

**BARRIERS AND OPPORTUNITIES
ASSOCIATED WITH INTRA AND
INTER-ORGANISATIONAL
COLLABORATION IN THE CONTEXT
OF LONG TERM CONDITIONS
PROGRAMME**

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ABSTRACT

In New Zealand, the Ministry of Health (MOH) and the District Health Boards (DHBs) have taken the lead in initiating long term conditions strategies or programmes. However in recent years the primary health care sector is also playing a vital role in delivering long term conditions related services. Popular chronic conditions management models signify the importance of working together in meeting the challenges of Long Term Conditions. Enabling partnerships and collaboration for such programmes is a challenge because of many barriers but there are also opportunities or strengths in such programmes.

This research has conducted a qualitative study involving a constructivist epistemological perspective. The main research question for this study was *“What are the main barriers and opportunities associated with intra and inter organisational collaboration in the context of Long Term Conditions programme implementation?”* Semi-structured interviews of key people, involved in Long Term Conditions programme implementation in the Wellington region, were conducted. Data from the interviews, following a thematic analysis, has corroborated the importance and effectiveness of collaboration, but also brings to fore the various barriers associated with partners working together to achieve common goals.

The study has identified that financial constraints, limited support from senior management, and communication barriers have affected the process of collaboration to an extent. In spite of these barriers, the study has also identified there is personal commitment from the research participants towards organisational collaboration. Also the implementation process has seen some progress made in developing partnerships and organisational collaboration. What is required now is further financial and policy support from senior management within these organisations for intra and inter organisational collaboration in the context of Long Term Conditions Programme implementation

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CHAPTER ONE - INTRODUCTION

Health systems throughout the world face challenges with chronic conditions. It is said that sixty percent of all deaths globally are due to chronic conditions and in the next ten years, the number of deaths attributable to chronic diseases is projected to rise by seventeen percent (Nolte & McKee, 2008). In New Zealand, chronic conditions account for more than eighty percent of deaths and also are the leading cause of morbidity (NHC, 2006). Chronic conditions are also responsible for nearly 70 % of all health costs (HRC, 2006). New Zealand, as other countries, is rising to meet this health challenge. Chronic conditions management and treatment is not new to the New Zealand health system but the Long Term Conditions Strategy has been introduced to the country quite recently (MOH, 2009).

The National Health Committee (NHC) in a report on Long Term Conditions (NHC, 2006) recommended the Ministry of Health (MOH) to work with District Health Boards (DHBs) to bring about comprehensive alignments within health and social sectors, between health providers and services, and across health disciplines. To follow recommendations of the NHC, the MOH and DHBs introduced collaborative and partnership models and change management processes. The current government is also emphasising the importance of partnerships at all levels including funding, operational, clinical networks, public private partnership, etc. (National, 2007). The Government wants better coordinated and integrated service planning and decision making at all levels of the health services (Ryall, 2009). The aim is to have better delivery of services at district, regional and national levels. Amongst many other requirements, partnership between health professional and administrators is a key requirement.

The MOH of New Zealand has taken the lead in developing a national Long Term Conditions Programme (LTCP) framework (MOH, 2008B). This framework will inform regional and district providers about chronic conditions service planning and delivery. The framework and implementation has also been adapted by the DHBs and the primary care sector. One of the key goals of the LTCP in New Zealand is to “galvanise action for effective Long-Term Conditions Management (LTCM) in the health sector and inter-sectorally” (MOH, 2008B). Many challenges face the implementation of the LTC strategy in terms of collaboration and partnership.

Previous studies have discussed the difficulties for organisations to come together to collaborate within the public sector (Lowndes & Skelcher, 1998). Also research has discussed the complexities and challenges associated with adopting an interorganisational collaborative approach to deal with Long Term Conditions (Rea, Kenealy, Wellingham, Moffitt, Sinclair, & McAuley, 2007). This study attempts to document issues associated with partnership and collaboration and in particular focuses on the barriers and opportunities associated with inter and intra organisational collaboration in the context of Long Term Conditions Programme implementation.

The implementation process of the Long Term Conditions Programme in the Wellington region was chosen as a background for this study. The Wellington region has been mainly chosen because of the presence of numerous organisations involved in Long Term Conditions Programme implementation and the convenience of recruiting participants for the study as the region is where the author resides.

The report begins with a literature review of general management literature around collaboration and partnership, chronic condition management models, and implementation of Long Term Conditions programmes in New Zealand. This is then followed by a section on the research methodology and methods adopted in this study and the research findings. The report ends with a discussion and analysis of the research findings.

CHAPTER 2- LITERATURE REVIEW

To identify what research has been done in the areas of ‘collaboration’, ‘partnership’ and in particular ‘inter and intra -organisational collaboration’, a literature review was conducted. The author utilised several sources to identify literature pertaining to the research topic including databases such as ‘Business Source Complete’, ‘Web of Science’, and ‘Newztext Newspapers’. Also web search engines like ‘Google Scholar’ and ‘Google Web Search’ were employed. Key words such as ‘Long Term Conditions’, ‘Chronic Conditions’, ‘Chronic Diseases’, ‘Inter organisational collaboration’, ‘partnership’, and ‘intersectoral collaboration’ were utilised to identify relevant literature. Further to this, grey literature such as hard copies relating to ‘Long Term Conditions Frameworks’ and Government Health strategies were obtained from research participants.

Initially in this chapter, literature from general management research about ‘partnerships’ and ‘collaborative ventures’ is presented. This is followed by a review of the current models being used in chronic conditions management. There after chronic conditions management in New Zealand is reviewed and finally the implementation of the Long Term Conditions Programme in the Wellington region is discussed.

2.1 Partnerships and Collaborative Ventures:

Multi-organisational collaboration has now become an important means of managing public programmes (Lowndes & Kelcher, 1998). Debates within academic and public management spheres are emphasising benefits that collaborative, inter-agency partnerships could offer (Lowndes & Skelcher, 1998). Collaboration, between and amongst organisations, range from partnerships to inter-firm networks. Partnerships add

value by bringing together matching services and encourage innovation and synergy (Lowndes & Skelcher, 1998). They also reduce duplication and enable sharing of overheads.

This cross sector collaboration has been assumed to be necessary and appealing as a strategy to address societal challenges (Bryson, Crosby & Stone, 2006). Overseas in countries, such as the UK, partnership work especially in the health and social sector has moved from the margins to mainstream activity based on which organisations are being scrutinised and audited (Mann, Pritchard, & Rummery, 2004). Collaboration according to its Latin root – Collaborare- means working together (Maccoby, 2006). While the meaning is clear, creating collaboration and partnerships between organisations is very complex because of the differing contexts and managerial challenges involved whilst engaging the human side (such as dealing with personalities and enabling trust among people) (Maccoby, 2006). The reality is that the push towards collaboration is changing organisations and challenging existing attitudes.

Environmental factors can greatly mark the formation of inter organisational relationship. Cross sector collaborations in particular are influenced by efforts to solve public issues (Bryson, Crosby & Stone, 2006). If a single sector or organisation fails to solve these issues on their own, there is an impetus to collaborate across sectors or organisations. Lowndes and Skelcher (1998) talk of various stages in this multi-organisational partnership including pre-partnership collaboration, partnership creation and consolidation, partnership programme delivery and partnership termination or succession. They state the balance and tensions between these stages could influence agenda for action and relationships between partners. While environmental factors do

influence development of interorganisational relationships, Vangen and Huxham (2003) also describe the role of partnership managers or leaders in the development of collaborative ventures. They state that partnership managers not only have to champion and nurture different stages of partnerships but also manage the tension between being supportive and being directive in such partnerships.

It might be assumed there is an overall and guiding inter-organisational theory or framework to inform inter-organisational collaboration, but according to Williams (2002) there is no consolidated body of inter-organisational theory). Research in this area is characterised by various concepts, theories and research results. It is found that resource dependency and network models dominate the theoretical approaches. Mann et al (2004) describe partners, in multi-organisational collaborative ventures within the public sector, have a significant degree of interdependence and are assumed to be in a relationship engaged on trust.

Williams (2002) suggests intra organisational forms influence the outcome of partnership initiatives. Also according to Williams (2002), bureaucratic and hierarchical forms of organisations are significant obstacles to inter-dependency because of compartmentalism and hierarchical control. While organisations designed around collaboration and networking are favourable to partnerships and interdependency. In describing inter-organisational relationships, authors like Snow and Thomas emphasise the importance of identifying barrier or conditions that are influential in determining the success or failure of collaborative ventures such as shared vision, communication, and teamwork; while authors like Huxham and Vangen focus on key themes in collaborative practice such as trust, leadership, accountability and power (Williams, 2002).

While currently, numerous forms of collaboration proliferate across both sectoral and organisational boundaries in the policy landscape, Williams (2002) argues that the discourse is positioned largely at an organisational level ignoring the individual actors who play a pivotal role in the management of inter-organisational relationships. A necessary part of inter organisational dynamics involves development and sustainability of effective personal relationships, while Williams (2002) suggests that fixation at the organisational and inter organisation domain levels diminishes the vital contribution of individual actors.

Within organisational cultures, selection of professionals with collaborative attitudes is necessary to enable collaboration (Maccoby, 2006). However for these professionals to make a bureaucratic culture collaborative time is very much required and resistance may arise because of personalities involved. Therefore leadership at the top is essential to create collaborative environments. This leadership involves a vision for collaborative strategies and an interactive personality (Maccoby, 2006). But real success will also depend not just on the creativity and determination of practitioners and managers but also Government edicts and structural change (Williams, 2002).

However collaborations do not solve all of the problems they tackle and, indeed, some outcomes of cross sector collaborations have been less than favourable (Bryson, Crosby & Stone, 2006). Often, governments insist that funding recipients collaborate even with scant evidence. Stress on collaboration or partnerships can be a way of deflecting attention from failure of public agencies to meet objectives of consumers and also little evidence is available that partnership work within the public sector has provided improved outcomes for end users (Mann, Pritchard, & Rummery, 2004).

Collaboration is no panacea to public problems, because of the very nature of interconnectedness means adverse changes in one place can reverberate dangerously across the system and complex feedback effects occur (Bryson, Crosby & Stone, 2006). Organisational barriers to joint working, including different aims, priorities, funding cycles and accountability arrangements, can be made worse by cost shunting and blame shifting (Mann, Pritchard, & Rummery, 2004). Because of this, issues such as health care are now being redefined in broader terms of economic competitiveness, industrial policy, education policy tax, expenditure policy, immigration policy and more (Bryson, Crosby & Stone, 2006).

Further inter professional barriers, within the health sector, have to be contended with when trying to work in partnerships. Managers, doctors, nurses, social workers all have different professional values (Mann, Pritchard, & Rummery, 2004). Overcoming these barriers can be difficult without enormous patience and a sense of shared goals. Maccoby (2006) provides examples of organisations like Mayo Clinic who have overcome professional barriers and created collaborative culture by developing shared goals within multi-disciplinary teams.

Lastly restructuring can also result in organisations that are engaged in partnerships to become inward focused (Mann, Pritchard, & Rummery, 2004). According to Miller and Ahmad (as cited in Mann et al, 2004) professionals working within the new structure would concentrate inwardly on their practice to protect themselves from job insecurities and stresses. Organisational instability and the development of new managerial structures can deflect managers on delivering their obligations.

2.2 Chronic Condition Management models- initiatives and opportunities:

A report from the Institute of Medicine in the US called for an overhaul of the entire health system to respond to people with chronic conditions (IM, 2001). This redesign of the health system would move away from a disease focus to a patient centred model of care. These models would emphasise multi-disciplinary team work and good communication. Coordinated and integrated services would have a better chance of providing effective and efficient care for people with chronic conditions. Also the National Health Committee of New Zealand (NHC, 2006) states that aligned systems feature collaborative relationships that clarify provider roles and enable clearly stated outcomes. There are benefits to both providers and users of services in achieving such integrated health systems

The 'Wagner Chronic Care Model', first described in 1998, is a chronic care model followed widely by health systems in the developed world (Rothman and Wagner, 2003; Rea et al, 2007). It identifies 'system organisation' as a key element to promote high quality management of chronic conditions. The model describes formation of partnerships between organisations to support processes that will fill gaps in services. The model also describes that leadership is necessary to bring changes in health care and partnerships between organisations will help promote change.

Research about chronic care programmes in New Zealand has highlighted the difficulties of securing a unified, collaborative intra- and inter-organisational approach to management of chronic care (Eggleton & Kenealy, 2009; Pullon, 2007; Rea et al, 2007). There are indeed challenges that have been noted with the implementation of chronic care models like self-management, choice of best practice models and decision support

tools and types of disease interventions (Rea et al, 2007). However for the purpose of this research, we will focus on the challenges associated with partnerships and collaboration.

2.3 Chronic Conditions Management in New Zealand:

Both the New Zealand Health Strategy 2000 and the Primary Health Care Strategy (PHCS) 2001 advocate for integrated care in addressing chronic conditions and disparities (Rea et al, 2007). Integrated Care has varying definitions but at the broadest level it includes preventative care, social care and care in the home needing a host of organisations or services to contribute to it. Some commentators like Hudson et al (as cited in Glendinning, 2002) have located integration at one end of a continuum of inter organisational collaboration which at the bottom has complete separation and at the top full integration. This kind of continuum resonates with other integrated continuums, such as proposed by Leutz (as cited in Glendinning, 2002). The Ministry of Health has led a national initiative called 'Leading for Outcomes' which draws upon the New Zealand Health Strategy 2000 to support a shift in the focus of the health system to improve health and wellbeing at population levels (NHC, 2006).

Further the current Government has in its 'Better Sooner More Convenient (BSMC)' strategy for primary care, which is a progression of the PHCS 2001, set as its medium term direction a 'single system' approach that is centred on the patients (MOH, 2009B). This means better integration between regulated health professionals, the non-regulated health workforce, and Non-Governmental Organisations; and better integration between primary and secondary care, primary care and public health, as well as primary care and social care. BSMC wants to create incentives for working together and for doing the

“right thing” (collaboration) (MOH, 2009B). It also wants to achieve strong relationships, high levels of trust and joint decision making between multiple parties (MOH, 2009B).

The New Zealand Long Term Conditions Programme in its ‘Framework for Action’ also calls for significant changes in current chronic conditions service delivery whereby the system is defined by clear leadership, strong partnerships, integrated policies, relevant accountability ; and the services are integrated and coordinated (MOH, 2008A) as described in Figure 1.

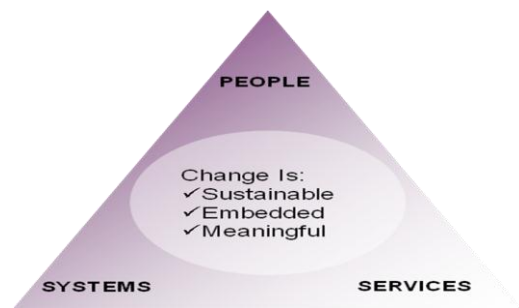


Figure 1. Framework for Action-Long Term Conditions Programme. From “A new approach to long term conditions in New Zealand” by MOH, 2008 A. power point presentation-slide 23.

In all of the chronic care models and strategies, primary care services play a key and substantial role (Pullon, 2007; NHC, 2006). This is because primary care services are the first point of contact with health system, continue over time and are generally well-coordinated (Pullon , 2007). The Primary Health Care Strategy 2001 enabled the formation of Primary Health Organisations and a broad population based approach to primary health care (Pullon, 2007; Rea et al, 2007). This has supported the development of multidisciplinary teams which not only involves hospital specialists working along with primary care practitioners but also increased input from social services and community groups in the care of patients. These multidisciplinary teams are supported by analysts,

administrators, managers, information management and patient management systems (Wellingham, 2007).

Care Plus, a primary care programme which aims to improve care for people with chronic conditions and high health needs, has enabled health professionals to work in a more collaborative manner and complementary way (Hill, 2008A). It has also enabled a 'partnership type model' of working with patients, where patients sign contracts to enter the programme and aim for self-determined goals. A review of the Care Plus programme in 2006 found while the programme was reaching patients with chronic high needs, the programme had to be enhanced to better facilitate care planning and to increase primary health care teamwork (CBG, 2006). Another study on Care Plus by Eggleton and Kenealy (2009) also recommends better teamwork and communication between professionals, involved in care of people with chronic conditions, for the programme to be more effective.

Elsewhere in the community, partnership based chronic care models include the example of Maori asthma self-management in Wairarapa in 1992 (NHC, 2006). This programme was a collaborative research initiative which established partnership between people with chronic conditions and health professionals, services and community support. The management plan was provided through clinics based on marae or other community settings. Evaluation both early and long term indicated multiple benefits to the participants.

The National Health Committee in its report on chronic condition management in New Zealand identified several issues that had to be addressed for improved chronic conditions service delivery. Key among these issues were a lack of coherent and whole of systems approach, lack of coordinated care and service provision, and need for multi-disciplinary working in primary care (MOH , 2008 A; NHC, 2006). Also in New Zealand, poor coordination between health professionals and social services has been very clearly identified (Pullon, 2007; Eggleton & Kenealy, 2009). Pullon (2007) in the same paper further elaborates the issues for primary care being poor alignment of health and social system structures with funding models not supporting multidisciplinary teams. It is also noted from a rural chronic conditions management case model that in spite of good intra sectoral partnerships and commitment, the practicalities of implementation do not keep pace with the optimism of business cases (Doolan-Noble and Tracy, 2007).

2.4 The Long Term Conditions Programme in the Wellington region:

The Greater Wellington region is home to more than 400,000 people (WCC, 2010) and has 11.1 % of the New Zealand population (Statistics NZ, 2010). Apart from 3 District Health Boards (DHBs) and several Primary Health Organisations (PHOs), the region is also home to central agencies like the Ministry of Health (MOH) (MOH, 2010). Health Needs Analysis (HNA) undertaken by the DHBs have identified numerous population groups with various long term conditions and high health needs (CCDHB, 2008) (HVDHB, 2009).

The National Health Committee in its report on Chronic Conditions Management had emphasized the importance of a coordinated and collaborative approach in dealing with Long Term Conditions (NHC, 2006). Likewise, the DHBs and PHOs of the region

emphasise the importance of coordinated approaches in positively influencing incidence of chronic conditions and improving the lives of chronic conditions patients (CCDHB, 2008; CPHO, 2009). The DHBs and PHOs in the region are in various stages of developing 'Long Term Conditions' Frameworks or Strategies or Implementation Plans (CCDHB, 2008; HVDHB, 2009; CPHO, 2009). These plans have been influenced by the NHC Chronic Conditions Framework and the MOH Long Term Conditions Strategy

2.5 Summary

In this chapter, it was noted organisations choose to collaborate when individual organisations on their own fail to solve societal issues. There is the advantage, in collaboration, of sharing of resources and reduction of duplication. The review also notes how individuals play an important role in development and maintenance of interorganisational collaboration. However the review also identifies various barriers for joint working including financial, organisational and professional barriers.

CHAPTER 3- METHODOLOGY

This section explores and explains the theoretical basis of my research and the choice of my methodology and methods.

3.1 Research Direction

In the previous chapter we noted that chronic conditions programmes involve inter-organisational and multidisciplinary input to realise aimed objectives. In fact the Long Term Conditions strategy has as one of its objective to work collaboratively towards addressing chronic conditions issues (MOH, 2008 A). That and various chronic condition care models emphasise the importance of collaboration or partnership across the health sector to meet the needs of patients.

However these partnerships or collaborations are not easy to manage. Challenges come in the form of poor co-ordination, non-alignment of systems, behaviour of team members, time frames, and funding limitations (NHC, 2006) (Pullon , 2007) (Rea et al, 2007). But government stakeholders have advantage as leaders because of their authority to make public policies, allocate funds, convene tax holders and thereon (Crosby and Bryson, 2005). There is also great promise in the work that has been already done to address chronic conditions (NHC, 2006).

In this regard, this study seeks to identify the opportunities and the barriers that would affect or influence intra and inter-organisational collaboration in the context of currently being implemented long-term conditions programmes in the Wellington region.

3.2 Research Methodology and Method:

In developing a research strategy, much thought goes into answering 2 questions. Firstly, what kind of methodologies and methods would the research employ and secondly, how would we justify the methodologies and methods we have employed (Crotty, 1998). Further to this, questions like what theoretical perspective lies behind the methodology and also what epistemology informs this theoretical perspective have to be answered (Crotty, 1998).

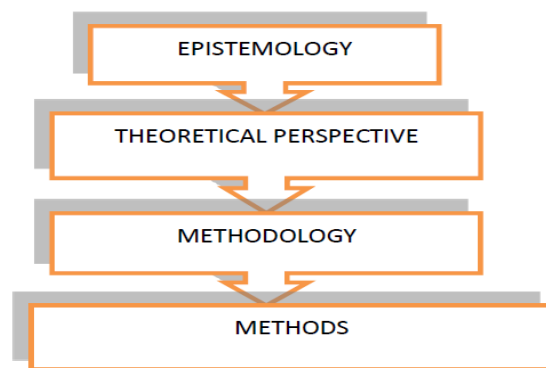


Figure 2. Four elements of Research Process. *From The Foundations of Social Research* (p.4), by Crotty.M., 1998, Allen and Unwin.

It has been stated that the issue of research method comes secondary to the issue of the research paradigm applicable to one's research (Saunders, Lewis & Thornhill, 2007). Paradigms are the worldviews, which guide the research process and include theoretical approach and choice of epistemology. Epistemology has been described as "*the theory of knowledge embedded in the theoretical perspective and thereby in the methodology*" (Crotty, 1998, p.3). One such epistemology is constructivist epistemology. While objectivist epistemology holds that meaning and in turn meaningful reality, is distinct from the operation of any consciousness; constructivist epistemology holds the opposite view of human knowledge (Crotty, 1998). It states that no objective truth exists and truth or meaning comes into

existence because of our engagement with the realities in our world. meaning is not discovered but constructed. It is the *“view that all knowledge and therefore all meaningful reality is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context”* (Crotty, 1998, p.42). This epistemological perspective was deemed to be relevant to this study which is focused on relationships (collaboration).

After adopting an epistemological position, consideration was given to the theoretical perspectives. Interpretivism, as a theoretical perspective, attempts to understand and explain human and social reality (Crotty, 1998). The approach seeks to obtain interpretations of the social life world from a cultural and historical basis. With this study, an interpretive stance is considered to be most suitable. This is because Interpretivism calls for the understanding of differences between humans in our position as social actors (Saunders et al, 2007). This perspective would be appropriate to study leadership, barriers and opportunities because these are the result of a particular set of circumstances. With this perspective the researcher would have to enter into the social world of research subjects and understand the world from their point of view (Saunders et al, 2007).

This research mainly intends to identify the barriers and opportunities that influence implementation of long term conditions programmes. Based on the literature review (section II) areas that need to be researched (barriers, opportunities.) have been identified. To obtain findings, data collection is required and the author has employed qualitative methods of data collection such as interviews.

A research method has been described as a specific research technique to obtain evidence about a phenomenon and examples include surveys, interviews, and participant observation (Crotty, 1998). Methodology involves more than methods or tools and has been described as “*the theory of how inquiry should proceed*” that “*involves analysis of the principles and procedures in a particular field of inquiry*” (Schwandt, 1997, p.93). Based on this methodology can be described as a “theory and analysis of how research should proceed” (Harding, 1987, p.3). Qualitative methods of data collection include focus groups, nominal group techniques, observational studies, and case studies but the main method of obtaining data for qualitative analysis is by interview (Fitzpatrick & Boulton, 1994).

An interview has been described as “*a process in which a researcher and participant engage in a conversation focused on questions related to a research study*” (DeMarrais, 2004, p.54). Interviews are used when a researcher wants to obtain an in-depth knowledge about a particular topic from research participants. The topics could include phenomena, experiences, or sets of experiences (DeMarrais, 2004). The intention of these interviews is to develop as much as possible of a picture of the topic from the words or experience of the participant. These types of interviews involve researchers developing a rapport with participants and discussing aspects of the topic being studied. As each participant in the research study is unique, each interview experience will also be unique (DeMarrais, 2004). Interviews can be highly formalised and structured using standardised questions or they may be entirely informal and unstructured observations (Saunders et al, 2007).

A very useful interview format for undertaking qualitative research is semi-structured interviews as they allow flexibility in structuring questions and eliciting response (Zorn, 2010). These types of interviews are also called as 'moderately scheduled'. In this interview, the format is neither highly structured with close ended questions nor is it unstructured with totally open ended questions. The semi structured interviews are constructed in a way to elicit participant's ideas and opinions by offering them topics and questions. The interviewer then follows up with probes to get in-depth information on topics of interest. With this form of interview, the researcher will have a list of theme and questions to be covered (Saunders et al, 2007). These themes and questions may change from interview to interview. There is flexibility allowed in the type and order of questions to be asked. This format of interviewing was found to be useful for this research as it would allow the researcher to question research participants around themes of partnership, barriers and opportunities.

Thematic analysis has been described as a method of identifying, analysing and reporting themes within data (Braun & Clarke, 2006). Various phases in thematic analysis include familiarising oneself with the research data, generating initial codes , searching for themes , reviewing themes , defining and naming themes and producing the report. Thematic analysis is flexible and describes data sets in detail. The other advantages of thematic analysis are it can usefully summarise key features of a large body of data and highlight similarities and differences across the data set (Braun & Clarke, 2006). Since data from the interviews would be organised around themes, thematic analysis was employed for data analysis in this study.

3.3 Sampling, Semi structured Interview and data analysis:

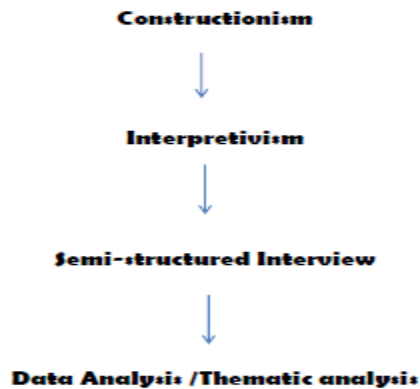


Figure 3. Research approaches for this study. By Author

The research design utilised a purposive or judgmental sampling strategy to obtain research participants. Purposive sampling strategy enables the researcher to select participants based on judgment, to answer research questions (Saunders et al, 2007). The sample selected through this process is not chosen for their statistical representation of the general population, but for the information rich data they provide.

Health Managers and professionals play a key role in managing long term conditions programmes in New Zealand (NHC, 2006; Pullon, 2007) and as discussed in section II, their leadership plays a key role in the success or not of collaborative programmes. For this study, it will be pertinent to obtain their views as to the barriers and opportunities they face in leading such programmes.

The study selected sample cases from 4 organisations in the Wellington region – The MOH, 2 DHBs, and a major primary health organisation – which are involved with implementation of Long Term Conditions in the Wellington region. Previous studies and documents have identified these organisations as the key drivers or leaders in

implementing the Long Term Conditions strategy or programmes (Pullon, 2007; NHC, 2006; Wellingham, 2007).

The key criteria for selection was that the persons selected for interviewing were actively involved in the implementation of the long term conditions programmes in line with the Long Term Conditions Strategy. The secondary criterion was that the programmes they were involved in had to have a collaborative model and intra or inter organisational partnership. Following identification of the participants, semi structured interviews were then utilised to collect information about key foci. The main research question was: “What are the barriers and opportunities facing intra and inter-organisational collaboration in the context of long term condition programmes in New Zealand?”

Because a semi structured interview format (See Appendix IV) was being adopted, foci were identified and they included the below:

- *Role of leadership in implementation of Long Term Conditions programmes*
- *Role of partnerships or collaboration in successful implementation of Long Term Conditions programmes*
- *The goals or objectives of such partnership or collaboration based Long Term Conditions programmes*
- *What are the barriers in leading these partnership or collaboration based programmes?*
- *What are the opportunities in leading these partnership or collaboration based programmes?*

The principal researcher conducted one initial interview with each of the participant at the participant’s offices or work place at times convenient to them. The participants received an information sheet and completed a consent form that outlined opportunity

to withdraw; confidentiality and other relevant information (See Appendices III for documentation). None of the above data collection involved accessing patient records or details; rather it involved collection of data relating to services delivered to client groups. In fact this research and research process could be also replicated in non-health service settings such as social services.

Initial interviews lasted approximately 60 minutes with interview data being recorded both on tape (based on consent) and by handwritten notes. Data from this interview was analysed to identify themes and the points of interest that emerged within each category. Themes and trends were analysed by repeated reading of the transcripts. Key themes were then identified and headings provided. The themes and data were rechecked against original data to ensure reliability. The data was also analysed for similarities and differences in the participant's answers in relation to various foci and the relation to the research question.

Following this a summary of the interviews was produced. Following the data analysis the researcher revisited the participants as a second stage of data collection. This involved another 30 minutes of interview with each of the participant to test the emerging themes and confirm barriers, opportunities and intersectoral collaboration along with any differing views.

3.4 Ethical Considerations

As stated by the Massey University code for ethical research¹ (Massey, 2009) ethical requirements are the result of an evolving understanding of human rights. In the context

¹ Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants (2009)

of research, ethics refers to the appropriateness of researcher's behaviour in relation to either study participants or those who will be impacted by the research (Saunders et al, 2006)

As far as my knowledge permitted, I did not foresee any risks the study would have posed. However the research could have highlighted barriers and bottlenecks for organisational collaboration in the context of Long Term Conditions Programme Implementation. The portrayal of this issue could reflect on the organisations in a negative manner. Therefore it was decided, identification of participants would be protected. This and other ethical issues (See Appendix I) were covered in an application made to the Central Regional Ethics Committee of the National Health and Disability Ethics Committee. An application was made to this committee rather than the Massey University Ethics Committee because the research covers health issues. As the research did not deal with patient or health services clients, an expedited review application was made and was approved by the committee (See Appendix II).

3.5 Other studies with similar research methods

A study conducted in Australia investigated mother's perceptions of vaccine-preventable diseases, and associated vaccines in terms of perceived susceptibility, severity, benefits and barriers (Bond et al, 1998). I utilised this study as an example because it dealt with similar themes as in my research barriers and opportunities. It also adopted a qualitative approach to study the issue. The study also used purposive and stratified sampling. Recruiting and interviewing continued until saturation occurred. Semi-structured interviews were used to collect information from parents regarding various themes. The type of interview allowed for the understanding of parents to be explored in detail while

providing a structure, which ensured the same topics were covered in all interviews. A single researcher at the participant's home conducted all interviews and the interviews lasted between 45-90 minutes. Then all interviews were audio taped and fully transcribed. The results from the study helped in contributed to the understanding of the reasons behind parent's decision not to immunise (Bond et al, 1998).

Another study that serves as an example sought to identify factors critical to implementation of integrated mental health services in rural community-based outpatient clinics in the USA (Kirchner et al, 2004). To gain the understanding, semi-structured interviews were conducted with 20 health care providers and staff. Following this four raters independently evaluated interview transcripts and content analysis was done to summarise the interview results.

3.6 Limitations of study's research method:

The sample size and research design approach has limitations in generalizability of the resulting information. There is also the possibility of selection bias or under representation because of access issues. Selection bias might have occurred, as the author chose organisations and participants in proximity to his work. Also there was a smaller sample as some potential participants declined to participate in the study because they felt they did not have enough information to contribute to the study or were no longer involved in the implementation of Long Term Condition programmes. Further they may be issues associated with the interview format in terms of reliability such as interviewer bias and also interviewee or response bias (Bond, Nolan, Pattison & Carlin, 1998) (Saunders et al, 2006).

However to reduce the risk of interviewer bias and response bias, a second round of interviews was conducted. Also it must be remembered that with non-standardised research methods the intent is not repeatability of findings but capturing of information for a particular context at a particular time (Saunders et al, 2006). Also qualitative studies, with similar research design, intend to provide greater understanding of behaviours and processes that influence programme implementation.

While the sample was small (4 participants) , the nature of the participants and their organisations (key people and key organisations in the implementation of Long Term Conditions Programme in the region) meant rich data was obtained. Also interviews were conducted in two phases to allow for more in depth exploration of foci. The reliability of the research design was enhanced by careful preparation for the interviews and obtaining the confidence of the interviewees. Provision of results to participants for feedback, following the first interview, also enhanced further reliability.

CHAPTER FOUR- RESEARCH FINDINGS

4.1 Voices of the informed:

As discussed in 3.3, purposive sampling was utilised to identify research participants for this study. Each participant had to belong to a key health organization involved in the implementation of 'Long Term Conditions Programme' in the Greater Wellington Region. In this direction, a concerted effort was made to identify research participants from the two DHBs in the region, a large PHO and the MOH. Participants from the DHBs and the PHO would represent the provider's point of view and the participant from the MOH would provide a funder's perspective. Inquiries were made through networks to identify people who were leaders implementing long term conditions programmes in the region. Following identification of 4 participants, semi structured interviews were conducted.

To maintain anonymity of the interviewees/research participants the names and departments are not stated. Though, because of the unique nature of the institution of Ministry of Health (the main central health agency and funder of health services in New Zealand) the organisation is named. However the name of the research participant and the department to which the participant belongs in the Ministry of Health is anonymised.

For the purpose of the study, the research participant from

- DHB 1 is identified as **PARTICIPANT 1**
- DHB 2 is identified as **PARTICIPANT 2**
- PHO is identified as **PARTICIPANT 3**
- MOH is identified as **PARTICIPANT 4**

Following thematic analysis (as explained in 3.3), the data is presented under 4 themes- namely:

- Leadership
- Partnerships and collaboration
- Barriers
- Opportunities
- Progress (in achieving partnerships and collaboration)

4.2 Leadership:

Both Williams (2002) and Maccoby (2006) write about individuals within organisation and the importance of them , as leaders, in enabling partnerships and collaboration within and external to organisations. In this direction, participants were asked about their role and time involved in implementing long term conditions programmes and the team they belonged to. The response from the participants, to these queries, varied with their time and their experience with the implementation of long term conditions programmes.

The participant from DHB1 had a clear history and involvement in the area, while other participants were settling into roles that had oversight of the Long Term Conditions Programme implementation process

PARTICIPANT 1:

“I have been the Advisor for the long term conditions programme for the DHB and I have helped with running a think tank I have been involved with the long-term conditions programme for the DHB in its present form for 3 years ... (and) I have a background in aged care so long term conditions have been part of my being for a number of years.”

PARTICIPANT 2: *“my role is Service Delivery Manger so most of the long term conditions programmes fall within my portfolio so I manage them from a service perspective as well as the contracting and service development side of it.”* and with the involvement being for *“Just over a year now”*.

PARTICIPANT 4: *“First of all, I need to clarify there isn’t a (specific) long-term conditions programme (within the organisation) but it is a focus for the team that I am part of.”* and *“In 2009 the long-term conditions focus (within our organisation) was moved into our team.”* and *“my role is still being determined.....but certainly the focus will be on long term conditions within the primary care setting.”*

The above comments highlight the difference in the history of the participants involvement in the Long Term Conditions Programme but at the same moment identifies the participants as key in the implementation of long term conditions programmes .

A further question was asked if there was a specific ‘Long Term Conditions’ Implementation team which they oversaw or were part of. The question was necessary to explore team dynamics and identify what support the participants had from their organisation. None of the participants or organisations had a ‘Long Term Conditions’ team, but had support from advisory groups or committees or from colleagues who were either working in the same area or had an interest in the programme.

PARTICIPANT 1: *“At this point in time we don’t have a formal team, we do have a Steering Group, which covers both secondary and primary conditions and advises members of the executive team from the DHB that has been providing governance to the different phases of the project that we have gone through so far.*

PARTICIPANT 2: *“There is no one officially in the long term conditions programme per say but the way we work I fall within the team of primary and integrated care which reports to our Director.”*

Also the participant worked collaboratively with the primary and secondary clinical advisors, primary integrated manager as well as other managers within the participants directorate.

PARTICIPANT 3: *“Long-term conditions Committee, which is made up of PHO Staff, clinical staff, general practitioners and those with interest in long-term conditions from the providers that (our) PHO works with. “*

PARTICIPANT 4: *“Yes, well (our) team does have an aspect of focus around long term conditions and certainly the team has been very involved over the last year with the development of the better, sooner, more convenient primary health work programme andimplementation plans will have a focus on management of chronic disease and long term conditions.*

4.3 Partnerships and collaboration:

Chapter two described how multi-organisational partnerships have now become an important means of governing and managing public programmes (Lowndes & Skelcher, 1998). Maccoby (2006) describes this kind of collaboration ranging from partnerships to inter-firm networks. This section summarises the responses of the participants to questions about partnerships their organisations have developed within their organisation and externally (in the context of long term conditions).

DHB1 had taken a leadership role in the area of Long Term Conditions and had worked with the MOH and neighboring DHBs in leading the implementation process in the region

PARTICIPANT 1: *“We have linked with our neighbouring DHB’s.... Last year there were a number of workshops that the Ministry of Health commissioned, but we were the lead DHB for the whole central region..... and it leads into the clinical leadership group for the region as well, so there is a multidisciplinary intersectoral clinical Leadership group which feeds into the regional clinical services planning work.”*

DHB2 and the PHO in this study worked closely together in implementing the Long Term Conditions programme by sharing of resources.

PARTICIPANT 2: *“they are PHO’s or NGO’s that actually deliver the services for long term conditions, so it is about working in partnership with them to actually deliver what we like to get out of it.
.”*

PARTICIPANT 3: *“The person that is in charge of the long term conditions programme at the (local) DHB is part of those meetings. There is also a direct interface between myself and the person on a regular basis where we talk about long term conditions planning from a DHB and primary care level.”*

The parent body of the PHO in this study also worked with another DHB and community provides in the region to establish partnerships in the implementation process.

PARTICIPANT 3: *““.....In Wairarapa there is quite a bit of partnership between (our parent body) and the DHB because we oversee that PHO as well. I think we have Maori Health Providers within our PHO’s so we already have that linkage there. I’m not just talking about a GP service I’m talking about whanau ora, tamariki ora, and the works..*

However the MOH and the research participant , because of the integration of the Long Term Conditions Programme implementation process into the Primary Health Care Strategy implementation was still in the internal consultation phase before external partnerships were developed.

PARTICIPANT 4: *“...I have met, for example, internally with all the people that have a focus in this area and there are many, the other teams etc. (health of older people, the focus around cardiovascular disease, diabetes and cancer, children and young people, work force, disability teams, mental health etc.).*
”

The issue of goals and objectives for the programme and these partnerships was explored. While some organisations relied on specific long term conditions frameworks and documents, others relied on organisational principles and governmental policy to guide them in their collaborative ventures.

Largely the goals and objectives were about improving conditions for people with chronic conditions, but their Long Term Condition frameworks also covered the aspect of working collaboratively with partners and other organisations to achieve programme objectives. This meant partners had to assume collective responsibility for meeting agreed objectives and assume collective ownership of all risks and opportunities and

incentives. This ensured performance was aligned and risk was shared, and knowledge exchanged.

PARTICIPANT 2: *“(our Long Terms Condition framework) document does cover working collaboration, particularly the primary and secondary interface, which I think; we have been developing and working towards developing further.”*

And

PARTICIPANT 3: *“No written formalised goals and objectives. The goals and objectives are that we are all of the same line of thinking and working collaboratively together.”*

PARTICIPANT 4: *“(our work is) all stemming from the work around better, sooner, more convenient and the opportunities for collaboration within that new model relates to an alliance based agreement modelit is being actively explored as a way to engage providers in the delivery of primary care services”*

The participants were also asked how important they felt partnerships and collaboration were important for the implementation of the Long Term Conditions programme. All of the respondents emphasised the importance and essentiality of partnerships and collaboration in success of the programme. The effects of partnerships and collaboration were demonstrated in sharing of resources and delivery of care to patients.

PARTICIPANT 1: *“It is absolutely essential. If we don’t have partnerships across the whole continuum of care.... then there will always be siloing. It doesn’t matter what we have done the last 9*

years as a DHB, whenever we talk to patients they talk about information sharing and having to tell their story so many times to different clinicians and asking if the clinicians actually talk to each other.”

Other participants also emphasised the benefits of partnership and collaboration is allowed for use of the same model and tapping into training resources. Both DHB’s used for example, the same model for long-term conditions in training.

The respondents were then asked about their experiences in relation to the issue of partnerships and collaboration. The experiences were varied, but held promise for further improvement. The responses provided some insight into the possibilities for further and enhanced collaboration.

PARTICIPANT 1: *“It has been mixed” but “...there has also been respiratory work with NGO’s and that was a really good experience in that the NGO’s and the primary and secondary providers worked together and a lot of good came from this.”*

PARTICIPANT 2: *“It varies depending on what you are working on together.... I guess there are always some difficulties but overall it has been quite positive.”*

PARTICIPANT 3:

“I think that the DHB and we have a good partnership for the long term conditions.”

4.4 Barriers:

Chapter 2 described that critical performance factors such as shared vision, communication, and teamwork can prove to be influential in determining success or failure of collaborative encounters (Williams, 2002). Also we know with Long Term

Conditions programmes in New Zealand, poor coordination; non-aligned systems, funding limitations and other factors have proved a challenge during implementation (Pullon, 2006; Rea et al, 2007). Questions were posed to the participants about the barriers they have encountered in relation to collaboration and partnerships. As indicated in this study's literature review, the participants listed political, financial and communication barriers amongst others.

For example the participant from DHB1 highlighted the divisions between the funder and primary and secondary care which came into fore in the implementation process.

PARTICIPANT 1:

“Especially when you get the individual clinicians working at the coalface together it works really well but often, particularly as I am seen to represent the DHB (funder), then that can become an issue. From a more senior management you do get the perspective between the hospital and primary care. Primary care sees the hospital as paternalistic. When the clinicians sit and talk together that is fine but when secondary care made an offer to seek primary care then sometimes primary care saw it as the hospital being paternalistic and sometimes the hospital sees primary care as (not) being competent so you do actually have some of those things you have to work through.”

The participant further related how availability of time and the ability to financially afford clinicians to participate in the implementation process is a major barrier. As well as the lack of availability of resources was an issue. The participant related how the organisations had to allow for non-clinical or project management type resource for implementation to work.

All the participants in their responses mentioned the importance of commitment from the management and government towards collaboration and how lack of it can affect progress of implementation.

PARTICIPANT 1: *“(collaboration) needs senior level management buy in to the whole thing because if the CEO of the DHB or PHO doesn’t buy in to the importance and need for them to be part of the process then nothing is going to happen”*

And

PARTICIPANT 3: *“One of the barriers is probably just getting the commitment from those with interest to be the driving force behind what the organisation wants to do. ...The barriers are that we sometimes silo things out and people’s energies, you aren’t looking at the picture as a whole.”*

Further all the participants described how lack of communication and differing aims can create barriers for collaboration

PARTICIPANT 2: *“Some barriers can arise if you have got 2 organisations whose goals are slightly different” and “Tensions may arise where people working together have different aims in what they are working towards.”*

PARTICIPANT 3:

“The partnerships could be stronger. The amount of communication between the organisations is probably limited at a low level when there could be a lot more communication about long term conditions
“:

But this participant acknowledged that the restructuring DHB2 was undergoing may have affected the communication process.

The participant from the MOH also stated that there was a lot of about the unknown and open communication and facilitation would be critical to get everyone's commitment in being on the same boat, being open and on board. The participant also mentioned the tension between national requirements for consistency in collaboration arrangements and local need for autonomy and flexibility.

The participants were asked about the actual impact of the above mentioned barriers on the process of collaboration. The barriers had a varying effect on the implementation based on the type of barrier and the phase at which the implementation was. However for participant 1, lack of resources and lack of commitment was a key issue affecting collaboration.

PARTICIPANT 1:

"...Not having dedicated project resource over the past few months have impacted... These (programmes) can't happen ,on their own, but there is some expectation that they will."

4.4 Opportunities:

While the previous segment brought to fore the numerous barrier faced by the participants and the organisations, this segment documents the opportunities for collaboration that have risen as a result of the implementation process. Also potentially some barriers could be seen as opportunity for a new way of thinking and working. The organisations in their implementation process brought different providers together. Solutions, that were not thought of earlier, were identified. The providers brought innovation, different access to resources and communities to the table and their

experience with working with different diseases enabled identification of areas that had to be targeted. Also the access to expertise was a huge opportunity.

PARTICIPANT 1: *“There has been work where people on the think tank talked with WINZ because people were being run around the shop so we wanted to find a single point of contact as it is an important part of the whole thing as well. That opportunity came out of the people sitting together talking about issues.”*

We have had small (providers) who have talked to the primary care and are now actually going out into those practices and providing peer support. We had a thing the other day where a nurse from a primary care practice and a secondary specialist nurse were talking about how it would be good if they didn't have to write letters from the hospital and the primary care nurse said while you are in the practice we can probably give you access to MedTech to enter the information directly. It was a big win in a small area and it was only because 2 people talked in the same room and started to trust each other that that happened.

And the participant from the PHO involved in the study related the example of the anticoagulation therapy program ,happening in their DHB , which prevents further deterioration of long term conditions and is a primary care managed process but was something in the past that used to be a secondary care initiative and over time it has evolved to the primary care but with no funding attached.

However *“...through the communication between the long term conditions Committee and the DHB there has been a process in place to look at the whole anticoagulation therapy and get some guidelines and definite processes in place to improve it so patients have better outcomes at the end.”*

Further the participants discussed the importance of having an overall collaborative strategy across services and at a regional or national level to achieve Long Term Conditions Programme objectives.

PARTICIPANT 1: *“At the moment, any collaborative work we have done for long-term conditions has been on the end of the job programme or individual service level rather than looking at long term conditions as a whole together.”*

So the DHB was looking to change that and set up a long term conditions working group that would work across primary and secondary care. Also the participant from the PHO related how there was a huge opportunity to have the partnership and collaboration happening across DHB's but it has to be more visible for them at primary care level.

“There may be collaboration between what (our) DHB are doing with other DHB's, but if it is a long term conditions programme for NZ then there is an opportunity to have that collaboration across.”

There was also support from the MOH for this kind of collaboration across the services and organisations.

PARTICIPANT 4: *“Although I am particularly looking at the level of work across the primary care setting there is also work looking at shifting services from secondary care to primary care with a particular disease focus like cardiovascular. It is really complex and we are still actively looking at that with people from DHBs, the business case groupings and the Ministry.”*

Participants from the DHBs highlighted the importance of involving clinicians in the planning for implementation and the clinicians providing leadership in the implementation process

PARTICIPANT 2: *“Clinical leadership can and has been shown to provide robust support for the development of and delivery of programmes in health care. Clinical leadership needs to be supported with effective programme and service development. The engagement with clinicians and enabling them to provide a leading role in health programmes is a significant benefit for services, and should be continued.”*

4.5 Progress

The participants had been asked where they felt they were at progressing the partnerships and collaboration. Generally all respondents felt their programmes were on track in spite of the challenges they faced. However they made it clear availability of resources and commitment from management was critical to ensure continued progress

PARTICIPANT 1: *“We are now back on track again but you have got to be constantly aware of all of those other things going on that can side swipe you of your objective...”*

And

D2A: *“Partially, some of that has been restricted through getting funding and resources. I couldn’t say we have got 100% but we are moving forward with our long-term condition framework.”*

And

P1B: *“I would say we are (progressing well), we could go further and give it a bit more drive and a push but it is certainly heading in the right direction.”*

In this chapter, the research participants discuss their experience with the implementation of Long Term Conditions Programme and collaboration. The next chapter discusses the findings in relation to existing research.

CHAPTER FIVE-DISCUSSION

(The Push, the Practice and the Promise)

This research set out to identify the barriers and opportunities associated with inter and intra organisational collaboration in the context of Long Term Conditions Programme in New Zealand. The last chapter discussed the participant's experience of barriers and opportunities for inter and intra organisational collaboration. Chapter two discusses how there is a **'Push'** by the Government for organisations to collaborate to address public problems with a view that collaboration can solve these issues. However, **'Practice'** (as the findings from this study) demonstrates - numerous barriers exist for organisational collaboration. But also in this study, participants have discussed the numerous benefits that have arisen out of collaboration and there is **'Promise'** or opportunity in strengthening (existing) organisational collaboration to continue to address Long Term Conditions issues.

5.1 The Push:

Governments encourage collaboration amongst public sector bodies or other organisations so as to maximise resource efficiency or increase synergistic gain (Lowndes & Kelcher, 1998). The New Zealand Government is therefore, through its 'Better Sooner More Convenient' health strategy, wanting better coordinated and integrated service planning and decision making at all levels of the health service (Ryall, 2009). Also the Long Term Conditions Framework has set out ways government agencies, health providers and community groups could work together to provide people with chronic conditions efficient health services (NHC, 2007). Better coordination and collaboration means improved management of chronic conditions, because of prompt services,

improved care planning, and decreased patient risk. This can happen only when organisations work closely together.

Because of restructuring and reorganization of the MOH, the original Long Term Conditions strategy and implementation has been incorporated into the Primary Health Care Strategy and implementation process. The group responsible for the Primary Health Care implementation has had to pick up the national Long Term Conditions from where it was left. They also had to view the implementation process through the lens of the 'Better Sooner More Convenient' policy and under the Primary Health Care umbrella.

A necessary part of interorganisational collaboration is the need to build and sustain effective personal relationships (Williams, 2002). Also managers not only need to advocate for such partnerships but also be supportive and directive when necessary. From the data collected it has been noted that DHBs, with the support of the MOH, have initiated partnerships with each other, their PHOs and relevant NGOs. The goals of these partnerships have firmly been based on the principle of achieving good health and lives for people with long term conditions. This has necessitated working collaboration between various disciplines but in particular the primary and secondary health care groups.

There has been real drive to ensure all those involved in the Long Term Conditions Programme implementation are of the same viewpoint and are working collaboratively. The MOH's 'Better Sooner More Convenient' policy has required participants to assume collective responsibility for meeting goals and objectives (2009A). It also requires

collective ownerships of risks and opportunities so as to share pain and gain. The same is reflected in the various collaborative ventures the DHBs and PHOs in the region have initiated. Advisory groups with multi-disciplinary membership and with both internal and external membership have been formed to inform the implementation process. DHB1 has for example also taken the lead in bringing together regional health bodies in implementing the Long Term Conditions Strategy. This is in the form of organizing workshops on telehealth and self-management and also informing regional clinical networks.

The PHO in this study and its parent body have not only linked in with their DHBs but also with community organisations such as Maori Health bodies to address chronic conditions management issues. While the MOH and the Long Term Conditions group has undergone reorganization, the MOH research participant has met with and is working with various other MOH staff whose work spans across the whole chronic disease continuum and age spectrum. The process of linking up with NGOs and professional bodies that have an interest in Long Term Conditions is also on the cards. These pieces of information demonstrate the drive towards establishing collaboration between and within organisations.

While Deliberations continue both in the academic and management fields about the benefits inter-organisational collaboration can offer to achieve public policy goals and act as an alternative to market determined relationships (Lowndes & Skelcher, 1998), the research participants unanimously agree on the importance of these inter-organisational collaborations. The participants felt that the implementation process wouldn't work

without the relationships and collaboration. Cross sector collaboration occurs because of many reasons, including the fact that we live in a shared world (Bryson et al, 2006). The PHO in the study, for example, found it useful working with their DHB in utilizing the same models, training, and sharing of resources to inform implementation. DHB1 found partnerships and collaboration helped in avoiding duplication and maximizing resource efficiency.

Bryson et al (2006) speak of 'sector failure' where cross organisational collaboration is influenced by the degree to which single efforts to solve an issue have failed. Especially so in Long Term Conditions programme implementation, as it deals with continuum of care for people with chronic conditions. Without collaboration between agencies there would be isolation of care. To make a difference in real care to patients, organisations and health professionals had to talk with each other. The participant from the MOH felt that asking for complex change or complex response required more than a single agency.

5.2 The Practice:

It is said that bureaucratic forms of organisations do not favour concepts of partnerships or inter-dependency, as their culture centres around rationality and compartmentalism (Williams, 2002). Also partnership working may be less favourable for less powerful partners with outcomes ranging from neutral to worse (Mann et al, 2004). However research demonstrates this is otherwise for the Long Term Conditions programme implementation. Both the DHBs and MOH are primarily bureaucratic organisations and inherently powerful because of their funding capability. The organisations, either due to the Long Term Conditions Framework or the BSMC policy, have pushed for both intra

and interorganisational collaboration. The PHO, in this study, has also favoured from partnership with its DHB in the areas of resource and information sharing.

However research also demonstrates the numerous barriers and challenges the participants and their organisation face to make their collaborative ventures work and achieve intended outcomes. Some commentators describe too much healthcare in New Zealand occurs in silos and there is not enough cooperation between health professionals (Hill, 2008B). Barriers, such as political, organisational, educational, and cultural, have impacted on the ability for health professionals to work together. Some attribute this to separate funding streams (Hill, 2008B). Likewise experience and information from the research participants corroborates this commentary. Participants talk of the divide between primary and secondary care, tight time frames, the constrained financial environment and silo funding – which all are a challenge for collaboration.

Funding for clinical and other personnel to engage in service planning and delivery is a big issue with the participants. Also the participants mention the vital need for political and senior management to support intra and inter organisational collaboration and Long Term Conditions programme implementation and how some times this has been not enough. Participants also discuss differing aims amongst partners and poor communication between partners. From the MOH perspective, the tension between maintaining national consistency amongst partnerships and yet considering local context is a challenge too. The MOH as the main funder of all health services in the country has to ensure cost neutrality in these collaborative ventures. Further it can't be seen as to directive with DHBs so as to ensure their autonomy.

Maccoby (2006) discusses that making bureaucratic culture collaborative provokes resistance and requires patience and time. Decision making tools within partnerships need to demonstrate and reflect consensus formation and trust building (Williams, 2002). Good communication and joint vision are critical for success of partnerships and failure to achieve these would be at the cost of success. Also, structural turbulence can cause organisations to become inward focused and wane away from external partnerships (Mann et al, 2004). Further real success of partnerships and interorganisational collaboration relies on the determination of leaders' as much as governmental policy and structural changes (Williams, 2002).

In practice, organisational restructuring and lack of executive buy in has impacted on the implementation of the Long Terms Condition programme in the region. There has been slowing down of the process of implementation and has made organisations move cautiously. Within organisations, professional divisions also had to be overcome to establish intra-organisational collaboration. Relationship building trust building and culture change in the region has required not only time but also required support of (organisational) leaders. The participants state how lack of resources (time and funds) and sometime support from Management is affecting collaboration and implementation of the programme. Communication between organisations also had to be strengthened from current levels, so there is more open communication and sharing of information.

5.3 The Promise:

In this study amongst many other barriers, limited communication, inter professional divisions, and limited inter organisational trust were noted as barriers for collaboration.

Experience from public sector in overseas has indicated that this divide can be crossed by achieving inter professional and inter organisational trust (Mann, Pritchard & Rummery, 2004). This trust and collaboration is possible through shared goals, commitment, honesty and the ability of individuals and organisations to learn constructively from mistakes. The participant from DHBs, in this study, stated how bringing professionals and organisations together helped in clearing misunderstanding and in establishing shared aims.

For collaborative problem solving efforts to make sense, stakeholders need to have an appreciation of their interdependence (Hudson, Hardy, Henwood, & Winslow, 1999). When organisations have similar goals, collaboration is more likely. The participant from DHB1, in this study, relates how in a meeting, which she facilitated, a primary care nurse and a hospital specialist shared frustration about delay in sending and receiving patient information. In the meeting the discussion of this issue led to the specialist receiving access to the Patient Management System in the practice and early retrieval of patient information.

Often working together provides organisations an opportunity for improved delivery of individual objectives and the development of new prospects (Lowndes & Skelcher, 1998). The PHO in the study worked with DHB2 to implement the anti-coagulation therapy programme in a better way which in turn improved patient health outcomes. By working with the DHB, the PHO was able to strengthen primary care delivery.

Difficult problems invite new ways of working and thinking, with a willingness to adopt different approaches (Williams, 2002). The DHBs and the PHO, in this study, in their drive to address Long Term Condition issues are looking at working across sectors and disciplines and see great opportunities for collaboration in this sphere. The Ministry of Health is working towards shifting some Long Term Condition Management services from secondary care to primary care , which will mean these services have to work together closely for this to happen. The organisations involved in this study have not restricted working amongst themselves but have also developed linkages and collaboration with various other groups. The DHBs are working with Accident Compensation Commission and Pharmac and the PHO is working with Maori Health Providers and agencies outside health such as Work and Income New Zealand. Again linkages with these agencies have led to sharing of ideas and resources to address chronic conditions issues.

The present Government in New Zealand through its Better, Sooner, More Convenient Policy is pushing organisations in the health sector to work more closely to address health issues (MOH, 2009A; National, 2007). However real success for collaboration depends as much on the determination and creativity of managers and practitioners as it will on Government policy and drive (Williams, 2002). Through this study, it is noted how the participants had not only led collaboration in challenging circumstances but continued to express enthusiasm for collaboration in the context of Long Term Conditions Programme Implementation.

Research on collaboration generally focuses at the organisational and inter-organisational domains, but it is necessary to recognise the pivotal contribution of individual personnel in the collaborative process (Williams, 2002). So the author argues opportunities for organisational collaboration do not just occur through external or internal partnerships or Governmental policy but also through the motivation of individual practitioners itself.

CHAPTER SIX-CONCLUSION

In the past sections we observed that implementing Long Term Conditions programmes is indeed a challenge, but there is a dire need to address the huge burden caused by chronic conditions to the health services. Popular and widely accepted chronic conditions management models advocate a collaborative or partnership based approach to address the needs of people with chronic conditions. With the Long Term Conditions Strategy being important to the New Zealand health system and the associated implementation process requiring organisations to work together, research was required in this area to document issues facing implementation.

The research had set to identify the barriers and opportunities associated with inter and intra organisational collaboration. Because of the research there is now documentation of the various issues facing collaboration in the context of Long Term Conditions Programme Implementation. The research has identified that government policy and support from organisational leadership are necessary for successful implementation. Also barriers such as the primary and secondary care divide, financial constraints and poor communication have affected the implementation. However the research has also illustrated the enthusiasm and interest the participants and some organisations have shown for collaboration and the benefits derived from such collaboration.

The study chose an important area (implementation of Long Term Conditions Programme) and a critical management issue (Intra and Inter organisational collaboration). Learning from this research will not only inform further implementation of long term conditions programmes but also contribute to the growing understanding around interorganisational collaboration.

Because of the small sample size in the study and the fact that the study was conducted in a particular region in New Zealand- there is further opportunity to conduct more research in the area of intra and inter organisational collaboration. Based on the author's experience, there are minimal studies in the area of organisational collaboration in a New Zealand health setting. Also based on the study's findings, advanced research is called for in the area of organisational collaboration in the health environment and in specific the influence of financial and political constraints on the collaboration process need to be further studied. Following on from this study, there is potential for additional research to monitor and document the progress in inter and intra organisational collaboration in the context of the Long Term Conditions Programmes - not just in the greater Wellington Region but in a larger geographical area.

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8 - APPENDICES

I. ETHICS REVIEW:

Based on “Massey. (2009). *Code of ethical conduct for research, teaching and evaluations involving human participants*. Massey University, Palmerston North.”

- A. **Respect for persons:** At all stages of the research, including the stage of access, respect for the personal dignity, beliefs, privacy and autonomy of individuals will be maintained. This means, among many other things, not attempting to apply any pressure on intended participants to grant access or remain in the study. Participant’s beliefs and views as regards to the research area will be respected and also be accurately portrayed in the results as far as possible.

- B. **Minimisation of risk of harm:** Sincere attempts will be made to avoid exposing participants to unnecessary harm. This includes avoiding exposing participants to emotional distress, embarrassment and exploitation. This means the transcripts/results of the research will be shared with the participants for review. Also care will be taken during the process of the research to avoid harm to the researcher himself, the participant institutions and to the reputation of the Massey University.

- C. **Informed and Voluntary Consent:** Participation in the research will not only be completely voluntary but also in the process of recruiting, participants will be provided all information relevant to make a decision to participate. This information will be provided in a written form and if needed further explanation/translation will be undertaken. Written consent will be generally taken but if necessary oral consent (recorded on tape) will also be considered. A third party would also be used as a witness to the consent and the consent will be stored securely with the relevant Massey University supervisor.

- D. **Respect for Privacy and Confidentiality:** The confidentiality of information obtained purposefully or incidentally will be respected and no participant will be identified without the consent of the participant. The data from the interviews will be coded and identification codes will be stored separately from the data. In the case of the requirement of a third party (other than the supervisor) to transcribe or access the data- a confidentiality agreement will be drawn and stored in a secure place along with participants consent forms.

- E. **Avoidance of unnecessary deception:** It is not expected with this research, that any information pertaining to purpose and procedures of research will be withheld from study participants.

- F. **Avoidance of Conflict of Role/Interest:** At this stage it is purported that the research will be undertaken in organisations where the researcher is not an employee; but if this becomes the case, this information will be clearly stated in the research and no undue pressure will be applied to colleagues to participate.

- G. **Social and Cultural Sensitivity:** While the proposal is not a community based research, due cognisance for the sensitivities of any communities that will be impacted by the research will be given.
- H. **Justice:** Due process will be followed to respect the principles of distributive justice and the Treaty of Waitangi. Also care will be taken to avoid discrimination in the selection and recruitment phase of the research and there will be no exploitation or overburdening of study participants.
- I. **Maori and the Treaty of Waitangi:** While the study is not focused on the Maori community, it is recognised that the Maori community are disproportionately represented in chronic conditions statistics. Therefore any research regarding chronic conditions in New Zealand –be it management of programmes or conditions- will have an influence on the Maori community. This fact will be taken into consideration during the research process.

II. ETHICS APPROVAL LETTER



Central Regional Ethics Committee

Ministry of Health
Level 2, 1-3 The Terrace
PO Box 5013
Wellington
Phone: (04) 496 2405
Fax: (04) 496 2191
Email: central_ethicscommittee@moh.govt.nz

21 April 2010

[Amendments to letter dated 7 April 2010]

Sandeep Reddy



Dear Sandeep Reddy

Ethics ref: **CEN/10/EXP/10**
Study title: Barriers and opportunities associated with intra and intra-sectoral collaboration in the context of long-term conditions programme in New Zealand

The above study has been given ethical approval by the Central Regional Ethics Committee.

Approved Documents

- Participant Information Sheet, dated 08/04/2010, Version 1.1
- Consent Form, dated 08/04/2010, Version 1.1
- Semi-Structured Interview Schedule, dated 08/04/2010, Version 1.1

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report

The study is approved until 30 September 2010. A final report is required at the end of the study and a form to assist with this is available at <http://www.ethicscommittees.health.govt.nz>. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date.

Amendments

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be

Administered by the Ministry of Health

Approved by the Health Research Council

<http://www.ethicscommittees.health.govt.nz>

carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study.

Yours sincerely

s.scott
Sonia Scott
Administrator
Central Regional Ethics Committee
Email: sonia_scott@moh.govt.nz

III.PARTICIPANT INFORMATION SHEET

Research Topic:

‘Barriers and opportunities associated with intra and inter-organisational collaboration in the context of Long Term Conditions programme in New Zealand’

Thank you for considering participating in this research project. Please read this information carefully before deciding whether or not to participate. If you prefer, we can go through this information sheet together. If you decide not to participate there will be no disadvantage to you of any kind.

I am undertaking this project as a principal researcher and as a Masters in Management student with Massey University. The project is being supervised by Dr.Jan Lockett-Kay, Senior Lecturer, College of Business, Massey University

The project has been reviewed and approved by the Central Regional Ethics Committee.

Background:

The Ministry of Health (MOH) of New Zealand has taken the lead in developing a national Long Term Conditions Programme (LTCP) framework. This framework will inform regional and district providers about chronic conditions service planning and delivery. One of the key goals of the LTCP in New Zealand is to “galvanise action for effective Long-Term Conditions Management (LTCM) in the health sector and inter-sectorally”. Many challenges face the implementation of the LTC strategy in terms of collaboration and partnership between relevant agencies to achieve better outcomes for

people with chronic conditions. The National Health Committee in a report recommended the Ministry of Health to work with District Health Boards (DHBs) and other relevant bodies such as Primary Health Organisations (PHOs) to bring about comprehensive alignments within health and social sectors, between health providers and services, and across health disciplines. To follow recommendations of the NHC, MOH and DHBs have to introduce collaborative and partnership models. To achieve these goals, there is a need to look into factors influencing implementation of such partnership models. The research proposal intends to examine these management issues and provide some understanding of the same.

Research Objective:

This study proposes to research the opportunities and the barriers that would affect or influence intra-organisational collaboration in the context of Long Term Conditions Programmes.

What we are interested in:

Semi structured interviews will be utilised to collect information about key themes. The foci would include the below:

- *Role of leadership in implementation of Long Term Conditions programmes*
- *Role of partnerships or collaboration in implementation of Long Term Conditions programmes*
- *The goals or objectives of such partnership or collaboration based Long Term Conditions programmes*
- *What are the barriers in developing these partnership or collaboration based programmes?*

- *What are the opportunities in developing these partnership or collaboration based programmes?*

How the interviews will be carried out:

- The interviews will be face to face with the interviewer (Sandeep Reddy)
- The interviews may be recorded on a tape recorder if you agree to this. If you do not wish to be audio taped then there will be no disadvantage to you and what you say will be written on paper.
- You can request that the tape recorder be stopped at any time during the interview.
- The interview involves a number of questions and the exact questions will depend on the way in which the interview develops
- There will be 2 interviews with each of the participant. The initial interview will last no longer than 60 mts with a follow up interview lasting approximately 30 mts to test the emerging themes identified in the initial interview.

Right to withdraw:

- You have the right not to answer any particular question(s)
- You can withdraw at any time without any disadvantage to you.

How the interviews will be used:

- The interviews will be written out and will be anonymised (i.e. your name or any other personal details will not be recorded with the interview transcript).
- Your identity will be confidential to the principal researcher and University Supervisor.

- Some parts of the interviews may be used as quotes in the report. Any quotes used will be anonymised.
- The results may be published and all quotes will be anonymised.
- The tapes will be destroyed at the end of the research project or, if you would prefer, we can return the tape to you.
- Should you wish we would be very happy to send you the results of the research project.

Questions or queries:

If you have any questions about this project, either now or in the future, please feel free to contact the principal researcher (Sandeep) as per below contact details:

Sandeep Reddy ,XXXXXXXXXXXXXXXXXX

IV. SEMI-STRUCTURED INTERVIEW SCHEDULE

Research Topic:

‘Barriers and opportunities associated with inter and intra-organisational collaboration in the context of Long Term Conditions programme in New Zealand’

Interview Questions:

1. Role of leadership in implementation of Long Term Conditions programmes

- 1.1. What has been your role in implementation of the Long Term Conditions programme in your organisation?
- 1.2. How long have you been involved in the role and with the programme?
- 1.3. Do you have a team which is involved in the implementation and how does the team function (role and responsibilities in the implementation)?
- 1.4. How does your role link with other organisations involved in Long Term conditions implementation?

2. Role of partnerships or collaboration in implementation of Long Term Conditions programmes

- 2.1. What has been your experience in partnering with other organisations in the context of long-term conditions programmes?
- 2.2. What are the agencies you have partnered with and what is their role in the partnership?
- 2.3. Have you found these partnerships important for implementation of the programme?
 - 2.3.1. If yes, how?

- 2.3.2. If no, why not?
- 2.4. Do you see further opportunities in developing partnerships or collaboration with organisations to implement the Long Term Conditions Programme?
3. **The goals and/or objectives of such partnership or collaboration based Long Term Conditions programmes**
 - 3.1. What are the goals and/or objectives of the partnership you have developed with other organisations in the context of Long Term Conditions programme implementation?
 - 3.2. Have you been on track on achieving these goals and/or objectives?
 - 3.2.1. If not on track, why?
4. **What are the barriers in developing these partnership or collaboration based programmes?**
 - 4.1. What have been the barriers for inter or intra organisational collaboration in the context of Long Term Conditions Programme (LTCP) implementation?
 - 4.2. How have the barriers impacted on the implementation of the LTCP?
5. **What are the opportunities in developing these partnership or collaboration based programmes?**
 - 5.1. What have been the opportunities for inter or intra organisational collaboration in the context of Long Term Conditions Programme (LTCP) implementation?
 - 5.2. How have the opportunities impacted on the implementation of the LTCP?

Please note the exact questions and any further questions will depend on the way in which the interview develops

THE END