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### Communiceren en improviseren: Omgaan met dynamiek en complexiteit bij de ontwikkeling en implementatie van een gezondheidsinterventie

ter Haar, W.M.A.

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# 5

## **Finding common ground in implementation**

Towards a Theory of Gradual Commonality

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## 5.1 Introduction

The BeweegKuur is a combined lifestyle intervention aimed at promoting sufficient physical exercise and a healthy diet among people in the Netherlands who are overweight and have a diabetes risk. Initially, the former Minister for Health, Welfare and Sports wanted the intervention to be included in the basic Dutch national medical insurance scheme for all Dutch people by 2011. A key condition for including an intervention of this kind in the primary health care package is that it is available nationwide. Work on developing the BeweegKuur started in 2007, led by the Netherlands Institute for Sport and Physical Activity (NISB), on the basis of literature, experience of existing interventions and interviews with expert panels and people who are overweight and have an increased risk of diabetes.

The intensive collaboration in a variety of local contexts and for diverse groups across the nation makes the BeweegKuur an interesting case, as it is not easy to implement a national protocol in a variety of contexts and for diverse groups. In a short period of time, the BeweegKuur protocol was implemented via regional and local networks in which various experts developed a joint policy and combined the coordination of the implementation. The stakeholders depend on each other for effective implementation. The General Practitioner (GP) calls in the nursing practitioner from the GP's practice as a lifestyle advisor to coach BeweegKuur participants. Together with the participant, the nursing practitioner selects an appropriate exercise programme, which the participant follows twice a week for ten weeks at a local exercise, sports or physiotherapy centre. All participants see a dietician and are informed as a group about nutrition. That way, between 2007 and 2012, multi-disciplinary networks were set up around participating practices as an implementation structure for the BeweegKuur. Does BeweegKuur work?

Yes BeweegKuur does work. The monitor on the implementation showed its success (Helmink et al., 2010, 2011, 2012). It showed that the majority (80%) wants to continue the BeweegKuur cooperation even after the Dutch government changed its policy and rejected further financial support. Even 43% of the participants think that the networks continue in future. Recent research on the alliances in the BeweegKuur (Den Hartog et al., 2013) showed three general conditions for successful coordinated action: 1. flexible protocols and management that allow for contextual adaptations, 2. making success and challenges visible, 3. time and funding to overcome differences in culture between sectors, to build trust. We agree on these lessons and would add the experience of working together and in line with that the reflection on shared events and practices. The reflection on their co-creation helps to build on trust and space for differences as well as to build a shared practice based knowledge. The presence of scientists helps to build in translations from experiences to theory and vice versa.

This study is part of a series into the complex collaboration between sports and healthcare. The aim of this study is to understand the dynamic process of complex collaboration. In a Delphi study, a common perspective on implementing the BeweegKuur is constructed systematically and interactively. The idea is to create a basis for a practice-based theory on collaboration through the analysis of the interactions. The central question of this empirical study is: How can we reach common ground for effectiveness in the complexity of the implementation processes of a nationally developed, combined lifestyle intervention that leads to a collaboration for local implementation by various stakeholders in sports and healthcare?

## 5.2 Background

National and international public health policymakers are increasingly calling for a collaboration in implementation using research and practice in the domain of public health (Van Daele et al., 2012). The diverging accountability regimes the various collaborating stakeholders face make the sharing of knowledge is difficult.

The objective of joint learning based on shared knowledge has been the starting point in the collaboration between practice and science before (Leeuwis and Pyburn, 2002; De Leeuw et al., 2008; Wehrens, 2013). Although scientists acknowledge the importance of having a knowledge basis that is shared by both science and practice, the process for designing scientific models is often far removed from the practical field. It is therefore not surprising, says Bal, that poor, little or no use is made of this knowledge in practice (Bal, 2012: 8).

Wierdsma stresses the value of co-creation when looking for new forms of involvement that are the prerequisite for both shared changes and linking up with a specific context (Wierdsma, 2004: 2). Co-creation is based on the idea that states knowledge generated and applied through the interaction among actors in a network or community of practice will have high potential to be used recognized and to have impact on practice (Wenger, 2002). Wierdsma shares the view that reality, as we perceive it, is a reality that is interpreted, constructed and accepted (Wittgenstein, 1958; Elias, 1971).

### Critical review on existing implementation theories

Almost half a century ago Wildavsky (1973) warned about neglecting local differences and avoiding the complex nature of policy implementation.

Reviewing the implementation literature since there three generations researchers can be distinguished. The first generation is focused on how a policy decision can be carried out as planned. Studies concentrate on suggestions for future research

with their modes of managing implementation as operational governance (Sabatier and Mazmanian, 1980; Hill and Hupe, 2009). Critiques lead to a new generation that paid more attention to an interactive relation with the local level (Lipsky, 1980; Scott, 1998) Bottom up should fill in top down gaps. Wandersman et al. (2008) as well as Meyers et al. (2012) discussed systematical step-wise approaches to build on (Quality) Implementation Frameworks: a synthesis of critical steps in the implementation process, relating to interactive systems for dissemination and implementation. This is similar to the dissemination of innovations as described by Rogers (2003). Even the third generation is sorting out the relative importance of explanatory variables (Wensing et al., 2010) without a comprehensive synthesis or a unifying theory to implementation analysis. The complexity, although almost in every research mentioned as very important, dealt with involving even more variables into the effectiveness research. It looks like we are stuck. Gradually, the implementation research is not only narrowing the possibilities to experiments, also the evidence based medicine tradition, dominates the art of effects that will be measured. The ambition is to distill theory and evidence and translate this knowledge into user-friendly innovations. Unexpected or unplanned effects are hardly considered. The interconnectiveness between management of change and effect research is having this effect (Bal et al., 2010).

Our aim is to get an advanced understanding of how the complexity of the implementation processes unfold, without narrowing down the complexity by choosing one perspective and simplify reality for the ability of research. The complexity of the combination of different professionals with various references, the mixed practices, the variety of contexts and fields gives serious doubts whether blue prints and evidence based steps give the hand-out in these complex settings to achieve diverse goals and empirical support. Since settings and people are changing, we could change our perception and approach all together to a more realist and constructionist one. From a scientific perspective it is more interesting to focus on the way actors create context and direction in their cooperation than to focus on theoretical evidence. We experience that categories are incomparable, old and much disputed and changing all the time. This explains our attempt to differ the approach: start from practice and build on experiments with new ways of cooperation between research and practice to come to new forms of knowledge building. It is an experiment with co-creation of knowledge between science and practice.

The starting point of this study is that reality and our understanding of it cannot be seen as something that can be explained by means of an underlying pattern or cause but that our knowledge about reality is a consequence of the process of attributing meaning in interaction (Knorr-Cetina, 1981; Weick, 1995). Practice is messy and

complex and cannot therefore be controlled by evidence-based rules, procedures and protocols that have been developed on the basis of theory.

Previous studies in this series suggest that possibilities for dealing with complexity have to be found by studying dialogues between stakeholders about their shared experiences and reflecting on them. The idea of generating theory by using empiricism as a starting point in order to achieve a more effective practice was elaborated by Glaser and Strauss in the 1960s and 70s with the Grounded Theory method (Glaser and Strauss, 1976). This study builds on this tradition. The aim is to construct a practice-based theory of collaboration, a theory that is accessible, recognisable and useful both for science and practice.

### 5.3 Grounded Theory

Grounded Theory is theory building based on empiricism using systematically obtained and analysed practice-based research data. The start is the reverse of the classical model in which theory is used as a search strategy for collecting empirical data that the theory must then verify or falsify. In the case of grounded theory, the theory is systematically constructed, via induction, on the basis of real events. The researcher moves back and forth between facts and analysis, an inductive process that is carried out in phases. Initially, open-coding data into categories, is based on the question: *'what do I see?', 'what is going on?'*. The coded concepts derived from the observations are then ordered by studying the codes on the basis of the question: *'What are the differences and the similarities that occur in specific circumstances and how can they be explained?'* In the process of comparing, during which the various data are ascribed meaning in the form of categories, it is possible to study which explanations clarify the relationships between the relevant categories. These explanations are the building blocks for the grounded theory. Because they are related to a specific practice and match experiences and mechanisms found there, not only researchers but also those involved in that practice can recognise them. This makes it a useful theory both for further theory development and for practical use (Glaser and Strauss, 1976: 78). Pandit defines the Grounded Theory method as a five-step process of research design, data collection, organisation, analysis, and comparison to literature (Pandit, 1996).

## 5.4 Method

### Delphi study

Following Elias (Elias, 1971), Stacey argues that people find it easier to see themselves as individuals taking rational, logical steps rather than thinking about themselves in terms of interdependence with others (Stacey, 2007: 294). When people collaborate, many of the choices they make in order to arrive at decisions are tied up with their interaction. Working together, people choose from an infinite number of alternatives of what to say and how to say it. How and what you say depends on the effect you want to achieve (Te Molder and Potter, 2005). The idea that collaboration is the result of interaction is why the researchers opted for a Delphi study.

Linstone and Turoff describe a Delphi study as a method of structuring group communication processes for the purpose of studying the group's relationship with a complex problem (Linstone and Turoff, 1975: 3; Turoff & Linstone, 2002).

Interactively exploring an option in writing in various rounds, using carefully designed sequential propositions, gives the Delphi study shape and substance. People respond individually and anonymously and are informed about the responses from previous rounds in each following round.

The Delphi method helps to connect individual perceptions to those of the other stakeholders and therefore arrive at a shared perception of the problem.

### Recruiting and informing participants

The participants for the Delphi study were informed and recruited from BeweegKuur networks all over the country; 35% from regional and 65% from local networks by the NISB, the National Association for Organised Primary Care (LVG) and the Regional Support Structure for Primary Health Care (ROS). A prerequisite for taking part in the survey was that stakeholders were involved in the implementation of the BeweegKuur or another combined lifestyle intervention. Participants were contacted by telephone and email four weeks before the first survey took place. 199 individuals received an invitation, individuals, not organizations, were selected on the basis of their participation in the Beweegkuur. The participants for the Delphi study were informed and recruited from regional and local BeweegKuur networks by the researcher. Through the networks of ROS, LVG and NISB people were asked for e-mail and phone numbers. They gave the e-mailaddresses of the regional networks that the researcher mailed with information on the Delphi method. When the reaction was low she phoned also to catch up with the local networks. Finally she mailed 199 participants all through their offices. Any double, incomplete

or prematurely aborted responses to the survey were removed. 107, 97 and 79 respondents, respectively, took part in the three rounds. Respondents varied in participation frequency; 53 of them took part three times, 43 twice and 37 once. As far as we can see there is no specific relation or pattern in how people were recruited and the response rate. What you could see though is that there were provinces that were more active than others. Then this was interpreted as a result of being more active from the start of the project. Although the distribution of the five categories varied a little over the three rounds, the representation of all categories in the three rounds was considered satisfactory (see table 1).

Table 5.1 | Respondent surveys

Respondent category	Survey 1 n (%)	Survey 2 n (%)	Survey 3 n (%)
Health service workers	17 (15.9)	16 (16.5)	14 (17.7)
Community services	21 (19.6)	22 (22.7)	18 (22.8)
Health professionals	27 (25.2)	20 (20.6)	18 (22.8)
Sports services	25 (23.4)	26 (26.8)	21 (26.6)
GP's/NP's	17 (15.9)	13 (13.4)	8 (10.1)
N	107 (100)	97 (100)	79 (100)

N = 199

### The study design

Seven propositions about ways of implementing the BeweegKuur were formulated in the first round. These propositions were based on insights from previous studies and tested by a small group of stakeholders and adjusted based on their responses. It was decided to use a four-point scale in order to avoid a 'neutral' central proposition. In three rounds, stakeholders constructed a common perspective of implementing an intervention in a systematic way and through interaction. Respondents were given the opportunity to elaborate on each option. The arguments, considerations and circumstances underlying the opinions and expectations were analysed, with the result instigating the next round.

The invitation contained the link to the web-based Survey Monkey survey programme. Researchers and respondents sent each other anonymous feedback and responses, thereby excluding mutual interference. Any attempts to get unfair access

were identified, and the collected responses are not accessible to third parties. Data was collected through Survey Monkey and prepared for statistical analysis via SPSS. The variance analysis (ANOVA) was used to compare the expert groups. The T-test was used to compare the regional and local networks.

For the purposes of statistical processing, the participants were classified based on substantial and organisational similarities, resulting in five categories:

1. Healthcare service workers: Regional Support Structure staff, 16%.
2. Community policy organisations (community policy officers, community health services, community mental healthcare service professionals), 22%.
3. Health professionals (exercise therapists, physiotherapists, dieticians), 23%.
4. Sports and exercise professionals (social services, fitness, sports clubs, sports support services), 25%.
5. General practitioners (GPs, nursing practitioners), 14%. The participation level varied per round; dropping by 6% among GPs and by 2% among health professionals. There was a rise in the number of participants from sports organisations (3%), community policy organisations (2%) and healthcare service workers (2%).

Individuals who did not continue with the poll came from all expert groups. The reasons for this, stated in emails, varied. Some missed the second round, but then picked it up again in the third.

## 5.5 The Results

The questions and the results of the Delphi study are given in table 1. The Delphi study was designed around the following questions: How is the coordination of the distribution of the intervention organised and what role does the BeweegKuur protocol play? What is the significance of face to face meetings for the collaboration, and are the networks able to deal with the differences between the sports and healthcare organisations involved in the long term?

### First round

The first round shows that all expert groups agree with the first six propositions (table 1). The respondents share the idea that the BeweegKuur protocol is implemented effectively and believe that the network around the BeweegKuur is worthwhile for other objectives. They also share the idea that over time and following concrete activities, the relationships in the network improved and that collaboration in the network is good and instructive and involves using each other's expertise. The experts recognise the ambivalence between the national protocol and

the local context, and that the participants in the network are not all equally important in the collaboration. The last proposition about openness in communication shows a significant difference (table 1). GPs rate communication higher than healthcare service workers, who were more unanimous in their perspective about the openness in the communication. Apart from the communication aspect, the T-test revealed no significant differences in response between local and regional networks. An analysis of the added comments shows that 'communication' is an important issue to all stakeholders. A walking trainer explains the tension between sports and care:

*During a network meeting, it was found that the intentions of the healthcare people were quite different from those of the sports professionals. The cases selected for discussion were also so problematic that there was only room for caregivers and therapists.*

The differences in expertise and working methods need attention and time to be paid to communication about the collaboration process. Stakeholders indicate that a flexible and open attitude and striving for equal participation encourages a good atmosphere and collaboration. They write about the tensions between sports organisations and physiotherapists.

### Second round

In the second round, the average rating for all propositions was more positive than in the first round. The expert groups agree on the identity (table 1) of the BeweegKuur. The T-test shows one significant difference: local networks show more conviction in investing energy in the network. They also show a significant difference in terms of the greater willingness to invest in meetings compared to regional networks. The variance analysis (table 1) shows two significant differences in the rating of face to face contact when collaborating on implementation compared to the average idea on this subject. Sports clubs and other sports professionals such as fitness centre staff and social workers consider meetings more crucial than healthcare service workers do. Within the group of healthcare service workers, there is more variation in how they rate face to face contact. The second significant difference (table 1) concerns the extent to which meetings are expected to remain valuable in the future. Healthcare service workers are less positive about this than the GPs.

When explaining their choices, participants are very much in support of a flexible protocol simply because users themselves are very different. Stakeholders have different ideas about flexibility, with some in favour of full customisation, while others wanted to combine a fixed core with a flexible part that supports the match with the specific context. Physiotherapists very much favour customisation, but also warn against unbridled variety at the sports clubs. A community officer:

Table 5.2 | Delphi

	M	SD	Difference five groups	Difference local/regional
<b>First Round (n=107)</b>				
• The protocol was implemented effectively.	2.77	.638	n.s.	n.s.
• The network is valuable for other purposes.	3.34	.565	n.s.	n.s.
• The relationships improved	3.04	.548	n.s.	n.s.
• Collaboration is good and instructive	3.00	.614	n.s.	n.s.
• The network experiences some ambivalence between the national protocol and local context	2.97	.614	n.s.	n.s.
• Not all participants are equally important.	2.59	.629	n.s.	n.s.
• The communication is good and open.	3.01	.558	significant difference p <.05 GP practice (M=3.35, SD=.493)	t (69,386)=2.464, p <.05 local: (M=3.10, SD=.561), regional & care workers (M=2.82 (M=2.76, SD=.437)* SD=.521
<b>Second Round (n = 97)</b>				
<b>1. Identity</b>				
If it is to be effective, it has to be possible to flexibly adjust the protocol to the specific users and the contexts in which it is used.				
a. This proposition is how I view a successful implementation.	3.37	.681	n.s.	n.s.
b. I expect this is what will happen.	3.02	.595	n.s.	n.s.
c. I am going to put my energy into the network provided it uses a flexible protocol.	2.92	.656	n.s.	t (95)' 2.487, p <.05 local (M=3.03, SD=.585) regional (M=2.69, SD=.738)
<b>2. Relationships</b>				
Effective collaboration is not possible without regular face-to-face contact.				
a. This is how I view a successful implementation.	3.42	.592	significant difference p <.01 care staff (M=3.06), SD=.574 & sports staff (M=3.69, SD=.471)*	n.s.
b. I expect this is what will happen.	2.99	.621	significant difference p <.05 care staff (M=2.56, SD=.512) & GP practice (M=3.31, SD=.630)*	n.s.
c. I am going to put my energy into meetings such as these.	3.16	.589	n.s.	t (52,8) =2,21 p <.05. local (M=3.26, SD=.538) regional (M=2.97, SD=.647)
<b>3. The processes (n=96)</b>				
The BeweegKuur is a way of connecting with local partners and maintaining a dialogue with them about local practices.				
a. This is how I view a successful implementation.	3.24	.518	significant difference p <.05 no difference between specific groups	n.s.
b. I expect this is what will happen.	2.96	.597	n.s.	n.s.
c. I will continue investing in the dialogue.	3.05	.622	n.s.	n.s.
<b>Third Round (n=79)</b>				
<b>4. Research preference</b>				
a. Local practices are compared using measurable effects based on a strictly enforced protocol.	3.51		n.s	n.s
b. Corresponding approaches are compared based on accurate and systematic descriptions of local practices.	2.89		n.s	n.s
<b>5. The importance of offline and online meetings</b>				
a. Meeting face-to-face in the local network is of key importance for incorporating new practical developments in the network.	3.51	.575	n.s.	n.s.
b. online meetings are suitable for the role of ROSs and sports support in the networks.	2.89	.620	n.s.	n.s.
<b>6. Limits to accommodating differences</b>				
a. The diversity of sports providers is difficult to deal with in the local network.	2.37	.737	n.s.	n.s.
b. It is important to make an extra effort to make the best possible use of the diversity of and between network participants.	3.13	.463	n.s	n.s.

n.s. = not significant, \* significant ANOVA, Post Hoc Scheffe

*A number of commercial partners in the network tend to take a different approach if funding is involved, keeping hold of participants for longer so that their shops (physiotherapist's fitness area) are kept busy for longer. (...) If little money is available then it's more about the motivation and collaboration between the various parties. This means that there are often fewer possibilities and the protocol has to be more flexible.*

Doubts about a loss of scientific evidence because the protocol is flexible support the call for strictly enforcing it. A healthcare service worker explains:

*Of course if the protocol is more flexible you can't say anything much about its effectiveness. In practice, all kinds of forms of combined lifestyle interventions are now being provided; taking us back to the unbridled growth we had before the BeweegKuur was introduced.*

Some healthcare service workers wonder whether aiming for face to face contact is realistic if there is no financial support.

### Third round

In the third round, the results (table 2) from the variance analysis as well as the T- test shows no significant differences between and within groups (see table 3). In this final round, consensus is achieved about 1. the basis of the study into the effectiveness of local practices 2. how the interaction in the network is organised and 3. dealing with differences in collaboration.

Table 5.3 | Statements Round 3 on a 4 points scale and 5 categories

Respondent category	N	S1 M (SD)	S2 M (SD)	S3 M (SD)	S4 M (SD)
Health service workers	14	3.21 (.579)	2.64 (.633)	2.21 (.699)	3.21 (.579)
Community services	18	3.56 (.511)	3.00 (.343)	2.39 (.608)	3.17 (.383)
Health professionals	18	3.67 (.485)	2.72 (.669)	2.50 (.786)	2.89 (.471)
Sports services	21	3.57 (.676)	3.05 (.740)	2.29 (.902)	3.29 (.463)
GP's/NP's	8	3.38 (.518)	3.00 (.535)	2.50 (.535)	3.00 (.000)
Total	79	3.51 (.575)	2.89 (.620)	2.37 (.737)	3.13 (.463)

The differences between the categories are not significant.

The first proposition in the third round (table 2) was not included in the variance analysis because apart from being able to choose, respondents were also able to suggest an alternative. The respondents could indicate their preference for the nature of comparative research into the effectiveness of local practices. Do respondents want to compare local practices by means of measurable effects based on a strictly applied protocol or on the basis of exact and systematic descriptions? A greater number of panellists prefer comparisons on the basis of exact and systematic descriptions. However detailed analysis shows that actual reality is more subtle. The opinions of the expert groups about measuring the effects of local collaboration are very similar. In their explanations, proponents show a more quantitative approach in their preference for being more flexible in enforcing the protocol. The proponents of a descriptive approach, on their turn, indicate this approach as difficult and time-consuming. A community mental healthcare service worker:

*'If you apply the protocol too strictly, you miss the connection with the target group. It's better to respond to their needs and take their resistance (e.g. against exercising) into account so that by going along with them first, you gain their confidence and support. Mind you, you have to give an accurate description of how everything goes.'*

An exercise therapist:

*'Describe measuring tools clearly and have a standard for everyone; a protocol is a means to an end, with a certain amount of flexibility.'*

The alternatives given show that, in practice, both approaches are reconciled and linked up with each other. The response of a community official:

*'Actually, I advocate a flexible protocol because so many different elements can come into play, and if you can take them all into account, you will get good results. Nonetheless, I still go for the quantitative option because I'm worried that otherwise it will involve an awful lot of written work, meaning time, for the local stakeholders. And there just isn't the time, and if there were, I'd prefer using it for something else. I'm also afraid that this option will involve a certain amount of subjectivity, though I do think that practices have to be compared.'*

Linking up a quantitative with a qualitative approach is done by applying the protocol flexibly, advocating customisation or a combination of both perspectives,

the message here being: ‘Count what you can count and describe what you can’t measure’. The suggested combination of a protocol with a fixed core and a flexible part, that supports the match with the specific context, links both approaches. The ANOVA analysis (table 1) and the comments are in agreement about the value of face to face meetings in the local networks, with a view to absorbing new developments in the network’s practice. An illustration:

*‘In local collaboration it appears that ‘knowing’ each other plays a far more important part than I would ever have realised. I’m now 57 years old and have been working in public health for over 30 years, but it’s becoming more and more obvious to me that you have to invest in getting to know and respect your discussion partners (their positions, opinions and possibilities). That takes time and you allow yourself too little!’*

The explanations show that people see regular meetings, joint reflection and learning as essential elements in ensuring long-term collaboration. A small group calls for independent monitoring of the effects of the collaboration and organising the reflections so as to learn from this information. With a view to learning processes and dealing with different references, it is often suggested to designate someone to drive the network. Online encounters are considered supplementary to real-time encounters.

The ANOVA shows no differences in opinions about being able to handle the diversity among sports clubs and investing energy in this. This is qualified in the explanation. Diversity requires structure and balance between what it delivers and what it costs in terms of energy. Worried respondents note that the balance is precarious. Sports support services, which are secondary organisations, argue that they want to map the quality and quantity of the sports available or to act as intermediates. Remarkably, the number of respondents giving explanations for their standpoints increased as the Delphi went on, from 33 in the first round, 63 in the second to 92 in the last round. Given the drop in participation, this is a substantial increase, possibly revealing a growing commitment among respondents over the course of the Delphi.

### The Delphi seen as a whole

From the onset, stakeholders show awareness of their mutual dependency in terms of achieving a result and wishing to respond to the context of the collaboration. In the Delphi, we see such commonality developing in relation to the basis for the implementation. In order to understand how this broad-based agreement has come about, we considered the following points when analysing the interactions:

1. The coordination of the collaboration and the role played by the protocol;

2. Communication during the collaboration, including the effect of face to face meetings on the level of commitment;
3. The networks’ ambitions and their development over time;
4. The context of the collaboration.
5. The connections between these elements form the ‘cornerstones’ which, interlinked, offer an explanation for the interactions in this specific practice. This explanation serves a theory about this specific practice.

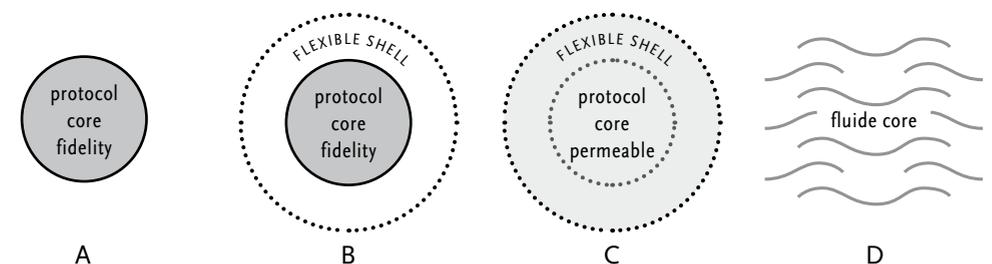
## 5.6 A theory of gradual commonality

We have observed two connected shifts in the practice of implementing the BeweegKuur, leading to what we call a theory of gradual commonality:

1. Over time, the coordination of the interaction in the network gradually shifts. At first, coordination consists of a strict adherence to the introduced protocol. Gradually, coordination shifts towards a mutual harmonisation of activities and, based on the shared ambition, towards concentrating on a match with the specific context. This creates room for differences in opinions, expertise and interests.
2. The better people get to know one another, the stronger and the more resilient the connections between them become. Stakeholders start adjusting to each other and their activities become more closely linked in the collaboration. The mutual ties and the identification with the shared perspective make it possible to connect to the specific context. The shared ambition is reinforced through the opportunities people create with one other, which in turn enhances the elasticity and resilience of their interactions with each other and with the context.

The first development concerns the emergence of commonality in the network in order to then achieve the connection with the specific context. Illustration c in the continuum of figure 5.1 illustrates this theory of gradual commonality, which forms the basis of the implementation process of the BeweegKuur.

Figure 5.1 | Gradual implementation development



The figure illustrates the interactions in the collaboration as they unfold over time. In figure 1, A, the coordination represents strict adherence to the protocol, with a centralising effect on the collaboration. Illustration C in figure 1 explicates the commonality in the collaboration. Illustration D shows that the intervention can become fully interlinked with the interaction in the context. The development of the implementation can be perceived as a gradually changing interaction.

The theory of gradual commonality covers the relationship between coordination, communication, ambition and context and is substantiated by providing a theoretical basis for the findings of the Delphi study.

### **Coordination**

The unfamiliarity with new collaborations creates insecurity and a need for stability and predictability (Weick, 1995: 153). It has become clear in the study that at the start of the implementation process, the collaboration was coordinated by a protocol based on which the stakeholders harmonised their input, thus giving the collaboration clarity and direction. Care professionals are familiar with this way of working and set great store by strict adherence to the protocol. Policymakers in community organisations are also familiar with such rational, plan-based approaches. The sports organisations in the Netherlands, often local clubs, are not familiar with this kind of coordination, so that, socially speaking, they tend to become side-lined in the collaboration. Sports clubs are organised by volunteers and they have only been sporadically involved in BeweegKuur networks.

As soon as concrete mutual activities have to be harmonised in practice, the focus shifts from adjusting the protocol to aligning activities. Attention is needed when coordinating the stakeholders' diverging contributions to the collaboration, and when actually aligning activities, space is needed to accommodate the wide variety of ways of implementing the protocol. The study shows that at the local level there is so much variation and diversity among the sports clubs, fitness organisations and social workers providing sports that you cannot get a clear overview. A physiotherapist puts it like this:

*'First of all, in our programme, we took stock of what was there already and what we might need. However, there is such a huge diversity in the field of regular sports. I don't really feel like looking into all the possibilities to which I could refer people to.'*

It's not clear what the quality of the coaching offered by sports clubs would be. Because of this, sports clubs will eventually lose their connection to the network. In

specific contexts, physiotherapists get sports clubs involved in the collaboration by equipping them to meet the requirements demanded by the network. The sports clubs lose out in favour of the physiotherapists and to a lesser extent the fitness professionals. As their form of organisation is so alien to sports clubs, they cannot sufficiently connect with these practices. This tallies with Scott's estimate that a lot of knowledge is implicit and linked to specific actions that are rooted in certain practices (Scott, 1998).

Because of their shared experiences in the collaboration, the stakeholders more or less automatically adjusted to each other. In the collaboration, resilience and elasticity come about through the concrete actions the network takes to create opportunities for reinforcing itself and others. By making use of each other's potential, mutual understanding increases and people are energised and enjoy participating. By making better use of each other's potential, room is created for different and new contributions to the implementation process. In terms of theory, the development described here fits in with what Stacey and Griffin (Stacey and Griffin, 2005) describe as the adaptive capability to adjust to the context of the collaboration. This is about the development and evolution of an entity in dynamic, constantly changing environments. Variation is important in such contexts in order to successfully combine that entity and the environment in processes of communicative interaction (Stacey and Griffin, 2005: 5). That is also what we saw in our study. We conclude that the coordination of the collaboration shifts from a uniform implementation of the protocol towards interaction based on shared ambition. The interaction is geared towards adjusting joint activities in practice, harmonising and interacting with the specific context.

### **Communication**

The growing appreciation the stakeholders had for one another is expressed in the way they make use of each other's potential and leave room for differences. This is in line with what Weick (Weick, 1995) and Stacey (Stacey, 2007) stress, namely that interaction helps to link up and identify with others, and create a shared ambition (Weick, 1995; Stacey, 2007). Face to face interaction helps to understand others' needs, interests, motives and intentions. Direct contact can create a feeling of safety; stakeholders know who they are dealing with and see the effects of the interaction. This is in line with the importance Gray ascribes to a good dialogue that creates mutual identification (Gray (1998): Problem setting requires identification of the stakeholders, mutual acknowledgement of these issues that join them, and building commitment to address these issues through face to face negotiation (Gray, 1989: 57). As we saw in the Delphi study, by communicating about shared experiences and learning processes, a joint implementation strategy develops where

partners speak the same language and understand one another. A sports support worker from the regional network:

*'I found the face to face meetings with the network extremely important. It helped us to understand one another. That takes time because you all start out with a different frame of reference, with different words, different abbreviations, different contacts. In this way, we also really inspired each other.'*

The study showed that traditional sports clubs did not take part in the discussions about harmonising activities in practice. The fact that the sports and fitness clubs hardly participate in face to face meetings explains why they were not able to sufficiently connect with the BeweegKuur intervention.

The saying *'unknown, unloved'* would seem to apply here. There is insecurity about how to harmonise regular sports offerings with the BeweegKuur. During the collaboration, stakeholders arrived at a joint solution based on their discussions about the situation. The physiotherapists decided to remove the insecurity by implementing the protocol in a flexible way. In local BeweegKuur sessions, they regularly conducted group-based sports activities, showing that they were capable of solving problems. Aarts and Van Woerkum conclude that this competence is a promising basis for the collective approach to complex problems (Aarts and Van Woerkum, 2002).

In terms of relationships, sports clubs lack sufficiently strong relationships with healthcare practices to be able to contribute. This leads to feelings of insecurity because it is difficult to overcome the large differences between them and the healthcare sector, as the study has shown. Sports clubs in the Netherlands have no close links with each other because each club provides a different sport. A community officer about the situation:

*'I think that with the exception of a few highly organised sports providers, most find it extremely difficult to participate in networks like that. They are often well-meaning volunteers who simply enjoy their game/sport. And suddenly they find themselves in one of these networks and hear things that basically they'd never even considered before.'*

Expecting local sports clubs to be able to link up with the BeweegKuur network would appear to be asking too much.

The study shows that by applying the protocol in a flexible way and taking things into their own hands, the physiotherapists' removed the insecurity in many local networks

about the group offerings. This enabled them to link their group sports offering to the demand arising from a specific context.

### **Ambition**

The study shows that the collaboration evolves from a strict adherence to the protocol to a joint ambition that can be flexibly implemented. The separate ambitions of the network participants converge in discussions about harmonising concrete activities in the specific context. Weick characterises this process as a 'state of being in which an individual becomes bound by his actions and through these actions to beliefs that sustain the activities and his own involvement' (Weick, 1995: 157).

The commonality in the harmonisation of concrete activities is the basis for the link with one another in the specific context. The study shows that gradually, the internal link, 'bonding', offers more support and confidence in the collaboration. As confidence in what is shared grows, so too does the capacity to collaborate, to acknowledge and overcome the differences with specific contexts, 'bridging', (Putnam, 2000).

We can conclude from the Delphi study that the stakeholders embraced the BeweegKuur ambition. Municipalities are pleased with the new networks that can also be used for other purposes. Dieticians, physiotherapists and fitness professionals have tapped a new market. The involvement of these health providers is motivated by the funding of their role in the approach. GPs are satisfied with the broad-based and extensive referral possibilities the approach offers due to the coordinated efforts of physiotherapy, fitness and dietetics.

### **Context**

The context in this study is the social and physical environment in which the collaboration becomes concrete. In the network's communication about the shared ambition, it is possible to highlight the various opinions about and interests in the collaboration. The social nature of the collaboration and being able to learn from one another connects the stakeholders with the shared ambition. The growing resilience of the network and the links support the interaction with the specific local context, so that activities are more or less automatically harmonised based on the interaction, replicating what happened initially in the network. A dietician:

*'It took a while to get to know everyone, to speak each other's language and to trust each other. Getting started doing practical things together also helped.'*

This observation ties in with Weick's assumption that: 'If people want to share meaning, then they need to talk about their shared experience in close proximity to where it happens and hammer out in a common way to encode it and talk about it' (Weick, 1995: 188). Stakeholders depend on each other when it comes to achieving harmonisation in the specific local situation. The learning that is interlinked with the communication between stakeholders accommodates the required connection between ambitions and context.

## 5.7 In conclusion

The findings in this study lead to what we have called a theory of gradual commonality. This theory offers an explanatory interpretation for developing commonality in the collaboration of the networks implementing the BeweegKuur. This theory covers two shifts: the first shift explains the emergence of commonality in the network, while the second explains how this commonality then supports the collaboration, creating links with specific contexts.

The insights gained from this study and this specific theory may form a starting point for research into other networks and domains so that we get a better idea of their value.

The theory of gradual commonality underlines the importance of research into interactive processes in complex collaborations. It shows that practice-based research can contribute towards the development of scientific insights that can act as a starting point for a shared knowledge basis for both science and practice. With large and complex projects such as the BeweegKuur, it is advisable to fully integrate the study in the collaboration, with a view to developing knowledge about such collaborations. It underlines the need to provide time and space in the practical field for nurturing relationships, for reflecting on the communication and the processes in order to learn together. After all, reflecting on interaction should be the first step towards future action.

## 5.8 Discussion

The main objections Wierdsma (2004), Gray (1998) and others have against theory-based research of complex collaborations is that it disregards the messy nature of such collaborations. Choosing theory-based research of collaboration implies choosing a simplification of the complexity and a disregard of coincidence and unplanned effects (Van Woerkum et al., 2011).

We have chosen a Delphi study methodology to gain deeper insight in the complexity

of collaboration processes. Delphi stems from the post war military concerns of the American Air force. 'Project Delphi' was the name of a research method to be able to see into all possible future options and movements that possible enemies could make. The Rand Corporation developed the tool.

This specific case shows interesting results that should be developed and tested further in other cases and contexts. It provides a basis for further development of the idea of a theory of gradual commonality. We think this theory might be relevant for other health promotion partnerships as well, but we also realize the problems and shortcomings of the current study. The main problem in this study is the dwindling response rates. Although all categories stayed represented in the third round we saw a bigger drop in response rates of health professionals and GP's/NP's. This might indicate a slight selection bias; the health professionals and GP's/NP's that are not so positive about the BeweegKuur might have dropped out. The consensus therefore might be a consensus among policy makers and supporting health care workers that is not fully backed up by health professionals. This possible divide in support for health promotion policies is an interesting aspect for further research.

Delphi studies are, as other methods, not free of bias and can have many difficulties. We have tried to overcome those with a careful execution of the study. First the selected respondents were actual professionals that work with the BeweegKuur and were involved in developing it. The main researcher of this study is part BeweegKuur network as well, preventing too much distance to the respondents. Second we provided timely (within two weeks) and adequate feedback (personal via e-mail) on the respondents answers in the several rounds. Thirdly the initial statements used in the research were as precise as possible and so were the statements in the second and third round containing the answers of the respondents. Fourth, to prevent superficial analysis of the data, we used a combination of qualitative and quantitative methods to analyze the data. The amount of respondents made statistical analysis possible. This does not account for the reasons that underlie the opinions of the respondents, we cannot know these different beliefs and attitudes on the basis of this research. This is a question for further research. Last but not least, the design of this Delphi study was informed by three earlier scientific studies (Ter Haar et al., 2010; 2012; 2014) about the BeweegKuur done by the researchers as well. This Delphi study was the last in a series of studies on this case and therefore the results of the earlier studies were used to design the Delphi.

Delphi is an interesting research tool Delphi is not a replacement of case study or interview based research, or discourse analysis. It is a valuable and interesting instrument because of its possibility to confront and stimulate anonymous interaction. When actors have different references and expertise in relation to a

central problem a Delphi can explore any opinion or any combination of those. Delphi can stimulate that possibilities are brought in for consideration and the impact and consequences of alternatives. The Delphi can give an impression about the acceptability of any particular option concerned. Group pressure or hierarchy in groups has no impact in the Delphi and it makes it easy to bring in opinions that could be left unspoken otherwise. The method serves the researcher to reveal ambitions, relations and communication patterns without group dynamical interferences. This Delphi research, although it is a real interactive strategy between partners in cooperation, gives only an impression about existing opinions of a short period in time. The question is how and why relationships develop over time and how they are connected with the context and how these relations proceed is important to learn about. A historical perspective is missing.

This being said, to gain a good understanding of collaboration, it is essential to recognise the messiness of the collaboration and its consequences. Thinking in terms of unambiguous causes and effects is not suitable. Ambitions are shaped by the many considerations and choices people make in the collaboration, with a view to the specific context. The collaboration emerges as a process without a clear beginning or end, and if we attempt to box it in, there is a major risk that this distracts our attention from what is really going on. And then we fail to know how what is happening now is heralding the changes to come. It is not possible to distance ourselves from the tendency to design, control or study the interaction from a distance. A greater commitment, literally and figuratively, would seem essential to really understand how the process of collaboration unfolds. The many varied perspectives that lead to choices in the interaction, the complexity generated by the diversity in the collaboration, the social processes and the influence people have on one another require a close look and a greater sensitivity to what is going on. Science and practice must constantly reflect on the interaction, and researchers must always be prepared to engage in critical description and self-examination. This form of research is accountable towards the subject and the question why certain choices are made in the process. In addition to the objections referred to above, theory-based study, so-called evidence-based research, has a strong tendency to generate preconceived results. That means that implicit theoretical premises or experiences that were gained elsewhere in similar processes and that may influence the choice remain unexamined. Therefore, the learning effect about how decision-making processes develop in a particular context is minimal.

To resolve this situation, studies into interaction are needed, and a more solid base needs to be established for the collaboration between practice and science. To make practice more evidence-based and science more practice-based, we

recommend permanently collaborating in joint projects. By allowing researchers to work more closely in practically implementing public health, they will experience issues of a different kind than those that theory-based observations normally focus on. This collaboration means that people in the practical field can benefit from the fresh perspective of outsiders, which forces them to explicate the often implicit, unconscious assumptions on which they base their decisions and actions.

Practice-grounded research allows science to be socially relevant. A Grounded Theory enhances the link to the practical field and encourages the use of this theory, thanks to the shared use of concepts that everyone in the practical field is familiar with. In this paper we suggest a Theory of Gradual Commonality as a perspective as a means to reflect on cooperation in practice. It maybe can serve as a handout to reflect on the experiences with coordination, communication, ambition and context. It is a practice based theory which has to prove itself in future, we don't know if we are able to resolve implementation problems better than the earlier described approaches that are on offer.

In conclusion we would like to add that if we indeed want to re-conceptualize the nature purpose of implementation as non-linear and capable of transformation by its participants through self-organization it demands a different role on science as well. To be able to effectively support implementation strategies we should also give more attention to discuss and elaborate on that role than we did so far. Production of knowledge and performing of reality become inextricably linked that gives rise to elaborate on the nexus between research, policy and practice (De Leeuw et al., 2008; Mantoura and Potvin, 2012). The idea of co-creation can ground a shared knowledge creation that stimulates shared implementation strategies (Wiener, 2007). It is just a beginning.

Reflecting for developing a better understanding, based on a close look without loss of detachment, as Strauss and Corbin had in mind, are still relevant today.

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