MACQUARIE UNIVERSITY

SYDNEY ~ AUSTRALIA

Report of the Evaluation of Negotiation Skills Training at Townsville Hospital and Health Service

Centre for Healthcare Resilience and Implementation Science

Australian Institute of Health Innovation

July 2016

Robyn Clay-Williams, Paul Lane, Lauren Camilleri, Andrew Johnson

Produced in 2016 by the Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation, Faculty of Medicine and Health Sciences, Macquarie University, Sydney, NSW 2109.

National Library of Australia

Cataloguing-in-Publication data: ISBN 978-1-74138-442-0

Table of Contents

Executive Summary

This report provides findings from an evaluation of the two-day Negotiation Skills training course for executives, senior clinicians, and managers at Townsville Hospital and Health Service (THHS). The THHS has sponsored negotiation skills training since February 2015, with 80 staff completing the program as of May 2016. The program focuses on intensive negotiation skills training using integrative bargaining, training participants to identify 'win win' solutions that can improve efficiency without incurring additional cost. Mr Michael Klug AM, an internationally recognised consultant and skilled negotiation specialist from large Australian commercial law firm Clayton Utz, facilitated the training. This evaluation was funded by a small grant from the Townsville Hospital and Health Service Research Trust Fund.

Eighteen staff members who had completed the training, comprising 25% of eligible participants, were randomly selected and interviewed for this study. Qualitative inductive interpretive analysis of transcribed interviews was undertaken to identify key themes relating to the negotiation skills training. Six primary themes - affective reactions, utility reactions, barriers to implementation, enablers for translation, work practices, and sustainability - and 28 sub-themes emerged from the analysis. Implications for THHS included recognition of constraints when negotiating with external organisation such as QLD Health, identification of time as a major barrier to implementation of the new skills, and the importance of an organisation wide strategy underpinning the training.

Based on our evaluation, six overarching recommendations have been formulated in terms of advice for the THHS leadership team:

Recommendation 1. Create opportunities for colleagues to communicate and collaborate.

1.1 Create processes for 'spreading the word' to improve implementation and uptake of new ideas.
1.2 Create cohesive collaborative networks to facilitate improved patient care.
1.3 Conduct negotiations face-to-face.

Recommendation 2. Provide flexible training options.

2.1 Open training to more staff.
2.2 Develop modular training.
2.3 Allow participants to self select onto training courses, depending on their perceived needs.
2.4 Tailor the training, including role-plays and discussion topics – this is especially important for clinicians.
2.5 Provide pre-reading or reference material.

Recommendation 3. Provide negotiation tools.

3.1 Provide easy access to the Negotiation Toolkit, specifically the 7 Elements of Negotiation Scoresheet, the Negotiation Worksheet, the Golden Rules, and the Behaviour Grid.

Recommendation 4. Create opportunities for translation.

4.1 Provide quarantined time to prepare for negotiations.
4.2 Create expectations that staff will negotiate (between and across levels) and authority to do so.

4.3 Consider standardising basic negotiation processes.
4.4 Reward those who negotiate successfully for win-win outcomes.

Recommendation 5. Explore opportunities to embed negotiation in QLD Health.

5.1 Approach QLD Health at an executive level to formally agree that both THHS and QLD Health will only enter into negotiations with parties that have appropriate fiscal, or other, decision making authority.

Recommendation 6. Address longer term sustainability.

6.1 Develop an organisation wide strategy underpinning negotiation skills training.
6.2 Provide opportunities for practise, refresher training, formal and informal discussion groups, mentoring, and access to expert advice.
6.3 Consider developing advanced training for those involved in more complex negotiations.
6.4 Formally align negotiation training and skills to other workplace key performance indicators.

1. Introduction

Background

Lack of resources is a perpetual problem in healthcare, an issue unlikely to change with the growing demands of an aging population and the rise in chronic health conditions. Healthcare professionals, especially those with management responsibilities, can often find themselves in situations where in order to maximise resources, they need to negotiate with their colleagues and patients, and sometimes a range of stakeholders including hospital boards, medical committees, politicians, lobbyists, community leaders, and business executives.[1] Intensive negotiation skill training endeavours to improve engagement and collaboration between healthcare professionals, and thereby improve resilience of the workplace. Negotiation offers a framework for increasing value in the organisation without extra cost, by promoting integrative 'win win' outcomes.

The location of this study, the Townsville Hospital and Health Service (THHS) in regional Australia, is currently undertaking intensive negotiation skills training for executive, senior clinicians and management staff. Research suggests that the effectiveness of negotiation training depends on the design and intensiveness of the program, and that post-training evaluation is crucial.[2 3] This paper reports the results of an evaluation of the training, including the implications of findings for organisational resilience.

This study will determine whether the two day negotiation skills training course was successful in providing staff with the skills necessary to enact integrative bargaining in the workplace. It will also add to an understanding of how such negotiations might facilitate better collaboration and resource management within complex healthcare organisations.

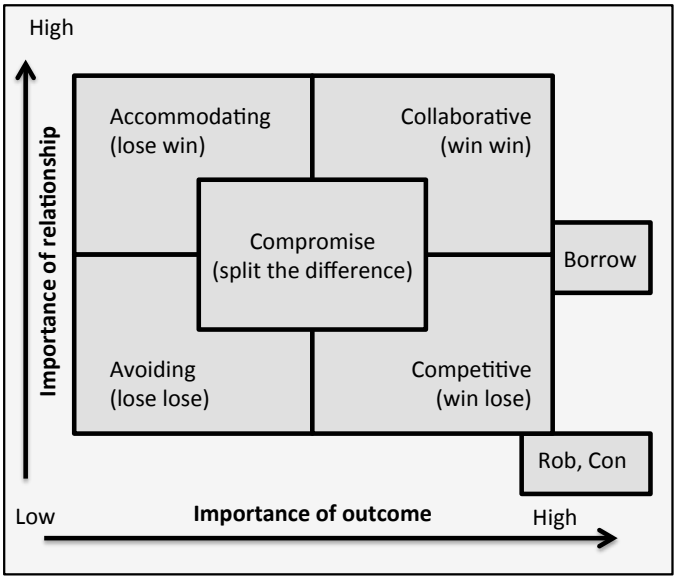
Intervention

The THHS has sponsored negotiation skills training since February 2015, with 80 staff completing the program as of May 2016. Three courses were run: one in early February 2015, one in late March 2015, and one in mid March 2016. The program runs for two days, and focuses on intensive negotiation skills training using integrative bargaining, training participants to identify 'win win' solutions that can improve efficiency without incurring additional cost. Mr Michael Klug AM, an internationally recognised consultant and skilled negotiation specialist from large Australian commercial law firm Clayton Utz, facilitated the training. During the training, participants completed a modified Thomas-Kilmann Conflict Mode Instrument (TKI) self-assessment questionnaire,[4 5] which identified their behavioural preferences for interacting with others. Outcome of the TKI placed the trainee on a grid with relationship/outcomes axes, and identified their natural preference for one of five negotiating styles: competitive, collaborative, accommodating, avoiding, or compromise (Figure 1). The training used a version of the TKI modified by Lewicki and Hiam,[6] which identified three additional styles lying 'outside' the grid: borrower, con and rob.

Corporate firms have long recognised the value of skillful negotiators and invested in training programs to increase the negotiation skills of their managers.[2] Healthcare professionals receive little or no training in negotiation as part of their medical training, and there is a growing need to implement negotiation training programs in the hospital setting. In the current environment, where

the required standards of care are high and the emphasis on cost-effectiveness continues to increase, negotiation is an important asset among health care providers, and probably the most important skill any clinician leader can have.[7] To our knowledge, this is the first study aimed at evaluating the effectiveness of an intensive negotiation training program targeting executives, senior clinicians and management staff at a major Australian health service.

Figure 1. Negotiation Style preferences



2. Research Aims

The aim of the research was to evaluate the effectiveness of the THHS intensive negotiation training by investigating whether staff members have implemented the integrative bargaining skills in the time period since the training, and if so, how and when. The study used a qualitative approach, involving face-to-face interviews with staff members who have completed the training. This study is part of a larger research initiative to evaluate the TenCs model of Resilience[8] in operational and educational healthcare settings.

3. Methods

Participants

All THHS executive, senior clinicians and management personnel who completed the negotiation skills training course, and who were employed by THHS on 16 May 2016 (with the exception of the study investigators) were eligible to participate in this project, resulting in a source population of 70 staff members. A random selection of staff members who completed the training were invited to participate in a semi-structured interview to collect post-implementation staff perceptions of the training and its utility. The study source population was stratified prior to random selection of interview participants to ensure that a representative spread was sought from the executive, clinical and management groups.

Recruitment

The investigators verbally informed staff members about the research, and provided to those who were interested written information about the research and a consent form. Staff members were informed of the voluntary nature of their involvement and that non-participation will not affect job performance appraisal. Those who elected to participate were scheduled for interviews as workload permitted.

Procedure

Interviews. Each participant was interviewed face-to-face in a private room. Interviews were audio recorded, and professionally transcribed verbatim to prepare them for analysis. Participants were asked about current workplace attitudes, behaviours and processes that may have been impacted by the negotiation training, and their experiences of applying negotiation skills in their workplace. Interviews were conducted at least eight weeks after completion of the training to allow time for the skills to be translated into practice.

Data analysis

Interview data were analysed in an integrated fashion. Inductive interpretive analysis of transcribed interviews was undertaken to identify key themes relating to the negotiation skills training. Coding the data allowed it to be organised and used to explore connections between data elements and to develop sets of concepts. Once coded, segments of data were linked in a formal fashion to allow themes to emerge and to determine relationships that may exist between different data sets. This is a way of studying real world complex systems such as healthcare. Deductive analysis was also completed to correlate data with the taxonomy provided by the TenCs model.

4. Results

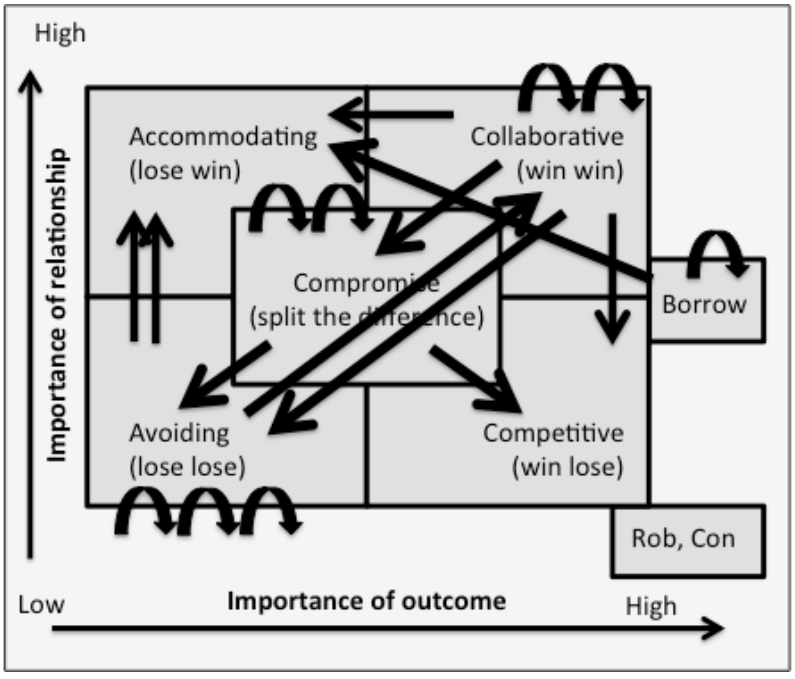
Participants

Eighteen staff members who had completed the training, comprising 25% of eligible participants, were randomly selected and agreed to be interviewed. Interviews were scheduled between 16-20 May 2016. Prior to selection for the study, health service administrators stratified eligible participants into executive, clinician or manager categories. Within each category list, participants were numbered; numbers were then selected for recruitment using a random number generator. Initially, the first six members in each category were invited to be interviewed. Where are a participant declined to be interviewed, or was unavailable over the scheduled interview week, the next number drawn in that category was invited to participate. Originally, it was intended to report results separately for clinicians, managers, and executives. During the interviews, however, it became evident that there was no distinct line separating managers and executives, and most managers/executives also identified themselves as clinicians; therefore, the results are reported as arising from a single sample. While eight of the 18 participants completed the course within the previous three months, the remaining 10 participants completed the training between 9-15 months previously. Six participants had either previously completed negotiation training, or had been exposed to the negotiating principles; for the remaining 11 participants, the training material was new. Participant demographics are in Table 1.

Table 1. Demographic characteristics of study participants	
Characteristics	**Participants (n = 18)**
Gender	
Male	8
Female	10
Age (years)	
20 – 30	1
31 – 40	6
41 – 50	10
51 – 60	1
Time in profession (years)	
< 1	5
1 – 2	6
3 – 4	5
≥ 5	2
Duration at organisation (years)	
< 1	1
1 – 5	7
6 – 10	5
11 – 15	3
≥ 16	2

Participants were identified by the self-assessment questionnaire to have a natural preference for the following negotiating styles: competitive (n=1), collaborative (n=6), avoiding (n=6), compromise (n=3), and borrower (n=2). When asked which style they moved to when under pressure, participants were each able to identify a style on the grid, resulting in the following range: competitive (n=2), collaborative (n=3), avoiding (n=4), compromise (n=3), accommodating (n=5), and borrower (n=1). While eight participants stated that they maintained the same style under pressure, the remainder moved on the grid (see Figure 2).

Figure 2. Movement of Negotiation Style preferences under pressure



Themes

Six primary themes and 28 sub-themes emerged from the analysis (see Table 3). Primary themes were affective reactions, utility reactions, barriers to implementation, enablers for translation, work practices, and sustainability. Sub-themes were: (1) word of mouth, (2) participant view of the facilitator (positive and negative), (3) personal negotiating style preferences, (4) spending time with colleagues, (5) balancing course time and content, (6) participant view of the organisation (positive), (7) practical negotiating skills, (8) tools and templates, (9) matching training to user needs (positive and negative), (10) time, (11/12) negotiating with other parties (QLD Health and THHS), (13) job mobility (negative), (14) provision of the Negotiation Toolkit, (15) standardisation of negotiations, (16) integral part of daily work, (17) noticing others, (18) gaining confidence, (19) improved understanding of behaviour - self and others, (20) preparation, (21) reduced stress, (22) examples of work practices, (23) few support mechanisms for translating learning, (24) refresher training, (25) coaching and mentors, (26) formal discussion groups, (27) advanced/tailored training, (28) implementing training more widely.

Affective and Utility Reactions

Most participants were excited at the prospect of training: they had heard positive things from colleagues who participated in previous sessions about both the training and the facilitator, and came to the course with high expectations of learning something new and interesting. Whether this positive affect persisted following the training seemed to depend on the participants view of the facilitator. For the majority of participants, the facilitator was admired and respected as an engaging speaker and an expert negotiator: "… *obviously, the person that was delivering the workshop was a very talented negotiator and very experienced in the field … a world leader in the area*" (Interview #3); and "*I think he was quite a skilled facilitator. I think he challenged some of those, probably, long held beliefs and challenged why people make a decision or work the way they do*". (Interview #9) Many participants were effusive in praise of the facilitator, typified by statements such as this: "*I could sit and listen to his examples forever. Just his insight and obviously the many things he's involved with, just fascinating really*". (Interview #1) In contrast, for a minority he was seen as self-promoting and verbose: "*the format was rambling and self-referential in the extreme … I think his skills are great, but … I just don't see that they're well-focused [for healthcare]*". (Interview #11)

Participants liked learning about their own negotiating style (and were interested in the styles of others): "*I enjoyed that it was group training … and learning more about my own style, but also recognising other people's styles*". (Interview #2) For those who were identified with primary 'collaborative'/'compromiser' styles of negotiation, the course reinforced their preference: "… *probably the style being taught would be my style anyhow … if I had come from the win at all costs perception, then possibly it would have made me reflect more*" (Interview #16), and "… *just reiterating what I learnt previously or the style I'd developed previously that that was okay or I needed to tweak it slightly this way*". (Interview #17) The course did not provide practical advice on how to move between styles, however, and for some of the participants, particularly those whose primary style was not assessed as 'collaborative' or 'compromiser', this was a frustrating omission. The 'avoiding' style, for example, was treated as slightly aberrant, and portrayed both as a problematic style from where one should transition to a more useful place: "*the awareness of one's personal style, personal background, for interactions is helpful … [but] I didn't in any way get a feeling of how to move or adapt my style to become more collaborative … [that] could have*

been delivered". (Interview #11) In addition, for some participants, the assessment seemed to be quite context specific and of questionable validity: "… *[I was told] 'you're that and you're the worse spectrum of that and those that are better spectrum can move but you can't because you're really back' … [but] I don't fall into that area … the questions put me there but I'm not, if it's something I value*". (Interview #14)

Many participants enjoyed the opportunity to spend time with colleagues: "*The network that it helped me to create has been helpful. It was the social and in between lectures and talks interactions with my management, and the fact that we did a common journey in that we were … sort of thinking the same that allowed us to speak with each other in a more informal way and that's continued on since the course*" (Interview #13), and also training with a mixed group of professionals: "… *it was great to actually make connections with people that you would not normally do that with because they might be in a completely different stream [at THHS]*" (Interview #15), and "… *we had a lot of senior people from varied elements of the organisation, and that worked exceptionally well*" (Interview #16), and "*Just the group I suppose, so the diversity [made the course enjoyable]*". (Interview #18)

Participants had a variety of responses to the groupwork and role play elements of the training, ranging from enjoyment and enthusiasm, to trepidation and dislike: "*I think the actual group work was quite good, in that it actually put people outside their comfort zone, which was, I guess, the purpose of it*" (Interview #9), and "*One of the activities where we were paired up I was paired up with a particularly difficult person to try and negotiate a deal, and I actually found that quite traumatic*". (Interview #17) How fellow trainees approached the groupwork sometimes affected the enjoyment of others in the group: "*I just enjoy group sessions but I suppose when you're with people who are either for it or not they sort of sometimes – you know, it may not be as enjoyable as it could have been*". (Interview #1)

Some participants, particularly those with previous negotiation experience, felt that two full days of training was too long and that breaking it up might give participants time to reflect: "*the two days may have more value if it was delivered at separate times. Not an intensive two days … I would just do the day and then a week or even a week and a half later do another full day*" (Interview #2), and "*[two days is] a very long time … if we were doing that in larger numbers, there would be quite hefty cost implications … from the backfill arrangements …*". (Interview #16) Participants with previous experience also felt that too much emphasis was placed on theory at the expense of skills practise: "*It was almost didactic …[if you've] done the pre-reading, you've done the course … there wasn't really anything new in the course that I hadn't come across either through my own reading or prior training … I was hoping the course would give me a little bit more practical skill in terms of dealing with difficult situations …*". (Interview #13)

Some participants expressed gratitude to the organisation for making the training available, and felt they needed to 'pay it forward': "*it's a lot of money to send me to that course, the best I can do is try to put it back into my work*". (Interview #1)

Almost all participants had positive utility reactions to one or more aspects of the training. Most participants expected to gain some practical skills as a result of training: "… *expect[ed] that I'd come away with some skill or improved skill that would help me in the workplace*". (Interview #2) For most, the useful components were the practical examples, the structured approach to negotiation, and the tools and templates: "… *just having that framework in your mind around how*

to do it and how to prepare for it certainly keeps a negotiation on track …" (Interview #5), and "*I liked the more practical, solution focused approach, how to deal with the situation*". (Interview #12) The key points (or 'golden rules') that work across a broad range of situations, the opportunity for short practice in the groupwork, and the insight into personal negotiating style preferences were also considered useful for work. Many participants actively planned to translate the training to the workplace; many arrived at the course with specific examples in mind of where they would use the training when they returned to work: "*I actually have quite a few meetings that are quite difficult in lots of ways, where there is a lot of negotiation ... I wanted to be there to learn how to manage those situations better*" (Interview #9). Many participants felt that they already possessed some of the skills from many years working in health services, but that the training added more structure to their approach to negotiation: "*I think I had the elements of the concepts there but then to have ... that structured approach and have a more structured process [helped]*". (Interview #1) In addition, the training provided a degree of self-insight in why some behaviours were more effective than others: "*Immediately, what I felt has changed is my relationships have improved, because I was willing to listen more rather than assert myself more*". (Interview #12)

Participants who had completed other training with QLD Health rated this course very highly in comparison: "*I've gone to some training and you walk away going ... what a waste of time ... I thought [this course] was probably worth every cent*". (Interview #1)

For others, however, the training was not matched to their needs. This was particularly the case for junior managers, and for some clinicians with clinical management responsibilities: "*… a lot of it was lost on me because I didn't have that work experience*." (Interview #2). In particular, the lack of clinical focus in the training anecdotes and in the groupwork scenarios resulted in the content lacking meaning and relevance for some participants: "*the focus was on executive non-health-related interactions ... just wasn't a good fit for clinical services, for clinicians …*" (Interview #11), and "*maybe clinical relevance [in the training scenarios] would make it easier to apply in the workplace*". (Interview #10) Some clinicians felt that there was potential for the training to be very valuable for clinicians, if it were tailored appropriately: "*the skills are very applicable to junior doctors as well who are dealing with difficult patients*". (Interview #10) The emphasis on large scale, complex negotiations also meant that participants working with smaller problems had to tailor the material to meet their needs: "*[the course is] not in context of the little [issues], its applying what you've learned to the smaller ... how to relate it back*". (Interview #8) The large course size (approx. 30 participants per course) did not allow the prior expertise of some participants, or their specific needs for more advanced training, to be taken into account: "*I really wanted to get into the difficult conversation end of the negotiation ... but [for that practise] I'd think there'd need to be fewer participants ... do it in supervised groups of five or six*". (Interview #13)

Barriers and Enablers

Some participants found the lack of pre-reading a barrier, in that they did not feel prepared to undergo the training: "*I didn't know much about it. I had no pre-reading. I had no pre-understanding*". (Interview #3)

Time was the biggest barrier to employing the skills in the workplace. Most of the participants identified the need to get organised and prepare for each negotiation, and felt that finding sufficient time to do so was a challenge: "*one of the biggest barriers for me as a clinician is having time to*

enact what I know". (Interview #6) Negotiating in the structured way taught was also perceived to take more time because participants were new to the process. Further, to achieve a win-win result often took a number of meetings over a number of weeks or months, whereas the organisation was after a quick result: "*… that's difficult … to let senior management know that yes, I'm actually working on it. But there's no outcome [yet]. That's what they want to see, the outcomes, because they're under pressure as well*". (Interview #18)

Participants who were involved in negotiations with QLD Health felt that the unwillingness of the department to negotiate, or the practice of sending negotiators who do not have authority to decide, was also a barrier to both successful negotiation and implementation of the skills: "*there are some things that you are able to negotiate but there's really some things in the structures that we have within [the health department] that you just can't"* (Interview #1), and "*… despite the outcome that comes out of the negotiation, it needs to be approved from someone that's not part of the negotiation … Another level of bureaucracy that will not be involved in the negotiation, that can either approve or trump the decision made, despite the difficulties and bargaining*". (Interview #12) Participants were both disappointed, and frustrated, that their skills were not able to be fully utilised in these high level discussions, which were critical for obtaining much-needed hospital and health service resources: "*on our really big ticket items there was just no real negotiation to it*". (Interview #1) Descriptions of recent negotiations with QLD Health, provided by a number of participants, suggested that the need for true negotiation is new to the department, and that they have yet to develop processes for health services wishing to negotiate resourcing: "*last year we were one of very few [health] service[s] … to argue or continually argue for stuff …*". (Interview #1)

In contrast, within THHS it was sometime difficult to negotiate, as others valued the relationship too much: "*… when you have a large number of people who are all trying to make sure other people feel OK about a negotiation, actually it becomes real, really difficult [to come to an agreement] … think within the hospital – within Townsville – when you're dealing with people and you invest in a longer term relationship, you tend to be a lot more wanting to please them*". (Interview #6) Even so, hierarchical relationships and formal reporting structures within THHS could make it difficult to implement the negotiation strategies taught in the training: "*… for someone in my position, I don't have the ability to knock on the door or make an appointment with someone two or three levels above me in structure … the channels of communication within this organisation are not open … what was being talked about in the course is assuming that you've got a [more flat gradient]*" (Interview #13), and "*one thing I found was in the workplace I would think I'm going into negotiation but actually it's already decided and it's not a negotiation … it wasn't actually open to negotiation*". (Interview #14)

A barrier for some participants to implementing the skills was that they frequently moved offices, or had a number of different jobs, so did not have easy access to the training material: "*because I've moved office to office … my stuff is kept somewhere else, so it's not easily on hand for me …*". (Interview #4)

The course provided templates that could be adapted for the workplace. The biggest enabler was provision of the Negotiation Toolkit – a series of worksheets to assist in preparing for negotiations: "*It's not about what I remember. It's about going back to [the toolkit] when I need to. I know that next time I'm going to a negotiation, I will use a framework, and I will go back to it and selectively use the things that I need to know to be ready for it. When I'm preparing for a negotiation, I'll go*

back and look at the material". (Interview #12) Elements that were most used were the 7 Elements of Negotiation Scoresheet (where relationship, communication, interests, options, legitimacy, commitments, and alternatives are listed and scored), and the Negotiation Worksheet (where theirs/ours interests, Best Alternative to a Negotiated Agreement, and No Deal Option are determined and noted). Some participants had these and/or the 'golden rules' laminated on their desks or pinned on the wall. Participants who reported using components of the toolkit in their interview are shown in Table 2; in some cases they showed the interviewer worksheets that were dog-eared and clearly worn.

Table 2. Useful components of the Negotiation Toolkit	
Negotiation Tool	**Participants reported using tool**
7 Elements of Negotiation Scoresheet	#3, #6
Negotiation Worksheet	#1, #5, #6, #8, #9, #12
Golden Rules	#3, #9, #14, #16, #17
Behaviour of self/others (Grid)	#2, #3, #4, #5, #11

A further enabler, associated with the tools, was the potential of standardising the way negotiations were approached, thereby bringing a common language or understanding to discussions: "*I felt that I had a framework that I could use at work when it came to a negotiation and that people that were there from my workplace also could use that framework in a negotiation when we were all in a negotiation with each other, so they know where I'm coming from*" (Interview #12), and "*… it was good to be able to go in there [with colleagues] knowing that we're all going to be on the same potential playing field of principles and understanding*". (Interview #15)

Work practice

Every participant indicated that negotiation formed an integral part of their daily work: "*… you always use negotiation every day …*". (Interview #4) Most participants had employed at least one aspect of the training in their work, and gave one or more specific examples to illustrate where they were approaching their interactions with others differently than in the past, or were more engaged in looking for 'win-win' outcomes. Participants who have been successful in the organisation may already have some of these skills: "*I think we have a really reasonable skill set, because I think everybody in health ... does this all the time*". (Interview #16) Participants could also point to examples where negotiation was starting to make a positive difference to relationships, personal performance, or organizational outcomes: "*there are changes happening [in my workplace] and I think it's for the better for everybody"*. (Interview #14)

Participants began to notice when others were employing the techniques: "*... from very, very early on I could see ... the way he was playing the* game *... I could see his endpoint from a mile away*" (Interview#3), and "*I like people watching. I observed [a colleague] on a number of occasions and ... I can see some skills that [came from the training]*". (Interview #7) Even those who had not noticed other using the skills, were observing others' behaviour in the workplace: "*No [I haven't noticed others applying the training], but I'm watching them*". (Interview #6) A number of participants mentioned the pastime of observing others in meetings to look for the negotiation skills and behaviours. For some, it was enjoyable and energising to negotiate, and to notice how others negotiated: "*so in that instance [when negotiating against a difficult opponent] I find negotiation becomes more sporting to me*" (Interview #3), and "*There is kind of an art to it. There is kind of a dance to it*" (Interview #12), and "*So it's almost like the tennis ball over the net. Okay, now it's*

your turn. I'll sit here and wait and see what you have to come to the table". (Interview #15) The examples provided by participants predominantly involved moving from a 'win-lose' to a 'win-win' situation: "*People are trying to work through [their problems] a bit more clearly rather than putting a line in the sand and putting another line in the sand and then digging a trench*." (Interview #5)

While there participants reported seeing the skills utilised at work, this has not yet translated to substantially increased skill or increased intensity of negotiations overall: "*Overall shift? Probably not, but certainly in individuals*". (Interview #5) Nevertheless, while each participant gave examples of where they had personally utilised the skills, a number of participants reported examples where others did not reflect on, or respond to, the training.

Some participants felt more confident following the training, both personally, and also in their ability to succeed in resolving longstanding or complex problems: "*I think that I'm probably more tolerant with both conflict and negotiation now. Rather than just looking for the quick result, no matter whether I win it or lose all, I'm happy to take the time and to find a satisfactory result for both parties*" (Interview #7), and "*I think it's given me more confidence. It has helped my negotiations*". (Interview #14) One participant explained how negotiations within THHS can be very context-driven. For example, to negotiate implementation of the same process across different service groups may require a different approach, depending on the needs of both parties and the degree of cohesion or rapport between them. The skills taught in the training showed how to use the best approach to ensure that during negotiation that the individual needs/wishes of the service group is respected, resulting in preservation of relationships and a win-win outcome. Participants gave examples where they were working differently as a result of the training, including increasing persistence in funding negotiations and trying multiple approaches: "*I learnt to think of it not just one way, put yourself in many shoes … and if they've said no here, how do you come around again …*" (Interview #1) For some participants, employing some of the negotiation techniques taught resulted in less stress at work. Having a walk-away position, for example, can lessen the frustration associated with negotiations that do not approach the zone of potential agreement: "*a release valve in terms of how I feel about a negotiation*". (Interview #6) Most participants found it more satisfying in the workplace to have win-win outcomes: "*… building bridges … that's the kind of stuff you do on a daily basis*". (Interview #17)

In some cases, despite participants not feeling that the course was well-matched to their needs, their comments in the interview showed that they have, in fact, gained an improved understanding about the behaviour of others in the workplace, and how to better engage with colleagues: "*I'm definitely more aware of how other people navigate through the hospital and how the people interact. I've definitely become more aware of different relationships and how certain things might play out and reading a room as well*". (Interview #2) The training has also provided participants with the skills to work as a team: "*So the three of us … two of us are more withdraw types, but we have a strong collaborator … I'm a little bit more assertive … [in the meeting] we were, as a group, using all of our skills. We were able to negotiate [our objective] with all the resources that we needed*" (Interview #2); and "*So we have the meeting and say 'remember this, remember he does flare, remember it's not reacting, remember it's we don't want him to go - he goes straight to compete'. So we do use [the negotiation] principles … in a team as well, not just as an individual*". (Interview #9)

Participants believed that preparation was the most important element of skilled negotiation, and

many gave specific examples to support this assertion: "*… preparation is essential … I think having - really having the knowledge and understanding what you have to bring to the negotiation, so your initial offer and how that differs to what your no-deal offer is, just having that prepared*". (Interview #12) However, the healthcare workplace infrequently allowed sufficient time for preparation, particularly for clinicians, and this hampered the ability to use the skills for many participants: "*The actual time to think and work on the business instead of in the business is very difficult to ring fence and protect*." (Interview #9)

A few of the participants gave examples where putting some of the strategies in place, while visiting and negotiating with regional and remote communities, achieved positive outcomes. In particular, face-to-face visits, and actively exploring win-win outcomes, appeared to be beneficial. These were sometimes complex negotiations in a public forum, and the training appears to have helped the participants reach satisfactory end points. A number of advantages were perceived in face-to-face negotiations, over those conducted by telephone: "*You've got far more immediacy in terms of picking up body language, which is a very, very quick thing. Actually, even the slight delay on telehealth makes a big difference to that. You can sense the mood in a room a lot quicker. Just the simple things of having a cup of coffee with someone and saying hello first before you get down to the nitty gritty. These are all really integral to our relationships with people … Also people aren't invested in that meeting. If you fly up for it they feel reciprocal. The law of reciprocity exists. They think oh, he's come all this way, he's shown good faith, okay, we'll cut him some slack*". (Interview #6)

Other examples where negotiation training were perceived to have made a positive difference in service agreements or workplace collaboration included: BreastScreen hyperbaric medicine, oral health, offender health, community health services, staff performance management and conflict resolution (examples included both managing up and managing down), consultations with unions, internal negotiations between THHS health service groups, day-to-day negotiations between wards and within THHS on clinical and administrative matters, interactions with patients' family members, team meetings, team working between medical and allied health professionals, executive level problem resolution, and working with service groups.

Sustainability

There was some overlap between ideas for improving sustainability and enablers for translating the training into the workplace, in that having processes for sustainability in place was considered to aid training transfer. Despite high levels of engagement, participant recall of specific learning points was variable, and was more dependent on whether the participant was using the skills in practice than how long since they had trained. All participants could recall their preference for negotiating style, and the style they reverted to under pressure, when shown a picture of the grid in Figure 1.

Most participants were disappointed to find that, following the training, there were few support mechanisms to assist in implementing the skills in the workplace: "*you come back to the organisation ... excited ... [but] there was nothing else, no follow up*" (Interview #1), and "*there needs to be more practical application for it to be something that's sustainable. To be a negotiator, you need to do it often. You need to do it often with people that are versed in how to do it, rather than people that are just coming in and being emotional about what their needs are*". (Interview #12) Reciprocity from colleagues, particularly if they had also completed the training, was

important for assisting participants in applying the skills: "*So I think ... [for example] that potentially setting an agreement with the group and then going okay so in our monthly meetings let's bring in case studies and work with it as a group to do that transition of learning*". (Interview #15) Many participants raised the need for assistance in translating negotiation skills to the workplace, and in sustaining learning. Because most came from senior or managerial positions, participants were also cognizant of the difficulty of sustaining learning: "*Because we're very busy. There is nobody that works in health that isn't very busy, whether they're clinicians or managers or whatever. The problem is you go into a course, which was exceptional. It was a very good course. But it's how do you keep that fresh in people's minds without that being onerous for them, because we have competing priorities all the time*". (Interview #16)

Most participants felt that refresher training would be useful, and had strong, but quite varied (and sometimes conflicting) views on how this should be delivered: options included repeating the course every couple of years, completing an abbreviated version of the training (half to one day), and completing monthly sessions with other interested colleagues to work through specific practical problems: "*I think you'd probably get a summative effect from going back and refreshing*". (Interview #6) Participants also felt that coaching, whether in the form of a mentor, or a person to call to discuss difficult or complex situations, would be helpful and enhance learning and training transfer: "*perhaps having a mentor, I think, would be beneficial, a senior mentor that you can go to a month after training, and then maybe six months, and then maybe 12 months, so that you can discuss - keep it fresh in your mind and discuss your progress and potential issues*". (Interview #7) Although the facilitator, Michael Klug, provided his mobile number and encouraged participants to call him anytime they had problems, none of the participants had taken advantage of this offer at the time of interview. While some said that they had not needed assistance, most felt that they didn't want to waste his time and that their problems were of too little significance: "*I didn't find him intimidating, I just thought he'd be a really busy man ... I couldn't waste his time* …" (Interview #1)

Some participants felt that having a mentor, and then becoming as mentor as experience was gained, might mean that refresher training was not required: "*You might not need [refresher training] if you had that mentor to build it in and then if you became a mentor for somebody else*" (Interview #4), and "*sustainability should really be around how we then pass it on to the people around us ... we all know that when you learn something you learn it by going over it again not too long afterwards*". (Interview #10) Others felt that just having someone to call if needed was a better option than a formal mentor: "*I've never been good with the mentor concept, to be honest*". (Interview #5) Certainly, some colleagues looked to others for support as they learned the new techniques: "*Having people around that knew the resource well [would make it easy to apply the skills in the workplace] ... after I did [the training] I spent some time ... had more contact time with [an executive who had completed the training earlier, who provided a role model]*". (Interview #9) Other refresher training options included a subset of refresher training at 18-24 months, where participants could choose to refresh on technical/process issues, practical/implementation problems or both.

The need for formal discussion groups was also raised by a number of participants: "*maybe a small work group of peers ... getting together and just having a half hour or so session ...*". (Interview #5) Practice was considered to be critical for sustainability: "*the more times you practise using the template, and the more times you practise a different negotiation style, the more likely that is to start to impact on your day-to-day [work]*". (Interview #6) Participants felt that if there was more

regular discussion, the principles were more likely to be assimilated: "*I think if we ... talk about it regularly, it would stick better in my mind ... if we did use it all the time, it'd be a lot easier to put into the workplace*". (Interview #4) In general, however, participants who regularly used the tools reported that by 12 months in: "*it's becoming a more unconscious skill*". (Interview #9)

Some participants also suggested the need for advanced training, for those already versed in the basic skills but needing to work through more complex, sometimes healthcare-specific, scenarios. Some participants also felt that the training needed to be applied more widely across the health service: "*I think the knowledge and education does need to be shared broadly*". (Interview #9)

Table 3. Main themes	
Affective reactions	Word of mouth
	Participant view of the facilitator (positive and negative)
	Personal negotiating style preferences
	Spending time with colleagues
	Balancing course time and content
	Participant view of the organisation (positive)
Utility reactions	Practical negotiating skills
	Tools and templates
	Matching training to user needs (positive and negative)
Barriers	Time for preparation for negotiations
	Negotiating with other parties (QLD Health)
	Negotiating with other parties (THHS)
	Job mobility (negative)
Enablers	Provision of the Negotiation Toolkit
	Standardisation of negotiations
Work practices	Integral part of daily work
	Noticing others
	Gaining confidence
	Improved understanding of behaviour - self and others
	Preparation
	Reduced stress
	Examples of work practices
Sustainability	Few support mechanisms for translating learning
	Refresher training
	Coaching and mentors
	Formal discussion groups
	Advanced/tailored training
	Implementing training more widely

5. Discussion

In healthcare, we might imagine that decisions are made, and resources allocated, by those authorised to do so, and in accordance with a structured plan. In reality, authority gradients are flat (and sometimes reversed), and clinicians and managers frequently need to convince others over which they have no authority of the need to pursue a particular course of action. Successful work-

as-done therefore often depends on establishing a series of small or large ongoing agreements between individuals or craft groups, and negotiation skills are crucial. Despite the large variety of negotiating styles that were found among the participants in our study, the importance of negotiation in the workplace, and the need for tools and techniques to assist in negotiating successfully in everyday work, were universally accepted, and we found considerable evidence that the skills are being applied. These findings confirm what we know from the literature: i.e. that content relevance and opportunity to perform have a strong to moderate relationship with transfer of training to the workplace.[9] Utility reactions to the training were also generally positive. In a meta-analysis of 34 studies, Alliger and colleagues[10] found that utility reactions correlated with learning; utility reactions have also been found to correlate with on the job performance.[10 11]

Word of mouth was an important element of participant affect and expected utility of the training: people talked about the course, and that talk seemed to be very positive. Despite high expectations, the course was enjoyed by most participants and perceived as more engaging and participatory than other courses offered by the health service. "*I thought his training was so good. I mean I walked out of there inspired*." (Interview #1). Viral spread is perhaps more prevalent that realised in health services, and an important element facilitating change in complex adaptive systems such as healthcare.[12 13]

The two days of training was an opportunity for participants to spend time with colleagues. Some participants found this valuable for networking; others found it useful to gain a better understanding of how other parts of the hospital function. Research has found that creating cohesive collaborative networks is associated with better patient care,[14] yet it is only during training that many professionals have a chance to get to know on another: "*there was people that I met from completely different streams that I don't see on a day-to-day basis when I'm working. That I think was quite useful … It made a substantial difference to how I do business with a couple of people that I hadn't met before that*". (Interview #16)

A number of participants drew heavily on the behaviour grid, both to provide self-insight and also to enable insight into the behaviour of others. In their normal work, most participants clustered around the collaborative/compromise/avoid behaviours. Shell[5] found that clinical professionals in the health care field systematically report both less competitive and more accommodating TKI scores than do executives in more traditional businesses. In contrast, our study found that behaviour most perceived as typical of healthcare professionals – accommodating – was only favoured when participants were under stress (and, even then, by less than one third of participants). In addition, from analysis of participant responses, the TKI-based questionnaire that was delivered in the training appears to be quite context-sensitive. Despite this, questions asked about reactions in non-healthcare context are used to derive a behavior assessment that the participant is then encouraged to apply in their healthcare workplace. While the TKI is a validated instrument,[15] and the work of Lewicki et. al.[6 16] provides a link from the TKI to the behaviour grid used on course, the questionnaire used in the training appeared to be based on different questions to the TKI. It was not possible from the literature, therefore, to determine validity of the course questionnaire for use in determining negotiating style preference. For these reasons, outcomes of the questionnaire should be treated with caution. While the instrument was likely offered by the facilitator just as a tool to encourage self-insight, the assessments were accepted by many participants as fact, and used to drive judgments about self and others at work. Perhaps because many participants treated the results of the questionnaire as fact, the outcome for each participant in some cases appeared to bias their reactions to the training.

Readiness for learning is important, therefore the training should be deliberately tailored to the immediate needs of the participants or, alternately, participants encouraged to self-select onto the training based on their perceived needs. The course was not suited to everyone. Those enrolled in the training who were new to their job did not seem to gain as much benefit as other participants, possibly because utility of the material was not yet established for these participants. Self-selection into training may be a viable option with this group of professionals, as participants were generally very aware of their personal limitations and the areas where they needed to learn or practise. Given the time pressures of clinicians, there might be value in modular training, where, for example, theory delivered via didactic modules or pre-reading, is followed by face-to-face training sessions interspersed with practise implementing the ideas in the workplace. Clinicians might also benefit more than executives from tailored training, especially the inclusion of more clinically relevant scenarios and group practise (perhaps in a similar format to current simulation training). Practicing clinicians also seemed generally to be more interested in the behavioural aspects of the training when compared with executives (who seemed more interested in the negotiation processes), perhaps because they interact with greater variety of individuals in their day-to-day care of patients. Clinicians also generally had a greater focus on learning through teaching others, again perhaps because this aligns more closely with how they teach and learn technical skills and non-technical workplace behaviours. Instituting formal refresher sessions or other ongoing training strategy is important for sustaining positive changes to the way people work.

Participants kept their course notes, and many said that they intended to reflect on the material, but admitted they had not got around to it. Lack of time to reflect on the training, to prepare for negotiations, and to apply the negotiation techniques, was a large and frequently reported barrier to implementing the skills in the workplace. There is no protected 'thinking time' in the participants' day, and, even where scheduled, it can be overridden by the more overt and seemingly urgent needs of others. Even at the highest level, time use of executives seems frequently to be controlled by others.

Noticing others using the skills in the workplace provided both a revision of the principles, and also, when those observed were successful, positive reinforcement of the value of using the skills. Laminating the material for mounting on wall or desk also enabled reflection or revision on the principles, and a visual 'aide memoire' to use them. The Negotiation Toolkit, in particular, proved to be very useful, with more than half of the participants saying that they used (or referred to) at least one element of the kit when preparing for negotiations. Previous research has found that, on average only from 10%[17] to 47%[18] of what is learned in training is applied at work. Unlike many training courses, the majority of participants in the negotiation skills training appeared to have assimilated at least some of the principles into their everyday work. Even those who trained most recently talked about their attitudes to solving disagreements, involving people or resources, in ways that showed the training was taking effect. Even those who did not like the training, or think it particularly useful, reported adopting some of the principles.

Annual service agreement negotiations between THHS and QLD Health, particularly as they involve funding, can be protracted. In some cases, although participants felt that the training would be useful in preparing and conducting such high level negotiations, it turned out in hindsight to be less relevant in practice: "*We tried to put a framework around it and I believe we certainly did but the department of health had no interest really in negotiating with us.*" (Interview #1) While QLD Health advertised their commitment to the concept of negotiation, the participants felt that the

stated intent to collaborate and negotiate was little more than an aspirational goal. The attitude of the health department is a barrier to smooth relations with THHS, and has potential to adversely affect job satisfaction of THHS employees. Transfer climate has been found to have a major influence on whether training is transferred,[19-22] and participants become frustrated when provided with a skill then prevented from using it. Implementing the training in the health department, therefore, would improve utility of the training at the health service level.

Negotiation training has given participants confidence to re-raise or reopen issues that were in THHS interests, but appeared to be already closed or decided. Participants were hopeful that, with the additional skills, traction with QLD Health would be better than in previous years and better outcomes would be forged. Possession of negotiating skills has also resulted in reduced workplace stress for some participants.

Implications for the organisation

Ideally, THHS executives should ensure, when negotiating with QLD Health or other external organisations that the other party has authority to negotiate and decide on outcomes. Our findings suggest that negotiations should be face-to-face, even where this involves travel costs. There seems to be a trade off between short and long-term gains – long term gains preserve relationships, but the organisation should be willing to accept that there may be no obvious immediate outcome. Standardising the negotiation processes across THHS and implementing training (or aspects of the training) more widely is likely to assist participants in trying to adopt the skills in the workplace, including those who move between jobs or departments.

Time was identified as a major barrier to successful development of negotiation skills. Consideration should be given on whether it is possible to simplify the training process or break it into shorter modules, and time should be allocated for staff to implement the processes at work (particularly in the first few months following training).

Our findings identified a need for an organisation wide strategy underpinning the training, including formal support for translating the skills to the workplace and for on-going sustainability of learning. As one participant said, "*there needs to be a complete commitment, not only from the line manager and the employee pre, during and post, but the organisation. Because if we're going to be doing this training does this training align with where the organisation wants to go or are we just doing it for the sake of doing it?*" (Interview #15) The training and skills development should be formally aligned to other workplace key performance indicators: "… *the organisation needs to ensure that people have the skills to be able to have respectful conversations all the time*". (Interview #16)

TenCs mapping

The TenC Resilience Model is a patient safety framework emerging from a decade of clinicians and managers working together on implementation of patient safety initiatives in a large, comprehensive, regional publicly-funded health service in Northern Australia. The model allows for the recognition of performance deficits, and for compensation with other traits and behaviours. Ten frequently-observed traits are identified in this resilient system: cohesion, cognition, clear ownership, communication, competence, challenge, capture, compliance, constraints, and culture

(Table 4).

Table 4. Resilient traits in patient care	
Trait	**Description**
Cohesion	mutual respect in practice
Clear ownership	knowing what people are responsible for, accepting accountability for doing it and "closing the loop".
Constraints	situational awareness of the impact the environment has on the action required
Communication	practicing the art of receiving and giving information necessary to complete the task, listening to patients and creating value through negotiation and collaboration
Cognition	thinking, and using the right process of thought for the situation
Capture	knowing what is happening and what is coming
Challenge	courage and conviction to act
Compliance	following the rules that apply; never means never, always means always
Competence	curiosity to seek knowledge and skills, applying them with professional attitudes, understanding the role of evidence, being willing to teach others
Culture	care and compassion at the centre of everything, understanding that people's responses are learned from past and present experiences

To map findings against the TenCs Model, five interview anecdotes of workplace negotiations were sampled and analysed. To maintain confidentiality, the interview numbers of the participants that provided the anecdotes and any other identifying details, have been omitted from the narrative.

Anecdote 1 – Offender health

"We have continually gone back to the department (**Clear Ownership**) to say we think that you're wrong and we've been able to prove to them … that we have been owed … more money (**Challenge**). So just then [we looked at] the] structure of it and the ability to rejig things, rethink them and come at them from another angle (**Capture, Constraints**). … I learnt to think of it not just one way, put yourself in many shoes and which direction do you need to come at it next time if they've said no here how do you come around again and go (**Capture, Constraints, Cognition**), okay I want another crack kind of thing (**Challenge**). So I think I've done that quite well (**Clear Ownership**). Because we have received an extra [x] dollars and although they did say we were going to get additional money we had a whole lot of other evidence (**Capture**) … to say that yes that's exactly right, and we should get more as well (**Cognition, Compliance**)."

Anecdote 2 – Rural communities

"Part of my role is that we need to negotiate with communities and manage community expectations of what the health care services that we provide are (**Clear Ownership**). Recently we went out to [a rural community] and did a community meeting (**Communication**). … the community's expectations were very, very different from what we could reasonably deliver (**Capture, Constraints**). So I consider that to be a very complex negotiation around [meeting peoples' needs] - and it was quite good (**Constraints, Communication**). … some people in the community were quite spirited as was I (**Culture**) and I realised one way - very early on was and realised [my ideal] option was going to be and where we wanted to land (**Cognition**) and use some of the strategies that Michael had given us to reach that end (**Compliance, Competence**). … I managed [the other party's] expectation (**Communication, Constraints**) and got to the point

where we managed some alternatives (**Competence, Constraints**) rather than just oh yeah, sure, we'll take that on board and we'll go and run with it, which I think is the way that - how organisation works sometimes (**Culture**), that we go oh yeah, sure, put in a business case and I'll take it somewhere and drop in to you on the way out the door; whereas I found that negotiation in a very public forum quite challenging to manage (**Challenge**) [the other party's] and the community's expectations to reach an end point where they were happy and we were happy (**Cohesion**)."

Anecdote 3 – Patient flow

"Just today we were negotiating … for an admission of some patients. Staffing's down, so the pressure from them to admit these patients, we don't have enough staff (**Constraints**), we didn't have the beds or suitable beds (**Constraints**), so we were negotiating when to admit people (**Communication**) so we came out with - because they wanted to admit two patients today that required one-on-one care (**Constraints**). It wasn't able to be done (**Cognition, Constraints**), so we negotiated (**Communication**) and got one in today and maybe one in a couple of days when the staffing is better (**Capture, Cognition**). … So, some of it was go in with everything (**Challenge**) and then you just pull back (**Competence, Cognition**). So, you end up with a win-win (**Cohesion**) so you don't have the win-lose."

Anecdote 4 – External relationships

"The difficult negotiations that I have to deal with are often from outside. So I'll be dealing with another health service group, and their walk-away position, as Michael would put it, is oh well, screw Townsville, basically, we don't care. So … it's a much more difficult relationship when trying to negotiate for new resources for the region and to say right, the money needs to come to Townsville because that's [where most of the work is done], because no one wants that. In the past I've had negotiations. We've tried to do them by telehealth and things because it's easier to get people in a room or by telephone. It's hopeless. It's a waste of everyone's time, quite honestly. One of the things I took away from that course … is when we are in further negotiations we will go (**Constraints, Challenge**). We will go or they will come, one of the two. You've got far more immediacy in terms of picking up body language (**Capture, Communication**), which is a very, very quick thing. Actually, even the slight delay on telehealth makes a big difference to that (**Constraints**). You can sense the mood in a room a lot quicker (**Capture, Communication**). Just the simple things of having a cup of coffee with someone and saying hello first before you get down to the nitty gritty. These are all really integral to our relationships with people (**Culture**). You can't do it via telehealth (**Constraints**) ... Also people aren't invested in that meeting [if you don't make the effort to go to them] (**Clear Ownership**). If you fly up for it they feel reciprocal (**Cohesion**). The law of reciprocity exists. They think oh, he's come all this way, he's shown good faith, okay, we'll cut him some slack (**Cohesion**). I just think, often, in health care - and not so much in other businesses, I suspect - we cut corners because we're time limited ourselves (**Constraints**). We don't want to go … to Cairns to have a meeting. I don't want to go to Mackay to have a meeting. I definitely don't want to go to Mount Isa to have a meeting. I think there's a reason that people in the real world - not in hospitals and not in Government - but I mean the real world where people make real money and do real jobs - the reason why they spend so much time flying around is because it works. It's as simple as that. I do think sometimes we've got to accept that we're moving - I think health care's moving to a much more real world environment in terms of funding, and we're going to have to respond to those challenges and become much more worldly in the way we deal with each other (**Clear Ownership**)."

Anecdote 5 - Interdepartmental working

"I was in [a meeting] and the [x] director was quite vocal in the fact that he didn't agree with the expected outcome [of a report] and he wanted it changed, and I had to say I can't change it because that's the team's expected outcome (**Clear ownership, Challenge**). That stands. You can write a note if you disagree. You get to write the action. We can tweak the action. We basically agreed to disagree in the meeting and then I caught up with him the next day and explained to him where I was coming from (**Communication**), and the fact that we have to honour the team's report to keep the integrity and validity of that (**Clear Ownership**) and also in respect to them, otherwise next time you ask them to be involved they go why would I bother (**Culture**). But I also gave him an opportunity to explain where he was coming from (**Cohesion, Communication**), and he'd had a rough day before our meeting and so had I (**Constraints**). So I guess it was about recognising that we couldn't leave it like it was (**Cognition**). …We talked about it the next day (**Communication**) … He understood. I understood. We talked through it and basically we ended up with a win/win (**Cohesion, Communication**). … So it was about taking it away to a different time when the emotion had passed (**Cognition**) … it was about building bridges and what have you (**Cohesion, Culture**)."

Limitations

Limitations of this study are that the data are self-reported, with all the attendant biases. In addition, participant views of the facilitator were polarised, with the majority displaying an intensely positive affective reaction, and this 'halo' effect [23] may have coloured their assessment of the training and its efficacy. The nature of the interview encouraged participants to report where they had used the training, and is therefore likely to have had a positive bias on the number of reported examples. The TenCs analysis mapping was limited to anecdotes where participants were able to be de-identified. A number of interviewees described negotiations involving human resources situations; while these negotiations broadly involved the same processes and similar stories of win-win successes as the negotiations around other topics, they have not been included in this report to protect identity of participants.

6. Conclusion

The qualitative evaluation of the Negotiation Skills Training at THHS found that participants generally valued the training and were applying the principles in the workplace. Six primary themes - affective reactions, utility reactions, barriers to implementation, enablers for translation, work practices, and sustainability - and 28 sub-themes emerged from the analysis. Implications for THHS included recognition of constraints when negotiating with external organisation such as QLD Health, identification of time as a major barrier to implementation of the new skills, and the importance of an organisation wide strategy underpinning the training. Six overarching recommendations were identified for action. Interviewing more than a quarter of participants, including participants who had completed training both recently and between 9-15 months previously, and randomly selecting those for interview from a stratified sample, all contributed to high confidence that our findings are valid.

7. Recommendations

Based on our evaluation, six overarching recommendations have been formulated in terms of advice for the THHS leadership team:

Recommendation 1. Create opportunities for colleagues to communicate and collaborate.

1.4 Create processes for 'spreading the word' to improve implementation and uptake of new ideas.
1.5 Create cohesive collaborative networks to facilitate improved patient care.
1.6 Conduct negotiations face-to-face.

Recommendation 2. Provide flexible training options.

2.6 Open training to more staff.
2.7 Develop modular training.
2.8 Allow participants to self select onto training courses, depending on their perceived needs.
2.9 Tailor the training, including role-plays and discussion topics – this is especially important for clinicians.
2.10 Provide pre-reading or reference material.

Recommendation 3. Provide negotiation tools.

3.2 Provide easy access to the Negotiation Toolkit, specifically the 7 Elements of Negotiation Scoresheet, the Negotiation Worksheet, the Golden Rules, and the Behaviour Grid.

Recommendation 4. Create opportunities for translation.

4.5 Provide quarantined time to prepare for negotiations.
4.6 Create expectations that staff will negotiate (between and across levels) and authority to do so.
4.7 Consider standardising basic negotiation processes.
4.8 Reward those who negotiate successfully for win-win outcomes.

Recommendation 5. Explore opportunities to embed negotiation in QLD Health.

5.2 Approach QLD Health at an executive level to formally agree that both THHS and QLD Health will only enter into negotiations with parties that have appropriate fiscal, or other, decision making authority.

Recommendation 6. Address longer term sustainability.

6.5 Develop an organisation wide strategy underpinning negotiation skills training.
6.6 Provide opportunities for practise, refresher training, formal and informal discussion groups, mentoring, and access to expert advice.

6.7 Consider developing advanced training for those involved in more complex negotiations.
6.8 Formally align negotiation training and skills to other workplace key performance indicators.

8. Dissemination of Results

The findings will be disseminated via a formal report to the funding body, and via peer reviewed publications and conferences. The results of this project have been accepted for presentation at the Healthcare Ergonomics and Patient Safety HEPS 2016 Conference in Toulouse, France, October 2016. Results will also be reported locally at the Townsville Hospital and Health Service Research Week Symposium in 2016.

9. Ethical considerations

Ethics board approval for the study was obtained from the Townsville Hospital and Health Service Human Research Ethics Committee (HREC/15/QTHS/219) and the Macquarie University Human Research Ethics Committee (MQ 5201600280). Specific Site Assessment approval for the study was obtained from the Townsville Hospital and Health Service Research Governance Office (SSA/16/QTHS/32). The study was funded by a small grant from the Townsville Hospital and Health Service Research Trust Fund; the funding body had no role in the conduct or reporting of the study.

There was negligible risk of harm to study participants, and the interview questions were not considered to be controversial or overly intrusive. All data were de-identified on analysis, and electronic data will be securely stored on password protected computers, accessible only by the named Macquarie University researchers. Paper consent forms, and paper files, will be stored in a locked cabinet at 75 Talavera Rd, Macquarie University, 2109.

10. Acronyms

We have tried to minimise the use of acronyms in this report. The full terms associated with acronyms in this report are in Table 5.

Table 5. Acronyms

Acronyms	Full Term
AIHI	Australian Institute of Health Innovation
ED	Emergency Department
HREC	Human Research Ethics Committee
ICU	Intensive Care Unit
QLD	Queensland
THHS	Townsville Hospital and Health Service
TKI	Thomas-Kilmann Conflict Mode Instrument

11. References

1. Anastakis DJ. Negotiation skills for physicians. The American Journal of Surgery 2003;**185**(1):74-78.
2. ElShenawy E. Does negotiation training improve negotiators' performance? Journal of European Industrial Training 2010;**34**(3):192-210.
3. Coleman PT, Lim YYJ. A Systematic Approach to Evaluating the Effects of Collaborative Negotiation Training on Individuals and Groups. Negotiation Journal 2001;**17**(4):363-92.
4. Kilmann RH, Thomas KW. Developing a forced-choice measure of conflict-handling behavior: The" MODE" instrument. Educational and Psychological Measurement 1977;**37**(2):309-25.
5. Shell GR. Teaching Ideas: Bargaining Styles and Negotiation: The Thomas-Kilmann Conflict Mode Instrument in Negotiation Training. Negotiation Journal 2001;**17**(2):155-74.
6. Lewicki RJ, Hiam A. *Mastering business negotiation: a working guide to making deals and resolving conflict*. San Francisco, US: Jossey-Bass Publishing, 2006.
7. Mellman D, Dauer EA. Negotiation: the CMO's indispensable skill. Physician Executive 2007;**33**(4):48-51.
8. Lane P, Clay-Williams R, Johnson A. The TenCs Model: a case from Townsville Australia. 4th Resilient Health Care International Symposium. 11-13 August, Sydney, Australia, 2015.
9. Burke LA, Hutchins HM. Training transfer: An integrative literature review. Human Resource Development Review 2007;**6**(3):263-96.
10. Alliger GM, Tannenbaum SI, Bennett W, et al. A meta-analysis of the relations among training criteria. Personnel Psychology 1997;**50**(2):341-58.
11. Ruona WEA, Leimbach M, Holton EFI, et al. The relationship between learner utility reactions and predicted learning transfer among trainees. International Journal of Training & Development 2002;**6**(4):218-28.
12. Braithwaite J, Clay-Williams R, Nugus P, et al. Health care as a complex adaptive system. In: Hollnagel E, Braithwaite J, Wears R, eds. *Resilient health care*. Surrey, UK: Ashgate Publishing Limited, 2013.
13. Clay-Williams R. Restructuring and the resilient organisation: implications for health care. In: Hollnagel E, Braithwaite J, Wears R, eds. *Resilient health care*. Surrey, UK: Ashgate Publishing Limited, 2013.
14. Cunningham FC, Ranmuthugala G, Plumb J, et al. Health professional networks as a vector for improving healthcare quality and safety: a systematic review. BMJ Quality & Safety 2012;**21**(3):239-49.
15. Thomas KW. *Thomas-Kilmann conflict mode instrument*: Xicom Tuxedo, NY, 1974.
16. Lewicki RJ, Hiam A. The flexibility of the master negotiator. Global Business and Organizational Excellence 2007;**26**(2):25-36.
17. Fitzpatrick R. The strange case of the transfer of training estimate. The Industrial-Organizational Psychologist 2001;**39**(2):18-19.
18. Saks AM, Belcourt M. An investigation of training activities and transfer of training in organizations. Human Resource Management 2006;**45**(4):629-48.
19. Goldstein IL, Ford JK. *Training in organizations: needs assessment, development, and evaluation*. 4th ed. Belmont, CA: Wadsworth, 2002.
20. Rouiller JZ, Goldstein IL. The relationship between organizational transfer climate and positive transfer of training. Human Resource Development Quarterly 1993;**4**(4):377-90.
21. Tracey JB, Tannenbaum SI, Kavanagh MJ. Applying trained skills on the job: the importance of the work environment. Journal of Applied Psychology 1995;**80**(2):239-52.
22. Warr P, Allan C, Birdi K. Predicting three levels of training outcome. Journal of Occupational and Organizational Psychology 1999;**72**:351.
23. Nisbett RE, Wilson TD. The halo effect: Evidence for unconscious alteration of judgments.

Journal of Personality and Social Psychology 1977;**35**(4):250.