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Challenges and Insights in Inter-Organizational Collaborative Healthcare Networks: An Empirical Case Study of a Place-Based Network

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CHALLENGES AND INSIGHTS IN INTER-ORGANIZATIONAL COLLABORATIVE HEALTHCARE NETWORKS: AN EMPIRICAL CASE STUDY OF A PLACE-BASED NETWORK.

INTRODUCTION AND BACKGROUND

In globalised and demanding economic environments, where trends such as rising customer expectations, 'budgetary constraints, global competition for investment, public sector reform programmes and changing demographics' (Price Waterhouse Coopers, n.d: p.3) are becoming the norm, public sectors and not-for-profits are expected to use resources more efficiently and effectively (Curristine et al., 2007, Afonso et al., 2010, Afonso et al., 2015) and at the same time, improve the quality of services (Amoo & Mervyn, 2014). Private sector organisations have over the past decades tried to mitigate and share the risk of such a global and economic changing environment by forming alliances and associations – and in a similar vein, public sector organisations are undertaking this through collaboration. The Triple Helix of university-industry-government relations reflects collaborative drives to meet grand society challenges (Etzkowitz and Leydesdorff; 2000). Etzkowitz, (2003) refers to the Triple Helix for understanding changing dynamics in the context of entrepreneurship, innovation, socio-economic development, new technological developments and knowledge transfer. Mode 1, or pure research is arguably restricted to advancing knowledge for knowledge sake (Bentley et al., 2015), while Mode 2 research seeks to create more pragmatic business and societal value. Flaws span both models, leading observers (Panda and Gupta, 2014; Huff, 2000) to propose Mode 1.5 which combines the practical structure of Mode 2 and the rigorous, in-depth theoretical and conceptual

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3 premise of Mode 1). Mode 1.5 approaches are increasingly proposed for enhancing
4 the applicability and relevance of research towards meeting significant healthcare
5 challenges, garnered through the convergence of university, industry, and government
6 in research work for maximum outputs (Boggio et al., 2016). These insights on
7 research modes highlight a much-needed but under-developed link between
8 academia and practice.
9

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11 Private sector organisations have adopted market models that infer that greater quality
12 and efficiency are driven by competition and consumerism, alongside networked
13 relationships and organisational forms to add value (Shuman and Twombly 2009).
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16 Public sector organisations such as those within the healthcare sector are also moving
17 to more networked relationships by adopting collaborative models that recognise that
18 increasing demand can only be supported through coproduced models of care that
19 bring the citizens assets into the provision and production of services. Collaborations
20 across health organisations are emerging (Friend et al., 1974, Metcalfe, 1993, Vangen
21 and Huxham, 2003b) as they transition from traditional hierarchies to networked
22 organisational forms (O'Toole, 1997, Thomson and Perry, 2006, Castells, 2000, Ferlie
23 et al., 2011). The shift to more accountable and integrated health service delivery
24 through strategic alliances is dependent upon the successful partnership of healthcare
25 organisations across organisational boundaries (Lewis et al., 2017). US-based
26 Accountable Care Organisations (ACO's) and similar UK-based accountable care-
27 based models are emerging in response to tensions including elevated healthcare
28 costs, variations in quality of care, aging and growing populations and a chronic illness
29 epidemic (Shortell et al., 2014). However, calls for more integrated health and social
30 care spanning primary, secondary and tertiary care are often tempered by
31 organisational silos, '...and consequently each part works to optimise its own
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3 performance with little if any, consideration for other parts in the care delivery system'
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5 (Shortell et al., 2014: p.1). This reflects the need for organisations to avoid simply
6
7 solving problems in isolation and show willingness to work for the greater good.
8
9 Change is ensuing i.e. through primary care-led integrated models (Turner, Mulla et
10
11 al., 2018) however more research is needed into the role of primary care in the context
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13 of whole system change and more focus on the impact of behaviours across the
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15 system which may subsequently impact upon other parts of system.
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21 Across the public sector there are various forms of collaboration, and depending on
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23 context, a network form of collaboration is often used to address complex problems
24
25 that traditional organisational structures cannot fulfil (Ferlie et al., 2011, Ferlie et al.,
26
27 2012; Thomson, et al, 2007). There is now in the UK, a proliferation of collaboration
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29 networks which, within the context of the current healthcare climate, are seen as an
30
31 approach that could help to enhance the value of investments in the various health
32
33 programmes, and also to reach patients and carers in complex environments (Litwin,
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35 1995, Perri et al., 2006, Carlsson, 2003, Malby et al., 2013, Shortell et al 2014). The
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37 NHS in the UK is following the global healthcare system trend of a mixed model of
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39 organisation in an increasingly interdependent system comprising competition for
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41 procurement; strong regulation for baseline performance; and collaboration through
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43 networks to address complex needs (Malby and Anderson Wallace 2016
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50 However, networks have different forms and functions. A typology of network types
51
52 exists in healthcare (Malby and Mervyn, 2012) and there are many challenges in
53
54 understanding how to design, implement and sustain such networked organisations.
55
56 One such approach is the innovative design of a collaborative place-based network to
57
58 secure quality and value. Collaborative place-based networks bring together the
59
60 providers and commissioners of health and social care for a population to make the
most of the combined resources and assets of each to secure better health outcomes.

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3 This approach addresses the issue of fragmentation and focuses on the immediate
4 need for services to be joined up.
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7 Current debate is heavily focused on changing the way professionals across whole
8 places work together and with patients. This paper looks at the key challenges and
9 insights of this approach using a single Case Study of a city-wide implementation of a
10 large-scale healthcare collaborative in the United Kingdom (UK).
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20 **THE CONTEXT**

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23 The chosen city is one of the major cities in England. It is also a major industrial and
24 commercial town with well-established centres for legal and financial services. As a
25 way of addressing the shortfall in UK healthcare outcomes, an Inter-organisational
26 Collaborative Network (IOCN) was designed by health and social care leaders in the
27 city, from across all the provider and commissioner organisations, to secure better
28 quality care, with-and-for patients. The IOCN website discusses how it was set up with
29 an overarching aim and objective to secure 'improvement in quality care by enabling
30 clinicians to develop shared expertise in innovation and improvement and developing
31 a rigorous approach to professional accountability, using data to review variation and
32 decision-making' with patients. It is one of the first of its kind regarding it being
33 structured as a health quality focused placed-based network. In this paper, we use a
34 qualitative study of IOCN to make the argument for why such a placed-based network
35 is best suited in such a context and why IOCNs almost neutral setting enabled health
36 organisations within the city to coalesce, discuss and address quality improvement
37 issues. This paper adds to the body of knowledge on networks and inter-organisational
38 collaboration in general. In particular, it focuses on the not-for-profit sector and
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3 illuminates the uniqueness of a City-wide Collaborative (place-based network) while
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5 addressing the on-going puzzle about how to spread efficiency and innovation across
6
7 service delivery. We illustrate how steps must be taken to facilitate the development,
8
9 testing and evaluation of new processes, policies and interventions across traditionally
10
11 disparate organisational settings. We also highlight challenges and insights and seek
12
13 to interpret and understand the key issues underpinning the network's development.
14
15 Basing the qualitative interviews on respondents who are part of the network, and who
16
17 are senior leaders and professionals spanning different organisations, we illustrate
18
19 how some of these challenges can be addressed i.e. through the senior leadership
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21 responsibility of giving direction and empowering those working at the front-line. Thus
22
23 a key focus of this paper is on leadership and strategy initiatives; and a culture of
24
25 organisational learning that enables and supports a community of practice (Wenger
26
27 and Snyder, 2000) of healthcare professionals.
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34 The remainder of this paper is structured as follows: in order to provide a theoretical
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36 framework, and highlight our main research question, we undertake a theoretical
37
38 review of the main concepts with particular reference to the healthcare sector. We then
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40 present and explain our research approach and methods. In the results and analysis
41
42 section, we use social constructionism to discuss the views of respondents,
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44 highlighting the challenges while at the same time providing insights on how these
45
46 could be addressed. We end with a summary and conclusion where we position our
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48 views in the light of extant literature and make recommendations for policymakers and
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50 future studies.
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THEORETICAL FRAMEWORK

Inter-Organisational Collaborations

There is a body of literature on collaboration as a concept and theory (Huxham, 1996, Vangen and Huxham, 2003b, Alexander, 1995, O'Toole et al., 2005). Collaboration is simply seen as working across organizations and as noted by Metcalfe (1993) is a recognized component of public management. Thomson & Perry (2006) defined collaboration in a process capacity, whereby self-directed individuals interact in both formal and informal ways and subsequently coproduce norms, rules, structures and conventions and make sense of the issues underpinning their point of integration.

This definition takes into recognition Ring and Van de Ven's (1994) frame of reference, which can validate the uniqueness of collaboration in contrast to cooperation. In our context of the Healthcare sector, The Health Foundation (THF) define a collaborative as 'a multi-organisational structured approach with five essential features: (1) there is a specified topic; (2) clinical experts and experts in quality improvement provide ideas and support for improvement; (3) multi-professional teams from multiple sites participate; (4) there is a model for improvement (setting targets, collecting data and testing changes); and (5) the collaborative process involves a series of structured activities' (Hulscher & Schouten, 2009 in De Silva, 2014:p.5).

In the public and not-for-profit sector, collaborations are now under scrutiny regarding their governance and management. Corporations undertake collaborations in a similar vein using commercial-sector type strategic alliances and joint ventures (Child and Faulkner, 1998, Child et al., 2005). This allows the participating organisations to combine resources; expertise; sharing learning; best practices in the form of joint ventures, partnerships; coalitions; and other strategic alliances – in effect it allows for

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3 sharing of costs or risks. It connotes the idea of the popular saying "The whole is
4 greater than the sum of its parts" and as suggested by Thomson and Perry (2006:
5 p.23), organisations "...may be achieving individual ends, but there's an additional
6 outcome that is shared (though not mutually exclusive) separate from the individual
7 ends", which is the driving force of such endeavour. In highlighting this desired
8 synergistic outcome of the collaborative activity, scholars have also noted that just like
9 the commercial-sector type strategic alliances, there are also difficulties (Judge and
10 Ryman, 2001, O'Toole Jr, 1997) due to inertia, alongside other factors such as
11 collaborative aims; power and politics; trust relationships, collaborative structures and
12 forms, leadership, autonomy and accountability (Eden and Huxham, 2001, Vangen
13 and Huxham, 2003b). The thus literature highlights the need to ensure more
14 comprehensive and better engagement is needed across organisational boundaries
15 to benefit the whole system. Hence the need for improvement through a whole system
16 model of transformation.

17
18
19 Within health and social care, a myriad of overlapping terms are used to describe
20 similar concepts such as 'inter-organizational collaboration' 'collaboration' and
21 'networks', but they fail to address the underlying problem of '...how can healthcare
22 professionals and managers working for different organizations be helped to work
23 together effectively across organizational boundaries in the interests of the intended
24 beneficiaries (the 'clients') of health and social care agencies?' (Jones and Thomas,
25 2007: 290). This also emphasises the lack of understanding regarding citywide
26 contexts to shared challenges.

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29 The emergence of networked entities such as inter-organizational collaboratives may
30 enable healthcare systems to address wicked issues beyond the capabilities of single
31 organisations (Crommelin et al., 2010), however large-scaled and often system-wide

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3 collaborative initiatives face unique initiation, design, implementation and
4 sustainability challenges (Clay-Williams et al., 2014, Mitsuhashi, 2002). Collaborative
5 improvement programmes which are now prominent across health systems
6 worldwide, exist at different stages of development, within which a plethora of
7 healthcare organisations are created and developed to address patient safety, quality
8 and reliability of care at an organization-wide level. These include state-wide quality
9 improvement collaboratives in the US (Wirtschafter et al., 2010) through to initiatives
10 in the UK such as collaborations for leadership in applied health research (CLAHRC's)
11 (Rowley et al., 2012, Kislov et al., 2012, Evans and Scarbrough, 2014, Doyle et al.,
12 2013) and the UK Safer Patients Initiative (Benn et al., 2009). These are issue-based
13 collaborations as they focus on specific clinical aims and objectives in contrast to
14 place-based networks which are a more recently becoming established to support key
15 strategic national priorities within real partnerships for local delivery. The Place-Based
16 Health Commission in the UK (NLGN 2016: p.11) reports: "...suggest[s] that most local
17 authority and health professionals agree that a place-based system could reduce
18 demand and deliver net cost savings to healthcare". This is important in the context of
19 the change in nature of demand, the need to work with citizen assets and also the
20 need for more system-wide solutions.

21
22 Collaborative networks have now become a very viable alternative to traditional
23 structures because large-scaled organisations such as the NHS have a tendency to
24 regress towards linear solutions to complex problems that arise within healthcare
25 (Keasey et al., 2009), and so the emerging area of network management, is becoming
26 particularly relevant in large and complex organisations that tackle wicked issues (Klijn
27 et al., 2010).

1 2 3 **Networks as an Innovative Form of Collaboration** 4 5

6 This literature review illuminates the nature of networks, within the context of the public
7 sector and healthcare. It also helps to determine network objectives, relationships and
8 underpinnings in the current climate of austerity and uncertainty, and thus may
9 enhance the value of investments in health programmes (Mays and Smith, 2011). A
10 network regarding how it is organized is a set of "nodes" or points connected by "links"
11 or pathways, where the "nodes" are people or organizations; the "links" are
12 relationships. Networks are seen as distinct forms of social organisation differing from
13 the traditional organisation, which relies on hierarchical, top-down powers to achieve
14 strategic objectives (Plastrik and Taylor, 2006). Networks encompass organisational-
15 type delivery mechanisms (for services and functions) and forms of collaboration
16 (Abbott and Killoran, 2005). Public network literature is also considerably fragmented,
17 encompassing a plurality of definitions, theories, methods and explanations (Turrini et
18 al., 2010; Isett et al., 2011). O'Toole, (1997), and Castells (1999b) defined a network
19 as a set of interconnected nodes, hierarchical and/or organic and fluid, and devoid of
20 a centre.
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41 In our context, the Health Foundation defined a network as 'a cooperative structure
42 where interconnected groups or individuals coalesce around a shared purpose on the
43 basis of trust and reciprocity' (Malby and Mervyn, 2012: p.7). Randall (2013) also
44 referred to networks in a cooperative capacity underpinned by peer sharing and
45 learning, and whereby members interact on the basis of conviction, respect and
46 mutuality.
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56 In the healthcare sector, networks often 'fill the gaps that can't be addressed by
57 conventional systems and structures' (Malby and Mervyn, 2016: 41) because they are
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3 creative, innovative places where resources are shared for the common good.
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5 Networks are useful for rapid learning and development and amplifying members'
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7 effectiveness. Networks can also be useful for advocacy on behalf of their
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9 membership; for delivering services in ways that make the most of network members'
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11 capability and resources. The distribution of power and leadership across members
12
13 coupled with their adaptability to survive and thrive adds to the novelty of networks
14
15 and highlights their distinctiveness (c.f. Malby and Mervyn, 2012). Networks in
16
17 healthcare exist to improve quality as a core purpose and are designed to do that
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19 through the full range of organizing principles from connecting individuals through
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21 social networks for learning and negotiating service improvement; through to networks
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23 that advocate for specific change; and to networks that deliver services (Malby,
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25 Mervyn and Pirisi, 2013).
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35 **Leadership in Healthcare Collaborative Networks**

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38 It is acknowledged that leadership in such organisations will require a form of
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40 leadership which could be far removed from the traditional approaches that we know
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42 (see also Huxham and Vangen, 2005, Armistead et al., 2007, Vangen and Huxham,
43
44 2003a) that write on collaboration). Two overarching styles of leadership are compared
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46 and contrasted as Transactional Leadership and Transformational Leadership (Bass,
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48 1991, Bass, 1985, Bass and Avolio, 1993, Jarle et al., 2008, Bealer and Bhanugopan,
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50 2014). The former is related to a more traditional and instructional style based on a
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52 model of reward and punishment, while the latter is more co-productive and
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54 participative in nature between leaders and subordinates (Ackoff, 1999, Hartnell and
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56 Walumbwa, 2011, Baškarada, et al., 2017). In the collaboration literature, due to the
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3 loose association and multi-layered participation of the network approach, leadership
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5 is seen as more informal, emergent, less structured and often of not much significance
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7 (Hosking, 1988). Leadership is thus less hierarchical, organised around decentring
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9 (Judge and Ryman, 2001), and a more "contingent" perspective of leadership is now
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11 emerging which refutes the universality of leadership traits/behaviours that denote
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13 success in all situations (Manning, 2013, Cole et al., 2011). Whilst there is value in the
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15 shared and distributed model within networks with more informal or emergent leaders,
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17 there is also (at least at the outset) the requirement in collaborative networks for an
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19 energetic and strategic leader holding the centre who will have to enact
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21 simultaneously, the dual but opposing role of both being facilitative (spirit of
22
23 collaboration) and directive (c.f. Vangen and Huxham, 2003b).

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29 While not discounting the value of other perspectives on leadership, as suggested by
30
31 Armistead et al. (2007), we are of the view that in more recent times, the inclusion of
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33 a contingent-reward component to a variant of the many forms of transformational
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35 leadership (i.e. Armistead et al.'s (2007) have emerged. Such contemporary theories
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37 of leadership can enhance the overall effectiveness of leaders; and reflect Heifetz,
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39 Linsky & Grashow's (2009) approach to wicked issues through the ability to be
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41 dynamic, adaptive and reflective to changing situations and contexts such as the
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43 management of integrated care (Edgren, 2011, Edgren and Barnard, 2012) marks a
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45 high-level leader (Avolio and Bass, 2001, Goleman, 2003). This form of leadership is
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47 what Collins (2001) denotes Level 5 leadership (see also: Collins, 2005, Owens and
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49 Hekman, 2012), where leaders are simultaneously comfortable working in shared
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51 leadership models where the functions of leadership can be dispersed to all members
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53 of the community within the organisation – the combination of the First (traits and
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55 behaviours) and Second Persons' (human interaction between groups) perspectives
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3 of leadership (Armistead et al, 2007, pg. 21). Such a composite approach of leadership
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5 can redress some recent criticisms of transformational leadership as being
6
7 ambiguous, idealised, heroic and far removed from practice (Alvesson and Kärreman,
8
9 2015, Blom and Alvesson, 2015). Therefore, leaders of collaborative networks need
10
11 to be both engaging and facilitating members to act, and providing direction and focus
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13 for the network as a whole (Ledema et al., 2017).
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21 **MAIN RESEARCH QUESTIONS AND AIMS / OBJECTIVES OF STUDY**

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24 Considering the emergent role of inter-organisational collaborations, the growing use
25
26 of networks as an innovative form, and the complexity of leadership in collaborative
27
28 networks, Hambleton and Howard (2013) suggest that innovative and creative
29
30 approaches to place-based leadership underpinned by a culture of controlled risk-
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32 taking can enhance people's everyday lives, empower local people and improve front-
33
34 line services.
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38 Hence, our main research question for this study is: What are the key challenges in
39
40 designing, and implementing a place-based collaborative model for improving quality,
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42 and are there any early lessons?
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46 In trying to address these research questions, we also focus on:
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50 What could be the key differences between the Inter Organisational
51
52 Collaborative Network and other forms of collaborative organisation?
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55 What makes a Place-based Collaboration best suited to the type of
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57 collaborative service delivery in this present economic climate?
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RESEARCH APPROACH

This study adopted a social constructionist approach, using inductive research and a qualitative methodology (Clouder, 2003, Cruickshank et al., 2011). IOCN was credited by respondents with being one of the first whole place-based collaborative network in health in England. Hence the adopted research strategy was an exploratory case study (Baxter and Jack, 2008, Stake, 2013, Yin, 2013) where we are more interested in exploring situations to highlight challenges and insights. The study was also a multi case approach where we looked at different units in networking of senior leaders and professionals spanning different organisations involved in healthcare. We used this research approach to provide a richer understanding of the challenges and insights involved in IOCN's inter-organizational collaborative network and to establish initial baseline findings for the Institute as an inquiry process. The study used three different stages: two data collection stages (Stage 1 and 3) and sandwiched between was a scoping literature review stage and an evaluation conference with experts in high performing systems (Stage 2). Data were collected at two different stages over a two-year period between 2014 and 2015. The purposeful samples were intentionally selected to learn and understand the central phenomenon (Barbour, 2001, Sandelowski, 2000) by inviting participation from those who would best answer the research questions and who were vessels of information (Patton, 1990), and to then develop a rich understanding of the underlying problem through the lens of assorted contextual factors (Creswell and Miller, 2000).

Stage 1 of data collection was aimed to establish initial baseline findings for the Institute as an inquiry process for IOCN. The first set of qualitative data in April 2014 was collected via a self-developed interview template which included semi-structured and open-ended questions. Where the template was designed as open-ended so that

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2
3 respondents can provide their own framework of meanings as much as possible
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5 (Patton, 1990, Britten, 1995). In using the semi-structured and open-ended questions,
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7 we were careful to follow similar approaches that had been used in qualitative studies
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9 and in particular in the healthcare sector (Britten, 1995, Morse & Field, 1995). For
10
11 example, we started with questions that the respondent can answer easily before
12
13 proceeding to more difficult or sensitive topics (Whyte, 2003). These questions were
14
15 derived from the Baker and Denis (2011) categories of high performing systems. This
16
17 approach also enabled us to divert from a narrow focus where a single reality is
18
19 traditionally sought, to a more pluralistic discovery of truths (Fraser, 2004). These
20
21 questions were used in 12 interviews conducted with senior health and social care
22
23 leaders from the city's Health and Care System. Participants were selected against
24
25 the criteria as described, and to secure a balance from all the health and social
26
27 organisations in the city. Participants were at director and executive director level. The
28
29 questions and were related to personal thoughts on performance and practices in
30
31 health systems leadership across the city; the motivators and barriers to working
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33 collaboratively and the impact of IOCN. Further insights were sought about respondent
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35 leadership styles and strategies; and how the Institute could improve its contribution
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37 and develop more effective and sustainable relationships.
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45 Interviews were transcribed and largely analysed by thematic identification by two
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47 readers of the text (with a total of 6 readers across all texts). The themes were then
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49 compared and aggregated across all the interviews.
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53 Stage 2: After the first stage of interviews, a significant scoping review was then
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55 undertaken into high performing systems. Further consultation of the literature findings
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57 and Stage 1 research findings were conducted with experts in high performing
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3 systems in an evaluation conference before a further, and more intensive round of
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5 interviews were undertaken.
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8 Stage 3: This follow-up study of 21 senior healthcare interviewees (see appendix for
9 roles and attributions of respondents) was undertaken in November 2014 using the
10 same stage 1, selection criteria and questionnaire development approach but with a
11 different sample. It is this data that forms the basis for this reported study.
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18 The credibility of this study was recognized when a range of other observers external
19 to the study into the IOCN network became acquainted with the findings (Rolfe, 2006).
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23 For the analysis of the Stage 3 Interviews, NVIVO was used to store and manage the
24 transcripts and facilitated the coding of responses. The interviews were transcribed
25 and analysed by thematic identification by two readers of the text. The themes were
26 compared and aggregated across all the interviews. After an initial round of transcript
27 reading, each of the interviewee transcripts was then rigorously re-reviewed, by
28 creating free nodes which were the less organised ideas and segments emanating
29 from the text. Free nodes based on Thomas' (2006) general inductive approach then
30 helped the researchers to identify later higher-level themes which were linked to
31 challenges and insights involved in IOCN's inter-organisational collaborative network.
32 Free nodes were regularly reviewed as new transcripts were coded to identify whether
33 themes about the research questions had continued through the following interviews.
34 Further coding was then undertaken which emphasised some of the more emergent
35 themes (Charmaz, 2013). The literature was again subsequently explored to underpin,
36 refute or support the evaluation research findings and a form of member checking then
37 ensued whereby we shared research progress with the informants to validate our
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3 interpretation and findings with the informants' viewpoints, thus increasing the
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5 trustworthiness of the data (Carlson, 2010).
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10 11 **RESULTS, ANALYSIS, FINDINGS AND DISCUSSIONS**

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15 Under this section, we present our study results and findings, while simultaneously
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17 providing some discussions.
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19

20
21 The Institute (IOCN) comprised a collaboration across health and social care
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23 organisations in the city, with programmes of change work supported by a learning
24
25 programme premised on a high performing healthcare system in the US
26
27 (Intermountain Healthcare's proven healthcare methodology, approach to professional
28
29 practice and quality improvement) (James & Savitz, 2011) and data analytics. IOCN
30
31 aimed to improve quality of care through enabling clinicians to develop shared
32
33 expertise in innovation and improvement and developing a rigorous approach to
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35 professional accountability. The objective was to create a culture of best quality clinical
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37 care at the best value, with patients, service users and carers as partners in decision-
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39 making, across the city.
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45 Our study sought to determine the extent to which IOCN contributed to the
46
47 improvement of quality in the City and therefore the development of the City as a high
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49 performing health system. The research broadly explored IOCN's impact and influence
50
51 on the leadership of the system as a whole, and briefly evaluated its impact on specific
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53 clinical priorities in terms of improvements in quality. In particular, we first explored the
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55 role of learning as an essential mechanism in the ICON for quality improvement. We
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57 then reviewed the challenges and contradictions of relationships within the IOCN
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3 network, before identifying how IOCN's strategy generates a shared narrative (an
4 important characteristic of high performing health systems). This led to a rich
5 theoretical discussion on the fundamental differences between a place-based network
6 and an issues-based network.
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16 **Learning: an Essential Mechanism for Development**

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19 In all spheres of life, being able to do something is heavily facilitated by your acquisition
20 of know-how (Bollinger & Smith, 2001; Lam, 2000) and this is also true in healthcare
21 organisations (Clarke, 2005). Intermountain HealthCare's high performing systems
22 approach to professional practice and quality improvement was blended with the city's
23 Universities teaching, research and local knowledge of working across organisations
24 within systems. Clear synergies and differences emerged between Intermountain and
25 IOCN which made IOCN unique in its development as a high performing health care
26 system. The importance of leadership programmes organised by IOCN has helped to
27 both set up and sustain the network. There were two training programmes – one
28 professional (PLP) for leaders working on specific local clinical change programmes,
29 and one advanced (ALP) training programme (for senior leaders working at city-level)
30 that had the objectives of coproducing learning and knowledge across the cities'
31 healthcare system:
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50 I think the engagement that we've seen already from the three PLPs is that
51 people want, they're surprised that they've been given this authority to do
52 this and I think it's about persuading them, just get on with it. We'll sort out ..
53 opening the doors... Because if we don't then the city is not going to achieve
54 what it is capable of (Respondent R4).
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3 While this learning was taking place, novel challenges emerged for senior leaders
4 involved in the advanced programmes in developing and sustaining momentum and
5 keeping a focus on the bigger picture. These leadership programmes brought together
6 the tops, middles, and bottoms across a patient pathway. The leadership programmes
7 provided a platform for nurturing the shared narratives and participants frequently
8 referred to being in the same boat and must learn to row together or sink. This was
9 evident around garnering acceptance that pathway work was a longer-term
10 commitment and should be supported as such. However, this reportedly lead to
11 hesitancy amongst the tops and issues arose regarding how committed the tops were.
12 A lack of support permeated to unease and despondency amongst otherwise
13 innovative and keen local leaders in the PLPs. Also 'Power and Politics' were at play
14 from tops to bottoms and subordinates were often hesitant to converse upwards
15 (Ibarra, 1993; Weber and Waeger, 2017). This reflected a need to break the "cultural
16 cycle" of where top and bottoms are not working or conversing (Oshry, 2007; Phillips,
17 et al., 2016)

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39 And so, you've got a sort of tops, middles, bottoms, so all the people in the PLP
40 are equivalent bottoms, so it's real group thinking full of...sort of in it together,
41 [but] the tops are out to get us...What do we need? We need the tops to pay
42 real attention to the bottoms. So, when a chief exec says, 'It's not going to
43 [provide] any outcomes', for me, you are not talking to any of the people on your
44 Professional Leadership Programme what they need from you to save money.
45 You know, you go in circles..., but...I think it will; absolutely think it will. No
46 doubt about it, I wouldn't be doing it if I didn't think it would solve the NHS's
47 problems. Will it do it in the next two weeks? No (R14).
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3 At a higher contextual level, this quote illustrates that quality improvement is a long-
4 term issue and that there are no quick fixes. However, it was clear from the responses
5 that the IOCN came into being at the right time (i.e. during a time of change and re-
6 organisation) and that low hanging fruit would give rise to richer pickings over time if
7 the support was maintained.
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15 Within the study, we found that these challenges of using learning as an instrument
16 for development, could be addressed using the association or connection with higher
17 education establishments and also taking advantage of a city that had a culture of
18 learning in healthcare systems. In our case study, the University and NHS connection
19 enabled the development of an enabling shared space. The contact between NHS,
20 clinicians and the University led to a form of balance as a result of the programme.
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22 IOCN helped clinicians see the bigger picture beyond the traditional confines of a
23 clinical evidence base, and respondents found the process of developing the IOCN
24 quite ground-breaking and exciting.
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37 I've been in the NHS for some 30 some years, and I think what I found was the
38 relationship that NHS professionals were having with leaders from the
39 university... I found the energy that came from both the NHS professionals but
40 also from people within the University to move things on at a pace really
41 refreshing (R3).
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49 The city's university's got a good reputation, so the fact that it is with that is
50 good. The fact that there are links that could be made into academia is also
51 good for the project. There is also the analytics that comes in to support some
52 of that, in terms of that modelling (R19).
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3 Respondents 3 and 19 applauded the collaboration for focusing minds and facilitating
4 the network. The link between theory and practice was thus seen as very important
5 for IOCN's development. Furthermore, the evidence suggested that a place-based
6 network can enable whole cities like the chosen city to become centres of excellence
7 and this, in turn, was mutually beneficial for the IOCN network to flourish.
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15 In our study, it became apparent that IOCN was developing the city as a culture of
16 learning in health care systems because it involved building on the local knowledge
17 and co-existing cultures in the city. The unique blend of local knowledge embedded in
18 the fabric of the city' participating organisations coupled with Intermountain
19 Healthcare's healthcare methodology, provided a potent underpinning to the place-
20 based network: *'So it's about being able to apply a robust health improvement
21 methodology and also to develop a culture of learning' (R1)*. The methodology was
22 widely seen as viable, pragmatic and IOCN was effectively seen as a localised city-
23 wide institute, brought about by the local people themselves and not a copied
24 perfectionist or of-the-shelf model. The IOCN is thus positively influencing and
25 promoting inter-professional and inter-organisational relationships within the city's
26 healthcare landscape (however this was not necessarily limited to Quality
27 Improvement). IOCN was also seen to be facilitating co-production and collaboration
28 and working to bond different facets of the healthcare system together in the city:
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48 We are almost like the grout between the tiles. Every other organisation are the
49 tiles and as primary care, we have been the bit that has tried to join it all
50 together. It's almost like saying, how do we get rid of those tiles and how do we
51 get rid of the grout a bit so that actually its one big tile so that everything flows
52 through slowly (R6).
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3 Hence there was a real need to try not to work in an isolated manner. IOCN offered
4
5 vehicles for new clinicians and healthcare personnel to come into the city for the first
6
7 time to work. This helped them to get up to speed with immediate knowledge and
8
9 understanding of the key issues within the healthcare system of the city. For R16, her
10
11 contact with IOCN altered the way that she dealt with leadership and decision making
12
13 in her organisation:
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18 I think probably because I'm still relatively new in this city, and so it's been
19
20 invaluable in meeting and getting to know other people in other organisations
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22 across the city, and we're also similar level of interests, shared agendas, etc,
23
24 so it's [been] informal as well as formal kind of learning and sharing cultures
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26 because we all know how things should be, you know, a huge amount of
27
28 leadership is about relationships and building networks. (R16).
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33 R16 had an externally facing role regardless, but IOCN supported her in system
34
35 improvement by facilitating her work with a range of other organisations when she was
36
37 outside of the IOCN environment:
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41 As a public health specialist, I've always worked across the system and, you
42
43 know, I've always been a system leader, if not I can't do my job internally it's
44
45 always a very externally facing role. But the work in The Institute has helped
46
47 strengthen those relationships and the understanding of where are the people
48
49 and organisations and ... in working with them (R16).
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53 Networks like IOCN played a dual role: they simultaneously facilitate learning across
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55 a whole place, while drawing upon the resource and expert knowledge of the
56
57 immediate environment which included the university, health and social care
58
59 organisations and also patients and carers.
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3 Word of mouth works as well doesn't it? You will get a respiratory physician
4 talking to a cardiac physician at some point saying well we've just done some
5 really amazing stuff and our stay is now reduced down to x, and they will go
6 well why can't we do that? And hopefully rather than having to go to the
7 cardiologists and say 'have you seen what the respiratory doctors are doing'?
8 Would you like to do the same? They'd be coming to me say I've just spoken to
9 my mates in respiratory and have just been doing this. We think we can do the
10 same and here's the solution. It just needs implementing. Can we do it? For
11 me, that would be the institute absolutely doing its job (R7).
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28 **The Core Strategy is Equivalent to the Shared Narrative**

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31 In contrast to traditional organisational forms, the evidence showed that place-based
32 networks could be planned, initiated and developed quite quickly if there is fertile
33 ground like a common purpose, human and capital resources, and capabilities
34 regarding knowledge and competencies. The core strategy and objectives of such
35 place-based networks were to improve quality; drive efficiencies, and to develop a
36 culture of learning (Popper & Lipshitz, 2000; Davies & Nutley, 2000).
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45 IOCN was seen as an establishment that was able to do these and thus apply a robust
46 health improvement methodology in a city-wide improvement collaborative for the city.
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48 On the question of IOCN network and what it sought to achieve, the respondents noted
49 that all of these core aspects should be built on local co-existing cultures in the city
50 and on best systems internationally.
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3 We had a visit to intermountain healthcare in October 2013 which started us on
4 a journey to develop the [IOCN]. We have adapted our approach to reflect the
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6 NHS as opposed to the American medical model or healthcare model and we
7
8 now have two linked arms for me. Firstly, the arm which is to train the senior
9
10 leaders in the health and social care economy in the city to understand quality
11
12 improvement methodology. So how do we approach making effective
13
14 continuous improvements in the quality of care? Secondly, we identified three
15
16 programmes of care that we believed would have the biggest, would have a
17
18 potentially significant impact on the citizens of the city but were of a scale which
19
20 meant that we could test some of this methodology in the NHS that actually had
21
22 never been done before. So for me, I think it's a very innovative project and that
23
24 presents opportunities as well as challenges (R17).
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31 Respondents frequently referred to the placed-based networks' strategic objectives
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33 which included looking at ways to work together on an economy of scale, and to make
34
35 a difference that was sustainable, embedded and doable i.e.
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39 So much more of a joined-up approach because clearly, we all share the same
40
41 service users...So we need to think about shared solutions and look at things
42
43 as pathways. And we can't just keep pointing fingers at each other and saying
44
45 well if you sorted your lot out we'd be alright and it's all your fault (R5).
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49 This core strategy and objectives were reflected in a shared narrative that was initiated
50
51 at both the beginning and also allowed to evolve through the journey of the
52
53 development of the network. The shared narrative and shared culture were seen as
54
55 core components that could sustain the place-based network. The implications of a
56
57 joint narrative had also permeated through interview responses:
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3 I think we've got one about common language, common training, a common
4 approach to putting data at the centre of what we do. A common approach to
5
6 reducing unnecessary variation and a common approach to doing that in
7
8 partnership with our patients. That's it (R7).
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13 However, a continuum existed between those that felt a shared narrative did not yet
14 exist; those that felt that it was partially developed but accepted that it would take time
15 to develop more fully, or those who seen it as even fully developed.
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20 Some suggested that a commonly shared wordage for universal conversations by
21 network stakeholders would be useful:
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26 So that it's almost a script that these are the things that whatever we get the
27 conversation we get these in. Clearly, there will be a spin on it from my spin or
28 their spin or whoever but at least it would be useful to have some core elements
29 that we all signed up to and shared (R5).
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36 ... shared appreciation, that shared thinking and problem-solving in a joined-up
37 way is brilliant and of course I've had very little if nothing to do with this
38 organisation prior to this, so to get to feel you about what potential there is here
39 to tap into was brilliant (R5).
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49 **Challenges and Contradictions of Relationships within Network**

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52 The evidence suggested that relationships took time to nurture, develop and become
53 cohesive. Strong relationships between IOCN and various other organisations existed
54 over a period, however, we found that clinical leaders could eventually develop more
55 robust relationships and a common view of the broader healthcare system. Another
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3 key finding was that expectations could not be over-blown and gradual incremental
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5 change is what was expected for sustainability:
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8 ... people are going to want to run before they can walk, and therefore three
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10 programmes that we have started, I don't think they can just be passed off and
11
12 left to work on their own.... I think there'll need to be something about a
13
14 continued supporting framework. So, I do not see IOCN being just an
15
16 educational and facilitator – facility organisation...it has to also continue to
17
18 support these programmes until they are sustainable. Or there has to be some
19
20 hand-off of the programme if you know what I mean (R12).
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25 However, there was an acceptance that impacts, and influences were still emerging
26
27 but also a recognition that many challenges remain, as highlighted by two
28
29 respondents:
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32 ...relationships and attitude to people have changed very significantly. And
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34 whether that translates to the top tier so-to-speak, I'm not sure that it has
35
36 because it's not really had the opportunity to [do so] (R2).
37
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40 I think there are some key things that need to be sorted out in terms of inter-
41
42 professional working around quality and safety and allowed accountability roles
43
44 and responsibilities (R1).
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48 Although there were challenges as noted by the respondents, the setting up of a place-
49
50 based network IOCN was recognized as an avenue that could help to address the
51
52 myriad of issues and intricacies, yet like a double-edged sword, it raised new tensions
53
54 and contradictions. For instance, these were related to demands for instant
55
56 improvements and financial success. The evidence also suggested that care must be
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3 taken when developing place-based networks and that no magic bullet existed in
4 achieving changes. Rather, slow and incremental forms of change were more realistic
5 and achievable. As underpinned by observers of health policy management and
6 evaluation '...few quality initiatives yield breakthrough results in short
7 timeframes...[and] sustained efforts to analyse and improve care have yielded ground-
8 breaking results in many areas' (Baker & Dennis, 2011: p.14). This was reflected in
9 our specific case study where there was compelling evidence from most of the
10 respondents who recognised the small, sustained but incremental progress that the
11 place-based network seemed to be making. Respondents referred to:

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25 ..small pockets of evidence of impact, however, there are many potentialities
26 and a feeling amongst network members that something powerful and exciting
27 is being enacted through the IOCN network (R1).
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32 Small incremental changes were much more realistic since that could avert the risk
33 element in a change process. Some were also of the view that Leadership should drive
34 such processes;
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41 ...but I still think there a million possibilities that we will never as a group of
42 leaders think of but the people in our organisations will and what we need to do
43 are to create the conditions for them to be able to make the changes, the small
44 incremental changes that are needed [i.e. 2% a 3%,a 5% improvement to be
45 made by many people] and then respond accordingly when those changes are
46 being made to make sure that the conditions then continue to adapt to allow
47 those conditions to flourish (R7).
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57 While small incremental changes were seen as more important than big bang
58 approaches, there was a recognition that it was very important to keep an eye on the
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3 bigger picture also: 'Small incremental changes would be good. But also being able to
4 demonstrate that you are contributing to some of the big system change challenges
5 and some of the ways that we want to address those' (R3). Investment in QI was seen
6 as particularly important because of the recognition that change could not happen
7 instantly, but as R3 suggested, there was a need to be proactive rather than reactive
8 or to disregard it completely. To bring about the sustained change at both micro and
9 macro contextual levels, respondents alluded to the critical role of an energetic and
10 strategic leader holding the centre whilst simultaneously recognizing and accepting
11 the shared and distributed models of leadership i.e. 'There is a need for a systematic
12 leader in the centre that recognises variations in performances and can address and
13 reconfigure them for transformational changes' (R1). This was further reflected in the
14 following quotations:

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32 'Having someone like [University Lead] drive and enthusiasm is very important';

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35 'It's very important to have that driving us forward, and...we shouldn't
36 underestimate that as a characteristic of The Institute' (R11).

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In our study, we also found that forms of leadership are important variables in operating or sustaining the collaborative venture, as some respondents referred to the utmost need and importance of a place-based network like IOCN but also raised concerns about the complexity and tensions within their own organisations. In theory, collaborative improvement networks will use a form of leadership based upon a variation of contingent-reward component types of leadership and authentic transformational leadership i.e. a Level 5 type of leadership (Collins, 2005). This emerged as a prerequisite. However, in practice as evidenced in our case study, we

1
2
3 found out that distributed leadership did not emerge in the form and scope first
4
5 envisaged:

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7
8 ...it's a really useful idea to have a kind of coordinating centre for improvement
9
10 activities, who not only coordinate but also does things. So I think that's really
11
12 useful as a concept and I'm a great supporter of that. And therefore, that's why
13
14 I am broadly speaking a supporter of The Institute, but I suppose the thing I
15
16 struggle with is that the specifics of my organisation, the work settings in which
17
18 I work, is that it's not all that simple to me (R17).
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24 There was recognition that power, politics and turf wars were inherent in collaborative
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26 ventures and this could have been the explanation for the failure of using a blend of
27
28 leadership styles and forms. This reflects Baker & Denis (2011) who referred to the
29
30 importance of ceding territory as key leadership work in high performing collaboratives.
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34 This case study sets out to ascertain how leadership in the IOCN was distributed and
35
36 how effectively it worked in practice regarding impact and influence. For instance,
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38 IOCN, members were permitted self-managed teams to investigate areas for
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40 innovation and improvement, and to prototype solutions. They did need to provide
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42 business cases for their change, and they did need to refer to the tops for the
43
44 embedding and implementation. The intent had been to enable networks of
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46 professionals and citizens to work as peer leaders to change services, recognising the
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48 boundaries of quality and value set by senior leaders and engaging senior leaders in
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50 the design of their new models. However, the senior leaders did not fully commit to
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52 this. Nonetheless, it was feasible to cite the intent, i.e., of frontline teams identifying
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54 problems with citizens, investigating and prototyping them. Also, the choice of priorities
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56 for that year (2015) emerged from a collective conversation with circa 100 clinical and
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3 managerial leaders from all levels across the system, working on which issues were
4 the most fertile in terms of collective ownership of the need for change, real passion
5 in the clinical teams for change, and issues amenable to data-driven scrutiny were at
6 the forefront. Hence, some of the intent was realised, but distributed leadership was
7 constrained by a lack of buy-in and commitment from senior leaders because, in
8 practice, it was hard to secure a collaboration between frontline teams and the 'tops'
9 (or to cede power between organisations within the collaborative – a key feature in
10 high performing collaboratives (Baker and Denis, 2011). This was one of the
11 highlighted challenges in setting up place-based collaborative networks. Respondent
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7 below illustrated how tops and bottoms worked well together in the IOCN.

...people on a PLP say what would be really helpful is if the data that comes out of the city's Teaching Hospital Trust on attendances, people turning up with atrial fibrillation; if they could be reported in this way rather than the way they currently are, that would be really helpful, but there's nobody on our PLP who has the power to make that happen. But if they bring that to me and I can speak to our finance director or the finance director at LTHT or whoever it is, it's then my job. I can sort that out. To then work out how do we implement that change that has been recommended on the front line. That to me is about creating the conditions for an empowered dispersed leadership model to work. So, they're escalating a problem to me that they can't solve that I then have the ability to just work out and if I don't know how to do it then I know who to ask to do it for me.

Fundamental differences between a place-based network and an issues-based network

In this paper, we have highlighted challenges and insights that emerged from a collaborative organisation. The organisation in the present study is specifically situated within the UK healthcare sector. Collaboration is a laudable venture in public sector organisations (Huxham, 1996a; Vangen, 2003) in that it allows the sharing of resources and knowledge to the mutual benefits of the participants (Thomson and Perry, 2006). The IOCN network was seen as an innovative alternative to traditional hierarchical structures (Keasey et al., 2009). We now provide some examples of why a place-based network is perhaps more suitable regarding efficiency and innovation, and why in our view it is best suited to the more deeply collaborative forms of engagement and service delivery. The Fig 1 diagram provides a comparison of a place-based network example like IOCN and an issue-based network like a CLAHRC. The challenges and insights grounded in the data, allowed us to look at the fundamental differences that a place-based collaboration brings compared to an issues-based network.

A range of temporal, spatial and contextual similarities and differences emerged between the two designs. Both networks were based on the premise that learning was an essential mechanism for development, as reflected in other studies (Forrest et al., 2014). However, the methodology promoted by IOCN was much more pragmatic; with respondents applying the methodologies to specific areas of work across the system. IOCN's ALPs and PLPs were unique and provoked much thought as to how innovation and quality improvement could be addressed at a wider contextual level. Both IOCN and CLAHRC's offered a necessary link between academia and practice, enabling the translation of theory to practice (Burgoyne and James, 2006). Both networks involved

1
2
3 collaborations between UK universities and their local NHS organisations. They were
4
5 inextricably focused on improving patient outcomes in different ways. There was much
6
7 overlap between the two designs. However, CLAHRC's focused specifically on applied
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9 research translation through research networks (Hanbury et al., 2010, Harvey et al.,
10
11 2011) while IOCN was more focused on unique spaces for learning, growing and
12
13 improving together.
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18 The IOCN network was a creative, innovative entity where resources were shared for
19
20 the common good, and which also enabled rapid learning and development while
21
22 amplifying members' effectiveness (Amoo, Malby and Mervyn. 2016).
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26 CLAHRC's were nationally dispersed across nine geographical areas of England,
27
28 while IOCN was situated in a single city. CLAHRC's thus had an emphasis on
29
30 healthcare delivery topics across wider geographical areas (Rowley et al., 2012, Doyle
31
32 et al., 2013, Evans and Scarbrough, 2014). Interrelations between the three-helix
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34 components (University, Industry, and Government) can help to identify and address
35
36 issues within healthcare that are increasingly organised on a knowledge basis. A
37
38 myriad of interactions is happening at different levels both related to internal changes
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40 and impact across organizations through the formation of new structures through the
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42 helixes' recurring effect among the three levels (Etzkowitz and Leydesdorff; 2000;
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44 Etzkowitz, 2003; Boggio et al., 2016). Somewhat akin to commercial-sector type
45
46 strategic alliances, there were many challenges and contradictions of relationships
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48 within place-based (IOCN) and issues-based networks (CLAHRC's) (Judge and
49
50 Ryman, 2001, O'Toole Jr, 1997). Thus, the context in both networked designs was of
51
52 utmost importance, because the new contexts required a new vision. IOCN seemed
53
54 to have taken more of a systems-based approach reflected by Huxham and Vangen
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56 (2000), Lowndes and Skelcher (1998) and in particular, Baker and Denis (2011).
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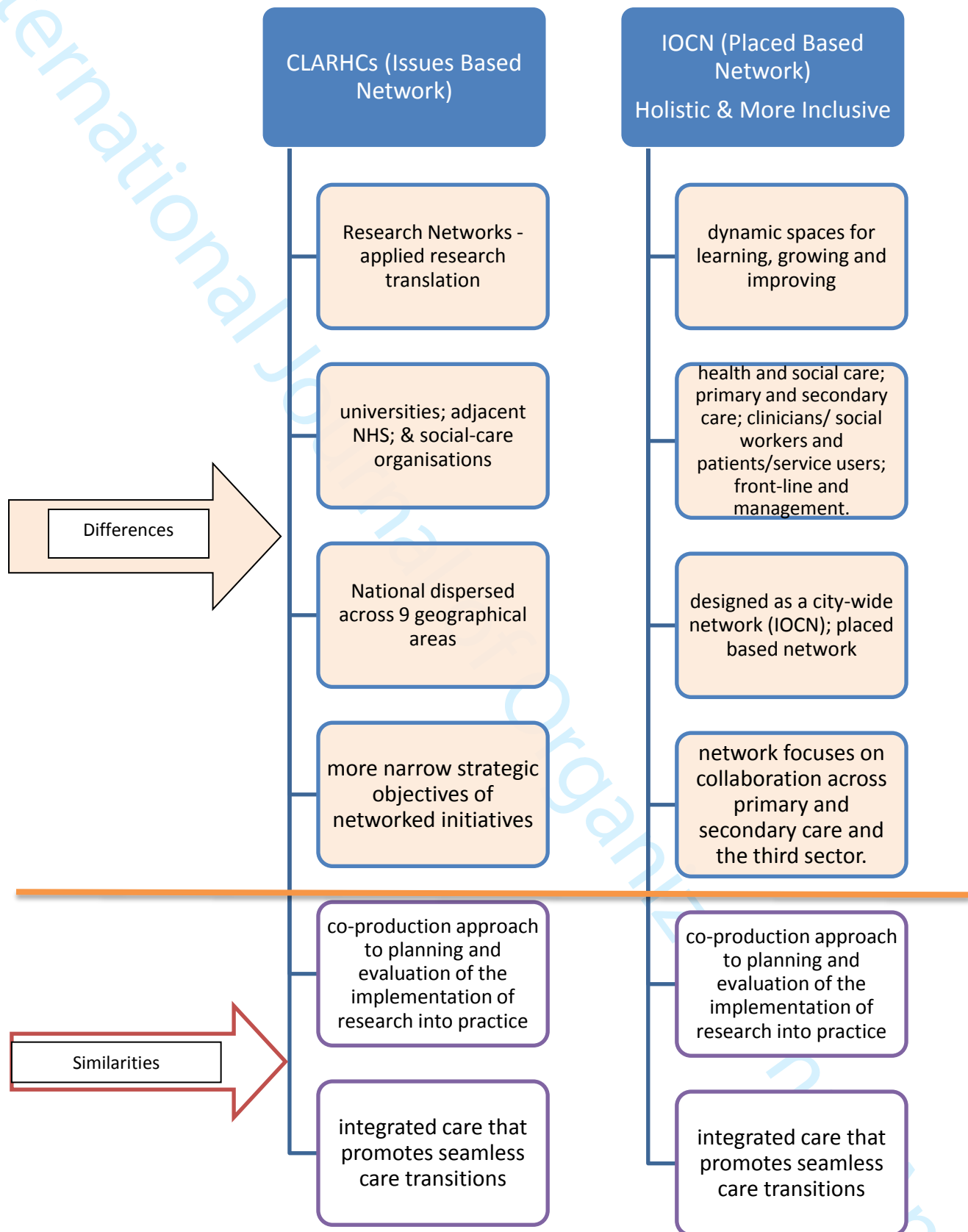


Figure 1 Comparison of Issues Based Network and Placed Based Network

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3 Both networks embraced a co-production-based approach to planning and evaluation
4 of the implementation of research into practice. Perhaps an issues-based network was
5 more limited in scope because of its lack of foresight into systemic improvement as a
6 core strategy, yet both sought to answer questions on i.e. ‘...how can healthcare
7 professionals and managers working for different organizations be helped to work
8 together effectively across organizational boundaries in the interests of the intended
9 beneficiaries (the ‘clients’) of health and social care agencies?’ (Jones and Thomas,
10 2007: 290).
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22 In IOCN’s case, this study identified the types of strategic challenges that must be
23 attended to and explored how these vital issues were diagnosed by the network
24 leaders before determining how these strategic challenges could be addressed. We
25 found the recognition that place-based networks that sought to bring about system-
26 wide change were a more sustainable entity (see e.g. Amoo, Malby & Mervyn, 2016).
27 Conversely, issues-based networks tend to focus more on single issues or a segment
28 of the local population i.e. those with mental health problems or in the context of
29 palliative medicine, such as variations in the cost of formal and informal health care
30 for patients with advanced chronic disease i.e. refractory breathlessness (Dzingina,
31 Reilly et al., 2017). The social, cultural and historical context between place-based
32 and issues-based networks also differed because of the bigger-picture thinking of a
33 place-based network and the strategic leadership role within that. This was reflected
34 for instance in how IOCN sought to promote a new culture of learning by changing
35 attitudes and behaviour with regards to innovation and quality improvement. IOCN
36 provided a platform for the growth of interpersonal networks and unconventional
37 information sharing and reflected findings in other studies (Mervyn & Allen, 2012;
38 Counts and Fisher, 2008, Fisher et al., 2010).
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3 In accordance with other studies (Doyle et al., 2013, Baillie and Matiti, 2013), both
4 networks were underpinned by the premise that diverse views should be encouraged
5 and embraced.
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10 Both and IOCN and CLAHRC's seem to have emerged at the right time; when there
11 was a need for change and re-organisation. Our evidence illustrated how large-scaled
12 and often system-wide collaborative initiatives like IOCN faced unique opportunities
13 and challenges associated with its initiation, design, implementation and sustainability
14 (Clay-Williams et al., 2014). However, IOCN seemed to create a more fertile
15 environment through which to develop a shared narrative for quality improvement
16 across a whole city. This place-based network was able to emerge and form quite
17 quickly, but time and patience were needed to nurture, develop and create a shared
18 language. In IOCN's case, there was no magic bullet for achieving change; rather,
19 slow and incremental forms of change were not always anticipated. For instance, in
20 IOCN's case, there was a shared sense of frustration with the pace of impact. These
21 further challenges were associated with inertia, alongside factors such as collaborative
22 aims; power and politics; trust relationships, collaborative structures and forms and
23 leadership (Eden and Huxham, 2001, Vangen and Huxham, 2003b). IOCN promoted
24 innovation and QI and required a gradual, incremental change while avoiding short-
25 term fixes, which seemed to contrast to the CLAHRC approach. IOCN provided more
26 of a neutral setting in which health organisations within the city could converge to
27 discuss innovation and quality improvement issues. This differed somewhat from
28 CLAHRC's in how it sought to facilitate more system-wide quality improvement. For
29 instance, IOCN positively influenced and promoted inter-professional and inter-
30 organisational relationships within the city's healthcare landscape, but this was not
31 necessarily limited to Quality Improvement.
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3 Thus, our work illustrates the transition from traditional hierarchies to alternative
4 networked organisational forms (O'Toole, 1997, Thomson and Perry, 2006, Castells,
5 2000, Ferlie et al., 2011). IOCN's network was one of the first known attempts at a
6 city-wide, place-based network for improving the quality of healthcare for citizens and
7 reflected the Place-Based Health Commission (NLGN 2016: p.11) report, which:
8 *"...suggest[s] that most local authority and health professionals agree that a place-*
9 *based system could reduce demand and deliver net cost savings to healthcare".*
10
11 Across the public sector, place and issues-based designs reflect the shift towards
12 networked forms of collaboration used to address complex problems that traditional
13 organisational structures cannot fulfil (Ferlie et al., 2011, Ferlie et al., 2012). Both
14 approaches are enhancing the value of investments in health programs, and reaching
15 underserved people in complex environments (Litwin, 1995, Perri et al., 2006,
16 Carlsson, 2003, Malby et al., 2013). We found however that collaborative place-based
17 networks are best placed to secure quality and value. IOCN built upon local co-existing
18 cultures in the city (and within GPs) and on best systems internationally. Its strategic
19 objectives included looking at ways to work together on an economy of scale, and
20 making a difference that was sustainable, embedded and doable rather than bit part
21 and only addressing one part of the problem (Baker et al., 2009, Hanbury et al., 2010,
22 Harvey et al., 2011, Kislov et al., 2012). IOCN differed from CLAHRC's also because
23 its core strategy and objectives were seen as, i.e., a shared narrative that should be
24 initiated at both the beginning and also allowed to evolve through the journey of the
25 development of the network. The shared narrative and shared culture were seen as
26 constituent elements needed to sustain a place-based network. The needs of patients,
27 carers, and families were also accounted for in both networks which both implicitly,
28 and explicatory supported the translation of research evidence into practice.
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3 Place-based networks required a form of leadership which is at odds with the more
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5 traditional approaches (see also Huxham and Vangen, 2005, Armistead et al., 2007,
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7 Vangen and Huxham, 2003a). IOCN contributed to the development of the city as a
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9 high performing health system, and evaluation of the impact included its impact on the
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11 leadership of the system as a whole, as well as the evaluation of its impact on specific
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13 clinical priorities, and data effectiveness. Place-based networks were seen to be fast-
14
15 moving and responsive entities. Their underlying value was the means through which
16
17 they drove improvement across a whole place. There were many benefits to be
18
19 garnered, with wide learning and positive influences emerging across a range of
20
21 healthcare organisations, but many challenges ensued. Nonetheless, place-based
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23 health networks catalysed broadening conversations and brought together people
24
25 from different fields across the health sector who would not otherwise have worked
26
27 together. IOCN also provided the space for network members to understand each
28
29 organisation's issues and pressures, which is even more important in the current
30
31 climate where financial challenges create the need to work together (Malby et al.,
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33 2013). In this respect, IOCN and city's healthcare systems must continue to respond
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35 to urgent financial and demand pressures.
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46 **SUMMARY AND CONCLUSION**

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49 This research sought to discover the key challenges in designing, and implementing
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51 a place-based collaborative model for improving quality, and any early lessons.
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55 We found that there are many challenges in such networked organisations and in this
56
57 study, we are of the view that place-based networks like IOCN offered a more
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59 innovative structure that can help to address complex issues beyond the remit of
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3 hierarchical structures, as long as the senior leader is willing to cede territory, and
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5 where there is a neutral academic partner to support the collaboration. One key
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7 challenge is how to enthuse clinicians and managers across the system to do
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9 something radically different for patients, service users, and carers. This requires a
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11 willingness to do over-and-above their day jobs by putting their time in to do that.
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16 In such place-based networks, we found that immense efforts must be made to
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18 ensure their sustainability. For instance, strong relationships and inter-professional
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20 working should be linked to leadership training programmes and development. The
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22 association between the health system and a higher education establishment
23
24 highlighted a culture of learning. The shared purpose and narrative that such an
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26 institution encouraged were of critical importance. This place-based network was also
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28 facilitated by the city in which it was based because, reciprocally, that place becomes
29
30 a centre of learning.
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35 The interplay between the university, the institute and the healthcare system in the city
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37 was cohesive and accommodating. Quality and systemic improvement as a core
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39 strategy was the main driving force behind such a network. Not discounting all of this,
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41 there are many challenges and goals paradox that we found (Vangen & Huxham,
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43 2011; Daley, 2009). Progress in such an initiative had to be viewed as an incremental
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45 change, and observers acknowledge that the notion of a magic bullet was flawed. This
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47 acknowledged the views of observers (Baker, 2011; Baker & Dennis, 2011) that the
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49 long-term results were more important than the short-term breakthroughs. We found
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51 that power and politics and the tendency to still work in silos was a common feature of
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53 such collaborative endeavours. The view that we found was that leadership, in as
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55 much as it can be distributed and shared within such a novel type of organisational
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3 structure, there was also the great need for a strong and energetic and strategic leader
4 that could hold the centre (Armistead et al., 2007; Alvesson and Karreman, 2015).
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8 Our findings have provided a clear understanding of the things that need unlocking at
9 system level. The findings also illuminated the activities that quality leaders in the city
10 were supposed to undertake but failed to adequately do so for unknown reasons by
11 the time that this paper was wrote.
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17 In this paper, important empirical perspectives into managing organisations in
18 healthcare have emerged that contribute to the study of public services management
19 and governance, and we have specifically highlighted issues of structural forms,
20 collaborative endeavours and leadership that enables creativity and innovation to
21 flourish when a place-based network is used.
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33 **STUDY LIMITATION AND AREAS FOR FUTURE STUDIES**

34 The limitation of the study is its restriction to data from one IOCN in one city in the UK.
35 Comparing this with data from other cities developing IOCNs would be beneficial. A
36 range of evidence-based components have helped to inform the design and delivery
37 of place-based networks in the UK. Future work could include the socio-cultural and
38 historical role of clinical place-based leadership and factors influencing the ability of
39 the tops to work as peers, (to both identify and solve some of the issues that need to
40 solve). Future studies could also consider the role of community integrators from the
41 acute sector in place-based networks; insights and challenges embedding quality as
42 a chief priority for i.e. a city; enhanced co-produced models of care through patient
43 and carer empowerment; development, testing and evaluation of community resilience
44 models; and a renewed focus on continuous improvement and learning within place-
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3 based networks. Institutes such as IOCN must be much more than educational and
4
5 facilitator-type institutions but must continue to support innovative programmes until
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7 they are sustainable.
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16 REFERENCES

17
18
19 Abbott, S. and Killoran, A. (2005) 'Mapping public health networks', Health
20
21 Development Agency.

22
23 Abel, J., Bowra, J., Walter, T. and Howarth, G. (2011) 'Compassionate community
24
25 networks: supporting home dying', *BMJ Supportive & Palliative Care*, 1(2), pp. 129-
26
27 133.

28
29 Ackoff, R. (1999) 'Transformational leadership', *Strategy & Leadership*, 27(1), pp. 20-
30
31 25.

32
33 Afonso, A., Schuknecht, L. and Tanzi, V. (2010) 'Public sector efficiency: evidence for
34
35 new EU member states and emerging markets', *Applied Economics*, 42(17), pp. 2147-
36
37 2164.

38
39 Afonso, A., Zartaloudis, S. and Papadopoulos, Y. (2015) 'How party linkages shape
40
41 austerity politics: clientelism and fiscal adjustment in Greece and Portugal during the
42
43 eurozone crisis', *Journal of European Public Policy*, 22(3), pp. 315-334.

44
45 Alexander, E. R. (1995) *How organizations act together: Interorganizational
46
47 coordination in theory and practice*. Psychology Press.

48
49 Alvensson, M. and Kärreman, D. (2015) 'Intellectual Failure and Ideological Success in
50
51 Organization Studies The Case of Transformational Leadership', *Journal of
52
53 Management Inquiry*, pp. 1056492615589974.

54
55 Armistead, C., Pettigrew, P. and Aves, S. (2007) 'Exploring leadership in multi-sectoral
56
57 partnerships', *Leadership*, 3(2), pp. 211-230.
58
59
60

1
2
3 Avolio, B. J. and Bass, B. M. (2001) Developing potential across a full range of
4 Leadership Tm: cases on transactional and transformational leadership. Psychology
5 Press.
6
7

8
9 Baker, GR., Denis, JL. (2011) A Comparative Study of Three Transformative
10 Healthcare Systems: Lessons for Canada. Canadian Foundation for Healthcare
11 Improvement. Ottawa
12
13

14
15 Baker, R., Robertson, N., Rogers, S., Davies, M., Brunskill, N., Khunti, K., Steiner, M.,
16 Williams, M. and Sinfield, P. (2009) 'The National Institute of Health Research (NIHR)
17 Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for
18 Leicestershire, Northamptonshire and Rutland (LNR): a programme protocol',
19 Implementation Science, 4(1), pp. 72.
20
21
22

23
24 Barbour, R. S. (2001) 'Checklists for improving rigour in qualitative research: a case
25 of the tail wagging the dog?', British medical journal, 322(7294), pp. 1115.
26
27

28
29 Baškarada, S., J. Watson and J. Cromarty (2017). "Balancing transactional and
30 transformational leadership." International Journal of Organizational Analysis **25**(3):
31 506-515.
32
33

34
35 Bass, B. M. (1985) Leadership and performance beyond expectations. Free Press;
36 Collier Macmillan.
37
38

39
40 Bass, B. M. (1991) 'From transactional to transformational leadership: Learning to
41 share the vision', Organizational dynamics, 18(3), pp. 19-31.
42
43

44
45 Bass, B. M. and Avolio, B. J. (1993) 'Transformational leadership: A response to
46 critiques'.
47

48
49 Baxter, P. and Jack, S. (2008) 'Qualitative case study methodology: Study design and
50 implementation for novice researchers', The qualitative report, 13(4), pp. 544-559.
51

52
53 Bealer, D. and Bhanugopan, R. (2014) 'Transactional and transformational leadership
54 behaviour of expatriate and national managers in the UAE: a cross-cultural
55 comparative analysis', The international journal of human resource management,
56 25(2), pp. 293-316.
57
58
59
60

1
2
3 Benn, J., Burnett, S., Parand, A., Pinto, A., Iskander, S. and Vincent, C. (2009)
4 'Perceptions of the impact of a large-scale collaborative improvement programme:
5 experience in the UK Safer Patients Initiative', *Journal of evaluation in clinical practice*,
6 15(3), pp. 524-540.
7
8
9

10
11 Bentley, P.J., Gulbrandsen, M. & Kyvik, S. (2015) The relationship between basic
12 and applied research in universities. *Higher Education*. 70 (4) pp 689–709. DOI:
13 10.1007/s10734-015-9861-2.
14
15

16
17 Blom, M. and Alvesson, M. (2015) 'A critical perspective on strategy as practice',
18 *Cambridge Handbook of Strategy as Practice (2nd Edition)*, pp. 409-431.
19
20

21
22 Boggio, A., Ballabeni, A. & Hemenway, D., 2016 Basic research and knowledge
23 production modes: a view from the Harvard Medical School. *Science, Technology, &*
24 *Human Values*. 41(2) pp.163-193.
25
26

27
28 Bollinger, A. S., and Smith, R. D. (2001). Managing organizational knowledge as a
29 strategic asset. *Journal of knowledge management*, 5(1), 8-18.
30
31

32
33 Britten, N. (1995). Qualitative research: qualitative interviews in medical
34 research. *Bmj*, 311(6999), 251-253.
35
36

37
38 Burgoyne, J. and James, K. T. (2006) 'Towards best or better practice in corporate
39 leadership development: operational issues in mode 2 and design science research',
40 *British Journal of Management*, 17(4), pp. 303-316.
41

42
43 Carlson, J. A. (2010) 'Avoiding traps in member checking', *The Qualitative Report*,
44 15(5), pp. 1102.
45
46

47
48 Carlsson, S. A. (2003) 'Knowledge managing and knowledge management systems
49 in inter-organizational networks', *Knowledge and process management*, 10(3), pp.
50 194-206.
51

52
53 Castells, M. 'Information Technology, Globalization and Social Development '.
54 UNRISD conference on Information Technologies and Social Development, Geneva.
55
56

57
58 Castells, M. (2000) *The Rise of the Network Society*. Malden, MA: Blackwell.
59
60

1
2
3 Charmaz, K. (2013) 'Grounded Theory as an Emergent Method ', in Hesse-Biber, S.
4 & Leavy, P. (eds.) Handbook of emergent methods: Guilford Press.

5
6
7 Chatman, E. A. (1987) 'The Information World of Low-Skilled Workers', Library and
8 Information Science Research, 9(4), pp. 265-83.

9
10
11 Chatman, E. A. (1991) 'Life in a small world: Applicability of gratification theory to
12 information seeking behavior', Journal of the American Society for Information
13 Science, 42(6), pp. 438-449.

14
15
16 Chatman, E. A. (1996) 'The impoverished life-world of outsiders', Journal of the
17 American Society for Information Science, 47(3), pp. 193-206.

18
19
20 CHILD, J. and FAULKNER, D. (1998) 'Strategies of Co-operation: Managing
21 Alliances', Networks.

22
23
24 Child, J., Faulkner, D. and Tallman, S. B. (2005) Cooperative strategy. Oxford
25 University Press, USA.

26
27
28 Clarke, N. (2005). Workplace learning environment and its relationship with learning
29 outcomes in healthcare organizations. *Human Resource Development
30 International*, 8(2), 185-205.

31
32
33 Clay-Williams, R., Nosrati, H., Cunningham, F. C., Hillman, K. and Braithwaite, J.
34 (2014) 'Do large-scale hospital-and system-wide interventions improve patient
35 outcomes: a systematic review', BMC health services research, 14(1), pp. 1.

36
37
38 Clouder, L. (2003) 'Becoming professional: exploring the complexities of professional
39 socialization in health and social care', Learning in Health and Social Care, 2(4), pp.
40 213-222.

41
42
43 Cole, M. S., Bedeian, A. G. and Bruch, H. (2011) 'Linking leader behavior and
44 leadership consensus to team performance: Integrating direct consensus and
45 dispersion models of group composition', The Leadership Quarterly, 22(2), pp. 383-
46 398.

47
48
49 Collins, J. (2005) 'Level 5 leadership: The triumph of humility and fierce resolve',
50 Harvard Business Review, , (7-8) (136-146), pp. 234.

1
2
3 Collins, J. C. (2001) *Good to great: Why some companies make the leap... and others*
4 *don't*. Random House.

5
6
7 Counts, S. and Fisher, K. 'Mobile Social Networking: An Information Grounds
8 Perspective', Hawaii International Conference on System Sciences HICSS Hawaii.

9
10
11 Creswell, J. W. and Miller, D. L. (2000) 'Determining validity in qualitative inquiry',
12 Theory into practice, 39(3), pp. 124-130.

13
14
15 Crommelin, D., Stolk, P., Besançon, L., Shah, V., Midha, K. and Leufkens, H. (2010)
16 'Pharmaceutical sciences in 2020', Nature Reviews Drug Discovery, 9(2), pp. 99-100.

17
18
19 Cruickshank, P., Hall, H. and Taylor-Smith, E. (2011) Enhancing the impact of LIS
20 Research Projects. Available at: [http://www.researchinfonet.org/wp-](http://www.researchinfonet.org/wp-content/uploads/2012/01/RiLIES_report_FINAL.pdf)
21 [content/uploads/2012/01/RiLIES_report_FINAL.pdf](http://www.researchinfonet.org/wp-content/uploads/2012/01/RiLIES_report_FINAL.pdf).

22
23
24 Curristine, T., Lonti, Z. and Joumard, I. (2007) 'Improving public sector efficiency:
25 Challenges and opportunities', OECD Journal on Budgeting, 7(1), pp. 1D.

26
27
28 Daley, Dorothy M. 2009. Interdisciplinary problems and agency boundaries: Exploring
29 effective cross agency collaboration. Journal of Public Administration Research and
30 Theory 19:477–93.

31
32
33 Davies, H. T., and Nutley, S. M. (2000). Developing learning organisations in the new
34 NHS. *BMJ: British Medical Journal*, 320(7240), 998.

35
36
37 De Silva, D. (2014) *Improvement collaboratives in health care*, London: The Health
38 Foundation. Available at:
39 [http://www.health.org.uk/public/cms/75/76/313/4932/Improvement%20collaboratives](http://www.health.org.uk/public/cms/75/76/313/4932/Improvement%20collaboratives%20in%20health%20care.pdf?realName=J4gdsn.pdf)
40 [%20in%20health%20care.pdf?realName=J4gdsn.pdf](http://www.health.org.uk/public/cms/75/76/313/4932/Improvement%20collaboratives%20in%20health%20care.pdf?realName=J4gdsn.pdf).

41
42
43 Doyle, C., Howe, C., Woodcock, T., Myron, R., Phekoo, K., McNicholas, C., Saffer, J.
44 and Bell, D. (2013) 'Making change last: applying the NHS institute for innovation and
45 improvement sustainability model to healthcare improvement', *Implementation*
46 *Science*, 8.

47
48
49 Dzingina, M.D., Reilly, C.C., Bausewein, C., Jolley, C.J., Moxham, J., McCrone, P.,
50 Higginson, I.J. and Yi, D., 2017. Variations in the cost of formal and informal health
51
52
53
54
55
56
57
58
59
60

1
2
3 care for patients with advanced chronic disease and refractory breathlessness: A
4 cross-sectional secondary analysis. *Palliative medicine*, 31(4), pp.369-377.

5
6
7 Eden, C. and Huxham, C. (2001) 'The Negotiation of Purpose in Multi-Organizational
8 Collaborative Groups', *Journal of Management Studies*, 38(3), pp. 373-391.

9
10
11 Edgren, L. (2011) 'Complex adaptive systems for management of integrated care',
12 *Leadership in Health Services*, 25(1), pp. 4-4.

13
14
15 Edgren, L. and Barnard, K. (2012) 'Complex adaptive systems for management of
16 integrated care', *Leadership in Health Services*, 25(1), pp. 39-51.

17
18
19 Eden, C. and Huxham, C. (2001) 'The Negotiation of Purpose in Multi-Organizational
20 Collaborative Groups', *Journal of Management Studies*, 38(3), pp. 373-391.

21
22
23 Evans, S. and Scarbrough, H. (2014) 'Supporting knowledge translation through
24 collaborative translational research initiatives: 'Bridging' versus 'blurring' boundary-
25 spanning approaches in the UK CLAHRC initiative', *Social Science & Medicine*, 106,
26 pp. 119-127.

27
28
29 Etzkowitz, H. (2003) Innovation in innovation: The Triple Helix of university-industry-
30 government relations. *Social Science Information*. 42(3) pp. 293-337.

31
32
33 Etzkowitz, H., & Leydesdorff, L. (2000). The dynamics of innovation: from National
34 Systems and "Mode 2" to a Triple Helix of university–industry–government relations.
35 *Research policy*, 29(2), pp. 109-123.

36
37
38 Evans, S. and Scarbrough, H. (2014) 'Supporting knowledge translation through
39 collaborative translational research initiatives: 'Bridging' versus 'blurring' boundary-
40 spanning approaches in the UK CLAHRC initiative', *Social Science & Medicine*, 106,
41 pp. 119-127.

42
43
44 Ferlie, E., Fitzgerald, L., McGivern, G., Dopson, S. and Bennett, C. (2011) 'Public
45 Policy Networks And 'Wicked Problems': A Nascent Solution?', *Public Administration*,
46 89(2), pp. 307-324.

47
48
49 Ferlie, E., McGivern, G. and Fitzgerald, L. (2012) 'A new mode of organizing in health
50 care? Governmentality and managed networks in cancer services in England', *Social
51 science & medicine* (1982), 74(3), pp. 340-7.

1
2
3 Fisher, K., E., Becker, S. and Crandall, M. 'eGovernment Services Use and Impact
4 through Public Libraries: Preliminary Findings from a National Study of Public Access
5 Computing in Public Libraries'. HICSS '10 Proceedings of the 2010 43rd Hawaii
6 International Conference on System Sciences Hawaii: IEEE, 1-10.
7
8
9

10
11 Fisher, K., E., Durrance, J., C., and Hinton, M., B. (2004) 'Information grounds and
12 the use of need-based services by immigrants in Queens, New York: A context-based,
13 outcome evaluation approach', Journal of the American Society for Information
14 Science and Technology (JASIST), 55(8), pp. 754.
15
16
17

18
19 Forrest, C. B., Margolis, P. A., Bailey, L. C., Marsolo, K., Del Beccaro, M. A.,
20 Finkelstein, J. A., Milov, D. E., Vieland, V. J., Wolf, B. A., Yu, F. B. and Kahn, M. G.
21 (2014) 'PEDSnet: a National Pediatric Learning Health System', Journal of the
22 American Medical Informatics Association : JAMIA, 21(4), pp. 602-6.
23
24
25

26
27 Fraser, H. (2004) 'Doing narrative research analysing personal stories line by line',
28 Qualitative Social Work, 3(2), pp. 179-201.
29

30
31 Friend, J. K., Power, J. and Yewlett, C. (1974) 'Public Planning: The Inter-Corporate
32 Dimension Tavistock', London, UK.
33
34

35
36 Goleman, D. (2003) 'What makes a leader', Organizational Influence Processes
37 (Porter, LW, et al. Eds.), New York, ME Sharpe, pp. 229-241.
38

39
40 Guilbert, T. W., Morgan, W. J., Krawiec, M., Lemanske, R. F., Sorkness, C., Szeffler,
41 S. J., Larsen, G., Spahn, J. D., Zeiger, R. S. and Heldt, G. (2004) 'The Prevention of
42 Early Asthma in Kids study: design, rationale and methods for the Childhood Asthma
43 Research and Education network', Controlled clinical trials, 25(3), pp. 286-310.
44
45

46
47 Hartnell, C. A. and Walumbwa, F. O. (2011) 'Transformational leadership and
48 organizational culture', The handbook of organizational culture and climate, pp. 225-
49 248.
50
51

52
53 Hanbury, A., Thompson, C., Wilson, P. M., Farley, K., Chambers, D., Warren, E.,
54 Bibby, J., Mannion, R., Watt, I. S. and Gilbody, S. (2010) 'Study protocol translating
55 research into practice in Leeds and Bradford (TRiPLaB): a protocol for a programme
56 of research'.
57
58
59
60

1
2
3 Harvey, G., Fitzgerald, L., Fielden, S., McBride, A., Waterman, H., Bamford, D., Kislov,
4 R. and Boaden, R. (2011) 'The NIHR collaboration for leadership in applied health
5 research and care (CLAHRC) for Greater Manchester: combining empirical,
6 theoretical and experiential evidence to design and evaluate a large-scale
7 implementation strategy', *Implement Sci*, 6, pp. 96.

8
9
10
11
12 Heifetz R.A, Linsky M, Grashow A (2009) *The Practice of Adaptive Leadership: Tools
13 and Tactics for Changing Your Organization and the World: A Fieldbook for
14 Practitioners*. Harvard Business Review Press

15
16
17
18 Hosking, D. M. (1988) 'Organizing, Leadership and Skilful Process [1]', *Journal of
19 Management Studies*, 25(2), pp. 147-166.

20
21
22
23 Huff, A.S. (2000) Changes in Organizational Knowledge Production. *Academy of
24 Management Review*. 25 (2) pp. 288-293.

25
26
27
28 Hulscher M., Schouten L. and R., G. (2009) *Collaboratives*, London: The Health
29 Foundation, 2009.

30
31
32 Huxham, C. (1996) *Creating collaborative advantage*. Sage.

33
34
35 Huxham, C. and Vangen, S. (2005) *'Managing to collaborate'*, Abingdon: Routledge.

36
37
38 Ibarra, H. (1993). Network centrality, power, and innovation involvement:
39 Determinants of technical and administrative roles. *Academy of Management journal*,
40 36(3), 471-501.

41
42
43
44 Lam, A. (2000). Tacit knowledge, organizational learning and societal institutions: An
45 integrated framework. *Organization studies*, 21(3), 487-513.

46
47
48
49
50 Ledema, R., Verma, R., Wutzke, S., Lyons, N. and McCaughan, B. (2017) 'A network
51 of networks: The governance of deliberative approaches to healthcare improvement
52 and reform', *Journal of Health Organization and Management*, 31(2), pp. 223-236.

53
54
55
56
57
58
59
60 Isett, K. R., Mergel, I. A., LeRoux, K., Mischen, P. A., & Rethemeyer, R. K. (2011).
61 Networks in Public Administration Scholarship: Understanding Where We Are and
62 Where We Need to Go. *Journal of Public Administration Research and Theory*: i157-
63 i173.

1
2
3 James, B.C. and Savitz, L.A., 2011. How Intermountain trimmed health care costs
4 through robust quality improvement efforts. *Health Affairs*, 30(6), pp.1185-1191.

5
6
7 Jarle, E., Bjorn Helge, J., Paul, T. B. and Odd Arne, N. (2008) 'Growing
8 transformational leaders: exploring the role of personality hardiness', *Leadership &*
9 *Organization Development Journal*, 29(1), pp. 4.

10
11
12
13 Jones, N. and Thomas, P. (2007) 'Inter-organizational Collaboration and Partnerships
14 in Health and Social Care The Role of Social Software', *Public Policy and*
15 *Administration*, 22(3), pp. 289-302.

16
17
18
19 Judge, W. Q. and Ryman, J. A. (2001) 'The shared leadership challenge in strategic
20 alliances: Lessons from the US healthcare industry', *The Academy of Management*
21 *Executive*, 15(2), pp. 71-79.

22
23
24
25
26 Keasey, K., Malby R., Turbitt I., Veronesi G. and Neogy I. 2009. National Inquiry into
27 Fit for Purpose Governance in the NHS. Centre for Innovation in Health Management.
28 The University of Leeds.

29
30
31
32
33 Kislov, R., Walshe, K. and Harvey, G. (2012) 'Managing boundaries in primary care
34 service improvement: A developmental approach to communities of practice',
35 *Implementation Science*, 7.

36
37
38
39
40 Klijn, E. H., Steijn, B. and Edelenbos, J. (2010) 'The impact of network management
41 on outcomes in governance networks', *Public Administration*, 88(1063-1082).

42
43
44
45
46 Lewis, V.A., Tierney, K.I., Colla, C.H. and Shortell, S.M., 2017. The new frontier of
47 strategic alliances in health care: New partnerships under accountable care
48 organizations. *Social Science & Medicine*.

49
50
51
52 Litwin, H. (1995) 'The Social Networks of Elderly Immigrants: an Analytic Typology ',
53 *Journal of Aging Studies*, 9(2), pp. 155-174.

54
55
56
57 Lowndes, V. and Skelcher, C. (1998) 'The dynamics of multi-organizational
58 partnerships: an analysis of changing modes of governance', *Public administration*,
59 76(2), pp. 313-333.

60
61
62
63
64
65
66
67
68
69
70 Malby B, Anderson-Wallace M. (2016) *Networks in Healthcare. Managing Complex Relationships*. Emerald

1
2
3 Malby, R., Mervyn, K. and Pirisi, L., 2013. How professionals can lead networks in the
4 NHS. *The International Journal of Leadership in Public Services*, 9(1/2), pp.47-58.

5
6
7
8 Malby, R. and Mervyn, K (2016) 'Types of Networks Explained' Chapter 3 in Malby, R
9 & Anderson-Wallace, m 2016). "Networks in Healthcare: Managing Complex
10 Relationships" (2016). Emerald Group Publishing.

11
12
13
14 Malby, R. and Mervyn, K. (2012) Networks – A briefing paper for The Health
15 Foundation, London: The Health Foundation.

16
17
18 Malby, R., Mervyn, K. and Pirisi, L. (2013) 'How professionals can lead networks in
19 the NHS', *International Journal of Leadership in Public Services*, The, 9(1/2), pp. 4-4.

20
21
22 Malby, B. and Mervyn, K. (2012) Summary of the literature to inform The Health
23 Foundation Questions

24
25
26
27 Malby, R., Mervyn, K. and Pirisi, L. (2013) 'How professionals can lead networks in
28 the NHS', *International Journal of Leadership in Public Services*, The, 9(1/2), pp. 4-4.

29
30
31 Manning, T. (2013) 'A "contingent" view of leadership: 360 degree assessments of
32 leadership behaviours in different contexts', *Industrial and Commercial Training*, 45(6),
33 pp. 343-351.

34
35
36
37 Mays, G. P. and Smith, S. A. (2011) 'Evidence links increases in public health
38 spending to declines in preventable deaths', *Health Affairs*, 30(8), pp. 1585-1593.

39
40
41 Mervyn, K. and Allen, D.K., 2012. Sociospatial context and information behavior:
42 Social exclusion and the influence of mobile information technology. *Journal of the*
43 *Association for Information Science and Technology*, 63(6), pp.1125-1141.

44
45
46
47 Metcalfe, L. (1993) 'Public management: from imitation to innovation', *Australian*
48 *Journal of Public Administration*, 52(3), pp. 292-304.

49
50
51
52 Mitsuhashi, H. (2002). "Uncertainty in selecting alliance partners: The three reduction
53 mechanisms and alliance formation processes." *The International Journal of*
54 *Organizational Analysis* **10**(2): 109-133.

1
2
3 Morse, J. M., and Field, P. A. (1995). *Nursing research: The application of qualitative*
4 *approaches*. Nelson Thornes.

5
6
7 Oshry, B. (2007). *Seeing systems: Unlocking the mysteries of organizational life*.
8 Berrett-Koehler Publishers.

9
10
11 O'Toole, J., Laurence J, Meier, K. J. and Nicholson-Crotty, S. (2005) 'Managing
12 upward, downward and outward: Networks, hierarchical relationships and
13 performance', *Public Management Review*, 7(1), pp. 45-68.

14
15
16 O'Toole Jr, L. J. (1997) 'Treating networks seriously: Practical and research-based
17 agendas in public administration', *Public administration review*, pp. 45-52.

18
19
20 Owens, B. and Hekman, D. (2012) 'Enacting humble leadership: An inductive
21 examination of humble leader behaviors, outcomes, and contingencies', *Academy of*
22 *Management Journal*, 55(4), pp. 787-818.

23
24
25 Panda, A. and Gupta, R.K. (2014) Making academic research more relevant: A few
26 suggestions. *IIMB Management Review*. 26 (3) pp.156-169.

27
28
29 Patton, M. Q. (1990) *Qualitative evaluation and research methods*. 2nd edn. Newbury
30 Park, CA: Sage Publ.

31
32
33 Perri, Goodwin, N., Peck, E. and Freeman, T. (2006) *Managing networks of twenty-*
34 *first century organisations*. Palgrave Macmillan.

35
36
37 Pettigrew, K. E. (1999) 'Waiting for chiropody: contextual results from an ethnographic
38 study of the information behaviour among attendees at community clinics', *Information*
39 *Processing & Management*, 35, pp. 801-817.

40
41
42 Pettigrew, K. E. (2000) 'Lay information provision in community settings: How
43 community health nurses disseminate human services information
44 to the elderly', *Library Quarterly*, 70 (1), pp. 47-85.

45
46
47 Pettigrew, K. E., Fidel, R. and Bruce, H. (2001) 'Conceptual frameworks in information
48 behavior', *Annual review of information science and technology (ARIST)*, 35, pp. 43-
49 78.

1
2
3 Phillips, J. M., Stalter, A. M., Dolansky, M. A., & Lopez, G. M. (2016). Fostering future
4 leadership in quality and safety in health care through systems thinking. *Journal of*
5 *Professional Nursing*, 32(1), 15-24.
6
7

8
9 Plastrik, P. and Taylor, M. (2006) 'Net gains: A handbook for network builders seeking
10 social change', Innovation Network for Communities.
11
12

13 Popper, M., and Lipshitz, R. (2000). Organizational learning: Mechanisms, culture, and
14 feasibility. *Management learning*, 31(2), 181-196.
15
16

17 Price Waterhouse Coopers (2018). The road ahead for public service delivery

18 Consulted online at:

19 https://www.pwc.com/gx/en/psrc/publications/assets/pwc_future_of_government_pdf

20
21
22
23 8.1.2018
24

25 Provan, K., G., and Milward, B., H. (2001) 'Do networks really work? A framework for
26 evaluating public-sector organizational networks', *Public administration review*, 61(4),
27 pp. 414-423.
28
29

30
31 Randall, S. (2013) *Leading networks in healthcare*: The Health Foundation, London.

32 Available at:

33 <http://www.health.org.uk/sites/default/files/LeadingNetworksInHealthcare.pdf>

34
35 (Accessed: 28.2.2016).
36
37

38
39 Ring, P. S. and Van de Ven, A. H. (1994) 'Developmental processes of cooperative
40 interorganizational relationships', *Academy of management review*, 19(1), pp. 90-118.
41
42

43 Rolfe, G. (2006) 'Validity, trustworthiness and rigour: quality and the idea of qualitative
44 research', *Journal of advanced nursing*, 53(3), pp. 304-310.
45
46

47 Rowley, E., Morriss, R., Currie, G. and Schneider, J. (2012) 'Research into practice:
48 Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for
49 Nottinghamshire, Derbyshire, Lincolnshire (NDL)', *Implementation Science*, 7.
50
51

52 Sandelowski, M. (2000) 'Focus on research methods-whatever happened to
53 qualitative description?', *Research in nursing and health*, 23(4), pp. 334-340.
54
55

56
57 Smith, J. (2010) 'The role of networks in developing integrated care', Available:
58 Nuffield Trust.
59
60

1
2
3 Sokolovsky, J., Cohen, C., Berger, D. and Geiger, J. (1978) 'Personal networks of ex-
4 mental patients in a Manhattan SRO hotel', *Human Organization*, 37(1), pp. 5-15.

5
6
7 Speklé, R. F. and Verbeeten, F. H. (2014) 'The use of performance measurement
8 systems in the public sector: effects on performance', *Management Accounting*
9 *Research*, 25(2), pp. 131-146.

10
11
12 Stake, R. E. (2013) *Multiple case study analysis*. Guilford Press.

13
14
15 Sullivan, H. Williams, P & Jeffares, S (2012) *Leadership for Collaboration*, *Public*
16 *Management Review*, 14:1, 41-66

17
18
19 Thomas, D. (2006) 'A General Inductive Approach for Analyzing Qualitative Evaluation
20 Data ', *American Journal of Evaluation*, 27(2), pp. 237-246

21
22
23 Thomson, A. M. and Perry, J. L. (2006) 'Collaboration processes: Inside the black box',
24 *Public administration review*, 66(s1), pp. 20-32.

25
26
27 Thomson, A. M., J. L. Perry, and T. K. Miller. 2007. Conceptualizing and measuring
28 collaboration. *Journal of Public Administration Research and Theory* 19:25–56.

29
30
31
32
33 Turner, A., Mulla, A., Booth, A., Aldridge, S., Stevens, S., Begum, M. and Malik, A.,
34 2018. The international knowledge base for new care models relevant to primary care-
35 led integrated models: a realist synthesis. 6.25

36
37
38
39 Turrini, A., Cristofoli, D., Frosini, F. and Nasi, G. (2010) 'Networking literature about
40 determinants of network effectiveness', *Public Administration*, 88(2), pp. 528-550.

41
42
43 Vangen, S. and Huxham, C. (2003a) 'Enacting leadership for collaborative advantage:
44 Dilemmas of ideology and pragmatism in the activities of partnership managers',
45 *British Journal of Management*, 14(s1), pp. S61-S76.

46
47
48
49 Vangen, S. and Huxham, C. (2003b) 'Nurturing collaborative relations Building trust in
50 interorganizational collaboration', *The Journal of Applied Behavioral Science*, 39(1),
51 pp. 5-31.

52
53
54
55 Vangen, S., and Huxham, C. (2011). The tangled web: unravelling the principle of
56 common goals in collaborations. *Journal of Public Administration Research and*
57 *Theory*, 22(4), 731-760.

Weber, K., and Waeger, D. (2017). Organizations as polities: An open systems perspective. *Academy of Management Annals*, 11(2), 886-918.

Wellman, B. (1999) *Networks in the Global Village*. Boulder, CO: Westview.

Wenger, E. and Snyder, W. (2000) 'Communities of practice: The organizational frontier', *Harvard Business Review*, 78(1), pp. 139-145.

Whyte, W. F. (2003). Interviewing in field research. In *Field research* (pp. 183-201). Routledge.

Wirtschafter, D., Pettit, J., Kurtin, P., Dalsey, M., Chance, K., Morrow, H., Seid, M., Byczkowski, T., Huber, T. and Milstein, J. (2010) 'A statewide quality improvement collaborative to reduce neonatal central line-associated blood stream infections', *Journal of Perinatology*, 30(3), pp. 170-181.

Yin, R. K. (2013) *Case study research: Design and methods*. Sage publications.

APPENDIX

Attribution of the Respondents in Stage 2 of the Data Collection.

Respondent	Job Title/Role	Organisation Type
R1	Clinical Chief Officer	Clinical Commissioning Group
R2	General Manager	Teaching Hospitals NHS Trust
R3	Director of Nursing and Quality	Clinical Commissioning Group
R4	Medical Director - Quality	Teaching Hospital NHS Trust
R5	AHP Strategic Lead	Partnerships NHS Foundation Trust
R6	GP and Clinical Director	Clinical Commissioning Group
R7	Medical Director (Transformation)	Clinical Commissioning Group
R8	Head of acute provider commissioning	Clinical Commissioning Group
R9	Lead Practice Nurse	Clinical Commissioning Group
R10	Programmes Manager	Community Foundation
R11	Director of Public Health	City Council
R12	Chief Medical Officer	Teaching Hospital NHS Trust

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3		Head of Cancer & Non Elective	
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5	R13	Commissioning	Clinical Commissioning Group
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7	R14	CEO	Health Management
8	R15	Chief Executive Officer	Community Pharmacy
9			
10	R16	Consultant in Public Health Medicine	City Council
11			
12			Partnership NHS Foundation
13	R17	Chief Executive Officer	Trust
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15	R18	Medical Director and Prescribing Lead	Clinical Commissioning Group
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17	R19	Chief Executive Officer	Clinical Commissioning Group
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19	R20	Primary Care Locality Manager	Clinical Commissioning Group
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21	R21	Data Scientist	Health Management
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