



Factors and Processes that Facilitate Collaboration
In a Complex Organisation:
A Hospital Case Study

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1 Abstract

Purpose: The purpose of this study was to increase the knowledge on the processes and factors that facilitate and/or hinder collaborative functioning, by testing the utility of a newly developed model: The Bergen Model of Collaborative Functioning (BMCF) (Corbin, 2006) in the hospital setting.

Health promotion strongly advocates for the use of effective collaborations. The aim is to achieve synergy, in which the output of the collaboration is greater than what partners could have produced individually. However, successful collaborative functioning in health care services is hard to achieve, because stakeholders have different aims, commitments, traditions, and mandates, and so on. Overcoming such differences to forge productive collaborations is a great challenge. Nevertheless, little attention has been paid in the health promotion- and hospital literatures to the actual factors and processes of collaborative functioning that lead to negative and/or synergistic outputs. Corbin (2006) developed a systems model for collaboration; the BMCF (figure 1) based on inputs (elements entering into the collaboration), throughputs (processes within the collaboration) and outputs (collaborative products), and the complex interactions between these. This model is the first to recognise the complex interaction between inputs, throughputs, outputs and processes in collaborations. Based on this model, the present study aimed to increase the knowledge on collaborative functioning by examining the utility of the Model through studying the factors and processes that facilitated and/or hindered the implementation of a complex hospital programme. This thesis also aimed to examine contextual factors that affect collaborative functioning.

Method: This qualitative research applied the case study methodology to study a comprehensive hospital programme to handle patient malnourishment. Data from seventeen interviews (twelve respondents) were utilised. Two waves of data collection were applied; twelve respondents were interviewed once, two months after the programme was launched. Then, five interviewees were selected for a second interview ten months after implementation. The interviews were conducted face-to-face, and lasted from 30 minutes to 1 and ¾ hours. The interviews followed semi-structured interview guides, which were continuously modified to improve their utility. Documents such as mission statement, minutes of meetings and surveys were also utilised. The data were analysed to address the aims and research questions of this thesis, and the BMCF (Corbin, 2006), along with allowing new emerging findings.

Results: The results told a story about the planning and early implementation of a hospital's mission to handle patient malnourishment. The programme required substantial collaboration across a number of departments and professionals.

The results show that committed partners overcame hierarchical challenges in the hospital, utilised the surrounding context, and lobbied for- and successfully collaborated to place the mission on the hospital's agenda. That process was a collaboration in itself that produced synergy-- the mission gained urgency and increased some partners' commitment; financial resources were allocated; much recognition was gained; and several extended effects followed. From that, a programme was established which aimed to screen all patients for malnourishment and act accordingly, educate all health professionals, and to create a pilot project to make meals more tempting, flexible and nourishing. The mission and its context, partners- and financial resources were inputs into the collaboration. The planning, production of tasks, and maintenance (fuel) of the collaboration was affected by; how inputs interacted, communication, structure, rules and roles, and leadership factors. Outputs were a result of the interactions above. Interestingly, the collaborative functioning of the general programme and the pilot project were like poles apart. The pilot project recruited several committed partners that interacted well. The project's structure allowed adjustment per context and partners, and thus produced successful interactions and outputs. On the other hand, the implementation of the general programme mostly applied a hierarchical approach to the collaboration. Several stakeholders were mandated to perform tasks, yet were not included as actual partners to influence- or participate in the collaboration. Furthermore, lack of assessment of applicability and feasibility in all the multicultural contexts involved in the programme, hindered the collaboration. The above resulted in partner resistance to the mission and even boycotting-- despite policy-production and the leadership's strong commitment to the programme. Committed partners interacted well, however an over-reliance on committed partners resulted in burnout and thereby loss of vital partner resources. Noticeably, the general programme applied a hierarchical approach that predominantly produced negative outputs, yet the pilot project produced much synergy using a collaborative approach.

Conclusion: The BMCF proved to be a useful research framework to study the collaboration at hand; however, the findings also suggest modifications of the Model. The findings indicated that the mission's context should be an input into the Model, because the context acted as a unique factor affecting the entire collaborative functioning. Secondly, the findings indicated a need to depict planning in the Model, as planning is essential prior to- and during

collaborations. The conclusion from the case was that a hierarchical approach to collaboration could hinder synergistic outputs. Recruitment of committed partners is essential to facilitate collaborative functioning. However, failing to include all partners to participate in- and influence a collaboration, and failing to assess a programme's applicability and feasibility in each area of implementation, can hinder partner commitment and create negative collaborative functioning and outputs. Therefore, this study concludes that a complex collaboration amongst multiple diverse partners can benefit from applying a model for collaboration. Knowledge on collaborative functioning can lead to successful planning that reduce the factors and processes that often produce negative outputs-- and thus increase the potential for synergy. These findings can aid current and future health care collaborations.

Keywords: collaboration, collaborative functioning, partnership, partnership functioning, hospital collaboration, hierarchy, context, environment, planning, health promotion.

2 Introduction

Contemporary health challenges require collaborations to be resolved satisfactory (Gray, 1989; Kickbusch & Quick, 1998). The World Health Organisation (WHO) conference in Jakarta in 1997 considered the status quo of health promotion; what had been accomplished; what strategies had been effective, and most importantly-- what needed to be done. The conference called upon strong collaborations and commitment to promote health (WHO, 1997a). “The Bangkok Charter for Health Promotion in a Globalised World” stated in 2005 that health issues must be addressed in collaboration internationally, and should be an integral part of foreign and domestic policies (WHO, 2005).

The literature describes three possible outputs for collaboration, in which synergy is the aim. Synergy occurs when the combined result is greater than the product of individual partners (Kickbusch and Quick, 1998). Additive outputs are the same as what individuals could have produced without the collaboration. Finally, antagonistic outputs are unplanned outputs that regrettably eat up resources (Corbin and Mittelmark, 2008).

The responsibility to create healthy outcomes for the population is a shared responsibility between the governments, health professionals, health institutions, communities and individuals (WHO, 1986). Such inter-sector collaboration can take place at various levels; governmental collaboration for example, can unify a national policy that promotes health. A smaller-scale example is collaboration between a community’s public and private institutions to improve community safety. In the hospital setting, various stakeholders can collaborate to ensure that patients are adequately nourished.

Nevertheless, collaborations are complex and challenging, and often require hard work (Huxham, 2003). Different sectors have different traditions, professional aims, rules and regulations, styles of working, and so on. Overcoming such differences to forge productive collaborations is a key challenge for health promotion. A reorientation of health services is called for to aid successful collaborations. This can be achieved by a multidisciplinary and multi-service approach to patients, and by encouraging a shift of power from health professionals to the patients. Such healthy collaborations can promote good health, and create efficiency and effectiveness in the health care services (*cf.* Nutbeam, 1998; Tones, 1996). Changing the health care system towards multi-sector collaborations is complex and time-consuming; however, health promotion programmes can facilitate such changes (Green et al., 2000; Whitehead, 2004).

The WHO in Europe established a Health Promoting Hospitals (HPH) network in 1990. One aim is to change the culture of hospital care towards interdisciplinary working, transparent decision-making and with active involvement of patients and partners (WHO, 2006). Such a multi-sector approach to health care can promote health, prevent disease, protect the individual, treat, diagnose, care for, and rehabilitate the individual (Whitehead, 2004; WHO, 1988). Inter-sector collaboration can also enhance health in the communities, which will decrease illnesses and therefore population demand of hospitals (Green & Kreuter, 1999). Recommendations from the experiences of HPH include (among others) the need for improved collaborations, commitment and participation, and improvement of communication and strategies (WHO, 1997a).

The collaboration literature lacks research on the actual factors and processes that lead to successful or unsuccessful collaborative functioning. Theoretical conceptualisations, rather than studies of actual practice, have dominated the literature (Corbin, 2006; Gray, 1989). As far back as 1989, the need for process-oriented theories of collaboration was called upon (Gray, 1989). Still, in 2002, Brinkerhoff stated that there was no framework for evaluating the process of collaborative functioning; researchers had only focused on outputs. Since then, few studies on collaborative functioning have appeared in the literature. Loxley (1997) argued that health practice requires models and frameworks that are reliable, coherent, and transferable to similar situations. Huxham (2003) sought a collaboration theory with a positive, actual, and direct influence. Macdonald & Chrisp (2005) sought studies of collaborative functioning leading to failure. Iedema (2007) found that there is mainly quantitative research on hospital interaction and communication, but argued health care services may benefit from qualitative and reflective knowledge on how health care professionals manage and organise their work. Considering the above, it is clear that research is needed on the processes of collaborative functioning in the health care sectors, including the complex hospital setting.

At the University of Bergen in Norway, a research group; “Policy Processes for Human Development” (PPHD) was established in 2006, which studies collaborations that aim to promote health. So far, two studies have been completed, in which the first focused on the functioning of a global collaboration working to gather and disseminate evidence for health promotion (Corbin, 2006). The second study focused on collaborative functioning amongst Norwegian non-governmental organisations working in the alcohol policy arena (Endresen, 2008). In the studies mentioned above, a systems model of collaboration, the Bergen Model of Collaborative Functioning (BMCF) (Corbin, 2006), has been developed, tested and is undergoing continuing refinement (Figure 1). The research completed so far indicates that

goal-oriented activities are not enough to succeed with inter-sector collaboration. Activities whose main purpose is to help the partners function well as a team are also required.

Haukeland University Hospital initiated a patient malnourishment programme in 2006. It was the first Norwegian hospital to recognise- and act on the problem of hospital- and disease induced malnourishment. The programme required inter-professional and intra-organisational collaboration including dietetics, medicine, nursing, kitchen services, and management and so on. This hospital was not a formal member of the HPH network; however, its nutrition programme was a prime example of the interdisciplinary way of working that HPH calls for. It was therefore considered important to evaluate the nutrition programme and to document how it functioned, so that Haukeland and other hospitals, policy-makers, practitioners and organisations can learn what factors are critical in successfully launching and managing such inter-sector health promotion collaborations. This thesis aimed to study the processes and conditions that facilitate collaborative functioning, by expanding on the newly developed BMCF (Corbin, 2006) in the hospital setting.

3 Study Aims and Research Questions

The research framework for the study was the BMCF (Corbin, 2006), as shown in Figure 1.

- i. The first aim of this study was to use the Model as a framework to study the factors and processes of intra-organisational collaboration in a complex organisation, by examining the planning of the nutrition programme, its authorisation(s)¹ and its early implementation. (Early implementation refers to the first year of activity following formal implementation of services and direct involvement of patients receiving the new nutrition programme services (the period December 2006 through January 2008)). Referring to Figure 1, the study concentrated on the input and throughput elements of the programme.
- ii. The study's second aim was to investigate the utility of the BMCF, in studying collaborative functioning in a different setting to what it has been used in before.
- iii. The third aim of this study was to study how contextual factors outside a collaboration affect the collaborative functioning. (Contextual factors outside a collaboration are people, events, processes, actions, expectations and demands outside the nutrition programme, that have the potential to influence the nutrition programme. Such

¹ Authorisation refers to agreements, permissions, contracts, memoranda of understanding, work orders needed for the nutrition programme to proceed to planning and then to early implementation.

contextual factors could conceivably impede programme plans. Alternatively, such factors might be engaged in ways that facilitate programme plans).

The study's aims were pursued by addressing seven research questions:

1. What contextual conditions hindered the nutrition programme's planning, authorisation and early implementation?
2. What contextual conditions facilitated the nutrition programme's planning, authorisation and early implementation?
3. What partner resources and financial resources were key inputs into the nutrition programme in the planning, authorisation and early implementation phases?
4. What influence did the mission itself (patient malnutrition) have on the nutrition programme's planning, authorisation and early implementation?
5. What role did maintenance tasks (activities to maintain the nutrition programme's viability) play in the nutrition programme's planning, authorisation and early implementation phases?
6. What role did production tasks (activities to deliver on the nutrition programme's intended outputs) play in the nutrition programme's planning, authorisation and early implementation phases?
7. What were the nutrition programme's participants' important experiences (self-defined) in intra-organisational collaboration at the planning, authorisation and early implementation phases?

4 Background

4.1 Collaboration

The collaboration rhetoric is based on partners desiring to work together towards a common aim. However, governments and policies also mandate collaborations. The term collaboration is often used widely and loosely without considering its real meaning. Huxham, (1996; 2003) argued that term collaboration is confusing because of its numerous definitions and synonyms. The words partnership, coalition, co-operation, teamwork, network and alliance all appear in the literature, describing stakeholders who work together. One organisation's "alliance" may be another's "partnership" (Lank, 2006).

El Ansari et al. (2001) distinguished between *collaboration*; "to work jointly with others on a project, where those collaborating with others take on specified tasks within the project and share responsibility for its ultimate success" (Michigan State University 1996,

cited in El Ansari et al., 2001 p. 216), and *partnership* as “a partnership is a formal alliance of organisations, groups and agencies that have all come together for a common goal “ (Butterfoss et al 1993, cited in El Ansari et al., 2001 p. 216).

The next definition by Kickbush and Quick (1998) described partnership more or less as a combination of the above definitions; “partnerships for health bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles” (p. 69). Wood and Gray (1991) had attempted a definition that includes all the key aspects of others’ definitions; “Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain” (p. 146). The present thesis used the term collaboration, defined as; a set of partners desiring to work together towards a common aim, to achieve an output that is greater than the sum of individual efforts.

Despite the incongruity on definition, the significance of collaboration has been increasingly sought after (Gillies, 1998; Lank, 2006). This might be a result of globalisation, increased expectations, economic and technological development, and the world’s changing environment (Gray, 1989; Kickbusch & Quick, 1998, Schriener, 1998). The aim of collaboration is synergy, which are collaborative products that could not have been produced by any stakeholder alone (Corbin and Mittelmark, 2008). Kickbusch & Quick (1998) explained the term synergy by which “2 plus 2 add up to 5” (p 69). Collaboration can empower partners to achieve goals by facilitating partner participation- and complementation, and thus resolve conflicts (Huxham, 1996). Collaboration may also facilitate valuable knowledge exchange; facilitate efficient delivery and development of the issue at hand; and be cost-effective (Kickbusch & Quick, 1998; Lank, 2006). The benefits of successful collaboration are numerous, however successful collaborations are hard to achieve. Collaborations can be time- and resource demanding, and create conflict (Brinkerhoff, 2002; Huxham & Vangen, 2004). When collaborations produce negligible outputs that prevail over the effort invested, the result is collaborative antagonism (Corbin and Mittelmark, 2008). One should consider the above, because knowledge on processes and factors that facilitate and/or hinder successful collaborations can enable stakeholders to avoid hindrances and aim for synergistic outputs (Huxham, 2003; Sullivan, 1998).

4.2 *Inter-sector collaboration in health care*

Health care is too complex to be the sole responsibility of one sector alone (Kickbusch and Quick, 1998). A sector can be defined as “a sociological, economic, or political subdivision of

society” (Encyclopaedia Britannica, 2008). Sectors required for collaboration in health care range from government sectors, public and private services, and non-governmental organisations- to specific departments and individuals. The health promotion glossary, *cf.* Nutbeam (1998) defines inter-sector collaboration as;

“A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone”. (p 14)

Inter-sector collaborations between health care services can improve the health outcomes of individuals and communities (Koeln & van den Ban, 2004). Goes and Park (1997) found that multi-hospital collaborations created exchange of knowledge- and resources; increased the understanding of environmental hospital trends, and hospitals became more positive to new implementations. Sectors outside health care are important as well. For example, Kickbusch and Quick (1998) argued that in terms of poverty, one needs to include civil society, and public and private stakeholders to make this everyone’s concern to grapple with.

However, successful inter-sector collaboration is hard to achieve. Different sectors have different traditions, aims, rules and regulations, legal constraints, styles of working, and so on. In addition, collaborations are sometimes mandated in health care, which is not a good foundation for successful collaborations (Alter and Hage, 1993; Sullivan, 1998). Overcoming the above forge productive collaborations is a key challenge for health promotion. Partners in a collaboration do not need to have joint visions and goals on the output of their personal role or sector, yet developing a common aim toward which one wants to collaborate is essential (Huxham, 2003). Inter-sector collaborations must therefore be developed based on various stakeholders who want to form a collaboration in which they then become partners. Collaborations then consist of a set of partners desiring to work together toward a common aim, to achieve an output that is greater than the sum of individual efforts.

4.3 Intra-organisational collaboration

All organisations face increased demands and pressure on resources, which can be handled by successful collaborations (Lank, 2006). Intra-organisational collaboration can occur within an organisation; between its different departments, units or individuals. However, an organisation is often unpredictable and varies in behaviour, which can make the planning of collaboration challenging (Broesskamp-Stone, 2004). Lasker & Weiss, (2003) found that an organisation is often viewed from individual parts and not as an organisation as a whole.

Broesskamp-Stone (2004) recommended separating between the behaviour of individuals, units, and the organisation as a whole to understand the organisation's behaviour.

Stakeholders within an organisation are often of diverse nature and have different aims and ways of working, which makes it challenging to develop a middle ground for collaboration (Macdonald & Chrisp, 2005). In fact, research shows that partners and the organisations themselves often create disincentives to collaborations (A. E. Ellinger, Keller and A. D. Ellinger, 2000; Gray, 1989; Sullivan, 1998). Partner commitment to the collaboration from the very beginning is vital (Gray, 1989). Winroth (2004) found that it is important to consider partners' psychological and social boundaries for a collaboration. Finally, Huxham (2003) urged stakeholders to agree upon the extent of the collaboration, negotiate with one another, and strive to maintain good partner relationships.

4.4 Collaboration in the hospital setting

Hospitals are often the apex of health care, and are claimed to be the most complex kind of social organisations (Iedema, 2007). Hospitals carry out multifaceted and emotional work, and have a range of multidisciplinary employees. Secondly, interventions in the hospital setting are complex due to governmental control, regulation, funding, and certification of health professionals (Iedema 2007; Sundhedsstyrelsen, 2006). Nevertheless, successful collaborations are sought after to improve efficiency, effectiveness and quality of services (L. Johnson, Zorn, Tam, LaMontagne and S. Johnson, 2003). Hobbs (2007) argued that hospital collaborations are critical to achieve good health outcomes. Iedema (2007) found that the qualities of interactions between multidisciplinary employees significantly affect the outcome of hospital care. Moreover, collaboration can aid hospitals' huge challenges to retain and recruit the largest amounts of resources at the lowest possible cost (Loxley, 1998).

Hospitals should collaborate with inter-sector- and intra-organisational stakeholders such as with the national and local government, general practitioners, community nursing, and between health care professionals, units and departments. Unfortunately, competition of funding in hospitals can make the initiation of collaborations difficult (Loxley, 1998). Goes and Park (1997) found that organisational barriers to change and pressures for conformity hindered collaborations in hospitals. Kerusuo (2007) argued that many hospitals are trapped in organisational models and practices that draw from conventional management thinking. Hospitals often have hierarchical structures. Collaborations in hospitals have habitually been mandated by policies that aim to achieve multidisciplinary goals, and to avoid health professionals acting as isolated operators (Jorm, Travaglia and Iedema, 2007). However, lack

of partner commitment and unwillingness to collaborate often occurs in hospitals (Sundhedsstyrelsen, 2006). Partner commitment to a collaboration and acceptance of interdependence with other partners is decisive for a good collaborative process and output (Leathard, 2003; Sullivan, 1998). Loxley (1997) argued that partners in hospital collaborations need a mutual perception of the collaboration's importance, its aims and possible outputs. Alter and Hage (1993) differentiated between mandatory collaboration in terms of knowledge exchange between stakeholders, with promotional collaboration having common objectives, and finally, systemic production collaboration in which partners produce something together. It is crucial in collaborations that partners desire to work together toward a common aim, to achieve an output that is greater than the sum of individual efforts. Hospitals are advised to undergo organisational changes to facilitate collaboration toward promotion of good health amongst all stakeholders (Green & Kreuter, 1999).

The present thesis sought to study collaborative functioning in the hospital setting, by investigating the implementation of a patient malnourishment programme. The next section will therefore explore the significance of this issue in relation to collaboration.

4.4 Evidence-based research on malnourishment in hospitals

Patient malnourishment is considered an actuality in all European hospitals today. According to the European Society for Clinical Nutrition and Metabolism (ESPEN), 30 percent of all patients in hospitals are malnourished, and many develop malnourishment whilst admitted. ESPEN recommended implementing a nutrition strategy in hospitals to prevent complications of treatment and disease, and to reduce avoidable consumption of hospital resources (Kondrup, Allison, Elia, Vellas, and Plauth, 2003). Unfortunately, the area of malnourishment has not been adequately addressed by Scandinavian hospitals (Mowe et. al, 2006). In fact, one study revealed that only 16 percent of Norwegian doctors and registered nurses reported to screen patients for malnourishment, and as little as 22 percent reported to measure patient nutritional intake. However, 88 percent of the health professionals asked thought these factors were important in patient treatment. Mowe et. al (2006) also found that Denmark and Sweden had better included nutrition in hospital treatment and that their health professionals' nutrition attitudes were better than that of their Norwegian colleagues.

Successful collaboration is required between multidisciplinary hospital employees to handle such a problem. Sundhedsstyrelsen (2006) pointed out that the hospital management is responsible of creating a nutritious milieu, by policymaking and education of health professionals. Sundhedsstyrelsen og Fødevarerdirektoratet (2006) revealed the following

barriers for successful collaboration on malnourishment in hospitals: First, lack of planning, administration and defined responsibilities. Secondly, lack of education and knowledge in patients and staff. Third, lack of interest and back up from the management, and finally, lack of coordination and collaboration between sectors. The above barriers are coherent with factors and processes that hinder collaborative functioning, which will be explored next.

4.5 Research on Collaborative Functioning

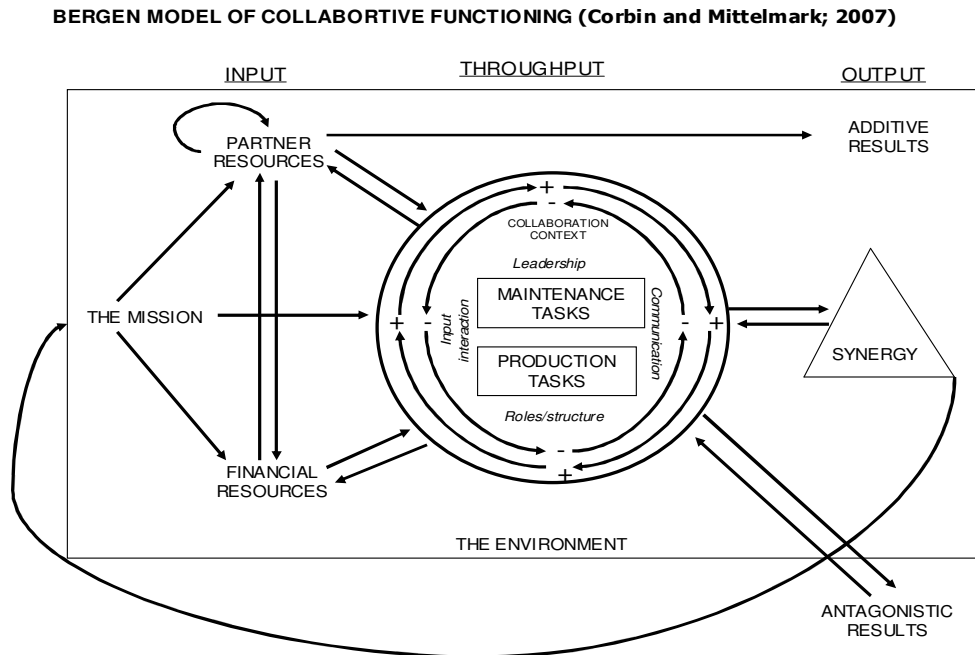
Research into the actual functioning of collaborations is widely sought after (Brinkerhoff 2002; Corbin 2006; Gray 1989; Huxham 2003). Knowledge on the process and factors that facilitate and/or hinder successful collaborative functioning can help partners avoid antagonistic outputs and thereby increase the chance for synergy (Huxham, 2003).

Alter and Hage (1993) introduced systemic production collaboration, in which partners work- and produce something together. Based on this framework, Broeskamp-Stone (2004) examined intra-organisational collaborations. Her main finding was that the contexts surrounding collaborations, such as external control, own visions, and operational processes affect outputs. Mitchell and Shortell (2000) investigated the role of governance and leadership in collaborative functioning, and found these factors to facilitate contextual forces and collaborative strategies- and capabilities. Brinkerhoff (2002) looked at integrating organisational processes into performance measurement systems to improve relationship performance and outputs. Lasker and Weiss (2003) developed a model for evaluating community collaborations, with much focus on the role of synergy. Proximal outputs of individual empowerment, bridged social ties and synergy were linked to processes and management. Finally, Wandersman, Goodman and Butterfoss (1997; 2005) studied an organisational framework of “synergistic working alliances”. Their open systems model traced inputs, throughputs and outputs, and their interactions with the environment. Resources turned into collaborative processes and outputs (Wandersman et al., 1997; 2005).

Based on this model, Corbin (2006) developed a systems model for collaborative functioning; The Bergen Model of Collaborative Functioning (BMCF), see Figure 1. Corbin (2006) argued that the models above overlooked the complexity of human interactions and casualty, because the models present one-way interactions and separate boxes. Secondly, many authors argue that several models on collaborative functioning have been obtained from literature and speculation, rather than studies of actual practice (Brinkerhoff, 2002; Corbin, 2006; Gray, 1989; Huxham, 2003). The BMCF was conducted based on a study of real-life collaborative functioning, and is the first to recognise the complex interaction between inputs,

throughputs, outputs and processes in collaborations. The BMCF's cycles have polarity-positive or negative that recognise that factors in collaborations can casually influence each other and facilitate and /or hinder outputs (Corbin, 2006). Corbin (2006)'s research indicates that goal-oriented activities are not enough to succeed with collaborations. Activities to help the partners function well together are required as well.

4.5 The Bergen Model of Collaborative Functioning



4.5 Figure 1: The Bergen Model of Collaborative Functioning

Inputs into the Model are the mission itself (the reason for the collaboration), and partner- and financial resources. The mission can be explained as 'fuel' in the collaboration. The mission's seriousness and urgency has several effects on the collaboration. Partners decide, based on their degree of commitment, if they want to participate and how much. Secondly, the mission has an ongoing effect on the day-to-day collaboration. Third, the mission can determine the amount of financial resources recruited. Partner resources are partners who contribute with skills, time, commitment, contacts, credibility, recruitment of funds, and skills for working as a partner. Financial resources can increase accountability and business-like functioning, and support the production of tasks. Poor finance can create over-reliance on committed partners and create collaboration imbalance problems. Partners and financial resources affect each other in that partners can recruit more financial resources and partners (Corbin, 2006).

Throughputs consist of production- and maintenance tasks, and occur within the collaborative context, which is the collaboration's milieu. Production tasks are tasks that lead directly to the outputs. These can be mission statements, deadlines, meetings, agreements and reporting, etc. Maintenance tasks are tasks that contribute to a good working milieu. These can be social relations, celebrations of progress and success, acknowledging partners' unique contributions, etc. Maintenance and production tasks are affected by cycles of interaction, which allow complex interactions that positively and/or negatively affect collaborative functioning. These cycles are affected by four elements: how inputs (the mission, partners and finances) interact, roles and structures, leadership, and communication (Corbin, 2006).

Three different *outputs* can be achieved; synergy ($2+2=5$); additive outputs ($2+2=4$), or antagonistic results ($2+2=3$ or 0). Synergy represents the aim of collaboration and is collaborative products that could not have been produced by any partner alone. Such outputs can increase the perceived success of the collaboration and further investment in the collaboration. Secondly, additive results are outputs that the various partners could have produced without the collaboration. Examples of additive outputs are reports or actions that would have been produced with or without the collaboration. Additive outputs do not necessarily damage a collaboration, and they might simply be necessary. However, they do consume resources and can distract attention away from work needed to produce synergy. Finally, antagonistic results are unplanned outputs that regrettably eat up resources. These outputs will interfere with the production of planned synergistic outputs. When antagonistic outputs become too weighty, the collaboration may fail to deliver planned synergistic outputs, and the collaboration may end before completion (Corbin, 2006).

Finally, *the environment* (referred to as context in the present thesis) is a box surrounding the Model that can affect every aspect of the collaboration. Contextual factors are people, events, processes, actions, expectations and demands outside the collaboration, that have the potential to influence the collaboration. Such contextual factors could conceivably facilitate and/or hinder plans (Corbin, 2006). Contextual conditions are not studied in detail in Corbin's thesis, but will be investigated in the present thesis.

4.5 The context

Corbin (2006) found that contextual factors continuously influence collaborative functioning. Health care services are interconnected with numerous external factors (Broesskamp-Stone, 2004). Utilisation of external contextual factors can aid collaborative functioning. Gray (1989) found that increased external focus on a mission could create urgency and recruitment

of partners. Ellinger et al. (2000) found that marketing could increase performance effectiveness. On the other hand, contextual issues such as organisational complexity, murkiness, insecurity and instability can hinder collaborations. Gray (1989) emphasised that many systems are not “geared for a highly interdependent environment” (p. xviii). Secondly, rapid changes in the external context can create discord by pulling partners in different directions (Macdonald & Chrisp, 2005).

Unfortunately, inter-organisational and inter-professional collaborations in the health care context often result in divergence rather than synergy (Sullivan, 1998). One Norwegian study indicated that chaos and unpredictability in the hospital made collaboration challenging. Registered nurses felt they were disrespected; experienced challenging relationship with doctors; found hardship in asserting their own work; and obstruction in their own performance (Skei, 2006). Johnson et al., (2003) advise to understand the context one works within, in terms of language, priorities, rules and regulations, ways of doing business, and so on. Either collaboration can increase contextual complexity, or one can collaborate to reduce them and gain control (Wood & Gray, 1991).

4.5 Commitment to the mission

Corbin (2006)’s model is the first to recognise that the actual mission impact collaborative functioning. The literature often assumes that partners in a collaboration are committed; however, some partners are not interested in the mission itself, nor its possible outputs (Macdonald & Chrisp, 2005). Health authorities often mandate collaborations, but many fail to live up to the collaboration rhetoric, which hinders commitment. Therefore, a move from hierarchical relations to inclusive and participatory collaboration is advised (Alter and Hage, 1993; Sullivan, 1998). Gray (1989) argued that a mission must be recognised enough by all partners to create successful collaboration. Johnson et al., (2003) found that lack of commitment hindered collaborative functioning. The authors recommend emphasising promising collaborative outputs; making issues that are non-negotiable clear, yet to compromise on disagreements. Failing to develop partner commitment and consequences in a collaboration could result in antagonism (Johnson et al., 2003).

4.5 Input interaction

The interaction between the mission itself, partners- and financial resources is referred to in the BMCF as input interaction. These interactions create positive and/or negative cycles of interaction that may facilitate and/or hinder collaborative functioning (Corbin, 2006). Partners

can contribute with commitment, various skills and knowledge; and the interaction and combination of these can aid the collaboration (Corbin, 2006). Lasker & Weiss (2003) argued that partners should be of diverse, but applicable backgrounds to promote exchange and experience in collaborations. Secondly, partners can recruit financial resources that can aid the mission (Corbin, 2006). On the other hand, limited or withdrawn partner- and financial resources can create an over-reliance of partners and result in loss of vital partners (Corbin, 2006). Providing adequate resources for collaboration is therefore a vital factor for success (Corbin, 2006; Johnson et al., 2003). Finally, the collaborative functioning, its outputs, and the surrounding context also affect inputs. For example, if the collaborative functioning is ineffective and achieves no results, it will probably lose partners and funding (Corbin, 2006).

4.5 Structures, rules and roles

Corbin (2006) found that structures, rules, and roles affect collaborative functioning by how these are defined, formalised, and function. Clear structure, rules and roles can create commitment, responsibility, investment, and satisfaction in partners (Wandersman et al., 2005; Weiss et al., 2002). Blurred structures, rules and roles on the other hand, can result in conflict (Corbin, 2006). The development of structure, rules and roles depend much on partners' and organisations' already existing aims, traditions, rules and roles (Corbin, 2006; Johnson, 2003). For example, by law, health professionals already have formalised roles and levels of accountability that are hard to change. If the collaboration is mandated in an already hierarchical structure, partners are regrettably often not included in the development of structure, rules and roles (Johnson et al., 2003; Weiss et al., 2002). Goes and Park (1997) recommended creating collective governance structures in hospitals to facilitate innovation. Engel and Gursky (2003) found that collaboration between health professionals is promoted by agreement of action, roles and tasks. However, such inter-professional collaboration is hard to achieve (Iedema, 2007; Leathard, 2003). One recent study found that collaboration between medicine, nursing, managers and policy-makers was challenged because doctors did not comply with policies (Jorm, et al., 2007). Based the above, it seems that collaborations in hospitals can benefit from agreed-upon structure, rules and roles.

4.5 Leadership

Leader commitment- and involvement is a critical factor for successful collaborations (Corbin, 2006; Wandersman et al., 2005). Collaborative leadership differs in need depending on the mission, partners, and the context and so on (Lank, 2006). Lasker and Weiss (2003)

found that good leadership could facilitate broad influence and control, create positive group dynamics, and ease and extend the collaborative process. On the other hand, poor leadership can create conflicts and cause partner withdrawal from the collaboration (Corbin, 2006). Leadership characteristics that can aid collaborations are numerous; conflicts resolution skills; recognising inputs from partners; partner inclusion; share autonomy, and invite open discussions (Corbin, 2006; Lasker et al., 2001). However, if these characteristics are replaced with antonyms, they may have a negative effect on the collaborative process (Corbin, 2006).

4.5 Communication

Communication is crucial for successive collaborative functioning and outputs. Face-to-face communication is most effective because it allows partners to build relationships, trust, creative exchange, and participation in joint decision-making and goal setting (Corbin, 2006; Wandersman et al., 2005). Corbin (2006) found that communication should be open, occur frequently, and be purposeful. Long, Iedema and Lee (2007) found that informal settings often provide positive partner interactions that might not have occurred in a formal setting. Furthermore, adequate information to partners may facilitate awareness of roles, expectations, and progress and so on (Johnson et al., 2003). In contrast, lack of sharing information on progress can make partners uninspired. Poor communication can create confusion, distrust and conflicts, reduce interaction and exchange, and thus hinder synergy (Corbin, 2006).

Hospitals have several different professional languages and styles of communication that can hinder successful collaborations (Huxham, 2003). Therefore, it seems important to put much effort into good quality communication in hospital collaborations.

Summing up this section, the surrounding context, the mission, partner- and financial resources- and the interaction between them, as well as structure rules and roles, leadership and communication can facilitate and/or hinder collaborative functioning. The literature shares consensus about the advantage of applying a collaborative model when endeavouring to collaborate. This knowledge can make partners avoid factors that lead to negative collaborative functioning, and thus increase the chance for synergy.

4.6 Rationale to explore collaborative functioning

The collaboration literature calls for research on the actual factors and processes that lead to successful or unsuccessful collaborative functioning. Theoretical conceptualisations rather than studies of actual practice have dominated the literature (Corbin, 2006; Gray, 1989).

Loxley (1997) sought a model that is reliable, coherent, and transferable to similar situations. Huxham (2003) highlighted the need for a collaboration theory with a positive, actual, and direct influence. Macdonald & Chrisp (2005) sought studies of collaborative functioning leading to failure. Iedema (2007) argued that health care services might benefit from more qualitative and reflective knowledge on collaborative functioning. The BMCF (Corbin, 2006) is one of the first models on collaborative functioning to recognise the above.

Disturbingly, there is little academic literature about collaboration in hospitals. This is unfortunate, as avoidable mistakes are likely to be repeated and great amounts of time and resources will be wasted. This study therefore sought to add to the literature on collaborative functioning, by testing the BMCF in the hospital setting. Corbin (2006) argued that more research is needed into the collaborative mission and its surrounding context. The hospital setting was chosen because of its complex interventions and interconnections with the surrounding context, and because it differs from the previous settings the Model has been studied in (i.e. Corbin, 2006; Endresen, 2008). Finally, this study sought to add longitudinal insight into a collaboration that evolves over time.

5 The case

The case selected was an innovative programme at Haukeland University Hospital. This public hospital is one of Scandinavia's largest hospitals. It serves the western area health service in Norway and has several specialities that serve all of Norway.

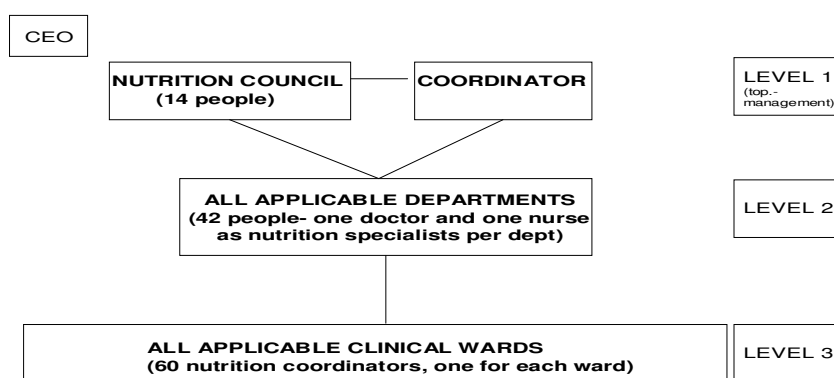
The aim of the programme was to reduce disease- and treatment induced patient malnourishment. This is a relatively neglected yet vital issue in hospitals today, because malnourishment can impede patients' recovery, increase length of stay and the cost of care. Haukeland University Hospital was the first Norwegian hospital to recognise- and act on the idea that the handling of patient malnourishment requires thorough planning and structure for implementation. Collaboration was required between managements, various clinical wards, doctors, dieticians, nurses, kitchen services and so on. These multidisciplinary stakeholders were dependent of each other to reach the programme's aims.

5.1 History and structure of the nutrition programme

Since 1981, numerous attempts had been made to place patient malnourishment on the hospital's agenda, however little action was taken until recent years. Several patient complaints and committed employees lobbied for improved nutrition, which was finally recognised by the hospital management early 2004. Subsequently, two work groups were

established to make an account for the problem and to suggest strategies for improvement. One group looked into actions required and feasible structures for implementation, and the second group investigated the organisation of nourishment in the hospital. Products of the above and results from a patient survey indicated that malnourishment was an improvable problem. Early 2005, the hospital management initiated a nutrition programme which was not launched until December 2006 due to time issues.

A mission statement directed a strategy for implementation: First, the management initiated a nutrition council of 14 multidisciplinary partners to be responsible for the nutrition programme. Secondly, a full-time nutrition coordinator was employed. Third, a decentralised nutrition network was to be established by appointing a nutrition responsible doctor and registered nurse in every department. Finally, every ward was to point out a nutrition coordinator. The diagram below (figure 2) outlines the structure for implementation:



5.1 Figure 2: Organisation of Haukeland University Hospital’s nutrition programme

The aims of the programme were to screen all somatic patients for malnourishment. Then, include all applicable health professionals to diagnose, refer, and treat malnourished patients. Secondly, a pilot project was established in one department (three wards), in which chefs were employed to make meals more tempting, flexible and nourishing. Third, the programme aimed to educate all applicable health professionals on the importance of malnourishment. Finally, the implementation was to be researched.

5.2 Selection of the case

The nutrition programme was chosen for this research because it required collaboration. The programme’s structure for implementation created a perception that it was a collaboration.

The mission statement recognised- and sought after the need for collaboration. However, there was no indication of recognition on the importance of collaborative functioning. Nevertheless, hospitals strive to collaborate to achieve their aims. The hospital setting allowed insight into a complex and challenging collaborative setting. Hospitals have numerous departments and wards, in which each unit differs in structure, expertise, staff, financial resources, and leadership and so on. Secondly, hospitals must obey governmental, inter-organisational and professional policies, rules and regulation. The above were considered interesting factors for research on collaborative functioning.

The supervising researcher of this thesis was acquainted with a manager of the nutrition programme, which assisted the principle researcher to access interviewees.

6 Methodology

6.1 Case study methodology

This qualitative study applied the case study methodology. This method provides the opportunity to explore holistic information on organisational processes and programmes (Creswell, 2003; Yin, 2003). A number of different strategies can be used to obtain data, including observations, interviews, document analysis and audio-visual materials, and so on (Creswell 2003). To acquire the richest possible data, the method for this study was decided upon in collaboration with the management of the case. Face-to-face interviews became the chosen method, which can allow the researcher to understand peoples' experiences and the situation from an internal and personal view (Kvale, 1996). Documents were also used to assist the researcher in getting a formal view of the case. Other methods have not been made use of due limitations such as time, availability, applicability and opportunities.

6.2 Data Collection

6.2 Documents

Documents were used to gain in-depth insight into the planning, authorisation and early implementation of the case (Kvale, 1996). The programme's managers provided the documents via e-mail. Only of official documents were used, which included minutes of meetings, work orders, mission statement, etc. The documents provided knowledge about the initiation and functioning of the case and prepared the researcher for the interviews. Secondly, the information was categorised as per the BMCF to provide an impression of coherency.

6.2 Participants

The study's participants² were key informants employed, formerly employed, or having service agreements with the hospital during the programme's planning, authorisation and early implementation. Seventeen interviews were conducted through two waves of data collection; twelve interviewees were interviewed once after the launch of the programme, and five selected participants were interviewed again ten months later. The interviewees were decided upon in collaboration with the nutrition programme's managers, based on their inside knowledge on information-rich participants. Interviewees ranged from the top-management- to a patient representative; and included managers of departments, wards and the programme itself. Participants were multidisciplinary, including four various medical/surgical professions, as well as nursing, dietetics, kitchen and financial professions. Not all departments could be included due to time limitations, however close attention was made to include great variety of professions, positions and perspectives of the programme.

The participants were approached via e-mail from the head of research and development in the hospital. The email notified the participants that the researcher would contact them shortly to invite them to participate in an interview, and that participation was voluntary. The informants were provided an informative letter about the aim and the nature of the thesis, a consent form, and the two interview guides (Appendix 1, 2 and 3).

6.2.2.1 Setting

The face-to-face interviews took place in locations and times selected by the participants. The majority of the interviews took place at Haukeland University Hospital, mostly in the participants' offices or in arranged meeting rooms. One participant was no longer situated at the hospital and was therefore interviewed in an office elsewhere. The interviews were conducted between 0800 and 1700 hrs. The first round of interviews was conducted during January-February 2006, and the second round during September-October 2006.

6.2 Interviews

Interviews were used to gain deep insight into the programme's collaborative functioning. Every interview followed a semi-structured written interview guide (see Appendix 1 and 2), based on this thesis' eight study questions. The interview guides were therefore derived from the BMCF (Corbin, 2006); however, the conversations were open to prevent confinement of

² The terms interviewees, participants, key informants, informants, and respondents are used as synonyms in this thesis.

the results, thus allowing the participants to touch upon other issues and elaborate as they preferred. In addition, the initial interview guide was produced in collaboration with the programme's managers, whose local knowledge ensured that the questions elicited the richest possible data. The interviews provided personal, professional, and departmental views of the programme that was not possible to acquire elsewhere.

Time one data collection took place two/three months after the programme was launched. The first interview guide included four main parts, in which the first explored the participants' earliest thoughts about the nutrition programme. The second part was about early discussions during which ideas for the programme were developed and planned. The third part included the processes through which the programme was formally approved, and the fourth part investigated the early implementation of the programme. Time two data collection took place eight months later- ten/eleven months into the implementation. The second interview guide focused on the implementation, and the process and maintenance of the programme. Both guides encouraged participants to elaborate and reflect on their own experiences on collaboration in the hospital. However, it has been argued that interviewees may feel uncomfortable talking about negative experiences of their organisation, managers and colleagues (Brinkerhoff 2002). Therefore, the questions were asked in a non-threatening and friendly manner, and the participants were frequently reminded of confidentiality, and the fact that the researcher sought experiences on collaborative functioning rather than sensitive and personal information.

The interview guide was modified continuously based on new information arising from participants to improve its utility. The interviews were tape-recorded using a mini-disc recorder, and notes were taken during each interview. The interviewees consented to being tape-recorded, and were informed when recording occurred. Most interviews required 30-45 minutes, however, some interviews extended to one and 3/4 hours.

Participants were offered the opportunity to check their transcribed interviews, some were asked to verify specific descriptions by email and/or in the second round of interviews, and all interviewees were offered the opportunity to verify the final report before submission. This method was utilised to enhance the validity of this report (Creswell, 2003).

6.3 Data analysis and interpretation

The analysis was ongoing and reflective, and questions were asked throughout designing the study, data collection, transcribing and interpreting data (Kvale, 1996). The researcher made continuous notes and thoughts on developing large categories and themes. The framework for

data analysis and interpretation were the study aims, the study research questions, and the BMCF (Corbin, 2006). Each interview (and document) was analysed as per this framework:

- In Stage 1, the documents obtained from the management were read to get an overview of the case (Creswell, 2003).
- In stage 2, interviews were conducted and tape-recorded and additional notes were taken to confine main points related to the framework (Creswell, 2003).
- In stage 3, the interviews were transcribed as recommended by Kvale (1996) to successfully transcribe the spoken word into text. An experienced transcriber was hired to transcribe the interviews, as the researcher was unable to do so due to practical reasons. The researcher ensured accuracy of the transcribed interviews by going through each interview carefully several times. Each round-one transcript was transcribed as soon after the interview as possible. The lines were numbered to ease the quotation process, and each interview was numbered. Evidence (in the form of quotes) was extracted in relation to each study question. Key findings not related directly to the study questions were compiled and their supporting quotes were indexed as well.
- In Stage 4, the researcher re-interviewed five participants, which were analysed as above.
- In Stage 5, transcripts were analysed following the study questions and cut across respondents. The content was clarified and analysed for meaning (Kvale 1996), and colour coded into the evolving categories. Evidence related to each element of the BMCF (Corbin, 2006) was illuminated systemically, and emerging findings were given attention.
- Stage 6 emphasised critical inspection of the Model, examining the data for evidence of weaknesses in the Model, and suggestions for modification to improve the Model.

6.4 Methodological considerations

6.4 The issue of translation

To avoid language confusion interviews were conducted in Norwegian and translated to English after completion of the entire data analysis. In this report, every effort was made to translate the meaning of quotes as expressed by interviewees, rather than word for word translation. The principal researcher, who is bilingual, in addition to being fluent in both languages' hospital terminology, translated the data. Furthermore, the researcher's bilingual supervisor verified the translations of selected and random quotes.

6.4 Role of the researcher

The primary researcher is a registered nurse, which enabled understanding of the nature of the hospital's organisation and functioning, and the hospital terminology. The researcher had no previous connection to Haukeland University Hospital; however, health professionals often perceive the hospital and the health care system based on their own profession, hierarchical placement, and area of commitment, and so on. Health professionals' biases and preconceived perceptions can be a threat to validity, also in the present thesis. Therefore, every effort has been made to be critical to own biases and preconceived perceptions.

6.4 Ethical issues

While no personal issues were addressed in this study, and there was no intervention or manipulation, important ethical issues are nevertheless at hand. Only documents authorised for public release by the hospital were utilised. The written consent provided information about the aims and the nature of this thesis. Participation in this study was voluntarily, and participants could withdraw or refuse to answer questions at any time, without difficulty or consequence. The words of participants were tape-recorded and transcribed, and these data were kept entirely confidential and stored with security and safety. The NSD- Norwegian Social Science Data Services gave permission to hold the data under prevailing rules and regulations for tape-recorded and transcribed interview data (Appendix 4).

The issue of interviewee anonymity emerged in this study. The participants often gave passionate responds to the questions raised. To maintain confidentiality, sensitive quotes were only included when applicable to other informants; however, all perspectives were included. Furthermore, the results bear a risk of interviewees recognising each other's points of view, and that others may recognise the participants in this study. All personal data was removed from the results. To ensure complete anonymity, the participants' allocated number attached to each quote was also removed. Consequently, all quotes in this study could have been spoken by any of the participants. In addition, the researcher e-mailed the final product to all participants to provide a one-month opportunity for approval of all quotes, and none objected to any of the material in this thesis.

7 Results

The results obtained from this study were coherent with the BMCF (Corbin, 2006), and will be presented as a story about the patient malnourishment programme and its evaluation

according to the Model's inputs (elements entering into the collaboration, throughputs (processes within the collaboration), and outputs (products of the collaboration).

7.1 Inputs

Inputs are factors that create- and facilitate and/or hinder collaborative functioning. As per the BMCF, the following inputs emerged from the data; the mission itself, partner- and financial resources. In addition, this thesis sought to study contextual factors, which had a unique influence on collaborative functioning and is thus depicted as an input into the collaboration.

7.1 Placing the mission on the agenda

The extensive history behind the mission was given significant attention by interviewees. The process of placing patient malnourishment on the agenda required collaboration between several stakeholders. However, stakeholders' commitment varied largely, which had a significant impact the programme's establishment. The manner in which the mission was presented to the hospital's management and the surrounding context, also affected the output. The results on placing the mission on the agenda will be presented below in three groups; commitment to the mission, presentation of the mission, and context of the mission.

7.1.1.1 Commitment to patient malnourishment

The common goal in hospitals is to deliver high quality hospital care, but its stakeholders inevitably have different opinions on how that should be accomplished. Hospitals struggle to deliver the best possible care for the lowest possible cost, which demands prioritising. Diversity in the perception of an issue can be a threat to collaboration. Commitment to the mission at hand varied greatly between individuals, professional groups, departments, and so on. This played a significant role throughout the process of the collaboration, as commitment to the mission itself was the reason why partners were interested in the collaboration.

Interviewees explained that stakeholders had unsuccessfully tried to place this mission on the hospital's agenda for decades. One interviewee passionately said:

I have worked here since 1981 and we have almost since then tried to accomplish something we call nutrition... a nutrition programme for the benefit of all patients.

Several interviewees believed that lack of commitment and knowledge was a hindering factor in this long process. The following two respondents explain:

1) Well, it is a very important point that it is so obvious that nutrition matters that no one has found it necessary to investigate whether it actually does. The level of knowledge has actually not been placed together in a sufficient manner, especially not in terms of a factor for successful treatment.

2) Nutrition is a great problem for the hospital, and that is naturally due to little knowledge about it in all professions. Those who have most knowledge about it besides the dieticians, naturally, are, hmm, yes- enrolled nurses followed by registered nurses. This might be beyond the pale-- but the enrolled nurses are closest in that situation. The doctors are terrible when it comes to that! What it comes down to is that it is not only motivation or commitment-- but there is a lack of knowledge.

Several interviewees believed that health professional's (especially doctors) lack of interest for nutrition impeded commitment. One doctor explained:

The doctors do not have sufficient knowledge in the field which is a cause of their lack of interest. They do not understand the importance of it. (...) I think the doctors are the greatest barrier. It (nutrition) is not fancy-- it is more fun to cut and inject and so on.

Concerns about the hospital's financial situation, and the manner in which hospitals are financed also hindered commitment to the mission. The next representatives explain:

1) *It (malnourishment) has been a topic of low priority, and has not been carried out because one has to cut costs.*

2) *You always have to invest money to save money-- that is how economy works elsewhere. However then there is the paradox that in the hospital and in health services one has to save money. You do not get any money even if there is an investment to be done, nor if one can save costs in the future, because it is always this budget-- this year that matters! So that is often a barrier-- the long-term financial planning does not exist at this level.*

Another reason for the long process of placing the mission on the agenda was lack of commitment at management level. The next quote represents several interviewees' opinion:

There are many who have been burning for a nutrition strategy in the hospital for a long time, both dieticians, some doctors and some registered nurses. And there have been initiatives through the years to promote this...but the problem is that it has not been anchored centrally within the hospital to make this reality and anchored in the management-- and get driving force and reference for substantial implementation, so that might have been to my credit.

As explained above, commitment to patient malnourishment had been low for decades due to lack of knowledge, interest, and financial concerns amongst stakeholders. Luckily, nutrition was influenced by contextual factors, which are explained in the following section.

7.1.1.2 The context around the mission

This thesis sought to explore contextual factors in collaborative functioning. Contextual factors can create urgency of a mission through evidence-based research, the government, and the media and so on. Secondly, internal factors such as operational cultures and strategies can facilitate and / or hinder change. All interviewees experienced that contextual factors uniquely influenced the process of placing patient malnourishment on the agenda. Therefore, the context is described as an input in this result section.

7.1.1.2.1 External context

The external context is everything surrounding the hospital such as other hospitals, governmental target areas, the media, trends, evidence-based research and so on. Interviewees experienced that such factors increased commitment, knowledge, and interest in the mission.

The following two passionate interviewees reflected on the various factors in the external context that had an impact on the hospital and patient malnourishment:

1) Everything outside the hospital has an impact on the hospital, because the hospital is part of society and you will always get trends into the hospital-- such as food. I am convinced that has been part of the problem!

2) When I started as a dietician in 1991, there was no interest in my profession at all. We were a hair in the ointment with uncomfortable messages and tasks to registered nurses and doctors-- "oh no, are you here again?" -There is always an increased workload after you have been here"-- and that was the communication we got, and they did not even know what title we had, and they called us dieticians and clinical-what? (...) But I could not predict that Fedon (Norwegian diet-celebrity) would put nutrition so extremely high on the agenda, and to a certain extent Dagblad (Norwegian newspaper) has contributed to peoples' engagement in nutrition. Nor could I predict that the research would indicate that we have to take this seriously to the extent it did!

Hospitals change ways of operation according to governmental action, evidence-based research and funding. One interviewee highlighted that changes in medical practice over the past decades contributed to the recognition of patient malnourishment:

Long-term patients were first treated a lot more at home, and then we entered a phase in which society required patients to be treated more in hospital- the patients were admitted longer. And now we are in a phase where the patients are treated a lot more out in the community (...) so this is a macro development on the patient population. We experienced poorly nourished patients in that middle phase; long-term cancer patients and long-term complications that we could not discharge and who were here, and one could see that they had a nutrition problem. And I think that is one of the reasons why nutrition gained more focus.

National and international patient malnourishment trends and evidence-based research also had an effect on placing the mission on the agenda. The following two quotes elaborate:

1) The trend in Europe, out these, it provided... it had to come about in order to change things, to get the patients more in focus in relation to eating-- because now we have got so much documentation that patients do not eat enough whilst hospitalised-- patients are malnourished!

*2) Well, it came about because there was more and more talk about it
LC: Do you mean in the context surrounding the hospital?*

-Yes, in the hospital context and in the context around the hospital. In addition, there were good national and international examples (...) and locally, the university has also aimed for this, which has mattered quite a lot as well.

Some interviewees also explained that concerns about the reputation of the organisation influenced the decisions to place the mission on the agenda:

Feedback from the organisation has confirmed that the food is not what Haukeland is famous for-- so I believe that taking hold of that part was an important factor for the hospital's reputation.

Most interviewees believed that external factors such as national- and international trends, changes in medical practice, evidence-based research, and a desire for a good reputation buffered stakeholders' commitment, interest and knowledge about the mission.

7.1.1.2.2 Internal context

The internal context can consist of operational structure and culture, stakeholders, and inter-organisational changes, and so on. These factors, as well as clients' developments and demands, influence how an organisation operates and the changes made.

The following two quotes explain how the clients' increased knowledge, interest and demands for better nutrition aided the establishment of the mission:

1) Generally, people and patients have more knowledge (about nutrition) today than previously. And then there is the fact that those who are admitted to hospital are much sicker than in 2001, and so I think the demands are greater as well. People are more concerned with food, not only as nutrition, but also as a culture and entertainment, and a social event.

2) The patients do not have that passive character they used to have, one is more aware of patient rights and you have a say. (...) And now we have become more aware of patients' rights and things like that, and there have been established patient representative committees and things like that. And I believe, especially when it comes to nutrition that this is a trend-- people are more aware that it actually matters.

Clients' opinions and demands had also been increasingly recognised in the hospital, which influenced the development of the mission:

The patient representative committee has struggled a great deal to be taken seriously, because we have had problems with that. It is only the last two years I have had the impression that they have been taken more seriously and considered in decision-making and processes.

Several interviewees explained that employees in the hospital also requested action:

The important thing from our point of view has been a repetitive request from our patients and our staff that the prior offer, in terms of food, was not good enough.

The hospital management underwent replacements, in which new leader(s) were considered more committed to malnourishment, which contributed to placing patient malnourishment on the agenda. The following two interviewees explained:

1) I think time was ready for it, and there had been some replacements in the people in the management.

2) I have been in hospitals just about all my life. I have been frustrated about nutrition in hospitals for years-- so it is great; when you come in to power you have to use it for something reasonable, you know!

Internal contextual factors, such as replacements in the management, increased demands, knowledge and interest amongst patients and staff contributed to placing the mission on the agenda. However, the next section explores the hierarchical factors that hindered the mission.

7.1.1.2.2.1 The hierarchical setting

Hierarchical organisations are cumbersome and complex to intervene in, because it is hard to simply get started without following a firm course. Powerful stakeholders who are committed to a mission are often essential to forge the mission through in a hierarchical milieu.

Several interviewees highlighted the power of the management in the hierarchy:

1) What happens in both society, in newspapers, radio, magazines, reports in TV, much focus from Oslo and the directorate of health can have an effect-- that is, have an effect if the person in the management wishes to do something about it him/herself. It does not matter if there is a negative attitude towards it, but I believe the personality and wishes of the person in charge do.

2) The current situation does not allow anything to happen without commitment from the management. It has been decided on centrally to endeavour in this, so it will be facilitated-- if it is decided that one should carry this trough.

Many interviewees also highlighted that doctors highly ranked in the hierarchy were vital to recruit to establish the mission. One respondent explained:

When you try to create a collaboration in the hospital setting, it is quite important to find a doctor in a high position that you collaborate well with, and then try to develop a common initiative. One needs doctors from several various professional fields.

According to some respondents, professional pride and low hierarchical ranking in the organisation hindered the process of reaching out, and placing the mission on the agenda:

The problem is that everyone is kings of their own castle, and the dieticians have been kings of their castle and are a state within the state. And they are very enthusiastic and they know this (...) But it is obvious that when one works in an organisation and reaches a certain level (in the hierarchy) -- people will finally listen.

The next quote highlighted the importance of patience and demands in the hierarchy:

It is obvious that this (reaching out) is a maturation process. Patience is one of the most important things in the hospital sector. I have worked in the hospital since 1972 and patience is one of the most important things, and to maintain pressure to forge through what one thinks is right-- and in terms of nutrition we know that we have been right all along

Many interviewees highlighted that the hierarchy was time-consuming and cumbersome to intervene in, and that one unfortunately was dependant on committed stakeholders highly ranked in the hierarchy to place the mission on the agenda.

Stakeholders in the hospital had unsuccessfully tried to place the mission on the agenda for decades. All interviewees believed that changes in the internal and external context uniquely influenced the decision to act upon patient malnourishment. External contextual factors such as the government, media, research and so on created urgency of the mission. Secondly, internal contextual factors such as increased demands by patients and staff, and replacements in the management also aided the mission. However, the hierarchical milieu and dependency of powerful stakeholders' commitment to the mission hindered the mission.

7.1.1.3 Presentation of the mission

Hospital managements receive multiple suggestions for improvements and have to prioritise these to deliver the best possible care at the lowest possible cost. In a hierarchical milieu, it is important to have strategies on how to reach out. The planning behind- and how the mission was presented to the management were given much attention. The next section explores how champions, evidence-based research, and powerful stakeholders facilitated the mission.

Continuous complaints from clients and staff largely affected the mission's establishment:

1) It was both suggestions from the patient representative committee-- the patient groups, who approached the hospital management to make nutrition a more serious matter, and there were also some clinicians.

2) I was called in for a meeting with the patient representative committee-- once again to try to stress the management on an attempt to put this into action.

Many interviewees thought that research on the financial benefits of the mission increased the management's commitment to adopt the mission, two interviewees explain:

1) There are people who have conducted research on this, and there are European numbers and such on this, and we collected those and sent them to the administration-- "look, you save"! So I believe that is what made them go for it.

2) The goal was probably to focus more on nutrition in the hospital, where one of the main aims were to nourish the patients so that one could decrease length of stay among other things-- they wanted to spend more money on nutrition so that they could save money in terms of treatment.

The management, however, had a different point of view:

LC: I have read that it is estimated that you can save 10-15 million NOK if the programme succeeds, do you think that was an important factor?

-I cannot remember that being highlighted at all. I have actually not considered it as a possibility and I think, perhaps, what it will reflect is shorter length of stay, less complications, and thereby greater patient stream-- and by that you do not save, yet one can treat more for the same amount of money. So that is a different perspective on the matter.

A patient malnourishment survey was conducted to map out the need for the mission. Several interviewees highlighted the significance of the survey to reach out to the management:

...I thought it was very good that they conducted a consumer survey, very good that many of those questions were mapped out. It provided the opportunity to highlight that there is a lack of systems and expertise and competence in that area, so I thought that was very good.

Interviewees identified several enthusiastic champions from all levels in the hierarchy who had aided the presentation of the mission for decades, represented by the next quote:

And I maintain that it has not come to light at all, the ground work that was done, the many enthusiasts that work in various parts of the system, and I have to say that here in this department there are many that have worked around the clock, the dieticians. And in the start up phase, and maybe I am jumping ahead in this interview, but in the start up phase, in this last year, those that have worked with this... everyone in the department has been involved. They have worked overtime and in their free time and

gone around the clock in the start up phase. And there are many champions that have worked with this, the Kitchen director and registered nurses that have worked with this, those you never hear about. The people that work with this every day, each in their own way, in the front, always talking about food and nutrition, and then there are those who say, 'oh no, is s/he going to talk about that again?'. We have a lot like that. And I want to state that they are heroes in this, because if it were not for the foot soldiers and the corridor politics, this would never have been an issue at all.

Champions and lobbying was vital, however commitment from the management was decisive:

We have had collaborative arrangements through the years and many champions have worked, but it becomes so narrow. And it ends when the champions stop-- when they reallocate or loose interest, or... that is allowed. And then everything stops. So the decisive matter was that the management took hold of this issue. And it was because of a complaint that they had to face it, right. That contributed-- that they had to. And luckily we had a competent person there (in the top-management) who had... What can I say-- experienced that patients need to be well nourished in own practice.

Many interviewees highlighted the importance of having enthusiastic and powerful champions presenting the mission to stakeholders with authority and interest:

So then we went to (CEO) and said that now we want to do something about this. And then things went non-stop.

LC: Why do you think things went non-stop then?

-Because we kept pushing, to be immodest, and I can be that-- I like to say that I never give up. When I get a no that does not mean a no-- it is a yes until the opposite is a fact. I believe that the way things have gone, the success factor is (the CEO) was very positive. So the next step was that we took this up with the hospital's leadership. There were two occasions, it was first in 2004 that this was an issue. And then it was decided to start a preliminary project, to map the situation as it was then (...) and so it was finally decided that we were going to go for this, and that decision was made in 2005.

A candidate from the top-management reflected on presentation of missions in the hospital:

If people put their souls, life and knowledge in presenting a constructive suggestion, they have to get a reasonable answer. That does not mean it will always be 'a yes' but they need a reasonable justification in that, as I am saying-- enthusiasm, work and strength is put into something.

LC: So a non-threatening management?

-Absolutely not! I am grateful, because I live of initiatives. Because from my position you cannot take all the initiatives, but you have to rank them because not all initiatives can be forged through, at leased they have to be placed in a queue-- otherwise you do not accomplish anything. So then you have a basis for prioritisation which is a crucial point, and from that perspective the nutrition programme was simple because it is so obviously important, it was obvious-- the opposite would be absolutely unforgivable!

The approach of presenting the mission to the hospital management created a decision to place the mission on the agenda. Interviewees emphasised the importance of enthusiastic,

powerful and committed champions who persistently insisted to forge the mission through. Secondly, research on client- and financial benefits of the mission supported its progress.

The process of placing the mission on the hospital's agenda was facilitated by numerous factors. Stakeholders' commitment to patient malnourishment varied, but was a decisive factor for progress. The context surrounding the mission clearly influenced the urgency of the mission, and increased knowledge and commitment. On the other hand, hierarchical factors delayed the establishment of the mission. Champions considered these factors when presenting the mission to the management, which had a noteworthy effect on its establishment. Finally, the mission evolved and was placed on the hospital's agenda.

7.1 Establishment of the nutrition programme

After several years of hard work, a formal decision was made to establish a nutrition programme, which became a hospital policy. The nutrition programme aimed to: 1) screen all patients for malnourishments, and diagnose, refer and treat accordingly. 2) Establish a pilot project in which a chef was hired to make meals more nourishing, tempting and flexible. 3) Educate all applicable health professionals on the importance of patient malnourishment.

The hospital's management was strongly committed to the mission. One leader stated that:

It was impossible to refrain to act on this because it is so well known that a nutrition strategy in hospitals undermines the total result we are to accomplish! We are not achieving the results we should-- because we do not have enough attention around this common, extensive problem.

One powerful champion recapitulated the process of establishing the nutrition programme:

I think I formulated the initiative myself to a great extent, but based on the enthusiasm of many to improve the nutrition in the hospital in different ways. And by that, it was easy to gather the troops and get going with the process, which became; an account for the project to map out necessary tasks and how to gather all troops. And then there were some statements, and we made some decisions and there was some money recruited-- and by that the entire thing started.

The mission statement directed the establishment of a decentralised network (as depicted in figure 2) to implement the programme, as excerpted below:

The project group suggests that the nutrition council in collaboration with directors of departments/wards is responsible for the implementation of the tasks outlined in this report. In order to proceed, it is important that one employ a coordinator (...). The council should consist of 8-9 people competent in nutrition, and should consist of a

doctor, a registered nurse, an enrolled nurse, a dietician, a representative from the kitchen and a representative from the central administration.

At level two (department-level) in the organisation, there should be designated one medical and nursing accountable as a permanent contact in the network.

At level 3(ward-level) in the organisation, there should be appointed a nutrition Ombudsman (Haukeland; Mission statement, 2004)

Consequently, multiple stakeholders were needed for the nutrition council / network. The programme's structure intended to increase commitment amongst the stakeholders needed:

We have requested that there are nutrition experts in every department, and that should be a doctor and a registered nurse-- that there are not only registered nurses, but that the doctors have to be in on it as well. And by that, there is a network of medically competent people as well, who are to be involved in developing guidelines. And then we have secured that there is a doctor in each ward, and then they should be able to create some interest within their own group.

However, most stakeholders were not to be included as partners in the collaboration, yet were mandated an extra task:

Yes, all the registered nurses are to do the screening, and then the doctors diagnose and initiate treatment, yes or approve - or prescribe it, and then the registered nurses carry it out.

Many stakeholders were still not committed to patient malnourishment, and did not want to be part of the collaboration. The next leader explained that the rationale behind the policy prevailed over the disunited commitment:

The importance and benefit of doing this is definitely what matters the most! So that the rationale in what we do must be absolutely-- everything we do should be based on professionalism and sense. This is professionally reasonable and that is one of the reasons why-- even though some people do not find this important, it has been decided that we are going to do this.

Several interviewees though this hierarchical approach would aid the mission:

When we realised which resources were released, or that were mandated... Or we can say; what people were instructed to do this and make it work-- we got hope that this time it would work!

Stakeholders successfully collaborated towards the establishment of the mission. The top-management was very committed to the nutrition programme, and formalised a mission statement that outlined the collaboration's needs. The programme required partners for a nutrition council / network, and a pilot project, and intended a hierarchical approach to get stakeholders to carry through the mission. The next section will explore partner recruitment.

7.1 Partner resources

Hospitals consist of multidisciplinary stakeholders with divergent interest, which can be a threat to collaboration. Many partners' time, skills, knowledge and commitment were required for the nutrition council, the nutrition network, and for the pilot project. Several committed partners were recruited, however, some were mandated an extra task in a demanding milieu. This section will explore the recruitment of committed partners in the hospital collaboration.

7.1.3.1 Partner commitment in the nutrition council and network

Collaborations are reliant of commitment from all partners to reach desired outputs. Several committed partners' were recruited to the nutrition programme, or requested to participate themselves. However, the mission was dependant on further stakeholders; therefore, a hierarchical approach was used to recruit partner resources.

Multiple critical aspects were considered in the recruiting phase:

We were looking for people with three qualities: positive attitude, knowledge and knowledge about the organisation. (...) One has to create a foundation, but at the same time-- if you choose the right professionals, you get both. They are good because they are critical, but at the same time they have to be concerned with the need for change.

Several champions contributing to the mission's establishment continued as committed partners in the collaboration, and assisted in recruiting further committed partners:

1) The coordinator position was announced, and I found out that s/he (current coordinator) had not applied, and I regretted that s/he had not applied, because I thought s/he was the right person to occupy that position (...) and so I encouraged her to apply for the position.

2) The way I experienced it, the first time I was in the nutrition council, which is under the top-management, under the director of research and development who hold the overall responsibility for the nutrition strategy... So it is obvious that I remained in the council because of (name), because s/he knows so much about kitchen and food because s/he has worked with that so much from before. And by that you have created connections.

Some partners were so committed that they recruited themselves into the collaboration:

As far as I can remember, patients' representatives were not considered for the council. So that when we raised that issue, we obtained a position immediately.

However, finding sufficient committed partners was a challenge. Two interviewees explain below how lack of commitment hindered the recruitment process:

1) We discussed this and tried to recruit enthusiasts. Recruiting doctors that were enthusiastic and had time was problematic, so we stranded some because of that.

2) Nutrition is often not prioritised in treatment, you focus much more on the main diagnosis and the fundamental caring for the patient than the nutrition aspect. But that also varies- you have got some registered nurses who are very good at ensuring adequate nutrition for patients, and then you have others who do not have the same interest and might focus on other things. It is natural in a way. The same goes for the doctors- you have got doctors who are very committed to malnourishment and others who might not have that as their area of interest.

The following quote explains concerns about the incessant implementations in the hospital:

(I am) positive to anything that can give the patients a better offer, but there is always “a but”-- Will this involve an increased work load? Is it possible to carry this out? (...) We cannot have too big expectations for this to proceed smoothly right away without using additional resources and so on.

Due to lack of commitment, several stakeholders were mandated to participate as partners in the nutrition council and network. In addition, the multiple health professionals that had to carry out daily operational tasks were not included as partners in the collaboration, yet mandated extra tasks. Below, a manager explains this hierarchical approach:

That was that the top-management had actually decided that we were to do this-- no one could come and say that “no, we do not want to”. Because it is actually the CEO who decides what to do in the organisation and one simply has to do that.

The nutrition council and network consisted of several committed partners who were eager to contribute with time, skills, knowledge and so on. However, to recruit enough partners, a hierarchical recruitment approach was utilised as well. The pilot project on the other hand, managed to recruit more committed partners, which will be explored in the next section:

7.1.3.2 Partner commitment in the pilot project

The pilot project was considerably smaller, and involved one department (three wards) in which a chef was hired in the department buffet, to make meals more tempting, flexible and nourishing. Several interviewees believed that commitment to the pilot project developed because of the obvious importance of the pilot project-- to aid the patients:

The main motivation has been to give a better offer to the patients and beyond that you do not need much support to put such a programme into action.

Much emphasis was put on recruiting committed partners, and recognising clients' and the organisation's needs. One manager explained:

In terms of the buffet, the development of the project out there, we were very concerned to recruit people who we believed in, so we have- I have not hand-picked them, but I have thought about; what qualities do we need? We need competent people in relation to food-- to the profession, but also great competence in caring-- we are actually in a hospital.

Another respondent explained how one can refuse to join a hierarchical programme, but that commitment- and allocation of resources by the management motivated participation:

Obviously, the fact that we (ward of pilot project) say “yes” is an important part of it, so that they (the top-management) can try this out in practice. It is clear that if we had been negative, they would not get to try this with us. So we have a certain role in this too. But undoubtedly, it is important that the (top) management say “yes” to such a project and is willing to spend extra resources in a period of time where there are cutbacks everywhere else.

New challenges were a commitment factor:

I thought it was a great idea, and what I was mostly aching for was that I felt that we could do something totally different than everyone else in the hospital-- that is to tempt the patient.

The pilot project had positive experiences on obtaining committed partners who were eager to participate. However, partner recruitment to the general nutrition council and network struggled to recruit enough committed partners, and a hierarchical approach was utilised. Stakeholders in a hospital are often pressured to the utter most, and worry about resources such as time and finances. The next section will explore the recruitment of financial resources:

7.1 Financial resources

A critical resource in the hospital is financial resources. Stakeholders are often concerned about the constant battle of having to cut costs, keep up with technology and new implementations, and at the same time deliver optimal health care. Allocation of finances in such a pressured financial context is challenging. Interviewees explained that financial resources were essential to recruit partner- and materialistic resources. Allocations of financial resources were dependent of commitment in the top-management, and some heads of departments. However, several partners experienced a lack of financial resources.

One interviewee explains below the significance of financial resources in such a programme:

If you do not get some money to run it, you will fail!

Commitment, will, and interest from the top-management contributed to the allocation of funds, as explained here by the following respondents:

1) (The Vice-CEO) saw to it that there was a decision in 2005 to invest some money into this-- because this is not free of charge, you need some resources for it.

2) It was done by means of the research and development departments' budget directly. It was decided that the position was to be established, and resources were located.

LC: ... and you need to be high up in the management to arrange that?

-Yes, to redistribute resources in constricted times is hard. So then one obviously needs will to carry it out, if you want to do fix something.

Some financial resources for the pilot project were allocated from the operational management, and were also based on commitment, as explained in the following quote:

It (the pilot project) was costly, and my superior and I said that "ok-- we will take care of those costs to implement the pilot project". (...) So the fact is, that we are so interested in implementing this that we take care of the costs.

The management of the pilot project decided to reallocate and reorganise local finances. One manager explained how his/her division' original way of thinking aided the implementation:

Our division has paid some money in order to implement small moves such as in relation to equipment-- it is actually quite small amounts when you think about the great picture. And we have also been very smart, I think we have been very smart; we have borrowed a trolley from the state railway (...) so we have been creative, and been out there to talk about it and got people along. So in that aspect it has not been too costive.

A head of department also allocated resources for the general programme's implementation, however expressed a challenge in allocating already pressured local financial resources:

This demands money, it demands time and time is money, and it demands people-- and we will do it. And what are we going to spend time on, spend the money on, and so on, but it is obvious it has been costive. In the beginning, up until now we have used the resources that have been available-- we have rearranged them. What we have used for this has not been allocated elsewhere like it normally would, but this is so important that we do this to get started. In the continuation, in this department, and what I see is necessary here, and what we have thought of--when I estimate what this will require; it will be two full time positions, and we do not have that-- nor will we get it.

Several respondents experienced lack of financial resources, and believed that inadequate funds would interfere with the daily operation of wards. The following quote elaborates:

LC: Were there any financial resources that made this possible?

-At least not of what I got to see (...) If we do not get any money to do this, they have to be collected somewhere else, and by that these kinds of programmes, whether they are

called nutrition or something else, they become affected. We cannot refrain to operate people so that others can get a nutrition strategy or something like that.

All respondents believed that financial resources were essential to implement the programme. Allocations of financial resources were dependent of commitment in the top-management, and some heads of departments. However, several partners experienced lack of finances, and believed that was a threat to the implementation.

The inputs presented above were factors that facilitated and/or hindered the mission's establishment. Four separate inputs emerged; the mission itself, its' context, and partner- and financial resources. First, the process of placing the mission on the agenda was explored, which was uniquely influenced by stakeholders' degree of commitment, and the internal and external contexts. In addition, the way the mission was planned and presented to the management also facilitated its establishment-- and the mission finally became a hospital policy. Secondly, recruitment of partner resources was presented, in which commitment was a keystone. Stakeholders' commitment to patient malnourishment varied largely, and despite recruiting some committed partners, a hierarchical approach for obtaining enough partners was utilised. Finally, financial resources were allocated from committed managers. However, some partners experienced insufficient resources and believed that could hinder collaboration. The next section will explore how the collaboration was implemented and how it functioned.

7.2 Throughput

Throughput refers to the implementation of the collaboration, and how production- and maintenance tasks were carried out. Production tasks are tasks that reach the mission's aims. Maintenance tasks are activities that fuel the collaboration, and contribute to a good working milieu. Four elements effected production- and maintenance tasks. These include the way inputs (the mission, its context, partner- and financial resources) interacted; structure, rules and roles; leadership; and communication. These elements created positive and / or negative cycles of interaction that affected how the collaboration functioned.

7.2 Input interaction

The inputs in the collaboration were the mission, the context, and partner- and financial resources. The combination of inputs; how they interact; and the effects they have on each other, is input interaction. Positive and / or negative cycles of interaction continuously affect the collaboration's functioning. For example, lack of resources can create an over-reliance on

committed partners. The interactions that evolved in the present case will be presented in the following groups: 1) partners and the mission, 2) the internal context, the mission, partners- and financial resources; 3) the external context, the mission, partners and financial resources.

7.2.1.1 Interaction between partners and the mission

Partner commitment in collaborations is significant for positive outputs; however, the partners in the present study were not all committed to patient malnourishment. Based on level of commitment, partners interacted differently. This section will explore the interactions between committed and uncommitted partners, and their affects on the implementation.

7.2.1.1.1 Interaction between committed partners

Many interviewees experienced positive interaction between committed partners, in that they encouraged- and fulfilled each other in the production- and maintenance of tasks.

The following quote explains the importance of good partner interactions:

We could not have managed without (the new coordinator position). No, because if we did not get that position, there would not be anyone who could bear the brunt-- and that is absolutely essential! In addition, the dieticians are intensely involved in committee-work, development of guidelines and education and so on. So even if I have a full-time position, I cannot manage on my own. They have to be included (two names) and it was very important that s/he came in, because s/he has a penetrating power at ward level, and s/he is very clever. Other than that, I received a mission statement, which was very specific, so I just got going, there were no more literature searches to be done, or anything like that- and “how do we do this”? It was a thoroughly completed plan.

Partners' commitment to take on new responsibilities was seen essential:

When we started this in the beginning, it turned out that many who had been in the network were not present, they had quit, or were passed on to other projects or similar. So, the way I feel, is that most people wanted to do something about it-- everyone agreed that we had to do something about this, but there were very few who rolled their sleeves up and said “I will take this, I will do this” (...) In a way we got an authority which took time before I realised I had. And maybe I have done what I have liked because I noticed that if I was to wait for everyone else-- nothing would happen.

The next three quotes tell the importance of commitment, personal chemistry, and relations:

1) The personal chemistry between (name) and I is very good. We have the same way of thinking, we are honest, we have no hidden agendas, and we want this to succeed-- so we keep at it. I think our personalities matter in this context. If the two of us had not been so charismatic, I believe this would have stagnated.

2) *I think we have complemented each other well, and it is obvious that s/he is in the department of research and development, so s/he has that relation, while I have relations to the products we are to deliver.*

3) *There are many enthusiastic people, but I believe the combination between (two names) has been decisive in order to set this up.*

Most interviewees believed that the committed coordinator was essential for the mission and good partner interactions. The next quote passionately represents several interviewees:

If (mentions the coordinators name) disappears, this will not go around (...) I cannot picture anyone who can replace her/him. I mean that-- s/he is actually irreplaceable. S/he is totally necessary in order to succeed, but s/he needs help. S/he needs partners. I believe that her/his character, her/his way of doing things are decisive in order to bring this to a successful close.

Some committed partners also experienced that they were important for their partners:

...and then there are the people around me, right. I think it makes a difference if I am involved in this or not. If I say that I cannot be bothered any longer... I think that I am a fairly important piece in this. I think if I said to (name) that I quit, I do not think (name) would be motivated to continue.

The next interviewee expressed hardship in losing interaction with a committed partner:

It is negative in that sense that we do not have one person that has the main supervision here. We need someone to pull the strings. (Name) and I worked well together in the way that I showed her/him completed work, and s/he demanded results. I think I worked more structured then. So in that manner, it is important- for me, personally (...) and it was important because s/he has a reputation out there and profiled the nutrition strategy, so we got a lot of pacing through that.

One interviewee believed that general management committed was more important:

I think it is very important that the (two central leaders) are committed to this, as an institution, as a position. But I do not think it mattered much for the implementation that (name) left.

All interviewees believed partner commitment was an essential factor that aided the implementation of the programme. Committed partners interacted well together, and promoted enthusiasm, wiliness and efficiency to reach the mission's aims.

7.2.1.1.2 Interaction between uncommitted partners

All partners were dependant of each other to implement the mission. Mandating uncommitted partners resulted in poor interactions. This section will explore interactions between uncommitted partners and the battles that developed during the implementation.

One interviewee explained the hierarchical partner recruitment process:

It is important that people who work on this have passion for the matter, but I think that in some wards... Everyone is to have people (representatives in the network), so it might be that people are not like; "Yes, I want to"! That they have been mandated, that; "this will be your job and your bitter duty to do this", that they become... It depends how enthusiastic people are about their job.

Several interviewees believed that partner commitment was a decisive factor for successful implementation of the programme. One interviewee passionately explained:

It depends on attitudes, and I think if we had stitched this up together, and been 100% engaged about it, more (people) about this-- if we had stitched this up together and just done it-- I think we could have accomplished this. It is that simple! I think we could have made the people in the wards and everyone understands that this is important. It would just sort it self out.

The next quote explains how poor partner commitment hindered the mission in one ward:

We were to have some dedicated people in the ward who were to... representing both doctors and registered nurses, who were to have more direct responsibility. We have that on the nursing side, yet I know that it is non-existent on the doctor side. I think they have given the task to a person who is not coping with that task. So, yes, I think it there too, this does not become a subject that s/he puts forward to the doctors to a great extent.

Doctors are powerful stakeholders in the hierarchy and were fundamental for the mission.

One committed doctor explained with frustration how his colleagues hindered the mission:

*LC: Ok... so the doctors are a barrier because they can hinder the implementation of the programme?
-Yes, because they are nonchalant-- they cannot be bothered, they do not care!*

Especially the surgeons in the hospital were given criticism for lack of commitment:

The surgeons are... Some are interested, but that is related to that person. But as a group, if I can talk in general terms, they only care about their area of interest, and they are to operate and send-- it could be a piece of meat-- Operate! Finished! Out!

Registered nurses were also observed to be ignorant about the mission:

The registered nurses were negative and the doctors were careless! (...) They do not want an increased work-load, more forms and so on, and that is understandable.

Some interviewees believed that many partners lacked commitment to the mission because one could not see immediate effect of the efforts made:

Yes, they have to see that it has an effect. They will not see that for a long, long, long time- that it has an effect (...) it is an additional task and they do not see the valuable effect of it because the patients are admitted for such a short time.

Many uncommitted partners were critical to the benefit of the mission:

I think that the cost/benefit effect is essential when implementing a programme. By that one can force something from above. But the ability to get it carried out is based on the visibility that this is sensible, beneficial-- that we can see the profit from this.

Some interviewees could not see the benefit of spending resources on a problem that goes beyond the hospital service, and sought the inclusion of other inter-sector health services:

*LC: So, what you are saying is that this should be more linked to the general practitioners?
-Definitely! (...) The public's nutrition is more important amongst community services than the two, three, four days that patients are hospitalised.*

Policies mandate health professionals, however much partner resistance was experienced.

Partner-partner conflicts were evident on individual levels and department-level. The next manager explained that some partners boycotted the strategy:

Yesterday, I received an email from (department) in which all registered nurses have been told not to screen patients! They do not choose-- the word boycott was used in the email I received.

Some interviewees thought boycotting the programme might give uncommitted partners a power feeling, and believed that the mission was not be feasible:

*LC: Why do you think people are boycotting this?
-I do not know, maybe it gives them a sense of power?
LC: Do you think there will be absolute screening of patients?
-100% ? No!
LC: Why not?
-To put it this way-- some patients one just cannot see the point in screening.*

Boycotting resulted in negative cycles of interaction, however, some partner's commitment overrode that-- and were even inspired to keep up the pressure:

*I think this is great fun! I am very happy I got this job and I think it is great fun to work this way and I really believe in it. I believe this will become much better and I think it is very challenging-- the challenges might be rather on the large side...
LC: What makes you de-motivated?
-I do become a bit de-motivated when I get such an email as yesterday about a ward boycotting. In a way I became de-motivated, but in another way it motivates me, that we have to really get them. No, so I am motivated all the time!*

During the second round of interviews, more committed partners were sought after:

1) The nutrition council has done some replacements to the better. We have got new people in that are very engaged (...) one has left-- who did not attend meetings anyways.

2) I have applied for leave from this position to work on this- on documentation and writing an article. If that goes through, we get another person who can breathe new spirit into this, and I believe some new energy can be good pacing. I am afraid the organisation is getting sick of my face [laughing]. I think it can be good to get more people involved and that we can keep going even more.

Partner commitment was vital for good interactions and the implementation of the mission. Several committed partners were recruited; however, numerous other stakeholders were mandated to become partners. Committed partners interacted well together, and aided the mission. However, uncommitted partners hindered the implementation and professional battles occurred. The interactions with the hospital's complex milieu will be explored next.

7.2.1.2 Interaction- the internal context, the mission, partners- and financial resources

Interviewees believed that the internal context hindered the implementation of the mission. Hospitals' hierarchical context can make them challenging and time-consuming to intervene in. Stakeholders are often dependant of each other, however the multidisciplinary staff are often busy and tend to focus their own areas of interest than that of others. Physical distances and high turnover of staff can also hinder implementations. In addition, the allocation of financial resources can aid and /or hinder new implementations. This section will explore the interaction between the mission, partner- and financial resources in this complex milieu.

The next quote explains the challenge of new implementations in the organisation's culture:

Everyone has an intuitive understanding on the importance of this, however the question is how to organise the integration of this into the busy workdays and the system that concerns so many. So it is about changing ones position and attitude-- and then you can start implementing things. It is almost a cultural organisational matter rather than a commitment matter, because it is intuitively right.

Many interviewees experienced that the hospital's complex hierarchical context and size negatively affected the implementation. One respondent passionately elaborated:

It is a gigantic organisation! The size is overwhelming in itself and that makes it... It is certainly easier to collaborate in a smaller organisation. They have hierarchies in other organisations as well, but this is so enormous. But I also think it has got something to do with the professions that are a bit unusual. Because it has not only been an administrative hierarchy, but some has been more "God" than others to put it

that way. That might be a bit beyond the pale, but there have been professions who have been leaders without being leaders, to put it that way. The doctors have, from the olden times, operated medical organisations and have run the hospitals-- even if they are not administrators, but because of their profession they have been in charge. It is hard to resolve that.

Another interviewee compared the complexity of the organisation with that of others:

It is obvious that in the private sector the decisions are made a lot faster and you get less breaking action than in such a big (organisation)... Here you have to consider the honorary office, occupational health and safety- all these things are important, but we have a common goal, and that is that we are going to be here tomorrow as well, both as patients and us who work here-- we cannot stop and make this more complicated than necessary!

The hierarchical milieu made one partner de-motivated to join the programme:

The first time I was present in the nutrition council, I thought "I cannot be bothered, I do not want to be here"-- because it was not inclusive.

Only one interviewee did not think the hierarchical context influenced the implementation:

It seems fairly hierarchical, but I believe the roles have become more and more clarified. So I do not really think that is a hinder, but it is clear that the system in it self is not a hinder, but individuals in a position in the system might be a hinder. But then there is something wrong with that person.

Many believed physical and mental distance in the hospital also hindered good interaction:

1) People protect themselves and their profession, and so... And one is physically working in different places, so one cannot see what others are doing. In the wards one can see that the various professions are working together, if they do not do the same task together all the time-- they still see each other and talk to each other, and by that at least they have the opportunity to understand each other better and what the other person is doing, and the possibility for collaboration should be better there (...) if one creates "meeting points" one can solve the problems.

2) To tell the truth, I believe it is impossible to get everyone along... It is like driving with an outboard motor on the high seas-- on a tanker [laughing]. That is, to make the most of it, that is why I am so impressed this has turned out the way it has, that it has come so far-- I think it is almost impossible to get everyone involved. .

3) There are so many employees here, various professional groups, and everyone have professional pride, and think and believe that... There are many powerful people here. There are very strong opinions and there are many who know best... (...) They are here to help the patients, and they look at all other extra tasks as a waste of resources, right-- "we are here to do the best for the patient, and we if we are to spend all our time in meetings..." , and things like that. They do not see it, it is not of their interest-- that is not why they became doctors, that is not why they became registered nurses. It is to help the patients--not to spend time on other things like this [said with irony].

4) *Even when there is more documentation and evidence and such, there are still some who don't pay attention because they have their own little area that they work with, and this is something for others to work with. So even if they have heard and seen that it is right, it is not what they work with -- they do not deal with it.*

Professional battles were considered a threat for successful collaboration in the hospital:

*LC: What do you think are the greatest threats for success in collaboration?
-That is a professional pride and "I know best" attitude amongst those involved. It has at least been evident here that there is a; "do not come and tell me"- attitude, and that is not acceptable, that there are such people! You need to know who to include in the team, right-- and there cannot be anyone there that are so powerful that they suppress the others.*

Some interviewees experienced a lack of respect and dependency of each other's professions:

But we have to respect that we are not doctors, we are not staff specialists-- we are what we are and we are good at that. It is not worse than that. That is my message, and that is very important the other way around as well-- that those who are doctors, and highly educated, and know a lot-- are completely dependent of our profession.

Partners' were dependant on each other's commitment, and many respondents believed that some partners did not commit to the mission because their effort alone would not matter:

I believe one of the barriers is that they (registered nurses) do unnecessary work because the doctors do not follow up-- they might feel they have to nag a bit. It is very dependant on which medical officer is on duty. Not all doctors are concerned with nutrition-- it is treatment that matters, nutrition will have to come up little by little.

In terms of the pilot project, partners' protectiveness of own profession and negative attitude towards change delayed the implementation. One interviewee explained:

So I feel that the "blinds went down" at the wards, and when we got out there to get them along, they were a bit like; "Now they are coming to take our jobs" (...) Yes, so I thought it was unnecessary to hold one (professional) group against the other (...) Because what we are thinking is that the most important thing is that we bear the brunt together. And in this project, from my point of view, we were completely dependent of optimism in order to make it happen. (...) I think this quite simply delayed the project to a certain extent.

Many interviewees believed that encouragement, openness and willingness could solve professional battles, in which the nursing staff in the pilot-ward was given credit for:

The staff has been very willing to take new things in and to be positive towards other people approaching their territory. If they had not been willing and refused to budge, it is not certain one would be approached with so much positivism at the buffets.

However, the general programme was negatively influenced by the hospital's milieu. Another hospital issue was time. Most respondents believed that partners' lack of time hindered partner commitment. Below, one interviewee covered many interviewees' thoughts on this:

Then, there is the part concerning people being very busy in the hospital-- they run fast and there are many tasks and many irons in the fire at the wards, and that competes with other tasks and considerations.

Many respondents believed that partners did have time to carry out production tasks:

I am convinced that have got time! (...) they are partly burned out in the wards, they have so much to relate to and they do not have the energy. They do not manage relate to it. Here is a schematic overview of everything a registered nurse does in a morning shift, and it shows that nine times throughout a day, the registered nurses are able to screen the patient-- but the still do not!

Turnover and high levels of sick leave also hindered the implementation of the programme.

Two discouraged interviewees explained:

1) So far, there is 5-6% sick-leave in the hospital, and over 11% at the department of clinical nutrition. They are understaffed all the time and when there is turnover in addition-- there is never anything that works like it should in the everyday life-- there are poor work conditions.

2) If only we had full-time and continuous positions, but there are so many on leave because we have a young- and female dominated profession. So many have always been on leave and there was little continuity in the work and constant interruptions.

Timing was an important factor during the implementation as well:

It took more time than we expected. Yes, one thing was that it apparently clashed with the summer holiday, so we did not get started properly until after the holiday-- and suddenly three months had passed. And then the subgroups were to have a meeting. To coax people inn to a meeting where people are available is, as you know-- a jigsaw.

All interviewees agreed that new implementations in the hospital setting are time-consuming:

It takes time to get it in as a permanent routine. We have seen that with other things before-- it can take as long as two years to get things up and running.

As explained above, the hospital's large, complex and hierarchical milieu made the implementation challenging. In addition, hospitals face tremendous demands for cuts of costs, which most interviewees believed hindered the implementation of the programme. The funding of the programme and its pressured financial situation will be explored below.

The allocated financial resources created enthusiasm, because it was not expected that the already pressured budget could recruit funds for the mission. One exited interviewee said:

We have had to fight for every fraction of employment, so the allocation of a full time position as nutrition coordinator, that was way beyond my expectations!

Another interviewee argued that the programme did not require large amounts of finances:

The smart thing about it was that it is a system that does not cost a lot. Administration wise it is cheap, and it is set out to regenerate itself, or that there is ongoing education-- consecutive education and updating.

One manager believed that partners' commitment was more important than adequate funding:

I believe it (financial resources) in that context is of subordinate meaning. It aids many collaborations-- but that is as far as I will stretch it. Collaboration is grounded on accomplishing something together, and it is that task in itself that is... But they might become more or less complicatedly dependant of for example financial conditions, so the collaboration can be put to tests-- but I do not think it is the decisive factor, but perhaps contributing.

One respondent believed that good interactions could decrease the demand for funding:

In relation to the screening and the pilot project, it is clear that the more interconnected one become in relation to that-- the less purchasing has to be done, thus less loss on supplies.

In terms of the pilot project, several interviewees did not think further financial resources could aid its implementation and functioning:

*LC: Would it be any easier to implement the nutrition strategy if you had other financial resources?
-No, I do not really think so.*

However, most interviewees involved in the general programme did not think there had been allocated enough financial resources, and had experienced severe consequences as a result.

Two interviewees passionately explained the challenges of extreme cuts of costs below:

1) One of the most difficult things you can do is to implement things at a time in which you have to use less staff, work smarter and cut costs wherever possible. It is the worst possible timing for implementation now. So, to come with new tasks that are to be done at the same time as we say "you cannot spend more time and so and so". Yes, so all professions are more and more pressured in relation to tasks, so then you have to find a way of sneaking it (implementations) through, and that takes some more time.

2) We have never had this many budget proposals and cuts of costs, and cuts in every possible way, and got messages to "do less and think through what you do-- work in new ways, but, here is something new-- you have to do this". So in that sense, the timing and the surrounding factors created resistance in the organisation.

The following quote explains how the financial situation affected partner commitment:

With these readjustments we have cut down on about 25 full time employees that is a cut-down on about eight percent-- and has been pretty heavy. And therefore, focus has been taken away from a few things and it has been problematic to get people to register-- to do things that we think... we should have had. Because focus had been removed from a few professional matters and been given to finance and analysing, and so on. That is something we feel strongly, that we have to get back that professionalism, we need to get back to what has to do with... But people have to work professionally without having a financial sword hanging over them.

Lack of financial resources created an over-reliance on committed partners. The following quotes represent several interviewees' passionate opinions:

1) The financial situation in the hospital is the reason for... we have to save here, there and everywhere-- in many ways you get psyched down and gagged in terms of not doing everything for nothing. We cannot work on enthusiasm and peoples kindness! There is a lot of enthusiasm and a lot of kindness and positive energy around the hospital, but one cannot aim for- or assume that. So, the way it looks now, if there will only be savings and cutting costs on employment, I do not think that... I believe the spark and the enthusiasm can die away-- and that is a bit risky.

2) First of all, the dieticians have not been allocated any additional resources-- but a pile of tasks. I considered it a real threat that they would pull out and not want to bear the brunt. But at the same time, I know they are-- they want to see their profession blossom, so they have an idealism which is contrary to all common sense-- to put ones foot down!

Eight months into the implementation, many interviewees highlighted that over-reliance of committed partners produced severe consequences. Two respondents passionately explained:

1) If I had more money... it would be helpful with more chefs, and it would be good with more people who could work on the nutrition strategy. At least in the implementation now that we have to start documenting things, we could have been more. And then there are the dieticians, almost everyone is on sick leave-- there is hardly a dietician left! They have asked for more resources and have not gotten that, and taken on tasks anyway-- and by that running themselves down completely, and people are quitting and are on leave and... Yes, it is critical there now! (...) That results in the department not being able to follow-up as well as they could. It is clearly a hindrance, because we are dependant on them for education around here, thus there is less education, less follow-up (...) It would be a great resource if they could go to the wards where they are familiar, and get them started and questioned why this is not working-- but now they do not stand a chance!

2) You get exhausted and cannot take more, which results in a standstill, and one has too many other things to do. I believe if we are to succeed, the "yes-people" and enthusiasts have to continue. If not, I think we will fail-- I know for sure we will fail!

The internal context had a predominantly negative effect on the collaboration. The hospital's strong hierarchical culture was challenging and time-consuming to intervene in. Lack of commitment to the mission and recognition of other colleagues was an interaction barrier. Physical and mental distance in the organisation also hindered interactions. Finances aided the pilot project and the establishment of the mission. However, the financial situation for the general programme prevented partner commitment and created an over-reliance on committed partners. The next section will explore how the external context interacted with inputs.

7.2.1.3 Interaction- the mission, the external context, partner- and financial resources

Several interviewees experienced that the external context positively interacted with the mission, and partner- and financial resources. External contextual factors such as supervising authorities; external institutions and stakeholders; partners' desire for a good reputation; and the media facilitated partner commitment and an urgency to handle the mission.

Many interviewees believed that increased governmental commitment to the mission created urgency, and positively affected partner's commitment. Two quotes represent below:

1) People (partners) can see that one connects to the central management by the nutrition council, with the Norwegian Directorate of Health and so on, who are the institutions who are supervising the health services. And it is clear that it is important and appreciated; seeing them suddenly grab hold of things and using the structure to take the advantage of its potential (...) We need to make ourselves visible, and that is also related to Health Bergen having some headings, so that we constantly add impressions and pressure on the case.

2) It is very important that other hospitals come along, so that we are not the only one. We are very conscious about being the first [laughing] (...) and by the way, it was very important that we got the Minister of Health and Care Services who gave us credit. And before that, a few cabinet ministers visited us and we got some publicity around that-- when they see that people "over in Oslo" are noticing it, I believe that has a positive effect (on the implementation).

Respondents experienced that the external attention provided partner acknowledgment:

Yes, everyone is talking about this. That is something everyone knows is important. And there are many hospitals that have nutrition as an area of commitment. Not everyone has had it as visible... And it is obvious that there is something about recognition-- if you do not get recognition, you have to go out and get it. And we have done that! It has been written about us in the newspapers, we have been on the radio, it has been written internally in the hospital, and internal publications. (...) We have got ourselves recognition and accept. We have been smart as well, we have invited people to the nutrition days, invited the other hospitals in Health-West, kitchen people... and we are, we see possibilities. Often the will is greater than the ability... but we talk a lot about it.

Several interviewees believed that all the attention would support the mission's development:

1) At some stage we need to make this big, and say that this is the organisation's policy- that is it-- do it! And that becomes much easier when we get the national guidelines (for patient nutrition in hospitals) (...) I think that will result in much pressure because there are many national documents on the table, such as the plan of action for the Norwegian diet 2007-10, and we are mentioned there, and all the ministers have signed that-- so it cannot just be dropped.

2) And now we have broadcasted this in the entire Norway. Everyone knows that this is an area of commitment. We have been on TV, publications, front page material in all the great newspapers in Norway. We cannot turn this around now-- it is too late!

Two respondents also believed that the external attention generated commitment from the top-management to continue to allocate financial resources:

*1) LC: Do you think the pilot project will be implemented in other wards as well?
-Yes! Otherwise the CEO will lose face.*

2) They have been flying the flag so high in the management, that I believe it would become a gigantic comedown if they do not get it up and running!

The second round of interviews revealed negative and critical attention to the programme, however several respondents believed that external factors aided the programme regardless:

1) There is no doubt that the nutrition strategy has given extended effects! The polytechnic university has nutrition as an area of commitment, all wards have had periods of increased commitment on nutrition; they have been trained in nutrition, studies are being written on nutrition-- so everyone are engaged in nutrition one way or the other (...) That is natural, but I think that the nutrition strategy- that we have had nutrition days and we talk about nutrition; it has been written about the nutrition strategy-- and that has an effect. (...) One has to choose to believe that all PR is positive PR.

2) It is clear that when there is focus on things, you remember it better, and you will probably think about it if you are refusing-- "No, I do not want to" but then might think: "but alright, I have heard of it and someone has said that we are to do it, so I should perhaps do it". But how much it matters for those on the floor...

Some respondents thought that the negative attention could support uncommitted partners:

I believe it (the media) has a positive effect, I believe that, because one knows that one is working on it. But I believe the negative focus- those who are against it are rubbing their hands together (when seeing negative media attention) saying it has not become better and think that "even if there is focus on it-- they (nutrition council) are not any better than anyone else, right?"

External contextual factors of supervising authorities, institutions and stakeholders, and the media interacted with partners and the mission, and uniquely increased partner commitment

and an urgency to handle the mission. The negative media attention was believed to have hindered partner commitment.

This section explored how the inputs into the collaboration interacted. Partner commitment uniquely influenced the interactions. Committed partners aided the mission and contributed to maintenance- and production tasks, however uncommitted partners hindered the collaboration. The complex internal context of the hospital interacted negatively with the mission with factors such as hierarchy, financial concerns, time, size and attitudes. The external context on the other hand facilitated the implementation by creating commitment, urgency and recognition. The next section will explore how the mission's production- and maintenance tasks were affected by structures, rules and roles.

7.2 Structures, rules and roles

Successful collaboration in a complex hospital setting demands a thorough structure, and clear rules and roles. The mission statement laid out the structure for the implementation of the programme. One hundred and sixteen partners were involved in the network; 14 people in the nutrition council, 42 nutrition specialist (doctors and registered nurses) in each department, as well as 60 nutrition coordinators in each ward (see Figure 2). In addition, numerous doctors and nurses were to carry out production tasks, but were not included as partners in the network. The structure demanded commitment from all partners, and was to be applicable and feasible in all the multicultural departments / wards. This section will explore the nutrition programme's structure and rules, then the partner's roles and accountability, and finally the significance of planning and creating routines.

7.2.2.1 Structure and rules

The nutrition programme was anchored in the central management and decentralised in the organisation, which is a vital factor for feasibility in the hospital setting. The programme also became a hospital policy, in which all health professionals were mandated to follow.

The programme's structure developed in the organisation after its launch (nutrition days):

The nutrition council was established very fast, and through them I got more people to collaborate with. And there was appointed work groups internally within the nutrition council, where we worked on smaller tasks. So it was first and foremost (names of the head of nutrition council and the coordinator) and the nutrition council until the nutrition days (...) Now (after nutrition days), we are handing over more and more to the nutrition specialists, they have been trained in clinical nutrition and are

responsible for screening the patients and to carry it out-- to make sure that it is carried out in the wards.

Anchoring the programme in the central management facilitated the implementation:

There was uncertainty whether the position was to be assigned the department of research and development, or the department of dietetics (...) and there is certainly power of being situated in the research and development department-- close to the centre of power to put it that way-- thus it gives more weight than if it was out in the periphery.

The multidisciplinary and decentralised network aided commitment in the organisation:

It is absolutely essential that there are nutrition specialists and nutrition coordinators and... Yes, you need someone who is a bit more exited about an issue. We have people who have excitement about various fields (...) you have people who you assign a certain expertise in various areas, and then you can make them accountable next time around and say; "How are you going about passing on your knowledge to the others"

However, many partners were mandated tasks that they did not want to do. Several respondents believed that the hierarchical approach hindered successful collaboration:

*LC: What do you think are the greatest threats for collaboration in general?
-That is if you are appointed something you think you should not do-- I believe that is the most important!*

One interviewee highlighted the assumption people make when a policy is developed:

We are so naive that when the boss says; "you have to do that now", one actually believes that they will do it.

On the other hand, interviewees believed that the pilot project's implementation was uncomplicated, non-hierarchical and easy to implement:

But we had few formal meetings to begin with. There was an education meeting, and then we got started. We had got an "ok", so there was no intense and ongoing process where we were to discuss and accomplish an arrangement-- "We are going for it now, and adjust as we go"

Doctors were not included in the pilot project, but were informed after the implementation:

We have just actually implemented it without saying anything to the doctors. We have now a better offer to the patients and have said that to them, and they are saying; "Great, that was a positive thing"

The programme's structure was thorough, anchored in the management, and decentralised. However, many partners were not committed to the mission and were mandated tasks. The

implementation of the pilot project however, was implemented in a less hierarchical manner. The next section will explore the functioning of partners' roles.

7.2.2.2 Roles

Clear and identified roles can aid collaborative functioning, however hierarchical and murky roles can de-motivate partners and create confusion. Assigning roles in the hospital is a challenging task because laws, policies, professions and commitment have to be considered.

The next interviewee explained the cautiousness needed when intervening in the hierarchy:

The minute you step on someone's feet-- if I do something I am not supposed to do and others are accountable for that, there becomes a lot of confusion and uncertainty in the system. And therefore it is important that as much as possible is clarified in advance, one can wish to make changes, but then in collaboration with the person accountable for that area.

Some professional's were considered more committed to the mission than others were:

The registered nurses are extremely enthusiastic! They wanted it, and we have therefore assigned them extra tasks in relation to screening and so forth. In order to achieve patient screening, we realised that we have to assign that task to the registered nurses-- otherwise we do not think it will happen.

However, laws hindered committed partners to handle the mission independently:

Yes, all the registered nurses are to do the screening. And then the doctors diagnose and initiate treatment, yes or approve - or prescribe it. And then the registered nurses carry it out. Nourishing a patient is resource-demanding treatment, which should be initiated by a doctor-- so the registered nurses cannot do it.

Some partners experienced that the roles laid out were somewhat murky, and others did not think some partners felt accountable for their roles. The next two interviewees explain:

1) LC: Do you think the roles are defined?

-No, I was wondering about that the other day. I almost perceived it as they came to the doctors with a blank piece of paper and said; " get this done"! That was probably parked fast-- but there certainly needs to be a clarification of roles here.

2) LC: Do people know which role they have?

-Yes, all those who work with the nutrition network do (several names), whilst the network... they have... I would not say they have shown that they know it, but they have got it in writing. The nutrition network has got it in writing, but I do not think that everyone take responsibility.

The partners in the collaboration were assigned complex and murky roles based on laws but not commitment. Accountability of partners' roles became important for the implementation.

7.2.2.2.1 Accountability

National law to follow policies mandates health professionals, however interviewees experienced that inadequate recognition of accountability hindered the collaborative process.

The next respondent explained health professionals' duty of care:

It is obvious that when the hospital management says that this is to be done, they (heads of departments/wards) are accountable for carrying it out.

However, many interviewees believed many partners lacked accountability:

LC: Do you think people feel accountable for implementing the strategy?

-No, I do not think so

LC: Why not?

-The nutrition network has been made accountable and they have got that in writing, so why they do not do it, or why they cannot handle it is hard to say. But you have to be incredibly strong in order to twist an entire ward around. And when no one else in the ward is taking responsibility... You are so on the decline that it is...

Some interviewees thought one should increase accountability in a hierarchical manner:

I think the important parts in terms of reaching the aims, are to increase accountability of people. That we allocate accountability and that we go on about their accountability so that they have to follow this up

LC: How will you do that?

-One thing is what you say, another thing is to demand results!

High autonomy and lack of time and commitment were factors that hindered accountability:

People do not have time, they have got so much else to do. They might prioritise other things, they might feel as though they are not mandated to do this. And they might think that it is more fun to do other things-- after all, people do have great freedom in what they are doing. Of course, they are to do their job, but there are many ways of doing that, and many ways to collaborate.

One manager believed his/her medical staff were resistant to new policies, as imitated below:

"It has been so good here from before, so we do not want to change it. We do not want to go on with changes and see if they work-- and if we are mandated to do these changes-- it shall at least be noticed that changes are mandated"!

Many interviewees recognised the challenge of obtaining accountability amongst doctors:

...I think it is crucial that the medical staff recognise this as part of their responsibility-- it is a responsibility for every health professional to be updated in their field!

Some interviewees believed that the roles should have been assigned the nurses alone because they were more committed to the mission and hospital policies:

1) This is about doctors' mentality, the registered nurses grasp it immediately-- whether they have got the message from (a common person, and the CEO), if they have got the message-- "Ok, we will do it". But the doctors, at least the ones who are a bit older have been trained to say "why are we doing this? What is the reason for it, which benefit is this giving us"? They question a lot-- and when they have asked these questions it turns to;" by the way, this requires extra time in which the same management has not given me, this management has even cut back on my plan of services"!

2) There might be some routines we have to establish in order to get his sorted, and I believe this has to be placed on nursing-level. Because they are more... rigidly law-abiding- to use such a silly expression in this context. There is no reason why the doctors cannot do the same, but they are like; "what is the use of this"? (...) The doctors are individualists!

Interviewees believed that the roles were hierarchical and murky, which created resistance and confusion. Assigning roles was a challenging task because laws had to be considered; however, some interviewees believed that commitment should have prevailed over that.

7.2.2.3 Creating routines

Health professionals have many routines that are of second nature, however the integration of new routines can be cumbersome, and hierarchical approaches are often used. The mission's tasks therefore needed to be incorporated in the existing routines as much as possible.

The next two quotes describe how existing structures can aid the integration of new routines:

1) It is not a question of doing it-- it is a question of not being allowed to refrain this! LC: And how do you manage that?

-It is about creating new routines. They are used to measuring temperatures', doing blood pressures and so on. And now they are to weigh patients and get a BMI, and do some questions about nutrition status, and that is... That is simple if it becomes a part of the routine. It almost does not take much strength, if one only gets used to it-- that is the critical stage. And that is what this network is about;. That there are some contact-people in the wards who are the coordinator's tools. And from that, the organisation adapts and individuals will do this. And if not-- it would be demanded. But it takes time-- by all means, it takes time.

2) There is nothing essential for it to be implemented, it is to be implemented.

LC: So how will you make them screen, like you said- many are still not doing it?

-By force [laughing]. No, as I said, trick them into doing it, make a routine. They are to have an admission conversation, and there you can add these points they have to go through. You will get it done, but it takes more time when you are pressured in other ways--and you cannot do it over night.

Many interviewees believed that the programme could have been systemised and integrated better to ease its implementation. One respondent said:

It is about creating an understanding of that; “this might not be the appealing thing you know in this world, but it is a routine” (...) And then the forms have to be constructed in a manner which makes it natural to do it (...) So there is something about us who systemise this-- we have to facilitate it.

One interviewee explained that his/her ward did not do the tasks because it was not a routine:

*But we do not screen systematically, we do not.
LC: Why not?
-Because it is not systemised.*

The screening tool to discover malnourishment had not been systemised in the hospital's computer system. The next interviewee explained how that hindered the programme:

And therefore, I have not stressed the follow-up in the wards because I have thought that considering the form (screening tool) is only available in paper, it is very cumbersome-- but if we get it electronically, I believe [looking hopeful]...

Interviewees believed that the programme was not a part of the hospital routine, and many did carry out their appointed tasks. Many respondents highlighted thorough planning as an important success factor prior to- and during the implementation, which will be explored next.

7.2.2.4 Planning

Sufficient planning by thorough assessments of applicability and feasibility of a mission can aid its' implementation. The process of placing the mission on the agenda was successfully planned; however, after the programme's launch many partners resisted the programme. Further planning of how to implement the mission became required.

Several interviewees believed that the more planning was needed prior to the implementation:

We had done much, but it is obvious that one can always do more, and in hindsight I do see that we should have though more about reaching out in the organisation. But it is hard-- it is a huge organisation!

Many respondents believed one should have planned to recruit more committed partners:

I believe it would be better if we had more people. If we had more dieticians that we could connect to the nutrition council, who could have focused and helps us more, so it would be easier. In hindsight, we should have connected more doctors who believe in this. We have done that later on, and that they could advocated a little for us.

Interviewees believed that including partners in the planning and implementation phases of the programme could have prevented partners' resistance. Two respondents passionately said:

1) We need to explain that; "alright, it is possible that this is beneficial, but we do not know and we have to conduct a study to establish that"-- I think that approach had been better that to say that "the management has decided that this is to be done, period"! There have been a few such moves; "The CEO has decided, the nutrition council has decided"-- without a rationale and without giving a basis for its background!

2) If one can see that someone is not following this arrangement, one can then go straight to them and say "dear friend, what makes you not do this? Is it because you want to boycott me or the CEO, or what? You have had the opportunity to oppose to this, and you have not done that-- and then I expect you to do it"!

During the second round of interviews, the management decided to do an applicability- and feasibility assessment of a department who refused to implement the mission:

I have got a student who is helping me to obtain a breakthrough in (boycotting department) (...) So now we will get a better overview in the entire department, and which patients that were screened in relation to screening results on various groups of patient. And then that will be raised with the heads of the department, and together we will come to a decision as to whether this should be a routine in that ward or not.

After the programme was launched, the implementation stagnated because some vital operational groundwork had not been completed:

The nutrition specialists who are to gain more responsibility to delegate to their nutrition coordinators, which is at level three (ward-level)... but they are not appointed yet-- partly appointed but not completely.

Moreover, the guidelines were undesirably made four months after the programme's launch:

The guidelines for example, for nutrition-treatment in Health Bergen-- there was a great deal of work with them. It was demanding, and...

LC: Were they not completed?

-No, they were finished this spring, in April I think it was. There was a group who were to work on it, and I imagined that we would write them in a few weeks-- but it took several months!

Goal setting is essential for collaborations and can make partners experience the mission's progress and increase commitment to the production of tasks. Many interviewees recognised that the programme's ambitious goals were hard to implement in practice:

1) It is an ambitious goal that all patients in the hospital are to be screened, and it might slip-up here and there-- I see that.

2) *And it is important that, and (name) strongly states that one cannot be too ambitious. You have to start modestly, at ground level-- that we do not decide to do everything for all patients now.*

The launch of the programme was an important goal for the partners:

1) *We discussed a lot how to do this, how are we going to increase the competence, how are we going to get attention; “ when are we going to cut the cord and say that we have started”? And then we decided that we were going to arrange the nutrition days (...) and that was only a stepping stone--now it begins!*

2) *...And that people are ambitious and aim high, so that the nutrition day became three days here. Three days kick-off instead of one like the mission statement suggested. That is because people are burning with enthusiasm for this, and; “one day is too little--we need more”.*

During the second round of interviews, one respondent sought after more short-term goals:

...but now, we do not have any deadlines!

Several respondents believed that lack of consequences and rewards hindered the mission:

One of the reasons is that they can refrain from this is that nothing happens if they refrain. It does not matter for the individuals' work situation if they do not do it-- they do not get any punishment or deductions of payment or anything.

Interviewees were unsure of what consequences were appropriate if resisting the mission:

1) *If one does not follow orders, there will have to be consequences'.*

LC: Which consequences' might they be?

-You do not resign people, mostly, because there are problems with labour supply-- but it must be notified.

2) *How do you follow up someone who is not doing satisfactory work?-- I cannot manage that!*

Last, one interviewee suggested a reward for implementing the programme:

Carrots are always a motivation, you know (...) maybe it is a good idea that if one had screened 85% of the patient you receive this reward, if one screens 90% you get that reward, and 95% another reward.

Thorough planning prior to- during the implementation of the mission was important.

Interviewees experienced lack of partner inclusion- and assessment of applicability and feasibility in the planning of the mission, which became required after the implementation.

Secondly, the planning of short-term goals aided the early implementation, however lack of short-term goals delayed further implementation. Third, lack of planning for operational tools

to produce tasks hindered the implementation. Finally, a need for planning consequences and rewards was suggested to handle partner resistance.

The implementation of the patient malnourishment programme demanded a thorough structure, and clear rules and roles. One hundred and sixteen partners were involved in the network; in addition, numerous doctors and nurses were to carry out daily operational tasks. The structure was hierarchical in which demanded partner commitment, and was to be applicable and feasible in all departments / wards. The decentralised structure aided the implementation in the organisation. Committed partners engaged in roles, however due to the complex and hierarchical system, roles became murky and given to uncommitted partners who displayed little accountability. Inclusion of all partners' in the planning prior to- and during the implementation was seen essential to ensure applicability and feasibility.

7.2 Leadership

Leadership can facilitate collaborative functioning by implementing good structures, rules and roles, aid communication, solve conflicts, and encourage diverse partners to reach intended goals, and so on. However, unsatisfactory leadership can hinder collaborations. The leadership for the patient malnourishment programme consisted of the CEO, the head of the nutrition council, the nutrition council, the coordinator, and department / ward managers.

Leaders in the hierarchical hospital setting have great power in the organisation. Most interviewees expressed much respect for the top-management, represented by the next quotes:

1) If you are to implement a programme that is so superiorly arranged, you need management support--from the very top! I do not think the nutrition programme... everyone can hold speeches, but there needs to be a constant pressure from above, from the people in management functions-- I believe that is the most important thing. If you think something is important whether it is a nutrition programme or something else, it is pressure and support from above, and some resources allocated from above, that are decisive for it to work-- that is whether one believes in it or not! That we believe in a nutrition programme or not believe in a nutrition programme has certain significance-- but the prevailing importance is that someone on the top is saying that this will work.

2) If the management does not follow up--their attitudes are transmitted down in the organisation; they can open or close gates, promote or wipe away commitment.

One respondent noted that initiation from the top-management could cause partner resistance:

I do not know how much the staff at ward level care about who is behind this. They are on the practical side, one can say that this coming from the management can have a

positive and negative effect, it can come to; “they say we have to cut costs all the time, but at the same time they introduce more things that we have to do--what do they really want”?

The top-management encouraged and mandated department leaders to commit to the programme. Many interviewees believed that was important for successful implementation:

We had a meeting with the leaders of departments where I presented the strategy and what we were about to do, and after that (top-leader) held an appeal, 5,6, maybe 7 minutes of which s/he said how important this was, the significance of it-- and s/he powerfully encouraged them to; “ now you do what the coordinator says and follow up on this; this is an important area of commitment for us, and it is absolutely essential for our patients that we do it-- and you are mandated to follow up on this”! And yes, spoke like that for a long time-- I believe that was very significant!

The next quote explains the importance of commitment amongst department leaders:

One has to visualise excitement from the management-- If I am sceptical and if I say that this is yet another thing we have to do, I think you can just forget about it-- then you have lost at the starting point. I believe that is the most important thing. And you have to create understanding on this being an important part in the overall patient care (...) if the person responsible talks positively about a matter, that is what it takes, if you are not positive-- things will stop.

The top-managements’ understanding of the mission, and their openness and trust for its implementation was important. One interviewee explained:

(Name) is in the top-management, and s/he is a dietician, so s/he is competent in the subject as well as in the implementation of the programme. It is obvious that those people are decisive for our success. It is not enough that the CEO says that this is important-- it needs to be anchored down (in the organisation). There has to be given trust and options for implementation, otherwise it will die out.

Many interviewees valued a non-threatening, open, and encouraging management:

1) One cannot seem threatening, and you have to be enthusiastic yourself and engage people and show that this is fun, beneficial and reasonable-- if one can convince people that we are going to do this, not just for the sake of doing it, but because it is for the patients’ common good; they recover faster, and they have a decreased chance of re-admission, and in the long run we can save costs. Getting people to believe in that is a key factor for good collaboration.

2) I used to be a bit scared of (leader). I have not known her/him. Now I know her/him a bit better (...) so there was no one else to talk to, so I had to pull myself together and talk to her/him, I was not anxious when we spoke-- and I expect that a leader listens to me and make decisions on the background of received information. Then, one hopes for a positive decision-- and it was in this case.

Leaders’ enthusiasm and ability to create partner commitment aided the implementation:

1) (Leader) is so unique when it comes to completing things and getting people involved, and the same with (leader), s/he gets people involved-- and there are creative solutions, job satisfaction, and people have drive and they like it.

2) (Leader) in her/himself is a success factor because of her/his personality, knowledge and enthusiasm. Without her/him we would not have come where we are today.

Partner recognition created encouragement and a sense of self-efficacy and self-esteem:

S/he has become much better at giving feed-back when s/he gets positive inputs, s/he gives feedback that this is good-- s/he never did that before, but s/he does now. Leaders have employees and respond to their initiatives-- both positive and negative. If they think it is poor, one should say so, but if one thinks that is good one should say that as well, otherwise the word does not move on.

Interviewees also explained that it was important to have leaders who expected results:

(Leader) is extremely impatient. S/he keeps going and demands results—s/he is a success factor. S/he is very strict, but s/he has drive.

On the other hand, interviewees also identified unsatisfactory leadership. Interviewees missed pragmatism for the hospital setting in one top-leader:

I had the feeling that s/he did not have much insight in how a hospital is operated- I think that was transparent on several occasions in terms of-- “it is just a matter of doing it”, right, but this is a very, very, very cumbersome colossus. I do not think s/he understood that.

Most interviewees called for more encouragement from the top-management:

You need a constant reminder or press-up to make it happen, not just to function, but to incorporate oneself completely in it-- and if that lacks or becomes unsuccessful, I think that one might revert to old practice. And we have been worried because there has been too little coming from the top lately.

The programme’s top-down approach created much resistance in the hospital, and conflict resolution became necessary. Partners required a better rationale for the programme and wanted to have a say in the collaboration. One leader explained partners’ needs:

I think it is about the benefit of doing this. This takes me two-and-a-half-minutes you say-- “but what on earth is in it for me”? And that is why we are going to challenge... so we are having a small meeting with (name) on Monday in which I think there must be presented data or a theory on the benefit of this!

The following quotes explain that partners’ voice was not to be heard in the hierarchy:

1) The management has actually decided that we were to do this-- no one could come to me and say that “no, we do not want to!” Because it is actually the CEO who

decides what to do in the organisation and one simply has to do that, so that was a very formal support, right.

2) They do not have a choice, no, but still many are saying; “no, I do not believe in it”. It is far from a resident doctor or a staff specialist to the CEO. And if the (department) managers do not keep going and say that this is important and so on-- “It is not only that it is important-- this is something we are to do! It has been decided! It is not up for discussion-- you are to do this”!

One interviewee explained how the mandating increased his/her commitment:

My motivation is that I have been mandated in my every-day work to carry out what the management have decided upon (...) Again, this is about interest, but it is clear that I have to contribute to point out for the employees that this is their duty through the job they have (...) That it is raised at staff meetings, that we focus on it, and that we quite simply tell them that; “ok, we notice what you are doing”.

Other leaders did not become committed when mandated. Some leaders believed that the CEO had to keep mandating resisting partners to implement the programme:

1) I think we have to make the managers more accountable. I have to raise this with (CEO) and get her/him further involved with the heads of departments. This is obviously a management issue, especially when an entire department decides to boycott, there is nothing... I can do some enquiries’, but I think it is important to get (CEO) to-- It is easier to take instructions from someone from the top-- someone they think matter.

2) I will raise this with the head of that department and ask what s/he is going to do about it, how s/he is going to handle it-- because it is decided that this is to be done. And we have to keep pounding and pounding and the CEO has to keep pounding and pounding!

The head of one boycotting department was not aware that there was so much resistance:

I think this is an okay programme in itself. I am a bit surprised (about the boycotting), but I understand why it is not carried out (...) I am wondering why this is not going-- as a routine, and we just have to work on that. I was actually of the opinion that this was going better than it was until a week ago.

The mandated nutrition programme required a strong and committed management. Some leaders were committed and encouraged partner commitment, openness and recognition. However, most interviewees believed the top- management had to become more involved. Many partners’ resisted the programme and overrode the powerful management, which required time-consuming conflict resolution. The next section will explore the manner in which partners communicated and how that affected the implementation.

7.2 Communication

Communication is vital in collaborations to achieve good interactions and maintenance (fuel). Hospitals have several complex ways of communicating. The mission used formal and informal means of communications; face-to-face meetings, e-mail, telephone calls, lectures and appeals, corridor conversations, media, publications, internet, and intranet. The general programme and the pilot-project communicated differently and functioned thereafter.

Many highlighted the importance of good communication during the implementation:

If we do not have it, we should have a communication strategy for nutrition...

Communication in the complex hospital setting is often time-consuming and multifaceted.

Below, one interviewee explained the process of creating guidelines for the programme:

So we sent a draft in all directions, and got some feedback, and sent it out for a hearing and got some contributions, and then we raised it in the council for further adjustments, and then to the top-management where the guidelines were approved; guidelines for nutrition-treatment in Health Bergen-- so now we have got them!

Informants believed it was important to utilise both formal and informal communication:

On one hand you have got the formal and on the other you have got the informal, and it is often the informal that is the... But in such a large organisation, and in order to get people jumping in the same direction-- you are reliant of both. I think both are important. I like to behave tidy, but it is clear that you need connections; you need to see what it takes. You can not wait to get it in writing-- that does not serve anyone.

The next three respondents explained how informal communication aided the implementation:

1) Yes, we were not very formal-- it would have been lethal if we were formal on such matters! Protocols were written, minutes from... I do not know what you mean about formal, but I was leading the discussions though-- so formal to the extent that I was chairperson, but there was no reason to be strict.

2) There was a great deal of grass root- and corridor conversations, and two and two sitting down and saying "what are we going to do about it, and who do we notify"-- there was a lot of that.

3) The nutrition council has to be a pusher, and one needs to encourage the nutrition specialist and nutrition coordinators (...) and (name) is trying to do that by way of having informal meetings with them-- because it is a huge ambitious arrangement!

Many committed partners experienced appreciative communication between each other:

I think we communicate well and have understanding, and we agree. People are very generous with each other, and there is room for mistakes, and that we try and that

there is room for some people getting more attention than others--there is a lot of experience of that. We praise each other, and back each other up.

However, during the second round of interviews, committed respondents experienced that lack of time prevented maintenance of the collaboration. One respondent explained:

I am with them (partners) because it is pleasant, and I enjoy myself with them, but we are not conscious on collaborating well together.

LC: Do you meet often?

-Casually, often but casually, but there are mostly emails (...) I have thought that we should have dinner together or I could invite them home to my place, to give us strength and become more connected-- but people do not have time...

Face-to-face communication is the best mean of communication, but was rarely used:

1) LC: How often do you meet in the nutrition council?

-Almost once a month

2) They (meetings) were mostly formal, and then there is the lobbying with phone calls and e-mails-- that is how the world moves forwards, it is not at meeting it moves forward (...) It (the communication) has been open-- and again it is about reaching a certain level within the organisation so that people listen to you, and then you have to use that influence the way you think is right.

Few face-to-face meetings hindered the maintenance of the collaboration:

I do not think it is maintained at all-- not consciously. We have had some network meetings, but there are very few who have turned up.

LC: Why do you think that is...?

-We have been up to 14 people, but there are 120 who should have turned up. It has not been prioritised for some reason (...) it is about motivation, they do not get to maintain their motivation. I have just sent summons and we have had interesting themes, that I have thought were interesting and that they have wanted us to raise, but I do not know why they are not coming (...) I try to demand results, but not many have replied to those emails. But I am wondering if I should have more one-on-one conversations with them.

During the second round of interviews, interviewees sought after face-to-face communication:

We do not maintain this good enough now-- there is no point in writing email, no point in writing letters! I think one has to contact people, talk to people, go out there and see how it is going in a nice and friendly manner- not instructively!

The next respondent sought guidance on effective communication strategies in the hospital:

If I had been more visible, and even more active, and better with communication, I think we would have accomplished more. If I had been less visible, less good with communication, we would have accomplished less than we have so far, so I believe there is a connection (...) I would like to have an advisor, someone who could have helped me, someone like (name) but perhaps with an even greater overview of the

hospital, one who is present in the hospital-- a God, preferably [laughing]! If there had only been someone like that in the hospital!

LC: What would you like advice on?

-Only in terms of communication, how to approach the (boycotting department), how to involve people-- how it is wise to establish the network.

On the other hand, partners in the pilot project communicated well. Face-to-face interaction was facilitated by the buffet's physical implementation in a department:

(The communication) between the buffet and the registered nurses is very good!

LC: Ok, why is that?

-Especially two of the people out there-- they are motive powers in the buffet and they are very positive people and the personnel are influenced by that too! The personnel feel that they are so positive, and they think that the personnel are positive-- and then you get that really good communication amongst them!

Another interviewee explained that communication issues were considered prior to the implementation of the pilot project, which aided the interaction between partners:

We do not wish to shove anyone out, we just want to be part of the total picture-- but to communicate food, care and health is a challenge. Because we do not want to step in and take (over) the care that health professionals are doing today, but we want to take part in influencing it (...) I have been very concerned about people in the ward having to know what we do-- know us and why we are there, so we have participated in ward meetings with everyone, there are three wards included in this-- and they have gotten to know us, they know what we look like and why we are here and that we have a common goal.

Many interviewees recognised the importance of communication. Partners in the pilot project interacted daily and communicated well. In the general programme, committed partners interacted well at first; however, lack of time and effort caused limited face-to-face meetings. Communication was a great struggle with uncommitted partners. Many interviewees believed lack of knowledge about the mission hindered commitment, which will be presented below.

7.2.4.1 Knowledge transmission

Hospital care develops fast, and health professionals are mandated to be updated in their field. Patient malnourishment is a topic concerning multiple health professionals, however transmitting the importance of the mission was a great challenge.

Most interviewees agreed with the next quote about knowledge and commitment:

1) It is (about) knowledge and knowledge is power-- I believe in that. The more you know about a topic, the more interested you become in that topic.

2) *The employees do not know enough, that is among other things why the (boycotting department) does not believe in nutrition-- they have not read the good documentation on the effect. Also, if they find a malnourished patient, they do not know what to do about it. Therefore; Education!*

One respondent pointed out the importance of continuous knowledge transmission:

One has to drip it in, and get it imparted via internet, the hospitals' intranet, and that one constantly attends meetings and uses it in practice-- that it becomes part of the wards' routines. And even if the doctors are not among us to begin with, when the registered nurses are doing it and the dieticians are doing it, and everyone are talking about it-- it has to reach them as well! When they are with the patient and the registered nurse asks "how does the patient score"?...or-- then they have to consider it, then they have to conduct themselves! And I think they can manage this a bit bottom-up, that it will reach the--that they will have to relate to it.

Much knowledge transmission was carried out during the launch of the programme:

1) *It is not easy to find ways of informing people, or ways of approaching them with information, but what we attempted to do during the week that the programme was launched, was that we had a few meetings and presentations to raise the issue and to create an interest-- even for the most clinical clinicians; we brought in a professor from Denmark and booked a meeting-point and time which the doctors and the entire hospital usually have-- and by that we thought that they are used to coming there, so if we have something that is not only about food, but studies and evidence and a professor-- then they have to get it. We also hoped that there would be support internally, and the CEO initiated- as a professor, colleague, and with such a high position to make an appeal after the meeting based on his experience-- "I have experienced this and I believe in it, this is important--, and I expect you to follow this up". And by that they have at least got the message!*

2) *We were to have seminars, posters, stands, the students were allowed to present their work. We were to have a demonstration of, or... we were to have a screening-school where employees could learn how to use the screening tool, which is really simple --so, quite simply much focus on the theme. Contact with media, interview in the radio, (local newspaper) and so on.*

Evidence-based research was important to convince health professionals:

1) *Hospitals are businesses of high technology and knowledge. Stakeholders are very experienced, have a high level of knowledge, and if one has programmes to implement without available definite results to refer to-- there will be more and more people questioning it as time goes by.*

2) *...Evidence-based research has particular effect on doctors who demand evidence. Even if not everyone is very research-minded, they demand evidence to carry it out. It is important to have doctors involved in this, and it is important to have a great deal of competence. And I do not know the literature well enough, but it is important to be updated all the time to parry the uncomfortable questions from the doctors*

Timesaving strategies for knowledge transmission were important to attract a large quantity of busy health professionals. One interviewee explained how that was considered:

...we had four lectures per hour for two days-- and by that we got over 400 people attending! If we had chosen to spend an hour they would not have had time to attend, but they have time for 13 minutes. So I think it (education) should to be short, and something written that people can access, which is extensive, so people can take a look at it afterwards.

From a management point of view, the programme was successfully presented to the hospital:

I think it was presented in a manner and with great influence which made people confident that we should implement this-- I cannot remember anyone indicating to strongly oppose to this.

However, many partners resisted the information on patient malnourishment. The following informants explained the challenge of reaching out to uncommitted partners:

1) It is partially implemented, it is starting to come around, but it takes time before this becomes incorporated in ways of thinking and practice--that is obvious. But the nutrition days we had as a kick-off, and the lecture (Professor) -- he was an eye opener for many professionals (...) It was a bit disappointing that there were few doctors at that lecture--I tried to whip them in, but it is clear that those present probably got a very good understanding of this.

2) We hold courses, and we are holding three courses this fall as well. One in October, November and January--by the way, the one in October was cancelled because there were not enough people enrolled, and that is not good!

First of all, it is about reaching everyone with information. The information is available, but getting people to read the information or to receive the information is very hard-- people have different interests.

Two frustrated respondents explained that some partners resisted evidence-based knowledge:

*1) LC: Why do you think they are boycotting?
-They say it is a professional matter, but I cannot understand that. In that case, we read the literature like poles apart! I cannot understand that it is possible to say that they do not believe in it considering the knowledge in the literature-- so there has to be another cause, no, I am not sure.*

2) Unfortunately, some doctors and oncologists still think that to nourish too much in every way-- can nourish the tumour! They are bit behind even though new research indicates something else. They have probably heard about it, but they are still sticking to their guns.

Some interviewees believed that the mission was not applicable to their area of expertise:

So far no one have told us that what we do badly here leads to longer sick-leave and rehabilitation (...) the impact this has on the (a patient category) in the phase where we are performing surgery--is actually still to be confirmed.

Several partners called upon visualisation of more specific results:

1) If this is to have penetrating power, if this is to reach people's bone marrow-- one will have to produce results! If there are no significant results, it is a threat, if it only leads to more expenses... Because at some stage, we will not be better off as the years go by-- so at some stage we will have to cut further costs.

2) That is documentation! That we document that malnourishment is common in Health Bergen and that we can publish it so there is scientific documentation on it.

Despite the efforts made to communicate the rationale for the programme and its' progress, several interviewees demonstrated that the communication had not been apprehended:

1) You have got the nutrition strategy and the pilot project. I was pretty well-informed about what it was-- but in relation to the nutrition strategy I did not realise in the beginning that it was the same case, but it kind of is.

2) We had a nutrition project that resulted in the initiation of a new method of serving in the wards (pilot project)-- I do not think that project was ever carried out in practice.

The communication in the patient malnourishment programme was a great challenge. Most interviewees believed that the programme benefited from non-hierarchical face-to-face communication; however such communication became a rarity. Knowledge transmission was difficult to achieve as many uncommitted partners resisted the knowledge on patient malnourishment, or required knowledge that was more specific. Furthermore, not all partners involved had attained the knowledge. However, the communication between committed partners and partners in the pilot project was visible and voluntary, and hence functioned well.

This section presented the throughputs in the collaboration. Production tasks (tasks that reach the mission's aims) and maintenance tasks (activities that fuel the collaboration) were affected by four elements and the complex interaction between them; 1) the way inputs interacted, 2) the programme's structure, rules and roles, 3) quality of the programme's leadership, and 4) communication. These elements created positive and / or negative cycles of interaction that affected the way the programme was implemented and how the collaboration functioned. The outputs that emerged from these cycles of interaction will be described next.

7.3 Outputs

The positive and negative cycles of interaction explored above produced different outputs. Three different outputs can be achieved; synergy ($2+2=5$), additive outputs ($2+2=4$), or antagonistic results ($2+2=3$ or 0). Synergy represents the aim of collaboration where the combined result is greater than the product of individual partners.

7.3 Synergistic outputs

Occur when $2+2=5$. These outputs are collaborative products that could not have been produced by any partner alone. Such outputs can increase the perceived success of the collaboration and further investment in the collaboration. Despite the challenges of implementing new strategies and creating commitment in the hospital, partners had successfully collaborated to place the mission on the hospitals' agenda. Several partners experienced synergistic outputs; the mission had gained urgency and increased some partner commitment, financial resources were allocated, and much recognition was gained.

One interviewee excitedly shared her experience on how his/her profession became promoted; the good collaboration with his/her partners; and the joy of overriding the hierarchical system:

I think the programme was... it has become bigger than what we were allowed to hope for! And that we (dieticians) have received more goodwill in the organisation than what we could hope for (...) I think we have collaborated despite of the hierarchy the hospital has. Hardly any organisation has a stronger hierarchy than a hospital-- and we have managed to collaborate where of everyone have been equally important, and it is important that everyone notice that they are equally important, and that we carry the brunt together.

Another passionate participant represents several interviewees when explaining the great expansion of the patient malnourishment programme:

I was asked if I wanted to be on the nutrition board (at the University of Bergen), because they knew I was interested in the subject. I said I would be happy to as long as they had research involved-- and that is what it turn out to be (...) I think it mattered a great deal to people that they saw this become such an extensive nutrition, research and educational area of commitment in Bergen-- which happened in parallel to an initiative in the hospital. So I believe many heard the nutrition message many places, which created security that this would be a great area of commitment. And that has lead to a lot; there has been allocated money from collaboration agents, much research money has been allocated, there have been created positions. Much has happened. We have got a network and coordinator, so people see that it is not only words, but it has become something!

All interviewees believed that the pilot project was a success. Clear synergistic outputs were reached; patients were eating more; the employees interacted well and were more satisfied; the work environment improved, and the hospital received a better reputation:

So this has been really exiting-- and it is incredibly good when we are in the nutrition council and the kitchen is asked about their opinion! We have entered a totally different world and that is very important for our profession. Because one thing is what you say, but it is the things you do that are decisive-- we tread the water, we are not concerned with positions, we are concerned with succeeding with what we are doing-- and with that we get recognition for what we are doing, so that has been a really exiting process, it really has!

The pilot project improved the work milieu, job satisfaction, and the hospital's reputation:

The work environment at Haukeland has been greatly affected by this. In the kitchen we have reduced sick-leave by 2 % in one year-- if the project has part in that, I do not know, but that is only guessing. But it is obvious that we have done a good job, gotten much positivism and recognition and get the opportunity to contribute, especially through (name) perhaps, in various context and to presented ourselves-- we get to show ourselves, tell people about our competency and what we are doing-- which makes people make a completely different effort! So I believe dollars in relation to food per kilo is only a small part of it-- but to have a good work environment, and to get recognition-- and to be an attractive employer in the hospital... In the wards, the health professionals can work with what they know and what they are educated in, not that; "I have to remember to order food" [said with a negative tone] there is a totally different calmness around that--they do not worry about that now and they do what they know and what they have chosen. And the third thing is about the hospital's reputation; many sick people come to Haukeland, maybe from other districts because we have special competence on some areas, and that makes them extremely surprised; "Oh, is that the way it is here"... so that plays a role too.

Another interviewee highlighted that the buffet was a starting point in the challenging process of overcoming professional battles in the hospital:

One thing is to understand what others are doing and have understanding for each other's jobs-- but also to meet and talk about problems and solve them. They are working a lot on that now. And a part of that is to bring the kitchen to the wards like they do (level of pilot project) and I believe that is an important part in this, to get the collaboration going-- to solve this professional..., yes partly professional battle, but also that one are physically far apart, and have different themes and that one does not understand what the other is doing.

Partners interacted so well and produced such effective and visible results that the department was willing to sacrifice already limited resources to fund the continuation of the project:

A year ago, when we started talking about the idea of hiring a chef in the wards and mentioned the idea; "if this turns out to be successful, can we take some off a nursing position to finance such a chef"? -- there was no way! It was completely impossible and we just had to move away. But now, the (name) department is going for it, they

are hiring a new chef because they have such good experience with that chef and all three nursing unit managers who have experience with having a chef available say that they will fight for this arrangement with tooth and nail! --They are willing to sacrifice an entire full-time nursing position in order to keep the chef-- That is unique! They have done a complete turnaround-- got such good experience!

The pilot project also boosted commitment to the general programme:

1) The department that holds the buffet are good at this and are more positive to the entire nutrition strategy (...)-- yes, you should have seen that report! The registered nurses, patients, everyone are really praising the buffet staff!

2) And after all, we are lucky to have the buffet as a pacer so to speak

The synergistic outputs created commitment to continue and expand the pilot project:

I do not believe that under any circumstance... that this pilot project will be closed down. I have said that we cannot do that-- it would be totally idiotic, because now it is established, it is working now, we do not exceed any budgets. Now we have a questionnaire that the patients have responded to... so we will suggest that this should be expanded. It does not cost that much, so I think we should manage that.

All interviewees involved in the pilot project experienced synergistic outputs, and were committed to continue. The project also boosted commitment to the general programme in that department. However, few interviewees expressed synergistic feelings from the implementation of the general nutrition programme. Other outputs will be explained below.

7.3 Additive outputs

Occur when $2+2=4$. Additive outputs are outputs (such as reports/programmes/actions) that partners could have produced without the collaboration. Additive outputs do not necessarily damage a collaboration, and they might simply be necessary. However, they do consume resources and can distract attention away from work needed to produce synergistic outputs.

One interviewee experienced additive outputs in that partners chose to work individually:

We were perhaps not collaborating well in the group, so it worked better when we emailed each other, than when we worked together in the group-- Yes, when we worked in that group I thought so, because professionally we have very different points of view, and many came unprepared to the meetings. So it is almost better that people get a draft of a script which they can work on in peace and quiet, and then pass it on, because then they can concentrate and work better.

7.3 Antagonistic outputs

Occur when $2+2=3$ or 0 . Antagonistic outputs are unplanned outputs that regrettably eat up resources. When antagonistic outputs become too weighty, the collaboration may fail to

deliver synergistic outputs. In health care services, partners of collaborations often experience a sense of wasted time when participating in mandatory collaborations.

Despite the efforts made, many interviewees believed that the general programme's aims had not been reached. Two interviewees summed up several respondents' perceptions about this:

1) Much has happened, and very little has happened. I think we have come far with many things and we have worked hard and intensely and many have been active-- despite that we have not come very far because there has been much more work with many things that we did not predict in advance.

2) LC: What has happened with the nutrition strategy?

-Not enough (...) we might do enough in the nutrition council-- but we do not get enough pressure out in the organisation to implement what the management has decided should be implemented!

The structure of the programme was completed; however, no action had been taken:

There is a, how should I put it... a skeleton-- it is decided that people should be here and there and take responsibility-- so it is out there in the entire organisation. (...) We have started--the tools are there, the guidelines are in place, the people to do it are there-- but someone needs to come in and-- they need to get the competency!

Interviewees thought that few partners were committed to- or even knew of the programme:

I do not reach through to the nutrition network. You remember the nutrition days? I calculated there were approximately 1000 people participating at the various arrangements we had-- there was a full house, many attended meetings. And now, when I have in-services around here I ask how many knew that there were nutrition days-- and by exception one or two will raise their hand! People do not know about it-- people do not know that we have a nutrition strategy, or about the nutrition days.

Many interviewees did not believe knowledge increased partner commitment to the mission:

Almost the entire nutrition council, that is about 125 (people), have attended courses in clinical nutrition (...) I hope we can reach people through that, but it does not look like it has mattered much-- that they have been to a course.

LC: Why do you think that?

-They are committed when they are attending, but then they get back to every-day life and then it is so hard to get it implemented. They go back to the routines that already exist (...) The scales are in order, the guidelines are in place, the literature is there, they think it is important, they want to do it-- and they are not doing it. I do not know!

Last, one interviewee miserably revealed the low numbers of improvements:

Now we are screening four times more than what we did a year ago...

LC: Last time I was here?

0.25% ...we might have reached 0.3% when you were here because there was a small increase. And now we have reached 1%, that is those who get diagnosed-- more

patients are screened but this is a diagnosis and then they have received treatment-- because there are quite a few who get screened, yet it is not grabbed hold of or they do not refer-- but if there are not more than 1% (of patients) diagnosed with malnourishment, it has been a lot of work for modest results. But I do hope that we will reach... that we will get more.

Antagonistic results only arose in the general programme. Despite the efforts made, few patients were screened nor treated / referred accordingly. Employees took little action after they were educated, which generated much frustration and burnout for committed partners.

The next section will start with a summary of the major findings from this study, followed by a detailed discussion.

8 Discussion

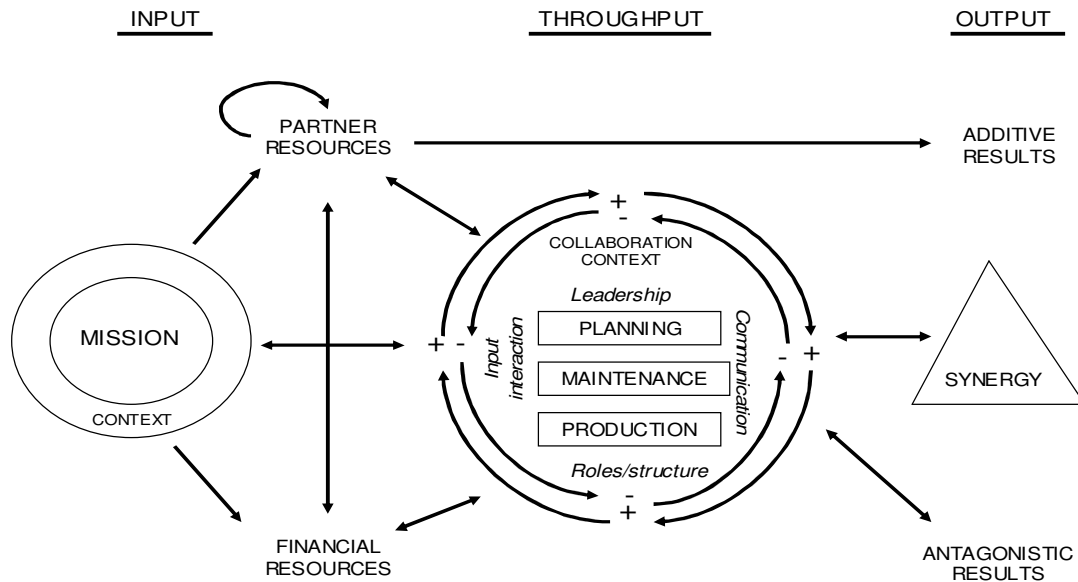
The results told a story about the collaborative functioning of a hospital's nutrition programme. First, the process of placing the mission on the agenda was presented, followed by its' establishment, implementation and outputs. The collaboration consisted of inputs (elements entering into the collaboration), throughputs (processes within the collaboration) and outputs (products), and the complex interactions between them. The findings were coherent with the Bergen Model of Collaborative Functioning (BMCF) (Corbin, 2006). In addition, the results demonstrated that the context surrounding the mission acted as a unique factor affecting the entire collaboration. Secondly, partners' commitment to the mission was a cornerstone for successful interactions. Finally, including all partners' in sufficiently planning and implementing the collaboration was vital for successful collaborative functioning.

Committed partners overcame hierarchical challenges, and utilised the context, lobbied for- and successfully placed the mission on the hospital's agenda. That process was a collaboration in itself that produced synergy-- the mission gained urgency and increased some partners' commitment; financial resources were allocated; and much recognition was gained. From that, a nutrition programme was established aiming to screen all patients for malnourishment and act accordingly; educate all health professionals; and create a pilot project to make meals more tempting, flexible and nourishing. The mission and its context, partners- and financial resources were inputs into the collaboration. The planning, production of tasks, and maintenance (fuel) of the collaboration were affected by; how inputs interacted, communication, structure, rules and roles, and leadership. Outputs were a result of the interactions above. Interestingly, the collaborative functioning of the general programme and

the pilot project were like poles apart. The pilot project recruited committed partners that interacted well. Its structure allowed adjustment per context and partners, and thus produced successful interactions and outputs. On the other hand, the general programme mostly applied a hierarchical approach. Stakeholders were mandated to perform tasks, yet were not included as actual partners to influence- or participate in the collaboration. Lack of assessment of applicability and feasibility in all the multicultural contexts involved hindered the implementation. The above resulted in partner resistance and boycotting, despite policy-production and the leadership's strong commitment. Committed partners interacted well, however an over-reliance of committed partners resulted in burnout and thereby loss of vital resources. Noticeably, the general programme applied a hierarchical approach that produced much antagonism, yet the pilot project achieved synergy using a collaborative approach.

The present thesis sought to study the factors and processes that facilitated and /or hindered collaborative functioning in the selected case. Secondly, it aimed to study the contextual factors that affected the programme, and finally to examine the utility of the BMCF in the hospital setting. The findings were applicable to the BMCF; nevertheless, this research raised questions and inspired discussions within the research group for refinement of the Model. The findings indicated that the context should be an input into the Model, because the context acts as a unique factor affecting the entire collaborative functioning. Supporting this, former studies on the Model found that partners' contributions to a collaboration depended on their own organisation's circumstances (Corbin, 2006; Endresen, 2008). Secondly, a third throughput task of planning has been added, in addition to production- and maintenance. The findings here indicated a need to depict the aspect of planning as the collaboration progresses. Also supporting this, Endresen (2008) found that planning prior to involving members is valuable in collaborations, and Corbin (2006) found that planning was affected by partners' sustainability. Finally, the Model was simplified to ease comprehension. The suggestion for refinement of the BMCF is depicted below (figure 3).

BERGEN MODEL OF COLLABORATIVE FUNCTIONING



8.1 Figure 3: The BMCF with suggestions for modifications

8.2 Placing the mission on the agenda and contextual factors

The contexts surrounding the mission at hand had a noteworthy effect on its' establishment. The findings suggest that making the best possible use of factors in the external context can aid the initiation of collaborations. These factors can be to exploit emerging evidence-based research, government action, and the media- and clients' demands. The context can create urgency and commitment to confront a problem, and thus place a mission on the agenda. Corbin and Mittelmark (2008) found that urgency contributed to partner commitment, which aided collaborative functioning. Gray (1989; 2004) found that timing is crucial for collaborations in that all partners involved need to have sufficient commitment.

On the other hand, the findings suggest that a hierarchical internal context can hinder the process of placing a mission on the agenda. Dependency of commitment and action by powerful stakeholders can hinder a mission. In addition, partners with contradictory areas of commitment- and lack of interest for others' concerns, may prevent common a consensus. Secondly, great physical distances in an organisation may prevent understanding- and

appreciation of colleagues' work. The above factors may hinder the process of establishing a mission. Supporting this, Broeskamp-Stone (2004) found that an organisation's visions, operational structures and processes affect the perceived effectiveness of collaborations and levels of conflict. Loxley (1997) explained that partners in a collaboration need mutual perceptions of a mission and accept interdependence with other partners.

Despite the above, committed partners overcame hierarchical challenges, and successfully utilised the surrounding context, lobbied for- and collaborated well to place the mission on the hospital's agenda. That process was a collaboration in itself that produced synergy; the mission had been placed on the agenda and was greater than what partners had hoped for- and could have achieved individually. From that, the mission gained urgency and increased some partners' commitment, financial resources were allocated and much recognition was gained. The next sections will discuss the implementation of the programme.

8.3 The pilot project

The pilot project was an element of the nutrition programme, wherein a buffet was established in one department (three wards) to make meals more tempting, nourishing and flexible.

8.3 Input interaction

Input interaction refers to the interaction between the mission itself, its surrounding context, and partner- and financial resources. The findings suggest that recruiting partners that are committed to the mission at hand is essential for successful collaborative functioning. In addition, partners with knowledge of- and humility to a new and complex context and capabilities to complement each other's tasks, can create positive partner interactions. Supporting the above, Corbin and Mittelmark (2008) found that partner motivation and diversity contributed to synergistic outputs. Crucial for the successful partner interactions in the pilot project was partner commitment, active (physical) interactions between partners, and visible results. The findings suggest that the above can create an understanding and appreciation of other partners' work and contributions, which aids collaborative functioning. Secondly, partners' positive interactions- and feedback from the hierarchy and media provided partner recognition and motivation for further implementation. Engel and Gursky, (2003) found that successful collaborations are promoted by an appreciation of other professional's contribution and satisfaction amongst professionals. Finally, the findings indicate that providing adequate financial resources may facilitate the production of tasks

without an over-reliance of partners, and the struggle to recruit further resources. Corbin (2006) also found that adequate financial resources in collaborations can aid its' functioning.

8.3 Structure rules and roles

Little attention was paid to hierarchically structure the implementation of the pilot project. The results suggest that allowing adjustment per partners and context when implementing a mission may create commitment, and facilitate feasibility and completion. Goes and Park (1997) observed that promoting shared power for implementations in hospitals could facilitate innovation. Other authors (Alter and Hage, 1993; Sullivan 1998) have also advised such inclusive and participatory collaborations. Secondly, the findings suggest that avoiding professional battles is vital when collaborating in a hierarchical setting. Recognition of interdependence with partners, and cautiousness of each other's professional roles, may support positive partner-partner interaction. Therefore, in line with Leathard (2003)'s findings; promoting inter-professional collaboration by accepting interdependence with other partners seems crucial for successful collaborative functioning in the health care setting.

8.3 Leadership

The findings indicate that commitment from all leaders is crucial for collaborations. Leaders' ability to be encouraging and inclusive aided the production of tasks and the maintenance of the collaboration. Secondly, despite the hierarchical context and the pilot project being mandated, much trust was given from the top-management to adjust the pilot project to its applicable context. Providing trust for implementation may create partner commitment, necessary implementation assessments, and thereby feasible collaborations. Finally, early conflict resolution created openness, humility and trust between partners, thus aided the collaborative functioning. Corbin (2006) also observed that openness, autonomy, and trust were important leader skills. Furthermore, Huxham (2003) found that leaders should cut across boundaries, invite open discussions, and share autonomy.

8.3 Communication

The findings indicate that frequent face-to-face communication can produce positive interactions between partners. Moreover, creating arenas where partners can physically interact and see the significance of each other's work, may promote positive interactions. Supporting this, several researchers have found that face-to-face communication was the best means of communication in collaborations (Alter and Hage 1993; Corbin, 2006; Lank, 2006).

Summing up, the mission and its context, and partners- and financial resources were inputs into the collaboration. The planning of the pilot project, the production of tasks, and the maintenance of the collaboration were affected by positive and negative cycles of interaction from how inputs interacted; structure, rules and roles, leadership, and communication. The findings suggest that the pilot project's collaboration functioned well, despite the challenges of collaborating in a hierarchical setting. Partner involvement- and adjustment of the implementation to its context created a well-functioning collaboration. Partners interacted physically and frequently communicated face-to-face, which promoted positive relations. Leaders' ability to provide trust for implementation, and their commitment and encouragement to the mission also provided positive interactions. Finally, the surrounding context provided partner recognition, which nourished further commitment. Next, the general programme will be discussed, followed by the mission's outputs.

8.4 The General Programme

The goals of the general programme were to screen all patients in the hospital for malnourishment, then refer appropriately, diagnose, and treat malnourished patients, and finally, to educate applicable health professionals about the significance of the mission.

8.4 Input interaction

8.4.1.1 Interactions between partners and the mission

The crucial finding in this study was that the general programme was not entirely set up to be a collaboration; several partners were mandated to carry out the mission's tasks, but were not included as partners to influence- and participate in the collaboration. This top-down approach assumed partner commitment. However, the findings revealed a chain of commitment, in which partners' degree of commitment hindered or facilitated the collaborative functioning. Lack of commitment and contradictory perceptions of the mission hindered collaborative functioning by limiting the production of tasks and creating partner conflicts and boycotting. Supporting this, Macdonald & Chrisp (2005) highlighted that it is not clear that people are interested in the collaboration process itself, nor its' possible outputs. Hardy, Lawrence and Grant (2005) found that successful collaborative functioning is contingent on a common consensus about a mission, its grounds, indications, and applicable solutions. Corbin (2006) observed that conflicts decrease valuable resources and hinders collaborative functioning. On the other hand, committed partners interacted well, and the

combinations of skills, knowledge and relations promoted motivation and positive production. Several authors have found that partners have powerful effects on outputs (Broesskamp-Stone, 2004; Corbin and Mittelmark, 2008; Huxham, 2003).

Recruiting committed partners into collaborations can facilitate a common consensus about a mission, and should be prioritised. Furthermore, involvement of all partners as active and influential partners in a collaboration, as opposed to mandating tasks, could conceivably increase partner commitment. Supporting this, a study of collaboration between hospitals and communities in Canada found that involvement of all partners was essential for good collaborative outputs (Poland et al., 2005). Several other authors have found that partners should have the ability to share power and be peered to utilise partner characteristics and perspectives, rather than being directed tasks (Goes and Park, 1997; Hardy et al., 2005; Lank, 2006; Lasker et al., 2001; Sullivan, 1998).

8.4.1.2 Interaction between finances, partners and the mission

The findings suggest that recruiting powerful partners with knowledge of- and commitment to a mission can provide financial resources. Financial resources can hasten an implementation and create commitment to provide further resources. Finally, allocating funds for a committed coordinator of a mission can be a valuable investment for successful implementation. Huxham (1996) found that having a facilitator who can aid collaboration is vital for positive outputs. Corbin and Mittelmark (2008) found that financial resources aid collaborative functioning by increasing accountability, and resources to carry out the production of tasks.

The present case also found that committed partners take on additional responsibilities, which may aid an implementation. However, several committed partners took on further tasks without being allocated sufficient resources. The findings suggest that insufficient partners in the implementation of a mission do not stimulate partners or the production of tasks. Limited partners and few committed partners may result in an over-reliance on committed partners, and thus increase turnover and sick leave, and thereby loss of vital resources. Johnson et al. (2003) found that providing adequate resources for collaboration is a vital factor for success. Corbin (2006) found that limited resources could have an impact on production, and thus create a loss of capacity. Moreover, she emphasised that the constant search for further resources can hinder collaborative functioning, as financial recruitment is a task on its own.

8.4.1.3 Interaction between the mission, its context and partners

The findings suggest that the surrounding context should be an input into the BMCF, because the context uniquely affected the entire collaborative functioning. Several authors in the collaboration literature have also discovered the significance of the context (Corbin, 2006; Gray, 1989; 2004; Huxham, 1996, Weiss et al, 2002).

The findings suggest that the external context may predominantly have a positive influence on collaborations by increasing urgency and commitment. Positive media attention can increase partner commitment and feelings of acknowledgement. Negative media exposure can create partner encouragement, but also discouragement. Moreover, authorities and other stakeholders' commitment to a mission may raise partner commitment. Ellinger et al. (2000) found that marketing had a positive impact on inter-organisational performance and effectiveness. Wandersman et al, (1997) found that external resources had an impact on collaborative functioning. Broesskamp-Stone, (2004) found that external control could affect collaborations, and recommended interrelation with the surrounding context.

On the other hand, the findings indicate that the internal context in a hospital setting may have a negative impact on collaborative functioning. Hierarchical factors such as mandating, non-inclusiveness, lack of colleague recognition, professional battles, and partners' resistance to change hindered the collaboration studied. Goes and Park (1997) found that organisational barriers to change and pressures for conformity in hospitals created hardship for innovations. Holst and Severinsson (2003) found that health care services lack facilitation for successful collaborative functioning. The findings also suggest that hospitals' heavy focus on cuts of cost can create frustration, conflict and an unwillingness to aid the organisation. Loxley (1998) also observed that pressure for recruitment and competition of funding in hospitals could make the initiation of collaborations difficult.

In addition, the findings indicate that an organisation's size; stakeholders' time-pressure; and complex, time-consuming strategies for implementations can have a negative impact on collaborative functioning. First, a large organisational size can impede visible interaction between partners, which may hinder valuable exchange and understanding of partners' work. Secondly, demanding additional tasks to already time-pressured stakeholders may generate resistance or over-reliance. Finally, complex and time-demanding strategies for implementations due to hierarchical demands for multiple stages of approval can be demotivating. Kerusuo (2007) concluded that hospitals are trapped within organisational models and practices that draw from conventional management thinking, which can inhibit

collaborations. Sullivan (1998) found that noisy health care contexts, in which partners have dissimilar autonomy and commitment, could hinder conclusions for best practice.

The mission and its' context, partner- and financial resources clearly produced positive and negative cycles of interaction that affected the collaborative functioning. Next, the affect of structures, rules and roles on the patient malnourishment programme will be discussed.

8.4 Structure, rules and roles

8.4.2.1 Planning structure, rules and roles

The findings indicate that welcoming partner participation when planning a mission's structure, rules and roles can increase feasibility and partner commitment. The collaboration rhetoric is based on partners desiring to work together toward a common aim, to achieve an output that is greater than the sum of individual efforts. However, the general programme's structure, rules and roles were based on the already established hierarchy-- to obtain partners by mandating stakeholders to produce tasks. Interestingly, the findings indicate that partners' resistance to the policy overrode the top-management's commands and commitment.

Supporting this, Goes and Park (1997) observed that creating shared governance structures in hospitals could facilitate innovation. Lasker and Weiss (2003) found that involving partners in planning and agenda setting could generate feasible participation from diverse partners.

Poland et al. (2005) found that involvement of partners in collaborations, and partners' commitment to conquer system barriers in health care, was vital for good outputs.

Secondly, the programme's universal structure was to be applicable and feasible in all multicultural settings in the hospital. However, every unit in a hospital differs in expertise, context, partners, and leadership, etc. Many partners believed that the mission was not applicable to their setting, and that other/further services should have been included. The findings suggest that overlooking the importance of including partners in planning and assessing feasibility and applicability in each context of implementation can cause resistance and partner conflicts. Supporting this, Mitchell and Shortell (2000) found that feasibility of an innovation was dependent of its context. Huxham (1996) suggested examining probable areas of hesitation about a mission to avoid tension. Broesskamp-Stone (2004) found that one should separately assess the behaviour of partners and the behaviour of the overall system, because there are no single grounds that produce single outputs.

Considering the above, the present study can hypothesise that; collaboration on a complex mission in a multicultural setting can benefit from applying a collaboration model. The above can motivate partners to focus on factors and processes that lead to positive and negative outputs, and thereby increase the potential for synergy. Such considerations seem to be especially applicable to the complex and hierarchical hospital setting.

8.4.2.2 Rules and roles

The findings indicate that roles were murky and overly segregated, thus partners were dependant of united commitment to produce tasks. Several partners did not demonstrate awareness, accountability, or commitment to their appointed role, which limited the production of tasks, created conflicts, and hindered collaborative functioning. Corbin and Mittelmark (2008) found that undefined roles could create partner conflicts. Several other authors have found that defined roles in collaborations can create commitment, accountability, and partner satisfaction (Wandersman et al., 2005; Weiss et al., 2002).

In addition, the findings suggest that several partners (mostly registered nurses) were more willing to take on roles and obey policy than others, but were hindered to do so by legal constraints. Several doctors on the other hand, expressed little commitment to the mission and the hospital policy, which clearly hindered the collaborative functioning. Jorm et al. (2007) found that doctors who do not comply with the systems and policies impede collaborations between medicine, nursing, managers and policy-makers. It is well known that regulation, control, and certification of health professionals can make hospitals challenging to intervene in. However, considering the above, one might suggest that recruiting merely committed partners (such as registered nurses) could have eased the implementation of the mission. Providing committed partners increased responsibility and the opportunity to participate in a collaboration might increase commitment, decrease murky roles, and dependency of multiple partners to produce tasks. Legal constraints must be considered, however one should note that hospitals are advised to undergo structural and cultural changes to achieve successful collaborations (Green & Kreuter, 1999; Green, et al., 2000).

8.4.2.3 Planning routines and consequences/rewards

Findings suggest that creating routines that become second nature to partners can facilitate successful implementations in hospitals. However, the programme's cumbersome routines hindered the production of tasks. The screening tool utilised to detect patient malnourishment was not integrated in the hospital's electronic journal, due to lack of planning and contextual

time-consuming processes for change. Therefore, the findings suggest that failing to plan and facilitate simple tools for the production of tasks may hinder collaborative functioning. Supporting this, Sundhedsstyrelsen og Fødevarerdirektoratet (2006) observed that lack of planning hindered implementation of missions in hospitals. Johnson (2003) observed that already existing routines influence that of a collaboration.

Secondly, the findings indicate that planning short-term goals and deadlines can create partner encouragement and commitment to produce tasks. The results show that the launch of the mission provided visual results and feelings of achievement. However, lack of further deadlines hindered the production of tasks. Corbin (2006) found that planning goal setting is vital in collaborations in that it forges production towards the mission's needs.

Finally, the findings suggest that planning consequences and/or rewards could aid the implementation of a mission. Despite legal obligations, numerous partners were resistant to the mission. Many interviewees called upon consequences and/or rewards to raise partner commitment. Loxley (1997) observed that collaborations in hospitals could benefit from continuing credit creation. Johnson et al., (2003) found that one should stress non-negotiable issues in hospital collaborations. However, the both authors highlighted the need to compromise on disagreements, because failing to develop partner motivation and consequences can result in poor collaborative functioning.

Considering the above, thorough planning of a mission's structure, rules and roles can facilitate successful collaborative functioning. Therefore, a third throughput task of planning has been added to the BMCF to recognise the need for planning in collaborations.

8.4 Leadership

The degree of visible commitment and openness from all leaders can aid partner commitment and collaborative functioning. However, in the general programme, many partners were mandated to carry out tasks, and little openness, inclusion and trust was given for the implementation. The findings indicate that partners resisted this hierarchical approach, which overrode the top-management's commands and commitment. Conflict resolutions and assessments of applicability and feasibility of opposing units became necessary after the implementation. Therefore, the findings imply that leaders who welcome partner participation and influence when planning- and implementing a mission can increase partner commitment, and avoid conflicts and time-consuming resolutions. Such a collaborative leadership, as opposed to a hierarchical leadership, can better the collaborative functioning and outputs.

Supporting the above, Corbin (2006) observed that leadership has to adapt according to the context and inputs of all sectors in a collaboration. Weiss et al., (2002) found that leaders who encourage open communication, share power, and disclose and confront negative assumptions could aid collaborative functioning. Finally, Goes and Park (1997) observed that creating shared governance in hospitals could facilitate innovation.

8.4 Communication

8.4.4.1 Communicating the general programme

The programme was predominantly communicated in a top-down manner, however partners sought a more explanatory and inclusive approach. The findings suggest that hierarchical communication can hinder partner commitment and participation, create conflicts and confusion, and thus hinder synergistic outputs. Corbin (2006) found that undesirable communication could reduce valuable interaction and create accountability issues. Secondly, the results show that sufficient and specific knowledge on a mission's rationale can increase partner commitment. Leaders in the present case assumed that general education about the mission would increase all partners' commitment, but several partners called upon a more specific rationale to their own area of expertise. Loxley (1997) also found that partners' need to have the right attitude, knowledge and skills about a mission. Finally, the present findings imply that lack of information about a mission's progress and limited visible results confirming its' benefit, can diminish partner commitment. Corbin (2006) also found that lack of sharing knowledge on progress could make partners uninspired.

8.4.4.2 Means of communication

Communication between many diverse partners' with various degrees of commitment to the mission was a challenging task. The findings suggest that corridor conversations and informal communication aided partner commitment, encouragement, openness and recognition. Long et al. (2007) found that informal settings often provide opportunistic interactions that might not have occurred in a formal setting. Nevertheless, the general programme utilised little face-to-face communication due to lack of time, diversity in levels of commitment, and physical distance between partners. Findings indicate that limiting face-to-face communication can hinder productive- and encouraging interaction amongst partners, and thus the functioning and outputs of collaborations. Increased face-to-face communication may aid collaborative functioning by creating arenas for exchange and discussions. Several other authors have found that face-to-face meetings are most effective for collaborations in that partners build

relationships and trust, develop creative exchange, and participate in joint decision-making (Corbin, 2006; Johnson et al., 2003; Lank, 2006; Wandersman et al., 2005).

The findings on communication revealed that poor communication hindered successful planning, production- and maintenance of the collaboration. This allows suggesting that the collaboration at hand could have benefited from a more thoroughly planned communication strategy by utilising a collaborative approach to the mission.

Summing up the general programme, the mission and its context, partners- and financial resources were inputs into the collaboration. The interaction of inputs, the mission's structure, rules and roles, leadership, and communication created cycles of interaction that affected the entire collaborative functioning. The mission was successfully placed on the hospital's agenda, however the key finding was that the general programme was not established as a true collaboration; rather a hierarchical approach mandated employees to produce the mission's tasks. The findings show that strong commitment from the top-management is not enough. Recruiting committed partners who want to take part in the collaboration is essential for good interactions. A chain of commitment emerged in this study, in which partners' degree of commitment had a noteworthy effect on the entire collaborative functioning. Secondly, failing to include all partners to participate- and influence in a collaboration, and failing to assess applicability and feasibility in each area of an implementation, can hinder partner commitment and create negative interactions. Third, limited partner resources can create an over-reliance on committed partners, and result in loss of vital resources. Finally, diminutive strategies for maintenance and communication can hinder collaborative functioning. Therefore, the findings suggest that a complex collaboration amongst multiple diverse partners can benefit from applying a model for collaboration. Knowledge on collaborative functioning can lead to successful planning that reduce the factors and processes that often produce antagonism, and thus increase the potential for synergy. The next section will discuss the mission's outputs, followed by a comparison its components.

8.5 Outputs

This thesis aimed to study the factors and processes that facilitated and /or hindered the missions' collaborative functioning; the contextual factors that affected the programme; and to examine the utility of the BMCF (Corbin, 2006) in the hospital setting. The thesis did not seek to study the outputs of the collaboration, however several outputs emerged from the findings, which demanded attention. Outputs from collaborative functioning were found to be

a result of inputs and throughputs, as described by Corbin and Mittelmark (2008). In addition, emerging findings of commitment, context, and planning affected the outputs as well.

8.5 Placing malnourishment on the agenda

The findings suggest that partner- and leader commitment and lobbying, and contextual evolution of patient malnourishment facilitated the process of placing the mission on the hospital's agenda. The mission became a hospital policy; resources were recruited in pressured financial times; partners experienced much internal and external recognition; and several extended effects developed in the surrounding context. Positive cycles of interaction resulted in a patient malnourishment programme that became greater than what partners had hoped for- and what they could have produced individually. Therefore, the output was synergistic, in that its whole was greater than the sum of its parts (Corbin and Mittelmark, 2008). The evolution of the mission created the general programme and the pilot project.

8.5 Pilot project

The results show that partners, staff and patients were pleased with the pilot project; the buffet operated well, and partners complemented and appreciated each other's tasks. Positive cycles of interaction were a result of committed partner interactions; open- and face-to-face communication; adequate resources; inclusive leadership; adaptable structures, rules and roles; and visible results. Partners experienced much recognition and an improved work environment, and believed that the collaboration was a step in the right direction for resolving hierarchical issues, professional battles and physical distance in the organisation. Wood & Gray (1991) also found that collaboration could reduce contextual complexity. Moreover, a shift in attitudes on patient malnourishment was experienced, as previously opposing partners developed shared consensus to continue the pilot project. In addition, the pilot project functioned as a buffer for the general patient malnourishment programme by increasing partner commitment. The above findings clearly indicate synergy, in that the outputs became greater than the sum of inputs (Corbin and Mittelmark, 2008).

8.5 The general programme

Despite the hard work of establishing the mission, educating health professionals, and recruiting partner- and financial resources, mostly antagonistic outputs emerged from the general programme. Negative cycles of interaction emerged due to non-inclusiveness of partners; uncommitted partner interactions; partner resistance; over-reliance on committed

partners; hierarchical leadership and structure; a non-adaptable structure; murky and segregated rules and roles; and lack of face-to-face communication and visible results. The results show that few patients were screened, referred, diagnosed and treated ten months after the implementation. Indeed, research suggests that 30% of patients in hospitals are malnourished (Kondrup, et al., 2003); however, only 1% of patients were diagnosed in the present case. Secondly, partners did not demonstrate increased commitment after education; some were ignorant, and many did not know about the programme far into the implementation. Third, much frustration and conflict developed between various partners-- and even boycotting occurred. Fourth, several committed partners experienced burnout due to over-reliance of committed partners, which removed vital partner resources. The outputs above were clearly antagonistic, because negative cycles of interactions lead to outputs that regrettably ate up resources (Corbin and Mittelmark, 2008). Last, the findings indicate that additive outputs were produced; some partners chose to carry out tasks individually because they did not interact well with other partners. Such outputs do not necessarily damage a collaboration, but can decrease the opportunity for synergy (Corbin and Mittelmark, 2008).

8.5 Comparing the programmes

The implementation of the pilot project and the general programme were poles apart. The pilot project produced predominantly synergistic outputs; however, the general programme produced mostly antagonistic outputs during the course of this study. The findings indicate that the pilot project utilised a collaborative approach in that partner influence- and participation was welcomed; assessment of the project's context was carried out; most partners demonstrated commitment to the project; partners physically interacted and frequently communicated face-to-face; adequate resources were allocated; and leaders were inclusive. The general programme on the other hand, applied a hierarchical approach to the collaboration; partners' influence- and participation was not welcomed; few applicability and feasibility assessments were carried out prior to implementation; several uncommitted partners were mandated tasks; leaders were mostly hierarchical; inadequate resources were allocated; and there was little face-to-face communication.

The general programme was more complex, involved numerous partners, and had physical barriers for effective interactions, compared to the pilot project who included fewer partners and facilitated face-to-face interactions. The main difference of the two programmes however, was their approach to collaboration; the general programme utilised a hierarchical approach, yet the pilot-project was more based on the collaboration rhetoric. The present case

indicates that hospital collaborations are challenging due to hierarchical traditions, complexity, and multiple different professionals and departments, and so on. Sullivan (1998) observed that inter-organisational and inter-professional collaborations in the health care context often result in divergence rather than synergy. However, the pilot project uniquely managed to overcome hospital barriers to collaboration and produced synergistic outputs. The above indicate that hospitals' hierarchical traditions for collaboration hinder successful collaborations more so than the actual hospital context. This thesis can therefore hypothesise, that applying a collaborative model for collaborations can facilitate synergistic outputs, by creating awareness of the factors and processes that lead to desired and unwanted outputs.

9 Methodological considerations

The present report was of qualitative nature and applied the case-study methodology. In line with all scientific research, threats to validity and credibility were present in this thesis. Therefore, transparency of methodological considerations must be discussed. The researcher has made every effort to display findings in an accurate manner; considering all participants' points of view, and the audiences' possible perceptions of this report (Creswell, 2003).

9.1 Validity

Validity can be threatened when the researcher brings bias, or fails to recognise discrepant and negative information incoherent with themes (Creswell, 2003). Although this study only included twelve participants, these were carefully selected to obtain a broad scope of opinions. The participants represented a wide range of multidisciplinary partners ranging from four various medical professions, nursing, dietetics, kitchen services, patient representative, and various managers. All participants were involved in the planning- and/or implementation of the programme, and represented various perspectives on the collaboration. There was much consensus on the results of this study, however, some participants were more critical or positive than others. Even though every effort was made to embrace various perspectives on the collaboration, the above might have affected the results.

The principle researcher was recruited to conduct a new study on the BMCF. The interview guide was based on the Model, and the questions asked might have confined the answers. However, open-ended questions were asked, and the researcher made every effort to avoid leading questions to prevent confinement of results, and to allow new emerging findings. To bring justification and accuracy to the present findings, a thorough effort was made to verify results across participants. Data from interviewees were compared to one

another in terms of positive and negative findings. Secondly, all results contrasting the main themes in this thesis were reported in the result section, to ensure that all data were considered in the analysis. Some interviewees were inconsistent of their opinion during the same interview. For example, one interviewee stated that the context had no significant effect on the programme, however emphasised factors such as media and the hierarchy later on. The researcher perceived these statements to be somewhat rhetorical; however, an attempt was made to clarify the above with the applicable participants. Finally, participants were offered to check their transcribed interviews, some were asked to verify specific descriptions by email and/or in the second round of interviews, and all interviewees were offered to verify the final report before submission. The above methods of triangulation, member-checking, and displaying negative and discrepant information, were utilised to enhance the validity of this report (Creswell, 2003). The primary researcher considered that the efforts made to handle validity issues were satisfactory. Nevertheless, methodological considerations can always advance to improve validity and prevent conclusion bias, so in the present study.

9.2 The role of the researcher

It is important to be clear about factors that can contribute to researcher bias. The researcher had no previous connection to Haukeland University Hospital, however professional connections developed. Objectivity has been emphasised largely by the researcher, however new relations may have biased the analysis. Another important issue is that the primary researcher is a registered nurse. Although the researcher strived to maintain neutrality throughout the study, some professional biases may have affected the findings in this report. However, participants were multidisciplinary which enabled various perspectives of the findings, and there was much consensus on the findings. Lastly, the researcher of this report had no previous experience conducting qualitative research. Considering that validity of findings is dependant on the researcher's ability to recognise and act on issues that are of threat, this may have influenced the present findings. However, every attempt has been made to critically reflect on own effort, and appropriate advice from experts has been sought.

9.2 Translation issues

The process of translation can be a threat to validity, as quotes can become incoherent if the importance of translation quality is ignored. In this report, every effort was made to translate the meaning of quotes as expressed by interviewees, rather than word for word translation. The analysis process was carried out in Norwegian, and then translated to English to avoid

language issues in the analysis. The principal researcher, who is bilingual and fluent in both languages' hospital terminologies, translated the data. Furthermore, the researcher's bilingual supervisor verified the translations of selected and random quotes.

10 Conclusions

The influence of the researcher is persistently encompassed in qualitative research, and so therefore in the present thesis. The validity of findings is affected by researchers' ability to recognise and act on issues they are accountable for. The researcher of this report made every effort to realise and handle such issues, and the interpretations were founded in research ethics and grounded in previous research. Therefore, the following conclusions were permitted:

10.1 Conclusions about the Bergen Model of Collaborative Functioning

The BMCF proved to be a useful research framework to study the collaboration at hand; however, the findings also suggest modifications of the Model. This thesis was the first BMCF-study to focus on contextual factors. The first suggestion for modification of the Model was to alter the context to an input, because the findings indicate that the context acts as a unique factor affecting the entire collaborative functioning. Secondly, the findings indicated a need to depict the aspect of planning, as planning is essential prior to- and during collaborations. The second suggestion for modification of the Model was to add a third throughput task of planning, in addition to production- and maintenance tasks. The final suggestion for modification of the BMCF was to simplify it to ease audience comprehension.

10.2 Conclusions about the nutrition programme

This research provided knowledge about a mission that required collaboration, in which one component of the mission applied a hierarchical approach, yet the other component applied a collaborative model. This study concludes that a hierarchical approach to collaboration could hinder collaborative functioning and outputs. On the other hand, a complex collaboration amongst multiple diverse partners can benefit from applying a model for collaboration. Knowledge on collaborative functioning can lead to successful planning that reduce the factors and processes that often produce antagonism-- and thus increase the potential for synergy.

Secondly, this study provides new knowledge on how partners' degrees of commitment affect collaborative functioning. Strong leadership commitment is not enough to create successful collaborations. This study revealed a chain of partner commitment affecting

the entire collaborative process. A collaboration including committed partners can aid collaborative functioning and outputs. Third, in this study, several stakeholders were not included as actual partners to influence- and participate in the collaboration, yet were mandated to produce tasks. Such failure to include partners' influence- and participation can hinder successful collaborative functioning. Finally, this study described the implementation of a mission in which one structure was to be adapted to multiple multicultural contexts. Failing to plan and assess applicability and feasibility of each area of an implementation can hinder partner commitment and create negative collaborative functioning and outputs.

10.2 Implications

Research on collaborative functioning is greatly sought-after to discover the practical functioning of collaborations--why they succeed and why they do not succeed. This study provided new insight into collaborative functioning by confirming the utility of the BMCF in the hospital context, and by adding new knowledge on factors of context, commitment, and planning. The findings of this research may facilitate current and future collaborations in health care. The Model has proved its overall utility as a good research framework to describe three studies (Corbin, 2006; Endresen, 2008). However, considering the modifications of the Model during the present study, and that the Model is relatively new, it needs further studies in a variety of settings to continue to prove its utility. Up to now, the Model has been used as a framework to describe collaborative functioning. However, the findings in the present thesis leads one to wonder if the BMCF is a good planning- and implementation framework as well. Considering the hierarchical approach to collaboration described in the present thesis, one can wonder if the BMCF, in combination with an action research methodology, can facilitate partner involvement- and participation in health care collaborations. Secondly, considering the continuous shift of health care from hospitals to community services, one can also wonder if it is more applicable to include a broader scope of services in such large health care collaborations. It would be illuminating to use the BMCF to establish a true collaboration in the hierarchical health care services, by welcoming partner influence- and participation and assessing feasibility and applicability issues. Would one produce more synergistic outputs by establishing collaborations based on the BMCF? Could a collaborative approach to health care facilitate positive health- and health services outcomes?

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Appendices

11.1 Appendix 1

Haukeland University Hospital's Patient Nutrition Programme

Interview guide, interview I

This interview will have four parts, the first having to do with your earliest thoughts and impressions regarding the patient nutrition programme. The second part will be about early discussions during which ideas for the programme developed. The third part of this interview is about the processes through which the programme was formally approved, and the fourth part has to do with the early implementation leading to the launch of the programme in December last year. I will mention when I come to each part so you can keep track of the interview's progress.

1. So, to the first part on the interview -- please think back to the very first time you heard about a patient nutrition programme here at Haukeland University Hospital.
 - a. What was your job position at that time?
 - b. What were the circumstances under which you first became aware of the programme?
 - c. Please tell me what your very first thoughts and reactions were.
 - d. Please tell me what the programme was to be about, as you remember it the first time you heard about it.
 - e. Did you think right from the start that the programme would come to realisation, or not?
 - f. What do you think were the most important factors that made the programme's initiation possible?
 - g. What do you think were the most important barriers that might have stopped or hindered the programme's initiation?
 - h. Thinking back to your first impressions, did you think the programme was or was not a good idea, and why?
2. Now to part two of the interview, please think back to the early discussions about how the programme should be implemented, before final decisions were made and before the programme was formally approved.
 - a. Can you please tell me who at Haukeland University Hospital was involved in the earliest discussions?
 - b. Who invited others to discuss a possible patient nutrition programme?
 - i. Who were the programme's 'champions'?
 - ii. Who were more reserved about the programme?
 - c. How formal or informal were the discussions?
 - i. What was your level of participation in the early discussions?
 - ii. Where did they take place?
 - iii. Was the discussion group officially constituted?
 - iv. Were meeting notes taken and distributed?
 - v. Was there discussion about who could and should take responsibility for various parts of the programme?

- vi. Was there discussion about departmental divisions of responsibility regarding the programme?
 - d. What were the main issues/problems/controversies that came up in the early discussions, as you recall?
- 3. Now to part three of the interview, please think back to the time when the programme finally was given formal clearance and started officially.
 - a. Do you recall any key events or decisions that moved the programme from idea to reality?
 - b. What were the most significant threats to the programme's move from idea to reality?
 - c. What were the most significant supports in the programme's move from idea to reality?
- 4. Now to the fourth and final part of the interview, please think back to late 2006, after the programme was approved and up to its official launch in December during the Nutrition Days.
 - a. What was the organisational structure of the programme?
 - b. Who were its leaders and coordinators?
 - c. What hospital departments were involved, and what was the nature of their involvement?
 - d. During this early period, what factors might have threatened the full implementation of the programme?
 - e. During this early period, what happened that was really essential to the successful launch of the programme?
 - f. A complex programme such as the patient nutrition programme requires collaboration across diverse areas of hospital operations and responsibilities, including operations having to do with food services, patient care, administration, the patients themselves, and the community outside the hospital, the hospital's owners, among many other stakeholders. In complex programmes such as this, that require a great deal of collaboration,
 - i. What are the greatest threats to success?
 - ii. What are the absolutely essential success factors?
- 5. Let me just ask if there is anything you can think of that I should have asked you about, but did not, that would help us better understand any aspect of the programme's early days?
- 6. Would you be willing to receive a transcript of this interview, and possibly provide notes on any subject that you feel requires additional clarification?
- 7. And finally, do you have any questions or comments for me, following your experience of participating in this interview?

11.2 Appendix 2

Haukeland University Hospital's Patient Nutrition Programme

Interview guide, Interview 2

This interview has four parts, the first having to do with the implementation and process of the nutrition programme. The second part will be about maintenance of the programme, and finally the third part will focus on your own experiences within collaboration in the hospital. I will mention this when I come to each part, so you can keep track of the interview's progress.

- It has been eight months--What has happened with the nutrition strategy since I last saw you?
- Is there anything you would like to add from the previous interview?
 1. The first part of this interview is about the implementation and process of the nutrition programme.
 - a. What facilitates the process of the programme in practice?
 - i: Partner resources?
 - ii: Financial resources?
 - iii: The context?
 - b. What threatens the process of the programme?
 - i: Partner resources?
 - ii: Financial resources?
 - iii: The context?
 - c. Which factors support the implementation of new procedures?
 - d. Which factors inhibit the implementation of new procedures?
 - e. The nutrition policy has become a policy in this hospital. Do you think that matters for the process of the programme?
 - f. How does your personal and professional role contribute to the programme?
 - g. Are there defined roles for the people involved in this programme?
 - i: Do you believe people take on accountability for the programme?
 - h. How do you think the communication functions between the partners in this programme?
 - i: Formal communication?
 - ii: In-formal communication?
 - iii: Frequency and nature of meetings?
 2. Now to part two of this interview, this is about the maintenance of the programme that makes it viable.
 - a. Are there any factors that motivate you to work with this programme?
 - i: Can you remember an occasion where the programme impressed you and you became inspired to keep working on it?
 - ii: Is there anything in the context within or without the hospital that inspires you?

- b. Are there factors that de-motivate you to work with the programme?
 - i. Can you remember an occasion where you became disappointed about the programme, and became de-motivated to work on it?
 - ii: Is there anything in the context within or without the hospital that de-motivates you?
 - c. What are your thoughts about maintenance between the partners in this programme?
 - i. How do partner resources and the context contribute to this?
 - ii. How do partner resources and the context inhibit this?
 - iii. Which role does the problem itself, malnourishment, play in the maintenance of the programme?
 - d. Do you trust /believe that the programme will succeed?
 - i: Why?
 - ii: Why not?
3. Now to part three of the interview, this is about your experiences within collaboration. It can be challenging to collaborate across sectors and the hierarchy in the hospital.
- a. What are your experiences in creating and maintaining collaboration the way you have done here?
 - i: What have been the essential factors which have lead to success?
 - ii: What have been the greatest barriers to collaboration between the partners?
4. Let me just ask if there is anything you can think of that I should have asked you about, but did not, that would help us better understand any aspect of the programme's early days?
5. Would you be willing to receive a transcript of this interview, and possibly provide notes on any subject that you feel requires additional clarification?
6. And finally, do you have any questions or comments for me, following your experience of participating in this interview?

11.3 Appendix 3

Informasjonsskriv

Organisering og funksjon av ernæringsstrategien ved Haukeland universitetssykehus:

Forhold og prosesser som gjør samarbeid lettere på tvers av sykehusavdelinger

Hensikt, mål og beskrivelse av prosjektet:

Hensikten med prosjektet er å studere prosesser og forhold som gjør samarbeid lettere mellom ulike sektorer innen en organisasjon.

Ved universitet i Bergen er det utviklet en forskningsbasert system modell for samarbeid. Modellen indikerer at en må jobbe målrettet for å fremme samarbeid mellom ulike miljø. Vi ønsker å teste denne modellen på samarbeid innen en institusjon. Ernæringsstrategien ved Haukeland universitetssykehus (HUS) er et godt eksempel på helsefremmende arbeid. Slikt samarbeid mellom sektorer (avdelinger, klinikker) er et viktig element for Helsefremmende sykehus (HFS), et nettverk utviklet av Verdens Helse Organisasjon. HUS er ikke formelt medlem av dette nettverket, men ernæringsstrategien er et utmerket eksempel på det HFS søker etter.

Ved å evaluere prosjektet, og å dokumentere hvordan det fungerer, kan HUS og andre sykehus lære hvilke faktorer som er avgjørende for at et samarbeid mellom sektorer skal fungere optimalt.

Målene med dette prosjektet er å bruke samarbeidsmodellen som en ramme til å dokumentere aktiviteter og prosesser i planleggingen, godkjenningen og tidlig implementering av ernæringsprogrammet. Neste mål er å dokumentere hvordan miljøforhold påvirker ernæringsprogrammets planlegging, oppstart og implementering. Til slutt vil vi studere modellens formålstjenlighet ved å observere samarbeid innen organisasjonen, og foreslå forbedringsmuligheter for modellen.

Deltakere i prosjektet (ca 12 personer) vil være intervjuobjekter. De har alle vært ansatt i Helse Bergen gjennom planleggingen, godkjenningen og implementeringen av prosjektet. Hver deltaker vil bli intervjuet to ganger, basert på en skriftlig intervjuguide som inneholder sju spørsmål. Denne guiden er utarbeidet i samarbeid med ledelsen for ernæringsprogrammet. Intervjuene vil bli tatt opp på lydbånd, og skrevet ut umiddelbart etter møtene, som vil vare 30-45 minutter. Intervjuene kan bli utført i to eller flere omganger, hvis deltakeren ønsker dette. Intervjuene vil finne sted der deltakeren ønsker, på det tidspunktet som passer best. Deltakeren vil kunne revidere det nedskrevne intervjuet, for å sikre korrekt gjengivelse av samtalen. De innspilte båndopptakene vil oppbevares sikkert ved universitetet i Bergen. Etter at prosjektet er ferdig vil dette materialet bli slettet, og kun opplysninger om deltakernes yrke i Helse Bergen vil bli beholdt i henhold til de nedskrevne intervjuene. Hvis deltakerne ønsker å referere til andre intervjuobjekter, vil det bli utført korte intervjuer uten båndopptagning. Første intervjurunde vil begynne i januar- februar 2007, og andre runde vil foregå i oktober 2007. Prosjektet vil være ferdig i august 2008.

Resultatene av studien vil bli rapportert i en masteroppgave, men en tar også sikte på konferansebidrag og ytterligere publisering.

Prosjektet er godkjent av Norsk Samfunnsvitenskapelig Datatjeneste (ref: 15957/SM).

**Organisering og funksjon av ernæringsstrategien ved Haukeland
universitetssykehus:
Forhold og prosesser som gjør samarbeid lettere på tvers av sykehusavdelinger**

Samtykkeerklæring

Jeg har lest informasjonsskrivet, og samtykker med dette til å delta i forskningsprosjektet. Jeg er innforstått med at min deltakelse er frivillig og at jeg når som helst kan endre mening, trekke meg, eller nekte å delta uten konsekvenser for meg. Jeg kan nekte å svare på spørsmål, og jeg kan stanse intervjuet, uten noen videre implikasjoner for meg. Jeg er innforstått med at enkelte utsagn kan bli direkte sitert. Min yrkestittel kan bli forbundet med teksten, men mitt navn vil forbli konfidensielt.

Jeg gir herved mitt samtykke til å delta i forskningsprosjektet.

Signatur deltaker

Navn med blokkbokstaver

Dato

Disse står bak studiet:

Lise Corwin, Master student, International Master's Degree in Health Promotion, Institutt for utdanning og helse, Universitetet i Bergen. Tlf: XXX. E-post: lise_corwin@hotmail.com

Veiledere:

Professor Maurice Mittelmark og MPhil Hope Corbin, Policy Processes for Human Development Research Group, HEMIL-senteret, Institutt for utdanning og helse, Universitetet i Bergen. Tlf XXX. E-post: maurice.mittelmark@iuh.uib.no

11.4 Appendix 4

Maurice Mittelmark
HEMIL-senteret
Universitetet i Bergen
Christiesgt. 13
5015 BERGEN

Vår dato: 09.01.2007

Vår ref: 15957/SM

Deres dato:

Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 20.12.2006. Meldingen gjelder prosjektet:

15957

Organisation and functioning of Haukeland hospital's patient nutrition programme: factors and processes that facilitate collaboration amongst a complex organisation's operational divisions

Behandlingsansvarlig

Universitetet i Bergen, ved institusjonens overste leder

Daglig ansvarlig

Maurice Mittelmark

Student

Lise Corwin

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

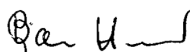
Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.


Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/endrings skjema>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/database/>

Personvernombudet vil ved prosjektets avslutning, 31.08.2008 rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen


Bjørn Henrichsen


Siv Midthassel

Kontaktperson: Siv Midthassel tlf: 55 58 83 34

Vedlegg: Prosjektvurdering

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