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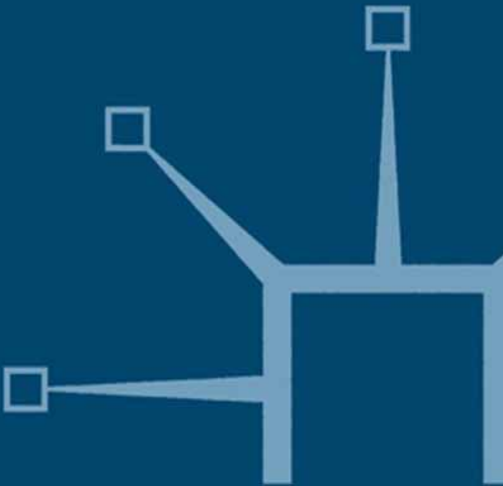
The Reform of Health Care

Shaping, Adapting and Resisting Policy Developments

Helen Dickinson

Russell Mannion



The Reform of Health Care

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Helen Dickinson and Russell Mannion
THE REFORM OF HEALTH CARE

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Shaping, Adapting and Resisting Policy Developments

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Acknowledgements

We would like to acknowledge all of the participants of the 7th Biennial Conference on Organisational Behaviour in Health Care, held in Birmingham in April 2010. The editors would also like to extend their gratitude to all those involved in the organisation of the conference, particularly Tracey Gray, Alana Clogan, Sue McLean and Ingrid Leeman who worked hard to make sure that we had a very successful conference.

Preface

This preface to the seventh book in the *Organisational Behaviour in Healthcare* series brings together papers from the conference held in Birmingham UK in April 2010. The subject matter of the conference and this book is a departure from the previous focus on the academic issues of concern to the discipline, such as power, leadership or culture, and turns instead towards issues of process. In particular what has been termed the implementation gap. The book concerns itself therefore, with the how more than the why, and in keeping with the innovative practitioner day at the conference, may therefore have a wider appeal to the practice community.

The academic role of this perspective however must not be underestimated, as it connects two communities – academic and practitioner – in ways which will provide insight into what impact academic work in the field can have, through the lenses of analysis, implementation and evaluation. Where this work changes future perspectives for both academic and practice communities it will demonstrate the impact that is now an increasing requirement to both justify academic work and practitioner developments.

The contributors to this edition provide insights from across the world, drawing attention to matters of shared concern as well as to the differences that cultural, geographical and political contexts can bring. The reasons for change set out in these chapters do however still focus on what are developed, rather than developing, world contexts, and given the speed of change we now see in for example China, as well as the instability experienced in some regions of the world, we know it is important to remember that health care is fundamental to the future of individuals, their communities and the societies in which they live. The starting point for this is the development of capacity in health provision, a basic component of which is the subject of our next conference in Dublin in 2012 – *Patient centred health care teams: achieving collaboration, communication and care*. Team working is such a fundamental part of health provision because no one individual in health can provide all the answers or represent all the views (Mark and Jones 2006) but as the conference title suggests the patient must be integral to this process. While governments around the world wrestle with financial constraints, and differing policy directions, the provision of treatment and care continues. Where policy direction is counterproductive to this process, as we have seen from the Birmingham conference contributions, individuals and groups will find ways to enable healthcare provision to continue.

Annabelle Mark
Series Editor
Middlesex University London
26th April 2011

Reference

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Introduction

Helen Dickinson and Russell Mannion

The first few months of 2010 were the coldest that the UK had experienced in 30 years. Heavy snow had covered many areas and had brought the country to a standstill. Then in early April the snow thawed as the sun came out to welcome the delegates to the 7th Biennial in Organisational Behaviour in Health Care (OBHC) conference, held in the pleasant environs of the University of Birmingham's Edgbaston campus. This conference is a key meeting for members of the Society for the Study of Organising Health Care (SHOC) and was highly successful, attracting over 150 academics and practitioners from across the globe with an interest in understanding heath care organisations and change. The title of the conference was '*Mind the Gap: policy and practice in the reform of healthcare*'. Visiting academics were invited to share their expertise, and present and discuss papers that explored how health care organisations shape, adapt and resist developments in health care policy and practice.

The topic was chosen as it was thought that it would encourage the participation of a range of different stakeholder groups, all of whom have a legitimate interest in the policy, practice and reform of health care. The conference clearly struck a chord with not only an academic audience, but also attracted a number of health care practitioners. As an innovation for this conference, an additional practitioner-focused day complemented the two days of academic debate; this was attended by senior managers and clinicians from the English NHS. This was important in providing a platform for the investigation of issues concerning the policy/practice 'gap' in health care. The conference was well attended and saw over 80 papers presented in addition to lively roundtable and panel discussions and three fascinating plenary sessions from distinguished keynote speakers: Professor Michael West from Aston Business School; Dr Peter Hupe from Erasmus University, Rotterdam; and Ben Page, from Ipsos MORI.

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This book serves as a historical record of some of the best papers at the conference and presents an opportunity to advance the concepts surrounding policy and practice. The intention is to provide a showcase for international research about the policy/practice 'gap', which we hope will continue the fruitful debates and discussions started at the Conference and which should help move critical academic thinking forward.

The 'implementation gap' is a phrase which is often used to refer to the difference between what a particular policy promises and what is delivered in practice. This gap (or deficit as it is sometimes called) is both puzzling and challenging to practitioners and researchers alike. It has provoked lively debates of late, partly as a consequence of the rise of movements in evidence-based policy, practice and medicine. In more recent years discussions have moved beyond the rather simplistic top-down vs. bottom-up debates that have traditionally characterised this area of study to consider a range of issues at the policy/practice interface in a more critical, complex and dynamic way. This book is testament to this sort of thinking and many of the chapters problematise the notion of this interface and the multifarious factors that might impact on the formation of policy and its realisation in practice. Policy implementation is more than simply a technical exercise and this is illustrated clearly throughout the structure of the book and the chapters that it incorporates.

The chapters contained in Section 1 of the book take a critical perspective on the role of professionals in implementing policy. The health sector has long been characterised as being, in the words of Mintzberg (1979), a professional bureaucracy, where professionals have a high degree of autonomy and control over the types of activities that they engage in. Although in many areas of the world reform processes are underway in an attempt to standardise the practice of health professionals, it is still well established that the ways in which professionals respond to policies and reforms can have a profound influence over the degree to which these are implemented and whether or not these will prove to be successful in practice. Therefore the focus of this section is on the actions of a range of different professionals in response to a variety of reform initiatives. The first group studied in this section is that of middle managers, an often forgotten group, but one which is crucial in the coordination of complex reform processes as they serve as the link between strategic policy and front-line service delivery (Chapter 1). The next chapter stays with the role of managers but moves on to consider the role of policy in shaping the psychological contract between employees and their organisations (Chapter 2). The conclusion reached is that a better understanding of the role of managers in the development of the psychological contract and policy can enhance practice. The next chapter moves on to consider the role of autonomy in health care practice (Chapter 3) and investigates the degree to which this is a reality and the degree to which professionals really have freedom to act. Staying with medical professionals the next chapters consider the roles that clinicians play in decision-making (Chapter 4) and a cross-European study of the quality of working life for doctors (Chapter 5).

Section 2 explores in more depth the role of culture and institutions in the implementation of policy. A number of the key themes in this section continue some of the debates and discussions first started at OBHC 2008 which was hosted in Sydney and focused on the theme of culture and climate in health care organisations. These chapters re-iterate the impact that micro-level forces of identity and culture have on the processes of policy implementation. The first chapter in this section considers the role of culture and identity in the merger of health care organisations (Chapter 6). Collaboration has, in a number of countries, been an important feature to the backdrop to reform processes in recent years and the next chapter considers the role of network forms in the governance of health care reform (Chapter 7). This chapter looks at the performance of networks and the degree to which they are effective, particularly drawing attention to the role they play in organisational learning and engaging clinicians in reform processes. The next chapter moves on to consider discourse, focusing on how different underlying meanings of innovation are discursively enacted in health policies across different institutional and political contexts (Chapter 8). The final chapter in this section investigates the types of discourses that have emerged with regard to an important contemporary policy issue; patient safety (Chapter 9).

Section 3 presents a series of chapters that provide a fresh empirical perspective on the issues of implementation and reform in practice. Addicott and Frosini employ Archetype theory to assess whether the Foundation Trust policy has been achieved in practice in English hospitals. Peter Nugus and colleagues employ ethnographic approaches in a case study of the treatment of vulnerable patients in emergency departments. Oswald and McEldowney reflect on 20 years of health reform in the Czech Republic, focusing particularly on health care professionals and their feelings about these reform processes. Debono and colleagues analyse the use of workarounds and the degree to which they widen or straddle gaps in the delivery of health care. Casebeer and

Reay provide an in-depth look into the degree to which primary health care reform in Canada has succeeded in response to quite a broad and non-specific policy demand. The book concludes with a chapter from Pilbeam and Buchanan that investigates the management of infection in a hospital and associated change processes following a crisis event.

Taken together the chapters contained within this collection represent work by a number of scholars from diverse theoretical and disciplinary backgrounds and working in a range of international settings and health systems across the world. These chapters demonstrate a wide range of theoretical perspectives from identity theories (Chapter 1; Chapter 6) through discourse analysis (Chapter 8) and symbolic interactionalism (Chapter 11). The methods employed illustrate a wide range of approaches incorporating ethnographic data collection, focus groups, interviews, large scale questionnaires, observation and documentary analysis. The case studies and the settings that the research has undertaken reflect the many different kinds of systems around the world and the diverse range of stakeholders that influence health care reform. They each provide rich empirical insight on the importance of understanding the policy/practice interface and the operation of reform processes in practice.

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Section 1

The Role of Professionals in Implementing Policy

1

The Lost Health Service Tribe: In Search of Middle Managers

Paula Hyde, Edward Granter, Leo McCann and John Hassard

Introduction

> *The Government will reduce NHS management costs by* ***more than 45%*** *over the next four years*
>
> (DH 2010: 5, our emphasis)

This chapter suggests potential consequences for the NHS of widespread denigration of middle management. It is based on ethnographic research in the UK NHS. In 1994 Tony Watson published *In search of management*, continuing an academic preoccupation with elaborating the lived experience of being a manager. This chapter derives from the opening phases of a study in this tradition. He argued that managers, in shaping their own identities, also shaped organisational work activities and we extend this argument to demonstrate that negative associations to middle managerial identity have the potential to allow for strategic gaps in co-ordination at the middle reaches of NHS organisations as managers have to handle increasingly complex, fluid and heavy workloads, while facing daily challenges from other NHS stakeholders.

Although middle managers are important to large organisations because of the role they play in co-ordinating activity between the upper and lower organisational reaches and across various departments, they appear to be one of the undisputed and less contentious targets of UK Government reforms (DH 2010). These reforms come almost 30 years on from the introduction of general management in the 1980s and bring NHS policy almost full circle. In the time before 'managers', hospital decisions were said to be made by 'consensus management' between administrators and clinical staff (Merali 2003: 549) in something resembling a

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feudal system (Day and Klein 1983). Several attempts had been made to strengthen hospital management and to reduce the supposed waste associated with consensus management. However, the introduction of management to the NHS is commonly linked to the Thatcher government, which instigated the 1983 NHS management inquiry by Sir Roy Griffiths (Deputy Chairman and Managing Director, Sainsbury). Antagonism towards management in the NHS dates back to this time as professional staff objected to the imposition of supermarket management ideas. Essentially, Griffiths, struck by the lack of clear lines of management authority and leadership, proposed the introduction of general managers to every level of the NHS from the Department of Health down to individual units or hospitals. These managers would have overall responsibility for services and for leadership in making services more efficient. Thirty years later, and following a rapid increase in numbers, managers and excessive management costs are blamed for health service inefficiencies (DH 2010).

Alvin Gouldner (1957) noted differences in role titles and underlying preferences that affected behaviour. These differences have some relevance to this consideration of middle management in health services, as they focus attention on tacit and explicit aspects of managerial roles and identities. Gouldner distinguished between the manifest roles attributed to organisational members and latent roles or identities. Manifest roles were broadly described in job titles. Latent identities drew on underlying values, beliefs and loyalties and influenced organisational behaviour. Differences in latent roles were argued to account for differences in behaviour or belief amongst those in similar manifest positions. They also offered some insight into intergroup conflict. The primary distinction was between cosmopolitans and locals. 'Cosmopolitans' were committed to a professional career transcending organisational boundaries, whereas 'locals' were committed mostly to an organisational career. We revisit these ideas with reference to middle managers to illustrate how competing latent identities can illuminate important and varied work of middle managers. Thus, we provide an account of how middle managers defined their work identities and how their work identities were constructed around them with consequent implications for the organisation of work.

Policy reform and management

Since the introduction of general management to the NHS, the total number of health managers has grown steadily. As a result, NHS managers account for approximately 3 per cent of the total health workforce with numbers increasing by over 12 per cent between 2008 and 2009 (NHS Information Centre 2010). Although this appears to represent a massive increase, proportions of managers in the NHS do not exceed those in most other developed countries (World Health Organisation 2006). In the NHS, managerial roles have extended as responsibilities have been delegated, staff have attained managerial titles (see Hassard et al 2009) and HRM responsibilities have been devolved (Hyde 2010; McConville 2006).

In all likelihood, managerial numbers will decrease in subsequent years as middle managers are targeted in health reforms aimed at reducing management costs. This comes at a time when effective organisational co-ordination will be central to maintaining safety during a period of reduced investment. The reforms introduced in 2010 intend to improve efficiencies by removing around half of these managers. Indeed, the subtitle of the reform document *Liberating the NHS* suggests freeing the NHS from bureaucratic management. There has been little reaction to the proposed cuts in management costs. Indeed, the removal of large numbers of middle managers follows recent trends in other industries (Hassard et al 2009). We suggest that there has been little objection to these reforms because of the popular stereotype of middle managers as petty bureaucrats. Moreover, we show how middle managers themselves do not identify with the 'middle management' part of their role and as a consequence, the title 'manager' has been relegated. It is falling out of use leaving 'middle management' as an identity no-one wants. It may come as no surprise then to find that middle managers are an easy target. We found that there was no standardisation of role titles and few people with managerial responsibility carried the title manager. Middle managers were other people who could be blamed for organisational difficulties and failures have been attributed to this imaginary group of people.

Research design

This work is the result of part of a longitudinal study examining roles and behaviours of middle managers in the NHS. The study is broadly ethnographic as '*it involves the ethnographer participating in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions: in fact collecting what ever data is available to throw light on the issues that are the focus of the research*' (Harrison and Ahmad 2000: 131). The study materials included 20 semi-structured interviews with managers, executives and policy-makers of about

60 minutes duration which were recorded digitally before being transcribed in full and subjected to analysis. Thirteen people with a middle management role (clinical managers, including doctors and nurses, and human resource managers). Five senior managers and two policy-makers were interviewed. The interview data was supplemented by eight full days spent shadowing middle managers including attendance at a series of management meetings, two days at service improvement events and two days of management development workshops. These data were captured in handwritten notes made at the time which enabled the researchers to develop a rich ongoing understanding of the realities of working life for middle managers. Statements referring to managerial work were noted in full where possible. This paper focuses on middle manager identities and their consequences for organisational functioning.

Middle managers are other people

> *Non-clinical people who are managers are middle managers …Certainly there's a hierarchy of management and it's much more powerfully obvious in nursing because they're used to such a tight hierarchy. And that's where you see middle managers in abundance. But there are middle managers in finance departments and human resource departments, in pathology departments. And physiotherapy there will be staff who you could classify as middle managers. From the medical point of view we're all consultants at the top and I would argue, and many others would argue that the consultant is a manager, because he has to manage his team of people. And he has to manage his workload. Many doctors don't quite understand that. But they're not middle managers.*
>
> (Consultant, Acute Hospital)

Middle managers were consistently identified as other people. The doctor/manager in the quote above clearly identified other managers as middle managers and this was a common finding. The middle managerial role was associated with sitting in a hierarchy and being controlled and this doctor was clear that whilst a doctor might manage they were definitely not middle managers. Most participants did not identify themselves as having more than a minor middle management role.

At the start of this project we invited a group of NHS middle managers from a number of disciplinary backgrounds and NHS organisational types to attend a meeting. Whilst willing to come along, many told us that they weren't middle managers. Moreover, during the day, when a senior representative of an NHS Managers' Association referred to middle managers as '*dross*' ('*there's a whole cadre of dross out there*') no-one took offence nor challenged the statement. There seemed to be a tacit acceptance that middle managers, out there, were not very good at their job.

Middle managers, in particular, have long been subject to negative appraisals in the popular and academic press (Mills 1953; Whyte 1960) with concurrent effects on their self image (Clarke et al 2009; Merali 2003) and their ability to make strategic contributions (Currie and Proctor 2005). On the whole, this view has gone largely unchallenged with only a small number of commentators identifying positive features of middle managerial work (Hassard et al 2009; Huy 2001). As a result it has been noted that managers, generally, are adopting new titles (Brocklehurst et al 2009). This reluctance to identify with the managerial role has, we argue, potential consequences for organisational functioning.

In the NHS, managers have also experienced considerable negative attention. They experienced difficult relationships, not least, with doctors (Davies and Harrison 2003) and between business and clinical managers (Hyde 2010). Managers are associated with business expertise whereas clinicians associate with public service values. We found that this ideological conflict between management and clinical cultures affected managerial identity to the extent that, where possible, middle managers drew upon their professional affiliation in preference to their managerial identity. In the absence of an alternative professional role managers emphasised their seniority, so, rather than being 'middle' managers they were 'more senior than that'.

Middle managers have been defined as 'any managers two levels below the CEO and one level above line workers and professionals' (Huy 2001: 73). In addition to general managers, there are a growing group of middle managers in health services: hybrid professional-managers (Fitzgerald et al 2006). Public and private sector middle management are said to diverge, for example, with professional identity and technical specialism being predominant in public sector organisations (Dopson et al 1992: 52). It has been suggested that there is no real satisfactory definition for standard seniority in the NHS (Dopson and Stewart 1990). Nevertheless, the following ranking which has been used in similar studies was also used here: junior managers are those responsible for staff but do not have managers reporting to them. Middle managers are those managers who have at least one manager reporting to them. Senior managers are those in charge of a function across the Trust (Merali 2003; Preston and Loan-Clarke 2000).

On the whole, people we identified as middle managers in this study did not identify themselves as such. Instead, they either identified along professional or hierarchical lines. Professional affiliation was chosen in preference to managerial identity; 'I am a nurse who also manages' or 'I'm not a middle manager I am more senior than that'. Being called a 'middle manager' seemed to imply an insult. This dislike for the term seemed to play out in the way work was done, with clinical professionals, for example, answering to more than one master and acting in middle, junior and senior roles in the organisation in various parts of their work.

Rather than drawing on simplified stereotypes, managers have been shown to draw on mutually antagonistic discourses in constructing identity narratives that are both fluid and fragmented and which emphasise their identity as moral beings (Clarke et al 2009). We also found that, rather than occupying a simple role in the organisational hierarchy, middle managers enacted highly varied roles involving other professional skills and responsibilities and they operated at various levels of the organisational hierarchy. In the middle reaches of NHS organisations services are generally managed between a triad of senior doctor, nurse and business manager and resistance to 'management' remains. Middle managers in the NHS are made up of a mixture of tribes and allegiances. These tribes, rather than relating to professional grouping alone, drew upon career trajectory and organisational mobility for their role identity.

The lost tribe: Mythical middle managers

> *People talk of the lost tribes don't they? And I think one of the lost tribes could easily be that middle manager group…I get a range of comments when I go out into the service – enthusiasm, anger; people saying 'you've no idea what it's like.'*
>
> (Senior Civil Servant, Department of Health)

Middle managers in health care have been described as barbarians, an invading mob doing damage to health care work:

> *…respondents used the survey to rid themselves of a great deal of aggression and distress they seemed to feel about NHS managers. They gave the impression of being conquered peoples of a once great civilisation, suffering the indignities and authoritarian brutalities of a barbarian, occupying power.*
>
> (McCartney et al 1993: 55 in Learmonth 2003: 15)

On the one hand, only one person in our study admitted to being a middle manager with the *caveat* that they were mainly a nurse. On the other hand, many others (who we might argue are middle managers) talked of middle managers as 'others' in the organisation either in different areas of work or above/below them. Most often participants were not referring to particular people but to others, elsewhere in the organisation, who were to some extent superfluous.

The term 'middle manager' has been used to denote a particular sort of person and set of actions – someone stuck in their role with limited hopes of progression, with few managerial skills and little managerial ability. The stereotype suggests a person who slavishly dotes on paperwork and petty rule enforcement. These portrayals of middle managers as barely competent scapegoats are common in popular management writing where middle managers are criticised, for example, as obstructive and afraid of change (see Handy 1995; Peters 1992; Kanter 1989). It is not so surprising then that middle managers, wanting to disassociate with these negative features of the identity, redefined their own roles along professional or hierarchical lines to cast themselves outside the lowly middle managerial tribe.

However, rather than being limited to one particular stereotype, it was notable that descriptions of middle managers had specific, if at times, oppositional features as described below.

> *A repository for those who can't do it in industry. It's a safe culture. There is no real performance management* (Research and development manager)
>
> *Often people who get sucked into there and don't necessarily have the skills* (Matron)
>
> *Clinicians with an opinion but no management experience* (Operations manager)
>
> *… never been exposed to a full blown business world and therefore finding it a little bit tough in something that's got a quasi market running through it that requires skills around marketing and sales* (Service director)
>
> *People just get on with the day job and don't look outwards… have just been getting on with the usual paper chase and haven't actually been watching the environment the world around them change* (Human resources business manager)

These descriptions did not relate to specific organisational members, rather, they referred to a mythical group of people with different characteristics – the outsider who cannot make it in the private sector, clinicians promoted above their ability, people who were insular and/or procedural. We draw attention to the function of this denigration for organisations in limiting serious review of strategy at the expense of 'middle management'. We argue that the real reasons for poor performance may be overlooked as 'middle managers' can be blamed. We speculated that middle managers formed a mythical or fantasy group of others on which blame could be laid for poor performance.

Middle management in action

Our study suggested that broadly speaking, middle managers formed more than one tribe with different cultures and social norms and having something in common with Alvin Gouldner's subsets of cosmopolitans and locals (Gouldner 1968). They were a varied group of people with similar manifest role titles – 'service director' 'business manager', but with differing latent identities – underlying values and attitudes that directed their work. The following vignettes describe contrasting latent identities of middle managers. They also indicate a range of organisational functions middle managers fulfil.

'Locals' included the following groups; firstly, those who identified with the ideology of the organisation and were committed to community agreements and focused on maintaining internal organisational cohesion and consensus. For example, a business manager who had worked for an Acute hospital for over 20 years and had moved from nursing into an operational management role. She described how she managed her service by drawing on the expertise of doctors' private practice in reclaiming the cost of NHS operations. She worked in a triad management system seeking consensus and drawing on business management ideas where they were useful to improve efficiencies. This did not gain much organisational acclaim. This manager had progressed slowly through the middle ranks and focused on enabling effective departmental functioning.

Secondly, there were those who were loyal to the place itself rather than distinctive values and who sought to adjust organisational values to those of the immediate environment to avoid external criticism and preserve the security of the organisation. This was achieved by more authoritarian and formal regulations to control behaviour. For example, a research and development manager had entered the NHS from the private sector and was concerned with regulation and ensuring good external appraisals through increased formal controls. These managers sought to protect the organisation from external threats.

Thirdly, there were a group of long term middle managers who had survived many reorganisations and continued to fulfil an administrative managerial role. Often in the lower middle reaches, these managers were of long-standing, for example an information manager who had remained within similar departments despite much reorganisation. She had many contacts across the organisation. These managers provided continuity for newer organisational members and had phenomenal informal networks.

In contrast, 'Cosmopolitans' included those who had little integration in either the formal or informal organisational structure. They had little loyalty to the organisation and little intention to stay. They were highly committed to their specialist skills and to their rating by external specialists. This group of managers included those on a sojourn from the civil service, private industry and management trainees who were gaining some 'hands on' experience before progressing to senior ranks as well as doctors developing a specialist reputation. These managers brought ideas from the outside and were able to improve the organisation's status with external bodies.

Each of these managerial types fulfilled different roles. A small number of other commentators have pointed to the positive contributions of middle managers. For example, Huy (2001) argued that middle managers are highly skilled, knowledgeable and committed workers with wide networks of contacts within and outside the organisation and a thin strand of strategic management literature points to the strategic contributions middle managers could and should make (Currie and Proctor 2005).

Rather than dividing along professional lines, our middle managers viewed managers with oppositional latent identities as having undesirable characteristics. For example, managers of long-standing dismissed those who were on fast-track schemes, who perhaps brought in external management ideas. It would be possible to categorise the managers in this study along these lines. The locals including a dedicated group, largely nurses, who were used to hierarchical line management, not averse to new business ideas as a means of improving efficiency and much of their work involved bringing different people together to get work done. There were other locals, those who focused on ensuring patient safety through regulation and risk management. In contrast, the cosmopolitans brought in business ideology working to establish superiority with little real power but bureaucratic backing. This distinction in latent identities refines previous analysis of managerial conflict in the NHS to date by identifying various vital organisational contributions.

The rise and fall of NHS management

Although we found that managerial titles were falling out of favour, managers in the middle reaches of the organisation were fulfilling important managerial roles described in the section above. The original aim of introducing general managers to the NHS was to develop a more powerful group of managers as 'strategic change agents' (Currie 1997: 304). This was followed by a move towards performance indicators (targets), incentive payments and quasi-market conditions. This link between managers and private sector business management ideology has led to ideological conflict, perhaps, demonstrated in the changing terminology associated to those in managerial roles. Learmonth (2005) suggested that the title 'manager', in superceding 'administrator', conferred status on its holder. Our research suggests that the term 'manager' has followed the trajectory of 'administrator', being relegated to those in first line management and to front line positions of lowly rank. Very few were willing to identify themselves as managers, let alone middle managers, and where they were there was a primary non-managerial identity construction i.e. nurse manager, consultant with some managerial responsibilities or business manager. At the same time there was some cynicism about these fluid labels;

> *Q. Are you a manager would you say?*
>
> *A. Most definitely. Depends where you peg yourself on the escalating scale of how people describe themselves. Some people years ago would call me an administrator, now it's fashionable to call yourself a manager and its getting more fashionable to call yourself a director and not a manager as this escalates someone has suggested we all just call ourselves God eventually.* (Service Director)

The relegation of management coincides with a significant reduction of emphasis on management in NHS policy and strategic literature and increased attention being given to leaders, and clinical leaders in particular as the future managers of health services. Health reforms have sought to include doctors and other clinicians in the business of managing health care. The reduction in management costs envisaged in coming years may be harder to achieve than first envisaged as a simple line management system has not been achieved for clinical services. Furthermore, NHS organisations are not operated along simple hierarchical lines amenable to simplified restructuring. Management activity forms but one part of complex organisational roles enacted by those in the middle reaches of NHS organisations and simple removal of such roles has the potential to leave significant strategic gaps.

Implications for future research

This study indicates numerous avenues for future research, particularly as the numbers of middle managers in the NHS begin to fall. Implications for researchers of NHS middle managers cover knowledge transfer activities, managerial identity work and service quality. In private enterprises, gaps have widened between the upper and lower levels of organisations and this seems likely for the NHS too. Restructuring will affect knowledge transfer activities, managerial identity work and has potential implications for service quality. For example, relatively little is known about the complex horizontal networks of middle managers and their informal knowledge networks. A study of middle managers' support systems and professional communities of practice as they shape, resist and adapt policy would be timely. The pervasive denigration of the middle management function alongside projected employment cuts may have obscured some of the vital functions such managers provide. Middle managers may become even more difficult to find and the vital co-ordinating role such managers play may be equally obscured. Research into service quality and managerial identity during the cuts would indicate both the evolution and effects of such changes for health service management and health service quality.

Conclusions

Our research suggests that rather than occupying a discrete section of the organisational hierarchy, NHS middle management roles form only one part of multiple working identities that draw upon differences in manifest and latent roles as well as differences in professional background, career trajectory and cross-organisational mobility. Middle managers, generally, have been subject to negative appraisals which shape their identities and also shape organisational work activities. These negative associations applied equally to NHS managers. We have suggested that these negative associations applied to middle managerial identity have real organisational consequences that have the potential to allow for strategic gaps in co-ordination in the middle reaches of NHS organisations. There is great potential for future research into the realities of managerial working life in the NHS to highlight where such denigration of managers, and the ensuing identity games, might contribute to low morale, high turnover and organisational failures.

Few NHS middle managers identified themselves as such (despite their co-ordinating role and limitations to their authority). Instead, management formed one part of a broader role. Real organisational difficulties were attributed to a non-specific set of workers, the 'middle managers'. More importantly perhaps, conflicts between public sector and business management models contributed to ideological conflicts for manager-professionals as 'managers' were blamed for poor performance, creating a gap in co-ordination between policy-making and the frontline. Sources of antagonism between managerial groups related to managers' latent identity orientation (Gouldner 1957). Middle managers continue to form a lost tribe of workers whose function and contribution are overlooked and the challenges facing middle managers remain obscured. At the same time, they provide a useful scapegoat function in that policy failures can be blamed on poor middle management.

We have shown how a complex feature of health care organising comes to be reduced to criticism of a 'mythological' group of overburdened, underperforming, paper-pushers. These negative associations have real effects on the middle reaches of organisations and perhaps more so in the context of the NHS. Many of the problems that Griffiths tried to address 30 years ago remain; too many initiatives, little clarity about what is most important and unclear lines of accountability and new health reforms target middle managers. These reforms have met with little resistance, however, little is known about the realities of health management and middle management work in the NHS is obscured.

Multiple lines of accountability and a vast diversity of roles mean that co-ordination at the mid-level is particularly messy and middle managers are identified as an anti-heroic group. The denigration of middle managers seems to have drawn attention away from the very real difficulties facing health care; increased demand as the population ages and reducing availability of funding compounded by almost continuous reorganisation. At the same time, serious review of strategy is limited at the expense of middle managers.

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Department of Health Disclaimer: The views and opinions expressed herein are those of the authors and do not necessarily reflect those of the Department of Health.

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2

Managing the Psychological Contract in Health and Social Care: The Role of Policy

Delia Wainwright and Sally Sambrook

Introduction

Research suggests that a well managed psychological contract can have positive benefits for both the organisation and the employee, including increased levels of commitment (Bartlett 2007; Guzzo et al 1994) organisational citizenship behaviour (Turnley et al 2003) and staff retention (Rousseau et al 2006). The psychological contract can be shaped by national and local policies, and how managers interpret, inscribe and implement these. There has been little exploration of psychological contracts in a health and social care setting, nor the role of policy, or through a qualitative lens.

This chapter presents an interpretive view of the interrelationships between the organisation, manager, employee and the role of policy in the psychological contract. We draw upon a study conducted in the British National Health Service (NHS) where we are investigating the psychological contracts of health and social care employees. Our research question here is: what is the role of policy in shaping the psychological contract? Despite the large body of literature examining psychological contracts, the context of health and social care has largely been ignored. The lead author is both researcher and team leader/manager within this context. Adopting an ethnographic approach, we have collected organisational documents, conducted an open-ended questionnaire survey of team members and interviewed managers within a community learning disability service. This chapter focuses on a comparative analysis of policy documents and employee perceptions. Our findings indicate that not only are managers viewed as being agents of the organisation and brokers of the psychological contracts but that they have a key role to play in the interpretation and development of policy at a local level.

H. Dickinson et al. (eds.), *The Reform of Health Care*

We begin with a brief overview of the research context, and provide some background to the study of the psychological contract, the role of managers and documents in shaping the formation of the psychological contract and the context of professionals and large organisations, such as the National Health Service (NHS). Next we explain our research study. Then we review three specific local policy documents and present findings from empirical research with team members and managers. Finally, we discuss the interpretation and implementation of local policies, and conclude by arguing that a better understanding of the role of managers in the development of psychological contracts and local policy can enhance practice which meets both individual and organisational needs.

Context

The construction and maintenance of psychological contracts is shaped by various individual, local and national factors, including organisational and government policies. This study was conducted in a Welsh Community Learning Disability Team (CLDT), providing integrated health and social services. The policy context for the delivery of integrated services to people with learning disabilities is provided by 'Fulfilling the Promises' (Learning Disabilities Advisory Group 2001). This states that by 2010 services for people with learning disabilities in Wales should,

> provide comprehensive and integrated services that will effectively support people to achieve social inclusion in all aspects of life and society in Wales (p. 6).

Previous guidance has also focused on the need to develop and progress services for people with learning disabilities (for example, Signposts for Success, Department of Health 1998). The Learning Disability Advisory Group was established by the National Assembly for Wales to prepare a draft service framework for people with learning disabilities. This group stated that by 2010, organisations should 'have fully developed collaborative partnerships to deliver flexible services, which are able to respond appropriately and quickly to the changing needs of users.' (p. 8)

The Health Act (1999) has provided the legislative framework for this integration to take place, and recommends partnerships across health and social care services.

> Partnerships are designed to facilitate the negotiation and delivery of public programmes cutting across the boundaries of a fragmented organisational landscape (Freeman and Peck 2006: 408).

The use of Section 31 flexibilities under the Health Act (1999) (now section 33) is voluntary in nature. A national evaluation of the implementation of Section 31 flexibilities (Hudson et al 2002) identified the importance of local commitment, trust and leadership, and the promotion of holistic professional work practices.

It was agreed that the CLDT would become integrated in the delivery of services, whilst the health employees (nurses and therapists) remained employed by the local NHS Trust and the social services employees (social workers) remained employed by the Local Authority (council). However, there were a range of policies which were jointly developed and adhered to by the CLDT and covered both sets of employees equally. There are separate line management arrangements for the two employee groups and these remain in place for the operational functioning of the team. Beyond this level management structures also remain separate, with service managers in both health and social services. It could be argued that these two organisations have distinct cultures and policies, which have shaped employee perceptions of their psychological contract. With the move towards integration, new local policies have been developed, and it might be expected that employees' original psychological contracts will be different and may have changed in response to the new structure.

This chapter focuses on three key policy documents, developed to support the integrated team, and their potential influence on perceptions of the psychological contract. We acknowledge that other health and social care settings may be influenced by different local and national policy contexts, but argue that these policies might have a similar effect in shaping psychological contracts.

Background

The psychological contract is usually conceptualised as existing between an employer and employee (Argyris 1960; Levinson et al 1962; Schein 1965) but little research has explored the role of organisational policy documents in shaping this relationship. Levinson et al (1962) defined psychological contracts as, 'a series of mutual expectations of which the parties to the relationship may not themselves be dimly aware but which nonetheless govern the relationship to each other' (p. 21). Schein (1965 in Anderson and Schalk 1998: 2) then defined the term as, 'the unwritten set of expectations operating at all times between every member of an organisation and the various managers and others in that organisation… Each employee has expectations about such things as salary or pay rate, working hours, benefits and privileges that go with a job… the organisation also has more implicit, subtle expectations that the employee will enhance the image of the organisation, will be loyal, will keep organisational secrets and will do his or her best.'

The psychological contract is shaped and held by *people*. Rousseau (1995) distinguishes between different types of human contract makers, either as principles or agents. She describes principles as individuals or organisations making contracts for themselves whereas agents are described as individuals acting for another… (party). However, Rousseau (1995) also referred to administrative contract makers – such as organisational mission and strategy, HR policy documents and job adverts, for example. Although little research has explored their impact on practice, these documents may communicate messages regarding expectations and obligations and thus shape the psychological contact. Rousseau and McClean Parks (1993: 29) state that 'organizations and individuals create contracts through communications at critical junctures… in the employment relationship.' We argue that policy documents may provide critical communication in shaping individuals' perceptions of the evolving psychological contract.

Shore and Tetrick (1994) believe that the employee is likely to view their manager as the chief agent responsible for establishing and then maintaining the psychological contract. Tekleab and Taylor (2003) point out that, 'messages from top management often refer to employees in general, but they do not state each respective employee's obligations and inducements' (p. 586). They argued that the immediate line manager represented the organisation when looking at perceived obligations and reactions to perceived obligations. However, Guest and Conway (2002) note that in large organisations, such as health and social care, the issue of who is the employer may be more problematic.

Having described the research context and briefly reviewed relevant literature, we now explain the empirical study.

Methodology

This chapter draws on one aspect of a larger ethnographic study. Here, our question is: what is the role of local policy in shaping the psychological contract within a health and social care context?

Data collection

As the lead author was both a team manager and researcher, we were careful to ensure data collection was rigorous and free from any potential coercion. Ethical approval was obtained from the Local Research Ethics Committee (LREC) and the NHS Trust's Internal Review Panel (IRP). A range of data collection methods were employed, including policy document analysis, qualitative questionnaires and semi-structured interviews.

Various government policies (Welsh Assembly Government (WAG) 2005, 2007) regulate practice and shape local policy. Documents are sources of data that have been underutilised by qualitative researchers (Silverman 2001; Prior 2003), as they remove the researcher from the research participants and remove face-to-face contact, recently emphasised in ethnographic studies (Hammersley and Atkinson 2007: 121). However, Lincoln and Guba (1985) suggest that documents are, 'a rich source of information, contextually relevant and grounded in the contexts they represent' (p. 277). Miller and Alvarado (2005) argue that whilst qualitative nurse researchers have underused this data source, 'efforts to incorporate documents can be expected to significantly advance qualitative nursing research' (p. 353). The specific local policy documents examined were: (1) the Operational Policy for the Integrated Team, (2) the Operational and Professional Management Protocol, and (3) the Integrated Managerial Supervision policy.

Sampling

We used purposive sampling, choosing participants who have specific characteristics (Bowling 1997; Miles and Huberman 1984), to ensure they could be involved in detailed exploration and understanding of the research themes. The sample consisted of members of the local Community Learning Disability Team (CLDT) for the qualitative questionnaire survey and the members of the Management Teams (both in social services and health) for the interviews. At the time of the study, the CLDT had approximately 30 members. The Management Health Team for Learning Disabilities consisted of seven members and the Management Social Services team consisted of six, totalling 13 managers.

Data collection instruments

To elicit views on the psychological contract, anonymous open-ended questionnaires were distributed to all 30 health and social care team members and 12 responded. Interviews were conducted with ten of the 13 managers within the wider Learning Disability Health and Social Care setting. The questionnaire and interview schedule focused on: who the contract is with; having a similar or different (idiosyncratic) deal to others doing a similar job; personality and equity sensitivity;

expectations and obligations, and how these are communicated; and professional and organisational/managerial roles. The questionnaire and interview transcripts were analysed using framework analysis (Easterby-Smith et al 2008).

Findings

In this section we analyse local policy documents, which provide the broad government and organisational context and possibly communicate messages regarding expectations and obligations in the psychological contract. Next we present selected findings from the questionnaires and interviews. Then we compare statements from policy documents with employee and managerial perceptions. Findings indicate that not only are managers viewed as being agents of the organisation and brokers of the psychological contract but that they have a key role in the interpretation and development of policy at a local level.

Policy documents

1. *Operational policy for the integrated team*

The operational policy for the integrated team is a key document to communicate to team members' elements of the psychological contract. This document includes service values and principles, role and function, service information, access to the integrated team, quality assurance, performance indicators and operational management issues. The document provides an explanation of what integration is and why it is taking place, the emphasis being on the development of services to meet user need. There is a section on service values and principles taken from WAG 2005 and 2007 documents:

> *All people with a learning disability are full citizens, equal in status and value to other citizens of the same age. They have the same right to*
>
> - *live healthy, productive lives with appropriate and responsive treatment and support to develop their maximum potential*
> - *be individuals and decide everyday issues and life-defining matters for themselves joining in all decision-making which affects their lives, with appropriate and responsive advice and support where necessary*
> - *live their lives within the community, maintaining the social and family ties and connections which are important to them*
> - *have the support of the communities of which they are part and access to general and specialist services that are responsive to their individual needs, circumstances and preferences.*

> Contemporary statement on Policy and practice for Adults with a learning disability: Welsh Assembly Government 2007 (this updates the All Wales Strategy)

This echoes statements made in the document 'Designed for Life; Creating World Class Health and Social Care for Wales in the 21st Century', Welsh Assembly Government (2005).

These statements reveal what the Welsh Assembly Government (WAG) views to be the obligations of learning disability services and what it expects will be delivered. By adopting these statements within the operational policy the team locally is showing connection to wider policy. The statements themselves demonstrate the context within which the document has been produced and shows links to the wider political arena.

2. Operational and professional management protocol

The purpose of the operational and professional management protocol is

> *To ensure role clarity, promote fairness, consistency and continuity for all CLDT members, to aid the delivery of effective, efficient and person centred services, to enhance team working, to avoid smaller disciplines becoming distanced and dislocated from their professional support networks.* (p. 1)

This is followed by sections that show which manager takes lead responsibility for different areas. The areas are: operational management supervision, clinical supervision, professional practice and development, individual management support, leadership and delivery of integrated services, study leave, annual leave, sickness, mandatory training, recruitment, accommodation and facilities, complaints, health and safety. The protocol has a section for signing by both the team manager and the professional manager. Within each specified area there are a few lines of explanation relating to the item. The protocol does communicate a variety of expectations through a range of statements in the different sections. The operational professional management protocol reflects wider organisational policy as some statements embody reference to other documents, for example, regarding appraisal and supervision, 'in accordance with Trust guidance'. Supervision and development are emphasised strongly within the protocol and are the first items listed and explained. Reference is made to items such as team development days and regular supervisions, indicating what the organisation expects to be able to deliver. Expectations of staff delivery are mentioned, but there is also the recognition of the reciprocal nature of this: staff should receive appropriate management support and they should deliver the job to a ‘high standard’. Performance issues should initially be dealt with informally, prior to progressing but again the emphasis is on this being done in a collaborative manner.

The operational manager is expected to ensure the team has a clear purpose and function, and this cross-references to the purpose of the team as laid out in the operational policy, there is an expectation that ‘efficient and effective services’ are delivered. When describing recruitment arrangements there is the inclusion of the phrase, ‘inclusive of service user involvement’, again indicating in this protocol some of the wider service philosophy that is expected to be shared with team members.

3. *Integrated managerial supervision policy*

The previous document was drawn up as one of the first integrated documents, but has since become an appendix to the Integrated Managerial Supervision policy. The policy itself applies to social workers and nurses whereas the other health members of the team, such as the physiotherapist, occupational therapist and speech and language therapist, make reference to the Operational and professional management protocol. Therefore this document relates to the psychological contracts of only certain members of the team, but these are the majority of members. The aim of the policy is to ‘set out a framework of core principles and minimum standards for managerial supervision’ (p. 1) and outlines;

- The basic principles and key aims of supervision
- The arrangements for carrying out supervision
- Record keeping
- Expectations of supervisors and supervisees in supervision

At the beginning of the document there is a commitment statement which suggests that the aim of supervision is to develop practitioners and to deliver high quality care. This emphasis and balance is maintained throughout the document and is reiterated in statements such as ‘To promote best outcomes for service users and enhance their care’ and ‘to encourage continuous professional development’ (p. 3). These statements are likely to speak directly to the members of the team.

Within the document the individuality of each employee is also recognised and the implication that the interaction is individually tailored to meet each employee's needs is expressed in a variety of statements such as,

- *The content and duration of supervision may vary according to the job and needs of individual practitioners.* (p. 4)
- *An important attribute of supervision is to balance accountability to the Agency, sensitivity to the supervisee (personal issues etc) and risks to Service Users.* (p. 5)

These suggest the organisation is supportive and potentially nurturing to individuals and that individual needs and differences should be recognised and brought into the supervision arena. This provides the framework for obligations to be individually interpreted, negotiated and exchanged and emphasises 'delivery'. The policy clearly communicates throughout that there is an expectation that the employee is going to deliver services to a high professional standard and that management supervision is a tool by which this can be facilitated. This 'tool' is enshrined in statements such as, 'Managerial supervision will have a written supervision contract agreed by both parties, and reviewed on a regular basis. The contract will include expectations, goals, boundaries, rights and responsibilities, methods of recording and confidentiality' (p. 4). This statement makes specific reference to contract (supervision) expectations being made explicit. However there are also elements of protection for the supervisee implicit in statements such as 'supervision should be seen as a confidential process between the practitioner and their line manager'. Conversely another statement within the supervision policy states, 'Managerial supervision contact records will be monitored to audit supervision and supervision records may be used as documentation in disciplinary or legal proceedings'. Overall there are slightly mixed messages about the status of supervision and, depending on each individual's interpretation of the policy, supervision may or may not be viewed as a suitable vehicle for the negotiation and refinement of the psychological contract.

Findings from questionnaires and interviews

Having analysed the three key policy documents, there is evidence that local policies are influenced by wider government documents, statements can be seen to shape aspects of the psychological contract in terms of expectations and obligations, and managers have the potential to negotiate idiosyncratic deals through the supervision process. We now present selected findings from the questionnaires and interviews, relevant to the local policy documents and statements identified above. Questionnaire respondents are identified as R1, R2 etc and interviewees as I1, I2 etc.

The role of managers as agents of the organisation

Regarding who the psychological contract is with, the majority of team members who completed the questionnaire stated that their psychological contract was with their line manager, although other responses included 'the service manager', and 'colleagues'. In addition, two respondents made the point that not only was it the line manager but that their line manager represented their organisation.

> *I think it (the pc) is with the organisational level but it is up to individuals (managers) to ensure that it is implemented.* (R4)

Three team members felt that the psychological contract was with the organisation and with people in the organisation. Similarly, two managers viewed their psychological contract as being with individuals at a higher level within the organisation (potentially their own line managers). Two viewed their psychological contracts as also being with those senior to them but also felt that they held psychological contracts with those they managed.

The negotiation of the psychological contract

Questionnaire responses indicated that the supervision process was where an exchange of obligations took place. Shaped by the local policy, supervision could be interpreted as the vehicle for the expression of actions, which the supervisee feels obliged to have demonstrated as part of their psychological contract. The supervisor's response may be a reciprocal expression of the obligations of the organisation. Six of the ten managers mentioned supervision as a vehicle through which elements of the psychological contract were communicated.

The role of local policies in communicating the psychological contract

Three questions in the questionnaire and interview schedule related to communication between the individual and the organisation regarding expectations and obligations.

When asked 'how you communicate what you expect from the organisation'?, almost all team members either referred to supervision and/or in conversation with their manager, both shaped by local policies. The methods by which respondents communicated their obligations to the organisation were through actions (n = 6), discussions with manager, including supervision (n = 2) and during annual performance development processes. The methods by which the organisation communicated its obligations to the respondents were through: the formal employment contract (n = 2), policies (n = 3), supervision (n = 4), appraisal, transparency, management and information, support, pay (n = 2), team meetings, emails (n = 3), and newsletter.

Nearly all respondents discussed oral communication methods as a way of receiving communication from and communicating to the organisation, and one of the 'critical junctures' identified was supervision. Individuals receive supervision with their line manager and these responses support the views of Shore and Tetrick (1994) and Tekleab and Taylor (1994, 2003) that the line manager is often perceived by employees to represent the organisation. The communication around expectations and obligations was similar for all respondents, which supports Herriot and Pemberton's (1997) observation that, 'while the content of psychological contracts is likely to be varied, the process of contracting may be similar wherever contracts are made' (p. 45).

Discussion

We now discuss the degree of congruence between what is communicated through government and organisation policy documents and what is acted upon at a local level, as perceived by team members and managers. This is particularly important as our participants talked about how expectations and obligations were not only communicated orally, but also through documents such as the formal employment contract, policies, management and information, emails, and newsletters. These could be considered what Rousseau (1995) referred to as administrative contract makers.

The Operational Policy for the Integrated Team included several specific statements from WAG (2005) and WAG (2007). These statements identify what the Welsh Assembly Government considers the obligations and expectations of learning disability services. Although few statements make specific mention of human resources, there are references to high quality 'skilled staff who provide services that work every time, but are still personal to the individual' (p. 4) and 'services that are accessible, fast, safe and effective, simple to understand, easy to use and responsive to changing need' (p. 4). These statements can be interpreted by both managers and employees to help shape their perceptions of their psychological contracts. When asked what was expected of them team members identified the qualities of working hard, being committed, showing innovation, being proactive, using problem solving skills, having high standards of professionalism, being continuously developed and following policies.

The Operational and Professional Management protocol can be viewed as a vehicle for the delivery of the psychological contract deal. The purpose of this protocol is 'to clarify operational and professional management responsibilities, so as to enable smooth and effective team working'. There are considerable areas of agreement between what team members stated should be included in the deal and what is identified as being offered by the organisation in this document. The organisation identifies certain elements that are offered: supervision and development are emphasised strongly within the protocol and are the first items listed and explained. There is also a statement that staff should receive appropriate management support and they should deliver the job to a 'high standard'. Staff protection is also mentioned in reference to documents such as the lone worker policy and there is an expectation voiced through the document that staff protection will be delivered by the organisation. These elements are identified by team members as being important, particularly supervision, support and safety.

Identifying the need to define operational and professional management is supported in the literature, recognising that certain employee groups have specific needs and develop specific psychological contracts (e.g. Guzzo et al 1994; Thomas and Anderson 1998). Bunderson (2001) suggests that professionals take account of both their professional and administrative roles and perceived role obligations and makes clear distinctions between the professional and administrative dimensions of their contract. George (2009) further suggests that professionals have to decide 'whether to develop a psychological contract with the employing organization, with the profession or with both' (p. 48).

The Integrated Managerial Supervision policy also has the potential to shape the psychological contract. Statements such as 'To promote best outcomes for service users and enhance their care' and 'to encourage continuous professional development' (p. 3) are likely to speak directly to the members of the team, who indicated the importance of the service user. McLean and Andrew (2000) found that social workers gained satisfaction from helping people, and both O'Donohue and

Nelson (2007) and Guest and Conway (2004) recognised that public sector employees are most interested in outcomes for service users. Therefore the document 'speaks' of the same interest and obligations to the service users that are likely to be experienced by the team members. When asked about the most satisfying elements of their professional role, every respondent made reference to working with the service users and most specifically referred to the satisfaction gained in improving or making a difference in a service user's life. This supports Coyle-Shapiro and Kessler's (2003) findings that public service employees reciprocate the treatment they receive from their employers and if public service employers can fulfil their obligations to staff this can have positive consequences for the quality of service provision.

Rousseau and McClean Parks (1993) noted contracts could be created through communications at critical junctures in the employment relationship. One of the 'critical junctures' identified was supervision. Within the service, individuals receive supervision with their line manager on a monthly basis. This is an opportunity for the manager, as the agent of the organisation, to discuss local policies. Team members indicated that the process of supervision was the ground where an exchange of obligations took place. Many indicated that their obligations were communicated through their actions, and the manager and the supervisee discuss actions as part of managerial supervision.

Conclusions

We have presented selected findings from an ethnographic case study exploring the influence of government policy on local policy, and the impact of local policy on the interpretation and negotiation of the psychological contract in a health and social care context. We recognise that other local/national policies will shape the psychological contract in other contexts. Our findings from an integrated community learning disability team provide evidence of how policy shapes the development of the psychological contract between health and social care workers and their managers. Our participants talked about how expectations and obligations were not only communicated orally, but also through documents such as the formal employment contract, policies, management and information, emails, and newsletters We identified statements in government and organisational policies which have potential to shape specific aspects of the psychological contract. However, these are interpreted locally by managers and employees, and negotiated through various means, particularly through managerial supervision. Our findings suggest that health and social care workers construct their contracts with line managers. They also blur the contents of the formal and psychological contract, shaping their perceptions of expectations and obligations. We demonstrated that policy documents have significant impact on the construction, negotiation and maintenance of psychological contracts, with implications for policy-makers and managers.

As health care policies change globally, in response to imperatives such as reducing costs and enhancing service user involvement, we argue that having a better understanding of the role of policy in the development of psychological contracts and the role managers play in the development of local policy can enhance practice which meets both individual and organisational needs. We suggest further research is needed to explore these emerging themes, and particularly the role of policy in shaping employee expectations and obligations.

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3

Autonomy in Health Care Practice: A Paradise Lost?

Peter L. Hupe

Introduction

There once was a time when professionals had complete autonomy over their role, while resources were abundant. There were no constraints on the freedom to act, other than the professional standards and codes of practice associated with specific occupations. Professionals were unrelentingly committed to their work, driven by altruism and without any self-interest.

Although this is an attractive image, it is one that has probably never existed in reality. Yet, for medical doctors this scenario may not be entirely fantastical. The doctor has a general duty to advise on equitable allocation and efficient utilisation of scarce health care resources, but this 'is subordinate to his or her professional duty to the individual seeking clinical advice' (British Medical Association 1980: 35). In other words, a doctor is expected to do what is best for the patient. The idea that services in health care 'should be available to *every citizen* on the basis of clinical need' is a corner stone of the British National Health Service (NHS) (Department of Health 1991: 4, emphasis in original). The image of the doctor working in the NHS stands for what can be seen as the ideal type of professional practice: after a lengthy and sustained period of training, the professional practices his or her occupation grounded on expert knowledge. This expert knowledge serves as a major source of legitimacy. Making reasoned decisions is based on professional judgement and experience built up during years of practiced craftsmanship. Professional autonomy is exercised so that individuals and the profession maintain the maximum possible freedom to act.

Reform is a recurrent theme in many health care systems over recent years, as other chapters in this text are testament to. Against this

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background of reform, this chapter investigates the notion of professional autonomy and explores the implications for professional practice in health care. The aim is to contribute to rethinking professional autonomy and its meaning in public service organisations in a context of reform. While international evidence is used, the primary focus is on examples from the UK. The argument is based on insights from the theoretical literature, with an open eye towards empirical variation. Rather than providing a historical overview of the topic the analysis will have a 'clinical' character. The notion of autonomy in health care practice is neither romanticised nor entirely written off.

In the following section the work of professionals is put in the context of the variety of institutional settings in which professionals work. Following on from this the issue of professional autonomy in health care is addressed. Finally, autonomy is positioned in a re-conceptualisation of the ideal type of the professional working in health care before concluding by setting out areas for further research.

Professional work in context

Beyond dichotomies

Just as professionalism was seen as a preferable alternative to bureaucracy (Freidson 1970), more recently professionalism itself has turned into an object of criticism (Clarke and Newman 1997). Professionalism is nowadays often criticised by contrasting it to management, or, rather, managerialism. Management is promoted as being 'innovative, externally oriented, performance centred and dynamic' (Clarke and Newman 1997: 65). Managers are 'pragmatic, enabling and strategic' and management is 'customer centred, transparent, results oriented and market tested'. Managers and management are therefore preferable to professionalism which is seen as 'paternalist, mystique ridden, standard oriented and self-regulating' (Clarke and Newman 1997: 65). At the same time Flynn (1999) argues that rather than being dichotomous variables, 'managers' belong to the same family as 'bureaucrats'. After all, public sector managers derive their legitimacy and purpose from legislation and government policy. Managers are therefore accountable bureaucratically to higher level officials and politicians. Hence the old contrast between professionalism and bureaucracy returns in a new fashion.

The emergence of new public management (NPM) from the 1980s onwards was seen as an important discourse in a power struggle aimed at curbing the relative independency of particular traditional institutions; not least, the medical professions (Clarke and Newman 1997). The central orientation of NPM is clear: first, a primary focus on the market as preferable to government provision; and, second, treating government as if it were a business. As such NPM was seen as challenging the 'professional paradigm' (Exworthy and Halford 1999a: 6) and the autonomy of professionals to practice within organisations. Thus, a contemporary dichotomy was born. Clarke and Newman (1997: 68) speak of new forms of 'bureau-professional' relations as characteristic of the 'traditional order' but NPM implied a move from a 'bureau-professional' to a 'managerialist mode of coordination' (Clarke and Newman 1997: 5). NPM is premised on the notion that public sector organisations should move away from traditional types of professional control and administration towards more generalised systems of management which allow less space for professional autonomy.

Yet the emergence of NPM was not without its critics (see, for instance, Hood 1991; Pollitt 1990; Gray and Jenkins 1994) and NPM should not be viewed as a unified programme that has been implemented everywhere in the same fashion. Indeed, the actual impact of NPM is 'uneven, contested and complex' (Clarke et al 2000: 7). Therefore one cannot say that the emergence of NPM brought about the end of administration and introduced management; much as we cannot say that prior to NPM there was no management and only administration. Prior to NPM we often saw administrators drawn from across the professions (Harrison 1999). Kirkpatrick et al (2005) speak about 'custodian administration' or 'custodial management' as dominant in the NHS before the introduction of NPM measures. Essentially these terms mean that 'the producers of services were largely able to define and control what public services are given within legal and financial constraints' (Kirkpatrick et al 2005: 23). So professionals were left to manage themselves, but there were then already management tasks to be fulfilled. While administrators in health are currently cast as managers, to the extent the latter are either practising professionals or of professional origin, Causer and Exworthy (1999: 83) see here 'a continuation of the principle of professional control'. As these authors observe, the principle of 'clinical autonomy' afforded doctors more autonomy from managerial control than professionals working in other public sector organisations. A degree of managerialisation of professional groups was underway in the UK well before the Conservative government was elected in 1979 (Causer and Exworthy 1999: 86–88).

Dimensions of variety

There is a vast academic literature seeking to define what constitutes a profession. A few examples of the most influential texts include Greenwood (1957), Freidson (1970), Johnson (1972) and Macdonald

(1995). Most authors focus on two dimensions: the specific nature of the work involved, and the position of that work in society. Both elements can be found in DiMaggio and Powell's definition (1983: 152), where a profession is defined as an occupation whose members have had success in defining 'the conditions and methods of their work' and in establishing 'a cognitive base and legitimation for their occupational autonomy'. Common across definitions is the substantive knowledge base of any profession; expert knowledge is needed to do expert labour. Another factor that most authors associate with a profession is that of social closure. Members of professions pursue strategies 'to justify and defend their special influence and privileged position' (Kirkpatrick et al 2005: 24–25). They do so at various scales of aggregation: in the relations between their profession and the outside world; in the organisations they work in, as well as in their individual work relations, especially with managers. The combination of expert knowledge and social closure forms the basis of professional autonomy.

Although there is much variety under the general headings of 'professionals' and 'professionalism' (Freidson 1994), medicine is seen as an archetypal type of professional institutionalisation (Ackroyd 1996). Physicians, general practitioners, surgeons and other medical specialists form a profession in the sense that they are 'granted an effective legal monopoly over the training and supply of expert labour' (Kirkpatrick et al 2005: 26). Similarly nurses have achieved a degree of occupational closure, although weaker than that established by doctors (Kirkpatrick et al 2005: 27). In health care a 'hierarchy of jurisdictions' can be observed between doctors on the one hand and nurses, midwifes, radiographers, physical therapists and other occupations on the other (Kirckpatrick et al 2005: 35). Most of these professional groups have organised themselves in (semi-)professional associations (Etzioni 1969). Along similar lines these types of divisions can be observed in professions outside the medical realm. Occupations such as social work, teaching and others viewed as the 'offspring and beneficiaries of welfare state policies' (Wilding 1982: 67), fulfil, like the medical professions, *public* roles. Paraphrasing Bozeman (1987) one could say '*all* professions are public'. Functioning in the public domain they fulfil roles for society as a whole. Whether freestanding, or 'employed by' a public service organisation, members of a profession can be conceived as 'agents of the state' (Ackroyd 1996).

The public and semi-public sector consists of a variety of subsectors. Organisations where professionals are working in a variety of policy fields have been termed 'street-level bureaucracies' (Lipsky 1980), 'agencies'

(Wilson 1989), or ‘professional bureaucracies’ (Mintzberg 1993). Currently, the labels ‘public service bureaucracies’ or ‘public service organisations’ have become *en vogue* (Kirkpatrick et al 2005). However the individuals working there are labelled they have always had to deal with more than just the requirements of their (semi-) profession. Public-administrative principles including equity and fairness, as well as political ambitions towards equality and other public values have been intrinsic to the work of these professionals from the beginning. This constitutes the scenario which Clarke and Newman (1997) label as ‘bureau-professional regimes’. While the nature of the organisations professionals work in may vary, professionals may also of course vary themselves. Some doctors have more experience than others trained in the same specialism, even if they do work in the same hospital. Younger doctors may have had a somewhat different vocational education than their older colleagues. Moreover, in countries such as The Netherlands the majority of medical students are now female – leaving the impact of gender on professional practice an object for further empirical investigation.

This short overview shows, first, that beyond discursive dichotomies there have always been some forms of ‘managing’ *within* the professions. This is in contrast with the notion of ‘old’ and ‘new’ public management. Second, while an ‘uneven constitution of managerial-professional relations across the public sector’ can be expected, both compromise and collaboration can be assumed as much as conflict (Exworthy and Halford 1999a: 14; see also Harrison and Pollitt 1994). Third, idealtypical constructions like those of ‘the professional’ and ‘the manager’ function as claims and counterclaims in discourse, rather than as devices explaining empirical variation. Instead of generalisation, better specification is needed. Fourth, while empirical variation across national systems of health care can be assumed, the mechanisms involved may work in a comparable way. In quasi-market situations, for instance, legitimacy is more and more derived from one’s activities being measurable. This has an impact on the position of medical specialisms in the informal hierarchy (Harrison 1999: 58–59).

Autonomy in practice

Autonomy and accountability

Flynn (1999: 22–23) distinguishes between several types of autonomy: institutional autonomy, referring to the characteristics of a specific profession, next to technical or work autonomy. As ‘contested, variable and contingent on many factors’ professional autonomy in health care has a characteristic form, that of 'clinical autonomy' (*ibid*). Harrison (1999: 51) describes it as used by doctors as 'a claim to be unmanaged themselves and to exercise some form of control over most other health care occupations'. Apart from its function in medical ethics and as a rationing device, clinical freedom may also legitimise professional dominance. However, the downside of autonomy is obvious as well – the possibility of an unrestrained freedom to act, irrespective of costs and unintended consequences, invites a counter-claim to curb such autonomy.

In most cases the term autonomy seems to function as a claim with a general character, rather than as a measure of empirical variation. If the term professional autonomy is used primarily to protect from outside intervention, it does not tell us much about what actually happens on the hospital floor or in primary care surgeries. First and foremost professionals have accountability to their own profession. They are supposed to be held accountable primarily by their colleagues as members of the same profession. Peer consultation and regulation is inherent to professional work – looking sideways rather than upward is a characteristic that distinguishes professionalism from other ways of organising work. Yet, at the same time, intra-professional consultation acknowledges the importance of what has been termed 'action prescriptions': norms for appropriate (professional) behaviour (Hupe and Hill 2007). Obviously professionalism is not a kind of unrestrained freedom to act.

In fact there is no unlimited freedom to act according *only* to the standards of the professional group that the professional belongs to. Certainly for those working in public service organisations influences on individual practice come from various directions. They do so in the form of a variety of action prescriptions. Accountability, a multiple concept, is practiced likewise: individual professionals are held accountable to more stakeholders than merely their own profession (Day and Klein 1987). Simultaneously – and of course to a varying degree – professionals seek feedback on their work both within their profession and beyond. Who is the *accountor* and the *accountee* therefore varies across time and place. In a three-by-three matrix Hupe and Hill (2007) distinguish three 'accountability regimes', each working at the scale of individuals, organisations and the system as a whole. *Professional accountability* implies, for instance, giving call to the constant tendency to harmonise practices. Protocols and guidelines serve as ways to establish a consensus about what is appropriate professional behaviour. Also apart from managerial targets quality assessment always is on the professional agenda. Ideas about 'good practice' constantly evolve and individual practitioners are expected to respond to these changes. Meanwhile specialisation continues, resulting in the possibility of intra-professional domain conflicts. Outside of professional spheres, policy measures and guidance are set out and government ministers expect the application of these rules in professional practice. Whether doctors view themselves as professional, rather than bureaucrats working at the street-level, does not affect the fact that a doctor is part of a set of vertical relationships – to be called *political-administrative accountability*. A third 'accountability regime', a system of social control in which mutual adjustment of action takes place, concerns *participatory accountability*: accountability towards society (Hupe and Hill 2007: 288–290).

Within all the three distinguished regimes a category of action prescriptions is valid. Stemming from, respectively vocation, state and society, their specific sources are located at various scales. For instance, in his or her direct contacts the doctor consults peers and encounters managers, but also in the interaction with individual patients he or she may get feedback on demonstrated behaviour. At the scale of the hospital (former) patients may be active in terms of advising the board in some collective form. And at the system level nationally organised associations of patients suffering from a specific disease may address the professional institutions of the medical specialism involved.

Professional decision-making

McDonald (2002: 155–157) explored how priorities are decided in the UK NHS. At the practice level she found that a variety of objectives are to be realised, but not all of these are shared equally. There is no maximising of one single objective, while many actions are taken implicitly. In this action – an end in itself, by the way – too much is always better than too little. Values and views prior to the situation at hand guide this action. In such situations, often highly ambiguous, knowledge is applied in a context-bound and to a certain extent person-bound way (McDonald 2002: 157–163).

Making an explicit ranking of patients deserving a specific medical treatment is, for obvious reasons politically risky. For board members of medical professional associations it is hard to react other than with a sentiment of 'leave it to us'. Referring to the functionality of implicit rationing, Harrison (1999: 60) speaks of 'the politics of clinical freedom'. As Hunter (2008: 138) indicates, what is called 'bedside rationing' is an inherent form of professional discretion. In fact, in *all* professions, including the so called semi-ones, many of the most important decisions are made on the front line.

The environment in which professionals exercise their tasks is multidimensional. The degree of institutionalisation of a profession, the kind of (public service) organisation professionals work in, the nature of the professional work and the tasks involved, and the personal characteristics of professionals all shape the specific context in which individual professionals do their work. Moreover, the actual behaviour of individuals observed in these settings will vary. Not only may nurse Norma act differently than doctor Donald, but also than nurse Betty, her direct colleague. Even with a *ceteris paribus* clause, work settings will display so much variation that only systematic and comparative empirical research would enable grounded generalisations. In some settings, for instance, the deliberate collective involvement of patients – possibly institutionalised in a board – may function as a countervailing power in respect to clinicians and managers.

Modes of dealing with autonomy

The role fulfilled in the political-administrative column for professionals implies the incorporation of organisational assets. This goes in particular for the adoption of managerial, or even 'managerialist' elements in their organisational behaviour (Savage et al 1992). Working in ways both effective and efficient (cost-aware) cannot be seen as exclusively 'managerial' objectives. They have become standard components of the professional's repertoire. The knowledge base and institutional position of medical doctors is so strong, that the latter may incorporate managerial and other considerations coming from 'outside' their profession into their daily practice. 'Doctors are taking on managerial responsibilities and, at the same time, maintaining both clinical autonomy and professional identity' (Exworthy and Halford 1999b: 122).

With an eye on cross-professional empirical research, autonomy can be defined as the actor-bound freedom to act. Then the actual dealing with that freedom can be measured, which may lead to a threefold distinction. In the *individualist* action mode the protection and maximising of the autonomy supplied in one's work by the profession involved is dominant. Situations demanding decision-making will *a priori* be encountered from the perspective implied by the profession concerned. In the *functional* action mode the adjective 'functional' means task-bound. The available freedom to act is pragmatically used in given circumstances. This pragmatism implies that professional requisites are of course prevalent, but not *a priori* dominant. Action prescriptions stemming from public administrative sources, managerial targets and societal expectations are taken into consideration as well. The third action mode can be called '*political'* because the professional involved actively aims at the enlargement of one's freedom to act as a professional. Practising accountability with regard to peers and colleagues, but also towards organisational supervisors and towards clients as individuals or organised in collectives, is a fact. Of course this is the case in an empirically varying way, impossible to overview here.

We now return to what seems to be the core of the autonomy of the individual professional. A substantive part of professional work ultimately demands the judgement of the expert. The aim of eliminating discretion actually enhances eliminating the intermediary role of judgemental craftsmanship (cf. Sennett 2008). After all, in the realm of action rather than of desired situations, medical treatments as concrete outputs and outcomes achieve form and substance. Much of this action to a large degree is invisible to the outside world, while taking place in the surgery or doctor's office. In this black box happens what makes the guidelines, formal rules and other action prescriptions literally come true. Here, trust in professional competence inevitably replaces oversight. Whatever the state of ICT might be, in contact-driven work in public service organisations direct surveillance – perhaps deemed desirable – is practically impossible. This distinguishes such work from screen-driven or system-driven work in other variants of public bureaucracies (see Bovens and Zouridis 2002). Overall, the necessity of judgement demarcates professional from other kinds of work.

What can be called an *evaluative imperative* seems to be prevalent here. It is related to the more general need to act, applying to all work at the ground floor of government – what Hupe and Hill (2007) have identified as an action imperative. As part of that action, perhaps practising *any* craft implies a need to judge. Only completely routine activities are exempt from the latter. Where professionals in public service always have to act, the demands stemming from the nature of their specific work determine the degree of the professional character of that work.

Professional autonomy in perspective

While stressing multi-dimensional empirical variation and the need to research these issues, one could acknowledge that professionals, and certainly the ones working in public health care organisations, simultaneously fulfil more than one role. Following the specification of accountability regimes outlined earlier, one could identify three roles, which taken together constitute what can be called a 'multiple responsive professional in health care'. This label refers to an ideal-typical construction going beyond the one of the 'pure' professional this chapter started with; see Table 3.1.

Table 3.1 The ideal typical professional and beyond

Ideal type	**The professional**	**The manager**	**The multiple responsive professional in health care**
Orientation	Exercising an occupation	Getting things done	Fulfilment of a public task
Educational background	General Specialisation Additional courses	Basic and beyond Training	General Career
Source of legitimacy	Expert knowledge	Formal position	Reputation
Guiding values (a.o.)	Reasoned judgement	Efficiency	Balanced judgement
Nature of competence	Craftsmanship	Skills	Experience
Autonomy	Claimed	Function-bound	Embedded and accounted for

First and foremost a professional in health care is a craftsman – although often in practice the professional is in fact a woman. Elements of craftsmanship are, for instance, the acquisition, usage and transferral of tacit knowledge; the development and situation-bound practicing of professional judgement; the competence to deal with and learn from ambiguity, and an awareness of possible external critique (cf. Sennett 2008).

Hunter (2008: 190–191) speaks of clinical governance as being a development tool, involving the re-engagement of clinicians as co-producers, responsible autonomy and, eventually, 'responsible professionalism'. This implies that doctors can be conceived as co-producers of both health and health *policy*. The paradox here is that the notion of individual responsibility to an individual patient occurs in a context in which the public service is a collective service. Doctors, nurses and other health care professionals working in medical care are co-makers of public policy. Their co-actors in the policy process towards health are, of course, individual patients. The latter can function as policy co-makers organised at a collective level as well, for instance associated as suffering from a specific disease. In addition, co-actors of doctors are to be found higher up in the vertical hierarchy. Together with managers, responsible for the organisation, civil servants framing the policy goals and political authorities expressing the latter, doctors co-produce health policy. Whether they like it or not, professionals working in public service organisations are part of the policy process. That they work in direct contact with citizens makes them 'implementers' of public policies – although functioning as more than mechanic rule appliers, as Lipsky (1980) has shown. Like citizens in their role as patient, clients or otherwise can be seen as co-producers of public service delivery, such a role in fact is being fulfilled by the surgeon in a NHS hospital as well. The latter is *qualitate qua* part of Government.

Finally, there is a role defined in terms of the relation between professionals and society. Professionals are craftsmen, they can be seen as policy co-producers, but they are also public officials, and are addressed accordingly. In a labour division within the polity, doctors not only represent Government, but also, in their white uniforms, the authority of experts oriented to the common good. All these three roles are components of professional behaviour. It is in the very way of dealing with the multiplicity of expectations implied by this combination of roles, that the professional can be distinguished from the non-professional. The *multiple responsive professional in health care* organises his or her own feedback in multi-local ways. He or she is able to simultaneously keep several 'balls in the air', because that is a defining element for being a professional. Governments could show trust in the values of professionalisation by promoting the organisation of countervailing powers and by enhancing the further institutionalisation of semi-professions within health care.

Conclusions

What does professional autonomy mean in the practice of modern health care? We started with the image of an ideal situation. Here 'clinicians were left to their own devices and remained largely unaccountable for their action' (Hunter 2008: 194). Since this 'Garden of Eden' seems to have been left, it has become an inexhaustible source for a sustained nostalgia (Hunter 2008: 194). It can be argued that the 'mythical golden age' (Hunter 2008: 116) in which there were an unrestrained professional autonomy was never real at all. However, this picture does seem to operate as a functional fiction, primarily used as a political claim to legitimise positions taken.

In contrast, the celebration of the manager's ultimate efficiency has a similar conceit. Whether managers actually succeed in meeting their operational objectives largely remains an open question. While outputs are proclaimed as important, if stated 'targets' seem to be met, the causal relationship with actual managerial behaviour is often attributed rather than evidenced – an example of claiming as well. Dichotomies like 'professional versus bureaucrat', or 'professional versus manager', presupposes individuals each working on an island, in splendid isolation. And when a non-peer knocks on the door, he or she is assumed to be encountered as someone from another world. The presumed mode of interaction is one of dominance, at least potential conflict. Of course there are real tensions. Different values, varying degrees of institutionalisation, and above all power inequalities are involved. At the same time words are not the same as deeds; complaints are not the same as actual coping with constraints.

We saw that professional autonomy seems more used as a claim – more precisely, a claim 'to be unmanaged', in Harrison's words – than that the degree and forms in which it occurs are actually investigated. Empirical reality is more complex than is suggested by images and claims, in the sense that various accountability regimes are active. It underlines the need for academics, first, to look beyond the rhetoric of claiming and counter-claiming and to document and explain in a focused way what actually happens, in all its empirical variation. The researcher of organisational behaviour in health care will then observe not only conflicts, but compromise and collaboration as well – to use the words of Exworthy and Halford (1999a). Such research may show insularly operating doctors, but team workers, too; protective behaviour next to open mindedness. It can be expected, for instance, that the adoption of managerial activities as elements of professionalisation can be watched. Second, there is a need for contextualisation. Overall, much variation can be assumed, even between professionals doing the same sort of work within one kind of health care organisation. Not all managers are cold technocrats; nor are all doctors altruistic Samaritans. Third, such research should be designed from a comparative institutional perspective extending beyond health care. After all, similarities and dissimilarities can be expected as much within that sector as between (semi-)professions, types of professional work, and modes dealing with autonomy across policy fields. What has been identified above as an 'evaluative imperative' seems inherent to professional work. The professional clearly functions as an expert, but he or she has also a responsibility towards government and to broader society. Making judgements and balancing between various considerations are inevitable. It is here that it becomes apparent why, after all, work done by professionals takes on a professional character.

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4

Affording Discretion in How Policy Objectives are Achieved: Lessons from Clinician Involvement in Managerial Decision-Making

Aoife McDermott, Mary A. Keating and Malcolm J. Beynon

Introduction

> *Policy implementation is what develops between the establishment of an apparent intention on the part of government to do something, or to stop doing something, and the ultimate impact in the world of action.* (O'Toole 2000: 266)

Many countries continue to face challenges in public policy implementation. One explanation for this is the need for local knowledge and insight to inform effective policy interventions (Matland 1995). This arises due to variations in local challenges, structures and stages of development, necessitating adaptation of policy requirements, to facilitate success (Hjern 1982; Matland 1995). However, in spite of increasing recognition of the need for local tailoring, traditional top-down and hierarchical modes of policy-making and implementation retain an enduring influence (Cho et al 2005).

In this chapter we report the findings of a study of the organisational factors facilitating clinician involvement in managerial decision-making in six Irish hospitals. Clinician involvement in managerial decision-making is an increasingly important policy objective in the Irish context. However, the Clinicians in Management initiative (CIM) in Ireland afforded local discretion to hospitals, regarding how this objective was achieved. As a result, we utilise our findings as a lens to identify considerations in affording discretion in how policy objectives are attained. Our findings draw attention to the potential benefits associated with policy design that facilitates local discretion. However, variations in 'intervention compliance' across the cases also draw attention to the contingencies underpinning the efficacy of such an approach. These include the need for:

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(1) cultural support for the policy objectives; (2) making the rationale underlying the introduction of policy objectives clear; (3) monitoring the attainment of the policy objectives and; (4) follow-up in the event that policy objectives are not attained.

The international policy context for clinician involvement in managerial decision-making

Involving clinicians in managerial decision-making has become a persistent theme in international health policy. This has been pursued through agency, in the form of clinical management roles (Llewellyn 2001) and structure, in the form of clinical directorate (CD) structures (Braithwaite and Westbrook 2005). The objective underlying both interventions is to balance clinical decision-making power with financial responsibility (Willcocks 1994), as clinicians are the major resource consumers in hospitals. Their decision-making accounts for up to 70 per cent of hospital expenditure (Hillman et al 1986). Consequently, it has been argued that clinician involvement can lead to improved corporate and managerial decision-making (Fitzgerald and Stuart 1992).

The Irish policy context for clinician involvement in managerial decision-making

Ireland was a 'late-adopter' of the internationally prevalent policy of involving clinicians in management. In 1998, the Department of Health and Children launched the CIM initiative. This aimed to '*provide for balanced involvement in decision-making between doctors, nurses and allied health professionals, and to decentralise the responsibility for managing resources down to local units with their direct participation*' (OHM 2001: 1). Clinicians were to be given responsibility for service-delivery, development and resource-allocation in clinical sub-units – interventions which closely mirror those inherent CDs. However, the manner in which CIM was operationalised was left to local discretion. Accordingly, our study provides an opportunity to examine organisations pursuing a common policy goal (clinician involvement in managerial decision-making) through different means.

Aims of the study

The aims of this study were twofold. The primary research objective was to examine the organisational factors (structural, management process and cultural) supporting the attainment of clinician involvement in decision-making. Half of the organisations in our study chose to pursue this objective through the introduction of CD structures, while the remaining three opted to make alternative amendments to their existing organisational structures. As a consequence the secondary research objective was to identify considerations in affording local discretion in how policy objectives are attained.

Our chapter continues by defining CDs. These are an internationally prevalent structural intervention, used to support clinician involvement in managerial decision-making. We explicate their form and underlying rationale and also provide an overview of research regarding alternative organisational interventions, also used to support clinician involvement in managerial decision-making. We then discuss the methodology we employed, before presenting our results. Finally, we conclude by considering the implications of our results for policy, practice and future research.

Attaining clinician involvement in managerial decision-making through clinical directorates

CDs are '*intermediate organizational arrangements through which defined parts of larger hospitals or health services are managed*' (Braithwaite and Westbrook 2004: 142). They entail a move away from professionally-oriented functional hospital structures, towards a speciality or task focus (Braithwaite et al 2005). In practice, this tends to involve either a divisional structure, derived from groups of pre-existing services such as 'medicine', or an institute-design, in which the CD is structured around the patient pathway (Braithwaite and Westbrook 2004). From an operational perspective, CDs tend to be comprised of a tripartite structure, with a (generally senior) doctor, supported by a nurse manager and business manager (Willcocks 1998). Each CD has a defined budget and, in this way, unifies resource decisions with financial responsibility (Llewellyn 2001). Clinicians are therefore involved in decision-making through the tripartite management structure and the devolution of budgets.

It has consistently been argued that CDs have the potential to address the pivotal policy issue of escalating costs (Dopson 1994), without compromising patient care (Shulz et al 1976). This is achieved by combining resource-allocation with service-delivery decisions (Pettigrew et al 1992; Ong 1998; McDermott et al 2002). In addition, it has been suggested that CDs improve responsiveness to '*changing patient demands*' (Button and Roberts 1997: 147), by decentralising decision-making power (Walker and

Morgan 1996). Improved collaboration and team-working have also been attributed to them, due to their boundary-spanning roles, which improve communication and cooperation between management and medicine (Atun 2003; Llewellyn 2001). In turn this erodes the 'tribal behavior' synonymous with health service organisations (Davies et al 2000). CDs have also been put forward as a mechanism to manage clinical governance (Lega 2008). However, the core underlying rationale is '*cost containment*' (Ong and Schepers 1998: 379).

Since their emergence in Johns Hopkins Hospital in the US in 1974, CD's have been widely adopted – including in the UK, the US, Australia, the Netherlands, Denmark, Switzerland, Italy and Canada. However, there is inconclusive evidence regarding their impact on the primary objectives they were designed to address, namely cost containment (Shulz et al 1976; Dopson 1994) and unifying resource decisions with financial responsibility (Llewellyn 2001). In spite of this, Braithwaite and Westbrook argue that the '*advantages are largely thought to outweigh the disadvantages'* (2004: 157).

Alternative organisational interventions used to support clinician involvement in decision-making

Although CD structures explicitly attempt to achieve clinician involvement in managerial decision-making (Willcocks 1994), a variety of alternative strategies have also been adopted. For example, in line with the rationale for budgetary devolution inherent in CDs, the centrality of accountability for decision-making has long been recognised. Specifically, an evaluation of the Resource-Management Initiative (RMI) in the UK stated that accountability is required to facilitate clinician involvement in decision-making and resource-management (Buxton et al 1989). In addition, the availability of accurate and timely information has been asserted to underpin effective decision-making (OHM 1999), while many attempts to include clinicians in management have begun by establishing management forums with representation from all relevant staff groups (Ong 1998). Finally, the receptivity of the context (Willcocks 1998) and cultural support from both senior clinicians and management (OHM 1999; Callanan et al 2002) have also been found to underpin successful clinician involvement in decision-making.

Methods

We adopted a qualitative approach to our primary research, which involved a comparative case-study design. Our hospital cases were selected by the research team, in conjunction with our project steering group (comprised of senior health care managers and clinicians). We purposively selected three hospitals with, and three without CDs, to facilitate evaluation of the range of organisational factors supporting the attainment of clinician involvement in managerial decision-making. Interviews were conducted with the senior management team, middle managers, clinical managers and doctors, nurses and allied health professionals (AHPs) in each hospital. Ninety-two interviews, each typically lasting one hour were conducted across the cases. Between 12 and 20 interviews were conducted in each hospital, in accordance with their scale. Each interviewee was asked about: their day-to-day role in service-delivery, their management within this role (performance-management, training etc.), their own management responsibilities, and their relationships in day-to-day service delivery and change. This approach provided rich descriptive data about whether, where and how stakeholders engaged in decision-making.

We undertook an iterative three-stage cycle of data analysis, which aimed to identify the organisational factors leading to clinician involvement in managerial decision-making. This was defined as occurring where doctors, nurses and allied health professionals (AHPs) had input into decision-making regarding service-delivery and improvement. In the first stage of our analysis we explored the data using a coding scheme derived from our interview schedule. In the second stage we considered six deductive themes relating to clinician involvement in managerial decision-making, derived from our literature review of prior research in this area. These themes included structural, management-process and cultural factors, as follows:

- *Clinical directorate structure in place* (CDP) – Whether hospitals have a tripartite CD structure, with a clinical director, a nurse manager and a business manager.
- *Budgetary devolution* (BDEV) – Whether hospitals have budgetary devolution, such that clinicians have authority and capacity to make and implement unit-level resource-allocation decisions.
- *Accountability* (ACC) – Whether hospitals have feedback mechanisms in place, making clinicians accountable for unit financial performance.
- *Information* (INFO) – Whether hospitals make high-quality, accurate and timely information available to clinicians.
- *Cross-professional decision-making forums* (CPF) – Whether hospitals have formal management forums with cross-professional representation.

- *Cultural support* (CULT) – Whether hospitals have cultural support for multi-stakeholder involvement in decision-making.

These factors are detailed for each case in Table 4.1. In the third stage of our analysis we undertook a cross-case comparison. As part of this we undertook qualitative comparative analysis (QCA), a secondary data analysis technique for case-oriented research (Kitchener et al 2002; Grofman and Schneider 2009). QCA identifies configurations of factors leading to an outcome. The growing popularity of QCA is underpinned by its suitability for 'small-N' research (Ragin 1987). Although our number of cases is smaller than that typically utilised in QCA, the technique helped us to identify patterns in our data, which we then explored through further qualitative analysis.

Table 4.1 Overview of six factors and clinician involvement in decision-making (CIDM) across the cases (Y – present, N – not present)

	CDP	BDEV	ACC	INFO	CPF	CULT	CIDM
H1	Y	N	N	Y	Y	Y	Y
H2	N	Y	Y	Y	N	Y	Y
H3	N	N	N	N	N	N	N
H4	Y	N	N	Y	Y	N	Y
H5	N	N	Y	Y	N	Y	Y
H6	Y	Y	Y	Y	Y	Y	Y

Key findings

Firstly, we found that clinician involvement in managerial decision-making was achieved in five of the six cases (all except H3). H3's culture was not supportive of clinician involvement in managerial decision-making. Neither senior managers nor clinicians supported the proposed shift, preferring a professional division of labour. As a result, there was no move to adopt CD structures, or to undertake alternative organisational interventions to attain clinician involvement in managerial decision-making.

Secondly, across the remaining five cases, we identified three alternative configurations of factors that supported clinician involvement in managerial decision-making. Firstly, where a CD was not in place (configuration 1, observed in H2, H5), a combination of financial accountability, availability of information and a supportive culture was sufficient to lead to clinician involvement in managerial decision-making. H2 and H5 devolved budgets and financial accountability to department level. In both hospitals, department managers were clinicians holding part-time management roles. These individuals had accountability for decision-making and resource-management in their departments. As a result, doctors, nurses and AHPs were involved in decision-making for their departments, in uni-professional forums.

Thirdly, where a CD structure was in place, configuration 2 (observed in H1 and H4) suggests that the minimum factors required to achieve clinician involvement in managerial decision-making were the availability of information to inform decision-making and the existence of formal cross-professional forums where clinician involvement into decision-making could take place. Interestingly, neither H1 nor H4 had budgetary devolution in place, classic features of CDs. They had adapted the intervention to suit their local context, adopting as many features as possible within organisational constraints (both cited the difficulty of allocating costs to hospital sub-units under their current financial system as a key barrier to financial devolution).

Thirdly, having a CD structure together with budgetary devolution, financial accountability, availability of information, cross-professional forums for managerial decision-making and a supportive culture also led to clinician involvement in managerial decision-making (configuration 3, observed in H6). Configuration 3, in which all of our considered factors are present, illustrates that the existence of budgetary devolution, financial accountability and a clinical and managerial culture supportive of clinician involvement in managerial decision-making can further support the attainment of our policy goal, over and above the minimum requirements detailed in configuration 2.

Discussion

As per our literature review, we emphasise that each of the factors considered in our analysis have previously been individually identified as important in achieving clinician involvement in managerial decision-making. As a result, it is the identification of alternative combinations of factors which support our outcomes that is of interest.

In considering the combinations of factors supporting clinician involvement in managerial decision-making, we note that configuration 1, evident in H2 and H5, led to the attainment of our desired policy goal, without a CD structure. H2 and H5 were characterised by strong financial accountability, held by department managers with clinical and managerial responsibility. Information was made freely available to these individuals and the hospital cultures were strongly supportive of clinician involvement in managerial decision-making. However, as accountability was department based, clinician involvement in managerial decision-making took place in uni-professional forums in these hospitals. We also note that configuration 2, evident in H1 and 4, showed evidence of variations in 'intervention compliance', with only some of the classic features of CDs adopted. Both findings lend weight to the argument that local discretion can be afforded in how policy objectives are obtained and that there is not necessarily 'one-best way' to achieve policy goals.

Nonetheless, even though our findings from configuration 1 provide a blue-print for hospitals without CD structures to achieve clinician involvement, a *caveat* does arise. Although the division managers in both organisations (H2 and H5) emphasised the efficiency benefits achieved within their structure and management-processes, other espoused benefits of CDs were not evident. In particular, although input from the full range of clinical stakeholders was achieved, this occurred in uni-professional forums. As a result, the structure did not encourage cross-professional collaboration (Llewellyn 2001; Atun 2003), or provide a mechanism into which to integrate multidisciplinary clinical governance (Lega 2008). Hence, we suggest that where local discretion is afforded in how policy objectives are obtained the rationale underlying the objectives should be made explicit to ensure that organisations achieve the full range of benefits intended to be associated with the intervention.

Finally, in reviewing the factors across all of the configurations we note that information, referring to the availability of high-quality, accurate and timely information was the only factor present across all of the three configurations. This suggests that the availability of information is necessary for clinician involvement in managerial decision-making to occur. This finding is in line with Buxton et al (1989), who found that relevant and accurate information underpins clinician involvement in decision-making.

Policy, practice and research implications

With regard to our first research objective, identifying the organisational factors supporting clinician involvement in managerial decision-making, we draw attention to the following important considerations for health service policy-makers and practitioners:

1. Firstly, we have identified the availability of information as a necessary factor to support in the achievement of clinician involvement in managerial decision-making.

2. Secondly, where a CD is in place, the availability of information to inform decision-making and the existence of formal cross-professional forums, where clinician involvement into decision-making can take place, are the minimum requirements to achieve clinician involvement in managerial decision-making. Budgetary devolution, financial accountability, and a supportive clinical and managerial culture can provide further support.
3. Thirdly, where a CD is not in place, a combination of strong financial accountability, the availability of information to inform decision-making and cultural support can also lead to clinician involvement in managerial decision-making. These factors should ideally be supplemented with cross-professional communication.

These findings suggest that caution should be exercised in considering CDs as the 'one-best way', to achieve clinician involvement in managerial decision-making. Of course, we note that there are additional espoused benefits of CDs, beyond their core rationale of 'cost-containment' (Ong and Schepers 1998). In addition, there are further benefits associated with the six influencing factors considered. These additional benefits must be considered to identify the appropriate course of action in a given context. For example, although clinician involvement in managerial decision-making can be achieved without cross-professional forums, there are broader benefits associated with these (Atun 2003). Hence, our findings suggest the need for further research. In particular, it would be useful to identify the factors supporting other beneficial outcomes of CDs (such as collaboration, improved team-working and clinical governance), in conjunction with decision-making. Finally, although our analysis has focused on the organisational factors supporting clinician involvement in managerial decision-making, we note that several authors have identified role-related challenges to the efficacy of CDs (Willcocks 1994; McDermott et al 2002). As a result, like Lega (2008), we recognise that future studies should evaluate the role-related influences on clinician involvement in managerial decision-making, as well as the broader organisational factors we have considered.

Our second research objective aimed to identify considerations in affording local discretion in how policy objectives are attained. Our findings draw attention to the potential for multiple approaches to achieving policy goals. As the most appropriate approach may depend on local history and context, policy-makers may wish to provide organisations with discretion regarding how specified objectives are pursued and achieved. However, our findings draw attention to a number of contingencies which may underpin the efficacy of such an approach.

Firstly, based on our finding from H3, where we failed to find evidence of clinician involvement in managerial decision-making, we note that affording local discretion may only be appropriate where there is cultural support for policy objectives. This finding also draws attention to the need for formal monitoring or reporting mechanisms, to ensure that policy objectives are obtained. Finally, this finding also suggests the need for follow-up in the event that policy objectives are not obtained. Secondly, our finding from 'configuration 1', where the chosen configuration of factors did not lead to cross-professional collaboration, a positive externality usually associated with the policy objective in question, suggests that policymakers should make the rationale underlying the introduction of policy objectives clear. This will help to ensure that maximal benefit is derived from any intervention. To support organisations in this regard, policy-makers may wish to identify potential alternative approaches.

Conclusion

International policy has advocated CDs as a structural vehicle to achieve clinician involvement in decision-making in hospitals. However, in the light of mixed perceptions and reports regarding their efficacy and impact, we have analysed configurations of factors influencing this outcome. Significantly, through cross-case analysis, we have identified alternative configurations of organisational factors that can support clinician involvement in managerial decision-making, in the presence and absence of CD structures. This is important as structural reform can entail major investment and upheaval, and the attainment of policy objectives through the tailoring of existing structures, rather than the introduction of entirely new ones, may be desirable in certain contexts.

More broadly, our findings suggest that, in Ireland and beyond, policymakers should question the strategic imperative of establishing 'one-best way' to achieve policy objectives. However, based on our study, we note that where policy-makers afford discretion to shape how policies are implemented, they should establish clear policy goals; make the underlying rationale for the policy objectives clear; identify alternative paths to achieving the policy goals and; have monitoring and feedback mechanisms to ensure that policy objectives are attained.

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5

Comparing the Quality of Working Life of Doctors with Other Workers Across Europe

Annabelle Mark, Suzan Lewis and Michael Brookes

Introduction

How does quality of working life in health care (particularly for doctors) in the UK compare with other sectors and between countries, especially in relation to pan European policies like the European Working Time Directive. In this chapter we summarise data from a wider European Union (EU) project (European Commission 2007) highlighting particular problems relating to hospital doctors in the UK.

Trends and changes in the nature, management and experience of work in the global economy have raised a number of concerns in Europe (Smith et al 2008). Economic performance and financial concerns have to be balanced with socially sustainable forms of work organisation now popularly termed work-life balance. Contemporary working patterns can reduce time and energy for personal life, including family (Lewis et al 2009). EU social policy has attempted to address this issue through a raft of employment policies, including the European Working Time Directive (EWTD) introduced to reduce the number of hours worked. Its impact has been the subject of much debate for health care and for the medical profession in particular and it is now subject to review by the European Union itself.

The project from which the data are drawn (www.projectquality.org) set out to examine how, in an era of major change, European citizens living in different national welfare state regimes evaluate the quality of their lives. In this chapter we focus on:

i) Factors influencing quality of working life among employees in four service sector organisations, including hospitals in the eight European countries

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ii) Hospital workers' experiences of quality of working life within this wider context – i.e. to compare their experiences with those in other sectors and other countries
iii) How a sample of British doctors experience quality of working life and the impact of the EWTD on these experiences.

The study draws on and integrates two theoretical traditions and associated concepts through what is termed the 'dual agenda' (Rapoport et al 2002) of:

a) Quality of life, and specifically quality of working life at the individual level and
b) Quality of work and the emerging theory of 'healthy organizations' at the workplace level

There is a growing consensus that quality of life is a complex, multidimensional concept (Cummings 2005). One dimension to have received considerable recent attention is that of quality of working life and the related notion of quality of work (Smith et al 2008). This takes as its focus work and working conditions such as the hours worked (Baker et al 2004) and the flexibility to manage the work-home interface. Employing this approach, at the individual level this paper draws on the demands – resources model of well being (Demerouti and Bakker 2001) to examine the antecedents of quality of working life (QOWL). Thus the analysis focuses on both work demands, such as intense workloads, and the resources, such as autonomy and control, that are associated with negative and positive individual outcomes. This approach further recognised that demands and supports at home, as well as at work, impact on QOWL; thus we review quality of life here from our data in terms of hours and intensity of work and levels of stress and work-family conflict.

The notion that organisations can be described as healthy or unhealthy has been discussed since the early 1990s (Cox and Haworth 1990; Wilson et al 2004). Most definitions focus on meeting both employee and workplace needs through the dual agenda. This assumes that working practices that do or do not meet the needs of the organisation or the employee in the short term, without addressing either in the long term, will not be fully 'healthy'. Such outcomes are not sustainable (Lewis et al 2007) and thus not healthy for the organisations or indeed the individuals within them.

The health care organisations in this cross country and sector study proved to have some particular areas of interest in relation to policy into practice issues. The question we wished to answer was 'are doctors' experiences compared to other workers across European countries different?' This is additionally important as the UK is seen to take the lead on such issues for doctors in Europe (House 2009).

The EWTD came into force in 1998 in the UK for all workers, except junior doctors and deep sea fishermen, and for offshore oil workers in 2003. From August 2004, a reduction in total hours being worked by doctors began, towards a total 56 hours in 2007 reducing to 48 hours in 2009, with a minimum of 11 hours rest in any 24 hour period. Since 2002 through the clarification of two rulings in the European Court, there is a requirement that all on call work undertaken at the place of work would also constitute working time. As a result there has been a change in the organisation of working patterns from on call rota working, which means working a normal day followed by being on call through the following night or weekend, to a pattern of shift working. Shift working is considered better human resource practice, having less impact on efficiency and thus the health and safety of staff and consequently patients (European Commission 2007). However the transition has highlighted the complexity of finding an appropriate balance between work and life and professional training, as individual specialties now increasingly demonstrate (House 2009). Alternative strategies, involving role boundary changes, to allow some tasks undertaken by doctors to be provided by others (Herbertson et al 2007), may have something to offer to reduce stress caused particularly by work intensification. However these cannot substitute for the training needs for doctors' development, particularly because the new shift working has compromised the former medical firm (team) structure. The former structure ensured the same team of juniors doctors, registrars and consultant were on call together, especially over weekends (Jagsi and Surender 2004) such continuity of care has now been lost through shift working.

Design and methods

The European research project employed a mixed methods approach across the participating countries of the UK, Finland, Sweden, Germany, the Netherlands, Portugal, Hungary and Bulgaria.

A survey covering aspects of quality of the respondents' working lives, as well as their individual and home situations, was carried out across four sectors (banks, hospitals, supermarkets and IT/technology companies) in each country. In most cases a web based survey was used with representative samples of staff in each organisation; these were identified by their respective Human Resource functions. However, in some organisations, especially in the retail sector, hard copies were circulated. Response rates ranged between 89 per cent and 20 per cent, varying between the European countries and sectors.

The UK sample includes 159 bank employees, 146 hospital employees, 131 employees in a retail company and 201 from a telecommunications firm; 60 per cent of the total sample are women, 72 per cent are married or cohabiting and 14 per cent have at least one child under the age of five.

Interviews

The aim of the qualitative stage of the wider research project across all participating countries, was to explore the notion of a healthy and socially sustainable workplace, specifically the factors that are perceived to contribute to, or challenge, quality of life and workplace effectiveness, in one specific organisation, in each country, to enhance understanding of local contextual issues.

In the UK, where the hospital was the focus, 21 members of staff were interviewed: they included 14 women and seven men, of whom nine were members of medical staff and 12 non medical. These staff provided a cross section of the frontline and support workforce. As part of the interview process the Director of HR and two trade union representatives were also interviewed to provide contextual information about the most recent changes within the hospital. These semi structured interviews were constructed by the transnational team to clarify and enhance understanding of the survey results. Interviews were recorded and transcribed and then subjected to thematic analysis (Braun and Clarke 2006).

Results

Outcomes of the statistical data are reported elsewhere (www.project-quality.org – Comparative Cross National Analysis D1.3) but in summary the conclusion drawn from the four perspectives used are as follows:

In relation to all four sectors in the eight countries, the overriding conclusion is that the UK overall performs badly and in some cases the worst on various aspects of quality of working life. There is some variation in work intensity between countries, though autonomy and colleague support are critical factors in alleviating problems. However, there are within country differences between sectors; for example, levels of work family conflict are high in the UK, but those respondents working in hospitals report less stress than employees in the telecoms industry. Colleague support is key in reducing stress everywhere, although shift working increases stress along with shortages of money and poor health, especially for women, which may be particularly relevant to the changing demography of medicine as a profession (Godlee 2008).The UK is mid way between other countries in terms of excess hours worked, banks working the longest.

Looking across the four sectors of banking, hospitals, IT and retail in the UK hospitals and the IT telecoms industry are characterised by high levels of work intensity compared to others, and also high levels of stress and work family conflict. The overall picture is somewhat damning in that the UK is one of the worst performers in terms of the quality of working lives compared to other countries and in the UK the hospital sector compares badly with other sectors.

Looking at the hospitals across the eight countries, work intensity is higher in UK hospitals than elsewhere, except Finland, with doctors the worst affected group. Much the same picture applies to stress, but Hungary is also adversely affected because emotional exhaustion and depersonalisation are key factors here, due to the relatively poor physician to patient ratio (Eurik and Kalabay 2008). In relation to work family conflict, the UK suffers the worst with the highest levels and doctors are the most seriously affected. With the exception of Portugal and Hungary, the UK hospitals also have the highest levels of excess hours. These outcomes confirm a similar picture that emerged in a previous eight country European study of nurses (Simon and Next-Study Group 2004).

In summary, the UK has arguably the lowest quality of working life of the eight countries in the sample; within the UK, the hospital sector is also one of the worst of the four sectors sampled. Finally, within the hospital sector, it is the doctors that have the lowest quality of working life in comparison to nurses and non-medical staff.

These conclusions from the quantitative data required further explanation, so it was then important to turn to the rich text of the qualitative data. This data across the eight countries had been taken from a number of hospitals, but in order to discover the extent to which the overarching themes reflected the lived experience in a particular context (Bamberger 2008) we turned to the interviews in a UK hospital to try and understand the reasons for this emerging picture. Various aspects of continuing change in hospitals and the wider NHS, including the way the EWTD was being implemented, emerged as very important in understanding these findings and the unique context that produced them.

Notwithstanding this further analysis of the key themes reveal issues for consideration across health in all participating countries especially in relation to the EWTD.

The main findings in respect of the specific factors outlined in our data are now set out in the remainder of this section.

Work intensity

All the doctors interviewed felt under pressure as the following quote exemplifies:

> *– you rush to get there before 8.30 to get the computer on, but my contract hours don't start until 8.30 – you have to rush to meetings, go to… do a long list, grab my food, rush without a break to (another hospital). It's that sort of atmosphere. I think we all feel pressurised…* (Woman, doctor)

Junior doctors were conscious that their workload had intensified as a direct consequence of the way in which the European Working Time Directive had been implemented; that is by a reduction in working hours, through the introduction of shift systems, but without matching additional staff or a fall in workload. This was leading to feelings of powerlessness and a loss of professional commitment to going the extra mile, now expressed more widely in the public sectors increasing reluctance to engage in such organisational citizenship behaviour (Coyle-Shapiro et al 2004):

> *It certainly intensifies work within a certain time period. But the workload is disproportionate… you have to work much harder during those hours so the work is more intense and more physically draining and exhausting.* (Man, doctor)

Moreover, the reduction in working time has resulted for some in the loss of overtime payments – so doctors are working more intensively **and** losing pay to achieve the same outcomes for patients (Jagsi and Surender 2004), this experience in the UK is confirmed in other countries; as studies in Germany (Fuss et al 2008) Sweden (Heponiemi et al 2008), Finland (Adám et al 2008) and Hungary (von Vultée 2007) demonstrate. The loss of value felt here was not only financial but also personal in reducing the role of doctor to service provider rather than professional expert leading to a sense of deprofessionalisation.

The pace and intensity of work in the UK were also exacerbated by organisational targets. However, some expressed views that things are starting to improve through initiatives like the NHS 'Improving Working Lives' policy set out in 2001, although without extra staff, such initiatives (such as promoting flexible working) result in people working harder, albeit for shorter hours.

One consequence of the intensification of work is a feeling of constant haste described here:

> *This is the busiest place I have ever worked… It has the highest level of demands when you are on call. It has the highest intake of patients. And there are fewest junior doctors of anywhere I have ever seen.* (Man, doctor)

Some participants are concerned that this intensification and haste can lead to mistakes; this may further damage the individual's internal locus of control and its association with well being, motivation and subsequent behaviours (Ng et al 2006) as well as the safety of patients. High workloads and tight staffing are also reported to be associated with an increase in reluctance to work together across disciplines, so that working practices become very fragmented, which can undermine efficiency. Such dysfunctional effects to the behaviours required for effective working, of interdependence and responsibility for others, are also predictive of work family conflict (Dierdorff and Ellington 2008).

Work related stress

In this intensified context some doctors said they feel exhausted, physically drained and have little time to think. It is recognised that this is not good for patients' or for doctors' quality of life.

> *…generally it (the hospital) provides a decent service, although it provides a decent service at the expense of morale amongst the staff who work in it, which is not really sustainable. Morale is low.* (Man, doctor)

The sustainability of a healthy work environment through the dual agenda seems to be at risk here producing low morale, uncertainty also affects people at all levels. Following changes to provision, including ward closures to meet financial targets, one doctor felt that the subsequent anxiety affected their every day practices, making them reluctant to ‘rock the boat’

> *The future of the hospital… it's very worrying. Last year has been very stressful for all of us… Before we were very independent and could speak our minds, talk freely. … People used to work until retirement but now we are worried.* (Woman, doctor)

Another doctor felt that resource issues were preventing them from doing what they are actually very good at:

> *We need better buildings, better equipment and to know that (our jobs) are secure so we can get on with it. We are actually a very good hospital if we can just get on with it.* (Woman, doctor)

Work related stress has increased due to low morale and uncertainty combined with the need to remove some perceived barriers to improving care such as poor quality work environments and reduced professional freedom.

Work family conflict

Staff are required to put forward their desired shift and working hours well in advance – up to six weeks – and the rota cycle is for a four week period. The rationale for this is for effective management of staff and to ensure that all areas are covered but this makes late switches difficult. Staff find this inflexible; it impinges on their family life and caring, whether for elderly people or children. There are also concerns about doctors’ shift systems:

> *The shift system for younger doctors… it's not a proper handover. They need to take responsibility, have ownership…. People need to feel empowered…. They have taken that away. We need more joined up working.* (Woman, doctor)

Shift systems need to think though the effects of shift working on the staff, patients and also on the family life of doctors (Bamford 2008), especially given evidence that a good family life has a protective effect on doctors to better withstand the pressures of the job (Reimer et al 2005; Stack 2004).

Among the younger doctors interviewed, some fathers, like mothers, were making career choices based on family commitments

> *Doing what I really wanted to do is unfeasible in terms of Modernising Medical Careers (the policy on which changes to training pathways*

> *in UK medicine are based) and having a family. I was forced into a 9–5 speciality – I would have really liked to do intensive care but it was not feasible with young children.* (Man, doctor training in geriatrics)

There is other evidence of pockets of change in gender roles and identities at least among some of the doctors

> *With the implementation of European Working Time Directive… Working blocks of 3–4 days and nights. They did try working in 4 blocks of 4 days on call but we managed to block that on the grounds of adversely affecting social and family life… we were supported by a senior consultant who has a family – a man.* (Man, doctor)

Doctor's career choices are always a function of the options affected by personal and organisational pressures, however it is important that the balance between them is acceptable so tracking this over time in relation to speciality needs will be important.

Actual hours minus contracted hours

Among the medical staff there is a feeling that their professionalism is being challenged by some of the changes. Medical staff are more closely managed and monitored; ironically this is the opposite of the trend in many workplaces to increase personal responsibility.

> *Now we are watched – what time we arrive and what time we go. There's a great sense of demoralisation. We are professionals; you don't clock in and clock out… A 'little boy' [said disparagingly] from accountancy firm came to measure my time use.… They were watching how long we take, how many patients we see – never mind if some patients are complex, take a bit longer-…* (Woman, senior doctor)

> *Medicine has been reduced to service provision alone.* (Man, doctor)

Many feel unappreciated, by the hospital and by the government, because of a lack of recognition of the efforts they are making under difficult circumstances

> *The government thinks we are not doing enough. … I do far more than I ever did.* (Woman, doctor)

Despite the threats to professional identity, a sense of vocation sustains some doctors though difficult times

> *Its difficult for me to get demoralised because I have worked all my life to be a doctor… this is what I have lived for since 11 years old…* (Man, junior doctor)

Building physician resilience, for women doctors in particular (Robinson 2003) given their increased participation in medicine, will be an important part of both sustaining and maintaining the workforce in the UK and elsewhere.

Discussion

Two aspects of research in health care organisation may help explain why such comparative information provides contextual insights; these are poverty in pragmatism and international collaboration (Mark 2006): *Poverty in pragmatism* identifies that what works in the short term, in this case a reduction in working time to improve the quality of life, is not carried through to the long term and indeed may be reversed. This is particularly so if the result of the EWTD decreases the quality of life.. This may be confounded further either because political interests are not served by seeing the long term, or because tracking across organisations (or time) requires understanding through the second research issue, the need for *international collaboration* in both the funding and undertaking of research. This research (European Commission 2007) and its outcomes have enabled such combined ways of seeing the outcomes to be observed and reported.

Policy to practice gaps

The key issues for both EU policy-makers and clinicians drawn from our Framework 6 study are that the context for implementation of change is critical to success. This relates to both national differences and sectoral differences. Health care does seem to have features which indicate that it remains a special case, not least because of the relationship between service provision and education as individuals pursue early career training and engage with family life. Furthermore if doctors continue to experience deterioration in the quality of life, this will have both short and long term impacts especially where the latter changes career path decisions. While it is important to understand that the interaction of personal and professional choices has always been critical in determining clinical specialty recruitment; it is also important to consider, through appropriate longitudinal studies, how this may be changing and what the impact of policies like the EWTD may be on such choices. The issue of context was also revealed as particularly important in requiring close monitoring of the variety of implementation settings. This would enable adjustments to be made in order to maintain objectives and outcomes for all the stakeholders. Because the complexity of factors geographical, cultural, social, professional all impinge on how policy is turned into practice and the unintended consequences that such pressures can produce. In conclusion it seem that further research on the changing expectations of doctors, in both training and career paths, will be critical to maintaining a healthy workforce and appropriate organisational setting for the delivery of effective patient care.

Since this research was completed and submitted as an EU Framework 6 Project, the European Union has announced, in March 2010, a review of the EWTD which is now in its second phase (European Commission COM(2010) 801 2010). In commissioning phase 2 the commission recognised that in relation to health care:

> On the one hand, patient safety needs to be ensured by making sure health and emergency services are not delivered by workers whose skills and judgment are undermined by exhaustion and stress resulting from long working hours. On the other hand, the sector is already facing a gap in supply of skilled professionals that will widen in the future unless appropriate measures are taken to address it. In order to recruit and retain health workers, it is important to make the working conditions more attractive. Reasonable working hours and work-life balance are crucial in that respect.

The challenge in the UK for doctors, as the NHS moves forward to major structural change and reductions in resources as set out by the new government elected in 2010, will be how to maintain the balance between work and life. Furthermore to ensure that the working conditions are good enough to both maintain and recruit the medical workforce.

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Section 2

The Role of Culture and Institutions in Implementing Policy

6

The Role of Organisational Identity in Health Care Mergers: An NHS Example

Niamh Lennox-Chhugani

Introduction

Organisational change driven by mergers, acquisitions, demergers, spin-offs, collaborative networks and strategic alliances have been a common feature of organisational life internationally for the past two decades and increasingly so in health care provision. As health care providers the world over are exposed to competitive market forces, consolidation has become more prevalent as they seek to realise economies of scale in the context of tighter and tighter financial constraints.

Such changes challenge not just health care organisations' identity or sense of who they believe themselves to be culturally and in terms of the image they wish to portray (Hatch and Schultz 2002) but also the identity of the wider institution in which they are embedded, the health system itself. In some countries such as the US, the health system is a loosely coupled network of providers and purchasers operating competitively and independently of each other, overseen by relatively light touch government regulators. In this context, health care organisations tend to have highly developed organisational identities that enable them to distinguish themselves from their competitors in the marketplace. At the opposite end of the spectrum, in countries such as the UK, the health system is a tightly coupled hierarchy of purchasers and providers to whom competition is a relatively formative concept. Government takes a much more direct role in mandating patterns of purchasing and provision. In this context, the identity of the National Health Service (NHS) as an institution is more prevalent than that of individual organisations. However, as policy changes and competition and choice become more widespread in the UK health service, organisations find themselves having to explicitly express an identity to distinguish themselves from their competitors.

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In many health care systems networks of collaboration, outsourcing and other forms of post-bureaucratic organisation (Hatch and Schultz 2002; Corley 2004; Pollitt 2009) are challenging organisations' ability to firmly establish a distinctive boundary (Brown 2001). In the past, organisational identity was defined as stable and enduring (Albert and Whetten 1985; Whetten 2006). Increasingly, scholars and practitioners are emphasising what is both enduring and changing in identity (Gioia et al 2000; Chreim 2005). Organisations do this through discourse by the use and interpretation of identity labels (Corley and Gioia 2004) and other practices such as organisational symbols and routines (Pratt and Rafaeli 1997; Kilduff et al 1997).

In a health care context, research from Canada, the United States and the United Kingdom has explored how identities at multiple levels of the organisation interact in complex ways. At the level of individuals, professional and other social identities influence the ways in which they respond to and interpret policy change (Chreim et al 2007; Pratt and Foreman 2000; Ferlie et al 2005; Leonard 2003; Doolin 2002). At the institutional level, policy change is interpreted in the light of what is deemed to be legitimate based on the central and enduring features of the institution (Dutton and Dukerich 1991; Scott and Lane 2000; Corley and Gioia 2004). Between these levels, at organisational level, policy change can challenge the form and culture organisations and these in turn influence policy (Golden-Biddle and Rao 1997; Hatch and Schultz 2002; Ravasi and Schultz 2006).

This paper explores how policy change influences specifically organisational identity and how individual/professional, organisational and institutional identities interact creating adaptive instability in organisational identity (Gioia et al 2000).

Organisational identity change and continuity in the context of policy implementation: A merger example

Organisational identity as a concept enables us to examine individual or group behaviour in the context of organisational frameworks (Albert et al 2000; Whetten 2006) and has been used to explain organisational behaviour such as strategic decision-making (Dutton and Dukerich 1991), individual members' identification with the organisation (Dutton et al 1994; Dukerich et al 2002; Foreman and Whetten 2002; Kreiner and Ashforth 2004) and managerial regulation of organisational identity in driving change (Gioia and Thomas 1996; Alvesson and Willmott

2002; Humphreys and Brown 2002; Corley and Gioia 2004). Most commonly, research has tended to focus on the effects of policy or market change on organisation's identity.

A common response to policy or market change in the health sector internationally is to merge existing organisations or create new organisational forms. This represents radical change for the workforce, often resulting in reduced employee support for the transformation and adversely affecting the extent to which the employees identify with the new organisation (Blake and Mouton 1985; Haunschild et al 1994; van Dick et al 2004). A key challenge for the new organisation, therefore, is to find ways to increase identification for employees who experience a discontinuity of their organisational identity from the 'old' legacy identity to the 'new' one. Organisational leaders usually do this by expressing a desired future identity for the merged or new organisation (Gioia and Chittipeddi 1991; Corley and Gioia 2004). This desired future identity is then interpreted by other organisational members through a process of sensemaking (Weick 1995; Corley and Gioia 2004). This is not just an internal process. Policy-makers, customers/patients, suppliers, professional associations, and board members to name a few also influence the desired future identity (Scott and Lane 2000; Hatch and Schultz 2002).

These multiple interpretations can lead to ambiguity in the changing identity which has various consequences for the organisation and its members as they attempt to resolve this ambiguity. Active resistance to policy change and the effect this will have on organisational identity is one possible response. This is often expressed in terms of resistance to changing working practices (Kilduff et al 1997). Such resistance can go some way to explaining the endurance over time of organisational identity. Other explanations of this endurance include the influence of power dynamics (Scott and Lane 2000), individuals desire to preserve their ontological security as expressed through the 'old' organisational identity and professional identities (Brown and Starkey 2000), and the influence of leaders who continue to identify strongly with the 'old' identity (Hogg and Terry 2000). The health system is a particularly rich empirical context in which to observe these dynamics. Professional identities at the individual level are strong in the health system and there is a considerable body of research exploring the nature and construction of professional identities in health care internationally (Pratt and Foreman 2000; Doolin 2002; Leonard 2003; Pratt et al 2006; Chreim et al 2007).

Identity change and continuity at the AHSC

In 2008, the Department of Health, using the US Academic Health Centres as a model, proposed the establishment of Academic Health Science Centres (AHSCs) in the UK which would bring together organisations from the health and higher education/research sectors in novel forms of governance. In the case presented here, the creation of the AHSC was preceded by the merger of two teaching hospital trusts.

The desired future identity

A desired future identity for the AHSC was expressed by a small group of leaders from all three organisations through a steering group which was set up in the 12 months prior to the merger of the two hospital trusts. The leadership of the AHSC exhibited coherence among themselves as a group about what the desired future organisational identity meant, but they recognised that it may be ambiguous to others. There was an assumption that too much emphasis on change would provoke resistance so continuity would be given prominence at this stage. This was reflected in the ambiguity of the documentation and presentations that accompanied the consultation process. Whilst there was almost universal support for the expressed desired future identity, many perceived ambiguity in what was expressed.

The desired future identity that was expressed maintained some ambiguity in order to ensure that internally organisational members would perceive continuity in the context of change. This ambiguity was explicitly used by the steering group pre-merger and during the consultation on the creation of the AHSC to create space for individuals and groups to preserve their social identities, usually professionally-based, and in some cases enhance them.

There was particular ambiguity in relation to the form that the AHSC would take. The merged hospitals were a legal entity as a single hospital trust after October 2007, but there was no formal or legal basis for integration with the faculty of medicine. To overcome this, the leadership consistently referred to the AHSC as a ‘virtual entity’, leaving room for a number of possible realisations of the relationship.

Making sense of the desired future identity

The desired future identity was interpreted in multiple ways by the organisation’s members, sometimes exhibiting continuity and sometimes changes. Organisational members perceived a high level of ambiguity in the desired future identity that was presented to them. While for some this was seen as an opportunity to reinterpret and shape the desired future identity, for many it was a source of anxiety and uncertainty. Professional and legacy organisational identities both had significant effects on how individual interpreted the AHSC identity as expressed by the leadership and how this interpretation shaped the identity being constructed.

Professional identities

A desire for professional leadership is a particular characteristic of the health sector. Parallel reporting structures are a feature in most health care providers in the UK as professionals report both to professional leads and operational managers. The leadership saw the new clinical leadership structure of the AHSC as resolving this issue for doctors by giving operational management responsibility to lead doctors, but it did not do so for nurses or allied health professionals who continued to report to two leads. Thus the message of clinical leadership was perceived as one of ‘doctor leadership’. However, even within this group ambiguity was evident, as many clinical doctors perceived the lead doctors to be predominantly medical academics and insensitive to their needs as ‘pure’ clinicians. Medical academics shared many of the leadership group’s perceptions of the desired future identity and what it meant to them. This is not surprising given that many of the leadership group were drawn from this group of medical academics. Clinical doctors, who differentiated themselves from medical academics, were more uncertain about the achievability of what they perceived to be an ambiguous and highly ambitious strategy.

This ambiguity concerned service and general managers as they struggled to discern their place in the ‘virtual entity’ that was the AHSC. It was unclear to them that they would have a place in the context of clinical leadership and many responded to this uncertainty by leaving the organisation. The human resource department of the AHSC reported anecdotally a surge in resignations among this group over the immediate post-merger period. This was also reflected among specialist managers in corporate departments such as human resources, communications, information technology and finance.

Legacy organisational identities

For many organisational members the ambiguity of the desired future identity of the AHSC was resolved by ignoring it. The persistence of legacy identities during the post-merger phase, 12 months after the merger of the hospital trusts, acted as an anchor in a sea of uncertainty and ambiguity. Old communication networks broke down as senior and middle managers from legacy trusts left the AHSC. Posts were left unfilled as the new structure was designed and many regular team meetings and team briefs were discontinued. In the communication vacuum described by many members, individuals continued to identify with the legacy organisation they had been committed to. Others managed ambiguity by reframing the desired future identity in terms of their past identity. Members of one of the merged hospitals described it as having a history of integrating medical research and service provision and saw continuity between that past and the AHSC desired future identity.

Institutional identities

The policy of creating AHSCs was intended to formalise the relationships between leading teaching hospitals and faculties of medicine with whom they had associations, leading to an increase in the amount and quality of translational research in the UK. Creating the first AHSC brought together a higher education organisation with two NHS organisations. Members of each clearly described what they saw as the differences between the institutional fields within which these sat. The higher education sector was described as more commercial and ruthless, the NHS as patient-focused and 'values-driven'. Many members of the NHS described their doubts about the ability of higher education leaders to understand the nuances and complexity of the NHS. Members of the university described the regime of general management in the NHS as 'unfit for purpose' in the context of clinical leadership and that a more commercial and 'hard-headed' approach was desirable in the NHS.

Constructing the new identity

Using the institutional, legacy organisation and professional identities, organisational members reduced ambiguity discursively by recontextualising the leadership identity discourse. Recontextualisation is a concept used by Fairclough (2005) to describe a process whereby one discourse is transposed or integrated into another. The leadership presented the desired future identity in its vision for the AHSC:

> *The AHSC's vision is that the quality of life of our patients and populations will be vastly improved by taking the discoveries that we*

> *make and translating them into advances – new therapies and techniques – and promoting their application in the NHS and around the world, in as fast a timeframe as possible*. (The Vision for the Academic Health Centre, June 2008)

Organisational members reinterpreted this vision in a number of ways to 'fit' with their professional identities, the legacy identities many still felt attachment to and their own desired future identities. Nurses reinterpreted this vision to be more patient centred with more of a focus on patient care and the whole experience of the patient. Clinical doctors translated the vision to mean that 'local' patients and populations would have access to 'world-class' treatments and that their clinical autonomy would be preserved in order to allow them to innovate in ways that contributed to this vision. Organisational members talked about continuity between 'old' and 'new' identities describing the AHSC as offering an improved version of historically innovative health care providers.

The relationship between policy change and an organisation's identity

Organisational identity change has been theorised as the result of sense-giving and sense-making strategies (Corley and Gioia 2004; Ravasi and Schultz 2006). Sense-giving succeeds policy change as a managerial group implements the policy in their local context.

Ambiguity in sense-giving can be used strategically (Eisenberg 1984) in order to preserve some flexibility both for the sense-giver in responding to new and unanticipated events such as a further policy change. It also allows for those making sense of the identity discourse to recontextualise (Fairclough 2005) or reinterpret it in terms that are meaningful to them. Those making sense of an identity discourse do so in the context of their individual and professional identities and persisting legacy organisational identities (Brown and Starkey 2000; Empson 2004). Thus continuity at the individual/professional and institutional levels is preserved whilst there is more overt change at organisation level.

This continuity of identity over time pointed to constraints on the construction of the AHSC's identity. There were some social rules and practices that proved sticky and enduring. The options for sense-giving and sense-making are not limitless (Gioia et al 2000). These constraints determine what organisational members perceive can be changed and what must endure. They define what comprises legitimate identity discourses, practices and symbols (Dutton and Dukerich 1991; Whetten 2006) in an organisation. That is not to say that these rules cannot be transformed, indeed it is possible that transforming identity itself constitutes transformation of the social rules (Lennox-Chhugani 2010). In this case the overwhelming constraint on policy implementation seemed to be the identity of the NHS itself as a provider of patient care reinforced by national legislation, other policies and the reporting system which formed the legitimate boundaries of the health system in the United Kingdom (Glynn 2008). The leadership of the AHSC sought to challenge some of these boundaries in the expressed desired future identity, and succeeded in integrating or mainstreaming medical research with service provision, but the pre-eminence of patient care within the NHS and how this was practiced, reasserted itself firmly in the emerging AHSC identity.

The process of constructing the desired future identity is presented in the model in Figure 6.1. This model, for the sake of clarity, simplifies a complex and recursive process.

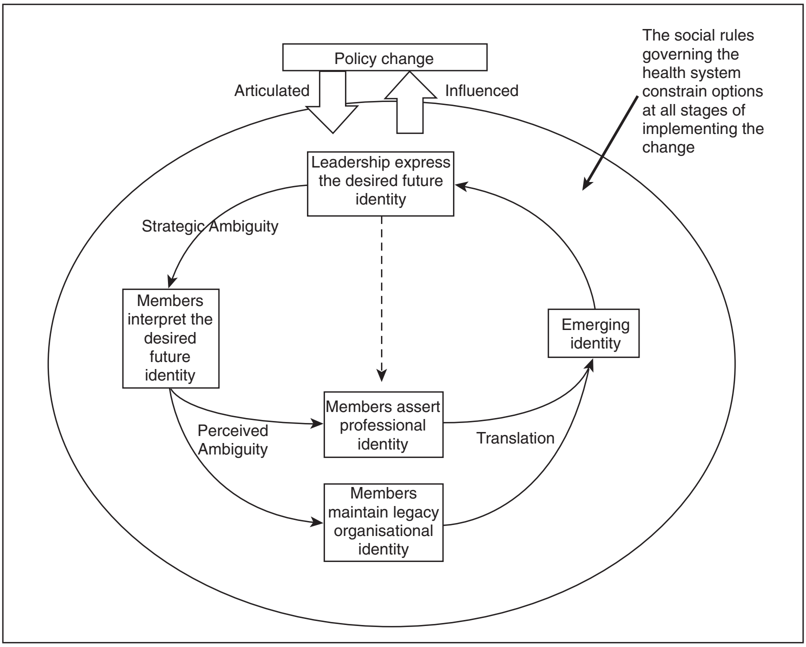

Figure 6.1 Model of the construction of desired future organisational identity

A policy change invariably implies change in organisational identity. This change takes place through social practices which are influenced by professional and legacy identities as well as the rules governing the health system. Organisational identity exhibits both continuity and change at all levels, health system, organisation, group and individual. Whilst identity change enables the organisation to work towards realisation of a desired future identity, continuity enables individuals and groups to make sense of this identity in ways that were meaningful to them and allows the organisation to operate successfully and legitimately within the health system. Thus the implementation of policy shapes and is shaped by identity.

Implications for policy implementation

Implementing policy in health care is a notoriously complex process in which there are both intended and unintended consequences (Reich and Takemi 2009; Frenk 2010). Organisational identity allows us to examine this process at multiple levels: individual; group (including professional); organisation; and institution. It also provides health system policy-makers and organisational leaders with a tool for engaging with members of a health care organisation at times of radical changes and reform. Engagement can embrace both continuity and change, giving emphasis to those features of the health system or organisation that they want to persist, such as the underlying values of providing the highest quality patient care, in addition to those that they want to change. This is already in evidence to some extent in health system rhetoric but engagement programmes are rarely explicitly designed around such concepts.

Professional identities are particularly relevant in the health care context (Pratt et al 2006; Chreim et al 2007) and the contributions of this study have a number of practical implications for mergers and organisational transformation in health care. Using identity as an analytical lens, we can gain a better understanding of how and why some organisational transformations are more effective than others. Understanding how a desired future identity shapes and is shaped by professional, legacy and institutional identities in health care organisations, may explain why policy-makers come up against more or less resistance as they attempt to enlist professionals and organisations in the process of implementation. Resistance to organisational and institutional level change amongst health professionals has been explored (Ferlie and Shortell 2001; McNulty and Ferlie 2002) and the likelihood of success of top-down managerially regulated policy change questioned (Ferlie et al 2005). By viewing the identity of health professionals as interacting with other levels of identity, we may begin to understand why they engage with policy implementation in the way that they do.

By aligning the discourse of policy change to what organisational members perceive the identity of the organisation, policy-makers can influence the success of implementation. In health care organisations, the purpose of the organisation is often differentiated on the basis of professional identities (Ferlie et al 2005; McNulty and Ferlie 2004). Unless policies are aligned with organisational members' professionally-based perceptions of who the organisation is, they will be resisted.

Several AHSCs have been established in the United Kingdom and this is an organisational form that is likely to become firmly established in the UK over the coming years. This study provides policy-makers, hospital and university managers and other interested parties with a wealth of information on how an AHSC identity can evolve from disparate sectoral and organisational identities and the implications this has for post-merger integration. Using organisational identity dynamics as a way of looking at organisational change and continuity in the AHSC context, managers can ensure that the desired future identity of the AHSC is aligned with strategic priorities. They can also identify potential conflicts with legacy and professional identities. The organisational challenges that may arise from this during the period of post-merger integration can then be addressed proactively.

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7

Organisational Networks – Can They Deliver Improvements in Health Care?

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Introduction

Networks are increasingly being used as a mode of governance within public management, with various advantages claimed for them in the policy domain over and above traditional governance modes of markets and hierarchies. But are they as effective as claimed? How can one indeed begin to assess the 'performance' of such networks? In the first part of this chapter, we will review the current literature on performance assessment in relation to public services networks and outline a performance assessment framework. In the second part, we apply and develop the framework to a particular case – assessing performance in a UK health care network. We draw out the more general lessons in the conclusion which indicate the complexities of making such judgements.

General review of the literature

Network performance has been studied for a long time in the public management/public policy field. Here we review the substantial literature which has already built up. In particular, *network overall effectiveness*, seen as the improvement of the well-being of clients or a community and as the overall quality of service delivery has so far been the main focus of attention (Provan and Milward 1995). The evaluation of the final outcomes and impacts of programmes and services that are delivered through networked organisations should be connected with the main public purposes of the public and non profit agencies forming a network. A review of this substantial literature suggests that at the client level, evaluation of network activities has often been developed by assessing the

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aggregate outcomes for the population of clients being served by the network. Different authors have empirically tested network success in school districts (Junke 2005; Meier and O'Toole 2001; O'Toole and Meier 2003), job and training networks (Jennings and Ewalt 1998), health care and community care networks (Conrad et al 2003; Milward and Provan 2003; Provan and Milward 1995; Provan and Sebastian 1998; Wagner et al 2000), community development networks (Mandell 1999), family and children services (Page 2003), local development networks (Agranoff and McGuire 2003a). Depending on the different characteristics of the sector under study, criteria for gauging effectiveness have been broadened to relate them to an overall benefit for the community that goes beyond client-increased well-being (Provan and Milward 2001).

Few authors have embraced this perspective measuring enlarged-community outcomes like distributional effectiveness and access (Conrad et al 2003; O'Toole and Meier 2004) or participation and activation of the community in health problems (Sabol 2002; Sofaer 2000; Wagner et al 2000). *Community- and client-level effectiveness* concepts are general concepts that pertain to the external effects generated by network structures. However, in an effort to improve the evaluation of network effectiveness, Provan and Milward (2001) have discussed another level at which effectiveness should be addressed, what they have called the *network-level effectiveness*. At a network level Provan and Milward (2001) refer implicitly to the *sustainability, legitimacy and maintenance of the networked structure per se*. In their own words: 'while a network may benefit the community in which it is embedded, especially the pool of clients it serves, it must become a viable inter-organizational entity if it is to survive' (Provan and Milward 2001: 417).

The long-term *sustainability* of a network have rarely been a topic for many scholars and, above all, few empirical studies have explored this issue (but see Ferlie and Pettigrew 1996 for an example in health care). Public management scholars have focused their attention more on intermediate – process oriented network effectiveness. For example, the (real or perceived) *capability of reaching network stated goals* (in terms of intermediate outcomes such as level of community accountability or integration among services) has been one of the favourite issues for studying the effectiveness of community care networks (Bazzoli et al 2003; Conrad et al 2003; Hasnain-Wynia et al 2003; Lasker et al 2001; Shortell et al 2002; Sofaer et al 2003; Weiss et al 2002). Finally *the capacity of the network to innovate and change* given conditions (either in the community, or in the single organisation or in the way in which services are delivered) has often been conceived as a different aspect to evaluate in network-level effectiveness (Goes and Park 1997; Meier and O'Toole 2003).

Table 7.1 shows the progress in the conceptualisation of network effectiveness in the extant literature, moving from the community client-level performance, towards the community-level performance and the network-level performance.

Table 7.1 Types of performance

Type of effectiveness	Selected References
Client-level effectiveness (including quality of service delivery)	Conrad et al (2003); Jennings and Ewalt (1998); Junke (2005); Meier and O'Toole (2001); Milward and Provan (2003); O'Toole and Meier (2004b); O'Toole and Meier (2003); Provan and Milward, B.H. (1995); Provan and Sebastian (1998)
Overall community-level effectiveness	O'Toole and Meier (2004a); Provan and Milward (2001); Sabol (2002); Sofaer (2000); Wagner et al (2000); Zacocs and Edwards (2006)
Network-level performance	
Ability to reach stated goals	Bazzoli et al (2003); Conrad et al (2003); Hasnain-Wynia et al (2003); Lasker et al (2001); Shortell et al (2002); Sofaer et al (2003); Weiss et al (2002)
Innovation and change	Meier and O'Toole (2003); Howlett (2002); O'Toole,(1997); Mandell (1999); Cooksey and Krieger (1998); Goes and Park (1997)
Sustainability and viability	Agranoff and McGuire (2003b); Ferlie and Pettigrew (1996); Fredericksen and London (2000); Provan and Milward (2001); Weiner et al (1998); Zacocs and Edwards (2006)

Following this general literature review, we now attempt to apply the framework developed in Table 7.1 to the assessment of the performance of a 'real world' network in UK health services.

Utilisation and development of the performance assessment framework within an empirical study of networks in UK health care

UK public management reforms have been moving away from the managerialist and market led reforms of the 1980s and 1990s (so called

New Public Management reforms) to looser and more network based models of management, typical of a 'network governance' model (Newman 2001; Klijn 2005) supported at a policy level in the UK by New Labour governments since 1997. Similar developments have been apparent in a number of other countries – such as Italy – and appear not to be a parochial UK development. Networks have been particularly influential in complex areas of services delivery or so called 'wicked problems' (such as policies to combat poverty, crime or drug use), where there has been a policy imperative for different agencies and public services professions to work together collaboratively and to learn jointly.

The time has come to try to assess the impact and performance of these new network forms. Do they have the advantages claimed for them? Research may be able to address the legitimate question: Should policy-makers continue to design network based solutions, or are they problematic in practice? Can research comment on the 'best' policy mix between networks, hierarchies and networks as governance modes (Thompson 2003)?

Research methods

We have been engaged in a large scale empirical study of the nature and functioning of current network forms found within the UK publicly funded health care (the National Health Service). This study has involved conducting eight case studies in four different types of network settings within the NHS: clinical genetics networks (2); cancer networks (2); sexual health networks (2) and services for older people (2). The methods used have been that of comparative case studies, with a set of semi-structured interviews with a range of key stakeholders (about 20 a case, total number of interviews 207), supplemented by analysis of documentation and attendance at some relevant meetings. As well as undertaking a broad overview of the network, we then decided to concentrate on one or two concrete 'tracer issues' in each network to provide a more focused assessment of the process of organisational change over time and then assess the degree of impact. The interview *pro forma* was constructed after a review of the theoretical literature so that the researchers were sensitised to possible theoretical frameworks in the collection of empirical data.

One of the objectives of the study was specified in our original study protocol as follows: '*to ascertain the factors which contribute to network performance, success factors and high impact within each network type*'. This objective begs the question of *how and on what basis* the assessment of higher and lower network performance is to take place. Below, we take as a worked example the performance assessment of a NHS managed cancer network studied.

A worked example: Performance assessment in a cancer network case

Improving cancer services is a national health policy priority, given historic evidence of poor clinical outcomes (five year survival rates) in the UK when compared to other EU systems. Such improvements entail not only increasing the flow of effective new drugs and treatments, but also changing the pattern of organisation and management to ensure treatments are undertaken in centres with sufficient expertise (with high enough volume to support specialisation and learning) and ensure that such expertise flows across conventional boundaries across the whole care pathway. The Evidence Based Medicine movement has led to the production of an increasing number of evidence-based policies (the 2001 NHS Cancer Plan) and tumour site specific guidelines (so called Improving Outcomes Guidance) which the newly created managed networks are supposed to implement. This policy may involve pulling services out of smaller hospitals where there is not evidence of sufficient volume to ensure adequate expertise. This policy agenda is likely to be controversial and be resisted by ‘losing’ sites and clinicians (Addicott et al 2006, 2007).

The ‘Managed Cancer Networks’ are supposed to secure such service reconfiguration and improvement across a wide geographical area (there are 34 of them in the UK). Marking an important break with the then dominant quasi market model, the Calman Hine Report (1995) first proposed the introduction of a managed network form, with the designation of recognised centres of excellence which would then network with other providers to ensure a ‘seamless’ patient pathway. The 2001 NHS Cancer Plan outlined an agenda for modernisation and reform, linked to substantial new resources. The new Network Management Teams were charged with implementing these changes and indeed central targets in their patches, although they had neither line managerial nor budgetary authority and had to rely on persuasion and influence, also backed by an increasing evidence base. Providers (such as NHS Trust) retained line managerial control within their own organisations; while purchasers (such as Primary Care Trusts) used their financial control to commission services from providers. As always, the senior clinicians exerted strong informal influence over decision-making (Addicott et al 2006, 2007).

The case study: Urban cancer network

Context

In this case study of a cancer network in an urban location we interviewed a range of stakeholders including clinicians and managers (27) using a semi-structured *pro forma*. We also examined key documents (public reports; minutes of meetings; internal reports) and undertook non participant observation of six meetings. The tracer issue selected for study was the reconfiguration of urology services which takes in a major tumour site which affects a large number of men (prostate cancer).

The Urban Managed Cancer Network (MCN) was founded in 2001, is located in a large regional urban centre (with large and traditionally powerful teaching hospitals) and covers a population of 1.6 million including a suburban and rural hinterland. So it relates to a large scale and complex setting with a substantial patient base. The MCN was established in order to: (i) implement the NHS Cancer Plan in its geographical area (in practice the centralisation of services in high volume centres was to prove the most contentious policy item) (ii) to develop all aspects of local cancer services so as to improve the patient journey for people with cancer and their families across conventional organisational boundaries (iii) to develop multidisciplinary teams and to make arrangements to ensure that all patients are reviewed by them prior to treatment (iv) to agree common protocols and serve patterns to tackle variations and make best use of resources (v) to develop workforce education and training strategies.

Governance

The highest level of MCN governance is the Network Board, made up of very senior executives from key health services agencies in the City. The next level down is the Network Management Team (NMT). It is led by the Medical Director (MD) (this MCN does not have a non clinical Director), managed by the Network Manager (NM) and also includes a Nursing Director and Service Development Manager. The MCN does not have line management authority or budgetary control over cancer services which remain with the core providers and commissioners and instead has to effect service change through influence and the use and local interpretation of top down national guidance, notably the Improving Outcome Guidance for each major tumour site. The NMT also oversees a range of tumour groups or Network Site Specific Groups (NSSGs) for each tumour site (e.g. Urology) which are headed up by a lead clinician but which also has multidisciplinary representatives. The

NSSGs tend to be the 'engine room' in getting the operational level work done.

The NMT facilitates the decision-making process by providing technical information, data, expertise and improving communication between the stakeholders. Its role has evolved over time. Initially, the network contained many representatives of the provider units and the clinical groups, not just because they were founding members of the network, but also because the early IOGs had particular implications for change in the acute sector. But it soon became clear that the commissioners (Primary Care Trusts) retained budgetary control and therefore the network gradually evolved into a consultative role, both to the acute sector and the commissioners. It became a source of expertise in a range of areas such as the interpretation of national policy, undertaking gap analyses and implementation plans, the setting of clinical guidelines, commissioning recommendations, audit and providing a strategic vision for the locality. The networks sees itself as an 'interface organisation', moving between different stakeholders and encouraging the flow of information. Both strategies – work in combination with the commissioners and the consolidation of expertise – provide an indirect power base for the network.

The historic heart of health services in the city had traditionally been located in the large teaching hospital located in the centre of the city, although large peripheral hospitals have now built up in the hinterland, to where much of the population has moved. There is always an issue about where cancer services should be located in the event of reconfiguration. IOG guidance typically seeks to centralise surgery in a small number of high volume centres on quality/evidence grounds and to 'cut out the dabblers'. One of the earliest reconfiguration exercises related to implementing the IOG in this locality was for gynaecology services where a number of issues of organisational process came to the fore. This centralisation process had been highly contentious and in order to break the deadlock, the NMT had asked Trusts to submit business cases which would then be judged by an external panel. The recommendation was to move services out of the historic centre that had provided them. This outcome came as a shock, but it was clear that IOGs were here to stay and that the outcomes of any reconfiguration process were not guaranteed.

Reconfiguration of services

We now describe the process of reconfiguration of urology services as our tracer issue following the publication of the Urology IOG (2002).

This involved three major service changes: (i) centralisation of services in high volume centres (ii) the development of MultiDisciplinary Teams and (iii) standardisation of work practices and the development of joint protocols. Of these objectives, service centralisation was going to have the most direct impact on providers and was the most challenging and contested part of the agenda.

The guidelines recommended the centralisation of specialist urology services in a single cancer centre, given the evidence that better clinical outcomes were linked to high volume. Common cancers are to be treated in local 'cancer units'; while rarer cancers are to be treated in more specialised 'cancer centres'. Explicit IOG guidance specified that certain procedures should only be carried out by surgeons who do no less than five procedures per annum, that each unit should be performing 50 procedures per annum and that centres are to cover a population of around one million patients.

Before the IOG guidance was published, these specialist procedures were being carried out in five hospitals in the locality. While the consultants in all units complied with the minimum number of procedures, no single unit covered the required population and so services had to be centralised. The process was likely to be contested and contentious, given that the teaching hospital and two other units were likely to put forward credible bids. The urology reconfiguration was heavily influenced by the earlier (difficult and in the end externally driven) process in gynaecology services. One of the aims of the urology review was to avoid going to an external panel at any cost.

In Stage 1 of the reconfiguration process, there was lengthy discussion between the consultants from the various hospitals at NSSG meetings and limited progress. There were many attempts to dispute the IOG and hope that it would be forgotten. This period took about a year, with fixed positions being struck.

In Stage 2 of the process, movement began to accelerate. The NMT described achieving service refiguration as its core 'legacy,' so members were keen to help secure implementation but had little direct power over the providers or commissioners. The network again asked providers to present business cases and encouraged more authentic internal discussion to avoid an external panel. This combination of pressures led to a more urgent consideration of the issues within the NSSG. A first decision was to seek to go for two centres rather than one, reflecting the numbers and location of the population in the city, and this solution had already been adopted in a previous reconfiguration (Upper GI). This meant resisting pressure for more than two sites.

Stage 3 of the process involved selecting which two services in the divided geographical areas would host the urology units. The two selected services were in the end the main teaching hospitals in each sector (one of which was historically less dominant but related to a large population base). These sites would host the services and in each case the consultants from the smaller non selected units with fewer cases would travel into these sites and work with them as part of the team. This new configuration did not imply that these consultants would stop doing surgery but rather that they would travel to designated centres to perform the operations. While this might be thought inconvenient and time consuming, the travel distances in the locality are relatively short.

The process was easier in one sector with the less dominant hospital as at these two units the consultants had voluntarily engaged in discussion and met regularly. The units were left to sort out operational implementation and while there were teething problems, there appeared to be effective communication and cooperation between the different surgeons. In the second geographical sector (which included the historically dominant teaching hospital), this process of integration did not work so well with a perception that consultants at the teaching hospital 'see themselves as the people who should be doing all the work' (urological consultant) which threatened to block the relocation of key consultant staff. Some respondents recorded concern about the difficult implementation phase and questioned whether there would be better outcomes for patients (for example, information systems; preparation time for surgery and patient follow up seemed problematic). Although the new pattern of surgery was up and running in both sectors by 2006, communication systems between the surgeons at different sites in this second sector continued to be problematic.

Throughout the urology narrative, the importance of learning from the earlier flawed gynaecology process was strongly apparent. We also observe that the network's core management style was to agree a process by which a collective decision could hopefully be made and also to maintain pressure and influence in various forms to try to ensure that progress was made. NMT members played an important but subtle role in moving service reconfiguration forward by using the IOG guidance to exert pressure. The case also displays various forms of influence being exerted by various stakeholders at different periods of the process but also the very influential role of senior clinical staff in both the decision process and outcomes.

Ex post performance assessment

We attempted to apply the performance assessment framework outlined above (see Table 7.1) derived from the earlier literature review to this case *ex post*. We found it not always easy to operationalise.

(i) Client-level effectiveness (including the quality of service delivery)

We found it impossible to gather reliable valid clinical outcome data within the timescale of the study (indeed using the conventional clinical measure of five year survival rates this would not have been possible until sometime in the future). Self reported data from patients on experience would have required an extended longitudinal design so that a before/after comparison could have been made. Even with such data, it would have been difficult to disentangle network effects from other effects (such as new drugs and treatments) on changes in survival rates. There was no area without a network as it was a mandated form so that an experimental/control pairways comparison was not possible.

We therefore had recourse to a proxy for the measurement of clinical outcomes – the extent of implementation of evidence-based national policy and IOG. The UCN did deliver the reconfiguration of urology services in line with national policy, despite some considerable difficulties. The standards set out in the IOG guidance were adhered to locally, even though some clinical consultants disagreed with them. Assuming that the IOG guidelines are indeed evidence-based (e.g. better clinical outcomes are produced in specialist services with high volume) then in the long term there should be improved clinical outcomes.

Nor was 'service quality' easy to define as we had little direct data. In the short term we suggest that the quality of the post reconfiguration services may be at one site than the other. The problems of the integration of the clinical team in one site may have produced more post operative problems than previously and complicated follow up care.

(ii) Overall community-level effectiveness

This dimension was not easy to operationalise and we had to think carefully about how to apply it in this setting. Again there was very little direct evidence which we could adduce and we had to think carefully about what indicators we could use. It could be argued that the very process of considering the nature of services provided to the population as a whole created some debate in local health policy circles about the current needs of the population, the best location of services and the nature of current demand. Without the IOG and the MCN, this deliberative process was unlikely to have occurred. Since the

MCN's focus is on the health needs of the whole population, it has broadened the health policy process out somewhat from historic domination by a narrow range of elite organisational and professional interest groups (Alford 1975).

(iii) Network-level performance

We developed the original model and adapted Turrini et al's (2009) model of performance assessment somewhat by adding further subcategories and also a temporal ordering of the various factors. These included:

Inclusiveness and engagement of stakeholders

There was evidence of the MNC adopting a strategy of inclusivity and engagement with a wide range of stakeholders. There was widely expressed satisfaction with the network's willingness and ability to engage with various groupings. One perceived advantage of the MNC was that it linked both commissioners and providers. There was also an inclusive process – for example, the Chair made considerable efforts to invite participation from user representatives.

Shared learning

There was strong evidence of shared learning in the case. First of all, there was learning from past events. In particular, the difficult early processes around reconfiguration for gynaecology and upper GI services had caused many stakeholders to reconsider. The learning was that IOGs were here to stay and that the NMT needed to ensure that they were implemented. Many clinicians reflected on their loss of control over decisions in relation to gynaecology services and determined that this process should not be used again. Secondly, there was evidence of sharing of information across locations to support the case for change. A main thrust of the network was to become a provider of information and expertise. From an early stage, expert staff were recruited and encouraged to develop their roles as 'expert providers at the interfaces'. The strategy had two core elements – the offering and provision of data and expertise and the crossing by network staff of organisational boundaries as 'carriers' of information. Sharing and learning also took place at local levels in smaller and multidisciplinary groups as the network sought to use the MDT and the NSSGs as the main power houses where the 'real' work was done. The network attempted to support these groups, but also tried not to usurp or undermine their power. Even when the urology reconfiguration was floundering and time pressures increasing, the NMT did not take the reconfiguration decision out of the hands of the NSSG. They did however use the IOG as a top down pressure and the possibility of the introduction of an external panel to hasten the decision.

There are still reservations, for example, the public nature of these forums is seen as discouraging clinicians from raising difficult issues there. There appears to be more work to be done in terms of encouraging the transparent sharing of difficult information. Nevertheless, there is an active and ongoing process of review which helps identify problems.

Innovation and change

As far as service change is concerned, it appears that changed service configurations for many cancers – including urology – have been achieved in the site, despite the difficulties involved in implementation including the complex and difficult nature of the setting. So the extent of service change can be seen as significant. Much of the service change was in line with national policy – indeed prescribed by it – so there is a question about whether it can be described as innovative or not. There are some indicators of possible innovative change in relation to both the decision process and decision outcomes:

- a shift of services from the most historically powerful provider (teaching hospital). This breaks the mould of institutional dominance found much more widely in health care and given that this is a strategic sector, could be seen as a radical shift.
- the establishment of a novel form of deliberative decision-making in relation to the reconfiguration of a major block of health care services for a defined population group in a large geographical area. This took account of patient demand, patient needs and their likely growth over a period of time. Again, these objectives have underpinned a large number of NHS reorganisations but have been rarely achieved.
- the trial of a mixed bottom-up/top-down approach to decision-making rather than a completely top-down and national policy led approach. Thus NSSG groups were given some key powers.
- at least a (marginal) attempt to include patients' views at the Network Board level and within the NSSGs.

Ability to meet stated goals

The research suggests that the majority of the network's stated goals were reached (above all, the centralisation of urology services), although there were some perceived limitations in terms of it guiding the implementation process (as opposed to shaping the initial decision). Nevertheless, our judgement in this respect was relatively favourable.

Sustainability and viability

It is still too early to judge the long term sustainability of these very major changes. There are some positive aspects to highlight: the shared learning from experience suggests change may be sustained. Respondents also suggested that a major policy driver of the change – evidence-base/IOGs – would not be likely to go away but be sustained in the long term, despite possible structural reorganisations. There is some evidence to suggest that the major changes made receive a lot of support from many of the general managers and some of the clinicians. Many respondents saw the network as being ‘successful’. There is the question of what the role of the network is once reconfiguration has been achieved.

Unintended outcomes (both perverse and serendipitous)

We added this new category to enable us to assess any unintended (as well as stated goals) policy or service outcomes of the network. There was evidence of the rebalancing of institutional power in the course of the reconfiguration of urology services towards a more pluralist pattern. The historically established and highly dominant position of the teaching hospital has been somewhat rebalanced. There was some evidence to suggest that the management systems in alternative service units were better geared up to supporting service and clinical improvements. Some of the problems in one of the sites remain unresolved and are seen to result from engrained staff attitudes.

Overall, while assessment was complex and nuanced, at least using the framework outlined, it appeared that the MNC could be seen as having made good progress on a number of indicators. So we would conclude that it appeared to be a ‘higher performer’.

Concluding discussion and implications for NHS policy and practice

What then are some implications of our study for NHS policy and practice?

The cases in the main study suggest some advantages and disadvantages of network based forms:

- they were an appropriate way of managing the substantial number of complex organisational and managerial problems and processes in health policy issues where a number of different agencies and professions are necessarily involved (e.g. cancer services; sexual health; older people's services);

- they had potential as 'implementation networks' which enabled central government to find a mechanism for implementing national health policy targets within localities (but they were more likely to be effective if they included an element of local customisation);
- They secured generally high levels of clinical engagement and legitimacy, especially when backed by an evidence-based policy framework;
- At their best, they develop lower level processes which enabled sharing and learning to take place across organisational boundaries;

The disadvantages of the network forms studied included:

- they could degenerate into 'a talking shop' where there are many meetings but little output; networks could multiply so that a very dense system emerged which was only comprehensible to and populated by a small policy elite;
- there is a danger of a loss of focus, so that some targets can be helpful in providing milestones;
- they require administrative resourcing ('an office') in order to retain energy and focus, and without this the network leadership could become overloaded and the network drift;
- they may be difficult to performance manage and contain a major emergent as well as a planned element (this is a disadvantage if a planned top-down mode of change is preferred; if more bottom-up planning is being considered this may become an advantage);
- many of them exhibited less emphasis on creative local innovation rather than implementation of national policy targets;
- there are high transaction costs associated with networking so that policy outcomes can take a long time to implement and there are few short term 'hits';
- despite attempts to broaden their composition, a number of them remained dominated by elite professional groups. They only weakly emphasised principles of user choice;
- many of them remained dominated by NHS and statutory providers and voluntary and private sector providers were more weakly represented; they may be 'closed' networks;
- they need skilled and well resourced management in order to be effective.

National frameworks and local customisation

The development of National Service Frameworks etc have been broadly positive in providing a national framework of policy and systems which support the managerial activity of local networks. They are legitimate and influential. Where national frameworks were weak (e.g. GKPS), networks struggled to make progress. But we suggest that is more helpful if they are f*rameworks* rather than *targets* so that there is some local discretion about which approach to adopt (as in the cancer networks). Clinician involvement at a national level in the production of frameworks is also helpful at a local level, as are the consultation processes which NICE is using.

Network based forms need highly skilled and well resourced management in order to be effective. It is a governance mode which is demanding to operationalise in practice. We reinforce the point made in an earlier study (Ferlie et al 2005) about the helpful presence of a distributed or small team approach to leadership ('duos and trios in service change') with complementary functions and skills rather than a highly individualistic or indeed a large group approach to network leadership. A trio of a CEO, Medical Director and a Nursing Director is one possible model. Such a small team enables the centre of the network to relate directly to three core constituencies. It provides more capacity to divide up the work which could well overwhelm one individual. It provides a source of mutual support and learning in what can be demanding and stressful settings.

Suggestions for future research

Suggestions for future research need to be informed by the direction of health policy. If the policy mix is swinging away from networks to a new emphasis on markets, contestability and choice, then the case for more research on networks is weak. We note however that network based forms still appear to exert appeal, with managed cancer networks held up as a role model. They retain high legitimacy as an organisational form with many clinicians. Assuming that networks remain of high policy interest, where might research go next?

The study also raised the following novel themes and perspectives where more work may be helpfully considered.

Governmentality in networks: this was a relatively novel theoretical approach we employed to understanding management in networks. We noted the role of transparent field wide and evidence based norms (as in the cancer cases) which eventually influenced professional behaviour, as they built high levels of legitimacy with clinicians over time. One could explore the utility of this theoretical perspective more broadly.

Performance assessment and explanation: we undertook a qualitative approach to performance assessment, building on an extant literature review. Can this early effort be developed further? Is it possible to complement qualitative data with more quantitative or even clinical outcome data (which would strengthen the framework) or is this methodologically too challenging? We noted methodological difficulties in assessing network performance in this study. The topic of performance assessment in networks and how better methods can be developed is both interesting and important. There is likely to be greater stress on performance, value for money and productivity in the next five to ten years, given the strong pressure on public finances and reduced taxation base. Assessing the added value of networks to the health service is an important research theme, given the likely pressure to reduce management costs.

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8

Discourses in Health Care Policy: Comparing UK and Canada

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Introduction

Health care policy has long provided an arena for debate around themes of services restructuring and the challenges associated with implementation initiatives in the public sector (Dawson et al 2007). Increasingly, researchers have been concerned with unpacking the 'gaps' between policy and practice in the process of health care reform. Notably, it has been argued that whilst evidence-based medicine has transformed clinical practice by rendering it more effective, this trend has not been followed by a similar logic in health management and policy-making, ultimately resulting in significant discrepancies between policy and practice (Walshe and Rundall 2001).

In this chapter, we argue the need to step back and analyse the development of policy discourse in different institutional and national contexts as an important starting point in further understanding how this policy-practice 'gap' develops over time. We consider this discourse not only regarding its role in the development of extant health care policy, but moreover *vis-à-vis* its ability to render concurrent political rationalities visible (Moon and Brown 2000). In this light, we consider the specificity of innovation in public settings, which is increasingly viewed as the key driver to performance improvement (Walker et al 2002). We also explore the linkages between the rise of a public sector innovation discourse and its varied manifestations with the different notions of citizen, user and, in our case, patient role in the innovation process. In so doing, we discuss the relevance of recent developments in services research, notably regarding the notion of 'service logic' (Chesbrough and Spohrer 2006; Lusch et al 2007), which places emphasis on the continuous user involvement through the various stages of service development

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and delivery. The user is hence viewed not as a passive recipient but rather as central to value co-creation in service innovation. In public health care, this approach is suggested to be increasingly relevant in conceptualising the patient's central role in restructuring care, especially through making 'informed choices' acquiring more control over the service (Fotaki 2005; Le Grand 2004).

Our approach is to unearth recent discourse developments, focusing on how different underlying meanings of innovation are discursively enacted in health policies across different institutional and political contexts. Following an approach to the study of innovation as a multi-dimensional and inherently political process (Frost and Egri 1991), we suggest that an international perspective on policy development can afford useful insights on the power dynamics that define the innovation language game (Asimakou 2008). To this end, we analyse stroke-care related policies in the UK and Canada. In the UK, we look at both the general 'umbrella' health care strategies that informed and influenced the reorganising of stroke-care services as well as the various reviews and policy guidelines that were generated after the launch of the National Stroke Strategy. In Canada, we looked at two levels of policy development, the federal Canadian Stroke Strategy and the various strategic provincial initiatives, focusing on the Ontario Stroke System, which has been acknowledged as an exemplar of successful implementation (Lewis et al 2006).

Our findings suggest that although the policy development of reorganising stroke services in the two countries seemed to occupy a different discursive space, there were a number of shared ideological references that became manifest in the different institutional contexts. We found that, in Canada, a bottom-up approach to service innovation was at play in a decentralised policy-making model. The emphasis on knowledge transfer and technology produced a policy discourse around the 'service'. This contrasted with more user centred notions of the service logic in the UK, with an informed patient discourse suggesting power, choice, and control by the patient in the service provision. By considering these conflicting themes that appear to frame the formation of policy in the UK and Canada, we attempt to unveil their latent ideological significations in order to understand better how they were related to 'service innovation'.

Policy development and service innovation

Public policy research has highlighted the *lacunae* of translating evidence into policy; Lang and Rayner (2007) have drawn attention to what seems to be a cacophony in theorising disease in frameworks 'fissured by significant ideological distinctions'. Policy is inexorably linked to new specifications of public governance as denoted by contemporary discourse of neoliberalism (Larner 2000). In this light, policy literature has employed the Foucaultian notion of 'governmentality' to conceptualise political change associated with government restructuring and the ways in which subjects discursively define their space in this process (Raco 2003). In health care, ideological analyses have focused on the values of 'informed choice' and 'participation' postulated in the politics of the Third Way as well as their links with the rhetoric of innovation (Prince et al 2006).

However, the nature and impact of service innovation in public sector settings continues to be under-researched (Walker 2006). Innovation is increasingly discussed as a process whereby provider and user engage in relationships that allow them to co-generate service exchange by sharing knowledge (Chesbrough and Spohrer 2006). A growing literature is looking at the value of a more consistent theorisation of services that integrates service research with management and policy research in order to understand innovation (Spohrer et al 2007). Yet services research has not adequately explored institutionally distinctive challenges associated with service innovation (Lehoux et al 2008).

The hybrid term 'co-creation' has been suggested to inherently contain some contradictory ideological signifiers that point toward the overlapping space of public policy and services logic perspectives. Turner (2005), for example, has highlighted the ability of policy to enter multiple discursive registers simultaneously, for example the bottom-up, participative innovation on the one hand, and rational economic notions of top-down innovation control on the other.

The rise of the service innovation discourse has been manifest amidst the growing interest around New Public Management (NPM). Key to this conception is the role of sequential models that describe the unfolding of innovation as a controlled process, wherein rational and autonomous individuals make definitive choices (Fonseca 2001). However, in our study we further highlight the multiplicity of stakeholders in health care, and the need to consider the various meanings that become attached to innovation. We consider this process as a continuous creation and negotiation of new meanings (Asimakou 2008), whereby it is not necessarily sharing and consensus that leads to innovative behaviours, but additionally a combination of miscommunication, anxiety and conflict that may lead to new meanings potentially becoming 'actualised as innovations' (Asimakou 2008: 67). Our study of health policy development in two countries allows us to examine these discursive themes in different institutional contexts.

We contribute a discursive understanding of the linkages between health care policy development and the 'ideological signifiers' of service innovation. To this end, we conduct a discourse analysis of health care policy in the UK and Canada, focusing on the area of stroke services. We examine the evolution of policy discourse that describes the planning and implementation of services restructuring programmes. In so doing, we explore the relevance of Grant and Hardy's (2004) conception of discourse as a 'struggle for meaning'. We look at 'texts' as a manifestation of this struggle and not merely as linguistic objects; in that sense, the array of policy texts do not simply reflect social conditions, but rather *are*, in fact, context (Chalaby 1996).

Yet, this struggle for meaning that inhabits policy discourse is not always overt. The apparent 'universality' of policy ends and the consensus-based processes that seem to underpin them, often disguise the involved stakeholders' 'political appearance', which 'is reduced to the level of an illusion concealing the reality of conflict' (Rancière 1999: 86). Hence ideology does not enter the discursive milieu of policy in the occurrences of political terms, such as 'patient empowerment', but rather in its ability to put down the manifestations of dispute and 'hold up the emergence of common interests' (Rancière 1999: 86). In this way our analysis of 'innovation meanings' in the UK and Canada seeks to extend Grant and Hardy's problematising of the interplay between local discourses and the 'context that is made up from them through the negotiation of meaning' (2004: 8), and thereby contribute to our understanding of the gap in translating policy into practice.

Methodology

We employ a combined interpretative approach, primarily based on policy document analysis and informed by ten in-depth interviews with policy experts, service providers and users in Canada and the UK. Apart from being able to establish good access in these countries, they were selected partly because of their varying levels of centralisation in structure of health care as well as the cross-referencing in policy development which became readily apparent. At the policy level, we analysed eight UK Department of Health stroke-specific policy documents and ten Canadian policy documents, at the national and various provincial levels.

Whilst an analysis of the Canadian and the UK stroke restructuring affords useful perspectives on the role of inter-organisational knowledge sharing and best practices diffusion, it must be noted that differences exist in the organisational structure of services between the two countries. In Canada there is a federal model of governance, which provides province-controlled health care, with loose overarching administration. However, despite the increased autonomy in designing and implementing strategy, the provincial Heart and Stroke Foundations and Health Care authorities are connected at the national level through the Canadian Stroke Strategy (CSS). The CSS is a joint initiative of the Canadian stroke network and the Heart and Stroke Foundation of Canada, to provide a forum for the exchange of information on national and provincial initiatives (and research) in stroke, and a platform for co-ordinated activity at the national level to support best practice implementation (British Columbia Stroke Strategy 2005).

In the UK, health care strategy is designed and implemented regionally, with Health for London constituting the local implementation of the large London region. The stroke strategy was developed in the area, as part of the overall strategic review of their services but regional managers worked toward ensuring alignment with the national document. For the national policy, there was significant representation from voluntary organisations such as the Stroke Association and patient representatives. The Department of Health (DoH) and the produced policy seemed to emulate a shifting political/ideological apparatus and hence a new institutional context within which the stroke service restructuring unravels.

Our methodological approach involved a combined, two-path discursive analysis. In trying to make sense of the text of the Stroke strategy documents and the main themes arising, we drew on the aforementioned interviews. We then returned to the policy texts, conducting an inter-discursive analysis of previously identified themes, ('service logic' and 'cross-organisational knowledge transfer') and the ways these were integrated in discussions of service innovation. In the UK, we looked at both Stroke-specific and general DoH policy documents in a similar fashion. We focused on the most frequently appearing themes of 'informed patient' and 'knowledge asymmetries' and explored their positioning in the texts *vis-à-vis* the rhetoric of innovation. Lastly, informed by the UK policy analysis we returned to the Canadian documents once again and attempted a final assessment of the ways in which themes of knowledge transfer were conceptualised, notably with reference to the different meanings of shared and participative innovation.

Analysis

Our analysis found that a 'service logic' language characterised the Canadian policy and evaluation documents, and this contrasted with political discourse being largely adopted in the UK. In Ontario, an exemplar case of successful re-organisation of Stroke services in Canada, strategy was designed around what is specifically defined as the *continuum of stroke care*. The following text from the provincial five-year strategic plan illustrates the significance of the key discursive themes: '*knowledge translation', 'innovation', 'quality improvement' and 'integrated service delivery'*:

> *[B]uild capacity through the generation, translation and integration of knowledge and foster effective use of resources through innovation, system change, quality improvement, and integration and coordination of service delivery*. (Ontario Stroke System Strategic Plan, 2007–2012)

In the production and formation of a stroke-specific strategy and ensuing policies, knowledge input from non-government actors, such as volunteer organisations, seemed to be more widely used and embedded in Canada. As early as 1997, the need for integration of the disorganised Ontario stroke services forged the basis of the Ontario Stroke Strategy. Actors in the volunteer sector were identified as leading partners involved in the design and launch of the co-ordinated stroke strategies.

Moreover, whilst in both systems the value of co-ordinating actors, resources and services across the stages of stroke-care provision was recognised, in Canada this value was consistently linked with the use and sharing of best practices across the service continuum. Hence, at the level of horizontal knowledge sharing (between stroke actors in the various stages of the service provision), the Canadian stroke strategy carefully considered the linkages between medical research and scientific evidence, evidence-based guidelines and other knowledge repositories:

> *The Ontario Stroke Strategy promotes the use of practices and care that have been supported by scientific evidence, or are considered the gold standard ('best practice') to prevailing knowledge.*

The discourse reflected a structured approach around themes of continuity, integration and transitionality of the service:

> *A comprehensive set of services ranging from preventive and ambulatory services to acute care to long term and rehabilitative services. By providing continuity of care, the continuum focuses on prevention and early intervention for those who have been identified as high risk and provides easy*

> *transition from service to service as needs change*. (New Brunswick Integrated Stroke Strategy 2007: 48)

At the national level, the Canadian Stroke Strategy emphasised the successful implementation of an integrated approach to service delivery and presented it as a model for service innovation internationally. Efficiency of the offered services was especially emphasised:

> *All Canadians have optimal access to integrated, high quality, and efficient services in stroke prevention, treatment, rehabilitation and community reintegration. The Canadian Stroke Strategy serves as a model for innovative and positive health system reform in Canada and internationally*. (The Canadian Stroke Strategy: Changing systems and lives 2007: 10)

Finally, across the Canadian policy texts, the notion of a shared vision was promoted without references to different stakeholders' interests or power positions, but rather as a depersonalised, common and systemic objective.

Meanwhile, in the UK, the National Stroke Strategy echoed a different discursive formation. The service itself was placed in the background of a thematisation around lay actor (that is, the patient) empowerment, targeted information provision to the user, and participative management of care. As alluded to in a number of policies, there seemed to be less of an emphasis on effective knowledge transfer and process integration around the service. More specifically, evidence-based practices were not embedded in the service lifecycle. Further, knowledge silos often appeared in processes that remain unlinked as a result of the absence of a nation-wide education programme:

> *Specialist knowledge has developed ad hoc in practice and there is no nationally recognised stroke-specific training. Nationally recognised, quality-assured and transferable training and education programmes for stroke linked to professional roles and career pathways are needed*. (The National Stroke Strategy 2007: 55)

This view was reiterated by carers in the conducted interviews, wherein there were frequent references to dissatisfaction with the practice of interacting with multiple points of contact – which appear to be disconnected from one another:

> *It's not looking at the administration side and the qualification side and how a patient is treated and the Stroke Unit equipment and all that, it's a*

> *mindset which affects all the staff, the 'just do my task' mindset.* (Carer, UK)

Recently, in order to address this need the DoH established the UK Forum for stroke training with a steering group and four task groups that consist of relevant professional bodies, voluntary organisations, social care and stroke survivors, hence emphasising the importance of user involvement in developing a 'Stroke-specific Education'.

However, the priorities set by the DoH seem to put little stress on the actual processes of training, education and knowledge transfer; rather the produced discourse was characterised by a focus on the power/control shifts that these processes would entail. Thus the reference to empowerment, informed choice and control of care *qua* 'the service' seemed to assume straightforward linkages between these notions:

> *If stroke survivors and carers receive more appropriate information and are more satisfied with support this will help empower them to take control of their own care.* (DoH 2007)

Interestingly, the NPM logic including themes of 'efficiency' and 'cost control' appeared, somewhat contradictory, to co-exist with allusions to positive evaluation of patient involvement. The aforementioned quotation was followed by a revealing admission:

> *… [A]lthough the benefits are valued by stroke survivors and carers they will not bring any direct health or social care savings.* (DoH 2007: 34)

Whilst the concept of user involvement is reflected in the restructuring of stroke services, it also appears to be systematically associated with the (need for) shifting focus of the delivery of care: from in-hospital provision to community services as well as home-care and ultimately self-care. This direction of organisational change is moreover presented not as an *ad hoc* initiative but rather as addressing the lay citizen needs as they have been communicated to the provider:

> *People tell us that they want more services in the community, closer to home.* (DoH 2006)

Overall, the stroke policy discourse seemed to draw heavily on the more general yet influential health care report, '*Our Health, our Care, our Say*', published by the DoH in 2006. Throughout the stroke-specific policies there were a number of direct references to this document, which provided the framing for a patient-centred focus in organising and delivering health services.

Discussion

Our study reveals policy as a struggle over ideas and values, rather than being driven by facts and rational debate (Russell et al 2008). Yet health policy literature has focused on the policy – practice divide through the dominant discourse of evidence-based medicine, and underlying assumptions of rationality and context free facts (Russell et al 2008). Jones (2009) suggests that policy will often reflect and sustain existing power structures. This might suggest that an overwhelming technical focus on the difficulties in using policy in practice is used to gloss over the contested and political aspects of health delivery which are embedded in the institutions (for example, hospitals, professional associations and research councils) and their cultures.

Stroke care in Canada reflects a more decentralised policy-making model, and this appeared to lay the ground for a bottom-up approach to service innovation. The multiplicity of needs dictated by a diverse set of local conditions placed an emphasis on the role of knowledge transfer throughout the development, provision and support of the care service. The produced policy discourse reflected these institutional tendencies and focused the innovation debate around ‘the service’ itself as opposed to the user.

‘Efficiency’ is of acute importance in service provision however it has entered the two countries’ policy discourse in different ways. In the case of Canada, efficiency is predominantly discussed in the context of the providers’ ability to develop ‘collaborative competency’ by absorbing knowledge from the user and their value networks (Lusch et al 2007). Terms such as ‘power’, ‘choice’ and ‘control’ have no place in this discourse, wherein the patient *qua* user is viewed as external to the service provision continuum.

Conversely, in the UK, more user-centred notions of the service logic seem to constitute the backbone of the restructuring discourse: the idea of the ‘local’ and its connection to the principle of ‘responsibility’ originate from the early Thatcherite NHS reforms (Moon and Brown 2000) and have constituted building blocks of the New Labour policy of ‘empowerment’. Studies of these reforms have explored these themes as part of a ‘consumerist discourse’ that nonetheless does not meet the lay user’s embodied and affective dimension of illness (Mol 2007). Moreover it has been suggested that modernisation policy is inexorably linked to a discourse that challenges the traditional distribution of expert knowledge (Dawson et al 2007), which illustrates the transition toward demedicalisation of health care policy and a break with hospital-based medical domination (Ranade 1997). Instead, it emphasises the notion of self-management and patient control over health care (Mol 2008).

Despite these differences in political tone and rhetoric (servitisation versus empowered participation), policy discourses across UK and Canadian institutional contexts reflect a view of service innovation that shares a multitude of ideological significations. The UK health care policy seems to be founded on the idea that more user involvement equals (ultimately) a better service. The Canadian policy prioritised knowledge transfer and service improvement. Yet the dominance of non-political, service-centred discourse that seems to almost refute the very idea of ideology is *per se* profoundly ideological.

We thus acquire a clearer view of the two sides involved in the 'innovation game' embedded within health policy; cognitive and cultural paradigms, normative frameworks and ideas are constituted in the formulation and implementation of stroke policy (Jones 2009). Knowledge transfer may not be acknowledged as a driver for service innovation in the UK policy discourse; it is assumed to unproblematically render the provider-user relationship into a 'partnership', by addressing knowledge asymmetries that previously hindered collaborative behaviours.

Conversely, the forms of relationships presented in Canadian health care discourse seem to be somewhat depersonalised and the restructuring of the service appeared to mediate knowledge 'diffusion' and 'integration'. No stratification of the involved stakeholders was acknowledged, and knowledge asymmetries were not mentioned. Knowledge sharing was in Canada, as in the UK, viewed to be the ultimate target; however pre-existing ideological presuppositions and power dynamics among patients, clinicians and policy-makers, seemed to be largely muted. In this case, there was no question of innovating through challenging the current *status quo*; service innovation appeared in policy discourse devoid of any 'discursive manoeuvres' (Grant and Hardy 2004). The reality of care was systematically depoliticised and the primacy of 'service logic' was discursively constructed as 'scientific fact' (Maguire 2004) containing no conflicting meanings. In the UK, potential conflict between different actors creating meanings was alluded to, but assumed to be unproblematically resolved by means of knowledge transfer and empowerment.

Policy discourse in both countries illustrates how it produced different meanings of service innovation. In Canada, innovation was projected as an imperative that seemed to invite an undifferentiated set of actors to engage collaboratively across the service continuum. In the UK, the sharing of knowledge was invested with political meaning and the value of a consensual approach to innovating was entangled with delegating control to the lay patient. The notion of consensus privileged a unified message of innovation. This was presented as an uncontested process (Kontos and Poland 2009), by 'abstracting meaning away from the specific actions that gave rise' (Grant and Hardy 2004: 8) to the policy discourse. Hence the struggles involved in the inevitable re-ordering of relations of power between existing health care groups remained largely unexamined.

Conclusions

Our approach contributes a more nuanced understanding of the complexities associated with health care policy interventions. It builds on the need for more critical reflection on how contextual factors shape health care professionals' assumptions. We join others, who suggest a need for greater methodological pluralism (Davis and Howden-Chapman 1996; Russell et al 2008) in developing a knowledge base around policy and practice. In particular we suggest a focus on examining institutional structures, relations of power and the contests over meaning. In addition to the current focus on the *content* of policy, we recommend a focus on the *context* of the policy process including the actors involved and the discursive resources embedded within the field level structures. This implies a need to go beyond a rational interpretation to the policy – practice divide and to conceptualise the challenges through a viewpoint of politics, values and legitimisation.

An implication of our work is to highlight that *where* health policy is made matters; the content of policy is not neutral and reflects *who* has *what* role in policy development. This in turn influences how policy is implemented and points to a need to invest more resources in research methods that go beyond health policy as a rational decision-making process so as to recognise processes of legitimation and resistance. Policy narratives (Jones 2009), for example, have been advocated as a method of powerful literary fiction that is better at representing the central issues associated with policy development, and more influential in reaching a wider audience, than traditional 'objective' approaches. As highlighted throughout the paper, we suggest that a discursive lens is one such method that may be particularly fruitful for researchers and policy developers alike in understanding the role of culture and institutions in shaping, adapting, and resisting policy in the implementation process.

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9

Patient Safety: Whose Vision?

Kathryn Charles, Lorna McKee and Sharon McCann

Introduction

This chapter problematises the concept of ‘patient safety’ and unravels how it is understood and enacted by acute Trust staff, both managers and health care professionals, in the NHS in England. In understanding patient safety we focus on what the concept means to staff at different organisational levels, as well as how it is linked to wider organisational processes, structures and strategy, exposing the diverse practices, cultural attributes, competencies and processes that are wrapped up in its meaning. In particular, it is suggested that much good practice supportive of patient safety may be ‘unseen’ and ‘tacit’ (Mesman 2007) and that many factors impeding safety may not be direct, or located at the frontline or ‘sharp end’ (Dixon-Woods et al 2009). A primary focus is on staff perceptions of what is ‘patient safety’; any perceived links with staff well-being; and, what circumstances might facilitate or prevent them from providing safe care. We explore whether patient safety is approached by Trusts as a strategic system-wide change, connecting formal and informal practices, processes, cultural attributes, competencies, staff well-being and broader contextual factors; or if patient safety improvement is tackled as ‘initiative-driven’, piecemeal policy, with poor connectivity to strategy?

The chapter engages with organisational and sociological literatures, providing a framework for prioritising narratives of practice (Waring 2009; Iedema et al 2006; Dixon-Woods et al 2009) and highlighting the relationship between patient safety and strategy and organisational contexts, processes, governance and structures. It draws from one project strand within a multidisciplinary study funded by the National Institute for Health Research Service Delivery and Organisation Programme, Dep-

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artment of Health (UK). This project strand adopted a comparative case study research design and employed qualitative methods to explore the characteristics of organisational culture and broader contextual influences in eight English NHS acute Trusts and how these linked to outcomes affecting patient safety and staff well-being. The fieldwork was conducted during 2005–2007 (McKee et al 2010).

Background and research focus

Patient safety has become a major focus for practitioners, policy-makers and researchers across the developed world (Baker et al 2004; McL Wilson et al 1995). The research agenda has expanded through many disciplines and approaches. In tackling patient safety, policy interventions seem to favour two dominant but not mutually exclusive approaches: one, essentially 'top-down' and management-inspired that focuses on performance and accountability and involves incident reporting; standardisation of procedures and analysis of the systemic factors linked to patient safety breaches; and, two, an inductive, bottom-up approach which emphasises development of a patient safe culture, changing values and mindsets and supporting organisational learning (Dodds and Kodate 2008).

Waring (2009) notes how much research emphasises measuring clinical risk, in order to be able to control it and derive management solutions. However, research attention has increasingly been paid to identifying, assessing and codifying cultural change and organisational climate (Kennedy 2001; Mannion et al 2008). Assumptions arise that patient-safe cultures can be created or modified to generate higher levels of safety. While many government investigations of serious safety breaches narrate the interaction between individual, structural and cultural barriers (Kennedy 2001), a multilevel research focus was initially uncommon, leading to a paucity of research on patient safety and organisational governance (Fulop et al 2008).

Increasingly, researchers are exposing these dualistic logics in policy and in research focus, revealing their potential tensions and implications. Dodds and Kodate (2008), in their critique of NHS patient safety inspired policy, highlight how the NHS regulation regime comprises two co-existing but opposing regimes, or one regime with two contradictory elements. They identify the inherent contradictory logic, as one regime focuses on a culture of organisational learning, emphasising systemic and shared causes of patient safety breaches, while the other emphasises individual professional accountability. Waring et al (2006) also draws attention to how incident reporting may be interpreted as providing surveillance and scrutiny of clinical practice, which then undermines a culture supportive of organisational learning.

More recently, sociological research has pointed to the need for a shift from a 'deficit' approach of studying safety to foregrounding how patient safety is constructed, promoted and embedded in everyday practice. Constructionist perspectives have signalled the importance of connecting different levels of analysis. Some commentators (Waring 2009; Braithwaite et al 2010) argue that consideration be given to a holistic understanding of patient safety, exploring how safety knowledge is embedded in social practice, as understood and constructed by those working in health care. He advocated use of ethnographic and narrative research methods, going beyond the surface level of patient safety risk analysis methods and hence accessing how patient safety knowledge is embedded and reflected in health care workers' language and interpretations.

Iedema (2009) also highlights the need for sophisticated contextual awareness, citing from the report 'To Err is Human' (US Institute of Medicine 1999: 30) that 'the task for clinicians and managers… is not to treat all situations as alike but to understand when specification and standardisation are appropriate and when they are not'. This involves not only identifying how context shapes clinical behaviour or human factors (Woods et al 2006), but also addressing the people-people interface in safety and how it constitutes positive or negative effect.

Mesman (2007: 282) refers to the search for built-in competences and 'resources of resilience' as 'exnovation'. Conceptually, she suggests that it is important to ask 'why things do not go wrong more often' and argues through her participant observation work that analysis should be extended to uncover the resources of strength manifested in sound and reliable practice. This plea to locate and make sense of everyday patient safety practices and refocus on positive risk management actions has been answered by ward-level ethnographic research. Dixon-Woods et al (2009), in a recent evaluation of a national UK patient safety initiative (the Safer Patients Initiative) explain that more needs to be known about 'risk reasoning' and how proceduralisation of patient safety is experienced. It was observed that medical ward staff routinely engaged in assessing and managing risk, which led to emergent changes in practice, shaped by social and cultural factors.

This chapter is situated within this constructivist tradition and supports the call to develop a holistic approach to patient safety, emphasising both how it is understood and shaped in practice as well as bringing understanding of the role of organisational factors. It prioritises staff accounts of 'doing safety' and the links they make with their local contexts and organisation. It is argued that patient safety be viewed as a multilevel process where practice, structures and culture continuously adapt in response to a range of social, economic, technological, political and legislative pressures. Processual frameworks for analysing change processes can thus usefully identify the dimensions of internal and external context, change content features (such as the character, scale and scope of the change) and process issues (see Pettigrew et al 1992; Dawson 1994). This literature orientates the researcher to explore what are receptive contexts for patient safety.

The management literature is also useful for orientating analysis of patient safety improvement as an organisational cultural change process requiring a patient safety vision. There have been efforts to create and articulate a 'change vision' around patient safety and has this provided a common organisational understanding, focus and motivation for change (Pettigrew et al 1992). In this literature two dominant approaches of visioning are identified: a leader-dominated approach (for example, Bennis 1989) and a co-creation approach (Nadler 1998). Leader-dominated approaches focus on the ability of the CEO to create a strategic vision that galvanises and inspires the organisation. In contrast, co-creation approaches involve staff participation and advocate high levels of participation that empower staff to forward their ideas and to fashion and implement a change vision. This chapter questions the reality in these case study NHS Trusts; is there evidence of any vision of patient safety, and what shape might that take?

Methodology

The study from which this chapter is derived was based in eight acute NHS Trusts (referred to as Trusts A–H) (McKee et al 2010). Trusts varied in terms of performance criteria in relation to patient safety and wellbeing, size, foundation or non-foundation status, location (including geography, accessibility and population). The aim was to ensure diversity, not representativeness.

The organisational strand adopted a comparative case study design, chosen to promote investigation of the dynamics of complex research settings and useful in uncovering the unfolding nature of change processes (Gummesson 2000). It allowed researchers to access rich descriptions of the phenomena of interest, and provided for an inductive and deductive interplay within the research strategy. A conceptual framework informed by research on organisational change and receptivity was used to guide, inform and support the research process. A processual methodology (Pettigrew et al 1992) was employed which analysed change content, context and process issues.

Data collection methods included in depth semi-structured interviews, formal and informal non-participant observation and analysis of Trust documents and Healthcare Commission reports. Four Trusts (A–C) were studied in some depth and four had less detailed data collection (E–H). Table 9.1 summarises the Trusts' characteristics.

Table 9.1 Sampling frame Trust descriptors

STABLE AND HIGH PERFORMING **Trust B** Annual Health Check – Excellent/Excellent Patient satisfaction – Above average Patient mortality – Slightly below average Infection rates – Well below average NSS response rate – 47% **Trust E** Annual Health Check – Good/Excellent Patient satisfaction – Above average Patient mortality – Slightly below average Infection rates – Average; improving NSS response rate – 58%	**UNSTABLE AND IMPROVING** **Trust A** Annual Health Check – Excellent/Excellent Patient satisfaction – Above average Patient mortality – Well above average Infection rates – Below average NSS response rate – 66% **Trust H** Annual Health Check – Excellent/Good Patient satisfaction – Above average Patient mortality – Slightly below average Infection rates – Well below average NSS response rate – 62%
STABLE AND LOW PERFORMING **Trust C** Annual Health Check – Fair/Excellent Patient satisfaction – Slightly below average Patient mortality – Above average Infection rates – Average; improving NSS response rate – 61% **Trust G** Annual Health Check – Good/Fair Patient satisfaction – Below average Patient mortality – Well above average Infection rates – Well above average NSS response rate – 50%	**UNSTABLE AND WORSENING** **Trust D** Annual Health Check – Good/Good Patient satisfaction – Average Patient mortality – Slightly above average Infection rates – Average; improving NSS response rate – 49% **Trust F** Annual Health Check – Excellent/Excellent Patient satisfaction – Below average Patient mortality – Well above average Infection rates – Below average NSS response rate – 59%

The total of 144 interviewees included senior managers (all Trusts' Chief Executives or their acting officers); the Executive Board (including medical and finance directors); staff with responsibilities for patient safety, risk, human resources and/or staff well-being; middle managers;

and front line staff. Table 9.2 summarises the number and roles of interviewees:

Table 9.2 Role groupings of staff participants across Trusts

ROLES	**TRUSTS**							
	A	B	C	D	E	F	G	H
*SL	4	6	4	5	3	3	3	5
*RISK	6	9	7	4	3	2	3	2
*OH	3	2	2	3	2	2		1
*FL/*MM	6	16	14	10	2	4	6	4
Total	19	33	26	22	10	11	9	14

*SL = Senior Executive Team, *RISK = Risk analysis, incident reporting, clinical governance, litigation, PALS, complaints. *OH = Occupational Health Support, HR Director, *FL = Front line workers, *MM = Middle managers

All illustrative quotes conserve anonymity of both Trusts and individuals. The interviews prioritised content, context and process aspects (Pettigrew et al 1992). Change content issues related to staff perceptions of the scale, scope, character and magnitude of the cultural change, including staff interpretations of the goals, vision, and understanding of the change strategy. Contextual issues focused on identifying the influences of organisational structure, culture, history and resource constraints on patient safety performance. Process issues focused on clinical governance processes, Trust leadership styles, incident reporting and analysis systems and processes supportive of staff well-being. Interviews were digitally recorded and subsequently transcribed. All names were removed from recorded data and numerical identifiers attached. Data was then stored securely, with only dedicated access granted to named researchers.

Limited non-participant observation, both formal and informal, was undertaken. A work base was provided in each Trust allowing opportunities for informal observations and extended interaction with key personnel over time (Easterby-Smith et al 2002). These observations were used to validate and interpret the interview data and to penetrate what people actually do, rather than what they claim to do (Mintzberg 1973). This method was useful in identifying ‘misinformation’, inconsistencies and ‘corporate speak’ (Douglas 1976). It was especially useful in understanding the power dynamics of the research contexts and the political influences on the change process.

Documentary analysis enriched understanding of the Trusts' internal and external context (Scott 1990), including annual reports, Executive board minutes, policy documents, reports of incidents, complaints, health and safety and infection control. External national data were also assessed for each participating Trust: for example, Healthcare Commission Annual Health Check information, NHS National Staff and patient survey information.

Data collection and analysis were concurrent. Three researchers were involved in data collection and also independently involved in the coding, analysis, cross-checking and comparing interpretations and emerging themes. Preliminary analysis of data sources for each Trust was undertaken and a narrative prepared highlighting key emergent themes. Transcribed and documentary data were then made ready for input into the NVivo 7 qualitative software package.

The processual framework and the notion of 'change receptivity' (Pettigrew et al 1992) provided the sensitising conceptual framework to guide analysis. Building on the earlier narrative analysis, data input and analysis of one mini-case study (Trust G) using the NVivo 7 software then served as a pilot for the next stage of analysis. Key categories were interactively derived from the conceptual framework and emerging themes generated by the data.

Data analysis involved 'decoupling, classifying and recombining data to develop, refine and create concepts that enable the presentation of new accounts' (Dawson 2003: 114). This was facilitated by the triangulation of multiple data sources and a search for alternative explanations to explain unexpected outcomes. Analytical generalisation of study findings was facilitated by the comparison of interview data against existing theory.

It is noted that the study data collection is time bounded and the process of aggregating Trust findings does not seek to belie the unique nuances and differences identified in each Trust. It is recognised that the field of patient safety and health policy is fast moving, with multiple initiatives and shifts in priority since the data was collected. It is also the case that there were more managerial and dedicated risk and safety staff were interviewed than frontline staff.

Findings

What is patient safety and whose vision?

Many staff reported that they found it hard to identify a common organisational view of patient safety. All were in agreement that it mattered, but tended to point to fragmented strategies or work organisation and to issues such as the management of specific risks, incidents and incident reporting. This picks up Waring's observation about the dominance of the 'measure and manage orthodoxy' (Waring 2009: 1723). For most interviewees, the language used to articulate patient safety was reported as elusive and it was difficult to conceptualise safety behaviours into a single framework. Patient safety interventions tended to straddle organisational levels, encompassed different degrees of risk, and were difficult to embody as a holistic strategy covering clinical governance, incident reporting, risk analysis and training.

At the time of this study, it was not even straightforward to identify key leaders with patient safety in their remit; tasks were usually distributed to different organisational tiers and roles, with limited interconnectivity or clear lines of communication or accountability. Only one Trust (Trust C) reported at the time of data collection that it possessed a joined-up, official, patient safety strategy, in which staff perceived linkages between processes supportive of clinical governance, incident reporting and analysis, training and complaints analysis. Another Trust (Trust H) reported that patient safety would at some future point have an explicit strategy.

> *I just don't think we've used the words 'patient safety' in a regular and repetitive way. I think it's a bit like the word 'hygiene', 'hygiene' never featured in any documentation,… but we are changing what we say, we are changing the words we use and 'patient safety', the word 'safety' we consciously included in our plan for the year, our Patient Services Plan.* (Nursing Director)

The language of patient safety was also consistently linked to providing quality care and sometimes linked to 'Lean Management' quality improvement practices. The interrelationship, inter-changeability of meaning and confusion between safety and quality was raised frequently and this could add to complexity when the words were used interchangeably, as reflected in the following comment:

> *Well I think people see the issues of quality, i.e. I want to do this procedure or use this drug or this kind of intervention but they don't, we don't translate that into some of the mundane routines that are about safety, about checking and having the systems that are fail safe.* (Chief Executive)

The elasticity of what constitutes safety and risk was frequently reported: even interpretation of what constitutes a patient safety incident was contested. Tolerance of risk and calculations of risk were not necessarily commonly defined or shared. For example, doctors could perceive that complications inevitably arose from time to time in medical practice, while it was suggested that patients saw these complications as patient safety incidents. This opaqueness of 'normal' risk, alongside the complexity of meanings and the labelling of incidents are revealed below:

> *Because, let's say somebody goes to theatre and… something goes wrong, maybe the appendix is very stuck to the bowel and therefore they can't get it off, you know they can't make a clean excision, it's stuck to everything, so they have to nick the bowel… so they have to over sew the bowel and maybe do a de-functioning colostomy, now they wouldn't see that as an incident.* (Risk Manager)

The pervasiveness and difficulties inherent in managing safety were raised in relation to the nature of work organisation and the diverse interactions between staff and patients. Many clinical staff referred to how they often could not track risk and safety, as their actions were contingent and sequential, with highly complex communication between phases of segmented care. Staff drew attention to issues of handover of poorly co-ordinated care processes. They lamented the systemic barriers to following up patients; the limitations in the continuity of care, or the challenges inherent in the number of steps and stakeholders in the care process – the 'long chains of consequences'. Thus staff frequently reported that the diffuse nature of care and the engagement of multiple actors across a care pathway could confound matters and create real barriers to patient safety.

Factors influencing a common understanding of patient safety

The data show that financial performance had come to dominate the agenda of many Trusts. Issues of patient safety did not always make it onto all Board agendas, unless there was a major incident or enquiry. There was also huge instability in senior management in a number of the Trusts with high turnover of senior personnel, especially Chief Executives. This instability at the top level of the organisation was reported as filtering down the organisation, setting the tone of engagement with patient safety initiatives and determining its (lack of) priority.

At an operational level staff reported many 'day to day' barriers to patient safety. Their accounts highlighted a range of resource, structural, process and cultural factors which they perceived as making their everyday jobs challenging. These might obscure the safety promoting or resilience behaviours which go unrecorded or that are taken for granted or tacit, as referred to by Mesman (2007) and others. Few accounts refer to any participation in systematic development of a patient safety culture, in any deliberative sense-making activities around safety, or in articulation of a change vision.

Instead many interviewees focused on aspects of their jobs which challenged a focus on safety. These included perceived threats to safe care, such as heavy workloads, poor staffing levels, staff communication failures, failure to follow and document procedures, limited awareness of risk and priority to achieve performance targets. Staff reported a wide range of patient safety barriers and identify different combinations and volume of such barriers.

Linkages between staff well being and patient safety

An important finding was that staff linked working conditions and resources to their own well-being and their inability to prioritise safety. Staff in all Trusts indicated that staff shortages, poor skill mixes and heavy workloads were associated with negative patient safety outcomes. This was especially emphasised in Trusts experiencing financial problems and severe 'environmental' pressures Examples of environmental pressures included Trusts experiencing a merger, enquiry, or other major restructuring or senior leadership change.

The study specifically asked participants about links between staff well-being and patient safety. The responses show, in common with other recent studies, that patient safety practices are not a 'bolt-on' of new procedures but are grounded in the day-to-day realities of coping with complex demands and moment-by-moment risk assessment and balancing of risks. The link most consistently perceived between staff well-being and patient safety related to staffing resources and shortages. Interviewees, including line managers, repeatedly drew attention to the potential negative safety implications of staff 'stretch', stress and overload. They linked this to reported resultant failures to attend to detail, missing behavioural cues, ignoring procedural guidelines, or communicating poorly, with one another and with patients and their representatives.

Across the Trusts, limitations in ward skill mixes were perceived as resulting in trained staff being overworked, unable to take breaks and having difficulty in maintaining control of their work. This led to staff confessing that sometimes they failed to maintain focus on their tasks and face the danger of making mistakes. Tiredness, stress, low morale and high demands, including the managing of challenging patients were all cited as critical risk factors. These themes and realities are expressed below:

> *You know, when you've got low morale, either they are moaning to patients perhaps or you know, they are not taking their time to do things properly,… Handovers are sometimes quite poor so you are missing important information there,… there's more process problems really I think.* (Governance Manager)

Staff also reported how low morale and job insecurity could be linked to poor staff vigilance and failures to communicate and engage with other staff. Involvement in an adverse incident was reported as creating stress and self-blame for staff and, as one senior nurse commented, 'people will bring guilt on themselves'. In contrast, participants suggested that motivated and empowered staff were more likely to question actions, be responsive and approachable and to engage with patients, and hence derive greater knowledge and awareness of patient safety. Trust interviewees also reported that their goodwill to perform beyond what was expected, 'to go that extra mile', was linked to feelings of being valued and respected by Trust management. In particular, nurses identified how displacement or relocation of nursing staff created stress, reduced nurses' confidence and sense of control over their work and reduced safety awareness.

While many frontline and managerial level staff recognised the interaction between everyday staff well-being and work conditions and provision of optimum care, few patient safety interventions were framed in this way. It was more common for safety to be tackled by incident reporting and other formalised and proceduralised interventions. This again shows the disconnection between overall strategy, clinical governance, risk management and other aspects of institutional practice, as in the management of complaints.

Discussion

This chapter has suggested that few participating Trusts conceptualised patient safety as a cultural change strategy. Most focused on piecemeal interventions and discrete, micro-level procedures and practices, with dispersed accountabilities. Patient safety had not typically made Trust board agendas and was concealed in wider clinical governance policies and practices. Patient safety champions did not always sit at the top executive levels and patient safety was comprised by its elusiveness and diversity of meaning.

This general absence of a Trust-level vision for patient safety may explain why most staff failed to perceive patient safety as a system-wide challenge, connecting clinical governance, risk management, complaints analysis, staff development, human resources and training. It might also explain why more barriers to safety were articulated in interview accounts than protective, tacit practices. It is suggestive, too, of a top-down, uncoordinated devolution of patient safety to the organisational periphery, indicative of a preoccupation with reengineering of activity and performance surveillance, rather than creating a systemic approach to organisational risk. There was less emphasis on cultural change, staff engagement, working with the grain, or reinforcing positive actions. It was hard to discern much visioning activity or strategic articulation of objectives. Despite numerous examples of committed clinical and managerial staff adopting new safety practices there was a recurrent strategic blindness: an under recognition of organisational influences and limited integration of safety related activities.

In analysing situations that influence successful change vision creation and formulation, resource constraints did seem to influence – and detract from – the focus on patient safety. Priority was given to meeting performance targets which staff felt could cut across the focus on safety. The interaction between large scale organisational change, financial resource constraints, skill mixes, staff shortages, staff supervision, displacement of staff, time pressures and training and well-being were rehearsed over and over again. Clinical and managerial staff perceived such organisational factors as negatively colouring work performance: leading to a sense of being rushed, pressured and stressed and resulting in weak communication and engagement.

There were many structural challenges to Trusts which could pressure the leadership, including mergers, PCT restructuring, applications for Foundation status, financial crises and top level instability and turnover of key senior personnel. This again appeared to have distracted senior management and was greedy of their time and focus. There appeared to be few experiments with internal structures in these trusts, although two trusts (A and H) did suggest they were moving toward an organisational structure characterised by adhocracy, more dispersed leadership and collaborative team working.

The study also suggests that Trust cultural attributes affect organisational receptivity to change (Pettigrew et al 1992). In particular, cultural norms which led to failures in both verbal and written communication were described as hampering patient safety. Professional status differentials and cultural diversity were seen to limit participation, questioning, communication and transfer of learning. These hierarchies and subcultures, especially between nurses and doctors, were said to directly affect incident reporting. Some interviewees mentioned that junior doctors' new training arrangements heralded new, unforeseen, ward-level safety risks, by increasing the speed of junior doctor attachments and breaking up the traditional mentoring roles of senior nurses. Issues of leadership, lack of continuity of leadership and top-level churn of Chief Executives were also problematic and said to reduce continuity of or focus on care. On the positive side, there were counterbalancing accounts of excellent leadership, learning and innovative engagement of staff in solving local problems at speciality level, often attributed to local leadership and cultures.

Conclusion

This chapter has drawn on change management literature to conceptualise patient safety as a multi-level cultural change. It has drawn on narrative accounts from staff across levels and with diverse responsibilities thus accessing the many and complex influences on patient safety. It has highlighted the long chains of consequences innate in clinical practice as well as the many tiered realities and levels that are both protective and causative of error. In 'getting inside' patient safety and unravelling the formal and informal practices and competencies inherent in clinical and organisational practice, the chapter has brought to the surface how the lack of a common purpose and strategy around safety limits a systemic approach.

The data reveal a powerful story of how staff themselves, make sense of their everyday working conditions and foresee risks in their practices and organisation. These stories and insights deserve to be listened to and factored into official responses and policy and to inform the co-creation of any patient safety strategy. The potential for insight and the deep grasp of the threats to patient safety were already there in the organisations we studied. Staff members' were articulate, passionate and individually informed about risks. What was often reported as missing was any formalised or collaborative way of harnessing local wisdom, putting a brake on busyness to create reflective spaces, elevating the priority given to these interactions and situating practices and expertise. As change intensifies, with new proposed restructuring of services and organisations, the messages inherent in this research will remain salient.

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Section 3

Case Studies on Implementation and Reform

10

Inside Foundation Trust Hospitals: Using Archetype Theory to Understand How Freedoms Translate into Practice

Rachael Addicott and Francesca Frosini

Introduction

As part of National Health Service (NHS) system reform in England, a novel type of provider organisation, the foundation trust (FT), was introduced in 2004. FTs were awarded considerably greater operational and financial freedoms relative to other NHS trusts (that is, publicly funded hospital groups), with new governance arrangements that replaced national accountability with accountability to the local community. The intention of the FT policy was that these new organisational forms could then use their freedoms and new governance arrangements to innovate more effectively, and improve their performance in financial management, quality and responsiveness of services delivered. The FT policy was initially developed following observation of similar reforms in other countries, such as Spain, Denmark and Sweden. However, there is very limited publicly available evidence regarding the success of these international reforms.

The recently published Health and Social Care Bill (House of Commons Bill 2010–11), based on the government's White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health 2010: 5), suggests greater flexibility in the FT model into the future – with an espoused rise in social enterprises and other provider models, and allowing NHS staff to have greater involvement in decision-making. As such, consideration needs to be given to the impact that this policy has actually had in practice.

Despite the significance of the policy and the fact that already 134 acute and mental health trusts (as at February 2011) have successfully gained FT status, there has been lack of clarity regarding

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whether the intention of the policy has materialised in practice. Early research conducted by the Healthcare Commission (2005) suggested that FTs felt more able to plan and develop services as a result of greater control over their resources and quicker decision-making processes. More recently, the Audit Commission (2008) – which is responsible for inspecting and reporting on public services – further reported that FTs welcome their autonomy and that this has facilitated organisational change.

However, it has also been suggested that FTs are not fully exploiting the borrowing and workforce freedoms awarded to them under the policy, and that foundation status has actually had little effect on quality, access and financial performance (Healthcare Commission 2005; Marini et al 2007; Audit Commission 2008).

This paper uses secondary evidence and examples from practice to further highlight the challenges the FT policy has faced. Using these examples, this paper then uses archetype theory to explain how and why the intention of the policy has not been fully realised in practice. The following section will firstly outline the conceptualisation and enactment of the FT policy context in more detail.

Policy context: The example of Foundation Trusts

The FT policy was developed in 2004, in a context of renewed emphasis on decentralisation and market incentives. However, these were embodied in a regulatory framework that emphasised the definition of national targets and centralised performance management of purchasers and providers (Allen 2006).

The 2010 change of government in the UK, and the subsequent health system reforms that are currently being legislated by the emergent coalition government, reinforce the continuation of the FT policy to give providers greater freedom to innovate. The Bill is also proposing to encourage even greater localism and reduce some of this centralised performance management.

FTs are constituted as separate legal entities and were established as public benefit corporations under the Health and Social Care Act (2003). By law, FTs are guaranteed freedom from the Secretary of State for Health powers of direction and are not performance managed by the Department of Health, or through Strategic Health Authorities (SHAs – which are the CURRENT link between the Department of Health and the local NHS). In addition, FTs can recruit staff under their own conditions and have the flexibility to offer new rewards and incentives to staff. FTs are financially independent organisations that (unlike non-FTs) can retain their financial surpluses and are free to manage their own budgets in order to shape the health care services they provide.

Moreover, FTs have access to a wider range of options to borrow money for capital investments. With this, FTs also face greater risk and responsibilities with no access to brokerage – the system of reallocation of funds from other parts of the NHS to cover deficits at the end of a fiscal year.

FTs' direction from central government is replaced with regulation from the independent regulator Monitor, which is accountable to Parliament through the Secretary of State for Health. At the time of writing, Monitor has statutory powers to authorise NHS trusts as FTs (much like a license to operate), to oversee compliance with the terms of authorisation, and to intervene in the event of significant non-compliance with the terms of authorisation and other statutory obligations. Under the reforms proposed in the Health and Social Care Bill (House of Commons Bill 2010–11), Monitor is to undertake a new role as economic regulator of all providers of NHS services but will continue to support the establishment of new FTs.

National accountability to the Secretary of State has also been replaced with accountability to the local community. The governance arrangements of FTs have two distinctive elements – a membership community and an elected Board of Governors. Patients, the public, staff, and other stakeholders in the local community can become members of the trust, which is then accountable to these members through the elected Board of Governors, as their representatives. The Chair of the Board of Governors also chairs the Board of Directors, which is responsible for overseeing the day-to-day operation of the trust.

Evidence of FTs' use of freedoms

Current evidence on the implementation of the FT policy and how they are using their freedoms is limited. However, together this research does provide some insights into the development and application of the policy. Early research from the Healthcare Commission (2005) found that Directors did feel an increased ability to plan and make decisions on investments as a result of their greater freedoms, and that they were clearer about their responsibilities and had more time to concentrate on strategic issues. The Audit Commission (2008) identified that FTs were positive regarding their capacity to develop governance arrangements and their connection to local communities (through governors and membership). The FT policy was associated with some improvements in financial management arrangements, and

FTs exhibited a more ‘business like’ approach to the way they manage their finances.

Several studies describe the challenges in developing new governance structures, with governors unclear of their roles and responsibilities, a small number of people volunteering for membership, members still largely unrepresentative of the local population, and low voting turnout (Day and Klein 2005; Healthcare Commission 2005; Lewis 2005; Lewis and Hinton 2008).

More recently, Ham and Hunt (2008: 38) concluded that ‘governance arrangements in FTs are now established and are becoming increasingly effective’. For example, they noted that there is greater clarity in the role of the Board of Governors and that an increasing number of governors participate in a meaningful way in the operation of FTs.

Despite research indicating some positive aspects of implementation, it has been suggested that FTs are not fully exploiting the apparent opportunities given to them under the policy. For example, the Audit Commission (2008) reported that FTs have not taken advantage of their borrowing and workforce freedoms. The research also found that the FT model is not driving innovation in service delivery or financial planning. At the time of publication, FTs had only accessed £100 million of the £2.5 billion surplus that was available to them. FTs also have the capacity for greater workforce flexibility and can move away from national contracts – although there is limited evidence that FTs have yet taken advantage of this freedom.

As all trusts move to become FTs, it is important to understand the impact of the policy on the behaviour of these providers and its translation into practice. Drawing on existing research and ongoing examples, this paper argues that organisational archetypes may provide a useful framework for better understanding the current status of the FT reform, and its apparent failure to fully realise its ambitions.

Archetype theory: Institutional theory and organisational archetypes

Greenwood and Hinings’ (1993, 1996) conceptualisations of archetype change provide a useful basis for extending our theoretical understanding of organisational change in health care. The previous discussion of the FT reforms could be reconceptualised and understood through the associated dynamics of ‘archetype’ change (Greenwood and Hinings 1993; Greenwood and Hinings 1996), with FTs representing a potentially emergent archetype (more market-oriented), or institutional form, in the public sector.

The FT policy (at least in its ambition) could be described as an archetype in this manner. Alongside organisational structures and systems of decision-making, a key component of an archetype is the ideology (values and norms), or what Greenwood and Hinings refer to as an interpretive scheme. 'An archetype is thus a set of structures and systems that reflects a single interpretive scheme' (Greenwood and Hinings 1993: 1052).

Archetype change is most likely when there is a strong and coherent reform ideology. Greenwood and Hinings (1993: 1058) propose that 'organizations that have structures and systems that are not manifestations of a single, underlying interpretive scheme will move toward archetypal coherence'. A successful 'track' (or outcome) of archetype change is dependent upon de-coupling from the initial archetype (in this case, a traditional bureaucratic hierarchy) and re-coupling with the emergent archetype (FT, or a market-oriented model) and there are a variety of potential outcomes of this transition (see Table 10.1).

Table 10.1 Potential outcomes (or tracks) of archetype change (Greenwood and Hinings 1988)

Track	**Description**
Inertia	structural consistency is maintained over long periods of time and changes that do not comply with the existing archetype will not be present or will be suppressed
Discontinued or aborted excursions	limited de-coupling from the existing archetype
Unresolved excursions	incomplete de-coupling and incomplete re-coupling
Successful reorientations	successful archetype change (most difficult to achieve and a number of facilitating forces must be evident)

It is evident that the FT policy does not represent a successful reorientation to an emerging archetype, as FTs have not fully embraced the freedoms that were available to them under the more decentralised model. Evidence regarding the limited shifts in either structure, systems of decision-making or underlying interpretive schema help to theorise how and why the full aspirations and freedoms of the FT policy have not been realised in practice. Each of these three features will now be considered in turn.

The Foundation Trust Model as an institutional archetype?

The FT structure is arguably the most advanced feature pertaining to a move towards a new organisational archetype. FTs have established Boards of Governors and Boards of Directors, and research suggests that FTs report increased local responsiveness and connections to their local communities (Audit Commission 2008).

However, FTs remain part of the existing NHS structure and continue to provide and develop services for NHS patients consistent with NHS standards and principles – free care, based on need and not on ability to pay. The greater operational and financial freedoms are balanced by a regulatory framework designed to ensure that FTs continue to treat NHS patients according to NHS standards. FTs cannot provide services outside the core of health services and face a cap on how much income they can collect through private patients (although this cap is to be lifted under the more recent reforms proposed). Authorisation indicates a list of mandatory services that cannot be discontinued without agreement with Monitor and local purchasers. In addition to the restrictions set in their license to operate, FTs are also required to meet national targets and standards. Thus, similarly to other NHS trusts, FTs are assessed annually by regulators on these targets and standards and performance rated accordingly.

Although the developed structure of FTs is arguably the most advanced archetypal feature identified (Greenwood and Hinings 1993), the fundamental structure of the FT model has been undermined through the conditional nature of FTs' autonomy (continual assessment by regulators and restrictions on the nature of care provided). Although new structures have emerged, they have not replaced many of the pre-existing mechanisms of control.

FTs have demonstrated some shifts in systems of decision-making, where local communities and staff are involved through Boards of Governors and membership. The Audit Commission (2008) found that FTs are increasingly seeking involvement from their membership in planning clinical services. In addition, the Health Select Committee (2008) indicated positive changes in decision-making processes, with Boards of Directors making decisions faster and paying greater attention to financial implications of decisions. Although some FT governors reported that they felt engaged in the operation of FTs (for example, through assisting with board appointments and sitting on working groups), it was unclear whether they had any direct role in informing local priorities or impacting on FT development.

Despite positive changes in *internal* decision-making systems of FTs, pre-existing *external* mechanisms of decision-making appear to be persistent. FTs are regulated by Monitor and no longer directly accountable to SHAs and central government. Yet, there is evidence that these agreements may be inconsistent with recent reports that the (previous) Chair of Monitor continually clashed with the Chief Executive of the NHS, regulators and ministers regarding FT governance and how they interact with other local providers. The recent 'deep clean' of NHS hospitals represents an example of how the Department of Health has failed to fully loosen the reigns of central control over these apparently more autonomous trusts.

Following a lapse in hygiene standards at a non-FT, the Department of Health issued a directive to all trusts (including FTs) to undertake a 'deep clean' of their institutions. The Chair of Monitor took exception to this, expressing concern over the 'directive' and 'instructive' correspondence and claiming that it was illustrative of the incapacity of central government to loosen control over the regulation and operation of FTs. A strong-worded correspondence followed between Monitor and NHS executives, where the power struggle over the operation of FTs was openly played out (Carvel 2008; House of Commons Health Committee 2008).

The recent crisis at Mid Staffordshire NHS FT further demonstrates that decision-making and roles and responsibilities were unclear in the new organisational structure. A Healthcare Commission (now Care Quality Commission – regulator of health and social care in England) report (2009: 10) highlighted significant failures in emergency care at Mid Staffordshire NHS FT, and high mortality rates. According to the report, 'the trust's board and senior leaders did not develop an open, learning culture, inform themselves sufficiently about the quality of care, or appear willing to challenge themselves in the light of adverse information'.

Although the timing of the failings was prior to FT authorisation, these findings raised particular concerns and criticisms of the FT policy reform, where arguments were made that the autonomy associated with FT status was related to these failings going unrecognised. Criticisms focused on the changing Board structure resulting from FT status, and potential confusion over the role of the Boards of Governors and Directors, and their responsibilities in overseeing clinical governance. Further, granting of FT status intended to indicate these organisations as high performing trusts, and failings called into question the assessment process and decentralisation of decision-making – could these trusts be trusted to operate more independently from central control?

The learning from this incident also highlighted the complex relationship between Monitor and the Care Quality Commission. It has been reported that 'the precise nature of responsibilities, particularly where individual bodies' responsibilities intersect or overlap has evolved and is not entirely clear, which can give rise to confusion and uncertainty' (KPMG 2009: 3). KPMG (tasked with identifying learning from the Mid Staffordshire incident) argued that at a senior level there is somewhat clear delineation of responsibilities, however at an organisational level there is greater complexity and confusion regarding how various governance and regulatory processes align and intersect.

Further, the recent Department of Health (2009: 5) consultation on the deauthorisation of FTs also demonstrates that systems of decision-making even at a higher, authorisation level may not have shifted as significantly as the policy intended. Recent FT failings raised concerns in parliament and with the Department of Health that Monitor's relationship with FTs was insufficiently influential to prevent and respond to such crises.

The Department of Health proposed instead that the policy must allow FTs to be stripped of their status on the basis of poor performance, and that the Secretary of State for Health should be able to request that Monitor consider taking specific additional actions where a FT has significantly failed their patients. If Monitor decides not to deauthorise, or take other actions requested by the Secretary of State, then they would be required to fully justify this in a written public report and set out the alternative steps it will take.

This example clearly demonstrates that the Department of Health is not fully allowing FTs to exploit their freedoms nor allowing Monitor to act independently as FT regulator, and is in fact seeking to retrieve some of the centralised control that the policy sought to remove. The Department of Health has proposed that the Secretary of State should have the power to ask Monitor to intervene in FTs only in cases where there are considered to be grounds for deauthorisation (Department of Health 2009).

These examples illustrate how the FT model has brought with it new governance and decision-making processes and new responsibilities to Monitor. However, they also demonstrate overlapping roles and responsibilities and how the model has inherited pre-existing systems of decision-making, resulting from the failure of central government to loosen control over FTs and entrust Monitor to act as their independent regulator. Throughout this process, it appeared that the Department of Health was attempting to recover some of the control they relinquished to FTs and Monitor. As such, the turbulent and conflicting systems of decision-making demonstrate that the FT policy has not seen a conclusive shift towards a new archetype in this manner, and thus offer some explanation why FTs have not been fully exploiting their freedoms. These co-existing systems of decision-making, and the resultant confusion over priorities and purpose, have contributed towards the inability of FTs to fully realise their espoused ambition.

These findings demonstrate the difficulties in reforming structures and decision-making processes however, it is shifts in the underlying interpretive schema (or values and norms) that are the slowest to manifest, with traditional professional or organisational norms and values persevering over time (Addicott 2005).

Although not specifically looking at FTs, recent evidence suggests a progressive shift towards a 'rational' culture among senior management in NHS hospitals, as a result of policy developments where market mechanisms are prominent (Mannion et al 2009). However, the same work also points to a rise in more traditional and bureaucratic 'hierarchical' culture over the same period. Overall the research concludes that these cultures compete rather than substitute each other. While the culture of senior management might be shifting, hospitals remain professional organisations (Currie and Suhomlinova 2006). As such the question remains whether the values and norms of professionals within them will shift accordingly. There is presently no evidence that examines this aspect in FTs, however other research would suggest that these values are difficult to change (Crilly and Le Grand 2004).

Research suggests that FTs remain embedded within their local health economy and its priorities, which constrain their willingness to move from the *status quo*, especially when this shift requires alteration of established patterns and loyalties. Both patients and GPs appear to be loyal to local providers and unwilling to receive treatment and move referrals away from their local hospital. Similarly, evidence indicates that purchasers of care are prompted not to change patterns of commissioning as they do not want to destabilise local providers. Such patterns moderate incentives set by national policies such as FTs. Exworthy et al (2009) found a persevering negative view towards profit-making in the NHS, which also hindered organisational change as FTs strive to maintain legitimacy in their local health economies. This is at odds with the ambitions of FT policy (and more recent reforms) and Monitor.

In addition, the reluctance of the Department of Health to loosen control over the awarded autonomy of FTs demonstrates a continuing emphasis on principles of centralisation, and traditional bureaucratic norms. At both local and national levels, the underlying norms of traditional bureaucratic financial and management structures remain.

Residual organisational cultures have continued to dominate at both local and national levels – ensuring that the ambition of the FT policy reform has not been fully realised in practice. The same argument could be made for understanding the introduction of the internal market model in 1991 (Exworthy et al 1999) and introduction of managed networks in the early 2000s (Addicott 2005). Attempts to devolve accountability to a local level have been consistently superseded by a continued emphasis on centralised accountability, through a bureaucratic hierarchy.

Conclusion

The intention of the FT policy was that these organisational forms could use freedoms and governance arrangements to innovate and improve performance in financial management, quality and responsiveness of services. However, it has also been suggested that FTs are not fully exploiting the freedoms awarded to them. FTs have not taken full advantage of their borrowing and workforce potential, and it has been suggested that foundation status has had little effect on quality, access and financial performance (Healthcare Commission 2005; Marini et al 2007; Audit Commission 2008). As the government proposes that all NHS trusts will become (or be part of) an FT (Department of Health 2010), it is evident that these findings are of direct practical relevance to policy-makers and those tasked with implementing recent White Paper reforms.

These findings illustrate how the FT model has brought new structures and decision-making processes, and new responsibilities to Monitor. However, they also demonstrate overlapping roles and responsibilities and how the model has inherited pre-existing systems of decision-making, resulting from failure of central government to loosen control and entrust Monitor to autonomously act as independent FT regulator. These findings demonstrate the difficulties in reforming structures and decision-making processes however, it is shifts in the underlying interpretive schema (or values and norms) that have been consistently slow to manifest, with traditional professional or organisational norms and values persevering over time.

The resistance to date of the Department of Health to loosen control over the awarded autonomy of FTs demonstrates a continuing emphasis on the principles of centralisation. At both a local and national level, the underlying norms of a traditional bureaucratic financial and management structure remain. The recent Health and Social Care Bill (House of Commons Bill 2010–11), and its emphasis on localism, demonstrates a further attempt to shift accountability and decision-making to a local level. However, its impact in practice remains to be seen.

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11

Structuring Emergency Care: Policy and Organisational Behavioural Dimensions

Peter Nugus, Mohamud Sheikh and Jeffrey Braithwaite

Introduction

This chapter takes an ethnographic approach, with the aim of advancing knowledge about emergency departments (EDs) and the theory of organisational behaviour (OB). The case study is the treatment of vulnerable patients in the ED. Patients from vulnerable groups – such as those with mental illness, older patients and those from culturally and linguistically diverse backgrounds – in general, fare worse in the ED, than do other patients (Dingwall and Murray 1983; Hwang et al 2006; Jeffrey 1979). Refugees, for example, face cultural, social, and linguistic barriers to accessing health services in countries of resettlement (Sheikh et al 2006). The worldwide problem of inadequate care received by particular groups of patients reflects inequitable health access for vulnerable groups, and is an important issue for policymakers working to reform health care. In seeking to understand how such inequitable treatment comes to occur, this chapter takes as its starting point the interconnections between hospital departments. Such a perspective is realised through direct observation in the 'natural', everyday setting of the hospital.

Systems of care and vulnerable patients in the emergency department

The treatment of vulnerable patients in the ED offers important lessons for a systemic perspective on studying dimensions of OB. The disadvantage experienced by vulnerable patients in the ED is a system-wide problem, stemming in part from the lack of connectivity and interdependence of health workers in different roles and across different departments. This includes cultural and discursive communities of

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which clinicians are members. For example, characteristics of patients and perceptions of them by clinical staff influence the way in which their ED care is organised and delivered (e.g. Hughes 1989; Vassy 2001). Cases which doctors have found to be more 'interesting' have been shown to mobilise action more efficiently than might otherwise have been the case (Dodier and Camus 1998; Jeffrey 1979). The relationship between perception of patients and the way in which their care is organised manifests in a mismatch between hospital services and the unique needs of at least two vulnerable groups: geriatric patients (e.g. Andersson and Karlberg 2000; Grief 2003) and psychiatric patients (Pestka et al 2002). For instance, psychiatric conditions have been considered by some stakeholders as somehow less 'worthy' of ED care than others (Jeffrey 1979).

Research into the way the mismatch between needs and services is manifested in the ED is important because frequent attenders of EDs (in the US, and elsewhere) are older than the average population (average age 55 years) and more likely to be vulnerable psychologically and have fewer social support mechanisms (Byrne et al 2003). Furthermore, this is increasingly important because EDs are receiving and treating increasing numbers of older patients (Burt and McCaig 2001; van Raak et al 2003) and patients with psychiatric conditions (Kalucy et al 2005). We focus on these two groups of vulnerable patients in this paper. This helps expose the kinds of increasing demands faced by reformers and other stakeholders who might be interested in shaping, adapting and resisting policy developments.

The way major Australian EDs are organised evokes a high degree of interconnectivity with specialised services (Nugus et al 2010a). Unlike many UK hospitals, patients in major public EDs in Australia are transferred directly from the ED to specialty wards, such as cardiology and neurosurgery, rather than to general medical and surgical wards for subsequent categorisation. Thus Australian emergency doctors and nurses have to negotiate directly with a complex organisational structure, comprising specialised knowledge communities across the hospital.

A systemic perspective on OB in health care

We know too little about the context and systems that produce inequitable treatment. OB research ought to have a role in examining context and systems, through its focus on collective behaviour, values and attitudes in workplace settings (Braithwaite 2006). In their account of hospital work, Strauss et al (1963) famously argued that the hospital was not a fixed object but a set of relationships which produced the hospital structure that influenced interactions – that is, a ‘negotiated order’. They believed that without total knowledge of the policies, networks, procedures, relationships and perspectives, ‘no one knows what the hospital “is” on any given day’ because the hospital is ‘continually being established, renewed, reviewed, revoked [and] revised’ (Strauss et al 1963: 164). Of course, total knowledge is not possible. From a negotiated order perspective, the organisation is understood as an ongoing and recursive accomplishment of members in interaction (Griffiths 2003).

Further, the hospital is a professional bureaucracy (Mintzberg 1979). Bureaucracy values the whole over constituent parts to reduce risk (Beck 1992: 47) with the goal of maximising overall efficiency (Weber (1968) [1921]: 1156). The hospital is an exemplar bureaucracy. Specialisation of its knowledge is the foundation for differentiation of departments and professional roles (Nugus et al 2010a). This echoes a broader pattern of modernity in which specialist knowledge is more highly valued than generalist knowledge (Brown and Webster 2004), and this is mirrored in the structuring of organisations.

ED work is inherently interdepartmental, specialised and bureaucratised (Nugus and Braithwaite 2010; Nugus et al 2009; Nugus et al 2010a). Bureaucracy is an appropriate concept for a study focused on the formal boundaries of the hospital. It does justice to the empirical research which has demonstrated that collective work practices and identities are developed in interaction, but build around formal organisational structures (e.g. Vassy 2001). Little empirical attention had previously focused on the formal boundaries of a hospital department and the dynamics of workers’ engagement with that structure. That modes of rhetorical and negotiation work are engaged with structured organisational power is well established in prototypical empirical studies of OB (e.g. Braithwaite 2006; Katovich and Maines 2003; Nugus et al 2010b).

We know from empirical research drawing on the sociological theory of symbolic interactionism that people generally behave according to available discursive choices based on role-based behaviour (Nugus 2008). Although interactionism regards social structures as ‘real’ in their consequences rather than imaginary, the individual can only ever abstractify or reify such structures. This is because human beings are not aware of the range of structural influences on their action (Katovich and Maines 2003). This ought to direct attention away from the isolated behaviour of individuals to the behaviour of individuals in social and organisational contexts (Nugus 2008). Collective work identity, or 'social identity', draws on people's tendencies to categorise and orient themselves according to available distinctions; that is, to make sense of one's social environment and locate oneself within it (Hogg and Terry 2000; Kärreman and Alvesson 2004). In terms of the organisation, Schatzki (2006) argues that a unit's shared perspective represents persisting practice structures which are passed on interactionally rather than cognitively (Schatzki 2006). For instance, powerful groups might have the means to disrupt broad social and organisational patterns, as exemplified by the ability of doctors to resist change and thereby facilitate the 'non spread' of particular innovations within England's National Health Service (Ferlie et al 2005). Accordingly, research into health services needs to be fertilised with social and organisational theory (Griffiths 2003).

Yet, OB research favours analysis of attitudes and external outcome measures (e.g. Ott 1989; Scott et al 2003). Such measures, taken at-a-distance, are important, but overlook the dynamic processes of organisation in real times and places. A weakness in qualitative organisational research in health care, as a relatively new field of research, is that it risks being theory-free (Griffiths 2003). To advance our understanding about inequitable treatment in health services – and to advance research in OB generally – we need to understand and theorise the relationship between processes and structures in context. We learn more about a system, such as an ED, a hospital, or the broader health system, from seeing how phenomena emerge in the processes of real times and places, rather than as the product of the system at a later time (Begun et al 2003). The aim of the present chapter, therefore, is to disentangle the role of hospital-wide structures and processes in the way patients are categorised in the ED. This helps adduce evidence for understanding the system that reformers seek to act on, shape or influence.

Methods

The exploration of structures and processes in real times and places presupposes an ethnographic research approach. Ethnographic research bears witness to the live interplay between the influence of large-scale systems on behaviour and the free will, or agency, of individuals. Drawing from a larger data set, we conducted semi-structured, audio-recorded interviews with 20 ED doctors, 20 ED nurses, 20 doctors from other departments and 20 nurses from other departments (80 in total) in two hospitals in Sydney, Australia. We also conducted 12 months of observation, part of which was unstructured, recorded in hand-written field notes, in each of the two EDs of those hospitals, and also undertook structured observation of three ED doctors and three ED nurses, in each ED, over two full shifts each. Human Research Ethics Committee approvals were secured from a university and the two hospitals in which the research was conducted.

We content-analysed the typed transcripts from more than 800 pages of observational field notes, and 640 pages of typed interview transcript. We drew out perceived and observed themes in the priorities of ED and hospital-based clinicians concerning the care of ED patients. Themes were discerned systematically, in an iterative process of 'line-by-line' coding (Glaser 1992). We represent examples of the patterns that were discerned and indicate either: the role and hospital of the interviewee, or the hospital, shift number, role and field note page number, of the participant being primarily observed while those data were collected. For example, we indicate whether this was the case for a senior nurse (SN), a junior doctor (JD)(intern), a senior doctor (staff specialist) (SD), or a Team Coordinator (Nursing Unit Manager) (TC). 'FN' indicates general field notes from informal observations. For instance, 'JDB1: 21' denotes that the excerpt of evidence was taken from page 21 of the field notes recorded during the first shift of the junior doctor observed in Hospital A. Names of participants have been changed to protect their identities.

Findings

Organ-specific priorities: The fragmented bodies of patients

Our findings show the power of interdependent relationships and cultural systems which influence individuals' behaviour and which they also construct in interaction. The following findings characterise interconnections across hospital departments. The three findings build stepwise, showing: how human bodies are regarded in hospital care; the consequences of this view for care delivery; and, ultimately, patterns of structured inequality in hospital care. The first finding is that priorities of many inpatient doctors and nurses reflect the organ-specific character of their particular surgical or medical disciplines. Most of the specialties with which Australian emergency clinicians engage correspond to particular inpatient hospital wards. Wards are dedicated to particular medical specialties that align with these organs, such as Cardiology and Respiratory Medicine, in addition to general wards and specialised service wards such as post-operative and rehabilitation wards. Following formal admission by an inpatient medical or surgical team of an ED patient to the hospital, the Team Coordinator (TC) (also known as the Nursing Unit Manager) and nurses enact transfer of the patient to the assigned ward. These admitted patients remain 'boarding' in the ED as 'outliers' when no beds are available.

Clinicians from inpatient departments related to particular organs take seriously the distinction between particular organs of the human body, with regard to organisational and identity differentiation. This division is organisationally significant because emergency clinicians need to negotiate the organisational compartmentalisation that corresponds with this division. Inpatient doctors conveyed that they expected targeted persuasion by emergency clinicians to accept care of an ED patient:

> *[If you want me to come down, you have to match the evidence to the specialty]. … You list the symptoms. I want evidence to come down. … [I don't want to hear: Oh, you have to come; they're short of breath.]. I'm only interested if I'm the [after-hours med reg]. In the day I'm a cardiologist. Not airy fairy stuff: 'The x-ray shows this. White blood cells. The temperature's elevated and low saturation and got sputum. Fast heart rate'. Yes, that's pneumonia.* (Interview, Inpatient Registrar, Hospital B)

Thus, cases must be shaped in relation to a particular medical or surgical specialty by aligning with a particular organ of the body. The ED is a site of engagement with clinicians from various departments, whose collective roles are structured by those departments.

Deflecting ambiguity: A fragmented organisational structure

The second finding is that, as a consequence of organ-specific priorities, inpatient clinicians favour unambiguous cases, and, where possible, seek to deflect care to other specialties. This reflects the systemic, or structural, power that stems from specialised knowledge of doctors from organ-specific teams, and discernible through ethnographic study. The following conversation between an emergency CMO (Career Medical Officer), an intern and an inpatient doctor relates to a patient who presented with serious wounds. An intern had advanced the patient's trajectory by seeking an x-ray and had contacted an orthopedic registrar. The orthopedic registrar came into the 'consults' room. He acknowledged to the CMO that the patient needed to be admitted but revealed the fine-grained distinction inpatient doctors draw between specialisations that permit inpatient doctors to resist becoming involved in the care of ED patients:

> *Orthopod [orthopedic registrar]: 'His ulcers are the worst thing'. CMO: 'Why ulcers?' Ortho [Orthopod]: 'I don't know. He's the worst historian. It's good you did the ultrasound. Page 'Andrew Nelson', the plastics reg [registrar]. He [the patient] probably can't go home. He'll have to stay here'. CMO: 'So you don't want to take him?' [Orthopod]: 'No, he can walk. He didn't give much info and he isn't the best historian'.* (JDA1: 17)

The significance of this excerpt is that the orthopedic registrar agreed that the patient needed to come into hospital, but drew on an organ-specific distinction to avoid accepting care of the patient. Thus, the game of selling ED patients involves the buyer (the inpatient department) drawing on the organ-specific distinction of their specialty to resist the sale (by the seller: the ED), and to seek to deflect care to another specialty. From a systemic organisational perspective, we can see that inpatient doctors wield organisational power by virtue of their specialised knowledge of a particular organ of the body.

Vulnerable patients and the challenge of patient transfer: How hospitals fragment care

The third finding is that emergency clinicians find it difficult to transfer older patients with complex conditions, patients whom they believe to be mentally ill, and patients less able to communicate their needs. The conditions of these patients are less amenable to organ-specific classification.

> *'It's difficult to get emergency doctors to assess patients who appear [to be mentally ill] for the [physical] condition for which they presented… If a patient's a bit disheveled and appears confused and maybe talking a bit loudly… there's a tendency to call us without doing a medical assessment … I understand the difficulties. Psychiatric patients… have difficult problems and difficult solutions… They're angry and they have a personality disorder. I mean they're not pleasant people to deal with. When you're busy in the middle of the night you don't want to deal with that. And, you know, to be honest, sometimes I don't either… Look I've worked in emergency as an intern and resident and I didn't like seeing psychiatry patients in emergency. I think it's the culture of emergency… 'cause they were just taking up too much time because they were difficult and we had all this other stuff going on. … So, I think, I mean, having [criticised emergency doctors] I've been in that situation and I've also thought the*

> *same way [as emergency clinicians do]'*. (Interview, Registrar, Psychiatry, Hospital B)

One particular patient appeared confused and the doctors were noted during the observations to have difficulty ascertaining the cause of his injuries. Possibilities included psychiatric review and admission. A Career Medical Officer (CMO) and an intern were concerned about the patient's mental health. The intern had learned of an alternative approach for psychiatric patients, which they conveyed to the first-listed author:

> *'The point for a psych patient is you've got to get them admitted for something medical. Get them in for something and then they can get a psych review'*. (JDA2: 28)

Thus, appeal to a psychiatric condition alone is not always sufficient for a patient to be admitted.

Older patients face similar challenges of being case-shaped into organisationally relevant categories. Older patients frequently have multiple and complex conditions. This places the aged care department at risk of being a 'dumping ground', as expressed by a registrar in geriatric medicine:

> *… Sometimes the poor old folk from emergency have been tossed from pillar to post… They've rung Respiratory and Respiratory have gone 'no, Cardiology' and Cardiology have gone 'no, Respiratory', and Respiratory have gone 'no, Aged Care', and, from their point of view, I can see that that's [frustrating] and then they ring me and if they had that story I'd say 'that's fine, I'll come down and sort it out'. But if they've rung me first and it sounds like a fairly uni-dimensional problem without any of the sort of aged-care type problems, without a complicated social situation or without a delirium or something else, then I'll say 'no, look, talk to respiratory or talk to the appropriate sub-specialty'. And you sort of feel a bit taken advantage of sometimes'*. (Interview, Geriatric registrar, Hospital A)

This demonstrates a potential pattern of difficulty in transferring patients to general, or 'whole body' departments or specialties. In an interview cited earlier, the AMR who was also a cardiology registrar, was able to clearly separate their day role as a cardiology registrar and their after-hours role as an AMR. However, the registrar of Geriatrics, in the interview excerpt above, equated the geriatric medical discipline with general medicine in terms of challenges of patient categorisation. The actions of individual clinicians are at least partly a function of their social structural location in the organisation.

It was observed that emergency registrars spent more time assessing and treating patients with patients in lower triage categories – three and four – than with patients in the higher triage categories of one and two. Because the Australasian Triage Scale concerns urgency rather than severity, patients in categories three and four might not be as urgently ill as patients in categories one and two. Yet, they might be as severely ill or might potentially be as severely ill as those in higher triage categories. Many of the patients in categories three and four fit the profile of an older patient taking multiple medications to treat multiple conditions. Such cases were difficult to case-shape into the single-organ structure of the hospital. Some such patients also required considerable time to resolve their diagnoses and treatment plans, to try to prevent inpatient admission or re-presentation to the ED.

The generalised character of the conditions of frail older patients makes them more amenable than other groups of patients to the hospital's bureaucratic influence on ED work. Older patients are especially amenable to organisational disadvantage in their receipt of hospital care. Since 'patient-passing' is associated with lack of organ-specific clarity in a patient's condition, it is likely that the more complex the case, the more reluctant medical and surgical teams will be to accept patients if they can possibly avoid it. Thus the more complex the condition, the more vulnerable is the older patient to not having their needs reconciled with the organisation's need for efficiency.

Discussion

OB and unequal hospital care

The chapter showed that it is relatively difficult for emergency clinicians to efficiently and effectively transfer patients whose presenting conditions do not align unambiguously with a single organ. The study adds an OB perspective to our understanding of the treatment of vulnerable patients. Such inequality stems from the way organisational power is distributed in the hospital, discernible through ethnographic observation. Like Ferlie et al's (2005) account of medicine's power to 'non-spread' innovations, this chapter showed a clash of two unequal systems. The ED is often structurally less powerful in the hospital than inpatient departments, especially those based on specialised knowledge of a particular bodily organ, as a foundation for organisational differentiation. This makes the hospital a classically evocative bureaucracy. To a large extent inpatient departments have the power to determine if, how and when they will become involved in the care of ED patients. Some patients are systematically disadvantaged in the ED because their conditions are less amenable to single-organ classification, and hence transfer.

A systemic perspective on specialisation

Clearly, patients benefit from specialised care. Specialisation is germane to modern society, enacted through bureaucracy. It is probably beneficial to patients for staff to hold each other to account and to ensure that referrals are appropriate. This might ensure that, in general, patients receive the right care by the right people at the right time and in the right place. On the other hand, merely because most patients might receive appropriate care most of the time, does not mean that instances of substandard service delivery are necessarily isolated instances. Using sociological and organisational research and theory, this chapter elucidated patterns of substandard service delivery for particular groups of patients.

The interdepartmental negotiation that was documented is not merely a form of organisational bargaining, evident in any form of technical work. Emergency clinicians bargain from a structurally unequal position. The chapter showed a battle of two hierarchies in the hospital: an individual, *interpositional hierarchy* that exists hospital-wide (such as the distinction between consultants or physicians, registrars and interns), and an *interdepartmental hierarchy*. At points of disagreement, the interdepartmental hierarchy prevails over the interpositional hierarchy. This means that, although an emergency consultant might have more formal positional authority than an inpatient registrar on most occasions, they do not necessarily have more actual influence. Further, in general, at the same formal positional level an inpatient registrar will have more influence than an emergency registrar.

The significance of an organisational perspective on health care was to show how staff are structurally located in their roles. We witnessed empathy among the participants for those in other roles, and participants reflected explicitly on their own action in different roles. Structurally unequal service delivery for some groups of patients is, therefore, not dependent on the moral benevolence or malevolence of individual clinicians, or necessarily on the level of communication skills individual clinicians possess.

Transferability of the findings

Redressing systemically unequal health care delivery will not necessarily be resolved by granting hospital admitting rights to emergency doctors, or transferring ED patients directly to general medical and surgical wards, as happens in the UK. The structural power of inpatient departments, relative to the ED, is exacerbated in Australia which, unlike the UK and continental Europe, follows the North American model of interventionist emergency medicine, having a long-established, independent College of Emergency Medicine, and characterised by seeking to deliver diagnosis and complete treatment in the ED, if possible, rather than transferring patients as soon as a diagnosis and decision for admission has been reached (Cameron 2003; Zink 2006). We argue that the findings concerning the clash of generalist and specialist cultures are relevant to the UK and other European nations, because categorisation for specialised treatment also occurs, there, even though the clash might be postponed to later in the patient's trajectory.

Conclusion: Implications for health policy implementation and reform

The tension around reconciling patient needs for holistic care with the structure of the hospital may be evidence that differentiation in the hospital outweighs collaboration. In other words, instances of integrated care in the ED might come about in spite of, rather than because of, the way the hospital is organised. The implication of the findings presented in this chapter for health policy implementation and reform is that redressing the needs of vulnerable patients in the ED requires more than benevolent clinicians with well-developed communication skills. It also requires more than policy-makers pushing out a new policy from the top such as 'be receptive to vulnerable patients' or 'admit or refer for treatment and discharge all patients within four hours'. Expecting stakeholders in complex socio-professional structures to be able to give such policies effect unproblematically is naïve.

If we are to close the gap in the care for vulnerable patients in the ED, we need more cohesive, less fragmented, better integrated systems. Accordingly, evaluation of and research into health care services must be based on systems rather than individual blame, a claim made often in patient quality and safety literature, but rarely examined in OB in health care literature. Inpatient clinicians and departments require incentives to provide care for patients' 'whole bodies' rather than caring only for their 'fragmented body' – that is, the individual parts of their bodies. Regard needs to be had for the dynamic processes of mutual influence – and OB in health care research and largely overlooked by policy-makers and researchers. It is, after all, at the frontline of service delivery – moment to moment – that professional health workers shape, adapt and resist policies.

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12

Chronicling Twenty Years of Health Reform in Czech Republic

Sharon L. Oswald and Rene McEldowney

Introduction

Health care reform has reached epidemic proportions throughout the world. From Germany to Australia, all seem to be searching for the magic formula that will deliver high quality care at lower costs. Nowhere has this become more apparent than in the Czech Republic. While privatisation of the industrial sector led to social cohesion, the same was not true for the health care sector (Oswald 2000). In 1992, the Czech government introduced massive health system reforms in an attempt to shift its post communist delivery structure toward a Bismarck model (Roberts 2003). The resulting public-private system has been continuously modified with varying degrees of success and acceptance. By illustration, a failed effort to institute a diagnosis related groups (DRG) system, out of control health care costs, and renewed discussions of full privatisation contributed to the Czech government collapse in spring, 2009 when Prime Minister Topolanek and his cabinet were forced to resign (Stage 2010).

Early change research (Lewin 1947) suggested individuals experience change through a progression of stages: unfreezing, moving and freezing. More recently, researchers have identified appropriate actions to reduce resistance. Armenakis et al (1993) argue that readiness (unfreezing) is an important factor of the change process and that a 'general set of beliefs shape readiness and provide the foundation for resistance or adoptive behaviors (Holt et al 2007)'. Readiness, states Armenakis et al (1993) 'is the cognitive precursor to the behaviors of either resistance to or support for, a change effort'. The authors identified five emotions that a change message must address to achieve readiness: discrepancy, appropriateness, efficacy, principal support and valence.

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In this chapter, we employ the Armenakis et al (2007a) organisational change recipients' belief scale on a sample of practicing Czech health care professionals to gauge propensity toward acceptance of, or resistance to, health care reform. Participants were enrolled in a US-affiliated health care MBA programme. The present study examines the role discrepancy, appropriateness, efficacy, principal support and valence play in recipient attitudes toward change. We further examined two factors previously determined to be relevant to a successful change process, psychological attachment (Armenakis et al 1999) and procedural justice (Korsgaard et al 2002), to assess any effect they had on participants' feelings about health reform.

The Czech health system: An overview

Prior to 1992, the Czech Republic was completely void of private physicians (Subrt 2009). Czech physicians were highly regarded throughout Europe, but quality standards of the health system were subpar. Under the communist regime, a copious supply of hospitals and hospital beds signified a good health system. The Czech Republic had 50 per cent more beds and physicians per capita than, for example, the US (Healy and McKee 2001) and was highly fragmented.

The 1992 Czech reform plan was designed to correct the inefficiencies of the Soviet-type system by creating a national insurance scheme, creating private insurance companies, privatising physician practices and transferring rural hospitals to private control. The General Health Care Insurance Office (GHIO) replaced the nationalised health system and served as the clearinghouse for all insurance claims. Moreover, a government-guaranteed General Health Insurance Fund (VZP) was established. By law, VZP covers maternity patients, students, children, disabled individuals, pensioners, military personnel, social security recipients and the unemployed and accepts any citizen who applies. The plan also established employer-backed private insurance companies for employee groups of 20,000 or more (Oswald 2000). Initially 26 private insurance companies were founded; but were reduced to nine by 1999.

One challenging reform attempt was the introduction of DRGs in 2007–08 (Maly 2008). According to Zamecnik (2009) compared to other industrialised countries, the Czech Republic has a disproportionate number of physicians holding political office and these doctors didn't support DRGs. Politically the physicians have the power to push agendas and block legislation that would adversely affect them. DRGs weren't fully realised by the end of 2008 because the physician-dominated parliament awarded exceptions to hospitals based on their own political agendas. In 2010, the VZP made DRGs mandatory; however, according to Pavel Bruna (2010) only about 10 per cent of the hospitals use the system correctly. In 2009, Minister of Health Tomas Julinek announced sweeping reforms including the privatisation of all hospitals and insurance companies and the introduction of co-payments: 30 Czech KC/doctor visit, 60 KC/hospitalisation, 30 KC/pharmacy visit and 90 KC/emergency visit. Co-payments benefited the government resulting in a gain of 10 billion KC but they were not popular with the general public and physicians. Today, most regional facilities, have completely disband co-payments (Zamecnik 2009).

According to Zamecnik (2009), 'reform is not a loved word because the people feel that all the government does is constantly change health care'. Yet, he notes reform is essential because the government is merely cost shifting rather than making the tough decisions. He blames the public dissent on poor communication from the Ministry.

An understanding of managing change

Pursuant to Lewin's (1947) change model, it is generally established that for change to be successful it must follow a process of readiness (unfreezing), adoption (moving) and institutionalisation (freezing). Armenakis et al (1999) suggests that the core to building commitment to change is the message and after a review of relevant literature, identified the previously mentioned five emotions to explain reactions of change recipients.

The emotions of change

Individuals often develop preconceived notions about an event when the requisite information is not available. When the event involves change, resistance is the defense. Past researchers have contended that resistance can be reduced if individuals feel the change is necessary (Bandura 1986). Armenakis et al (1999) refers to this as discrepancy, or the difference between the current and desired state. Accordingly, an individual must believe that some deviation from the present is necessary to be motivated to participate in the change. Therefore, to understand and embrace change, the need must be apparent. In the case of the Czech health reform, the impetus for change was apparent from the efforts to privatise the country because it no longer could function under a communistic-style health system. Zamecnik (2009) said the general belief is that reform continues to be necessary, and therefore we expected discrepancy to be high.

Research stresses that change must address discrepancy. Armenakis et al (1999) notes that the 'introduction of change creates a great deal of uncertainty and confusion' and, thus, the change message must address the appropriateness of the change. When change recipients recognise the change appropriateness, uncertainty will diminish. Specifically, the more an individual understands the necessity for the change, the more likely that individual can formulate positive feelings. With regard to Czech health reform, Zamecnik (2009) contends that the message for change has been unclear. 'The former Minister didn't listen to anyone and most of the people didn't know what was going on'. Consequently it appears appropriateness is almost impossible to assess.

Armenakis et al (1999) notes that the change message must address personal valence or, 'what's in it for me?' For example, the change can result in increased rewards, such as money (extrinsic) or more autonomy in decision-making (intrinsic). Also, rooted in the concern for personal valence is the need for the change to be fair and just. Cobb et al (1995) argue that perceptions of justice are important for those affected to support the change. In the Czech example, the introduction of co-payments drew resistance because people saw only the negative features (paying a nominal fee). This, coupled by the fact that the change efforts were not well communicated, suggests that the reform message did not adequately address valence.

Bandura's social learning theory (1986) states that people perceive support for an initiative through informal networks. In a change process it is important for individuals to believe there is principal support from formal and informal leaders (Armenakis et al 1999). Research suggests that the ability of the leader to adequately justify change correlates with the degree of resistance (Bies 1987). In the Czech Republic reform efforts by one party were criticised by another (Zamecnik 2009). Armenakis et al (2007a) notes, if the individuals believe principal support for the change is inadequate, this influences how well the change initiative is embraced. Thus, each transformation of the Czech health system may be viewed as merely a fad. Consequently, we expect perceived principal support to be low due to the lack of consistent message of support.

Another emotion widely cited in the literature as playing an important role in the change initiative is efficacy (Amiot et al 2006; McGuire and Hutchins 2006). In this content we define efficacy as 'confidence in one's personal and organizational abilities to successfully implement the organizational change' (Armenakis et al 2007b). Bandura's (1986) noted that there is a human tendency to avoid or reject those activities perceived to be beyond one's capabilities. Efficacy implores the question, 'do I/we believe I/we can get behind, support, and implement the change'. If the answer is no, the outcome will not be optimal. As suggested by Vroom (1964), to be motivated to support a change, individuals must feel that success is possible. If a change is viewed as impossible or unlikely to succeed, support will be scant (Armenakis et al 2007b). Czech health reform is in its second decade and monumental strides have been made. The study participants have seen firsthand that change is possible but not all change has been favourably accepted. Thus, if change is truly considered to be nothing more than a fad then the motivation to support another change effort may be far-reaching. Given this, we expected efficacy to be low.

Additional antecedents of change

Past research suggests that commitment is important to the institutionalisation of change. In his seminal research Kelman (1958) identified three dimensions of commitment: compliance, identification and internalisation. The latter is believed to occur because individuals feel that the ideas and actions are appealing and proper. It is at this point where the fear of the unknown may cause an individual to resist change. As noted by Armenakis et al (1999) to create internalisation-based commitment there must be a psychological attachment between individuals' beliefs and values and that of the culture. Research has found psychological attachment to be linked to preference for change (Harris et al 1993) such that the more committed one is to the organisation's values, the more likely that attachment will translate into a belief in the change initiative. In the case of Czech health reform, if those involved in the management and delivery of health care understand the changes and believe that the Ministry is sincerely making the necessary changes; their belief in the change should be greater. However, the constant changes and communication problems suggests that it would be difficult to develop any meaningful psychological attachment.

Procedural justice

Procedural justice relates to the perceived fairness of decisions and has been found to affect an individual's commitment to an organisation or person. Common sense tells us that people are more likely to buy into an effort or programme if they feel it is just. In their study of strategic change in employment situations, Korsgaard et al (2002) found that reaction to change was dependent upon perceptions of procedural justice, such that employees were more willing to forfeit their obligations and leave the company when they viewed the change process as unjust. By extension, if Czech physicians perceive reform to adversely affect their income, they will likely consider the reform to be unjust and not support the changes. Likewise, if the reform is believed to result in a redistribution of money to different health facilities or the closure of others, procedural justice could be compromised particularly if the necessity for change is not fully understood. Trust in those responsible for the change can also be seen in terms of just or unjust (Korsgaard et al 2002), suggesting that if individuals understand and believe change is in their best interest or the best interest of the country, they will support the change and trust in the health care leaders. However, since the communicated reasons for recent changes have been ambiguous we believe there will be no perceived procedural justice for this study sample.

Methodology

The study sample comprised 76 practicing health care professionals (including medical doctors, pharmaceutical managers, insurance managers, hospital directors and hospital department heads) enrolled in a Czech Health Care MBA programme. For optimum comprehension, the questionnaire was prepared in English, translated into Czech and back translated.

Questionnaires were administered to three cohorts during regularly scheduled classes who were told the survey was part of a research project on health reform. Respondents were asked to return completed surveys to the programme's executive assistant resulting in 39 usable surveys for a 49 per cent response rate. Average age of participants was 45 (standard deviation = 9.2), average number of years in the health field was 16.2 (standard deviation = 8.8), and average years in present position was six (standard deviation = 4.6).

Measures

Belief in the change was measured using a five point Likert scale and represented an adaptation of Armenakis et al's (2007a) 24-item organisational change recipients' belief scale. Based on previous research, the scale assesses the previously discussed five critical beliefs to the change.

Example items include, Discrepancy: 'We need reform in our health system;' Appropriateness: 'When I think about change, I realize it was appropriate for our country;' Self-efficacy: 'believe we successfully implemented health care changes;' Principal support: 'The top leaders supported changes in our health care system;' Valence: 'I will earn more money due to changes in the health system'. (1, 'strongly disagree' to 5 'strongly agree').

Perceived procedural justice was measured using Parker et al's (1997) 7-item scale of procedural and distributive justice. Example items include, 'People most knowledgeable about health care and health care operations are involved in the resolution of problems' and 'If health care directors perform well there is appropriate recognition and reward from the Ministry.' Perceived Injustice was assessed using a four item injustice scale (Hodson et al 1994). Example items include, 'Some people involved in our health care system get credit for doing more than they actually do,' and 'Some people involved in our health care system receive special treatment because they are friendly with individuals in the Ministry of Health'. (1, 'strongly disagree', to 5 'strongly agree'). Psychological attachment was assessed using an adaptation of O'Reilly and Chatman's (1986) 12-item survey and a seven point Likert scale. Examples items include, 'My personal values and those of the Ministry have become more similar since I have been involved in health care,' and 'My private views about our health care system are different from those I express publicly' (1, 'strongly disagree', to 7 'strongly agree').

Results

Data were analysed in a mixed ANOVA framework. We sought to correlate the attitudes individuals involved in the management and delivery of health care to their level of support for reform efforts. The results were mixed and may not truly represent a correlation between attitudes and willingness to support health reform measures. Taken as a whole, at best, the data are merely suggestive that study participants agreed to a need for change to the health system. The most robust finding in the study was for the dimension discrepancy. The results indicated a high degree of discrepancy which suggests that there is a significant difference between the actual state and desired state of the health system. However, the results do not confirm or deny that the change efforts were effectual in solving the problems of the current system. For the indicators, appropriateness, self efficacy, personal valence and principal support, the results were inconclusive. Specifically, there was a lack of significance for any of the variables. We tested for perception of procedural justice again, our results were inconclusive. Inconclusive results were also found for psychological attachment.

Additional demographic and educational correlations were performed but proved inconclusive. As mentioned previously, the only statistically significant finding was that the study participants felt that health reform was needed. Therefore, our results could be viewed as raising more questions than answers. Specifically, the results do not lead us to any definitive conclusions as to whether the study participants believe reform efforts will address the issues and shortcomings of the current Czech health care system.

Study concerns and limitations

The findings of this research suggest possible limitations. First, the sample size was insufficient to warrant generalisability. Further, multivariate analysis suggests that there should be at least ten times as many subjects as items or in cases involving a large number of items at least five subjects per item. The small sample size constrained the ability to conduct more sophisticated statistical analysis. Another possible limitation lies with the survey instrument. There was sufficient evidence to suggest that item five on the discrepancy subscale, 'I believe the changes that have occurred have been favorable', item 10 on the efficacy subscale, 'I had the capability of implementing all reform efforts', the entire justice survey, and item 39 in the attachment subscale 'What the Ministry of Health stands for is important to me', did not achieve acceptable psychometric properties. Perhaps the true meaning of the item was lost in the translation or the items may be a variance to the actual constructs they attempt to measure. Third since the Czech health care system has been under a nearly constant state of reform since communism and no specific reform was identified in the survey instrument, it is possible that those surveyed were confused as to which reform effort was in question. More definitive language would be imperative for future replications.

Conclusions and implications

In this study we assessed the beliefs and attitudes of Czech health care professionals toward their country's reform efforts. While our results indicated that those surveyed felt reform was necessary, the results provided no further detail as to their true attitude toward the reform. Interestingly, informal classroom discussions with sample participants resulted in much more definitive opinions and concerns not seen in the written surveys. Future research should examine the possible lingering effect communism has on the Czech citizens with respect to expression of written opinions. Political culture theory suggests that 'the relation between political structure and culture is interactive, that one cannot explain cultural propensities without reference to historical experience', and further that 'a prior set of attitudinal patterns will tend to persist in some form and degree and for a significant period of time, despite efforts to transform it (Almond 1983)'. Extrapolating this to the Czech Republic where communism was prevalent until 20 years ago, the respondents may feel uncomfortable articulating positions contrary to the Ministry. Our results provide support for Sandholtz and Taagepera's (2005) assertion that cultural orientations change slowly in post-communist societies. While the youngest survey participant was only three or four when communism ended, the culture of secrecy and oppression could have a formative effect for many generations. This may explain why our results showed that participant age had no bearing on responses, and in particular on questions related to justice and injustice.

The lack of variation in responses could also be explained by Hofstede (1980) who contended that culture was 'the collective programming of mind which distinguishes the members of one human group from another… the interactive aggregate of common characteristics that influences a human group's response to its environment' (p. 25). Past research suggests that national culture differences can be identified on the basis of how members of a given culture perceive the world (Stewart and Bennett 1991), process information (Hall and Hall 1990), and relate to one another (Trompenaars 1994). Again, since research suggests that the cultural orientation of communism is still somewhat prevalent (Sandholtz and Taagepera 2005) responses may reflect the national culture.

The pace of change within the Czech system might offer some additional insight into the lack of definitive responses among study participants. According to Abrahamson's (2004) Repetitive Change Syndrome, 'initiative overload manifests itself when organizations launch more change initiatives than anyone could ever reasonably handle'. The result of this overload often leads to a subtle form of sabotage, 'people faking it, acting as if they are cooperating with a new initiative while secretly carrying on business as usual'. Thus, confusion over which changes were being addressed in our survey, coupled with the pace at which new initiatives were being introduced and then abandoned may have fostered a 'play it safe' attitude of non-commitment by our study participants.

Policy implications

Much has changed for the Czech citizens in 20 years. The introduction of a market economy gave way to varying levels of unemployment, and for some less security. Health care has been inalienable right. Since the initial attempts to privatise the health system there has been a lot of inconsistency in health policy due to two interrelated factors: 1) the constant turnover in the Ministry of Health and 2) the powerful position of Czech physicians. The lack of stable leadership within the Ministry of Health is key to the limited success in enacting comprehensive health reform. Since 1992, the Ministry of Health has had 16 different Cabinet Ministers; the longest of whom served less than three years (Table 12.1). This near constant turnover in top leadership makes it nearly impossible for those within the Ministry to develop and build the kind of support necessary to ensure a successful reform effort (Roberts 2003). Given this contentious and often unstable environment, our findings suggest that even when the need for reform is consensual, agreement on what those changes should be may be difficult to achieve.

Table 12.1 Czech Republic Ministers of Health

Dates	Minister	Political Party	Time in Office
2 Jul 1992–22 Jun 1993	Petr Lom	ODS	11 mo
23 Jun 1993–10 Oct 1995	Ludek Rubás	ODS	28 mo
11 Oct 1995–2 Jan 1998	Jan Stráský	ODS	27 mo
2 Jan 1998–22 Jul 1998	Zuzana Roithová	CSSD	6 mo
22 Jul 1998–9 Dec 1999	Ivan David	CSSD	17 mo
10 Dec 1999–9 Feb 2000	Vladimír Spidla (acting)	CSSD	14 mo
9 Feb 2000–15 Jul 2002	Bohumil Fiser	CSSD	29 mo
15 Jul 2002–14 Apr 2004	Marie Soucková	CSSD	21 mo
14 Apr 2004–4 Aug 2004	Josef Kubinyi	CSSD	4 mo
4 Aug 2004–12 Oct 2005	Milada Emmerová	CSSD	14 mo
12 Oct 2005–4 Nov 2005	Zdenek Skromach (acting)	CSSD	<1 mo
4 Nov 2005–4 Sep 2006	David Rath	CSSD	10 mo
4 Sep 2006–23 Jan 2009	Tomás Julínek	ODS	28 mo
23 Jan 2009–8 May 2009	Daniela Filipiová	ODS	4 mo
8 May 2009–13 Jul 2010	Dana Jurásková	INDP	14 mo
13 Jul 2010–	Leos Heger	TOP09	

Source: R. McEldowney, 2010

Practice implications

This study highlights several possible practice implications for frontline managers, chief of which is the concern for symptoms of Repetitive Change Syndrome. Abrahamson (2004) suggests that managers should measure the current rate of organisational change against their degree of internal organisational stability. And if they find that they and/or their staff are routinely spending more than one third of their time addressing change initiatives changes should be enacted before harm to critical frontline operations result. Another consideration is the speed at which proposed changes are introduced. If too much change is mandated within too short of a time frame, mid-level managers and staff will often adopt a survival play it safe attitude and become resistant toward all change efforts.

On a broader level, our study further suggests that finding the root cause of change resistance may be complicated by a number of factors including political and cultural histories which could remain for decades and the rapid introduction of often contradictory unprecedented change. In this respect, researchers of organisational and political change in the Czech Republic should consider employing aggregate research methodologies where respondent identity is anonymous.

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13

Achieving and Resisting Change: Workarounds Straddling and Widening Gaps in Health Care

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Background

The international movement to reform health care and improve patient safety encompasses a range of strategies. These strategies include restructuring (Braithwaite et al 2005), policy reform measures (World Health Organization 2005; Garling 2008; National Health and Hospitals Reform Commission 2009; Hurst 2010) and programmes to standardise practice (Pronovost et al 2006; Gawande 2009; Iedema et al 2006). A social movement approach has been used to promote large scale change to the way in which patient safety is perceived and enacted within and across health services and systems (Bate et al 2004). Examples of this approach include international campaigns such as *Five Moments for Hand Hygiene* (World Health Organization 2006) and *5 Million Lives Campaign* (McCannon et al 2007).

Research has highlighted that despite intensive efforts including campaigns and publicity, increasing access to resources through the internet and awareness of the reform necessities and the patient safety problem, there is slow uptake of evidence-based medicine (Eccles et al 2005), effective hand hygiene practices (Whitby et al 2006) and clinical guidelines (Stratton et al 2000) to name only three. Health care delivery is becoming bound by increasing numbers of rules and regulations, policies, guidelines and policy-makers and managers are striving to enact change and reform of various kinds in this context. A potential unintended consequence of the proliferation of these approaches to reform patient safety is that clinicians resist attempts at standardisation and change. That is, when clinicians perceive that the delivery of care is altered by a new policy, structure or guideline they may workaround the block or alteration rather than comply.

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A myriad of gaps exist in health care. There is a separation between policy, practice and empirical knowledge (Nugus and Braithwaite 2010; Timmermans and Berg 2003). The uptake of research findings by clinicians does not reflect the knowledge of evidence-based practice (Evensen et al 2010; Grimshaw et al 2002; Eccles et al 2005). Within the one organisation, and even the one department, there can be little uniformity in clinical practices (Mohr et al 2004; Mano-Negrin and Mittman 2001). There is a gulf between perceptions about and use of electronic incident reporting among health care workers (Travaglia et al 2009). In many instances, senior managers' mental models of organisations and the complex organisational reality they reside in do not match (Anderson and McDaniel 2000; Braithwaite et al 2009). Similarly, the espoused and enacted leadership of health care teams can be worlds apart (Greenfield 2007; Braithwaite 2008).

Information technology (IT), bureaucratic rules and clinical guidelines have proliferated in an attempt to negotiate such gaps, create order and standardise conduct. Through strategies such as these, organisations strive to manage the complexity they face. In response, clinicians resist, they adapt and shape their environments, develop behaviours to get the job done, and employ strategies to manage gaps. These behaviours are known by a variety of terms including workarounds (Morath and Turnbull 2005; Ferneley and Sobreperez 2006), violations (Runciman et al 2007) and shortcuts (Halbesleben et al 2008). A difficulty is that there is no common framework for the analysis of these behaviours. Definitions are infrequently offered and those that are presented are often ambiguous (Halbesleben et al 2008). Similarly, existing frameworks (for example, Ferneley and Sobreperez 2006), need further clarity and development, and examination of their applicability to health care. Workarounds are explained as 'work patterns an individual or a group of individuals create to accomplish a crucial work goal within a system of dysfunctional work processes that prohibits the accomplishment of that goal or makes it difficult' (Morath and Turnbull 2005: 52). In a step toward understanding workarounds, Hablesleben et al (2008) have delineated them by contrasting workarounds to similar constructs, such as errors or mistakes, deviance and shortcuts. They argue that workarounds can be differentiated by motive. While workarounds are primarily motivated by a need to get around a blockage to complete a task, deviance is motivated by other factors including self gain (Halbesleben et al 2008). However, behaviours such as violations match definitions for workarounds. Violations have been defined as 'deliberate – but not necessarily reprehensible – deviation from safe operating procedures, standards or rules' (Runciman et al

2007: 122). In light of these definitions, it is not clear whether workarounds are synonymous with a category of or a broader class of violations. Further research is needed to investigate this issue. This chapter is concerned with behaviours that health professionals employ to address the gaps in health care. The term workarounds will be employed to cover the variations of conduct that exist and the above definition is adopted.

Workarounds provide first order solutions to problems (Tucker and Edmondson 2003), enabling tasks to be completed albeit not in the prescribed or expected way. Workarounds are ubiquitous, occurring at all levels of the organisation and morphing in response to changes in policies, procedures, technologies, situations and perceptions of those involved. Health care workers are touted as the 'masters at workarounds' (Morath and Turnbull 2005: 52), with their use noted in relation to: electronic health records (EHR) (Varpio et al 2006; Varpio et al 2009; Saleem et al 2009); high pressured workloads (Kobayashi et al 2005; Espin et al 2006; Hakimzada et al 2008; McKeon et al 2006); managing system inefficiencies (Mohr and Arora 2004); and electronic medication systems (Koppel et al 2008; Pirnejad et al 2009; Patterson et al 2002; Patterson et al 2006; Marini and Hasman 2009; Vogelsmeier et al 2008; Barber et al 2007; McAlearney et al 2007; Ash et al 2009; Hsieh et al 2004). Nevertheless, the current understanding of workarounds in health care is in its infancy. To date the literature on workarounds is predominantly descriptive and discussion of the consequences of workarounds speculative or deductive rather than empirical (Halbesleben et al 2008). Workarounds are described as both supporting and disturbing workflow. They are perceived to facilitate and confuse EHR mediated communication (Varpio et al 2006; Varpio et al 2009; Saleem et al 2009), and assist and disrupt work processes in high pressured situations (Kobayashi et al 2005; Ferneley and Sobreperez 2006; Hakimzada et al 2008). Workarounds have been observed to enable short term navigation of problematic organisational processes (Mohr and Arora 2004; Ferneley and Sobreperez 2006) but in doing so can create additional unexpected problems elsewhere in the system (Mohr and Arora 2004; Kobayashi et al 2005). Health professionals' use of workarounds are thought to negate the safety features provided by electronic medication systems (Patterson et al 2006; McAlearney et al 2007; Vogelsmeier et al 2008; Koppel et al 2008), and they are believed to compromise data integrity (Ferneley and Sobreperez 2006). It is argued that workarounds potentially contribute to medical error and create error prone organisations (Spear and Schmidhofer 2005). Therefore, workarounds have the potential to erode attempts at improvement and standardisation and undermine benefits they seek to achieve. Conversely workarounds are also perceived as quick fixes that get tasks accomplished economically, address systems glitches and provide opportunities to identify areas for improvement.

In essence, then, there remains a shortage of empirical research as to how workarounds can be understood, classified and their consequences (Ferneley and Sobreperez 2006). An examination of how workarounds simultaneously straddle and widen gaps in the delivery of health care is needed, as is information that highlights the implications of workarounds on policy in practice. The structure of the remainder of the chapter is outlined below. Following an explanation of the method, a description of the five themes identified in the analysis of the data is presented. Within the exploration of these themes, we touch on notions of resistance and potential implications of workarounds for policy implementation and propose a four-factor matrix for the classification of workarounds. We conclude with the implications of workarounds for health care delivery, policy-makers and researchers.

Method

A research project is underway to develop a theory of workarounds. The study uses electronic medication systems as an exemplar. The research considers a range of factors – cultural, organisational and systemic – that experts in the field believe contribute to the development, maintenance, proliferation and normalisation of workarounds. The present research study, phase one of the larger project, comprises a focus group and opportunistic follow-up interviews to explore emerging issues.

Study participants

Thirteen health professionals (nine female and four male) with health services research or clinical experience (medicine, nursing and allied health) were purposively selected to participate. The objective of purposive sampling (Creswell 2003; Liamputtong 2009) is to draw on the experience, knowledge and opinions of participants with appropriate experience of the topic under investigation. Participants are affiliated with the Australian Institute of Health Innovation at the University of New South Wales.

Design

The focus group was conducted in August 2009 to investigate health professionals' interpretations and perspectives of workarounds in the health care setting. Focus groups have been used to adduce clarifying information and to generate new ideas (Spehar et al 2005; Brooks et al 2005). The focus group method uses group interaction, taking advantage of participants questioning each other and offering explanations to gain insights, expose articulated concepts and discuss perceptions that may be unavailable from individual interviews (Liamputtong 2009; Morgan 1996; Kitzinger 1996; Bowling 1997). The focus group was conducted in a meeting room at a university and facilitated by the primary author. Discussion was initiated with the statement '*Let's talk about workarounds*'. A definition of a workaround was not offered to the participants so that the study could examine, through the participants' discussion, how they conceptually understood workarounds. The focus group was audio recorded and transcribed by the first named author. Informal interviews were conducted with four participants following the group interview. These opportunistic interviews, in the form of spontaneous conversations, aimed to further develop issues that they had raised during the group interview (see Greenfield 2009). This is grounded, iterative methodology.

Analysis

Content analysis (Sandelowski and Barroso 2003; Bowling 1997) was undertaken to identify recurrent concepts in the interview transcripts. The concepts were grouped into key themes. Triangulation of analysis, providing a rich explanation of the data (Gawel and Godden 2008; Creswell and Miller 2000; Mathison 1988), was achieved through independent blinded concurrent analysis by two of the researchers. The analyses were then compared and variations were discussed by the reviewing researchers. Resolution of differences through discussion added layers of description unavailable with a single perspective (Gawel and Godden 2008; Mathison 1988; Creswell and Miller 2000).

Results

Analysis of the data identified five key themes which are presented in Table 13.1. These are described below.

Table 13.1 Key themes about workarounds identified in the focus group

Key Theme
• Clinicians conduct workarounds to deliver services in a timely manner
• Clinicians workaround organisational safety mechanisms
• Localised workarounds affect other microsystems
• Data created by workarounds may not reflect clinical practice
• Managers are unaware of or choose to ignore workaround behaviour

Clinicians conduct workarounds to deliver services in a timely manner

Participants identified that at times clinicians experience organisational requirements, such as policies, guidelines and IT systems, as hindrances to delivering care. Clinicians actively resist these organisational requirements and act to overcome these perceived obstacles so as to meet their patients' needs, manage their workloads or a combination of both. For example, administering analgesia to a patient in pain or a cardiac drug to a patient with ischaemic heart disease requires the update of a medication order in the EHR. This task may be delayed because the EHR is not current. At this point a clinician may choose to circumvent the delay by administering the medication before it has been entered into the EHR and complete the documentation afterwards. Similarly, clinicians engage in other behaviours to deliver care in real time, as they believe necessary. For example, guidelines instruct that procedure and resuscitation trolleys be stocked with enough equipment for a single procedure. Clinicians over-stock these trolleys in order to avoid spending time restocking between procedures. These types of resistant actions (resistant, that is, to the formal protocol) are implemented by clinicians and justified as necessary to meet their patients' needs while managing their workloads in a timely manner.

Clinicians workaround organisational safety mechanisms

The tension between clinicians' desires for autonomy and the need for practice to be standardised within an organisation was discussed by participants. Strategies such as the implementation of organisational policies, clinical guidelines and the use of electronic ordering and recording systems were noted as drivers for standardisation. The discussion covered, for example, how guidelines for clinical practices such as the insertion of central lines specify when and how such interventions should take place. Similarly, electronic medication systems require a predefined sequence of steps to be completed for the administration of medication. The group noted how clinicians, in formal settings, state that strategies such as these provide guidance for and promote safe practice. However, participants recounted many instances whereby individual clinicians perceived that they applied to others, who in their judgement, were not as careful, knowledgeable, skilful or experienced as themselves. That is, that their individual clinical judgement exempts them from following the policy, guidelines or electronic systems' requirements. Clinicians take actions whereby they deliberately ignore or bypass such organisational safety mechanisms, thereby maintaining their independence. They often justify their actions claiming they are exercising their clinical autonomy for the benefit of the patient.

Localised workarounds affect other microsystems

The group discussed the impact of clinicians' non-compliance behaviours at local and systems levels. For example, clinicians may mark the non critical tests as 'urgent' to get results quickly. The outcome of this action for the individual patient and clinician is that the results of the blood test are received more quickly than they would otherwise. However there is a flow-on impact through the integrated systems that changes the work priorities of other personnel and services, and ultimately the care delivered to patients. For example, phlebotomists prioritise and take bloods that are marked urgent thus delaying taking bloods not marked as critical. As a result, pharmacists are delayed in preparing specific drugs (for example chemotherapy) the composition of which is dependent on daily blood results. The porters are occupied taking 'urgent' bloods to the lab and are therefore unavailable to transport patients. The lab technicians are required to process urgent blood tests before non urgent tests so delaying the processing of other blood tests. In this way individual practices that deviate from those prescribed in policies and guidelines have a cascading impact on systems other than those within which the clinician and patient are operating. However, clinicians focused on their delivery of care to individual patients may not consider, or be unaware of, the impact of their behaviour on the system within the local and broader organisational environment.

Data created by workarounds may not reflect clinical practice

Participants talked about the data collection practices employed to create a desired image rather than to report actual activity. For example, emergency departments may be required to triage and examine patients within a specified time period set by the Department of Health. Data on wait times contributes to the performance indicators of a hospital. Those patients who have been triaged as not urgent may be kept waiting as more urgent cases present. When the 'cut off' time approaches, the timeframe specified by the Department of Health in which patients must be treated following triage, the examination may be initiated and paused, and only completed later. In this way clinicians resist policies imposed on them. As only the initiation of examination data is collected, the collected data indicate that patients have been triaged, assessed and treated within the required time. While the benchmark is met, in reality, the collected data do not reflect the actuality of clinical practice. Similarly, research data collected in health care settings may not reflect actual behaviour. Participants, for example, described how in some studies, failure to provide a response in a questionnaire is recorded as non-compliance to the study protocol. When research studies request information that staff do not want to provide, or when the questions do not make sense in a given setting, rather than be recorded as non-compliant, staff have been known to record nonsensical, inaccurate or irrelevant responses.

Managers are unaware of or choose to ignore workaround behaviour

Participants gave consideration to how clinician compliance with organisational standardisation requirements enables managers and executives to direct and gauge the practices within their department and organisation. When clinicians bypass standardisation initiatives the organisation and delivery of care may be compromised. Clinicians are reported to pass on non-compliance conduct to new staff informally. Senior managers may be unaware that some clinicians' behaviours are not officially endorsed. This is problematic when management decisions are based on expectations that there is complicit conduct in their organisation. In some instances, managers choose to ignore workaround behaviours. For example, clinicians have been observed to locate equipment in areas that facilitate immediate access rather than in its designated place. Managers may overlook this behaviour when there appears to be no direct compromise to patient care. However, when required to locate equipment in the correct place so as to comply with accreditation requirements, managers may direct that staff relocate equipment in the designated area. This has potential ramifications should the equipment be required in an emergency situation as staff firstly look for equipment in its unofficial place. As one focus group participant reported, 'the worst time to have a "Code Blue" (an emergency code) is when the compliance team is about to arrive because no one knows where anything is because it has all been put in the right place'.

Discussion

The themes emerging from the study underline the byzantine nature of workarounds in the health care setting, the multiple dimensions of workarounds and the different ways in which they are understood. The impact of workarounds in health care systems is double edged as they both straddle and widen gaps in the delivery of health care.

This study confirms the belief that clinicians conduct workarounds to resist and overcome policies, guidelines and system requirements at times perceived and experienced as obstacles when delivering care (Koppel et al 2008; Georgiou et al 2007; Owen et al 2009). Non-compliance behaviours are implemented to address organisational requirements that stand between the clinician and the patient, and are justified on that basis. Administering medication before it has been confirmed in the EHR, and entering it later crosses the divide created by clinicians' desire to deliver care and the requirement that medication administration be firstly documented in the patient's EHR. Likewise, clinicians bridge physical and time spaces caused by equipment related policies. In these ways, in the immediate patient encounter, workarounds can be used to straddle gaps in the delivery of patient care.

In the case of people bridging gaps in the delivery of immediate care, the findings reveal that these same behaviours can create gaps. Those activities that bypass safety mechanisms increase the risk of error and so augment clefts in providing high quality and safe care. Atypical compliance with official organisational requirements, such as the location of equipment, can create confusion when this behaviour is not the norm of a service. Failure to immediately locate an item such as the resuscitation trolley in an emergency could have severe ramifications. Additionally, such behaviours can result in confusion between prescribed policy and unofficial managerial support that only becomes apparent at times of critical incidents or adverse events. Should an adverse event occur as a result of a breach in protocol, the clinicians involved may find themselves unsupported by their manager or supervising clinician, and professionally exposed. This has particular implications for new staff as workarounds are passed on informally and established as organisational norms (Mohr and Arora 2004).

Practitioners employing workarounds to navigate gaps in the immediate delivery of patient care may be unaware of their cascading effect at clinical, administrative and managerial levels. The cumulative effect of workarounds on limited resources may choke an organisation's ability to deliver care efficiently. In destabilising the standardisation of practice and compromising data collection, they enhance the potential for error and undermine managers' abilities to gauge service and system needs within their organisation and respond appropriately.

Whether or not an action is perceived to create or straddle a gap in health care is a complex question. This research, extending and more nuanced than previous studies (Ferneley and Sobreperez 2006), suggests that a decision must clearly specify the motive, who benefits and the consequences attributed to the workaround, coupled with an analysis of the perspective of the person viewing it. Difficulties in understanding the complexity of workarounds are compounded by the lack of clear definitions and the fact that it is hard to differentiate workarounds from other constructs in the health care literature (Halbesleben et al 2008). A scarcity of complementary classification systems and the absence of a distinct framework with which to analyse workarounds adds to the research challenges. Workarounds may be discussed as only those behaviours that violate prescribed work practices to get the job done with self-gain a secondary motive (Halbesleben et al 2008). Alternatively, they may be defined as practices that benefit the patient or the clinician (Eisenhauer et al 2007). Participants in this study held that while some workarounds benefit only the patient (for example breaching protocols to administer required medication), others benefit only the clinician (for example overstocking procedure trolleys) while still others benefit both (for example marking non urgent blood test orders as urgent). Some workaround practices are justified in the name of professional autonomy, which is to primarily benefit individual clinicians. This finding is supported by research which reported that other professionals engage in similar conduct, for example 'Fire Officers ignore or misuse a system that does not allow them the perceived appropriate level of discretion and autonomy' (Ferneley and Sobreperez 2006: 352). Thus the motive for and the beneficiary of workarounds are important variables in understanding them.

The perspective of those viewing an action influences whether it is perceived to straddle or widen a gap in health care. While clinicians may perceive a workaround as bridging, managers may perceive the same behaviour as deviant, and perhaps creating a gulf in the delivery of health care. Whether behaviour is seen to bridge a problem or create shortfalls in the delivery of care is shaped by the consequences that flow from it. Workaround behaviours in emergency situations are perceived by both managers and clinicians as bridging gaps in immediate health care delivery. The perspective of those viewing an action and what they conclude from it, and the consequences of the behaviour, are two further important variables.

From this analysis, a four-factor matrix for the classification of workarounds is proposed. The matrix has four categories by which behaviours are analysed: motive; beneficiary; perspective of the viewer; and consequences of the conduct. More extensive empirical research across a range of organisational and clinical settings to test the veracity of the matrix is required.

The findings provide further insight into how workarounds widen and connect divides in health care delivery. Additionally, they support the call for a clearer definition and delineation of non-compliance behaviours, such as workarounds (Halbesleben et al 2008). Limitations of the study include the use of a single focus group and the interests of the members of that group. The effect of workarounds on compliance and the ability of an organisation to measure what is practiced within itself was a salient thread. This may reflect the participants' particular interest in clinical governance more than the immediate concerns of current frontline staff in health organisations. Additional research with current clinicians, managers and administrators will shed light on this phenomenon.

Conclusion

Workarounds are complex and the answer to the question we started with is: they both straddle and widen gaps in the delivery of health care. They can simultaneously undermine and enable attempts to standardise clinical and organisational services, and quality and safety strategies. The proposed four-factor matrix offers the outline of a tool by which the range of non-compliant behaviours can be investigated and analysed. We can foresee that health professionals will continue to employ such conduct and that these forms of organisational behaviours will not cease. The better our understanding of them and the factors that shape their development and proliferation, the more effective will be our attempts to understand and improve health care.

As to implications of this work we have several suggestions. Policy-makers need to recognise that increasing top down measures create pressure on layers below and may have the unintended consequence of creating more workarounds as a response. Several researchers including Braithwaite (Braithwaite et al 2009), Berwick (Berwick 2002; Berwick 2003) and Amalberti (Amalberti et al 2006) argue for less recourse to top down strategies and giving space for clinicians to engage in local solutions. Furthermore, research by Greenfield has highlighted the innovation that can emerge when clinicians are given this freedom (Greenfield 2010). For researchers a key implication is that this is a fruitful area for uncovering informal behaviours and real world responses by clinicians to policies and guidelines, exposing patterns of resistance, new practices and innovative solutions.

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14

Taking Policy-Practice Gaps Seriously: The Experience of Primary Health Care Networks in Western Canada

Ann Casebeer and Trish Reay

Introduction – Considering the gaps

What happens between the development of a broadly espoused public policy and its effective implementation? How do health care organisations actually implement government policies when those policies are of an over-arching nature, providing direction but few specifics? These questions are not new, but we still struggle to find answers that benefit both policy-makers and service providers.

Primary health care policy in Western Canada is an excellent example of broad policy with weak mechanisms. Primary health care providers have deliberatively sought opportunities for exploiting this policy stance. In this chapter we report on a three year study of Primary Care Networks (PCNs) to demonstrate how government, physicians and health regions advanced service delivery by actively maintaining 'healthy gaps' between policy and practice priorities, spheres of influence and action. We seek to understand how key actors managed the legislatively created gap between government policy and local practice. We describe how newly formed PCNs took action based on broadly espoused policy, to formulate and implement new ways of providing primary health care via a series of multiple level actions, interactions and reactions. We followed ten PCN sites from a period of initial development through to early trials and transformations to eventual emergence of 'new ways of working' that have since become 'the new normal'. A qualitative multiple case study approach was used involving observation, interviewing, discussion, and feedback techniques over three years.

H. Dickinson et al. (eds.), *The Reform of Health Care*

Background – Conceptualising the gaps

In Canada, provinces are responsible for population wide provision of all medically necessary services, excluding physician services. Physicians are reimbursed for their services directly from the provincial government; they can hold advisory positions in the health system, but as service providers are not official decision-makers in the governance structure. As part of their mandates, provincial health systems are responsible for implementing policies that operate within wider governmental health policy, requiring integration within the organisation as well as developing connections with allied health professionals, especially physicians. We wanted to understand how a large public sector health system responded to broad, non-specific public policy calling for primary health care reform. We were able to deliberatively observe the process that unfolded both within and at the boundaries of the levels and actors who have responded to this broad policy direction from higher levels of government. As well, we were able to look both retrospectively and in real time at the mechanisms used to support action focused on innovation in primary care. This case provides further empirical evidence concerning the way strategy unfolds within a loosely structured public sector policy environment – linking various jurisdictions, roles and actors together to attempt to improve and extend practice.

Implementing government policy – Insights from the literature

The literature concerning the strategic efforts of organisations attempting policy reform contains messy and mixed messages (e.g., Dye 1981; Jenkins 1978; Anderson 1984). As Colebatch (1998) reminds us: ‘policy is a term that is used in a variety of ways at different levels’ (p. 6). Howlett and Ramesh (1995) capture the problem well:

> *Public policy is a highly complex matter, consisting of a series of decisions, involving a large number of actors operating within the confines of an amorphous yet inescapable, institutional set-up, and employing a variety of instruments. Its complexity poses grave difficulties for those seeking comprehensive understanding of the subject.* (1995: 198)

Policy is multi-layered, including a range of planning and implementing activity. It can encompass both broad vision and goal statements that allow more specific actions that are responsive to the strategic aim, but also flexible enough to react to events encountered along the way (Evans 1986). Previously, the policy implementation literature has been pre-occupied by whether the process is best conceptualised as top-down or bottom-up. But newer work focuses on a synthesis of the two approaches (Hill and Hupe 2002). As Hill and Hupe point out, there are two clusters of variables in policy implementation studies that remain of great importance: the nature of the substantive policy issue, and the relevance of the institutional context (2002: 83). Government services are increasingly delivered in the context of a 'hollow state' – where government sets parameters and funding levels, and relies on contractual relationships for service delivery (Howlett 2000). As we see more and more examples of broad, exhortation type policies, the importance of the organisational context increases. There has also been increasing attention to networked organisations in the public sector, and the impact that these arrangements have on policy implementation (Hall and O'Toole 2000; Meier and O'Toole 2003). Hall and O'Toole (2000) argue that implementation studies should give specific attention to the level of programme administration, where services are actually delivered. Therefore, more focus on institutional or organisational context is needed, yet few studies have taken up the call.

Organisational responses to broad government policy

When policy is only broadly defined at the government and top organisational levels, the responsibility for developing and implementing specific strategies shifts to individuals in the middle of organisations. This means that it is important to understand the policy implementation process inside organisations. But so far, most reports have focused on negative experiences that did not result in sustained implementation of planned changes (Thompson and Fulla 2001). Instead, we report here on overall positive experiences as a way to highlight and learn more about policy implementation processes. This work builds on research that conceptualised the relationship between policy and health care change as 'loosely coupled' (Hinings et al 2001, 2003), and studies identifying key components of sustained change driven by health policy shift (Casebeer and Hannah 1998; Casebeer et al 2000; Reay and Hinings 2009). Two observations thread through most of this previous analysis – the pivotal role of individual action and the importance of leadership. The recent work of Falkenberg (2006) resonates well with our own experiences. And Kuhl et al (2005) discuss in particular the role of 'lateral' leadership, which, again, aligns with the shared leadership and interaction amongst multiple levels and layers of leadership activity observed in our case.

Rationale for closing gaps in our current knowledge base

In the context of a continuum of policy options, governments in Canada have increasingly adopted only the weakest form of policy action, what Pal (1992) would call 'exhortation', ignoring the stronger regulatory options such as detailed legislation, leaving decisions concerning the use of policy mechanisms to individual health care organisations. This move toward exhortation types of policy allows governments to set broad direction, with the resultant demand that local decision-makers develop appropriately specific strategies for change. In spite of the prevalence of this policy style, we have very little information about how organisations respond to broad government policy, and the impact that this has on members of the organisation as noted in calls for further research on how organisations evolve broad policy into actionable strategy (e.g. Falkenberg 2006; Balogun and Johnson 2005). The lack of higher level unified or mandated governmental policy makes the study and evaluation of more localised experimentation crucial if potentially sustainable or transferable lessons are to be observed, learned and eventually shared to allow for broader reflection, adaptation and implementation. Our case study exemplifies exhortation style policy at the government level that is being addressed through the adoption of organisational level action, interaction and reaction. Some of this strategy as 'learning to practice differently' work is clearly set out, and some of it is much more opportunistic. Through the analysis of this case study, we provide new information about organisational response to exhortation style government policy, in a relatively under studied public health system context.

Research context and setting – Locating the gaps

We followed the progress of ten primary health care (PHC) innovations in six regional jurisdictions over a three-year period. Our research approach was based on partnerships with health system decision-makers, and as part of the research process, we provided ongoing feedback to them about our findings. Although we expect our research to make theoretical contributions to the academic literature, our findings also provide important information for managers, physicians and other health professionals who are interested in improving delivery of PHC services.

Our research was based on the need to develop new and better ways of delivering primary health care (PHC) services in Canada (Romanow and Future of Health Care in Canada Commission 2002). In response to calls for the reform of PHC services, many isolated experiments have yielded promising new approaches, but implementation of these good ideas on a broad level has yet to occur (Hutchinson et al 2001). There have been many special PHC projects that reported positive local findings from implementing new collaborative working relationships (Stewart 2000; Martin-Misener et al 2004), and introducing alternative practices in community-based health centres (Auffrey 2004), and home care agencies (Oandasan et al 2004). However, these projects also reported skepticism that learnings could be transferred to the mainstream health care system.

We still do not know enough about how innovations can be spread, implemented, and sustained in health care. For example, an extensive systematic review (Greenhalgh et al 2004) found that the 'most serious gap' in the extant literature is lack of attention to the processes by which particular innovations in health service delivery and organisation are 'implemented and sustained (or not) in particular contexts and settings' and how these processes can be enhanced.

Our decision-maker partners identified similar concerns. Health care managers from rural and urban regions in Alberta and British Columbia told us that while they were excited and hopeful about many of the PHC experiments going on in their regions, they wanted more information about how to best transfer the learning from individual innovation sites to other PHC settings in their regions.

Through access provided by our decision-maker partners on this three-year research programme (2005–2008), we were able to observe patterns of learning and innovation (and potential sharing of learnings to other sites and regions) in different contexts.

Research objectives and methods – Examining the gaps

Our overarching research objective was to understand how organisations learn to spread and institutionalise good ideas about providing primary health care. Findings reported here focus on what we learned about how several kinds of 'gaps' existed among levels and actors and how these gaps either supported or hindered primary health care practice learning and innovation. We identified how participants made sense of the changes they were involved with, how learning evolved and led to new ways of 'doing' primary health care.

We employed a longitudinal case study design consisting of three phases (Pettigrew 1990; Strauss and Corbin 1994). In each phase, researchers visited all ten sites to conduct in-depth interviews. All interviews were semi-structured and designed to provide in-depth, rich data about learning processes and dynamics within the PCNs. We also asked interviewees to tell us about processes of learning that involved other innovation sites and other primary care initiatives. Interviews were tape-recorded (with permission) and transcribed verbatim. If interviewees did not wish their comments to be tape-recorded, we followed established protocols of note-taking to develop a written account of the interview. All data were coded and organised with the use of qualitative data analysis software (NVivo). Analysis was based on a grounded theory approach with iterative attention to data and the extant literature (Glaser and Strauss 1967).

Results – Interpreting the gaps

Several processes are observable within the new PHC environments that seem to allow learning and innovation to be advanced. These are discussed and reported in earlier writing (Reay et al 2009; Casebeer et al 2010). The results reported here expose and interpret a series of observable 'gaps' that either enable or impede policy implementation. Subsequently, attention is drawn to two consistent messages – the critical roles of dedicated management and the necessity of targeted resources. Additionally – we explore and emphasise the value of 'learning to practice differently' as a framework for implementing broad policy within complex health system jurisdictions.

Our observations across three years indicate that gaps exist and operate on a number of levels. Below we explain how these gaps serve important functions for a variety of key actors. Table 14.1 synthesises observations of key actor leadership and gap attention.

As identified in Table 14.1, some gaps are ***enabling***: acting as buffers, providing distance and establishing domains of interpretation and interaction, supporting and allowing further delineation of policy appropriate for local circumstances. The following quotes indicate how some of the enabling gaps are used:

> *So for me, my role in this is to get them [PHC practitioners] to the point where they will try these programs, and if they don't work to give me feedback so that I can – so that I can tweak them… And so that I kind of*

Table 14.1 Observations of key actor leadership and gap attention

Key Actors	Observations	Nature of Leadership	Nature of Gap Attention
Policy-makers: Government & Medical Association Powerful Sponsors	Formal endorsement and permission for PHC innovation through PCN dev't Continued sanction of PHC as overall Gov't/System priority.	Leadership as sanction; Delegating further action to executive management.	***Enabling –*** *Broad policy guidance* *Targeted resources* *High level monitoring*
Executive Management Agile & dedicated CEOs; Vice-presidents	References policy-maker sanction to validate debate and decisions; Provides agreement to proceed Adds evaluative component.	Leadership as sponsorship; Delegating further action to Steering Committee.	***Enabling –*** *Supporting local leaders* *Accessing resources* ***Neutral –*** *Setting scope* *Assigning accountability*
Executive Directors & Physician Champions Committed & knowledgeable Middle managers; family physicians	Creation of buy-in; Provision of information and opinion; Problematic but critical debate; Negotiation.	Leadership as integration of operational frames; Delegating further action to projects.	***Enabling –*** *Negotiating resources* *Encouraging Local vision & solutions* *Supporting learning* ***Problematic –*** *Buffering interference* *Evaluating progress* *Diffusing innovations*
PCN Practitioners Willing Family physicians and other health professionals	Joint planning action for: Innovation and learning; Clarity of purpose; Risk-taking; Identification of successes.	Leadership as action and learning; Attempts to share and sustain proven innovation.	***Enabling –*** *Collaborating* *Experimenting learning* ***Problematic –*** *Securing ongoing funding* *Demonstrating progress* *Sustaining innovations*

> *nudge them in the direction of change. I help them – I help them to um experience that change. I think that's a huge piece of my role.*
>
> *So it's really a management support role as well as identifying the risks associated with what we're doing.*

Some gaps are ***neutral:*** benign gaps identifying reasonable boundaries of scope and role and defining accountabilities and responsibilities. These relatively straight forward gaps were attended to by various health system actors responsible for ensuring usual and acceptable organisational processes were followed:

> *We learned early on that our planning process, the first thing we do is do a common vision and we set some principles for the network.*
>
> *… This is process work. And we need to acknowledge that process work takes time. And you have to carefully manage that. And that has been a significant learning.*

Other gaps are more ***Problematic:*** at times fracturing connections and reinforcing silos. In the early stages of attempted practice responses to primary health care policy and the development of PCNs it was what practitioners and managers alike often referred to as failures or mistakes:

> *… When we went through the planning process it was pretty evident that what we do for one clinic may not work for another clinic.*
>
> *We've got rules or guidelines that we do work within regionally… but yeah I think the importance of flexibility is paramount.*

These problematic experiences exposed gaps in understanding. One practitioner put it as follows:

> *I need to know that there are people above me who are watching my back and that I'm supporting the people below me. We're going to make mistakes, it's not all going to work, we do the best of our abilities, we try to communicate as best we can.*

These gaps are used by various actors within the health care systems to implement policy – to move policy from broad exposition to regu-

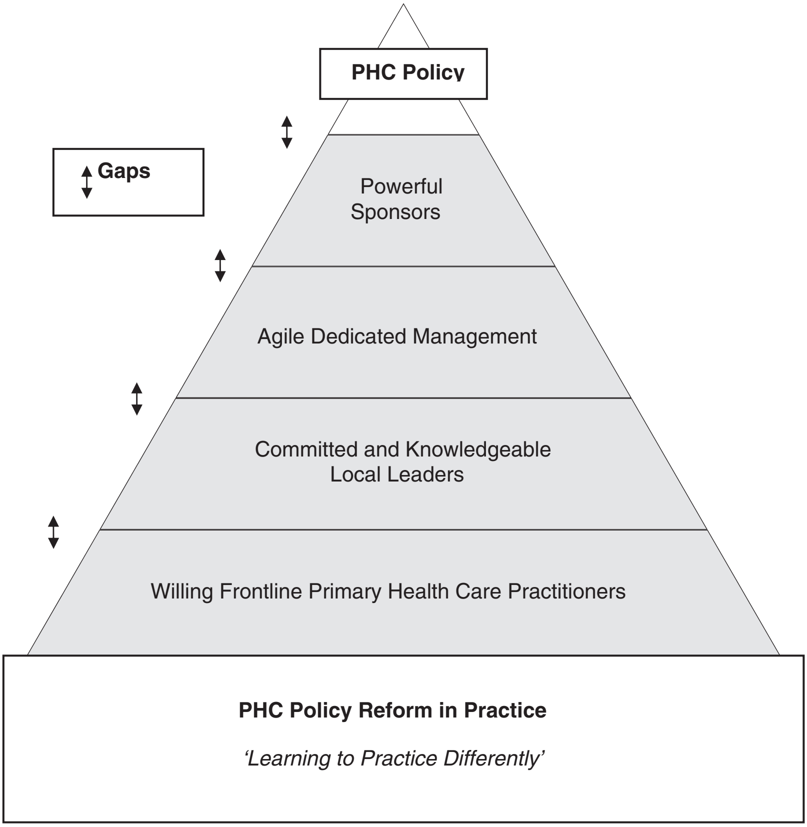

Figure 14.1 Key actors working the policy-practice gaps

lation and eventual practice action. We observed four important levels of actors working various policy-practice gaps in strategic ways – using a 'Learning to Practice Differently' approach. Figure 14.1 visualises key policy into practice actors and their instrumental actions in relation to gaps allowing and/or requiring attention.

Powerful sponsors (permission and resources)

Arising from open debate and discussion, we see continued variability in ownership and understanding amongst the executive tiers of the provincial government and medical association; however, we also see the emergence of an agreed strategic focus that guides organisational decision-making and action at this level – essentially through the regulatory guidelines and resources directed to the development of PCNs. It is the broad policy framework and the policy documents and guidelines produced at this high level that gives both permission and resources and allows action at other levels to both 'mind' and 'fill in' the gaps with doable action within the broad policy intentions set out.

Agile dedicated management (attention and resources)

In addition to being mindful of the policy-practice gaps identified, it is at the executive level that the provincial policy initiative and subsequent adoption of Primary Care Networks (PCNs) as the strategic response and its intentions are more fully debated, articulated and resourced for actual implementation. The agreement to deviate from existing ways of doing things, in this case to support PCNs, is formulated through executive management deliberation, partnered with physician leadership and subsequent action at the frontline PCN level. The following quote from a senior manager indicates the importance of having a strategy as an anchor for testing and validating priority setting and decision-making activities.

> *I think by having the strategy, whatever the strategy is at this point in time, lends itself to supporting initiatives especially in the primary care area. And so it validates or justifies that that is why we would want to spend the time, energy and money.*

Deliberations among members of the executive management team illustrate the role of debate at the executive level, particularly in relation to the level of shared understanding. As one interviewee commented, 'I think there is a lot of work to be done in terms of creating that shared vision – maybe those who are closer to the business of primary care would answer differently'. This is where the levels of complexity and uncertainty of the very nature of organisational responses to broad policy initiatives become more apparent. On the one hand, this complexity and uncertainty creates havoc for those who look for a clear and linear decision-making process. And, on the other hand, they create opportunities for those who look for multiple routes to encourage organisational innovation through relatively unstructured individual leadership action and a loose framework for encouraging shared executive decision-making. Simply put by one executive manager: 'The executive has to really say that this is a priority and dollars will be allocated, and you will be accountable for it'.

Committed local leaders (vision and negotiation)

Key managerial roles emerged – PCN Executive Directors – who interpreted and negotiated and implemented local PCN actions that aligned to – or at least could be tried out within – the provincial tripartite policy guidelines. We observed that it is at the level local leadership that the crux of a paradox emerges in relation to valuing (or not) a clear organisational step-by-step approach to change. This appears to stem from real differences in expectation at the individual level: 'There are people who say "play with it, do what you want"… there are people who say "no, no, you've got to sit and think and work it out and get it right"'. Traversing the differences – the gaps in shared vision – was left to those committed to locally defined solutions.

Physician champions and PCN managers personified a diversity of expectation – those who saw change as opportunity for learning and potentially innovation for 'their' PCNs, appeared to have greater success at mobilising broad policy goals and new resources towards locally recognised solutions and improvements at the practice and community level.

> *It is the team approach that we are hoping to see. And I think we are still working through how they are going to get that done. But we now have some better ideas about how to incorporate clinical practice guidelines, and how to let each clinic develop their own flavour while still maintaining best quality as an outcome.*

Recognising that policy-practice gaps actually enhance opportunity to successfully move practice in locally acceptable ways but still in line with policy goals was a critical piece of work for these local leaders.

Willing frontline practitioners (learning and innovating)

We see evidence that the resources associated with a PCN enabled local action for learning and innovation. In some cases this led to sustained new ways of working together and enhanced primary care services (ref earlier work). We believe that awareness of and attention to taking a number of policy-practice gaps seriously also is critical to fruitful learning and innovation. As one practitioner put it:

> *So much comes down to good intentions, goodwill and finding the time and energy.*

There are numerous project-based initiatives developed and incubated within individual PCNs that are organisationally sponsored via Executive

Director and Physician leadership and within the approved limits of provincial policy guidance. These projects involve trials of specific primary health care reforms and innovations that can be funded with the envelope of the tripartite agreement accepted provincially and aligned to the broad policy goal of improving primary health care in Canada. As such, PCNs create relatively safe spaces for limited risk-taking-experimentation that may lead to valuable primary health care innovations.

> *… I think we're all 'experimenting'; we're all trying to figure out how to affect how to orient the system to affect health outcomes. That's what we're all trying to do and not sure anybody's figured it out so I think that's one of the things we have to make sure that everybody understands is that this isn't easy. Its not gonna happen easily and it's a lot of trial and error and trying to figure things out.*

It is this level of frontline practitioner action that has been able to garner resources for testing innovations in primary health care. At the project-based level of policy implementation we see projects led by champions that try things out. Sometimes they work and are in sync with the broader policy goal. Sometimes the piloted 'experiment' fails. The idea is to learn what to do, and what not to do. Without these 'gaps' – spaces for resourced, time-limited, relatively safe learning about what works in relation to improving primary health care – the broader policy objective would not be able to move from a goal to reality.

Discussion and implications – Mining and minding policy-practice gaps

Data analysis from our ten sites across three years strongly suggests that 'taking the gaps seriously' (minding the gaps) allows important healthy tensions to play out, ebb and flow, supporting advances in learning and practice, and eventually leading to sustained enhancements to care delivery. We further suggest that taking a 'learning to practice differently' approach to policy implementation in complex health system jurisdictions helps key actors to successfully traverse policy-practice gaps.

Our work conceptually aligns to the work of Falkenberg (2006) and concentrates on enhancing understanding of how strategy develops and travels through and among the multiple levels of an organisation. Like Falkenberg, we find the notion of 'strategy as practice' (Whittington and Whitehall 1996) and her subsequent framing of this as the 'co-evolution of strategy formulation and implementation' far more compelling than more traditional notions of strategy as something embedded within policy formulation and simply enacted by organisations. Our findings provide additional empirical experience of strategy as ongoing practice (what Mintzberg (1987) framed as 'strategy as craft'). Looking within and across level differentiated actions and leadership, even in the face of strategic uncertainty and organisational complexity, we have seen evidence of health care impacts and health outcomes emerge. The impacts primarily translate into varying degrees of learning taking place that is at least loosely aligned to the existence of an organisational policy that espouses improved provider relationships with primary care physicians and improved primary health care for the populations served. Managers and providers employed what Howlett and Ramesh (1995) would call 'a variety of instruments' which supported activities within and across organisational levels and policy-practice gaps, and which, in turn, connected actions occurring within the multiple levels of policy implementation described. These organisational 'strategies' created supports that people working at all levels of policy implementation could draw on at the critical points of connecting required. Connecting the levels, across, through, and/or in spite of policy-practice gaps, became the key to actual policy implementation. From one top-down perspective, to move down from broad policy espousal to learning how to implement specific innovations; from another bottom-up perspective, to expose the frontline learning and implementation, communicating and demonstrating the success; and, from another middle level perspective, connecting back up through the organisational levels and bridging or maneuvering through gaps for ongoing support and recognition of implementation efforts.

The examination of multiple PCN cases illustrates how broad public policy aims are actually pursued within a large complex health care system. Careful, longitudinal observation demonstrates that policy implementation requires sustained work at all organisational levels, multiple actors and actions, and mindful of the gaps if practice progress towards policy aims is to occur. We observed different types of work going on depending on the level of attention. We also observed that efforts are taken to co-ordinate work across gaps and levels. For example at the provincial level, we observed a great deal of time devoted to developing guidelines and determining the ranking of priorities etc. There was also attention to developing a message that could be used throughout the province. At the executive management level we observe that individuals say they use the provincial guidelines strategically, but then they have to figure out what that means more operationally and 'navigate the middle ground' so that the frontline PCN work can progress relatively unfettered until results need to be reported and supported by executive levels and 'blessed' by policy-makers.

Our study improves theory and empirical understanding about implementing policy through the identification of roles and actions required within and among organisational levels – in part by taking the policy-practice gaps seriously. What we have seen is that under an umbrella of broadly espoused policy, the acknowledgement of 'gaps' – their potential benefits and their pitfalls provides a useful and reflective lens when attempting to understand policy-making within a large public sector health authority. We have attempted to shed light on the age-old question of *how* to implement policy in ways that will sustain the desired changes. Further understanding of the 'how' can extend our knowledge base in relation to the role of multiple and multi-level organisational response to broad public policy mandates within health care system environments.

The current recognition that defining a government policy is at best an enabling guide for a difficult journey, and, that the limited role of strategic planning and action lies in the 'crafting' of it, rather than in its rationality or linearity of attainment, leave us with starting points for moving forward – for approaching the policy-practice gaps in healthy and constructive ways. We suggest that through further longitudinal, in-depth studies that follow the actions of individuals throughout organisations – we can begin to gain new and important insights into effectively formulating and implementing very broad government policy. In our own longitudinal study of new government policy proposing the development of Primary Care Networks we found that the key events, discussions and disagreements occurred at the middle and frontline levels in the organisation, some distance from the policy arena itself. Our findings point to the need for appropriate resources to encourage individuals in taking on leadership roles that have previously not been part of their job description. When policy is only broadly specified at government and top organisational levels, middle managers and front line workers must take on the responsibilities of developing appropriate change strategies as well as directly implementing them. In doing so, they must recognise and attend to the gaps encountered when implementing desired policy. And in health system environments, it is the people at the frontlines who are well placed, and hold the knowledge and experience to develop workable solutions.

We posit that our work contributes a sustained and in-depth look at what learning to practice differently actually looks like, demonstrating how middle management knowledge brokering (Delmestri and Walegenbach 2005) and sense-making work (Balogun and Johnson 2005) is undertaken across time, and interpreting, supporting and implementing policy objectives only broadly defined before introduced into large and complex organisational systems.

The gaps observed and worked by various system actors at varying organisational levels are not necessarily an indication that the policy mechanism or actions are somehow flawed or inadequate. In fact, it may be precisely the point of the relatively weak form of policy (exhortation) to serve as a platform for variation and experimentation in an otherwise risk adverse environment. Colebatch (1998) suggests that 'policy is a concept that we use to make sense of the world – but we have to work at it' (p. 114). Perhaps the use of a fairly broad and diffuse organisational strategy to fill a policy void or gap at higher levels of the system, is also something we use to make sense of world – and 'working at it' is also prerequisite to any real strategic gain or policy reform. Extending and sharing knowledge of how we implement policy to make the concept a reality, contributing to policy goals and organisational objectives, is also worth 'working at'. In our cases we see that strategic attention within and to policy-practice gaps allows progress towards local implementation of otherwise diffuse policy guidance. This strategic attention operates at and across levels of organisational responsibility and focus.

As recent work by Pal (2006) underscores, traditional linear notions of policy implementation are increasingly recognised to be insufficient. Our exploration of the actions, interactions and reactions required to traverse policy–practice gaps in order to forward broad policy aims contributes insights into what might actually be required. Results so far suggest a far more dynamic interplay of actors and actions is necessary. We also need to 'take the gaps seriously' – nurturing those that are inherently useful and enabling – minimising or leaping those which are problematic or even dangerous.

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15

A Very Unpleasant Disease: Successful *Post*-Crisis Management in a Hospital Setting

Colin J. Pilbeam and David A. Buchanan

What's the problem?

Research concerning accidents, crises, and other serious incidents has focused mainly on causes, and on crisis management. The implementation of change following such extreme events has attracted less attention, but is often problematic. This chapter examines the experience of Burnside Hospital, where an outbreak of the 'superbug' *Clostridium difficile* (*C. diff*) was successfully managed, resulting in a dramatic and sustained reduction in the incidence of infections. What are the implications for management practice and health care policy, and for further research?

Surveys in USA and Europe suggest that between 5–10 per cent patients become infected after entering hospital. The rates are higher in Asia and Africa. These nosocomial infections (or Healthcare-acquired infections (HCAIs)) such as *Clostridium difficile* (*C. diff*) are 'modern' diseases and a world-wide problem that will become more important as the global population increases, the frequency of impaired immunity increases through age and illness, and the bacterial resistance to antibiotics increases (Ducel 1995). Strains of *C. diff* originating in Canada are identical to those responsible for patient infection in the UK. Between 2003 and 2005 at Stoke Mandeville Hospital, over 330 patients were infected with *C. diff,* and 33 attributable deaths (Healthcare Commission 2006). Likewise, between 2004 and 2006, *C. diff* was implicated in the deaths of 60 to 90 patients at Maidstone and Tunbridge Wells Hospital, where over 500 other patients were also infected (Healthcare Commission 2007). Subsequently, outbreaks of *C. diff* have occurred in The Netherlands, Finland and Denmark.

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The National Health Service (NHS) in England is state-run, provides health care that is free at the point of delivery, employs around 1.4 million people, and has an annual budget of over £100 billion (US$160bn). The service is regulated by numerous audit, inspection and accreditation agencies. Recently, outbreaks of *C. diff* at two hospitals heightened concern regarding HCAIs and infection control targets were introduced, and patient safety became a national priority (Department of Health 2009). Beyond those 'high profile' incidents, *C. diff* was mentioned as an underlying cause of around 3,000 deaths in England and Wales in 2008 (National Statistics Online 2010). All providers were to adopt a 'zero tolerance' approach and to develop improvement plans (Department of Health 2010). Failure to meet targets attracted financial penalties and could trigger organisational crises; in the two cases mentioned, several senior staff resigned.

The causes of HCAIs are understood, but implementing the remedies can be problematic. At Burnside, high levels of *C. diff* infections could have led to a 'high profile' incident, but rapid action averted this outcome, and the reduction in infection rates was maintained. In health care, problems and failures attract attention, but 'success stories' are often overlooked. This study reports a success story with significant implications for policy, practice, and theory.

Crisis and aftermath

In the aftermath of serious incidents, receptiveness to change should be high, but that is not always so, and 'cultural readjustment' is not inevitable (Toft and Reynolds 2005). Investigations identify 'lessons learned', but these are not always implemented. Understanding of the subsequent change implementation phase is limited. Considering serious incidents in health care, Donaldson (2000) noted that passive learning (identifying lessons) is straightforward, but active learning (implementing lessons) is often overlooked. The National Patient Safety Agency (2004, 2006) produced guides emphasising lessons rather than implementing change. Conceptualising these events in terms of learning difficulties may be part of the problem. These incidents should also be viewed through a change implementation lens that considers the interaction of factors at different levels of analysis (Langley 2009).

Following a crisis, receptiveness to change may be low if an incident is seen as unrepresentative. Controls imposed to deter 'the guilty' also apply to 'the innocent' fostering resentment. The membership of an investigating team affects the credibility of recommendations. Stakeholders may disagree, and use the incident to pursue other agendas (Smith and Elliott 2007). Externally imposed change, by a regulating body, may not be seen as acceptable. The recommendations from an inquiry may be costly to implement and impractical, and are likely to compete for resources with other ongoing initiatives. The agenda may not be appealing to change agents who may not enjoy implementing the ideas of others, where there may be little recognition for success, only criticism for failure.

The assumption that change will be welcome after a serious incident may thus be incorrect. The sense of urgency that often underpins change (Kotter 2008) may have dissipated during the time taken to complete an inquiry, may never have been present if the incident was regarded as idiosyncratic, and can be difficult to stimulate in parts of the organisation where the incident did not occur.

Methods and Burnside Hospital

A mixed-method case study approach is appropriate to the study of change processes that unfold over time in a given organisational context, where the aim is to understand how outcomes or consequences were generated through the combination and interaction of a number of factors at different levels of analysis (Langley 1999).

Burnside was an acute hospital with over 2,000 employees, 400 beds, and annual revenue of £120 million. Burnside's responses to a rise in *C. diff* infections were successful, making it an 'outlier' and so worthy of investigation (Pettigrew 1990). To construct the event sequence narrative (Langley 2009), data were gathered from hospital documentation, including external audits and records of infection rates, and from interviews with eight key informants identified through snowballing from referrals beginning with the hospital's Chief Executive. Following a process perspective, Langley's (1999: 703) method of 'temporal bracketing' was used to identify the main phases of the narrative; pre-crisis, crisis, emergency response, and maintenance. This analytical strategy also identified the factors interacting in this context and their contribution to the outcomes, which in this case involve a rapid, dramatic, and sustained fall in infection rates. Findings have been validated subsequently through presentations to the infection control team and to a group of involved doctors. These respondents confirmed that we had captured their experience accurately. Table 15.1 summarises the phases of this event sequence.

Table 15.1 Burnside event sequence narrative

Phase	Characteristics
Pre-crisis	problem understood but tolerated isolation unit opened in January 2007 broad-spectrum antibiotics widely prescribed throughout hospital poorly resourced infection control team with no administrative or IT support staff notice rising rates of infection, but information is not collated in a form that triggers action Comparative position in national infection rate league tables unknown
Crisis	SHA sends support team in July 2007 and offer wide-ranging advice; they meet an 'open and non-defensive' response 'bloody hell Burnside's in the bottom ten' in June 2007
Emergency response	chief executive signals priority turnaround team established with authority to act additional resources allocated facilities improved prescribing policy changed infection control given direct corporate reporting
Maintenance	turnaround team continues to meet second and third SHA support visits in January and June 2008; note 'spectacular improvement' screening programme introduced extensive staff education and training improvements to care environment whole-hospital hand hygiene programme new dress code to limit cross infections patient tracking software developed consultants and medical secretaries relinquish office space to create isolation rooms on wards

The pre-crisis phase

In 2006, the *C. diff* infection rate at Burnside Hospital was 20 to 30 new cases a month, rising to 47 in November (Figure 15.1). The infection control team held an incident meeting, and junior doctors reported the increase to senior colleagues. *C. diff* was a known problem, but there was no formal information reporting, and managers were not at first aware of the depth of this crisis. Table 15.2 summarises the pre-crisis phase, highlighting the factors contributing to this incident.

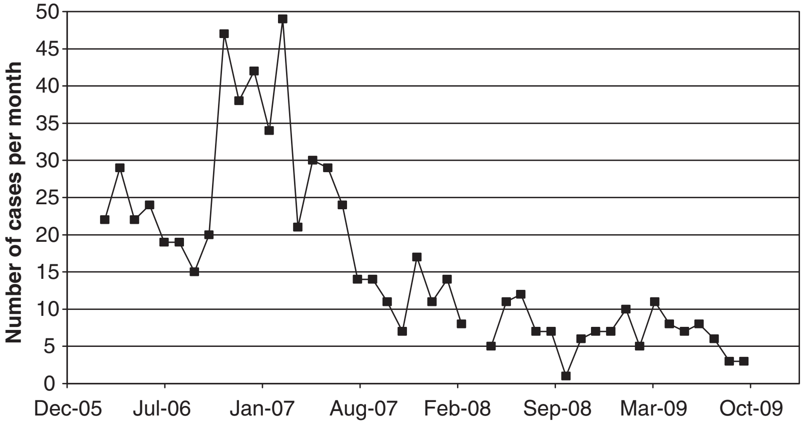

Figure 15.1 *C. difficile* rates at Burnside Hospital

Table 15.2 Pre-crisis: Factors contributing to the Burnside *C. difficile* incident

Factor	Nature	Implications
Environmental	*C. diff* strains vary by location government targets	Local variation in infection focus attention on monitored activities
Technical	development of broad-spectrum antibiotics low grade paper towels inconvenient location of basins	reduce health risks from prescribing bacterial infection control drugs no need for targeted prescriptions increased possibility of antibiotic resistant microbials ineffective hand washing
Organisational	functional silos weak reporting lines of infection control team poor governance structures	Incidence of *C. diff* not communicated no corporate awareness of *C. diff* rates low awareness and poor auditing of responses
Managerial	no monitoring or communication of HCAIs	no ownership of HCAI issues unknown performance relative to other hospitals limited resourcing of infection control team HCAIs given low priority

Table 15.2 Pre-crisis: Factors contributing to the Burnside *C. difficile* incident – *continued*

factor	nature	implications
processes	uncoordinated patient movement	increased potential for cross-infection
	infected patients not isolated	risk of cross-infection
	limited patient screening	lack of awareness of carriers
	liberal use of broad-spectrum antibiotics	development of antibiotic resistance
	inappropriate dress code	impede effective hand washing
	variable hand washing regime	

The crisis and emergency response phases

In June 2007, national league tables were published showing the incidence of HCAIs. Burnside was in the bottom ten. The crisis was now apparent, and management acted immediately. A support team from the Strategic Health Authority (SHA, one of ten regional NHS monitoring bodies in England) visited in July, issuing recommendations concerning clinical care, infection control practice, and management and governance. The SHA support team was impressed by the open, non-defensive way in which the hospital responded to their advice, and by the speed with which plans were implemented. Reassuring this key external stakeholder was an important 'political fix' complementing the 'real fix' to the hospital's infection control issue.

The maintenance phase

Events following the crisis management phase of incidents such as this have rarely been investigated. At Burnside, this phase was crucial to the hospital's ongoing efforts to control infection rates. The number of new cases of *C. diff* dropped below 15 a month in August 2007, and continued to fall. By the end of 2009, it was down to below five new cases a month, a rate that has been maintained since. Success was due to the combined impact of several actions managed as an evolving programme, a six-component 'package deal', rather than the typical stepwise change management approach.

1. Turnaround team

Immediately the league table position was known, top managers established a cross-departmental turnaround team of clinicians and managers who had authority to act.

2. Appraise and prioritise

The turnaround team implemented immediate actions including improved hygiene facilities, and changing antibiotic prescribing practice (withdrawing some antibiotics). Other changes, such as altering bed layouts, and depriving senior doctors and medical secretaries of their offices to create more isolation rooms, took more time and resources, and sensitive handling, but consultants and secretaries did not resist.

3. Emergency response

Managers were quick to demonstrate that the problem was understood, and that a solution was being implemented. An autocratic, ‘no questions – no negotiations’ style was adopted, highlighting the importance of the required actions, and driving the pace.

4. Systemic solution

Systemic problems need systemic solutions, including individual, team, organisational, financial, infrastructural, and other factors. Burnside introduced changes to personal hand hygiene, ward performance audits, prescribing policy, screening practices, budget allocations, bed and ward layouts, dress codes, training, practice manuals, and pharmacy-led ward rounds. Communications were authoritative, compelling, frequent, and appealed to professional values – ‘People are dying because of what we’re doing’ – rather than to external targets. The approach recognised ‘infection control fatigue’, and methods were constantly refined, to attract attention and maintain interest.

5. Measure and report progress

Infection rates were monitored and published with audits of ward hygiene practices. Elsewhere such information found in committee minutes and board papers, is summarised for the purposes of external audit. At Burnside, all staff were constantly aware of how well the hospital and specific areas were performing on these key metrics. The continued lowering of infection rates provided both incentive and motivation to maintain that trajectory.

6. Plan for continuity

Performance has improved, the crisis is over, external stakeholders have left happy, so work for the turnaround team is over? No. At Burnside, the turnaround team continued their work, to maintain the focus on the agenda, and to sustain the reduction in infection rates. The seamless move from the immediate emergency response to the continuing maintenance phase was critical to their success.

Implications: Practice, policy, research

As Figure 15.1 shows, the number of new cases of *C. diff* per month fell below 15 in August 2007, and continued subsequently to decrease further. By the end of 2009, this had fallen to fewer than five new cases a month. As the infection control nurse observed, 'We've actually got a 75 per cent reduction between January 2007 and January 2008. A 75 per cent difference – which is incredible really'. The SHA concurred. In a follow-up review in July 2008, they noted that Burnside's *C.diff* rates between August and December 2007 had been 'significantly better than the NHS average in 2006. This is a terrific achievement'.

In considering how events unfold over time, processual perspectives are particularly helpful (Langley 1999 and 2009). Applied to the Burnside experience, three conclusions are evident, concerning the multifaceted approach, the changing change agenda, and the attention to sustainability.

Multi-faceted approach

The reduction of *C.diff* rates at Burnside cannot be attributed simply to a small number of key issue, but to a combination of factors interacting and contributing to those outcomes over time in this particular context. These external, financial, technical, organisational, managerial, processual and individual factors are summarised in Table 15.3. It is difficult to prioritise these factors in terms of significance or impact. Outcomes rely on the combined effects of these factors. This suggests that guidance on infection control that relies on protocols, techniques, and vigilance, while necessary and valuable, may have only partial success in addressing the problem. Judging from this case. a wider, longer term, context-specific, creative, and continuing management agenda with components operating in a mutually reinforcing manner at different levels of action may have a greater impact.

These changes were managed, not as a one-off initiative, but as an evolving programme. This approach may have been assisted by the absence of three factors that often accompany incidents of this kind:

1) A lack of media scrutiny. This inevitably focuses on attributing blame, ensuring punishment, and the rapid implementation of simple remedies, and can derail the application of appropriate measures, and

Table 15.3 Burnside response to the *C. difficile* incident

Factor	Actions	Consequences
External	similar incident occurred in a nearby hospital	management aware of wider problem and implications
	national league tables show comparatively poor performance	seriousness of problem exposed, seen as 'at crisis level'
	SHA sends team to investigate and support	guidance, support, legitimacy for radical actions and investment
Financial	immediate additional funding	new isolation unit
	increased recurring budget	bigger infection control team, better resourced and supported
		isolation bays in wards
		increased space between beds
Technical	upgrade hand towels	improved hand hygiene
	upgrade hand washing facilities	increased rates of hand washing
Organisational	create *C.diff* turnaround team	integrated cross-functional working focused activities
	change reporting lines for infection control, to directorof nursing and chief executive	direct access to executive management group and board
	double the size of infection control team	highlight importance of HCAIs
	create and staff dedicated *C.diff* isolation unit	skilled staff caring for patients patients segregated to reduce cross infections
Managerial	chief executive and board 'own' HCAI rates	collective hospital-wide ownership of HCAIs
	communication appeals to personal and professional values	significance of HCAIs widely understood commitment to change
	challenge behaviours (e.g., hand hygiene)	
	confront resistance to change (e.g., prescribing practices)	
Process	amend dress code	
	training increased	
	develop manual of practice	
	daily ward rounds by infection control nurse and pharmacy staff	All lead to reduced cross infection
	routine patient screening	
Individual	choice of autocratic change agent	direction and energy

destabilise organisation management by encouraging the resignations (or sacking) of key staff;

2) Avoidance of an investigation or enquiry, other than the two-day visit by the SHA team. Enquiries can be protracted, and can delay the implementation of changes which, as they were not developed by those who will put them in place, may be disregarded;
3) Identifying a scapegoat. In these circumstances it was not appropriate to 'pin the blame' on an individual or group, an activity that diverts attention from other contributing factors and conditions.

In other words, Burnside's success has to be explained in part by the presence of key factors, and also by the absence of other potentially distracting conditions.

Changing change agenda

The comment from an infection control nurse concerning 'infection control fatigue' was astute. Through the psychological process of habituation, frequently repeated signals cease to attract attention. New dimensions were introduced to the infection control initiative, changing signage, improving physical facilities, and running fresh training and awareness programmes. Most practical guidance on change presumes a clearly defined agenda. While this was certainly the case with regard to Burnside's emergency response, the subsequent agenda was constantly refined and redefined in creative ways to maintain interest in and focus on the infection control agenda.

Attention to sustainability

One of the problems with 'high visibility' change concerns 'the improvement evaporation effect' (Buchanan et al 2007). A problem is detected, solutions are considered, change is implemented, the problem is solved, and success is demonstrated. However, when the site of the innovation is revisited, the initial gains are often found to have dissipated, and performance levels have returned to 'normal'; the improvements have evaporated. Successful changes are not automatically sustained. Among the factors jeopardising sustainability are exhausted budgets, loss of key staff, and senior management distracted by other priorities. Burnside appears to have sidestepped these problems with its initial investment, recurring budget for infection control, the involvement of different functions across the hospital, thus reducing dependency on key individuals, and ensuring that infection control continued to be seen as a top team priority.

Changes required to achieve a particular level of performance can be different to those required to maintain that same level. This threat to sustainability has been demonstrated, for example, in relation to the reduction of patient waiting times (Appleby 2005). Often, a 'quick fix' relies on additional resources, but maintaining that success often requires wider-ranging and more radical system changes. Burnside avoided 'improvement evaporation' by moving from the emergency response phase into an ongoing maintenance phase.

Implications for practice

Burnside hospital handled this crisis in a particularly effective manner by adapting practice to meet policy requirements. Significantly, the senior management team at Burnside effectively managed the custodians of the policy agenda, acknowledging poor performance, proactively developing strategic and operational solutions and inviting external feedback. In so doing management and key staff maintained control of the content and pace of the change agenda. They were subject to no internal or external investigations. They did not have to deal with media reporting. There was no 'witch-hunt'. Management incorporated external advice into a programme that was already under way, rather than wait for that guidance, or allow it to refocus their attention. The six components in the 'package deal' explained earlier, summarised in Figure 15.2, were effective through their combined impact. This framework represents an ongoing configuration of action, and is not a step-wise guide in the style typical of routine change management advice. The combination of factors contributing to the management of this incident offers a guide to the *pattern* of actions which, appropriately adapted, could assist other organisations in similar circumstances to develop a context-specific crisis management and maintenance strategy.

Implications for policy

In the professionalised organisational setting of health care, performance metrics are more likely to be accepted, pursued, and achieved where they are consistent with personal and professional values. Metrics that are perceived to have no basis in clinical evidence, and to be motivated instead by the sight of political gain, are more likely to be subverted or ignored, or given lip service only. Performance management in health care in the UK remains dominated by a culture of 'deliverology' based on measurable outcomes of different kinds (Seddon 2008). It would be appropriate for policy to identify metrics that are more likely to have personal and professional rather than political appeal.

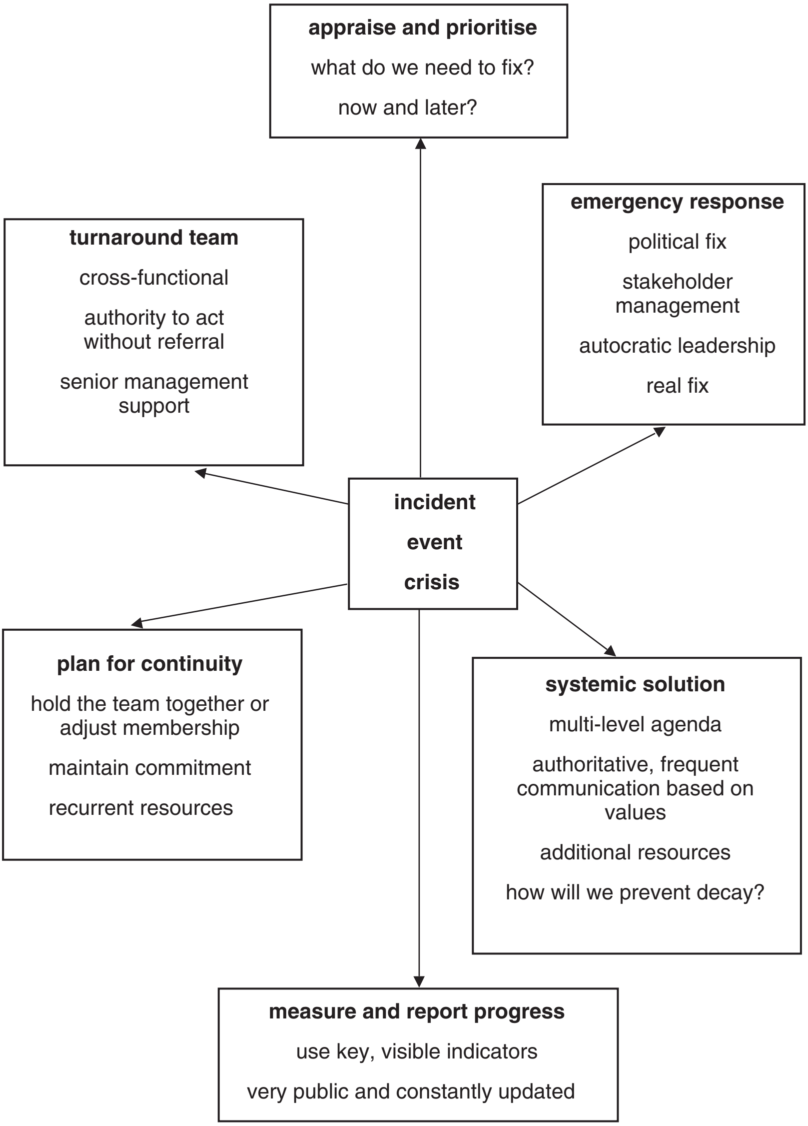

Figure 15.2 Managing the aftermath: Practical implications

In the constant search for interesting stories, the media tend to escalate all serious but manageable incidents into 'high profile crises'. Media scrutiny, however, can derail post-crisis management by forcing the pace, shaping the agenda, and demoralising those involved. Where regional and national audit and regulatory bodies are at least in part responsible for channelling those stories to the media, greater caution may be advised before broadcasting a problem as a 'crisis'.

Policy developments which demand particular activities or results can generate organisational crises, especially where the organisation is likely to fail to meet expectations. Attending to these demands may divert managerial attention from more compelling or important local issues, and consequently may be counter-productive to patient care. Unsurprisingly while such demands may be resisted they inevitably shape the delivery of health care locally.

Implications for research

As indicated previously, research attention has focused primarily on events before, during, and immediately following accidents, major incidents, serious events and other forms of crisis. These kinds of incidents have been conceptualised in terms of organisational learning, and failure to implement recommendations from investigations and inquiries are attributed to learning difficulties (Elliot and Smith 2006). Research attention, in health care and other sectors, now needs to shift to the post-crisis phase, and to view the ongoing sequence of events through a change management and implementation lens, as well as from an organisational learning perspective.

Crises are more interesting and newsworthy and attract attention, while successes are seen as unremarkable and often pass unrecorded. In redressing somewhat this imbalance, this analysis of the Burnside experience demonstrates that, following a crisis, it is possible to implement change rapidly and to maintain a success trajectory in a sector better known for the slow pace of implementation and for improvement evaporation. However, lessons learned are not invariably implemented. Adopting a processual change perspective may help to explain why such difficulties can arise, and offer practical advice for effectively managing the crisis aftermath.

The claim that 'it is not possible to generalise from a single case' relies on the notion of statistical generalisation, extrapolating findings from a representative sample to a wider population. One problem with this approach is that, for most organisational case studies, it is not clear what the wider population includes. The central question regarding generalisation, or external validity, concerns whether it is reasonable to claim that findings from a single case apply to other settings. There are four other modes of generalisation apart from statistical (Buchanan 2011). First, Williams (2000) uses the term *moderatum generalisation* to refer to speculative associations based on similar structures and 'shared reality' in different settings. Second, Stake (1994) labels the process through which we learn from case accounts and apply them to our own contexts as *naturalistic generalisation*. Third, Tsoukas (2009) argues that case research findings generalise from experience and observation to theory, through *analytical refinement*, broadening understanding of phenomena under investigation. Finally, Toft and Reynolds (2005) argue that 'lessons learned' from crises can often be applied in other settings which are comparable with regard to the nature of the event, the sector, the process involved, or to operational characteristics, referring to this transfer as *isomorphic learning*.

These modes of generalisation are neither discrete nor mutually exclusive, and they each apply to the case reported here. The broad similarities between acute hospital structures, staffing, and working practices invite *moderatum generalisation* and *isomorphic learning*. Clinical and managerial staff in other acute settings will readily assess the relevance of events in this case to their own circumstances. The features of post-crisis change management in this case differ sharply from current change implementation wisdom, thus suggesting other models of change. We can confidently argue that other organisations facing similar problems will not necessarily be successful with a 'copy exact' approach to the change model reported here. But we can with some confidence claim that other organisations in similar circumstances are more likely to address these problems effectively with a broadly similar pattern of post-crisis management, emphasising in particular the maintenance phase.

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Disclaimer

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16

Conclusions

Helen Dickinson and Russell Mannion

In this final chapter we shall attempt to draw together the range of contributions made in this book into a conclusion. This is never an easy task with edited collections and this is no exception given the vast terrain that the contributions have covered, geographically, conceptually, methodologically and practically. We should not really be surprised by this range given that health care organisations comprise a diverse range of stakeholders who hold different values, beliefs, attitudes and amounts of power. The main theme of the policy/practice gap in the reform of health care clearly resonated with contributors and underpins and binds together all of the chapters.

Conceptualising the gap

The notion of an implementation gap (or deficit) has often been a rather contentious issue. Initially it was not a topic that featured heavily in studies of policy processes, but following Pressman and Wildavsky's (1973) seminal work Implementation: how great expectations in Washington are dashed in Oakland or, why it's amazing that federal programs work at all, this being the saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes interest in this topic area expanded. So much so, that Hargrove (1975) wrote that policy implementation was the 'missing link' in the study of policy processes.

In the early stages, there were essentially two competing schools contributing to the debate. There were those who favoured 'top-down' accounts of policy and in contrast those who advocated a 'bottom-up' perspective. Both these schools were essentially providing accounts of the ways they thought policy implementation should be undertaken. Hill and

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Hupe (2002) portray these as being largely descriptive studies of the way things are, and also mostly normative in the sense that they provide an account of what ought to be. Often these types of studies sought to depict the way they observed policy implementation to operate and from this to adduce how policy implementation should operate. There have been syntheses of these approaches of course (e.g. Sabatier 1986), but as Hill and Hupe (2002) argue, despite a range of theorists seeking to combine top-down and bottom-up approaches, there is no one theory of implementation and many aspects of these processes remain contested. For a while we saw academic attention on the issue of implementation and the 'gap' between policy and practice wane, before then gaining a resurgence in recent years associated in part with the rise of evidence-based policy and practice movement.

In this recent incarnation there is probably even more contestation over the nature of this gap than hitherto. However, as the chapters set out in this book exemplify we are not by any means returning to the normative and prescriptive types of studies of old. None of the contributions in this volume could be classified as broadly functionalist in approach and many investigate the enactment of reform in practice drawing on a wide range of different theoretical and critical traditions. Peter Hupe draws on political theory in his deconstruction of the myth of the autonomous health care professional. Eivor Oborn and colleagues draw from work on discursive analysis and the types of linguistics employed around services as a way of illustrating studies over ideas and beliefs in relation to policy. Kathryn Charles and colleagues base their analysis on sociological and constructivist traditions in the study of patient safety. Addicott and Frosini use institutional and organisational archetype theories in their studies of hospitals in England, whilst Peter Nugus and colleagues draw on symbolic interactionalism in their study of emergency departments and make reference to sociological notions of the body in relation to organisational behaviour. Several chapters were also situated in the more general change management literatures (Chapter 12, Chapter 13) but all of the contributions offered in this volume adopt some sort of critical and conceptually sophisticated stance.

Shaping, adapting and resisting policy developments

A number of contributions to this book take up themes associated with identity and the importance of the actions, remit and autonomy of a range of individual, organisational and professional stakeholders in terms of how they mediate and react to policy and whether they therefore choose to implement, shape, adapt or resist developments. Hyde et al focus on the often neglected group of middle managers and show how they draw on multiple identity narratives to situate themselves in ways that might be more amenable to interaction with a range of different stakeholders. Niamh Lennox-Chhugani's chapter also focuses on the issue of identity but this time at an organisational level, albeit looking at the way that organisational identity mediates and interacts with individual, professional and institutional identities. This chapter draws attention to the role of resistance in policy adoption, an area which is much under investigated and this chapter sets out some fruitful avenues for future study.

Wanwright and Sambrook focus on the micro-level, but rather than addressing identity they instead investigate the concept of the 'psychological contract' and the degree to which there is a congruence between what governments and organisations communicate and what is acted upon at the local level. This paper sets out some interesting themes in relation to the role of policy in shaping employee expectations and obligations that are worthy of further empirical exploration.

What most of the contributions draw our attention to is that there are no easy answers when it comes to this subject. If we are going to go beyond the old normative prescriptions then we must produce more nuanced accounts of these issues. Yet even within these there are themes – or mechanisms as they are called in other areas of the literature – that might be identified as important, such as those concluded by Aoife McDermott and colleagues in their chapter. What most contributions have in common is that they draw attention to the importance of context and the wider political, organisational and cultural factors that serve as backdrop to the implementation of reform programmes (Chapter 5).

Investigating the gap

As this volume illustrates, the policy/practice interface lends itself to both quantitative and qualitative study. We have seen a wide range of methodological techniques used, ranging from documentary analysis (Chapter 2), mixed methods (Chapter 5), processual methodology (Chapter 9), interviews (Chapter 8), observation (Chapter 11), focus groups (Chapter 13) questionnaires (Oswald and McEldowney) with a number of chapters adopting ethnographic approaches which offer a rich understanding of the words and actions of individuals (Chapter 1, Chapter 2, Chapter 11). Often these rich ethnographic approaches are interested in linking what stakeholders' state they do and compare this with what they do in practice.

Case study designs were popular either as a single case (Pilbeam and Buchanan) or as a comparative case study design (Chapter 4, Chapter 7). Given that most of the case studies developed in this volume either comprised mixed methods or purely qualitative approaches, most studies had relatively limited numbers of individual case study settings. This raises some interesting questions about the reliability and generalisability of these types of approaches and how single cases should be designed.

We were pleased to see that there were contributions which are able to take us beyond simply snapshots of policy developments in particular times and settings. The chapters by Sharon Oswald and Rene McEldowney and Ann Casebeer and Trish Reay both take longitudinal glances at policy developments over a number of years in the Czech Republic and Canada respectively. We also saw a contribution where the lead author is the team manager of the group who were the subject of study (Chapter 2). This raises a series of interesting questions about the role of reflexivity in research and ways of engaging practitioners in research beyond the traditional roles. It will be interesting to see how this academic/practice gap develops over time and is reflected in the types of papers presented at future OBHC conferences.

The implementation gap going forward

A number of the chapters touch on issues that will undoubtedly remain important as this field of study develops and evolves. The types of long-standing issues covered in the volume include: the key role of networks in influencing processes of implementation of policy (Chapter 7, Chapter 14); the importance of engaging professionals – and in health care particularly clinicians – in reform processes (Chapter 4, Chapter 3); how to deploy change management processes (Chapter 9); and, patient safety (Chapter 13, Chapter 9). We hope that just as the issue of culture was revisited a number of times at the OBHC 2010 conference, following the theme in OBHC 2008, many of the themes contained here will be returned to in subsequent OBHC conferences (and associated texts).

We offer this collection of chapters as a further contribution towards constructing an international knowledge base that draws on social science theory and is informed and inspired by the practice of health care policy and management. We hope that readers find this a helpful source of new knowledge and that it will provoke reflection on their own practice. Ultimately we hope that this volume will stimulate further high quality and theoretically rich empirical research on the implementation of policy across a diverse range of health care settings.

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