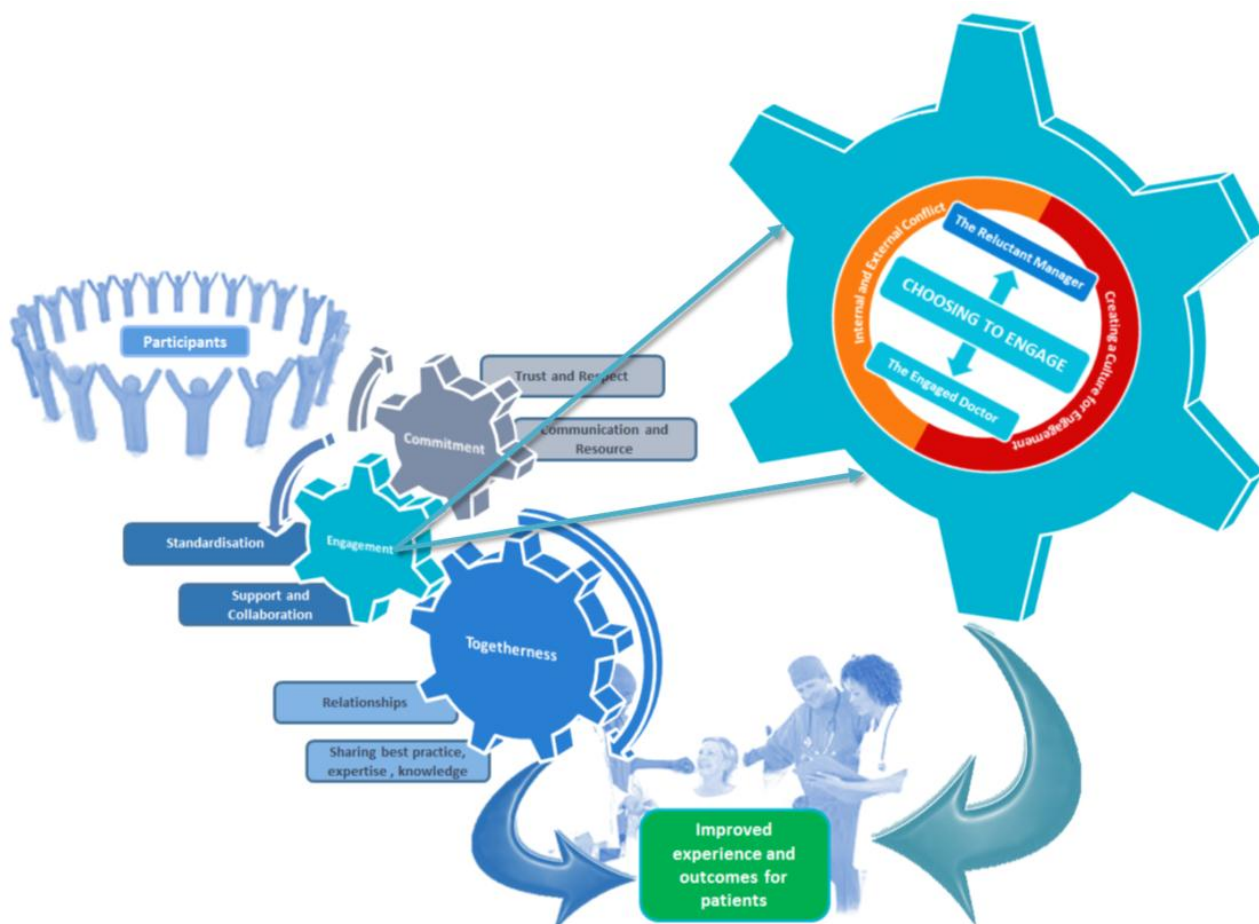
SUMMARY OF CHAPTER 5

This Chapter explored the research findings from the perception of research participants. Systematic data analysis facilitated the identification of patterns and relationships in the data and the description of outcomes through a number of key concepts. This enabled a logical sequence of enquiry. The extraction of narratives from the data aided meaningful enquiry, as participants' accounts and experiences were analysed for interpretation and meaning. In many instances, the collection of stories added to the richness of the data, enabling key concepts to be explored from a number of different angles, thus recognising the multiple realities of the social context akin with the constructionist perspective.

The findings from this Chapter describe the research participants' perspectives of the engagement experience, and the final Chapter provides a summary of the key research findings linked to the research questions and the literature, concluding this research study.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

This final Chapter presents the author's interpretation of the key outcomes from this study. These are compared to recent literature on engaging doctors and conclusions are drawn from the outcomes. A number of recommendations for the future are included as well as suggestions for further research. A summary of key outcomes from this study is provided in tabular form in Appendix 13.

6.1 Introduction

This study is concerned with social and organisational issues associated with why doctors choose to engage in a clinical network in order to inform the wider debate around why doctors choose to engage in the management and leadership of the NHS. This research has garnered opinion from doctors in terms of what makes them choose to engage and has told the doctor story through narrative accounts. The importance of the subject was explored in Chapter 1 in terms of why doctors should be engaged in a modern day NHS, and this Chapter compares the findings from this study to current relevant literature on doctor engagement.

6.2 Conclusions

The purpose of this research study is to explore how doctors explain and make sense of their engagement in a clinical network to inform a strategy for engaging doctors in the management and leadership of the NHS. This research has determined the requirement for engaging doctors, and through the development of the conceptual framework, has identified factors that influence doctors' choice of engagement. The findings from this research indicate that choice of engagement leads to both the engaged doctor, and the reluctant manager, and has highlighted that choice of engagement is influenced by a perceived internal and external conflict. Exploring why doctors choose to engage in a clinical network has confirmed the requirement to create a culture for engagement and identified that successful engagement leads to improved patient care, a factor that has been constant throughout this research study.

Requirement for engaging doctors

As already determined, the positive contribution of doctors to the management and leadership of the NHS is widely recognised (House of Commons, 2013; Department of Health, 2001; 2004; 2013; Darzi, 2008; UK Coalition Government, 2012; Ellins and Ham, 2009). It is suggested that doctors have a clear understanding of the day-to-day workings of the health service and that the basis for engaging doctors in the management and leadership of the NHS, is to inform the political agenda and to influence patient care and outcomes (Bohmer, 2012). This focus on patient care and outcomes presents a reason for some of the perceived conflict between doctors and managers highlighted in this research, particularly where doctors might suspect that managers are more concerned with the financial priorities of the service. Over the years, there have been many attempts to involve and engage doctors in the management structures of the NHS, particularly in terms of improvement and change programmes (Darzi, 2008), and this research has confirmed that doctors choose whether to be involved and engaged or not.

This study has established that all participants are engaged in the Network and endorses the requirement to engage doctors. Data obtained through the survey questionnaire confirms that research participants demonstrate a high level of engagement in the Network. There is a level of debate regarding the measurability of engagement (MacLeod and Clark, 2009) and a number of tools are available to measure levels of engagement. The Medical Engagement Scale (MES) has been introduced in to the NHS (Atkinson *et al*., 2011) as part of the Enhancing Engagement in Medical Leadership project, a UK-wide initiative undertaken jointly by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement (Hamilton *et al*., 2008). This programme aims to create a culture where doctors are more engaged in the health system in which they work, although findings from this research revealed that none of the research participants had, at the time of interview, heard of the MES. The MES is designed to assess medical engagement in management and leadership in NHS organisations and the scale differentiates between personal and organisational factors for engagement, something that has been highlighted in this research. Results from top performing Trusts applying the MES were utilised to identify factors for engagement and in congruence with the findings from this research, the outcomes demonstrated that medical engagement takes time and that disengagement can be sudden and impulsive. Additionally and again in congruence with the results of this study, all organisations acknowledged

that they faced challenges from internal and external forces and there was a recognition that understanding why clinicians engage is important so that resources can be deployed effectively to generate engagement. The importance of generating an environment that promotes and fosters effective relationships, managerial stability, provision of management training and understanding of a common goal as factors for positive engagement is recognised (Atkinson *et al.*, 2011) which again support the results of this study. Findings from this study indicate that engagement is not something that can be forced, and that people generally need to have a compelling reason to make them choose to engage and the author therefore asserts that with this choice comes both engagement and disengagement.

Choosing to engage

There is a suggestion that participants perceive that clinicians are best placed to be able to say how the NHS should be run and the results from this research confirm that they consider that this just does not happen. Participants suggest that they are often bystanders to a frustrating process where decisions are made that affect patient care without their involvement, although how much of this is real, and how much is perceived, is a question for further debate, as the author observes that the opportunities for engagement appear to be there should doctors choose to be involved. This research presents a number of narratives through which doctors make sense of their choosing to engage. It appears to the author that the landscape has, and continues, to change at a rapid pace and findings from this research indicate that the doctor voice in management is not as powerful as it once was. Additionally, this research has recognised that choice of engagement can be influenced by historical factors and fuelled by previous frustrations, particularly where doctors might perceive that they do not have a voice and are therefore unable to influence decisions.

It is suggested that engagement is a two-way process between the organisation and the employee and that employees have a choice in their engagement (MacLeod and Clark, 2009; Scottish Executive Social Research, 2007). This point is reinforced by Ellins and Ham (2009, p.24) who assert that engagement is characterised as a "*two-way relationship between employer and employee*" and suggest that the relational process occurs as employers strive to engage their workforce and employees choose the level at which they are willing to be engaged. Organisations have a responsibility to lead and encourage engagement (Scottish Executive Social Research, 2007) and this study reveals a

number of factors that influence the positive engagement of doctors in a clinical network.

This study acknowledges evidence suggesting that doctors should be engaged in the management and leadership of the NHS and findings reveal that not all doctors want to undertake clinical management roles. Furthermore, findings from this study highlight a group of doctors who, it is suggested, deliver the clinical service and choose to have no involvement in the management of the NHS. A report by The Royal College of Physicians (2005) proposes that doctors participating in clinical and managerial roles is an important aspect of medical professionalism and that this should be encouraged. Outcomes from this research indicate that doctors have a choice whether to engage or not and the author proposes that in exercising this choice, doctors exert a level of power. Clinical and non-clinical managers might therefore want to identify strategies to utilise this power to positive effect, based around a common desire to improve patient care.

A review of the literature has revealed that doctors have historically held a position of power and control in the management of health care (Reinersten, *et al*, 2007; Berwick, 1994; Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2013). Reinertsen *et al.* (2007) recognise that doctors generate business through their operational practice and create operating costs and assert that very little happens in the health care system without the authority of doctors. Findings from this research indicate that participants perceive that their power base is being threatened as managers in the NHS have the autonomy to make decisions that affect patient care, often without their input. Additionally this research reveals that doctors are not really sure where the power sits in the modern day NHS and that they are no longer convinced that it sits with them as a professional body. This indicates a huge shift as the power base transfers from the profession to the organisation and implies a potential change in the nature of medicine as a specialty. Findings from this research infer that all decisions that managers make are bad and the author asserts that, in telling themselves this story, doctors compensate for their loss of control, as when things go wrong, they can absolve themselves of any responsibility. It is advocated that the practice of medicine is distinguished by "*the need for judgement in the face of uncertainty*" and that doctors take responsibility for their decisions and any emergent consequences (Royal College of Physicians, 2005). Revisiting the literature has established that doctors are

accountable in the clinical environment; this is what they are trained for and where their expertise lies (Rosen and Dewar, 2004; Ham and Dickinson, 2008), and this research suggests that participants are more than used to working in a tightly governed clinical environment where they are answerable for their actions. This research also indicates that doctors want the best for patients, and that having to take accountability in the management environment does not always sit comfortably with doctors who may not want to take responsibility for the financial and resource implications of the very service that they are trying to deliver. This research therefore highlights a clinical/manager dichotomy for doctors as a factor that influences their choice of engagement in management.

This research suggests that doctors are selective about their choice of engagement and indicates that if they do not have a belief in the value of the work that they are involved in, that they are unlikely to stay involved and engaged in that aspect of their work. The author proposes that this reveals that doctors consider that they have the power to engage or disengage at will, which again gives some indication of their perceived sense of power and control in terms of their choice of engagement. In some respects therefore, the stories that doctors tell themselves regarding their engagement in the management and leadership of the NHS, justify the position that they want (or choose) to take, particularly if the position is that they do not want to be involved (or engaged), where involved would have been; involved but not actually prepared for management.

Findings from this research reveal that doctors choose to engage in management for a number of different reasons. This is either for self-interest or personal gain, for the kudos that doctors perceive their engagement affords them, to maintain the status quo or because they have a vested interest or think that it is the right thing to do and believe in it, or because they want to be involved and engaged to make a difference for patients. Additionally there is a perception that some doctors might choose not to engage in the management of the NHS because they find themselves undertaking tasks that they themselves would not choose to do. The author, however considers this to be a poor excuse as all job roles contain elements that the job holder might not enjoy undertaking and advocates therefore that there is a deeper reason why doctors will choose not to engage in clinical management, for example a lack of management skills as indicated in the research findings.

Elements of this research determine that participants consider that doctors sit at opposing ends of an engagement scale. The findings reveal that, at one end of the scale are doctors who suggest that they are "engaged out" and as a consequence suffer from "engagement overload", and that at the other end of the scale, are doctors who are disillusioned with what they suggest, are thinly veiled attempts at engagement, leading to the view that they are not engaged with enough. The suggestion of engagement overload is seemingly underpinned by a perception that non-clinical and clinical managers (although primarily non-clinical) attempt to engage all of the doctors, all of the time, in every aspect of health care that requires change. Findings from this research reveal that participants perceive that the NHS is not clinically led and that doctors are not engaged. Whilst the author appreciates that the feeling of "not engaged" is genuine for doctors, findings from this research suggest that doctors have been engaged with, but that where they have not been able to influence change or "get their own way" as a result of this engagement, that they choose to perceive this as "not having been engaged with". In taking this stance, doctors can free themselves of any responsibility, which might suit them, particularly when they do not agree with decisions made by managers or where they are faced with an impossible situation. This research has also highlighted that, whilst it is important to get doctors involved and engaged in the management of the NHS, not all doctors need to be, or should be engaged in management (particularly when they do not agree with decisions and exert their right to be disruptive or obstructive), but that rather the right doctors should be engaged with at the right time, over the right issues. This is a powerful finding from this research as there is a perception in the NHS that all doctors should be engaged with. The NHS operates within the right care principles to maximise value for patients. These principles state that patients should receive "the right care, in the right place, at the right time" (NHS Right Care, 2015). The author suggests that these principles could be applied to doctor engagement such that the NHS engages with "the right doctors, in the right place, at the right time".

Choosing to engage – The engaged doctor

This research suggests that doctors gain a number of perceived benefits when they choose to engage. Participants reveal that choosing to engage for doctors is about power and recognition, being trusted, valued and respected, being listened to and having a voice, being involved and influencing, being supported and being safe in the care that they deliver as individual practising clinicians and also through the collective knowledge of the Network that influences their

practice. Networking requires an element of trust and respect, although earlier research (Shepherd, 2012) demonstrates that trust has to be earned, a finding that is reiterated by Hunter (2001).

All participants advise that they are engaged in the Network; they were selected for this study based on their level of engagement and as a consequence this study has explored the engagement experience. MacLeod and Clark (2009) propose that engaged employees experience job satisfaction, organisational commitment, job involvement and feelings of empowerment. They also suggest that workforce performance determines organisational success and that gaining an understanding of the relationship between employees and their employer is a key to unlocking productivity and to subsequently transforming the working lives of employees. MacLeod and Clark (2009, p4) also assert that employee engagement enables a two-way relationship between leaders and managers, and employees, leading to achievement of the organisational goals, for example improved patient care and that, in organisations where production is standardised, employee engagement "*is* the difference that *makes* the difference". This research has revealed what the engagement experience feels like for doctors and participants suggest that engagement feels good, that it is satisfying and that it gives them a sense of pride. Additionally participants revealed that engagement is a rewarding and pleasant experience and that to them engagement feels "like family". In being engaged, participants indicate that they feel that they are being heard and respected, that they are being listened to and that their expertise is being used. They describe a sense of being valued and of being involved and that they gain a sense that they are contributing. Above all they describe a feeling of positive regard and that when they are engaged this is good for patients. Whilst the stories that doctors tell themselves about their engagement justify their desire to belong, they express a greater need for doctors to feel that they are being heard and respected and that their expertise and knowledge is being used and is valuable. This describes their need to be involved.

The findings from this research suggest that doctors choose to engage when they consider that they are listened to and have a voice and that in being involved, they are able to influence the management process. For participants, this research reveals that engagement therefore means being valued and respected and that in being engaged, doctors can influence patient care. Ellins and Ham (2009) concede that the strongest driver for staff engagement in the NHS is a

sense of being valued and involved and this research indicates that where doctors perceive that they are not involved in the decision-making process, they are less likely to choose to engage. Likewise, Clark (2012a, p.4) propose that securing greater engagement of doctors will "*almost certainly create the sort of organisational culture where all staff feel valued and involved*". This research study, however suggests that doctors will choose to engage where they perceive that they are valued and are involved, the difference therefore is that Clark (2012a) identifies being valued and involved as the **effect** of engagement, whereas this research confirms being valued and involved as the **cause** of engagement. The author proposes that doctor involvement is therefore about choice and influence. Findings from this study imply a link between engagement and value in that, where participants do not see either that they as individuals are valued, or that there is a value in that management, they are less likely to choose to engage. Participants specify that they see a value in the Network and therefore choose to engage in the work of the Network.

The findings from this study reveal that doctors want to be included in the decision making process and based on the results, it is evident that a lot of the time they want to be making the decisions. This research has revealed that there is a perception that where doctors are not involved in management, that this is detrimental to patient care which places patients as the victims of the situation. Through the narratives, there is however also an indication that doctors themselves are sometimes the victims, which the author proposes might be a convenient perception, particularly when things go wrong, reinforcing doctors' perceptions of managers as the "baddies". Additionally, the research has highlighted mutual respect as a factor for engagement suggesting that clinical managers need to demonstrate clinical credibility in order to gain the respect of their colleagues. This research highlights a relationship between mutual respect and positive regard, although through the narratives, there is an indication that doctors often perceive non-clinical managers as the antagonists, which could create some of this positive regard.

The findings indicate an element of recognition for doctors in being engaged and this correlates with results from a study on doctor engagement where participants revealed that recognition of their efforts, feeling supported and being appreciated underpinned their engagement (Snell, Briscoe and Dickson, 2001) The author suggests that this reveals an inherent need for doctors to be recognised. This research reveals a perception that doctors are intelligent beings who are

recognised for their academic abilities and achievements throughout their secondary and medical school education, and for their expertise as they progress their medical careers. From her experience, the author suggests that doctors work hard to achieve their doctor status and that they are rewarded for their hard work when they qualify as doctors. This research suggests that they are recognised by their peers as being a part of an elitist group and by their patients as being "godlike" (medical gods), capable of restoring good health.

This research has clearly demonstrated a number of benefits associated with engaging doctors in the management and leadership of the NHS, however, it has also confirmed a number of factors that influence their choice of disengagement.

Choosing to engage – The reluctant manager

A key aspect of the findings from this research relates to a perceived lack of preparation for doctors in management, which it is suggested influences doctors' choice of engagement. Bohmer (2012, p.22) acknowledges that many doctors describe themselves as "*accidental leaders*" who stumble into management with no formal training and lack of training support is recognised as causing a particular challenge for medical leaders (Bohmer, 2012; Mountford and Webb, 2009).

The results from this research highlight that where doctors are unprepared for management, they are likely to develop their own style of management, which participants suggest introduces a level of variation into the management environment. Participants indicate that doctors are prepared for their clinical role with both adequate training and experience and are therefore likely to defend their clinical practice with almost lion-type aggression. This research reveals that participants indicate however that they will gladly discard their clinical management role if they do not feel that they are properly equipped to undertake this role to the standard that they would want. The role of consultant carries with it a level of managerial responsibility and so these results suggest a contradiction between being a manager in the clinical field, and being a manager in the management field. Additionally, these findings determine that participants consider that the health care system is too complicated to navigate and that this, in itself affects doctor engagement in the system.

It is recognised that many doctors consider that the political and cultural environment of health is disabling for their profession and that, as the political

and health care landscape, and public and patient expectations have changed, so too has the position of doctors within the social order (Royal College of Physicians, 2005). Doctors today are expected to be up-to-date on current medical information, technology and treatments to manage patient conditions and advise on preventative strategies. In addition, they are expected to be up to date on national NHS policy and procedure, regional guidance and local implementation plans and to navigate their way through what research participants describe as the "treacle" of NHS bureaucracy, to understand commissioning, purchasing directives and financial incentives.

The research reveals that participants perceive management to be a foreign environment with a different language, something which Nicol (2012) proposes heightens antagonism between clinicians and managers. Doctors are renowned in the health service for talking a different language, the language of medicine (Llewellyn, 2001), and so, whilst participants might perceive that management presents a different language for doctors, this is considered by the author to be much less difficult than the medical discourse spoken by doctors, which in turn managers have to interpret in the management environment. Llewellyn (2001) asserts that doctors and managers have different experiential backgrounds and thus, different frames for sense making, which adds to confusion arising from the different use of language. Doctors are therefore faced with an additional dilemma in today's NHS. Trained in medicine, many doctors are expected to traverse to the field of management. Bohmer (2012, p.4) proposes that doctors are ambivalent about taking on leadership roles and attributes this to a "*sense of disenfranchisement*" and a "*suspicion of the motivations of NHS managers*". For some senior doctors therefore, convincing themselves that they are not prepared for management might actually be a coping strategy that, when repeatedly told through a story becomes reality and helps them accept the dilemma of unpreparedness. In this respect, these narratives become myths that act as palliative care for doctors in order to make the problem less severe or intense. Palliative care in a medical sense gives an extra layer of support; it is about achieving the best quality of life for patients with serious illness. In the context of these research findings, palliative care is care that doctors give themselves (through the use of narratives) to help them cope with these difficult issues. The more they tell the story, the more likely the myth becomes a perceived reality.

This research has demonstrated that participants indicate that they are not prepared for management. The author however considers, doctors to be

intelligent beings and participants themselves have indicated a perception of their intelligence quotient through a number of narratives. The author suggests that it is therefore likely that an element of this perception that "doctors are not prepared for management" is a convenient cover up and shifting of responsibility for doctors' own inadequacies within the management environment. This research has however also revealed that the world of medicine and medical training does not prepare doctors for management. Whilst many skills are transferable between jobs, these different professions require a different set of skills. Edwards, Kornacki and Silversin (2002) recognise the requirement to better equip doctors for taking on management and leadership roles and suggest that much more needs to be done earlier in medical careers. This research suggests that doctors are trained to "get it right first time" and indicates that the risks of getting it wrong are great in terms of patient care. The author proposes that for doctors who have worked hard to get to the top of their profession and who are confident and competent in their clinical role, being less confident in a management position is likely to sit less comfortably with them and might explain why some doctors choose to escape management as highlighted in these research findings. In order to more actively involve doctors in the future in the planning, delivery and transformation of health services, the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement have jointly developed the Medical Leadership Competency Framework (MLCF), which describes the intrinsic leadership role of doctors within health care services (Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement, 2010). The framework supports the concept of shared leadership whereby leadership is not restricted to those who hold designated leadership roles and is designed around 5 key concepts for delivery the service; demonstrating personal qualities, working with others, managing services, improving services and setting direction. Three main career stages have been identified and used throughout the MLCF; up to the end of undergraduate and postgraduate training and up to 5 years or equivalent continuing practice. Whilst this framework might therefore better prepare doctors for leadership positions in the future, it does not address the perceived gap identified by research participants in this study; in other words, there is a large body of senior consultants already in the system who have a gap in their management and leadership skills and knowledge, which affects their choice of engagement in the management and leadership of the NHS. Whilst the author appreciates that the MLCF complements the NHS Leadership Qualities Framework (LQF) developed as a tool for senior managers in the NHS (NHS Institute for Innovation and Improvement, 2006) and might therefore facilitate the

development of better leadership skills for doctors and better working relationships with clinical and non-clinical colleagues, it is obviously very doctor-centric and therefore does not address some of the elements identified by research participants in this study that influence their choice of engagement i.e. doctor-manager conflict, where the perceived conflict sits with the manager. Although this obviously addresses a current gap for doctors, it does not address a gap in terms of providing a generic framework for all staff. This gap was later recognised by the NHS Leadership Academy as the NHS LQF has since been superseded by a revised NHS Leadership Framework designed for all staff working in health care (NHS Leadership Academy, 2011). Norris *et al.* (2005) suggest a number of barriers that prevent professionals working together for example culture, professional norms and rivalry. They identify that no studies have investigated what skills are important to enhance collaboration between professionals and whether there are any associated training needs. Likewise the author has identified a requirement in terms of skills required in engaging doctors in management. It is to be noted that training needs might vary according to individuals not necessarily related to their profession. The author would argue that skills in management and networking are not the same as those required for engagement and management. When looking at personal and behavioural qualities (albeit in terms of leadership), Kirkhaug (2010) suggests that professional employees are often pre-equipped with values and norms during their professional training that are akin to those of the organisation., This research has however confirmed that doctors perceive a difference between the clinical and management environments intrinsic in the NHS.

This research suggests that doctors measure success by improved patient care and that they consider that the complexity of the system and of managers in the system often affects this, leading to frustration and disengagement from the system.   It indicates that doctors are often well placed to deal with the complexities of the system as they have an overview of the clinical environment. The author suggests that the convergence of the clinical and management pathways however, could be at the root of the problem and as this research has revealed, doctors who are expected to cross the line into management are often unprepared for the challenges and complexity of this environment. A greater influencer in terms of choice of engagement might therefore be around the confusion that this research highlights. Doctors are expected to undertake management and leadership responsibilities in the NHS (General Medical Council, 2012), but participants perceive that they do not have the appropriate

training. They are trained to care for the individual patient and their training does not equip them to manage the whole system, which it is suggested inevitably leads to stress and frustration (Edwards, Kornacki and Silversin, 2002). They are expected to manage in the clinical and managerial environment but there is no real indication of what this means in terms of purpose, influence or performance. Bohmer (2012) discusses the issue of confusion recognising that there is no real clear indication of whether doctors are expected to lead at the highest level of the system or at the interface with patients and whether the requirement is for doctors to lead change or to assure the performance of the organisations. In part, this very confusion, along with the perceived skill gap, might provide doctors with the perfect excuse to escape, or avoid management should they choose to do so. Participants suggest that doctors inherently want to do good for their patients, and this research has revealed that some participants consider that placing doctors in the management environment presents them with a dilemma should they be perceived as the "baddie". Revealing that they are not prepared for management might therefore be a convenient ploy for them not wanting to get involved in management decisions and in them consequently not having to take responsibility for the things, which are therefore out of their control, i.e. the enforcement of national directives and financial incentives.

Findings from this research suggest that doctors' choice of engagement is influenced by a level of internal and external conflict.

Factors influencing engagement - internal and external conflict

This research reveals that barriers to doctor engagement hinge around internal and external conflict and a lack of preparedness for the management role. It also suggests that doctors are competitive and use their status as a position of power and that they are suspicious of management where they perceive hidden agendas giving rise to conflict.

Through the use of narratives, findings from this research identify different areas of conflict that doctors perceive arise in their dealings with management, namely doctor and manager conflict, doctor and doctor conflict and doctors as managers conflict. The findings reveal a number of heroes and villains within the concept of this perceived conflict. When doctors talk of doctor and manager conflict, the heroes are other clinical managers and doctors who support them. The villains and enemies are described as managers, including other clinical managers and it is the patients who are perceived as the victims, unless clinical managers are

disrespecting the non-clinical managers, in which case they are perceived as the victims. Doctor/doctor conflict gives rise to other doctors as the villains and, in this instance, doctors suggest that the clinical managers who manage in adversity become the heroes. Within the context of doctor/doctor conflict however, clinical managers who come under attack, or who become unpopular with medical colleagues also become the victims. Doctors as managers conflict, cites other doctors as the villains. In some respects, the construction of villains creates a positive regard for doctors, whereby they gain respect in difficult circumstances and it is possible that an element of this conflict is manufactured in order for doctors to gain collaborative advantage.

Findings from this research indicate that doctors perceive that clinicians have the monopoly on patient care and that managers are therefore not in a position to interfere and should certainly not make decisions that affect patients, without consulting the clinical opinion. Doctors care for their patients and are concerned about patient safety and this research reveals that sometimes doctors think that management decisions are dangerous, which gives rise to some of the doctor/manager conflict. Findings reveal a perception that management should not make decisions that directly affect patient care, although the author suggests that many management decisions influence patient care at a strategic level, which doctors might not always appreciate. This research also indicates that as doctors move up the hierarchy of the clinical management structure, there appears to be a greater appreciation of the management role, in terms of difficulty and strategy which results in a better relationship between the doctors and managers. The relationship between health managers, who oversee the distribution of resources, and doctors, who set the standards against which these resources are targeted, is recognised as one of the most important of all relationships in any modern health system (Royal College of Physicians, 2005; Ross Baker and Denis, 2011) and there is a recognition that a disconnect between doctors and managers contributes to failures in health care (Hamilton *et al.*, 2008). This research suggests that a solution to this problem is for clinicians to work with management to help them see the clinical picture, and for management to listen to doctors and to include them in the decision making process. Additionally, the findings from this research indicate that participants seem to value clinical managers above non-clinical managers and several participants suggested that the author has clinical insight and therefore presumed that she has a clinical background. The author suspects therefore that this research has revealed that clinical credibility equals respect.

Throughout this research, participants have repeatedly revealed the competitive nature of doctors and therefore it would appear that, given the number of times that participants suggest this, they perceive that doctors are competitive and want to be the best at what they do. Whilst their education and medical training might prepare them to be the best doctor, it does not prepare them to be the best manager and so, as these findings indicate, where doctors find themselves "failing" in management they either do not pursue the management route and "give-up" or blame their lack of achievement on a lack of preparedness. This research has revealed that the challenge is to harness this competitiveness into the management field, because if doctors are competitive by nature, then this would suggest that they will strive to be competitive in management and will want to perform well and offers the potential to produce high performing organisations. Findings reveal that doctors engage in the work of the Network and it is interesting therefore that the Network culture is non-competitive and that participants recognise equality in membership. This research indicates however that participants engage in the Network because they want to do the best for critically ill patients, which suggests that the Network has reached the point of success and that as a result, patients win, doctors win and managers win.

This research has revealed that in choosing to engage in clinical management, participants perceive that doctors put themselves in an unpopular position with medical colleagues and non-clinical managers alike often finding themselves in a position where they make decisions which will be unpopular and often being in a no-win situation whereby they are seen to have a bias by the clinicians to management or by management to the clinicians. In this instance, there is a suggestion that doctors do not fit well in either camp and participants reveal that as managers they are considered by some colleagues to have "gone over to the dark side". This concept is recognised by Dickinson *et al.* (2013) who identify doctor relationships with managers as a barrier to medical leadership which includes the negative perceptions of doctors who are perceived to go over to the dark side when they take on management or leadership roles. Clark (2012b) however asserts that doctors are moving away from the dark side as they take on more formal management and leadership roles and suggests therefore that clinical managers are moving to centre stage. This research however demonstrates that clinical managers still have some way to go before they are totally accepted as both clinicians and managers by clinical colleagues.

Findings from this research indicate that doctors and managers experience levels of conflict in the management of the NHS and the author suggests that both groups need to come together and work cohesively for the benefit of patients. This view is echoed by Reasbeck (2008) who proposes that the perceived imbalance of power between doctors and managers is becoming more pronounced and that there is a requirement to create more effective working relationships between doctors and managers. Kirkhaug (2010) advises that in professional organisations, members are more likely to work collaboratively and support each other where there is a high level of collegiality enabling the group to cope with uncertainties that they may come across in their work. Additionally Kirkhaug (2010) reflects on the work undertaken by Schein (1994) where he argues that groups are effective when they perform complex, interdependent tasks together to generate new and creative ideas and where they socialise and train together. Ham and Dickinson (2008) assert that collegial influences depend on the credibility of professionals at their core and this research confirms that the Network is a collegiate body which influences the positive engagement of doctors.

Greening (2012) is a practising doctor who gives her personal view of how to improve the effective engagement of doctors in clinical leadership and cites many concepts to enhance engagement that are similar to the outcomes of this study. She concludes that doctors receive little management training, which she asserts has led to internal and external conflict and possibly a contributing factor to lack of clinical engagement.

This research indicates that managers need clinical insight and that doctors bring the clinical view to inform management. The author asserts therefore that doctors need to frame the issues in a way that lends itself to a management solution and suggests that this recognition provides a potential for both doctors and managers to change the narrative to provide this solution.

Factors influencing engagement – creating a culture for engagement

It is proposed that understanding factors that influence management in health care organisations is crucial for creating environments in which clinicians can develop the skills necessary to become effective managers (Spehar, Frich and Kjekshus, 2012). This research has confirmed that doctors engage in the Network and has demonstrated that the culture of the Network influences this engagement.

Findings from the research suggest that the Network is a self-organising group and that engagement occurs because there is less bureaucracy enabling easier application of things that matter to its members. The Network is an agile evolving organisation that is more simplistic in its structure than participant member organisations. Earlier research (Shepherd, 2012) has revealed that the value of the Network is embedded in human factors, that is what gives it its culture, and that the Network is reliant on relationships, without the members there is no Network. Gaining and maintaining the engagement of participant members is therefore crucial for the existence of the Network (Shepherd, 2012). From her experience of working across organisational boundaries, the author recognises that organisations have their own cultures, language and practices and power differences and suggests that working collaboratively in a network demands a compromise between members and member organisations and an appreciation of competing Trust priorities.

The findings from this research indicate that participants claim ownership of the Network and that in being engaged in the Network, doctors gain a sense of colleagueship and togetherness. It is suggested that companies experience an increase in productivity when employee ownership is introduced and, within the NHS, the Government supports a form of ownership through the implementation of Foundation Trusts and social enterprises (Ellins and Ham, 2009). The Network is a collaborative of staff working in the field of intensive care medicine. Participant members have the opportunity to work with managers in the Network to set the strategic direction of the Network and to operationalise plans. Findings from this research indicate that participants do this because they see specific benefits for themselves and for their patients. The author considers that the Network model is in this respect similar to a (non-financial) model of a co-operative, run jointly by its members to create value for its patients. This research confirms that the Network is a place where staff can escape the rigors of their employing organisations. These organisations are subject to stringent targets, performance measures and a greater level of hierarchical control and as these organisations strive to operate within the bounds of NHS reforms, micro-management from within, affects staff motivation and morale (Ellins and Ham, 2009). This research alludes to these tight controls when participants advise that they are being closely judged and scrutinised, and suggest that this affects their inclination, or disinclination, to engage in their Trust management structures. An element of this choice could however relate to doctors desire for more freedom

than they consider they are afforded, which may give rise to some of the perceived conflict. Findings from this research indicate that the Network offers doctors refuge from the rigors of daily life and that the Network is a place where they are regarded as equals, and where they can gain a mutual satisfaction in the knowledge that they share a similar view of the world of critical care and of the, at times, hostile world beyond.

This research reveals a unique social [human] side to the Network and confirms that participants perceive that the Network has teeth even though it has no formal power. Research findings reveal that the power is in the collective expertise which enables organisations outside of the Network to get an informed and often evidence based view on an area of health care to effect change efficiently and effectively. Findings also suggest that for doctors in the Network, choosing to engage is about delivering safe quality patient care. Furthermore, this research reveals that the Network provides a safety net as participants indicate that doctors have the support of Network colleagues and the backing of a collegiate body. This research has confirmed that the Network is a virtual organisation but that it is there for doctors to share expertise and knowledge, for support when things go right and when things go wrong and that it is a place where doctors learn from each other and in doing so prevent incidents and promote improved patient care. Participants suggest that critical care clinicians have a unique understanding and appreciation of their specialty and that they make difficult, life changing decisions on a daily basis. One participant described critical care as "*a funny specialty in that we want to do the best for patients but we dehumanise them – you can feel very isolated because of that… when we get our patients they are very often already unconscious or they become unconscious very quickly. Contact with relatives is fairly stressed and we are not seeing them at a good place for them.*" This research has revealed that the Network engenders a safety culture, which is important for critical care. It is asserted that securing engagement requires a cultural change and that engagement requires a "*highly inclusive approach*" (Clark, 2012a, p.4). Likewise, it is recognised that enhanced engagement is a cultural issue for organisation which needs constant support (Hamilton, *et al.*, 2008). Kirkhaug (2010) determines that for an organisation to become efficient it needs to address both the external and internal environments and that the better the internal structures and processes fit the needs of the employees, the more likely they are to conform to the objectives of the organisation. Through this research, participants have revealed that the Network provides evidence of clinically led services as the culture facilitates a flexible

approach, which enables clinically driven imperatives to be evaluated and implemented to improve patient care. Furthermore it suggests that the Network structure and culture enables less bureaucracy in terms of process, judgement and implementation, which in turn generates a high level of clinical engagement and fosters the development of positive relationships. Ferlie *et al.* (2010) distinguish these value led, supportive attributes as important lateral leadership traits and recognise the important role of the clinical manager in joining the professions. Additionally Ferlie *et al.* (2010, p30) refer to the "*wicked problems*" in health policy and propose that the network model of health care facilitates collaborative work to address these problems   According to Hunter (2001) these wicked issues are often complex in nature with no clear solution and are better solved where agencies and professionals work in partnership.   Likewise, Edwards (2002) suggests that the multifaceted patterns of relationships providing possible solutions for tackling difficult issues and ways around obstructions. Hudson (2000) suggests that a joined-up approach to problem solving is seen as essential and it is suggested that whilst some networks have a diverse membership ranging across a number of specialties (Sheaff *et al.*, 2011), specialty specific clinical networks are more likely to attract clinicians from within the network specialty.

The final stage of this research study has determined that medical engagement in the Network is dependent on a number of different factors, both organisational and individual.   Organisational engagement is likely where the Network contributes to the requirements of the organisation for example, providing an overview of regional capacity requirements and individual engagement is likely where personal interests or opinions are met (Sheaff *et al.*, 2011). Effective clinical networks are characterised by high levels of clinical engagement and sound personal and organisational relationships creating high levels of trust between members who together shape the network for patient benefit (Shepherd, 2012). This research indicates that in choosing to engage in the work of the Network, doctors gain a sense of togetherness and collaborative advantage. They develop sound relationships and come together to share and to offer and gain support. The findings reveal that doctors view the Network as a power base that provides a place where they have a voice, where they are listened to and where they can influence. It suggests that doctors no longer perceive that they have any power in their Trust where managers make the decisions and that by joining together in the Network they become a powerful collaborative voice. This research identifies that the culture of the Network facilitates this, as participants

perceive that the power base rests with the clinicians and indicates that the author is a servant of the Network to facilitate delivery of the clinical vision. Findings suggest that the Network listens and thatit gives doctors the voice that they so badly want because up until now, doctors have had a voice. In some respects, the findings that arise from this research suggest that the Network strokes doctors egos, it is their specialty base and area of expertise, it speaks their language, is their collective forum, their escape, their support, their safety net, their Arcadia. This research suggests that the Network is a non-competitive environment on both a personal and organisational basis, with no competing agendas and indicates that it does not expect too much from doctors or place unreasonable demands on them. Participants reveal that the Network provides an environment where there is no market competition, which they suggest is unlike hospital Trusts which operate in an open market environment. This research has revealed that the Network gives doctors back some of the power that they feel they have lost, it recognises their specialty and knowledge and skills, and their area of expertise for the benefit of all their patients and so in their eyes it really works which enforces their choice of engagement in the Network. It further reveals that doctors provide insight into the clinical arena and that, by choosing to engage in the work of the Network, doctors and managers together deliver an improved service for critically ill patients in the region. This research suggests that the Network provides the model that doctors are looking for; they come to the Network, exert their clinical opinion, and return to their Trusts to deliver patient care. Participants perceive that through the work of the Network their opinion is enacted and so they take ownership and drive implementation; they are involved, engaged and empowered. The author asserts that the Network genuinely holds the role of honest broker and research findings reveal that participants recognise this. Additionally, this study suggests that the Network gives all parties equal voice, with equal standing and strives for total equity and that as an honest broker, it is interested in what members do and engenders a culture of trust, faith, willingness to engage, sharing and giving and this research confirms the Network culture. This research indicates that the Network focus is on patient centred care and that the people who hold positions in the Network are the mouthpiece of the organisations that they represent. As indicated in earlier research (Shepherd, 2012) participant members are crucial to the success, or otherwise, of the Network, they influence stakeholder membership in terms of implementation and delivery. The Network relies on high levels of engagement for the operation and delivery of its objectives. Authority is given freely by member organisations, not because of their hierarchical position, but because of

their level of equity and there are little, if no political issues to grind at the Network level. This research, in exploring why doctors choose to engage, therefore provides an illustration of the reasons that doctors engage and make the Network the successful organisation that it is for improving care for critically ill patients.

This research has revealed that participants perceive that the Network works when it improves the experience and outcomes for patients and through this research, doctors have established that they choose to engage in the work of the Network if there is a benefit for patients. Therefore, the author purports that the reason doctors choose to engage in the Network and the reason the Network works is the same and this research has identified that doctors choose to engage in the work of the Network because it improves the experience and outcomes for patients.

Factors influencing engagement – Improving patient care

This research has revealed that a key to doctors' choice of involvement and engagement is in their ability to influence patient care. Patient care is at the heart of a modern day health service (Darzi, 2008; UK Coalition Government, 2012) all NHS staff have a duty of care to patients (Department of Health, 2013). Up until the introduction of general management in the NHS in the 1980s doctors were in charge of the decision making processes and therefore had an apparent power through which they were able to influence decisions for their patients (Rivett, 1998). Findings from this research suggest that Network members share a value commitment, to improve outcomes for patients, and work together as a supportive and cohesive group.

This study has established that there is an on-going interest in engaging doctors in the management and leadership of NHS organisations and has provided a unique view of the engagement experience from the perspective of doctors engaged in the work of a clinical network. Previous studies have resulted in a number of different frameworks for medical engagement, which focus on the more tangible elements of engagement for example, leadership, appointment processes, culture, clarification of roles and responsibilities, communication, professional behaviour, support and development. In exploring doctors' perceptions of the engagement experience however, this study identifies the more intangible elements of engagement and reveals that engagement occurs when doctors have a personal interest and commitment, when they feel that they

are listened to and have a voice, when they perceive that they are valued and respected, where they are involved and able to influence, where they have power and respect and where the environment that they work in fosters collaboration, facilitates the sharing of expertise and specialised knowledge and offers both personal and professional support leading to improved patient care.

Literature pertaining to doctor engagement recognises strategies for engagement and identifies a number of frameworks to facilitate the better engagement of both clinical and non-clinical staff in the NHS. The added value of this research is that it has explored the engagement experience from the perspective of senior doctors working in a clinical network and therefore connects the tangible and intangible elements of engagement and in offering a view of engagement through the other end of the telescope, provides a unique perspective to inform the medical engagement debate.

Finally, there is a need to determine whether the outcomes from this research address the research questions and the author concludes that there is clear evidence as to what makes doctors choose to engage in the Network and suggests that this study has evidenced how doctors give meaning and make sense of their engagement in the Network. Whilst the author appreciates that the structure of the Network organisation is much less complex in terms of the layers of administration than the layers within an acute hospital organisation, many of the findings can be used to aid other organisations in engaging doctors.

6.3   Recommendations

This research set out to explore how doctors explain and make sense of their choosing to engage in a clinical network. The research questions were designed to examine why doctors choose to engage in a clinical network in order to ascertain what is it about the Network that has engaged doctors. This research has clearly identified why doctors choose to engage and has explored the Network model in this context. A further aspect of the research identified some of the triggers and cues for engagement and explored if doctors engage more readily with a networked organisation and if so the reasons for this. Participants accounts are suggestive of their engagement in a networked model of health care and, in exploring the cultural aspects of the networked organisation, this research gives meaning to their engagement.

This study has described doctors' perceptions of the engagement experience via narrative accounts. It has confirmed to the author that doctors are inveterate story tellers. The solution to better engage doctors in the management and leadership of the NHS might therefore be to influence the narrative to change their behaviour as well as finding a common language to marry the discourse of clinical and non-clinical management. Reframing language for both clinicians and managers might lead to greater engagement, so instead of managers considering how they can engage doctors in the management environment, they might be better to consider how they can engage with the clinical environment. Outcomes from this research inform this debate.

This research concludes with a number of recommendations to enhance the choice of doctor engagement based on six key elements as illustrated in Figure 18.

FIGURE 18 - CHOOSING TO ENGAGE FOR IMPROVED PATIENT CARE

Being listened to and having a voice:
- Provide an environment for the doctor voice to be heard and demonstrate that doctors are listened to
- Create opportunities for engagement and allow the medical voice to be heard, paying attention to what doctors have to say
- Create a mechanism to ensure that the clinical voice is heard at the centre to direct the policy and vision of the NHS
- Communicate the clinical vision throughout the organisation

Being involved and influencing:
- Ensure that doctors are given the opportunity to be involved and engaged

- Involve doctors in deciding the vision for engagement and give doctors a compelling reason to engage
- Harness the competitive nature of doctors in a constructive way into management
- Deliver the clinical vision

Being valued and respected:

- Ensure that doctors and managers appreciate the professionalism of each group and value the contribution of each profession so that they can continue to work together to find a common ground and a common language for improving patient care
- Appreciate the requirement for different management and leadership styles and explore different models, where possible matching doctors to the right situation and environment for their style and approach enabling a flexible model of leadership
- Recognise the management role and clinical role and the role of clinical management
- Create opportunities for doctors to use their management and leadership skills in areas of management that interest them
- Connect the management and clinical environment by providing a forum for doctors to listen to clinical managers to enable them to gain an appreciation of the management role and a forum for managers to listen to doctors and provide an opportunity to reframe the narrative
- Encourage team working where clinicians and managers share skills and knowledge and work together for the benefit of patients
- Ensure that clinical engagement is genuinely valued and is constructive for the requirements of the service
- Ensure that doctors feel valued for their professionalism and expertise
- Include doctors in the decision making processes and set realistic targets/benchmarks based on quality of outcome
- Select the right leaders with the right skills for the right task at the right time
- Engage with "the right doctors, in the right place, at the right time".

Being supported and sharing

- Agree a process to prepare doctors for management. Tailor this to the individual doctor to ensure that they feel prepared. Monitor and maintain management skills appropriate to the job role and current NHS climate
- Generate a programme of clinical management training delivered by clinical and non-clinical managers working together
- Work with the relevant Medical Colleges to explore ways to strengthen medical management and inter-professional management training and education
- Encourage doctors to take responsibility for their management training
- Consider introducing a clinical/manager programme where together doctors and managers gain an appreciation of the clinical and management environment

- Support doctors in clinical management training and build management and training time in to clinical manager job plans
- Design a template advising of how the management functions of the hospital operate i.e. mechanism to develop a business case, who does what and introduce a process to ensure that this is current and relevant
- Ensure doctors are informed of the landscape of the NHS and that this is current
- Provide opportunities for potential clinical managers to shadow other senior managers and for exposure to the management environment
- Develop a programme of coaching and mentoring
- Find a mechanism for clinical managers to adapt some of their clinical skills to the management environment

Additionally this element includes:

Creating the right culture for engagement:
- Nurture a collaborative, open and honest culture where doctors have the opportunity to be involved and engaged and where they are supported
- Foster a culture of mutual respect between doctors and managers and create opportunities for sharing expertise and knowledge
- Create an organisational memory and mechanism for sustainability of key directives from conception to delivery
- Design a robust selection process for the appointment of clinical managers to identify the right kind of doctors for the role and maintain a process of succession planning for clinical managers of the future

Having a personal interest and commitment
- Offer doctors the opportunity to be involved in management
- Ensure doctors are engaged with when there is a genuine reason for engagement and where that engagement will be useful
- Avoid engagement overload
- Accept that not all doctors need to be engaged all of the time
- Engage the right doctors in the right situation at the right time

Valuing relationships and a sense of belonging
- Nurture joined up working between doctors and managers
- Nurture joined up working between primary and secondary care
- Create an environment for commissioners and providers to work more closely together
- Ensure that doctors recognise the skills of their non-clinical managers and their professionalism towards patients
- Develop a process to deliver clinically led management
- Ensure a mechanism to join up strategic decision making and operational implementation
- Help doctors to see that they bring the clinical view to management and help them frame issues in a way that lends itself to a management solution

- Develop a communication structure to inform staff at all levels of management decisions

6.4 The Contribution of the Research to Practice

This research study in its entirety has addressed elements of the social aspects of a critical care network and has provided insight into what participant members actually think about the Network, why they think it works and why doctors specifically choose to engage in the work of the Network. Awareness of the more intangible elements of the Network has provided insight into the effect that this has in terms of outcome and function of the Network and the impact that this has on patient care. Previous research into clinical networks has produced a bias towards the more tangible elements of these organisational models with a greater emphasis on structures and processes as determining factors of success and effectiveness. Likewise, research studies examining doctor engagement investigated at this stage of the study has focused on tangible outcomes for engagement and the findings from this research therefore inform the more intangible elements of the engagement experience, the values and beliefs that doctors attribute to their choice of engagement, from the perspective of senior doctors working in a clinical network. An exploration of the literature identified that not all doctors choose to engage, and exploring why doctors choose to engage has therefore offered a novel perspective of the engagement experience.

The author suggests that the unique contribution of this research to academic knowledge and to the health care sector is that, in using thematic and narrative analysis, this study offers a new theoretical understanding of the engagement experience from the perspective of senior doctors working in critical care network environment. In presenting an interpretive viewpoint, this research demonstrates that the Network structure facilitates doctors' choice of engagement and in contributing further empirical data on the subject of medical engagement, establishes the foundation of a new theoretical understanding, which invites further research. Findings from this study suggest that doctors are more likely to engage when a context is created which enables them to create meaningful stories which gives them a positive role [in the Network]. Through this research, the author has therefore discovered the things that contribute to the engagement experience, the things that make it worthwhile for doctors to engage. This novel understanding of the engagement experience, told by senior doctors through a series of narratives, has led to changes in the way that the author communicates

with doctors, and what is communicated, in order to more effectively secure medical engagement in practice. This research has therefore provided the author with new communication strategies that can be employed in order to better encourage doctor engagement.

This study gives an insight from the author as a senior manager working in the NHS, into the engagement experience for senior doctors working in the field of critical care medicine and engaged in the work of the Network, interpreted through the use of narrative accounts. It therefore gives a manager view point of the stories that doctors tell themselves to deal with difficult situations in respect of their experience of choosing to engage in the management and leadership of the NHS and offers a framework for doctor engagement. Gaining access to senior doctors is also a considerable achievement, as doctors to not normally engage so readily with social scientists.

The interpretivist approach to this qualitative research has enabled the author to seek knowledge within the uniqueness of a clinical network and has afforded the author the opportunity to understand the engagement experience from the perception of senior doctors working in the NHS. The process of analysis has provided a clear understanding of doctors' perceptions of engagement within the context of a critical care network and of the meanings that they attribute to their experiences.

This research did not set out to solve the problem of engaging doctors in the management and leadership of the NHS. It did however seek to explore why doctors choose to engage in a clinical network, and in doing so has contributed to the body of knowledge on medical engagement. As already noted, research examining clinical networks (Ferlie *et al*, 2010) suggests that the "*wicked problems*" in health policy are often best addressed through a networked model of care and the author suggests that this research addresses some of the "wicked problems" of doctor engagement. The research has offered a compelling case for doctor engagement and highlighted issues in engaging doctors in the management and leadership of the NHS. Furthermore, this study has presented the engagement experience using narratives and, as a senior manager in the NHS, has enabled the author to realise the potential benefit of creating a structure and context which enables doctors to construct a narrative which makes it easy for them to engage. The findings from this study could be utilised to

inform a strategy for engaging doctors in the future management and leadership of the NHS.

6.5 Scope for Further Research

In terms of generalizability, whilst this study reports the findings of a single case study within the context of a critical care network, this exploratory research process could be repeated within another clinical network to present a comparative study, or undertaken within any organisation seeking to discover why doctors choose to engage in the management and leadership of their organisation.

There is a call for clinical engagement, but little evidence of the engagement experience. The most effective way to build strategies for engagement is to learn from those who are engaged. This research is limited to why doctors choose to engage. A potential line of research could therefore be to explore why clinicians choose to engage. This would open up the scope of the study to incorporate views of the multi-professional workforce. This research could be undertaken in the same Network to provide a comparative study linking the outcomes from the different professions. The intent would be to understand the different perspectives of each profession to inform a strategy for wider clinical engagement in the management and leadership of the NHS.

An alternative investigation would be to apply the research methodology and methods to another critical care network, or other specialty ODN to provide a comparative study. Additionally, the research methodology and methods could be applied to any of the member Trusts to gain a perspective of doctor choice of engagement in the acute hospital sector.

A further area of research would be to explore the converse of why doctors choose to engage and research, why doctors choose *not* to engage in the management and leadership of the NHS. This would identify barriers to engagement and add to the body of knowledge on doctor engagement.

SUMMARY OF CHAPTER 6

The prime aim of this research study was to explore how doctors explain and make sense of their engagement with the Network in order to inform a future strategy for doctor engagement. This final Chapter presented the author's interpretation of the findings that arose from the analysis of the research data and drew conclusions from these interpretations. Through analysis and enquiry this Chapter reports the conclusions of this study to make sense of engagement from a medical perspective. Outcomes from this study are reported and are suggestive of why doctors choose to engage in the management and leadership of the NHS. This Chapter has confirmed that undertaking this research has given meaning to how participants' make sense of their engagement in a clinical network and has presented a series of recommendations and suggestions for further research.

CONCLUDING REMARKS AND CRITICAL REFLECTION

This study in its entirety has demonstrated the effectiveness of the Network as a collaborative, agile organisation and this stage of the study has revealed why doctors choose to engage in the work of the Network. Throughout the study, participants have recognised a sense of togetherness and of working collegially for a common purpose; to improve the experience and outcomes for critically ill patients. This research has demonstrated that by working together in a networked model of care, this aim can be realised and that patient care is improved as a result. The author opened this research document with a quote from Bronowski and, given the findings of this research, considers that this is a fitting way to end this document.

"... every man, every civilisation, has gone forward because of its engagement with what it has set itself to do. The personal commitment of a man to his skill, the intellectual commitment and the emotional commitment working together as one, ..." (Bronowski, 2011, p.330).

Learning through reflection – Author's reflections on Document 5

Document 5 presented me with an opportunity to further practise research skills of my choosing. I have always considered that I have a natural tendency to favour qualitative research, and reflected on the real enjoyment and satisfaction that I felt whilst undertaking quantitative research at Document 4. My natural tendencies however won through, and I could not resist the temptation to persuade colleagues to share their inner most thoughts with me further. As it happened, there was little persuasion required.

Critical reflection:
- **Write** – I am not sure why I found it so difficult to begin writing this document, but on reflection, I think I just needed a convincing reason to do so. This ensued following a supervisory meeting, as I realised the value of my subject both in the professional and academic field and for me as an individual – it was satisfying to appreciate that networks are still my passion.
- **Reflect** – Reflections from Document 3 confirmed my curious and inquisitive nature – this has not changed; I still relish the opportunity for further enquiry and find joy in the research process. In an attempt to push myself more however, I soon realised that undertaking a further phase of qualitative research was not going to be as easy as I first envisaged as I introduced new techniques and methods of analysis into the process.
- **Data overload** – In my attempt to ensure a systematic process of data collection and analysis, at some point in the process I disappeared under a mountain of information. I became almost obsessed with ensuring that all data was stored neatly for confidentiality and accessibility, but soon came to realise that my excessive handling of data was providing a useful distraction to the actual task required.
- **Avoidance** – My supervisors set me firmly on my path towards my analysis of the data and into what turned out to be the most enjoyable part of the research process – my journey of discovery.
- **Appreciate** – that I am not a machine and that it is normal to feel exhausted given the pressures of work, family life and excessive hours of study late into the night. Life is unpredictable, and sometimes major things come along that put paid to the best laid plans. I learnt that this journey is my journey and that the only person to put me under pressure, was me (*and at times my poor husband who has temporarily given me up to allow me to pursue my studies*).
- **Realise** – the time taken to collect and sort data, to code both manually and electronically and the time needed to learn new computer programmes to enable this to be undertaken efficiently.
- **Celebrate** – the fact that I have greatly improved my research skills as an academic researcher and as a health care professional and seek satisfaction in sharing the findings from my research.
- **Remember** – those who have sustained me on this journey; be grateful for their continued enthusiasm and support.
- **Incentives** – know that something great awaits the end of this journey.
- **New beginnings** – appreciate that this is not the end, but the beginning ...

REFERENCES

6, P., GOODWIN, N., PECK, E. and FREEMAN, T., 2006. *Managing Networks of Twenty-First Century Organisations.* Hampshire, UK: Palgrave Macmillan.

AAMODT, A.M., 1991. Ethnography and Epistemology: Generating Nursing Knowledge. In: J.M. MORSE, ed, *Qualitative Nursing Research. A Contemporary Dialogue.* Revised edn. USA: SAGE publications, pp. 40-53.

ACADEMY OF MEDICAL ROYAL COLLEGES AND THE NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT, July 2010. *Medical Leadership Competency Framework. Enhancing Engagement in Medical Leadership.* Third Edition. Coventry: NHS Institute for Innovation and Improvement.

ACADEMY OF MEDICAL ROYAL COLLEGES AND THE NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT, 2013-last update, Enhancing Engagement in Medical Leadership. Available:http://www.institute.nhs.uk/building_capability/enhancing _engagement/enhancing_engagement_in_medical_leadership.html[28February, 2015].

ADDICOTT, R., MCGIVERN, G. and FERLIE, E., 2006. Networks, Organizational Learning and Knowledge Management: NHS Cancer Networks. *Public Money & Management,* **26** (2), pp. 87-94.

ADDICOTT, R., MCGIVERN, G. and FERLIE, E., 2007. The Distortion of a Managerial Technique? The Case of Clinical Networks in UK Health Care. *British Journal of Management,* **18** (1), pp. 93-105.

ANDERSON, J.M., 1991. Chapter 2. The Phenomenological Perspective. In: J.M. MORSE, ed, *Qualitative Nursing Research – A Contemporary Dialogue.* California, USA: SAGE publications Inc, .

ATKINSON, S., SPURGEON, P., CLARK, J. and ARMIT, K., 2011. *Engaging Doctors: What can we learn from trusts with high levels of medical engagement?* Coventry: NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges.

AUSTRALIAN MEDICAL ASSOCIATION LTD, 2010. *Doctors' engagement in the management of hospitals.* Australian Medical Association Limited. Available https://ama.com.au/sites/default/files/documents/Doctors_engagement_in_the_manage ment_of_hospitals_Posit%25E2%2580%25A6.pdf [February 2014].

BAKER, C., 2002. *Managed clinical networks: a guide to implementation.* HCO 077. NHS Scotland.

BARBER, P., 2015-last update, Gestalt in Action. Available: http://www.gestaltinaction. com/about-gestalt [June, 2015].

BATE, S.P. and ROBERT, G., 2002. Knowledge Management and communities of practice in the private sector: lessons for modernising the National Health Service in England and Wales. *Public Administration,* **80** (4), pp. 643-663.

BERWICK, D., 1994. Eleven worthy aims of clinical leadership of health system reform. *The Journal of the American Medical Association,* **272**, pp. 797-802.

BLAIKIE, N., 1993. *Approaches to Social Enquiry.* Oxford, UK: Blackwell Publishers Ltd.

BOHMER, R., 2012. *The instrumental value of medical leadership.* London: The King's Fund.

BOWLING, A., 1997. *Research Methods in Health. Investigating Health and Health Services.* Buckingham: The Open University Press.

BREWER, J.D., 2000. *Ethnography.* Buckingham: Open University Press.

BRITISH SOCIOLOGICAL ASSOCIATION, March 2002-last update, Statement of Ethical Practice for the British Sociological Association. Available: http://www.britsoc.co.uk/media/27107/StatementofEthicalPractice.pdf [1 August 2012].

BRITTEN, N., 1996. Qualitative interviews in medical research. In: N. MAYS and C. POPE, eds, *Qualitative Research in Health Care.* London: BMJ Publishing Group, pp. 28-35.

BRONOWSKI, J., 2011. The Long Childhood. *The Ascent of Man.* Reading, UK: BBC Books, Edbury Publishing, pp. 330.

BROOME, B., GROTE, K., SCOTT, J., SUTARIA, S. and URBAN, P., 2013. Clinical operations excellence: Unlocking a hospital's true potential, *The post-reform health system: Meeting the challenges ahead* 2013, pp. 1-10. Available: http://healthcare.mckinsey.com/sites/default/files/MCK_Hosp_ClinOpExcellence.pdf

BROWN, B., AHMED-LITTLE, Y. and STANTON, E., 2012. Why we cannot afford not to engage junior doctors in NHS leadership. *Journal of the Royal Society of Medicine,* **105**, pp. 105-110.

BRYMAN, A. and BELL, E., 2007. *Business Research Methods.* Second edn. Oxford: Oxford University Press.

BUCHANAN, D., JORDAN, S., PRESTON, D. and SMITH, A., 1997. Doctor in the process. The engagement of clinical directors in hospital management. *Journal of Management in Medicine,* **11** (3), pp. 132-156.

BUGLEAR, J., 2007. *Quantitative Methods for Business. The A-Z of QM.* Oxford: Elsevier.

CALMAN, K. and HINE, D., 1995. *A policy framework for commissioning cancer services: A report by the Expert Advisory Group on Cancer to the Chief Medical officers of England and Wales.* 22293. London: Department of Health.

CAVILL, S., 2006. *A suggested framework for the self assurance of service delivery networks.* NHS Networks, Leicester.

CLARK, J., 2012a. *Medical Engagement. Too important to be left to chance.* London: The King's Fund.

CLARK, J., 2012b. Medical leadership and engagement: no longer an optional extra. *Journal of Health Organization and Management,* **26** (4), pp. 437-443.

CROTTY, M., 1998. *The Foundations of Social Research.* Australia: SAGE Publications Ltd.

CUNNINGHAM, F.C., RANMUTHUGALA, G., WESTBROOK, J., I. and BRAITHWAITE, J., 2012. Net benefits: assessing the effectiveness of clinical networks in Australia through qualitative methods. *Implementation Science*, **7**:108.

CURRIE, G., STARR, T., WHITE, L., DINGWALL, R., WATSON, A. and TRUEMAN, P., September 2010. *Comparative evaluation of children's services networks: Analysing professional, organisational and sector boundaries in Paediatric Nephrology, Children's Safeguarding and Cleft Lip and Palate Networks.* SDO 08/1718/149. HMSO.

DARZI, A., October 2007. *Our NHS our future. NHS Next Stage Review Interim Report.* 8857. London, England. NHS Next Stage Review Team, Department of Health.

DARZI, A., June 2008. *High Quality Care For All. NHS Next Stage Review Final Report.* 10106. London, England: Department of Health.

DEPARTMENT OF HEALTH, 2000. *Comprehensive Critical Care. A review of adult critical care services.* London: Department of Health.

DEPARTMENT OF HEALTH, July 2001. *Shifting the Balance of Power within the NHS - Securing Delivery.* London: Department of Health.

DEPARTMENT OF HEALTH, June 2004. *The NHS Improvement Plan. Putting People at the Heart of Public Services.* London: Department of Health.

DEPARTMENT OF HEALTH, April 2005. *Research Governance Framework for Health and Social Care.* Second edition, 4747. London, England: Crown.

DEPARTMENT OF HEALTH, 2011. *Governance arrangements for research committees . A harmonised edition.* 20 May. Leeds: Department of Health.

DEPARTMENT OF HEALTH, 26 March 2013. *The NHS Constitution the NHS belongs to us all.* Crown Copyright 2013. 2900013. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf [December 2014].

DEPARTMENT OF HEALTH, 2015-last update, Gov.UK - Department of Health Website. Available: https://www.gov.uk/government/organisations/department-of-health [January, 2015].

DEPARTMENT OF HEALTH, NHS MODERNISATION BOARD, March 2003. *The NHS Plan - a progress report.* 31115. London, England.

DEPARTMENT OF HEALTH and NHS EMPLOYERS, December 2013-last update, Engaging your staff. The NHS staff engagement resource. Available: http://www.nhsemployers.org/SiteCollectionDocuments/Staff%20engagement%20toolkit.pdf [2 April 2014].

DICKINSON, H., HAM, C., SNELLING, I. and SPURGEON P, April 2013. *Are We There Yet? Models of Medial Leadership and their effectiveness: An Exploratory Study.* Southampton: NHS National Institute for Health Research Service Delivery and Organisation Programme.

DICKINSON, H. and HAM, C., 2008. *Engaging Doctors in Leadership: Review of the Literature.* NHS Institute for Innovation and Improvement, Academy of Medical Royal Colleges, University of Birmingham.

DOYLE, A.C., 2015-last update, A Scandal in Bohemia. Available: http://sherlock-holm.es/stories/pdf/a4/1-sided/scan.pdf [February, 2015].

DRYDEN, J., 2001. *Selected Poems.* London: Penguin Group.

EBSCOHOST, Online Research Databases. Available: https://search.ebscohost.com/ September 2014].

EDWARDS, N., 2002. Clinical Networks. *British Medical Journal,* **324** (January 12), pp. 63.

EDWARDS, N. and FRASER, S.W., 2001. *Clinical Networks; a discussion paper.* London: The NHS Confederation.

EDWARDS, N., KORNACKI, M.J. and SILVERSIN, J., 2002. Unhappy doctors: what are the causes and what can be done? *British Medical Journal,* **324** (6 April).

ELLINS, J. and HAM, C., 2009. *NHS Mutual. Engaging staff and aligning incentives to achieve higher levels of performance.* London: The Nuffield Trust.

ELLIOTT, J., 2006. *Using Narrative in Social Research. Qualitative and Quantitative Approaches.* London: SAGE Publications Ltd.

ELLIOTT, R. and TIMULAK, L., 2005. Descriptive and interpretive approaches to qualitative research. In: J. MILES and P. GILBERT, eds, *A Handbook of Research methods for Clinical and Health Psychology.* New York: Oxford University Press, pp. 147-159.

EMERALD, Insight. Available: www.emeraldinsight.com [September 2014].

FERLIE, E., FITZGERALD, L., WOOD, M. and HAWKINS, C., 2005. The nonspread of innovations: the mediating role of professionals. *Academy of Management Journal,* **48**(1), pp. 117-134.

FERLIE, E., FITZGERALD, L., MCGIVERN, G., DOPSON, S. and EXWORTHY, M., February 2010. *Networks in Health Care: a Comparative Study of Their Management, Impact and Performance.* HMSO.

FERLIE, E., HAWKINS, C. and KEWELL, B., 2002. Managed networks within cancer services: an organisational perspective. In: R. JAMES and A. MILES, eds, *Managed Care Networks. Principles and practice.* London: Aesculapius Medical Press, pp. 1-15.

FERLIE, E. and PETTIGREW, A., 1996. Managing Through Networks: Some Issues and Implications for the NHS. *British Journal of Management,* **7** (1).

FETTERMAN, D.M., 1989. *Ethnography. Step-by-Step.* Newbury Park, CA: SAGE Publications Inc.

FISHER, C., 2007. *Researching and Writing a Dissertation. A guidebook for business students.* Second edn. Essex: Pearson Education Limited.

FORBES, T., HALLIER, J. and KELLY, L., 2004. Doctors as managers: investors and reluctants in a dual role. *Health Services Management Research,* **17**, pp. 167-176.

FRASER, S.W. and GREENHALGH, T., 2001. Coping with complexity: educating for capability. *British Medical Journal,* **323** (15 September), pp. 1-4.

GEERTZ, C., 1973. *The Interpretation of Cultures.* New York: Basic Books.

GENERAL MEDICAL COUNCIL, 2012. *Leadership and management for all doctors. Working with doctors. Working for patients.* Manchester. Available: http://www.gmc-uk.org/Leadership_and_management_for_all_doctors___English_1015.pdf_48903400. pdf [February 2015].

GILL, J. and JOHNSON, P., 2005. *Research Methods for Managers.* Third edn. London: SAGE Publications Ltd.

GOODWIN, N., 6, P., PECK, E., FREEMAN, T. and POSANER, R., 2004a. *Key lessons for network management in health care.* London: National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development.

GOODWIN, N., 6, P., PECK, E., FREEMAN, T. and POSANER, R., 2004b. *Managing Across Diverse Networks of Care: Lessons from Other Sectors.* London: National Co-ordinating Centre for NHS Service Delivery and Organisation R & D.

GORSKY, M., January 2013. 'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry. *Medical History,* **57** (1), pp. 87-107.

GREENING, J., 2012. How can we improve the effective engagement of doctors in clinical leadership? The view of a consultant psychiatrist. *Leadership in Health Services,* **25** (1), pp. 20-26.

GUBA, E. AND LINCOLN, Y., 1994. Competing Paradigms in Qualitative Research. In: DENZIN, N. AND LINCOLN, Y., ed, *Handbook of Qualitative Research.* London: SAGE, pp. 105-117.

GUTHRIE, B., DAVIES, H., GREIG, G., RUSHMER, R., ALTER, I., DUGUID, A., C OYLE, J., SUTTON, M., WILLIAMS, B., FARRAR, S. and CONNAGHAM, J., April 2010. *Delivering health care through managed clinical networks (MCNs): lessons from the North.* SDO 08/1518/103*,* HMSO.

HAINES, M., BROWN, B., CRAIG, J., D'ESTE, C., ELLIOTT, E., KLINEBERG, E., MCINNES, E., MIDDLETON, S., PAUL, C., REDMAN, S. and YANO, E.M., 2012. Determinants of successful clinical networks: the conceptual framework and study protocol. *Implementation Science,* **7**:16*.*

HAM, C., 2003. Improving the performance of health services: the role of clinical leadership. *The Lancet,* **7**:361.

HAM, C. and DICKINSON, H., 2008. *Engaging Doctors in Leadership: What we can learn from international experience and research evidence?* 9587. Coventry: NHS Institute for Innovation and Improvement.

HAMILTON, K.E.S., SULLIVAN, F.M., DONNANA, P.T., TAYLOR, R., IKENWILO, D., SCOTT, A., BAKER, C. and WYKE, S., 2005. A managed clinical network for cardiac services: set-up, operation and impact on patient care. *International Journal of Integrated Care,* **5** (September), pp. 1-13.

HAMILTON, P., SPURGEON, P., CLARK, J., DENT, J. and ARMIT, K., 2008. *Engaging Doctors. Can doctors influence organisational performance? Enhancing Engagement in Medical Leadership.* 10133. Coventry: NHS Institute for Innovation and Improvement.

HAMMICK, M., 1996. Managing the ethical process in research. In: R.A. BROWN and G. CASTLEDINE, eds, *Key Management Skills in Nursing.* UK: Quay Books Division, Mark Allen Publishing Limited, .

HINCHMAN, L.P. and HINCHMAN, S.K., 1997. Introduction. In: L.P. HINCHMAN and S.K. HINCHMAN, eds, *Memory, Identity, Community: The Idea of Narrative in the Human Sciences.* New York: State University of New York, pp. xiii-xxxii.

HOUSE OF COMMONS, 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volumes I, II and III (Chaired by Robert Francis QC).* HC898. London: The Stationery Office.

HUDSON, B., 2000. Inter-agency collaboration - a sceptical view. In: A. BRECHIN, H. BROWN and M.A. EBY, eds, *Critical Practice in Health and Social Care.* London: SAGE Publications Ltd, pp. 253-274.

HUNTER, D., 2001. 'Mind the gap!' Managing across boundaries. *British Journal of Health Care Management,* **7** (12), pp. 482-484.

HUSSEY, R., SILVERSIN, J. and KORNACKI, M., 2013. *Improving Healthcare White Paper Series - No.12. Doctors: Leaders of change. Overcoming the barriers that prevent clinicians from leading quality improvement.* Wales: GIG NHS CYMRU Wales, 1000 Lives Improvement.

HUSTLER, D., 2005. Chapter 1. Ethnography. In: B. SOMEKH and C. LEWIN, eds, *Research Methods in the Social Sciences.* London: SAGE Publications Ltd, pp. 16-23.

INTEGRATED RESEARCH APPLICATION SYSTEM (IRAS) VERSION 3.4, 27 October 2011-last update, Streamlining the Research Process. Available: https://www.myresearchproject.org.uk/ [1 August 2012].

JACKSON, P.M. and STAINSBY, L., January 2000. Managing Public Sector Networked Organizations. *Public Money & Management,* **20** (1).

JONES, M., 2013. *Document 5 - Thesis. Exploring Strategic Turnaround in English Local Authorities*, Nottingham Trent University.

KAHN, W. a., 1990. Psychological conditions of engagement and disengagement at work. *Academy of Management Journal,* **33** (4), pp. 692-724.

KAISSI, A., 2012. *A Roadmap for Trust: Enhancing Physician Engagement.* Canada: Regina Qu'Appelle Health Region.

KANTER, R.M., 1994. Collaborative advantage: the art of alliances. *Harvard Business Review,* (July/August), pp. 96-108.

KELLIHER, F., 2005. Interpretivism and the Pursuit of Research Legitimisation: An Integrated Approach to Single Case Design. *The Electronic Journal of Business Research Methodology,* **3** (2), pp. 123-132 Available: www.ejbrm.com [April 2015].

KENNEDY, A., 2007. *Guide to effective managed care networks for critical care.* Report commissioned by the National Critical Care Network Managers' Group (England) in partnership with the Department of Health to determine the benefits of Managed Care Networks for Critical Care.

KIRKHAUG, R., 2010. Charisma or Group Belonging as Antecedents of Employee Work Effort? *Journal of Business Ethics,* **96** (4), pp. 647-656.

LAMONT, M. and WHITE, P., 2005. *Workshop on Interdisciplinary Standards for Systemic Qualitative Research.* National Science Foundation.

LANSLEY, A., 3 April 2012a. *Letter from Andrew Lansley to LAs.* Whitehall, London: Department of Health.

LANSLEY, A., 3 April 2012b. *Letter from Andrew Lansley to NHS FTs.* Whitehall, London: Department of Health.

LANSLEY, A., 3 April 2012c. *Letter from Andrew Lansley to NHS Trust Chief Executives.* Whitehall, London: Department of Health.

LANSLEY, A., 3 April 2012d. *Letter from Secretary of State to CCG.* Whitehall, London: Department of Health.

LEMER, C., ALLWOOD, D. and FOLEY, T., 2012. *Improving NHS productivity. The secondary care doctor's perspective.* London: The King's Fund.

LEVENSON, R., DEWAR, S. and SHEPHERD, S., 2008. *Understanding Doctors. Harnessing professionalism.* London: King's Fund.

LEWIS, M., 2012. Reflections on a changing role in clinical management. *International Journal of Clinical Leadership,* **17** (4), pp. 227-234.

LLEWELLYN, S., 2001. 'Two-way Windows': Clinicians as Medical Managers. *Organization Studies*, **22**, pp. 593-623.

LUBITSH, G., DOYLE, C. and VALENTINE, J., 2005. The impact of theory of constraints (TOC) in an NHS trust. *Journal of management Development,* **24** (2), pp. 116-131.

MACLEOD, D. and CLARK, N., 2009. *Engaging for Success: enhancing performance through employee engagement. A report to Government.* London: Department for Business, Innovation and Skills.

MALBY, R. and ANDERSON-WALLACE, M., 2014-last update, Network Toolkit. Developed in partnership with University of Leeds; Centre for Innovation in

Health Management and NHS Improving Quality. Available: http://www.nhsiq.nhs.uk/capacity-capability/networks-for-health/network-toolkit.aspx [14 November, 2014].

MALBY, R. and KIERAN, M., 2012. *Summary of the literature to inform The Health Foundation Questions. The Health Foundation Networks Programme.* April. Leeds: University of Leeds.

MARSHALL, C. and ROSSMAN, G.B., 2006. *Designing Qualitative Research.* Fourth edn. Thousand Oaks, California: SAGE Publications Inc.

MAURICE, F.D., 1870. *Mediaeval Philosophy Or A Treatise Of Moral And Metaphysical Philosophy From The Fifth To The Fourteenth Century.* London: Macmillan and Co.

MAYS, N. and POPE, C., 1996. *Qualitative Research in Health Care.* London: BMJ Publishing Group.

MCINNES, E., MIDDLETON, S., GARDNER, G., HAINES, M., HAERTSCH, M., PAUL, C.L. and CASTALDI, P., 2012. A qualitative study of stakeholder views of the conditions for and outcomes of successful clinical networks. *BMC Health Services Research,* **12** (49).

MCLEAN, K., 13 June 2011. *Clinical Advice and Leadership. A report from the NHS Future Forum.* London: Department of Health.

MID TRENT CRITICAL CARE NETWORK, 2002. *Network Transfer Audit, Access Database.* Nottingham, England.

MILES, M.B. and HUBERMAN, A.M., 1994. *Qualitative Data Analysis: An Expanded Sourcebook.* 2nd edn. Beverley Hills: SAGE.

MONTOUTE, K., 2013. Challenges faced by NHS clinical directors. *Health Service Journal,* 25 March. Available: http://www.hsj.co.uk/leadership/challenges-faced-by-nhs-clinical-directors/5056107.article#.Vjs9OSzhV8E [February 2014].

MORSE, J.M., 1991. *Qualitative Nursing Research – A Contemporary Dialogue.* California, USA: SAGE publications Inc.

MOUNTFORD, J. and WEBB, C., 2008. *Clinical leadership unlocking high performance in healthcare.* London: McKinsey & Company.

MOUNTFORD, J. and WEBB, C., 2009. *When clinicians lead.* February. London: McKinsey & Company.

NHS COMMISSIONING BOARD, December 2012a-last update, Developing Operational Delivery Networks. The Way Forward. Available: http://www.england.nhs.uk/wp-content/uploads/2012/12/develop-odns.pdf [February 16, 2014].

NHS COMMISSIONING BOARD, December 2012b-last update, Operational Delivery Networks update. Available: http://www.england.nhs.uk/wp-content/uploads/2013/01/odn-update.pdf [February 16, 2014].

NHS COMMISSIONING BOARD, 2012c. *Strategic Clinical Networks. Single Operating Framework.* November. London: .

NHS COMMISSIONING BOARD – A SPECIAL HEALTH AUTHORITY, July 2012d. *The Way Forward: Strategic clinical networks.* Published to NHS CBA website, in electronic format only: Crown copyright 2012.

NHS EMPLOYERS, 2010. *Briefing 79. Staff engagement in the NHS: some local experience.* November. London: NHS Employers.

NHS ENGLAND, October 2013. *Prescribed Specialised Services Commissioning Intentions 2014/15-2015/16.* London.

NHS ENGLAND, September 2014. *Commissioning Intentions 2015/16 for Prescribed Specialised Services.* London.

NHS HEALTH RESEARCH AUTHORITY, 2012-last update, National Research Ethics Service (NRES). Available: http://www.nres.nhs.uk/ [1 August 2012].

NHS HEALTH RESEARCH AUTHORITY, 2013-last update, Summary of the role and operation of NHS Research Management Offices in England. Available: http://www.hra.nhs.uk/documents/2013/10/nhs-rd-summary-ver-1.pdf [2 February 2015].

NHS HEALTH RESEARCH AUTHORITY, 2015-last update. Available: http://www.hra.nhs.uk/about-the-hra/ [2 February 2015].

NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT, 2006. *NHS Leadership Qualities Framework.* Coventry: NHS Institute for Innovation and Improvement.

NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT, 2008-last update, Clinical Engagement. Available: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/clinical_engagement.html [February 20, 2014].

NHS LEADERSHIP ACADEMY, 2011. *Leadership Framework. A summary.* Coventry: NHS Institute for Innovation and Improvement.

NHS RIGHT CARE, June 2015-last update, A Right Care Collaboration 2015/19. Forward View. Available: http://www.rightcare.nhs.uk/wp-content/uploads/2011/06/Right-Care-Forward-View-2015-191.pdf [30 June 2015].

NHS SCOTLAND, 2002a. *Managed clinical networks: a guide to implementation.* October. London: Hayward Group plc.

NHS SCOTLAND, 2002b. *What are managed clinical networks?* October. London: Hayward Group plc.

NICHOLSON, S.D., 2011. *Equity and Excellence: Liberating the NHS - Managing the Transition.* 13 April - Gateway reference 15966 edn. London: Department of Health.

NICOL, E.D., 2012. Improving clinical leadership and management in the NHS. *Journal of Healthcare Leadership,* **4**, pp. 59-69.

NORRIS, E., ALEXANDER, H., LIVINGSTON, M., WOODS, K., FISCHBACHER, M. and MACDONALD, E., 2005. Multidisciplinary perspectives on core networking skills. A study of skills: and associated training needs, for professionals working in managed clinical networks. *Journal of Interprofessional Care,* **19** (2), pp. 156-163.

NOTTINGHAM TRENT UNIVERSITY, 2009a. *Doctor of Business Administration, Handbook Cohort 10 - 2009/12.*

NOTTINGHAM TRENT UNIVERSITY, 2009b. *Professional Standards in Research.* April. Nottingham: Nottingham Trent University.

NOTTINGHAM TRENT UNIVERSITY, 2010. *Doctor in Business Administration (DBA). Ethical Approval Process. Principles and Guidelines.* November. Nottingham: Nottingham Trent University.

NOTTINGHAM TRENT UNIVERSITY, 2014. *Research Data Management Policy.* June. Nottingham: Nottingham Trent University.

PEDLER, M., 2001. *Issues in health development. Networked organisations - an overview.* NHS Health Development Agency.

PLSEK, P.E., 1999. Section 1: Evidence-based quality improvement, principles and perspectives. *Quality Improvement Methods in Clinical Medicine,* **13** (1), pp. 203-214.

PLSEK, P.E. and GREENHALGH, T., 2001. The challenge of complexity in health care. *British Medical Journal,* **323** (15 September), pp. 625-628.

PLSEK, P.E. and WILSON, T., 2001. Complexity, leadership, and management in healthcare organisations. *British Medical Journal,* **323** (15 September), pp. 746-749.

PROUDLOVE, N., MOXHAM, C. and BOADEN, R., 2008. Lessons for Lean in Healthcare from Using Six Sigma in the NHS. *Public Money & Management,* **28** (1), pp. 27-34.

QSR INTERNATIONAL PTY LTD, 2015. *NVivo 10 for windows.*

RAAB, J., LEMAIRE, R.H. and PROVAN, K.G., 2013. Chapter 10 The Configurational Approach in Organizational Network Research. In: PEER C. FISS, P. C., B. CAMBRÉ and A. MARX, eds, *Configurational Theory and Methods in Organizational Research (Research in the Sociology of Organization .* Volume 38 edn. Emerald Group Publishing Limited, pp. 225 - 253.

RANDALL, S., 2013. *Learning report: Leading networks in healthcare. Learning about what works - the theory and the practice.* January. London: The Health Foundation. Inspiring Improvement.

REASBECK, P., 2008. Relationships between doctors and managers in an acute NHS trust. *The International Journal of Clinical Leadership,* **16**, pp. 79-88.

REINERTSEN, J.L., GOSFIELD, A.G., RUPP, W. and WHITTINGTON, J.W., 2007. *Engaging Physicians in a Shared Quality Agenda. IHI Innovation Series white paper.* Cambridge, MA: Institute for Healthcare Improvement.

RICOEUR, P., 1981. *Hermeneutics and the social sciences* New York: Cambridge University Press.

RIEMER, F.J., 2012. Chapter 7. Ethnographic Research. In: S.D. LAPAN, M.T. QUARTAROLI and F.J. RIEMER, eds, *Qualitative Research. An introduction to methods and designs.* San Francisco, CA: John Wiley & Sons Inc. Jossey-Bass.

RIVETT, G., 1998. *From Cradle to Grave. Fifty years of the NHS.* London: King's Fund Publishing.

ROSEN, R. and DEWAR, S., 2004. *On being a doctor. Redefining medical professionalism for better patient care.* London: King's Fund Publications.

ROSS BAKER, G. and DENIS, J., 2011. Medical leadership in health care systems: from professional authority to organizational leadership. *Public Money and Management,* **September**, pp. 355-362.

ROUTLEDGE, C.W., 2005-last update, C5. A Sociolinguistic Model of Narrative. Available: http://cw.routledge.com/textbooks/0415281059/about/pdf/Stylistics_C5.pdf [24 July, 2015].

ROYAL COLLEGE OF ANAESTHETISTS AND ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND, October 2006. *Good Practice. A guide for departments of anaesthesia, critical care and pain management. Third Edition.* London..

ROYAL COLLEGE OF PHYSICIANS, 2005. *Doctors in society: medical professionalism in a changing world.* Report of a Working Party of the Royal College of Physicians of London. London: RCP.

SALDAÑA, J., 2012. *The Coding Manual for Qualitative Researchers.* London: SAGE Publications Ltd.

SAMBROOK, S. A., JONES, N. and DOLORIERT, C., 2014. Employee engagement and autoethnography: being and studying self. *Journal of Workplace Learning*, **26,** (3/4), pp 172-187.

SAUNDERS, M., LEWIS, P. and THORNHILL, A., 2000. *Research Methods for Business Students.* Second edn. Essex: Pearson Education Limited.

SCHEIN, E., 1994. *Organizational Psychology.* 3rd edn. Upper Saddle River, NJ: Prentice-Hall.

SCHUTZ, A., 1967. *The phenomenology of the social world.* Northwestern University Press.

SCOTTISH EXECUTIVE, 2002. *Promoting the Development of Managed Clinical Networks in NHSScotland.* NHS Circular: HDL(2002)69.

SCOTTISH EXECUTIVE, 2007. *Strengthening the Role of Managed Clinical Networks.* NHS Circular: HDL(2007)21.

SCOTTISH EXECUTIVE SOCIAL RESEARCH, 2007. *Employee Engagement in the Public Sector. A review of literature.* Government Social Research. Available: http://www.gov.scot/resource/doc/176883/0049990.pdf [21 June 2015].

SCOTTISH OFFICE, 2000. *Managed Clinical Networks.* Department of Health.

SECRETARY OF STATE FOR HEALTH, July 2000. *The NHS Plan. A plan for investment. A plan for reform.* Crown copyright.

SHEAFF, R., SCHOFIELD, J., CHARLES, N., BENSON, L., MANNION, R. and REEVES, D., May 2011. *NHS National Institute for Health Research: The management and effectiveness of professional and clinical networks.* 08/1518/104. Queen's Printer and Controller of HMSO 2011.

SHEPHERD, S.C., July 2009. *Document 1 - Project Proposal. Understanding Networks: The role of Managed Clinical Networks in the application of Lean thinking: The case of Mid Trent Critical Care Network.* Doctorate in Business Administration edn. Nottingham: Nottingham Trent University.

SHEPHERD, S.C., March 2010. *Document 2 - Critical Literature Review and Initial Conceptual Framework. Understanding Networks: Managed Clinical Networks' predisposition for the application of Improvement Methods: The Case of Mid Trent Critical Care Network.* Doctorate in Business Administration edn. Nottingham: Nottingham Trent University.

SHEPHERD, S.C., December 2012. *Document 3 - An Interpretive Report on a Piece of Ethnographic Research. Understanding Networks: What makes a clinical network work? An examination of participants' perceptions of a network.* Doctorate in Business Administration edn. Nottingham: Nottingham Trent University.

SHEPHERD, S.C., July 2013a. *Document 4 - A Report on a piece of quantitative research. Understanding Networks: Does a systematic networked approach to managing the transfer of critically ill patients improve outcomes for patients? An analysis of critical care transfer incidents.* Doctorate in Business Administration edn. Nottingham: Nottingham Trent University.

SHEPHERD, S.C., 2013b. *Operational Delivery Networks. Governance Framework.* April. Available: http://www.nsc-ccn.org.uk/wp-content/uploads/2013/03/Agenda-Item-8-ODN Governance Framework Version 1.3 SCS April 2013 0111.pdf [March 2014].

SILVERMAN, D., 2006. *Doing Qualitative Research.* Second Edition edn. London: SAGE Publications Ltd.

SILVERSIN, J. and KORNACKI, M.J., 2000. *Leading Physicians Through Change: How to Achieve and Sustain Results.* Florida: American College of Physician Executives.

SNELL, A.J., BRISCOE, D. and DICKSON, G., 2001. From the Inside Out: The Engagement of Physicians as Leaders in Health Care Settings. *Qualitative Health Research,* **21** (7), pp. 952-967.

SOWA, J., 2008. Implementing Interagency Collaborations: Exploring Variation in Collaborative Ventures in Human Service Organizations. *Administration and Society,* **40**, pp. 298-323.

SPEHAR, I., FRICH, J.C. and KJEKSHUS, L.E., 2012. Clinicians' experiences of becoming a clinical manager: a qualitative study. *BMC Health Services Research,* **12** (421).

SPENCER, L., RITCHIE, J., LEWIS, J. and DILLON, L., 2003. *Quality in Qualitative Evaluation: A framework for assessing research evidence.* London: Cabinet Office. Government Chief Social Researcher's Office. Crown 2003.

SPRADLEY, J.P., 1980. *Participant Observation.* New York: Holt, Rinehart & Winston.

SPURGEON, P., BARWELL, F. and MAZELAN, P., 2008. Developing a medical engagement scale (MES). *The International Journal of Clinical Leadership,* **16**, pp. 213-223.

SPURGEON, P., CLARK, J. and HAM, C., 2011. Chapter 7. Why does it matter? Medical engagement and organisational performance. *Medical Leadership: From the Dark Side to Centre Stage.* London: Radcliffe Publishing Ltd, pp. 81-98.

STREUBERT, H.J. and CARPENTER, D.R., 1999. *Qualitative Research in Nursing. Advancing the Humanistic Imperative.* 2nd Edition edn. Philadelphia, PA 19106: Lippincott Williams & Wilkins.

THE AUDIT COMMISSION, 1999. *Critical to Success. The place of efficient and effective critical cre services within the acute hospital.* London: The Audit Commission.

THE HEALTH FOUNDATION. INSPIRING IMPROVEMENT, 2014. *Effective networks for improvement. Developing and managing effective networks to support quality improvement in healthcare.* March. London: The Health Foundation.

THE KING'S FUND, 2011. *The Future of Leadership and Management in the NHS. No more heroes. Report from The King's Fund Commission on Leadership and Management in the NHS.* London: The King's Fund.

THE NHS CONFEDERATION, 2007. *The challenges of leadership in the NHS.* London: The NHS Confederation.

UK COALITION GOVERNMENT, 2012. *Health and Social Care Act 2012.* Norwich: The Stationery Office.

VYGOTSKY, L.S., 1978. Chapter 6. Interaction between learning and development. *Mind in Society: The development of higher psychology process.* Cambridge, MA: Harvard University Press, pp. 79-91.

WALSHAM, G., 2006. Doing interpretive research. *European Journal of Information Systems,* **15**(3), pp. 320-330.

WATSON, J.J., 2001. *In search of management (Revised Edition).* London: Thomas Learning.

WEBER, M., 1947. *The Theory of Social and Economic Organization.* New York: Free Press.

WILSON, T. and HOLT, T., 2001. Complexity and clinical care. *British Medical Journal,* **323** (15 September), pp. 685-688.

APPENDICES

APPENDIX 1 - NETWORK MEMBER ORGANISATIONS AS AT JUNE 2015

Mid Trent Critical Care Network, Member Organisations
Patient Groups i-Canuk Intensive Care After Care Network
Nottingham University Hospitals NHS Trust
· Queen's Medical Centre Campus
· (includes Paediatric Intensive Care Unit, QMC Campus)
· City Hospital Campus
United Lincolnshire Hospitals NHS Trust
· Grantham and District Hospital
· Lincoln County Hospital
· Pilgrim Hospital, Boston
Derby Hospitals NHS Foundation Trust
· Royal Derby Hospital
Sherwood Forest Hospitals NHS Foundation Trust
· King's Mill Hospital
Burton Hospitals NHS Foundation Trust
· Queen's Hospital Burton
Independent Sector Hospitals/Centres
· The BMI Healthcare Trust, The Park Hospital Nottingham and The Lincoln Hospital
· Nuffield Nursing Homes Trust, Derby
· Ramsey Health Care UK, Nottingham and Boston
· Circle partnership, Nottingham NHS Treatment Centre
· Nations Healthcare, The Midlands NHS Treatment Centre, Burton
· Nottingham Neurodisability Service
· Nottingham Brain Injury Rehabilitation Centre
Area Team
· Derbyshire and Nottinghamshire
· Leicestershire and Lincolnshire
Clinical Commissioning Groups
· NHS Mansfield and Ashfield
· NHS Erewash
· NHS Hardwick
· NHS Newark and Sherwood
· NHS North Derbyshire
· NHS Nottingham City
· NHS Nottingham North and East
· NHS Nottingham West
· NHS Southern Derbyshire
· NHS Rushcliffe
· NHS Lincolnshire East
· NHS Linconshire West
· NHS South Lincolnshire
· NHS South East Staffordshire
Ambulance Service Trusts
· East Midlands Ambulance Service NHS Trust
· West Midlands Ambulance Service NHS Trust
Strategic Health Authorities
· NHS Midlands and East
Affiliated Universities
Health Protection Agency/Public Health Departments

APPENDIX 2 - LETTER OF INVITATION TO PARTICIPANTS

[Address and personal details removed]

[date]

Dear [name]

Research Study – Understanding Networks: Why do doctors choose to engage in the work of a clinical network?

As you are aware, I am in the process of undertaking a research study as part of my doctorate studies with The Nottingham Trent University towards a Doctorate in Business Administration. My research topic is clinical networks and I am particularly interested in the social aspects of networks. This stage of my research is designed around doctor/medical engagement in the Network and I would be grateful if you would be willing for me to come and ask you some questions for my research. I anticipate that each interview will take between 1-2 hours.

If you are happy for me to come and meet with you, can you please ring me on my mobile [removed] or alternatively e-mail me [removed]

I am happy to come and see you at a time and place that is convenient to you.

I am grateful to you for your help and look forward to hearing from you.

With best wishes

Yours sincerely

Sue Shepherd
Director
Mid Trent Critical Care Network
  and East Midlands Major Trauma Network

APPENDIX 3 - RESEARCH PARTICIPANT INFORMATION SHEET (PIS)

[Address and personal details removed]

Understanding Networks: Why do doctors choose to engage in the work of a clinical network? The case of Mid Trent Critical Care Network

Research participant information

Supervisors:
Professor Colin Fisher and Dr Donald Harradine

Student*:*
Sue Shepherd, Director
Mid Trent Critical Care Network
and East Midlands Major Trauma Network

Version 2, April 2014

Understanding Networks: Why do doctors choose to engage in the work of a clinical network? The case of Mid Trent Critical Care Network

Thank you for agreeing to consider participating in this research study. Before you decide whether to grant an interview, it is important that you understand the reason why this research is being carried out and what your participation will involve. I will be grateful if you can take time to read the following information. Please feel free to contact me if anything is unclear.

What is the purpose of the study?
Following the introduction of a National Health Service (NHS) the structure and delivery of health care in the UK has undergone continuous and at times radical change often as a result of, or in response to, clinical and financial pressures and developments. This study arises from a growing interest in managed clinical networks in the NHS in the UK.

The election of a coalition government in England in May 2010 heralded the introduction of new changes within the NHS. The health white paper released in July 2010 outlined the Government's plans for the NHS to deliver significant changes within the architecture of the NHS as well as improvements for patients and professionals. A considerable change has been a shift in commissioning responsibilities to GP commissioning consortia, supported by the NHS Commissioning Board. The Board hosts a number of clinical commissioning networks (Strategic Clinical Networks) in order to group specialist expertise and facilitate service delivery. Following on from the publication of the health white paper, the NHS Chief Executive highlighted the importance of a national clinical engagement exercise. A number of key messages emerged following the engagement process which recognised the importance of clinical and professional networks in the new system. In identifying clinical networks as an effective model to improve the quality of care across integrated pathways, the NHS Chief Executive requested that the NHS Medical Director and national clinical directors work together to strengthen clinical networks in order to determine how best to improve outcomes for patients. The Government response to the NHS Future Forum report clearly identifies that the Forum recommends "*embedding networks at all levels of the new system*".

In July 2012, a number of clinical networks were formally identified as Operational Delivery Networks in the new NHS architecture. These Networks are designed to deliver a collaborative model of care to improve the experience and outcomes for specific groups of patients based on regional and local needs. They will focus on co-ordinating pathways of care and will work closely with patients, commissioners, providers and other stakeholders and clinical networks to ensure access to high quality care. Clinical networks provide a model of care designed to facilitate the delivery of services within agreed geographical areas but what do clinical networks look like and more importantly; how do they work? The first part of this question is likely to be answered by the NHS Future Forum. The Clinical Advice and Leadership work stream suggest that work should be undertaken to "*define and review the function, effectiveness and range of different types of networks*" and an outcome of this work

will be the delivery of a recommended operating model and performance measures for the future management of networks.

Much of the literature on clinical networks explores the process of network development and looks at the structural aspects of networks. There is little empirical evidence on the value and effectiveness of network models or of known outcomes and although literature on networks explores the relationships between organisations and recognises the importance of behaviours and of trust as an important indicator of network success, it does not address the importance of social factors in clinical networks in respect of how networks work. This research study seeks to address this gap and in so doing, to enhance the body of knowledge in respect of managed clinical networks in the NHS.

The key research objectives for this study are summarised in the following table:

Research Objectives

Research Objectives
• identify how clinical networks work
• identify what it is that actually makes them work
• identify why people engage in the work of a clinical network
• identify elements of a successful clinical network
• identify the value of networks in the new architecture of the NHS
• understand the importance of human factors in clinical networks and the impact on function and outcome

The primary objective of this study has been to gain a greater understanding of what it is that makes a clinical network work (from a people perspective). Qualitative research undertaken at Document 3 examined participants' perceptions of what makes a clinical network work. Using the Mid Trent Critical Care Network as a case study; outcomes demonstrated that the Network is deemed to work if it improves outcomes for patients. Quantitative research undertaken at Document 4 examined an element of the Network that participants perceived to be successful; namely the Network Transfer System in order to identify if the Network does improve outcomes for patients. Research demonstrated that in this respect the Network does improve outcomes for patients. From early qualitative research, a number of key themes emerged relating to engagement of clinical staff particularly around collaborative working and a sense of togetherness. Clinical networks as non-statutory organisations rely heavily on the engagement of participant members to deliver the work of the network and early research has demonstrated that participants are engaged in the work of the Mid Trent Critical Care Network. This stage of the research therefore lends itself to explore clinical engagement in more detail and in order to scope the research study, examines doctor engagement in the Network. Key research questions at this stage of the study are:

- Why do doctors choose to engage in a clinical network?
- What is it about the Network that has engaged doctors?

- What are the triggers and cues that we need in an organisation to get doctors involved?
- Do doctors engage more readily with a clinical network than with their employing organisation and if so why?
- Do doctors behave differently in a networked organisation?

The research for this stage of this research study will commence in April 2014 and is due to complete mid-2015.

Who is running this study?

This research study is being conducted by Sue Shepherd, Director of the Mid Trent Critical Care Network and East Midlands Major Trauma Network, East Midlands Ambulance Service NHS Trust, as part fulfilment of the requirements of the Nottingham Trent University degree of Doctorate in Business Administration.

Why have I been chosen to take part?

During this stage of the research study, critical care doctors will be interviewed and the interviews will be tape-recorded.

You have been asked to take part in this study as you have been recognised as being an engaged member of the Mid Trent Critical Care Network and will therefore have experience of the topic under investigation. If, during the interview, you do not feel comfortable, please let me know that you would rather not answer the question. The tape recordings will be coded to protect the identity of all participants. If during the interview it becomes apparent that any participant could be identified due to subject matter, this will be discussed and a way forward agreed between all parties.

Do I have to take part?

Participation is voluntary and is appreciated. If you have any questions before, during and after the interviews, you should not hesitate to contact me. If you do decide to take part, you will be given this information sheet to keep, and you will also be asked to sign a consent form. Every participant has the right to withdraw from this study, without having to give any reasons for withdrawing. Under these circumstances, the data provided by you will not be considered and will be destroyed. If you decide not to take part, or to withdraw at any stage, you will not be asked to give a reason.

What do you want me to do?

I would like you to take part in an interview lasting between 1 – 2 hours. This will take place in a location and at a time convenient for you. Every participant in this research project will be asked to give written consent to participating, before it begins.

What will happen to the information I give in my interview?

The tape of your interview will be transcribed. I will then analyse the information and feed it in to my results. At the end of the study all the transcripts, digital recordings and notes will be destroyed in accordance with The Nottingham Trent University process for data handling.

How will you protect my confidentiality and anonymity?
The collected data will be treated anonymously. The tape and transcript will be handled by me as researcher in line with data protection principles and approved research protocols. Hard copies of research notes will be kept in locked filing cabinets, and electronic files will be kept on a password protected computer which is not accessible to other members of staff.

Normally, only the researcher and her Supervisors will have access to the transcripts, although under exceptional circumstances they may need to be viewed as part of the examination process. In all cases, those who have access will do so in order to ensure that the overall project meets academic standards and they will themselves be bound to maintain strict confidentiality. As stated above, at the end of the study all the transcripts, digital recordings and notes will be destroyed in accordance with The Nottingham Trent University process for data handling.

You will not be named in any publications arising from this project unless your role forms part of a narrative that is already in the public domain: for example if you were the named author of a published document. No unpublished opinions or information will be attributed to you, either by name or position without your express consent.

I will, unless consent is given, exercise all possible care to ensure that you cannot be identified by the way I write up my findings.

What are the possible disadvantages and risks in taking part?
The main cost to you will be the time needed to be interviewed. The main risk is that you might give me information that is detrimental to you or your organisation, or that runs counter to data protection laws. I am confident that the arrangements described above will prevent any of your information being shared with anyone outside the research team. For this reason, I believe that the risk of detriment is very low.

What are the possible benefits?
I hope that you will find the interview interesting and will take satisfaction from helping to develop knowledge of this important and current topic. I also hope that you will find the results of the project helpful to your work.

What will happen to the results?
The results will form the basis of the following outputs:
- Submission of mandatory documents in line with the structured DBA course
- Sharing of results via appropriate routes

Has anyone reviewed the study?
The DBA process enables the development of a research proposal and a critical literature review. Additionally the research process is structured into 3 documents, Documents 3, 4 and 5. These are formal pieces of work and to date I have submitted 4 documents (Documents 1,2,3 and 4) which have been assessed and formally awarded a pass by the Board of Examiners of The Nottingham Trent University. This stage of the study is to inform Document 5. As the study progresses, as researcher and as a student of the NTU, I have regular meetings/discussions with my academic supervisors.

The DBA process allows for an update of the study at various stages of the academic workshop sessions.

In addition, the study has been reviewed by the NRES Committee East Midlands – Derby 2 Research Ethics Proportionate Review Sub-Committee and via the following Hospital Trust R&D processes:

- Nottingham University Hospitals NHS Trust
- Derby Hospitals NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Burton Hospitals NHS Foundation Trust

Who is responsible if anything goes wrong?
This project forms part of the fulfilment for the degree of Doctorate in Business Administration. The Nottingham Trent University is therefore responsible for the conduct of the project.

Contacts for further information

If you wish to withdraw you should contact me or my academic supervisors.

I can be contacted by e-mail: [removed]

My supervisors are as follows:

Professor Colin Fisher ([removed])
Dr Donald Harradine ([removed])
Nottingham Trent University
Burton Street
Nottingham
NG1 4BU

Thank you for your contribution

APPENDIX 4 - RESEARCH PARTICIPANT CONSENT FORM

Understanding Networks: Why do doctors choose to engage in the work of a clinical network?
The case of Mid Trent Critical Care Network

CONSENT FORM

Supervisors:
Professor Colin Fisher and Dr Donald Harradine

Student:
Sue Shepherd, Director
Mid Trent Critical Care Network

CONSENT FORM

Version 3: April 2014

Name of site:

Please read and confirm your consent to being interviewed for this research study by initialling the appropriate box(es) and signing and dating this form

1. I confirm that the purpose of the research study has been explained to me, that I have been given information about it in writing, (participant information sheet Version 2: April 2014) and that I have had the opportunity to ask questions about the research ☐

2. I understand that my participation is voluntary, and that I am free to withdraw at any time without giving any reason and without any implications for my legal rights ☐

3. I give permission for the interview to be tape-recorded by research staff, on the understanding that the tape will be destroyed at the end of the project in line with University and Trust Policy ☐

4. I understand that the relevant sections of the data collected during the study may be examined by individuals from the Mid Trent Critical Care Network or Nottingham Trent University as part of the research audit process. I give permission for these individuals to have access to my records ☐

5. I agree to any direct quotes being used in this study ☐

6. I agree to take part in this research study ☐

_____   _____ _____

Name of respondent   Date   Signature

_____   _____ _____

Name of researcher taking consent   Date   Signature

Researcher contact details: Sue Shepherd, e-mail: [removed]
Mobile: [removed]

Supervisors contact details: Professor Colin Fisher ([removed]), and
Dr Donald Harradine ([removed])

Conducting research in part fulfilment of the requirements of Nottingham Trent University for the degree of Doctorate in Business Administration

APPENDIX 5 - SURVEY QUESTIONNAIRE

NHS
Mid Trent Critical Care Network

Network Questionnaire

As Network Director, I am currently in the process of undertaking part-time study with The Nottingham Trent University studying for the degree of Doctor of Business Administration. My research topic is clinical networks and I am particularly interested in the human aspects of networks. Much of the research around this aspect will be undertaken via qualitative methods and in order to enhance and inform this work I am keen to take this opportunity to ask you a few questions about the Network. This stage of my research is designed around doctor/medical engagement in the Network and so I would be grateful therefore if you will take the time to complete this short questionnaire.

Please Note:
- All questions relate to The Mid Trent Critical Care Network
- Any response will be anonymous unless you want to include your contact details. It will however be useful for me to understand the demographics in terms of replies and so the final section is designed to capture this
- Direct quotes might be used in any subsequent papers written in order to fulfil the requirements of the course
- There are no right or wrong answers - I am interested in your perception

1   **Please describe what engagement means to you?**

2   **On a scale of 1-5 how engaged are you in the work of the Network?**

1	2	3	4	5
not at all engaged	want to be engaged but don't know how	mildly engaged	moderately engaged	considerably/ fully engaged

3   **What makes you choose to engage in the work of the Network?** *(if answer to question 2 is 1-2, please skip this question)*

4   **On a scale of 1-5 what is the level of doctor/medical engagement in the Network?**

1	2	3	4	5
extremely low	low	moderate	high	extremely high

5   **On a scale of 1-5 what is the level of doctor/medical engagement in your Trust?**

1	2	3	4	5
extremely low	low	moderate	high	extremely high

6   **Please list any words that you would use to describe the culture of:**

the Network	your Trust

APPENDIX 6 - RESEARCH INTERVIEW SPINE OF QUESTIONS

Strategic question - What can we learn from Doctor Engagement in a clinical network?

Understanding Networks: Why do doctors choose to engage in the work of a clinical network?

Research interview spine of questions

Introduction – for face-to-face interviews

Introductory greeting, formal thanks and explanation of research that has led to this point.

The interview will not have rigid rules and should be regarded as a conversation between 2 professionals working in a specific area of health care. I have developed a framework of questions to help guide the interview but would like to encourage you to offer your opinion freely without constraint. **I am interested in hearing your story.**

THERE ARE NO RIGHT OR WRONG ANSWERS – I AM SEEKING YOUR PERSPECTIVE AS A DOCTOR

Can you tell me a bit about how you got to where you are now? How long have you worked in critical care? How long have you worked in the Network? How long you have held a management position?

So, firstly, we have been told that there is a huge drive to include doctors in decision making in the NHS and that the NHS is clinically led -

- What do you think?
  Do you think this has happened - has there been this big drive that we read about? and if so, Has it been successful – is that reality?
- You're a doctor – tell me about doctor engagement and the delivery of healthcare?
- Do you think it matters if doctors are engaged?
- So what do doctors contribute to managing healthcare – do you manage this – if not, what do you think stops you from doing that?

So, I just want to ask you a little bit about the Network:

- How do you think you are treated in the Network?
- Does this differ from how you are treated in your Trust?
- Do you think you are valued in the Network?
- How do you think you are valued in the Network?
- Do you think you are valued in your Trust?
- Does how you are valued in the Network differ from in your Trust?
- What do you learn when you come to the Network?
- What do you learn when you go to your Trust?

Talking specifically about the term engagement?

If I say the word Engagement – what image, opinions, opportunities, etc. does that conjure up?

- What does engagement mean to you?
- To me engagement implies an inclination to become involved – As a doctor, why do you choose to engage in the work of the Network? What makes you choose to engage?
- How do you think the Network fosters that inclination for you to become involved?
- How does the culture of the Network influence doctor engagement?

Seeking narrative accounts of engagement (*I AM AFTER A STORY – IT IS CRITICAL IN THE SENSE THAT IT WAS OF IMPORTANCE TO THEM, OR HAD POTENTIALLY IMPORTANT CONSEQUENCES*):

NETWORK - TRUST	WORK WELL

Can you think of a situation that you were involved in in the Network - Trust that was important and represents engagement working well?

NETWORK - TRUST	WORK NOT WELL

Can you think of a situation that you were involved in in the Network - Trust that was important and represents engagement working not so well?

Ask each point and prompt discussion with the following:

- What happened?
- Who was involved?
- What was the situation that led to it?
- What did you do, what part did you play?
- How did everyone respond?
- What was the outcome?
- How did you feel in that situation?
-

FINAL QUESTIONS:
Can you tell me what you think are the problems with engaging with the Network?

Can you tell me what you think are the problems with engaging with the Trust?

Do you think you engage differently in the Network and the Trust and if so in what way – why is this?

How do you think doctor engagement impacts on the delivery of health care?
Conclude with thanking participant for their time

APPENDIX 7 - RESEARCH INTERVIEW PARTICIPANTS

Tape number	Tape File reference	Profession	Time in Critical Care (years)	Time in Network (years)	Grade	Gender	Age	Date of Interview	Start Time	File Size		Transcription size (words)	Place of interview	Travel miles	Travel time (mins)
										Hour/ Minutes	KB				
1	D1-24-n-14 CC02	Doctor	24	14	Senior Consultant	M	52	28.4.14	09:23	1:36:30	90,467	11,921	Interviewer Office	0	0
2	D2-28-n-14 CC05	Doctor	27	14	Senior Consultant	M	55	1.5.14	11:28	0:53:48	50,439	10,147	Interviewer Office	0	0
3	D3-25-n-14 CC01	Doctor	24	14	Senior Consultant	M	49	21.5.14	13:44	1:39:51	93,615	16,921	Interviewer Office	0	0
4	D4-10-n-7 CC03	Doctor	10	7	Senior Consultant	F	46	28.5.14	13:37	1:08:22	64,090	8,870	Participants place of work	32	60
5	D5-12-n-6 CC03	Doctor	12	6	Senior Consultant	M	41	29.5.14	11:46	1:18:08	73,255	11,435	Participants place of work	32	60
6	D6-11-n-5 CC03	Doctor	11	5	Senior Consultant	M	37	29.5.14	13:53	1:44:42	98,153	10,643	Participants place of work		
7	D7-14-n-5 CC02	Doctor	14	5	Senior Consultant	M	40	30.5.14	13:06	1:41:44	95,378	16,218	Participants place of work	34	60
8	D8-16-n-14 CC02	Doctor	16	14	Senior Consultant	M	48	30.5.14	14:11	0:52:55	49,605	7,650	Participants place of work		
9	D9-25-n-14 CC05	Doctor	26	14	Senior Consultant	M	52	2.6.14	09:16	1:20:07	75,108	11,725	Participants place of work	6	30
10	D10-12-n-9 CC05	Doctor	12	9	Senior Consultant	M	43	9.6.14	10:46	1:46:08	99,494	14,444	Interviewer Office	0	0
11	D11-16-n-6 CC05	Doctor	16	6	Senior Consultant	F	40	10.7.14	14:43	1:10:42	66,282	10,532	Participants place of work	6	30
12	D12-18-n-11 CC04	Doctor	18	11	Senior Consultant	M	46	5.12.14	13:34	1:01:23	57,543	11,052	Interviewer Office	0	0

APPENDIX 8 - NARRATIVE FRAMEWORK

Interpretation from
Narrative Framework

Setting (Who, What, Where, When?)

Who are the main characters and what part do they play?		

What is the problem or conflict?

Are there any heroes and allies?	Are there any villains and enemies?	Are there any victims?

Plot (provides relationships between component parts i.e. characters and setting)

What happens – what is the sequence of events?

Where is the conflict?

What is the response to the problem?

What is the resolution?

Who responds, who resolves the problem?

What does it mean to them?

What do they get out of it?

What is the outcome - Morale of Story – or Summary?

Theme?	Language?

What is my interpretation of what this means?

APPENDIX 9 - NARRATIVE ANALYSIS – CATALOGUE OF THEMES AND CONCEPTS – 1-21

Tape number	Tape File reference	Original Text Transcription size (words)	Relevant Text Transcription size (words)	No.	Lines	size (words)	Key theme	Concept	
1	D1-24-n-14 CC02	11,921	10,800	NF1	145-289	1,370	Preparing doctors for management	The Reluctant Manager	
				NF2	298-395	1,086	Engaging in a Network	Creating a Culture for Engagement	
				NF3	464-578	1,110	Clinical engagement	Choosing to engage	
				NF4	587-653	652	Engaging in a Network	Creating a Culture for Engagement	
					717-743	148			
2	D2-28-n-14 CC05	10,147	8,065	NF5	44-115	438	Preparing doctors for management	The Reluctant Manager	
				NF6	115-385	1,694	Doctor and Manager Conflict	Internal and External Conflict	
				NF7	436-637	1,072	Engaging in a Network	Creating a Culture for Engagement	
				NF8	648-731	590	Doctor and Doctor Conflict	Internal and External Conflict	
				NF9	128-225	665	Engaging in a Network	Creating a Culture for Engagement	
					861-1029	863			
3	D3-25-n-14 CC01	16,921	16,251	NF10	58-110	571	Preparing doctors for management	The Reluctant Manager	
				NF11	119-201	745	Clinical engagement	Choosing to engage	
				NF12	207-259	545	Clinical engagement	Choosing to engage	
				NF13	273-421	1,206	Preparing doctors for management	The Reluctant Manager	
					586-613	292			
				NF14	427-504	725	Doctor and Manager Conflict	Internal and External Conflict	
				NF15	510-583	645	Doctor and Doctor Conflict	Internal and External Conflict	
				NF16	689-770	806	Doctors as Managers Conflict	Internal and External Conflict	
				NF17	773-890	1,107	Cultural Issues	Creating a Culture for Engagement	
				NF18	892-1004	978	Competitiveness	Internal and External Conflict	
				NF19	1585-1660	767	Engaging in a Network	Creating a Culture for Engagement	
4	D4-10-n-7 CC03	8,870	8,377	NF20	40-168	910	Preparing doctors for management	The Reluctant Manager	
				NF21	220-341	878	Clinical engagement	Choosing to engage	

(Narrative columns span "Original Text", "Relevant Text" and "Narrative" which includes Reference No./Lines, size (words), Key theme, Concept. A green arrow labelled "Improving Patient Care" runs down the right-hand side.)

APPENDIX 10 - NARRATIVE ANALYSIS – CATALOGUE OF THEMES AND CONCEPTS – 22-42

Tape number	Tape File reference	Original Text Transcription size (words)	Relevant Text Transcription size (words)	No.	Lines	size (words)	Key theme	Concept
5	D5-12-n-6 CC03	11,435	10,985	NF22	110-183	712	Clinical engagement	Choosing to engage
				NF23	185-244	620	Cultural Issues	Creating a Culture for Engagement
					334-383	482		
6	D6-11-n-5 CC03	10,643	8,706	NF24	133-235	1,176	Clinical engagement	Choosing to engage
				NF25	352-488	1,213	Preparing doctors for management	The Reluctant Manager
7	D7-14-n-5 CC02	16,218	14,087	NF26	43-133	885	Preparing doctors for management	The Reluctant Manager
					1781-1903	1,452		
				NF27	260-387	1,222	Doctor and Doctor Conflict	Internal and External Conflict
					1034-1078	475		
				NF28	693-737	328	Engaging in a Network	Creating a Culture for Engagement
8	D8-16-n-14 CC02	7,650	6,403	NF29	190-256	639	Clinical engagement	Choosing to engage
				NF30	407-621	1,842	Preparing doctors for management	The Reluctant Manager
9	D9-25-n-14 CC05	11,725	10,924	NF31	165-274	1,042	Preparing doctors for management	The Reluctant Manager
				NF32	342-536	1,566	Doctors as Managers Conflict	Internal and External Conflict
				NF33	591-699	961	Clinical engagement	Choosing to engage
10	D10-12-n-9 CC05	14,444	12,119	NF34	122-313	1,870	Preparing doctors for management	The Reluctant Manager
				NF35	327-357	359	Engaging in a Network	Creating a Culture for Engagement
				NF36	1066-1399	2,207	Doctor and Doctor Conflict	Internal and External Conflict
11	D11-16-n-6 CC05	10,532	8,711	NF37	211-294	711	Doctors as Managers Conflict	Internal and External Conflict
				NF38	300-467	1,103	Doctor and Manager Conflict	Internal and External Conflict
				NF39	480-662	1,127	Engaging in a Network	Creating a Culture for Engagement
12	D12-18-n-11 CC04	11,052	9,616	NF40	136-289	971	Doctors as Managers Conflict	The Reluctant Manager
				NF41	387-579	1,671	Clinical engagement	Choosing to engage
				NF42	801-891	876	Doctor and Manager Conflict	Internal and External Conflict

Improving Patient Care

APPENDIX 11 - SAMPLE COMPLETED NARRATIVE FRAMEWORK

Interpretation from D1-24-n-14 CC02 145-289		NF1

Narrative Framework

Setting (Who, What, Where, When?)
Doctors working as clinical managers in an acute Hospital Trust

Who are the main characters and what part do they play?

Doctors as clinicians	Doctors as Managers	
• Doctor	• Clinical Manager • Doctors use their clinical status to make up for their lack of management skills	

What is the problem or conflict?
Doctors are not prepared for management. There is conflict between the clinical and managerial roles of the doctor

Are there any heroes and allies?	Are there any villains and enemies?	Are there any victims?
Doctors as clinicians - Confident in their skills and abilities	Doctors as Managers - Hold back in a restricted way, not venturing out into management	Doctors – because they do not become senior managers Patients (224) – because if doctors are unprepared for management the system crumbles (221)

Plot (provides relationships between component parts i.e. characters and setting)
Doctors become managers in the health system with little or no training in management skills; this often means that they then choose not to pursue the management route

What happens – what is the sequence of events?
Doctors are confident as clinicians and have the clinical expertise
Doctors enter management unprepared – management training is "hit and miss" (97) and doctors feel unprepared intellectually (150)
They give it their "best shot" (151) but their lack of management skills stagnates their progression as a manager
Doctors use their consultant status to equal management but this is risky (156)
Management is "trial and error" (156) and individuals who don't like management can escape from the management exposure (131)

Where is the conflict?
Doctors are not prepared for a management role. They feel "vulnerable" (146) "second class" and out of their "comfort zone" (153)
Management is an "added on extra" (193) but no-one is telling them they are ineffective at management (250), no-one cares (259)
Doctors are by nature competitive (277) and they try to match their clinical and management achievements but the management side doesn't sit comfortably (282) because they are unprepared

What is the response to the problem?
Doctors defend their clinical role
Doctors feel inadequate as managers
Doctors hold back in terms of being involved in management (166)
They discard the management role

What is the resolution?
Success builds confidence and in being confident this might unleash a desire to go down the management route
Formalised management training (125) – management training should be compulsory; doctors should be given time for management training and achievements should be monitored (126)
Support of other doctors in management roles

Who responds, who resolves the problem?
Some doctors self-learn
Trust senior managers (clinical and non-clinical) – mentoring and supporting

What does it mean to them?
It means that they experience personal feelings of inadequacy as a manager – doctors feel "vulnerable" (146) because they are not "matching" the managers" (147) – doctors like to be recognised for their intellectual ability. They become aware of their "non-successes" (205) and repeat failures of not having achieved at management despite their best efforts and attribute their failure to a lack of management skills (208)

What do they get out of it?
Frustration and discomfort
Doctors can influence management decisions

What is the outcome - Morale of Story – or Summary?
If you want doctors to be effective managers, make sure they are prepared for the management arena – doctors like to be prepared for all eventualities

Theme?		Language?
Preparing doctors for management	The reluctant manager	"fire-fighting" (260) "trial and error" (156) "vulnerable" (146)
Doctors as managers	Conflict in the doctor/manager role	"trouble-shooting" (260) "second class" (146)

What is my interpretation of what this means?
My interpretation is that for some doctors a lack of management skills presents a challenge to their intellectual ability as a manager. This lack of skills leads to frustration and in some instances doctors relinquish their management role within the Trust. Clinical training prepares doctors to be doctors. Management training is often non-existent and does not prepare doctors for management.

APPENDIX 12 - NHS NRES ETHICAL APPROVAL CONFIRMATORY LETTER

Re-issued letter due to document listing error 13.12.11

NHS
Health Research Authority

NRES Committee East Midlands - Derby 2

08 November 2011

Mrs Susan C Shepherd
Mid Trent Critical Care Network

Dear Mrs Shepherd

Study title:
Understanding networks. What makes a clinical network work? An exploration of the human aspects of a clinical network. The case of Mid Trent Critical Care Network

REC reference:

Thank you for your letter of 31st October 2011, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

A Research Ethics Committee established by the Health Research Authority

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved by the Committee are:

Document	Version	Date
Covering Letter		22 July 2011
Covering Letter		31 October 2011
Interview Schedules/Topic Guides	2	31 October 2011
Investigator CV		21 July 2011
Letter from Sponsor		
Letter of invitation to participant	1	21 July 2011
Other: CV for Colin Fisher		21 July 2011
Participant Consent Form	2	01 October 2011
Participant Information Sheet	1	21 July 2011
Protocol	1	21 July 2011
REC application		21 July 2011
Referees or other scientific critique report		21 July 2011
Response to Request for Further Information		31 October 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports

- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Enclosures: *"After ethical review – guidance for researchers"*

APPENDIX 13 – SUMMARY OF KEY RESEARCH OUTCOMES

Factor		Narrative	Findings		
			Network	NHS	Trust
Choosing to engage	Engagement	Means active involvement, sharing and commitment, a sense of belonging and of being valued	Doctors gain a sense of togetherness and support from colleagues. The Network seeks their viewpoint and listens to what they have to say. It provides a collaborative environment for working together, sharing best practice. Doctors have confidence that the Network enacts the business for patients and achieves its aims and objectives	The NHS pays lip service to clinical engagement. Management is centrally driven and out of touch with reality. The NHS is increasing in complexity and is financially led and is moving further away from the patient	Decision makers are far removed from the patient which introduces an element of danger in to the process. Doctors are engaged with at a superficial level and don't feel valued enough. The work of the Network is transacted with more ease than in the Trust
Choosing to engage	Being engaged	Means: **being involved** **being able to influence** **being listened to** **having a voice** **being respected and supported** **having a personal interest and commitment** **being valued** **mutual respect** **positive regard** **working together** **seek to understand the views, perspectives and beliefs of others**	Doctors indicate that in the Network they have the opportunity for **sharing knowledge and expertise** and that they value **relationships** and a **sense of togetherness** and belonging and gain personal and professional **support.** They are **listened to and have a voice**, they are **valued and respected**, they are **involved and able to influence** decisions for patient care. They **feel pride and are enthusiastic** and **gain insight** into the management process by **being involved** and are **able to influence**	Doctors are suspicious of decisions and decision makers. They have hope in the NCDs but a lack of trust leading to doctor/manager conflict	Do not have a voice, no influence and no input - feel excluded from management process and are active bystanders of bad decision making by managers
Significance			Meets requirement for engagement	Doesn't meet requirement for engagement. Doctors nearer the centre perceive greater clinical engagement	Disconnect between managers and clinicians
Outcome			Doctors choose to be engaged	Frustration. Affects choice of engagement	Leads to confusion and frustration

Factor		Narrative	Findings		
			Network	NHS	Trust
Choosing to engage	Power	Doctors are considered to have a level of power and autonomy	Positive power of the Network - Power of individual members and of collective power of the Network.	This is being eroded as doctors become less involved and engaged in the management and leadership of the NHS	Shift in balance of power from secondary to primary care
Significance		Medicine is a competitive world	Members have equal power which fosters a collaborative working environment and the development and maintenance of solid relationships.	Doctors have the greatest understanding of the day-to-day workings of the health service and so the basis for engaging doctors in management and leadership is to inform the political agenda and influence patient care and outcomes	Lack of understanding in terms of power base
Outcome			Participants use the power of the Network to their advantage. Empowers engagement	Disengagement	

	Factor	Narrative	**Significance**	**Outcome**
Choosing to engage	Clinical engagement is done at a superficial level	Clinical engagement is done at a relatively superficial level - people are engaging with doctors only because they have to. But not all doctors need to be engaged with all of the time. The medical voice is not heard where the outcome has already been decided	Doctors suffer from engagement overload. Engage with the right doctors in the right discussions at the right time	Disengagement with the management process. Engagement becomes a tick-box exercise leading to disillusionment, disappointment and future disengagement
Choosing to engage	Engaging the right doctors in leadership and management roles	There are managers who are clinicians first and foremost - these doctors avoid a management role. There are doctors who engage in management and tell other doctors what to do. There are doctors who engage in management for self-interest. There are doctors who engage to do the best for patients.	Doctors choose to engage in mangement for different reasons and so there are different types of doctors engaged in management of the NHS	Doctors can influence health care management and doctors feel that other doctors should be engaged in some sort of management role

Factor		Narrative	Significance	Outcome
The Reluctant Manager	Doctors are unprepared for management	Doctors confirmed that not all doctors choose to engage in the management and leadership of the NHS. There is an indication that this is due a lack of preparedness for management. There is a suggestion that doctors self-select for management.	Doctors enter management without the necessary skills. Management skills are learnt on the job or by observing others. There is an element of a lack of responsibility on the part of the doctor. This unpreparedness is unlikely to happen in the clinical environment.	Unpreparedness can affect their performance as a manager and cause an unnecessary level of stress. Doctors feel vulnerable in the management environment. Doctors become disillusioned and walk away from management roles. Disconnect between doctors prepared for the clinical role and management role.

Factor		Narrative	Significance	Outcome
Internal and External Conflict	Lack of power and control - external	External conflict relates to conflict that is perceived by the participants to occur between them as doctors and other people, i.e. doctors and managers. Doctors don't have the power in the management structure and suggest that the power sits in the politics. There is a suggestion that doctors are told what to do on a daily basis by managers.	Doctors have responsibility but no power to change anything, so they have the responsibility without the authority.	Doctor manager conflict. Frustration. Lack of engagement and rebellion.
Internal and External Conflict	Lack of power and control - internal	Internal conflict relates to doctor behaviour. Doctors suggest that they have power as individuals and as a professional body, so they have the monopoly over managers in terms of their clinical knowledge. Doctors are sometimes disparaging of colleagues if they consider they do not make the right decisions in management.	There is a perception that the clinical argument will triumph over the management argument	Doctors use their power to manipulate situations to their advantage. Frustration. Doctors will choose to engage or disengage according to the value they place on the issue

Factor		Narrative	Significance	Outcome
Internal and External Conflict	Doctor and Manager conflict	Doctors indicate that they are well engaged in the Network and less engaged in their Trust. Engagement in the Trust is less inclusive and there is more of a manager/doctor split. Whilst doctors bring the clinical view to management they do not always have the necessary skills to manage. Doctors percieve that managers do not always have clinical insight or the skills to manage which leads to doctor/manager conflict.	There is a perceived level of power with the doctor as both engagement and disengagement gives the doctor a level of perceived power. Doctors are able to manipulate situations either for personal or professional gain. The focus on patient care and outcomes presents a reason for some of the perceived conflict between doctors and managers	Doctors can choose to engage or not and will bypass clinical managers where they have little regard for their ability as a manager. This leads to frustration for managers and doctors. Doctors suspect managers are more concerned with the financial aspects of the service giving rise to conflict.
Internal and External Conflict	Implicit and Explicit contract	The implicit contract is different from the explicit contract. The implicit contract for doctors is that they are in charge of health care; but the explicit contract is that doctors work for the hospital and are employed by the CEO which leads to tension	Throughout their training doctors are taught to believe that they are in charge of health care. Doctors are accountable to the clinical manager in a hierarchical structure	Leads to doctor/manager conflict and impacts choice of engagement

Factor		Narrative	Significance	Outcome
Internal and External Conflict	Doctor and doctor conflict	There is a suggestion that being a clinical manager is hard work, often made harder by doctor colleagues who make the job more difficult. Clinical managers are seen as making decisions that other doctors do not agree with. It appears that doctors apreciate the pressures that their clinical manager colleagues are under but sometimes find it hard to care. There is however a suggestion that doctors will unite if they are attacked.	Clinical managers are not liked by their medical colleagues. This dissuades doctors from choosing to engage in clinical management roles. Doctors display child like behaviours if they do not get their way. This doctor/doctor conflict can therefore feel more personal and there is a heightened sense of betrayal.	Doctors choose not to engage in clinical manager roles
Internal and External Conflict	Doctors as managers conflict	There was an indication that the right doctors need to be engaged in the management of the NHS. The narratives reveal a number of pit-falls for doctors who are perceived by colleagues as having gone over to the dark side of management. Doctors need to be allowed time for management duties . Succession planning is done really badly. Doctors again recognise a lack of management skills	Medical training demands a different cultural norm to management. Some doctors are administrators with clinical skills. Serving two masters doesn't work. Management is not appealing.	Doctors need to have real drive to be clinical managers. Not all doctors should be managers. Doctors unprepared for management "look like an idiot"

Factor		Narrative	Significance	Outcome
Creating a Culture for Engagement	Engaging in a Network culture	The Network is detatched from their employer. The Network shows progression towards the aims and objectives. Doctors take responsibility for their role in the Network and if things do not work, question their role. The Network provides the right mix between formal and informal and is not intimidating. The Network constructs business in a constructive way. The Network is prepared, organised, reliable and appreciates its members. The Network is multidisciplinary and is useful, it is patient focussed, and provides an environment for the sharing of ideas. There is an indication that doctors are treated differently in the Network to the way they are treated in other organisations and that some of the employing trusts are less inclusive and less transparent with a hint of hidden	The culture of the Network encourages people to be engaged and provides an opportunity to be engaged. The Network is non-hierarchical and does not place unreasonable demands on the people who are engaged. The Network is fun. The Network demonstrates achievement and discussions in the Network are helpful, transparent, honest and frank. The Network offers a safe environment for doctors to share their expertise and knowledge and operates within a collaborative culture with shared leadership and responsiblity. Doctors recognise the social aspects of the Network.	The Network feels like it is for the members and therefore doctors choose to engage in the Network. The Network provides the right balance between a formal and informal culture allowing members to share ideas and express opinion without intimidation and the confidence that their ideas will be embraced and implemented. The Network is patient focussed and embraces engagement. Doctors are more cautious in their Trusts where they perceive it is more difficult to get things done.

Factor		Narrative	Findings	
			Network	Trust
Creating a Culture for Engagement	Network and Trust Culture	There is a contrast in language that doctors use to describe the culture of the Network and of their employing Trusts.	Doctors use more positive language when describing the culture of the Network: Proactive Collaborative supportive proactive co-operative progressive well-lead open and honest Sharing Engaging Fun	Language used to describe employing organisations is less positive and describes organisations are are more complex and bureaucratic in their structure Reactive disorganised chaotic larger over-stretched constant change poorly structured top-down internally divided a mess improving trying hard to improve reliable listening engaging
Significance			The culture of the Network influences doctor engagement.	Employing organisations are larger and more complex in size and structure than the network.
Outcome			Doctors choose to engage in the Network, the level of engagement is higher in the Network	Levels of engagement vary in the employing organisations

Document 5 – Confidential

Factor		Narrative	Significance	Outcome
Creating a Culture for Engagement	Doctors describing what engagement FEELS like [in the Network]	Doctors describing positive engagement: a sense of satisfaction and pride they choose to engage they feel valued decreases stress and increases productivity gives them positive power and positive regard makes them feel good about themselves they are involved and able to influence is rewarding especially when they are being heard and being respected gain self-gratification where engagement leads to improved patient care makes them feel like they belong gain a sense of community and of belonging feels like family	These are the stories that doctors tell themselves about positive engagement, in the context of a network	Doctors choose to engage in the Network

Factor		Narrative	Significance	Outcome
Improving Patient Care		The Network is deemed to be successful if it improves the experience and outcomes for patients. Doctors stories suggest that they are more likely to engage in the management and leadership of the NHS if they are able to influence and improve patient care The Network promotes an honest and open culture and provides an environment for clinicians to work collaboratively fostering a sense of togetherness and of belonging, encouraging comradeship and the formation of solid relationships	The Network demonstrates evidence of improving patient care	Doctors choose to engage in the Network

Factor		Narrative	Significance	Outcome
Improving Patient Care	Triggers and cues for engagement	Value Choice involvement pride excitement listening giving and receiving feedback patient benefit seeing results for engagement being engaged for genuine reasons time to manage adequate preparation for management education in terms of NHS structure and how to navigate the system doctors engage if they perceive a personal threat to them or their service	Doctors identified triggers and cues for engagement	Doctors choose to engage when these factors are in place or realised