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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

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

Private sector organisations have adopted market models that infer that greater quality and efficiency are driven by competition and consumerism, alongside networked relationships and organisational forms to add value (Shuman and Twombley 2009). Public sector organisations such as those within the healthcare sector are also moving to more networked relationships by adopting collaborative models that recognise that increasing demand can only be supported through coproduced models of care that bring the citizens assets into the provision and production of services. Collaborations across health organisations are emerging (Friend et al., 1974, Metcalfe, 1993, Vangen and Huxham, 2003b) as they transition from traditional hierarchies to networked organisational forms (O'Toole, 1997, Thomson and Perry, 2006, Castells, 2000, Ferlie et al., 2011). The shift to more accountable and integrated health service delivery through strategic alliances is dependent upon the successful partnership of healthcare organisations across organisational boundaries (Lewis et al., 2017). US-based Accountable Care Organisations (ACO's) and similar UK-based accountable care-based models are emerging in response to tensions including elevated healthcare costs, variations in quality of care, aging and growing populations and a chronic illness epidemic (Shortell et al., 2014). However, calls for more integrated health and social care spanning primary, secondary and tertiary care are often tempered by organisational silos, '…and consequently each part works to optimise its own

performance with little if any, consideration for other parts in the care delivery system' (Shortell et al., 2014: p.1). This reflects the need for organisations to avoid simply solving problems in isolation and show willingness to work for the greater good. Change is ensuing i.e. through primary care-led integrated models (Turner, Mulla et al., 2018) however more research is needed into the role of primary care in the context of whole system change and more focus on the impact of behaviours across the system which may subsequently impact upon other parts of system.

Across the public sector there are various forms of collaboration, and depending on context, a network form of collaboration is often used to address complex problems that traditional organisational structures cannot fulfil (Ferlie et al., 2011, Ferlie et al., 2012; Thomson, et al, 2007). There is now in the UK, a proliferation of collaboration networks which, within the context of the current healthcare climate, are seen as an approach that could help to enhance the value of investments in the various health programmes, and also to reach patients and carers in complex environments (Litwin, 1995, Perri et al., 2006, Carlsson, 2003, Malby et al., 2013, Shortell et al 2014). The NHS in the UK is following the global healthcare system trend of a mixed model of organisation in an increasingly interdependent system comprising competition for procurement; strong regulation for baseline performance; and collaboration through networks to address complex needs (Malby and Anderson Wallace 2016

However, networks have different forms and functions. A typology of network types exists in healthcare (Malby and Mervyn, 2012) and there are many challenges in understanding how to design, implement and sustain such networked organisations. One such approach is the innovative design of a collaborative place-based network to secure quality and value. Collaborative place-based networks bring together the 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.

This approach addresses the issue of fragmentation and focuses on the immediate need for services to be joined up.

Current debate is heavily focused on changing the way professionals across whole places work together and with patients. This paper looks at the key challenges and insights of this approach using a single Case Study of a city-wide implementation of a large-scale healthcare collaborative in the United Kingdom (UK).

THE CONTEXT

The chosen city is one of the major cities in England. It is also a major industrial and commercial town with well-established centres for legal and financial services. As a way of addressing the shortfall in UK healthcare outcomes, an Inter-organisational Collaborative Network (IOCN) was designed by health and social care leaders in the city, from across all the provider and commissioner organisations, to secure better quality care, with-and-for patients. The IOCN website discusses how it was set up with an overarching aim and objective to secure 'improvement in quality care by enabling clinicians to develop shared expertise in innovation and improvement and developing a rigorous approach to professional accountability, using data to review variation and decision-making' with patients. It is one of the first of its kind regarding it being structured as a health quality focused placed-based network. In this paper, we use a qualitative study of IOCN to make the argument for why such a placed-based network is best suited in such a context and why IOCNs almost neutral setting enabled health organisations within the city to coalesce, discuss and address quality improvement issues. This paper adds to the body of knowledge on networks and inter-organisational collaboration in general. In particular, it focuses on the not-for-profit sector and

illuminates the uniqueness of a City-wide Collaborative (place-based network) while addressing the on-going puzzle about how to spread efficiency and innovation across service delivery. We illustrate how steps must be taken to facilitate the development, testing and evaluation of new processes, policies and interventions across traditionally disparate organisational settings. We also highlight challenges and insights and seek to interpret and understand the key issues underpinning the network's development. Basing the qualitative interviews on respondents who are part of the network, and who are senior leaders and professionals spanning different organisations, we illustrate how some of these challenges can be addressed i.e. through the senior leadership responsibility of giving direction and empowering those working at the front-line. Thus a key focus of this paper is on leadership and strategy initiatives; and a culture of organisational learning that enables and supports a community of practice (Wenger and Snyder, 2000) of healthcare professionals.

The remainder of this paper is structured as follows: in order to provide a theoretical framework, and highlight our main research question, we undertake a theoretical review of the main concepts with particular reference to the healthcare sector. We then present and explain our research approach and methods. In the results and analysis section, we use social constructionism to discuss the views of respondents, highlighting the challenges while at the same time providing insights on how these could be addressed. We end with a summary and conclusion where we position our views in the light of extant literature and make recommendations for policymakers and future studies.

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

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

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

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

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

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

Networks as an Innovative Form of Collaboration

This literature review illuminates the nature of networks, within the context of the public sector and healthcare. It also helps to determine network objectives, relationships and underpinnings in the current climate of austerity and uncertainty, and thus may enhance the value of investments in health programmes (Mays and Smith, 2011). A network regarding how it is organized is a set of "nodes" or points connected by "links" or pathways, where the "nodes" are people or organizations; the "links" are relationships. Networks are seen as distinct forms of social organisation differing from the traditional organisation, which relies on hierarchical, top-down powers to achieve strategic objectives (Plastrik and Taylor, 2006). Networks encompass organisational-type delivery mechanisms (for services and functions) and forms of collaboration (Abbott and Killoran, 2005). Public network literature is also considerably fragmented, encompassing a plurality of definitions, theories, methods and explanations (Turrini et al., 2010; Isett et al., 2011). O'Toole, (1997), and Castells (1999b) defined a network as a set of interconnected nodes, hierarchical and/or organic and fluid, and devoid of a centre.

In our context, the Health Foundation defined a network as ‘a cooperative structure where interconnected groups or individuals coalesce around a shared purpose on the basis of trust and reciprocity' (Malby and Mervyn, 2012: p.7). Randall (2013) also referred to networks in a cooperative capacity underpinned by peer sharing and learning, and whereby members interact on the basis of conviction, respect and mutuality.

In the healthcare sector, networks often ‘fill the gaps that can't be addressed by conventional systems and structures’ (Malby and Mervyn, 2016: 41) because they are

creative, innovative places where resources are shared for the common good. Networks are useful for rapid learning and development and amplifying members' effectiveness. Networks can also be useful for advocacy on behalf of their membership; for delivering services in ways that make the most of network members' capability and resources. The distribution of power and leadership across members coupled with their adaptability to survive and thrive adds to the novelty of networks and highlights their distinctiveness (c.f. Malby and Mervyn, 2012). Networks in healthcare exist to improve quality as a core purpose and are designed to do that through the full range of organizing principles from connecting individuals through social networks for learning and negotiating service improvement; through to networks that advocate for specific change; and to networks that deliver services (Malby, Mervyn and Pirisi, 2013).

Leadership in Healthcare Collaborative Networks

It is acknowledged that leadership in such organisations will require a form of leadership which could be far removed from the traditional approaches that we know (see also Huxham and Vangen, 2005, Armistead et al., 2007, Vangen and Huxham, 2003a) that write on collaboration). Two overarching styles of leadership are compared and contrasted as Transactional Leadership and Transformational Leadership (Bass, 1991, Bass, 1985, Bass and Avolio, 1993, Jarle et al., 2008, Bealer and Bhanugopan, 2014). The former is related to a more traditional and instructional style based on a model of reward and punishment, while the latter is more co-productive and participative in nature between leaders and subordinates (Ackoff, 1999, Hartnell and Walumbwa, 2011, Baškarada, et al., 2017). In the collaboration literature, due to the

loose association and multi-layered participation of the network approach, leadership is seen as more informal, emergent, less structured and often of not much significance (Hosking, 1988). Leadership is thus less hierarchical, organised around decentring (Judge and Ryman, 2001), and a more "contingent" perspective of leadership is now emerging which refutes the universality of leadership traits/behaviours that denote success in all situations (Manning, 2013, Cole et al., 2011). Whilst there is value in the shared and distributed model within networks with more informal or emergent leaders, there is also (at least at the outset) the requirement in collaborative networks for an energetic and strategic leader holding the centre who will have to enact simultaneously, the dual but opposing role of both being facilitative (spirit of collaboration) and directive (c.f. Vangen and Huxham, 2003b).

While not discounting the value of other perspectives on leadership, as suggested by Armistead et al. (2007), we are of the view that in more recent times, the inclusion of a contingent-reward component to a variant of the many forms of transformational leadership (i.e. Armistead et al.'s (2007) have emerged. Such contemporary theories of leadership can enhance the overall effectiveness of leaders; and reflect Heifetz, Linsky & Grashow's (2009) approach to wicked issues through the ability to be dynamic, adaptive and reflective to changing situations and contexts such as the management of integrated care (Edgren, 2011, Edgren and Barnard, 2012) marks a high-level leader (Avolio and Bass, 2001, Goleman, 2003). This form of leadership is what Collins (2001) denotes Level 5 leadership (see also: Collins, 2005, Owens and Hekman, 2012), where leaders are simultaneously comfortable working in shared leadership models where the functions of leadership can be dispersed to all members of the community within the organisation – the combination of the First (traits and behaviours) and Second Persons' (human interaction between groups) perspectives

of leadership (Armistead et al, 2007, pg. 21). Such a composite approach of leadership can redress some recent criticisms of transformational leadership as being ambiguous, idealised, heroic and far removed from practice (Alvesson and Kärreman, 2015, Blom and Alvesson, 2015). Therefore, leaders of collaborative networks need to be both engaging and facilitating members to act, and providing direction and focus for the network as a whole (Ledema et al., 2017).

MAIN RESEARCH QUESTIONS AND AIMS / OBJECTIVES OF STUDY

Considering the emergent role of inter-organisational collaborations, the growing use of networks as an innovative form, and the complexity of leadership in collaborative networks, Hambleton and Howard (2013) suggest that innovative and creative approaches to place-based leadership underpinned by a culture of controlled risk-taking can enhance people's everyday lives, empower local people and improve front-line services.

Hence, our main research question for this study is: What are the key challenges in designing, and implementing a place-based collaborative model for improving quality, and are there any early lessons?

In trying to address these research questions, we also focus on:

> What could be the key differences between the Inter Organisational Collaborative Network and other forms of collaborative organisation?
>
> What makes a Place-based Collaboration best suited to the type of collaborative service delivery in this present economic climate?

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

respondents can provide their own framework of meanings as much as possible (Patton, 1990, Britten, 1995). In using the semi-structured and open-ended questions, we were careful to follow similar approaches that had been used in qualitative studies and in particular in the healthcare sector (Britten, 1995, Morse & Field, 1995). For example, we started with questions that the respondent can answer easily before proceeding to more difficult or sensitive topics (Whyte, 2003). These questions were derived from the Baker and Denis (2011) categories of high performing systems. This approach also enabled us to divert from a narrow focus where a single reality is traditionally sought, to a more pluralistic discovery of truths (Fraser, 2004). These questions were used in 12 interviews conducted with senior health and social care leaders from the city's Health and Care System. Participants were selected against the criteria as described, and to secure a balance from all the health and social organisations in the city. Participants were at director and executive director level. The questions and were related to personal thoughts on performance and practices in health systems leadership across the city; the motivators and barriers to working collaboratively and the impact of IOCN. Further insights were sought about respondent leadership styles and strategies; and how the Institute could improve its contribution and develop more effective and sustainable relationships.

Interviews were transcribed and largely analysed by thematic identification by two readers of the text (with a total of 6 readers across all texts). The themes were then compared and aggregated across all the interviews.

Stage 2: After the first stage of interviews, a significant scoping review was then undertaken into high performing systems. Further consultation of the literature findings and Stage 1 research findings were conducted with experts in high performing

systems in an evaluation conference before a further, and more intensive round of interviews were undertaken.

Stage 3: This follow-up study of 21 senior healthcare interviewees (see appendix for roles and attributions of respondents) was undertaken in November 2014 using the same stage 1, selection criteria and questionnaire development approach but with a different sample. It is this data that forms the basis for this reported study.

The credibility of this study was recognized when a range of other observers external to the study into the IOCN network became acquainted with the findings (Rolfe, 2006).

For the analysis of the Stage 3 Interviews, NVIVO was used to store and manage the transcripts and facilitated the coding of responses. The interviews were transcribed and analysed by thematic identification by two readers of the text. The themes were compared and aggregated across all the interviews. After an initial round of transcript reading, each of the interviewee transcripts was then rigorously re-reviewed, by creating free nodes which were the less organised ideas and segments emanating from the text. Free nodes based on Thomas' (2006) general inductive approach then helped the researchers to identify later higher-level themes which were linked to challenges and insights involved in IOCN's inter-organisational collaborative network. Free nodes were regularly reviewed as new transcripts were coded to identify whether themes about the research questions had continued through the following interviews. Further coding was then undertaken which emphasised some of the more emergent themes (Charmaz, 2013). The literature was again subsequently explored to underpin, refute or support the evaluation research findings and a form of member checking then ensued whereby we shared research progress with the informants to validate our

interpretation and findings with the informants' viewpoints, thus increasing the trustworthiness of the data (Carlson, 2010).

RESULTS, ANALYSIS, FINDINGS AND DISCUSSIONS

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

The Institute (IOCN) comprised a collaboration across health and social care organisations in the city, with programmes of change work supported by a learning programme premised on a high performing healthcare system in the US (Intermountain Healthcare's proven healthcare methodology, approach to professional practice and quality improvement) (James & Savitz, 2011) and data analytics. IOCN aimed to improve quality of care through enabling clinicians to develop shared expertise in innovation and improvement and developing a rigorous approach to professional accountability. The objective was to create a culture of best quality clinical care at the best value, with patients, service users and carers as partners in decision-making, across the city.

Our study sought to determine the extent to which IOCN contributed to the improvement of quality in the City and therefore the development of the City as a high performing health system. The research broadly explored IOCN's impact and influence on the leadership of the system as a whole, and briefly evaluated its impact on specific clinical priorities in terms of improvements in quality. In particular, we first explored the role of learning as an essential mechanism in the ICON for quality improvement. We then reviewed the challenges and contradictions of relationships within the IOCN

network, before identifying how IOCN's strategy generates a shared narrative (an important characteristic of high performing health systems). This led to a rich theoretical discussion on the fundamental differences between a place-based network and an issues-based network.

Learning: an Essential Mechanism for Development

In all spheres of life, being able to do something is heavily facilitated by your acquisition of know-how (Bollinger & Smith, 2001; Lam, 2000) and this is also true in healthcare organisations (Clarke, 2005). Intermountain HealthCare's high performing systems approach to professional practice and quality improvement was blended with the city's Universities teaching, research and local knowledge of working across organisations within systems. Clear synergies and differences emerged between Intermountain and IOCN which made IOCN unique in its development as a high performing health care system. The importance of leadership programmes organised by IOCN has helped to both set up and sustain the network. There were two training programmes – one professional (PLP) for leaders working on specific local clinical change programmes, and one advanced (ALP) training programme (for senior leaders working at city-level) that had the objectives of coproducing learning and knowledge across the cities' healthcare system:

> I think the engagement that we've seen already from the three PLPs is that people want, ….. they're surprised that they've been given this authority to do this and I think it's about persuading them, just get on with it. We'll sort out .. opening the doors... Because if we don't then the city is not going to achieve what it is capable of (Respondent R4).

While this learning was taking place, novel challenges emerged for senior leaders involved in the advanced programmes in developing and sustaining momentum and keeping a focus on the bigger picture. These leadership programmes brought together the tops, middles, and bottoms across a patient pathway. The leadership programmes provided a platform for nurturing the shared narratives and participants frequently referred to being in the same boat and must learn to row together or sink. This was evident around garnering acceptance that pathway work was a longer-term commitment and should be supported as such. However, this reportedly lead to hesitancy amongst the tops and issues arose regarding how committed the tops were. A lack of support permeated to unease and despondency amongst otherwise innovative and keen local leaders in the PLPs. Also ‘Power and Politics' were at play from tops to bottoms and subordinates were often hesitant to converse upwards (Ibarra, 1993; Weber and Waeger, 2017). This reflected a need to break the "cultural cycle" of where top and bottoms are not working or conversing (Oshry, 2007; Phillips, et al., 2016)

> And so, you've got a sort of tops, middles, bottoms, so all the people in the PLP are equivalent bottoms, so it's real group thinking full of…sort of in it together, [but] the tops are out to get us...What do we need? We need the tops to pay real attention to the bottoms. So, when a chief exec says, ‘It's not going to [provide] any outcomes', for me, you are not talking to any of the people on your Professional Leadership Programme what they need from you to save money. You know, you go in circles…, but…I think it will; absolutely think it will. No doubt about it, I wouldn't be doing it if I didn't think it would solve the NHS's problems. Will it do it in the next two weeks? No (R14).

At a higher contextual level, this quote illustrates that quality improvement is a long-term issue and that there are no quick fixes. However, it was clear from the responses that the IOCN came into being at the right time (i.e. during a time of change and re-organisation) and that low hanging fruit would give rise to richer pickings over time if the support was maintained.

Within the study, we found that these challenges of using learning as an instrument for development, could be addressed using the association or connection with higher education establishments and also taking advantage of a city that had a culture of learning in healthcare systems. In our case study, the University and NHS connection enabled the development of an enabling shared space. The contact between NHS, clinicians and the University led to a form of balance as a result of the programme. IOCN helped clinicians see the bigger picture beyond the traditional confines of a clinical evidence base, and respondents found the process of developing the IOCN quite ground-breaking and exciting.

> I've been in the NHS for some 30 some years, and I think what I found was the relationship that NHS professionals were having with leaders from the university… I found the energy that came from both the NHS professionals but also from people within the University to move things on at a pace really refreshing (R3).

> The city's university's got a good reputation, so the fact that it is with that is good. The fact that there are links that could be made into academia is also good for the project. There is also the analytics that comes in to support some of that, in terms of that modelling (R19).

Respondents 3 and 19 applauded the collaboration for focusing minds and facilitating the network. The link between theory and practice was thus seen as very important for IOCN's development. Furthermore, the evidence suggested that a place-based network can enable whole cities like the chosen city to become centres of excellence and this, in turn, was mutually beneficial for the IOCN network to flourish.

In our study, it became apparent that IOCN was developing the city as a culture of learning in health care systems because it involved building on the local knowledge and co-existing cultures in the city. The unique blend of local knowledge embedded in the fabric of the city' participating organisations coupled with Intermountain Healthcare's healthcare methodology, provided a potent underpinning to the place-based network*: 'So it's about being able to apply a robust health improvement methodology and also to develop a culture of learning' (R1).* The methodology was widely seen as viable, pragmatic and IOCN was effectively seen as a localised city-wide institute, brought about by the local people themselves and not a copied perfectionist or of–the-shelf model. The IOCN is thus positively influencing and promoting inter-professional and inter-organisational relationships within the city's healthcare landscape (however this was not necessarily limited to Quality Improvement). IOCN was also seen to be facilitating co-production and collaboration and working to bond different facets of the healthcare system together in the city:

> We are almost like the grout between the tiles. Every other organisation are the tiles and as primary care, we have been the bit that has tried to join it all together. It's almost like saying, how do we get rid of those tiles and how do we get rid of the grout a bit so that actually its one big tile so that everything flows through slowly (R6).

Hence there was a real need to try not to work in an isolated manner. IOCN offered vehicles for new clinicians and healthcare personnel to come into the city for the first time to work. This helped them to get up to speed with immediate knowledge and understanding of the key issues within the healthcare system of the city. For R16, her contact with IOCN altered the way that she dealt with leadership and decision making in her organisation:

> I think probably because I'm still relatively new in this city, and so it's been invaluable in meeting and getting to know other people in other organisations across the city, and we're also similar level of interests, shared agendas, etc, so it's [been] informal as well as formal kind of learning and sharing cultures because we all know how things should be, you know, a huge amount of leadership is about relationships and building networks. (R16).

R16 had an externally facing role regardless, but IOCN supported her in system improvement by facilitating her work with a range of other organisations when she was outside of the IOCN environment:

> As a public health specialist, I've always worked across the system and, you know, I've always been a system leader, if not I can't do my job internally it's always a very externally facing role. But the work in The Institute has helped strengthen those relationships and the understanding of where are the people and organisations and ... in working with them (R16).

Networks like IOCN played a dual role: they simultaneously facilitate learning across a whole place, while drawing upon the resource and expert knowledge of the immediate environment which included the university, health and social care organisations and also patients and carers.

> Word of mouth works as well doesn't it? You will get a respiratory physician talking to a cardiac physician at some point saying well we've just done some really amazing stuff and our stay is now reduced down to x, and they will go well why can't we do that? And hopefully rather than having to go to the cardiologists and say 'have you seen what the respiratory doctors are doing'? Would you like to do the same? They'd be coming to me say I've just spoken to my mates in respiratory and have just been doing this. We think we can do the same and here's the solution. It just needs implementing. Can we do it? For me, that would be the institute absolutely doing its job (R7).

The Core Strategy is Equivalent to the Shared Narrative

In contrast to traditional organisational forms, the evidence showed that place-based networks could be planned, initiated and developed quite quickly if there is fertile ground like a common purpose, human and capital resources, and capabilities regarding knowledge and competencies. The core strategy and objectives of such place-based networks were to improve quality; drive efficiencies, and to develop a culture of learning (Popper & Lipshitz, 2000; Davies & Nutley, 2000).

IOCN was seen as an establishment that was able to do these and thus apply a robust health improvement methodology in a city-wide improvement collaborative for the city. On the question of IOCN network and what it sought to achieve, the respondents noted that all of these core aspects should be built on local co-existing cultures in the city and on best systems internationally.

> We had a visit to intermountain healthcare in October 2013 which started us on a journey to develop the [IOCN]. We have adapted our approach to reflect the NHS as opposed to the American medical model or healthcare model and we now have two linked arms for me. Firstly, the arm which is to train the senior leaders in the health and social care economy in the city to understand quality improvement methodology. So how do we approach making effective continuous improvements in the quality of care? Secondly, we identified three programmes of care that we believed would have the biggest, would have a potentially significant impact on the citizens of the city but were of a scale which meant that we could test some of this methodology in the NHS that actually had never been done before. So for me, I think it's a very innovative project and that presents opportunities as well as challenges (R17).

Respondents frequently referred to the placed-based networks' strategic objectives which included looking at ways to work together on an economy of scale, and to make a difference that was sustainable, embedded and doable i.e.

> So much more of a joined-up approach because clearly, we all share the same service users…So we need to think about shared solutions and look at things as pathways. And we can't just keep pointing fingers at each other and saying well if you sorted your lot out we'd be alright and it's all your fault (R5).

This core strategy and objectives were reflected in a shared narrative that was initiated at both the beginning and also allowed to evolve through the journey of the development of the network. The shared narrative and shared culture were seen as core components that could sustain the place-based network. The implications of a joint narrative had also permeated through interview responses:

> I think we've got one about common language, common training, a common approach to putting data at the centre of what we do. A common approach to reducing unnecessary variation and a common approach to doing that in partnership with our patients. That's it (R7).

However, a continuum existed between those that felt a shared narrative did not yet exist; those that felt that it was partially developed but accepted that it would take time to develop more fully, or those who seen it as even fully developed.

Some suggested that a commonly shared wordage for universal conversations by network stakeholders would be useful:

> So that it's almost a script that these are the things that whatever we get the conversation we get these in. Clearly, there will be a spin on it from my spin or their spin or whoever but at least it would be useful to have some core elements that we all signed up to and shared (R5).

> … shared appreciation, that shared thinking and problem-solving in a joined-up way is brilliant and of course I've had very little if nothing to do with this organisation prior to this, so to get to feel you about what potential there is here to tap into was brilliant (R5).

Challenges and Contradictions of Relationships within Network

The evidence suggested that relationships took time to nurture, develop and become cohesive. Strong relationships between IOCN and various other organisations existed over a period, however, we found that clinical leaders could eventually develop more robust relationships and a common view of the broader healthcare system. Another

key finding was that expectations could not be over-blown and gradual incremental change is what was expected for sustainability:

> ... people are going to want to run before they can walk, and therefore three programmes that we have started, I don't think they can just be passed off and left to work on their own.... I think there'll need to be something about a continued supporting framework. So, I do not see IOCN being just an educational and facilitator – facility organisation…it has to also continue to support these programmes until they are sustainable. Or there has to be some hand-off of the programme if you know what I mean (R12).

However, there was an acceptance that impacts, and influences were still emerging but also a recognition that many challenges remain, as highlighted by two respondents:

> ...relationships and attitude to people have changed very significantly. And whether that translates to the top tier so-to-speak, I'm not sure that it has because it's not really had the opportunity to [do so] (R2).

> I think there are some key things that need to be sorted out in terms of inter-professional working around quality and safety and allowed accountability roles and responsibilities (R1).

Although there were challenges as noted by the respondents, the setting up of a place-based network IOCN was recognized as an avenue that could help to address the myriad of issues and intricacies, yet like a double-edged sword, it raised new tensions and contradictions. For instance, these were related to demands for instant improvements and financial success. The evidence also suggested that care must be

taken when developing place-based networks and that no magic bullet existed in achieving changes. Rather, slow and incremental forms of change were more realistic and achievable. As underpinned by observers of health policy management and evaluation '…few quality initiatives yield breakthrough results in short timeframes…[and] sustained efforts to analyse and improve care have yielded ground-breaking results in many areas' (Baker & Dennis, 2011: p.14). This was reflected in our specific case study where there was compelling evidence from most of the respondents who recognised the small, sustained but incremental progress that the place-based network seemed to be making. Respondents referred to:

> ..small pockets of evidence of impact, however, there are many potentialities and a feeling amongst network members that something powerful and exciting is being enacted through the IOCN network (R1).

Small incremental changes were much more realistic since that could avert the risk element in a change process. Some were also of the view that Leadership should drive such processes;

> …but I still think there a million possibilities that we will never as a group of leaders think of but the people in our organisations will and what we need to do are to create the conditions for them to be able to make the changes, the small incremental changes that are needed [i.e. 2% a 3%,a 5% improvement to be made by many people] and then respond accordingly when those changes are being made to make sure that the conditions then continue to adapt to allow those conditions to flourish (R7).

While small incremental changes were seen as more important than big bang approaches, there was a recognition that it was very important to keep an eye on the

bigger picture also: 'Small incremental changes would be good. But also being able to demonstrate that you are contributing to some of the big system change challenges and some of the ways that we want to address those' (R3). Investment in QI was seen as particularly important because of the recognition that change could not happen instantly, but as R3 suggested, there was a need to be proactive rather than reactive or to disregard it completely. To bring about the sustained change at both micro and macro contextual levels, respondents alluded to the critical role of an energetic and strategic leader holding the centre whilst simultaneously recognizing and accepting the shared and distributed models of leadership i.e. 'There is a need for a systematic leader in the centre that recognises variations in performances and can address and reconfigure them for transformational changes' (R1). This was further reflected in the following quotations:

> 'Having someone like [University Lead] drive and enthusiasm is very important';
>
> 'It's very important to have that driving us forward, and…we shouldn't underestimate that as a characteristic of The Institute' (R11).

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

found out that distributed leadership did not emerge in the form and scope first envisaged:

> …it's a really useful idea to have a kind of coordinating centre for improvement activities, who not only coordinate but also does things. So I think that's really useful as a concept and I'm a great supporter of that. And therefore, that's why I am broadly speaking a supporter of The Institute, but I suppose the thing I struggle with is that the specifics of my organisation, the work settings in which I work, is that it's not all that simple to me (R17).

There was recognition that power, politics and turf wars were inherent in collaborative ventures and this could have been the explanation for the failure of using a blend of leadership styles and forms. This reflects Baker & Denis (2011) who referred to the importance of ceding territory as key leadership work in high performing collaboratives.

This case study sets out to ascertain how leadership in the IOCN was distributed and how effectively it worked in practice regarding impact and influence. For instance, IOCN, members were permitted self-managed teams to investigate areas for innovation and improvement, and to prototype solutions. They did need to provide business cases for their change, and they did need to refer to the tops for the embedding and implementation. The intent had been to enable networks of professionals and citizens to work as peer leaders to change services, recognising the boundaries of quality and value set by senior leaders and engaging senior leaders in the design of their new models. However, the senior leaders did not fully commit to this. Nonetheless, it was feasible to cite the intent, i.e., of frontline teams identifying problems with citizens, investigating and prototyping them. Also, the choice of priorities for that year (2015) emerged from a collective conversation with circa 100 clinical and

managerial leaders from all levels across the system, working on which issues where the most fertile in terms of collective ownership of the need for change, real passion in the clinical teams for change, and issues amenable to data-driven scrutiny were at the forefront. Hence, some of the intent was realised, but distributed leadership was constrained by a lack of buy-in and commitment from senior leaders because, in practice, it was hard to secure a collaboration between frontline teams and the 'tops' (or to cede power between organisations within the collaborative – a key feature in high performing collaboratives (Baker and Denis, 2011). This was one of the highlighted challenges in setting up place-based collaborative networks. Respondent 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

collaborations between UK universities and their local NHS organisations. They were inextricably focused on improving patient outcomes in different ways. There was much overlap between the two designs. However, CLAHRC's focused specifically on applied research translation through research networks (Hanbury et al., 2010, Harvey et al., 2011) while IOCN was more focused on unique spaces for learning, growing and improving together.

The IOCN network was a creative, innovative entity where resources were shared for the common good, and which also enabled rapid learning and development while amplifying members' effectiveness (Amoo, Malby and Mervyn. 2016).

CLAHRC's were nationally dispersed across nine geographical areas of England, while IOCN was situated in a single city. CLAHRC's thus had an emphasis on healthcare delivery topics across wider geographical areas (Rowley et al., 2012, Doyle et al., 2013, Evans and Scarbrough, 2014). Interrelations between the three-helix components (University, Industry, and Government) can help to identify and address issues within healthcare that are increasingly organised on a knowledge basis. A myriad of interactions is happening at different levels both related to internal changes and impact across organizations through the formation of new structures through the helixes' recurring effect among the three levels (Etzkowitz and Leydesdorff; 2000; Etzkowitz, 2003; Boggio et al., 2016). Somewhat akin to commercial-sector type strategic alliances, there were many challenges and contradictions of relationships within place-based (IOCN) and issues-based networks (CLAHRC's) (Judge and Ryman, 2001, O'Toole Jr, 1997). Thus, the context in both networked designs was of utmost importance, because the new contexts required a new vision. IOCN seemed to have taken more of a systems-based approach reflected by Huxham and Vangen (2000), Lowndes and Skelcher (1998) and in particular, Baker and Denis (2011).

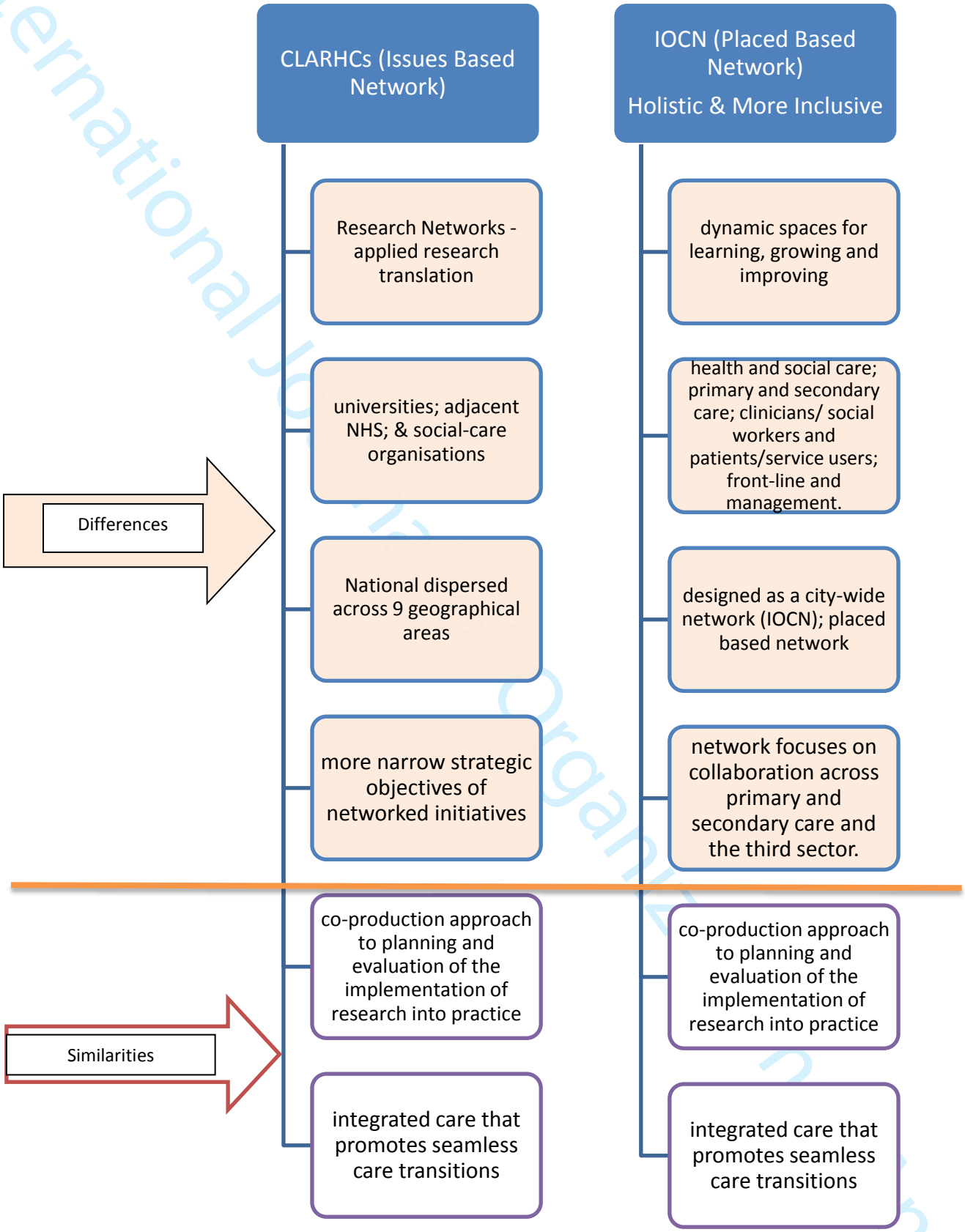

Figure 1 Comparison of Issues Based Network and Placed Based Network

Both networks embraced a co-production-based approach to planning and evaluation of the implementation of research into practice. Perhaps an issues-based network was more limited in scope because of its lack of foresight into systemic improvement as a core strategy, yet both sought to answer questions on i.e. '...how can healthcare professionals and managers working for different organizations be helped to work together effectively across organizational boundaries in the interests of the intended beneficiaries (the 'clients') of health and social care agencies'?' (Jones and Thomas, 2007: 290).

In IOCN's case, this study identified the types of strategic challenges that must be attended to and explored how these vital issues were diagnosed by the network leaders before determining how these strategic challenges could be addressed. We found the recognition that place-based networks that sought to bring about system-wide change were a more sustainable entity (see e.g. Amoo, Malby & Mervyn, 2016). Conversely, issues-based networks tend to focus more on single issues or a segment of the local population i.e. those with mental health problems or in the context of palliative medicine, such as variations in the cost of formal and informal health care for patients with advanced chronic disease i.e. refractory breathlessness (Dzingina, Reilly et al., 2017). The social, cultural and historical context between place-based and issues-based networks also differed because of the bigger-picture thinking of a place-based network and the strategic leadership role within that. This was reflected for instance in how IOCN sought to promote a new culture of learning by changing attitudes and behaviour with regards to innovation and quality improvement. IOCN provided a platform for the growth of interpersonal networks and unconventional information sharing and reflected findings in other studies (Mervyn & Allen, 2012; Counts and Fisher, 2008, Fisher et al., 2010).

In accordance with other studies (Doyle et al., 2013, Baillie and Matiti, 2013), both networks were underpinned by the premise that diverse views should be encouraged and embraced.

Both and IOCN and CLAHRC's seem to have emerged at the right time; when there was a need for change and re-organisation. Our evidence illustrated how large-scaled and often system-wide collaborative initiatives like IOCN faced unique opportunities and challenges associated with its initiation, design, implementation and sustainability (Clay-Williams et al., 2014). However, IOCN seemed to create a more fertile environment through which to develop a shared narrative for quality improvement across a whole city. This place-based network was able to emerge and form quite quickly, but time and patience were needed to nurture, develop and create a shared language. In IOCN's case, there was no magic bullet for achieving change; rather, slow and incremental forms of change were not always anticipated. For instance, in IOCN's case, there was a shared sense of frustration with the pace of impact. These further challenges were associated with inertia, alongside factors such as collaborative aims; power and politics; trust relationships, collaborative structures and forms and leadership (Eden and Huxham, 2001, Vangen and Huxham, 2003b). IOCN promoted innovation and QI and required a gradual, incremental change while avoiding short-term fixes, which seemed to contrast to the CLAHRC approach. IOCN provided more of a neutral setting in which health organisations within the city could converge to discuss innovation and quality improvement issues. This differed somewhat from CLAHRC's in how it sought to facilitate more system-wide quality improvement. For instance, IOCN positively influenced and promoted inter-professional and inter-organisational relationships within the city's healthcare landscape, but this was not necessarily limited to Quality Improvement.

Thus, our work illustrates the transition from traditional hierarchies to alternative networked organisational forms (O'Toole, 1997, Thomson and Perry, 2006, Castells, 2000, Ferlie et al., 2011). IOCN's network was one of the first known attempts at a city-wide, place-based network for improving the quality of healthcare for citizens and reflected the Place-Based Health Commission (NLGN 2016: p.11) report, which: *"...suggest[s] that most local authority and health professionals agree that a place-based system could reduce demand and deliver net cost savings to healthcare".* Across the public sector, place and issues-based designs reflect the shift towards networked forms of collaboration used to address complex problems that traditional organisational structures cannot fulfil (Ferlie et al., 2011, Ferlie et al., 2012). Both approaches are enhancing the value of investments in health programs, and reaching underserved people in complex environments (Litwin, 1995, Perri et al., 2006, Carlsson, 2003, Malby et al., 2013). We found however that collaborative place-based networks are best placed to secure quality and value. IOCN built upon local co-existing cultures in the city (and within GPs) and on best systems internationally. Its strategic objectives included looking at ways to work together on an economy of scale, and making a difference that was sustainable, embedded and doable rather than bit part and only addressing one part of the problem (Baker et al., 2009, Hanbury et al., 2010, Harvey et al., 2011, Kislov et al., 2012). IOCN differed from CLAHRC's also because its core strategy and objectives were seen as, i.e., a shared narrative that should be initiated at both the beginning and also allowed to evolve through the journey of the development of the network. The shared narrative and shared culture were seen as constituent elements needed to sustain a place-based network. The needs of patients, carers, and families were also accounted for in both networks which both implicitly, and explicatory supported the translation of research evidence into practice.

Place-based networks required a form of leadership which is at odds with the more traditional approaches (see also Huxham and Vangen, 2005, Armistead et al., 2007, Vangen and Huxham, 2003a). IOCN contributed to the development of the city as a high performing health system, and evaluation of the impact included its impact on the leadership of the system as a whole, as well as the evaluation of its impact on specific clinical priorities, and data effectiveness. Place-based networks were seen to be fast-moving and responsive entities. Their underlying value was the means through which they drove improvement across a whole place. There were many benefits to be garnered, with wide learning and positive influences emerging across a range of healthcare organisations, but many challenges ensued. Nonetheless, place-based health networks catalysed broadening conversations and brought together people from different fields across the health sector who would not otherwise have worked together. IOCN also provided the space for network members to understand each organisation's issues and pressures, which is even more important in the current climate where financial challenges create the need to work together (Malby et al., 2013). In this respect, IOCN and city's healthcare systems must continue to respond to urgent financial and demand pressures.

SUMMARY AND CONCLUSION

This research sought to discover the key challenges in designing, and implementing a place-based collaborative model for improving quality, and any early lessons.

We found that there are many challenges in such networked organisations and in this study, we are of the view that place-based networks like IOCN offered a more innovative structure that can help to address complex issues beyond the remit of

hierarchical structures, as long as the senior leader is willing to cede territory, and where there is a neutral academic partner to support the collaboration. One key challenge is how to enthuse clinicians and managers across the system to do something radically different for patients, service users, and carers. This requires a willingness to do over-and-above their day jobs by putting their time in to do that.

In such place-based networks, we found that immense efforts must be made to ensure their sustainability. For instance, strong relationships and inter-professional working should be linked to leadership training programmes and development. The association between the health system and a higher education establishment highlighted a culture of learning. The shared purpose and narrative that such an institution encouraged were of critical importance. This place-based network was also facilitated by the city in which it was based because, reciprocally, that place becomes a centre of learning.

The interplay between the university, the institute and the healthcare system in the city was cohesive and accommodating. Quality and systemic improvement as a core strategy was the main driving force behind such a network. Not discounting all of this, there are many challenges and goals paradox that we found (Vangen & Huxham, 2011; Daley, 2009). Progress in such an initiative had to be viewed as an incremental change, and observers acknowledge that the notion of a magic bullet was flawed. This acknowledged the views of observers (Baker, 2011; Baker & Dennis, 2011) that the long-term results were more important than the short-term breakthroughs. We found that power and politics and the tendency to still work in silos was a common feature of such collaborative endeavours. The view that we found was that leadership, in as much as it can be distributed and shared within such a novel type of organisational

structure, there was also the great need for a strong and energetic and strategic leader that could hold the centre (Armistead et al., 2007; Alvesson and Karreman, 2015).

Our findings have provided a clear understanding of the things that need unlocking at system level. The findings also illuminated the activities that quality leaders in the city were supposed to undertake but failed to adequately do so for unknown reasons by the time that this paper was wrote.

In this paper, important empirical perspectives into managing organisations in healthcare have emerged that contribute to the study of public services management and governance, and we have specifically highlighted issues of structural forms, collaborative endeavours and leadership that enables creativity and innovation to flourish when a place-based network is used.

STUDY LIMITATION AND AREAS FOR FUTURE STUDIES

The limitation of the study is its restriction to data from one IOCN in one city in the UK. Comparing this with data from other cities developing IOCNs would be beneficial. A range of evidence-based components have helped to inform the design and delivery of place-based networks in the UK. Future work could include the socio-cultural and historical role of clinical place-based leadership and factors influencing the ability of the tops to work as peers, (to both identify and solve some of the issues that need to solve). Future studies could also consider the role of community integrators from the acute sector in place-based networks; insights and challenges embedding quality as a chief priority for i.e. a city; enhanced co-produced models of care through patient and carer empowerment; development, testing and evaluation of community resilience models; and a renewed focus on continuous improvement and learning within place-

based networks. Institutes such as IOCN must be much more than educational and facilitator-type institutions but must continue to support innovative programmes until they are sustainable.

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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

R13	Head of Cancer & Non Elective Commissioning	Clinical Commissioning Group
R14	CEO	Health Management
R15	Chief Executive Officer	Community Pharmacy
R16	Consultant in Public Health Medicine	City Council
R17	Chief Executive Officer	Partnership NHS Foundation Trust
R18	Medical Director and Prescribing Lead	Clinical Commissioning Group
R19	Chief Executive Officer	Clinical Commissioning Group
R20	Primary Care Locality Manager	Clinical Commissioning Group
R21	Data Scientist	Health Management