L'entrepreneuriat institutionnel : le rôle des individus dans les processus de changement institutionnel

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THE ROLE OF INDIVIDUALS IN INSTITUTIONAL CHANGE: WHEN INDIVIDUALS ACT AS INSTITUTIONAL ENTREPRENEURS

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ABSTRACT

While early neo-institutional studies did not explicitly tackle the issue of agency, more recent studies about institutional entrepreneurship have brought it to the forefront. Institutional entrepreneurship has been presented as a promising way to account for institutional change. However, this notion faces a paradox insofar as there seems to be a contradiction between the agency of institutional entrepreneurs and institutional determinism. How can organizations or individuals innovate, if their beliefs and actions are all determined by the very institutional environment that they wish to change? This paradox is labeled the 'paradox of embedded agency' (Holm, 1995; Seo and Creed, 2002). To overcome it, it is necessary to explain under what conditions actors are enabled to act as institutional entrepreneurs.

Some neo-institutional theorists have already addressed this issue. They have highlighted a number of organizational-level and organizational field-level enabling conditions for institutional entrepreneurship. In this dissertation, I aim to complement their work by showing that there are also individual-level enabling conditions for institutional entrepreneurship. By doing so, I take into account the individual level of analysis that neo-institutional theorists often tend to neglect. More specifically, I concentrate on the analysis of one individual-level enabling condition, that is, individuals' social position. I develop a model that highlights the impact that individuals' social position has on the likelihood for them to act as institutional entrepreneurs. I test this model with data from ninety-three change projects that were conducted by ninety-three clinical managers from the National Health Service (NHS) in the United Kingdom between 2002 and 2004.

This research contributes to overcoming the paradox of embedded agency that is inherent in neo-institutional theory and thereby to setting up micro-foundations for the development of a theory of action within its frame. It also has some important managerial implications insofar as it highlights the profile in terms of social position of the individuals who are more likely to initiate divergent organizational changes, that is, to act as institutional entrepreneurs.

Keywords: Human agency; institutional change; institutional entrepreneurship; social position.

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CHAPTER 1
INTRODUCTION

The importance and endurance of the agency vs. structure debate in social sciences can be indicated by the number of different names it goes by: person vs. situation, strategic choice vs. environmental determinism and voluntarism vs. determinism. This debate is directly related to the assumptions made by organization scholars about human nature (Burell and Morgan, 1979; Astley and Van de Ven, 1983). In organization studies, like in any other discipline in the social sciences, assumptions about human nature are central, as human life is essentially the subject, and object, of inquiry.

Early neo-institutional studies contributed to the agency vs. structure debate by suggesting that patterns of action and organization were shaped by institutions rather than solely by instrumental calculations (Meyer and Rowan, 1977; DiMaggio and Powell, 1983). These studies emphasized ways in which institutions constrained organizational structures and activities, and thereby explained the convergence of organizational practices within the same institutional environment. They proposed that actors' behaviors were determined by the need to be regarded as legitimate in their institutional environment. It was implicitly assumed that individuals and organizations always tend to comply, at least in appearance, with the institutional pressures to which they are subject. In fact, neo-institutional theorists did not explicitly address the issue of human and organizational agency in these early studies. They began addressing it when they tackled the explanation of the phenomenon of institutional change.

Institutions are supra-organizational patterns of action or organization that are taken-for-granted in a given field of activity. Marriage and the corporate form are two examples of institutions. Institutions are characterized by their self-activating nature (Lawrence, Hardy, Phillips, 2002: 282; Jepperson, 1991: 145). Actors tend to reproduce institutions in a given field of activity without requiring either repeated authoritative intervention or collective mobilization (Clemens and Cook, 1999: 445). Even though institutions are characterized by their self-activating nature, we know that they do change (e.g., Fligstein, 1991). Since the late 1980's, neo-institutional theorists have started addressing the issue of institutional change. They have highlighted the role that organizations and/or individuals play in institutional change. To do so, many of them (e.g., DiMaggio, 1988; Holm, 1995; Fligstein, 1997; Rao, 1998; Beckert, 1999;

Garud, Jain, and Kumaraswamy, 2002; Maguire, Hardy, and Lawrence, 2004) have relied on the notion of institutional entrepreneurship - derived from Eisenstadt (1964; 1980) - , which incorporates the role of interests and active agency in neo-institutional theory. Institutional entrepreneurs are actors who have an interest in particular institutional arrangements and who mobilize resources to create new institutions or transform the existing ones (DiMaggio, 1988).

Institutional entrepreneurship has been presented as a promising way to account for institutional change endogenously though this notion is also a source of controversy among neo-institutional theorists. The controversy revolves around the ability of actors, who are supposed to be institutionally embedded, to distance themselves from institutional pressures and to act strategically. How can organizations or individuals innovate, if their beliefs and actions are all determined by the very institutional environment that they wish to change? This question alludes to the 'paradox of embedded agency' (Holm, 1995; Seo and Creed, 2002). To uncover the roots of this theoretical paradox, it is necessary to understand the dialectical nature of the relationship between institutions and human agency. Institutions do not merely constrain human agency; they are first and foremost the product of human agency (DiMaggio and Powell, 1991). As explained by Berger and Luckmann (1967: 60), it is important to keep in mind that the objectivity of the institutional world is a humanly produced, constructed objectivity. Before being 'objectivated' (i.e., experienced as an objective reality) by human beings, institutions are first produced by them. Human beings tend to believe that institutions have always been there because most often those who are constrained by institutions, and those who initially created these institutions, are not the same.

The paradox of embedded agency stems from the fact that neo-institutional theorists have barely tackled the issue of human agency. They have tended to neglect the individual level of analysis, concentrating, instead, on the organizational and societal levels of analysis. Such neglect is all the more surprising as individuals are in the end the ones who either reproduce or transform or create institutions. As stated by Friedland and Alford (1991), an adequate social theory must work at all three levels of analysis, i.e., the individual, the organizational and the societal levels of analysis. These three levels of analysis are nested. Individual, organizational and institutional dynamics are interrelated. Organizations and institutions specify progressively higher levels of constraint, as well as opportunity for individual actions (Friedland and Alford, 1991). New institutionalists too often regard attempts at analyzing the role played by individuals in institutional phenomena as reductionist approaches. It is for this reason that they are struggling

with the paradox of embedded agency. To overcome this paradox and thereby set up foundations for a theory of institutional entrepreneurship, it is necessary to explain under what conditions individuals are enabled to act as institutional entrepreneurs.

1.1. Research question

Researchers have already identified a number of organizational field[1] and organizational-level conditions that are conducive to institutional entrepreneurship. What is striking is that the studies that examine the enabling conditions for institutional entrepreneurship hardly account for the individual level of analysis. However, not all individuals are equally likely to act as institutional entrepreneurs even when they are embedded in the same environment (Clemens and Cook, 1999). Thus, the question that needs to be addressed is: **what are the individual-level enabling conditions for institutional entrepreneurship?**

In this dissertation, I propose to complement the existing body of literature about institutional entrepreneurship by addressing this research question. I do not claim that individual level enabling conditions are sufficient conditions for explaining institutional entrepreneurship. I propose that, among other conditions (namely organizational field and organizational level conditions), individual level conditions may facilitate institutional entrepreneurship. Specifically, I concentrate on the role of one individual level enabling condition for institutional entrepreneurship, that is, individuals' social position. Individuals' social position may be a key enabling condition for institutional entrepreneurship insofar as it relates individuals to the structural context in which they are embedded. Other individual-level conditions, such as psychological factors, may affect institutional entrepreneurship but analyzing their role without accounting for the fact that individuals are embedded in a social position corresponds to the trap of methodological individualism and, thereby, is in contradiction with the premises of neo-institutional theory. As the impact of other individual factors on the occurrence of institutional entrepreneurship may be mediated by individuals' social position, it is necessary to analyze the impact of individuals' social position first and foremost. Such analysis will open the way for

[1] An organizational field encompasses "those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services of products" (DiMaggio et Powell, 1983: 148).

research that will take into account the impact that other individual level factors may have on institutional entrepreneurship.

One potential difficulty associated with the study of institutional entrepreneurship at the individual level of analysis has to do with the fact that the study of variation in institutions requires a longer temporal frame than the study of variation in individual actions. Similarly, the relevant spatial extent over which activities can be organized is wider for institutions than it is for individuals (Friedland and Alford, 1991). However, the analysis of institutional entrepreneurship at the individual level is possible in organization studies because organizations correspond to one type of setting in which individuals may act as institutional entrepreneurs. It is the case when individuals conduct divergent organizational changes that break with the dominant institutional logic in a given organizational field. Institutional logics are taken-for-granted social prescriptions that guide behavior of actors in fields. They represent a field's shared understandings of what goals to pursue and how to pursue them (Scott, 1987, 1994). Though most fields may contain multiple logics (e.g., D'Aunno, Sutton and Price, 1991; Friedland and Alford, 1991; Thornton and Ocasio, 1999; Schneiberg, 2002; Seo and Creed, 2002), one institutional logic that is widely shared-across and taken-for-granted often tends to hold a dominant position in a field (Dobbin, 1994; Schneiberg, 2002; Reay and Hinings, 2005).

The focus on divergent organizational changes helps to overcome the problem that is related to the inadequacy of the relevant temporal frames for the study of variations in institutions and individual actions, insofar as divergent organizational change occurs through shorter periods of time than institutional change. In addition, the focus on divergent organizational change helps to overcome the problem that is related to the inadequacy of the relevant spatial frames for the study of variations in institutions and individual actions, insofar as divergent organizational changes, which participate in the institutionalization of a new logic at the organizational field level, are conducted by individuals within the boundary of their organization. Therefore, the study of divergent organizational change is a methodological device that renders possible the study of institutional entrepreneurship at the individual level of analysis.

The key question that is at the heart of this study, then, is **how individuals' social position affects the likelihood for them to conduct divergent organizational changes that break with the dominant institutional logic in the field**. Individuals who conduct such changes can be regarded as institutional entrepreneurs. Some studies (e.g., Leblebici et al., 1991; Haveman and Rao, 1997; Garud et al., 2002) have already highlighted the impact of

organization's social position on the likelihood for the organization to act as an institutional entrepreneur. It has been showed that organizations that act as institutional entrepreneurs are most often at the periphery of institutional arrangements, which means that they are not advantaged by the existing institutional arrangements. It is legitimate to wonder whether this finding can be transposed to the individual level of analysis, that is, whether individuals who are more likely to act as institutional entrepreneurs are at the periphery of institutional arrangements. To address this question, I develop a model that highlights the impact that individuals' social position has on the likelihood for them to conduct divergent organizational change, that is, to act as institutional entrepreneurs.

1.2. Data and methods

I test this model with data from ninety-three change projects that were conducted by ninety-three clinical managers from the National Health Service (NHS) in the United Kingdom between 2002 and 2004. Some of these clinical managers conducted change projects that significantly diverged from the dominant institutional logic in the NHS, i.e., the logic of medical professionalism, while others conducted change projects that did not diverge from this logic. The former can be regarded as institutional entrepreneurs. I develop a measure of the degree of divergence of the ninety-three change projects from the logic of medical professionalism. Then, I analyze the relationship between the degree of divergence of the change projects that the clinical managers initiated and the characteristics of their social position. It enables me to identify the profile in terms of social position of the individuals who are more likely to initiate divergent organizational changes, that is, to act as institutional entrepreneurs.

1. 3. Results

The results suggest that individuals' social position in a given organizational field is an important enabling condition for institutional entrepreneurship but that its impact varies depending on the dimension on which individuals break with the dominant institutional logic. There are at least two different dimensions on which a change project may diverge from the logic of medical professionalism. The first dimension has to do with organizations' roles division. Change projects that diverge from the logic of medical professionalism on this dimension aim to develop a more integrated healthcare system. The second dimension has to do with professionals' roles division. Change projects that diverge from the logic of medical professionalism on this

dimension aim to empower non-physicians. Depending on the dimension that is considered, the profile in terms of social position of individuals who are more likely to act as institutional entrepreneurs is radically different.

1.4. Theoretical contributions

There are a number of theoretical contributions associated with this study. First, the focus on individuals' social position contributes to the development of neo-institutional theory by linking the individual level of analysis back to the organization and organizational field levels. Of course, such an approach does not imply that individuals' actions are the only sources of institutional change. I agree with Jepperson (1991) when he states that successful influence attempts by a delimited agent, carrying a specific interest, represent only one category of possible social change explanations. Institutional change processes are complex processes, in which different types of forces and agents are involved. However, individual change agents' actions, which have so far received scant attention, correspond to one type of force that might affect the institutional order.

Second, this study also contributes to better accounting for the nature of institutional change processes. To comprehensively account for these processes, it is necessary to rely on a multi-level approach that aims at capturing the interactions that exist between the different levels of analysis. Actors, be they organizations or individuals, are both constrained and enabled by their institutional environment (Sewell, 1992). Multi-level research, taking into account the individual, organizational and organizational field levels of analysis, has been suggested as a promising avenue of research for studies dealing with institutional change and thereby aiming to account for the dual nature of institutional processes (Occasio, 2002; Palmer and Biggart, 2002; Strang and Sine, 2002). However, there has been little work so far in this direction (Reay and Hinings, 2005). One reason for this may be that the relevant temporal and spatial dimensions for studying variation in institutions and individual actions are not the same. This research contributes to overcoming this obstacle by focusing on divergent organizational change.

The third contribution has to do with the fact that this study highlights the role of individuals in institutionalization processes. These processes have already been studied quite extensively. Neoinstitutionalists (e.g., Meyer and Rowan, 1977; DiMaggio and Powell, 1983; Meyer and Scott, 1983) have insisted on the central role of legitimacy in such processes. The problem with most of these studies is that they do not account for the behavior of early adopters

who adopt practices and/or organizational forms that are not yet regarded as legitimate in a given organizational field. As Greenwood and Hinings (1996: 1044) note, there is a need for more in-depth studies of 'early movers.' In addition, it is striking to note that most of the studies about institutionalization processes have concentrated on the organizational level of analysis. The scarcity of studies that take into account the individual level of analysis when examining institutionalization processes is all the more surprising as individuals play a central role in such processes insofar as they are the ones who adopt the new emerging logics and disregard the old ones. In the frame of this dissertation, I complement the existing literature about institutionalization processes by focusing on the role of early individual adopters in the diffusion of practices and/or organizational forms that diverge from the dominant institutional logic in a given organizational field.

Fourth, this research participates in the development of the body of research about institutional entrepreneurship by highlighting the enabling role of individuals' social position and thereby providing new guidelines for overcoming the paradox of embedded human agency. Overcoming this paradox is crucial because it is a prerequisite to setting up the foundations for a theory of institutional entrepreneurship which, in fact, corresponds to the theory of action of neo-institutional theory.

Finally, this research contributes to the literature about organizational change by showing that there are different types of divergent organizational changes that break with different dimensions of the dominant institutional logic. The results show that the individuals who are more likely to initiate these different types of divergent organizational changes have different profiles. Overall, this study suggests that organizational change divergence should be treated as a multi-dimensional concept rather than a uni-dimensional one.

1.5. Managerial implications

In any society, one can see organizations that continue to use institutionalized practices even though they are permanently failing the organization (Meyer and Zucker, 1989). To break this vicious circle, it is necessary to know how to change institutionalized practices. One possible source of change, among others, is the action of individuals acting as institutional entrepreneurs. For this reason it is important to be able to identify individuals who are more likely to act as such. When CEOs want to implement changes that break with the existing institutions in a field, they need to identify the people on whom they can rely to locally initiate these changes. Similarly,

when governments want to implement major public reforms, they need to identify the people on whom they can rely to locally initiate these reforms. Highlighting the profile of individuals who are more likely to act as institutional entrepreneurs will help CEOs or government to identify the people, on whom they can rely locally, when they need to implement major changes that break with institutionalized practices.

1.6. Outline of the dissertation

This dissertation is comprised of seven chapters (including this introductory chapter). In chapter 2, I highlight the importance of the issue of agency in institutional theory and I present the theoretical research question that motivated this study. In chapter 3, I develop a model that highlights how individuals' social position affects the likelihood for them to behave as institutional entrepreneurs in a given organizational field. In the following two chapters (chapters 4 and 5), I first present the setting that is the NHS in which I tested this model and then, the methods that I used to operationalize the different variables contained in the model. Chapter 6 presents the obtained results. Finally, in chapter 7, I discuss these results and I highlight the theoretical contributions, future research directions and managerial implications associated with this study.

CHAPTER 2
THE ISSUE OF AGENCY IN INSTITUTIONAL THEORY

2.1. The agency vs. structure debate in social sciences

This debate is directly related to the assumptions made by organization scholars about human nature. As stated by Burell and Morgan (1979), social sciences can be conceptualized in terms of four sets of assumptions related to ontology, epistemology, human nature and methodology. In organization studies, like in any other discipline of social sciences, assumptions about human nature are central ones. Astley and Van de Ven (1983) regard the assumptions made by organization scholars about human nature as one of the two analytical dimensions that can be used to develop a typology of the different views of organization and management.

The assumptions made about human nature deal with the relationship between human beings and their environment. One can distinguish two extreme perspectives regarding the relationship between human beings and their environment in organizational theory. The first perspective that has a deterministic orientation considers that human beings respond in a deterministic fashion to the situations they encounter in their external world. Human beings and their experiences are regarded as products of the environment. In other terms, the proponents of this perspective assume that humans are conditioned by their external environment. They leave almost no room for human agency. Therefore, the deterministic orientation focuses not on individuals, but on the structural properties of the context within which action unfolds, and individual behavior is seen as determined by, and reacting to, structural constraints that provide organizational life with an overall stability and control (Astley and Van de Ven, 1983).

This perspective can be contrasted with another that has a voluntaristic orientation. This voluntaristic perspective attributes to human beings a much more creative role. The proponents of this perspective assume that free will occupies the center of the stage (Burell and Morgan, 1979). Individuals are regarded as autonomous, pro-active and self-directed agents. They are seen as the basic unit of analysis and source of change in organizational life (Astley and Van de Ven, 1983). This perspective highlights the role of human agency that corresponds to individuals' ability to intentionally pursue interest and to have some effect on the social world, altering the rules or the distribution of resources (Scott, 2001).

2.1.1. The undersocialized view of action of rational actor models

The rational actor model –also called the model of the homo economicus– that is used in neoclassical economics corresponds to an extreme view of human agency. Indeed it assumes that agents always select the most efficient alternative, that is, the alternative that maximizes output for a given input or minimizes input for a given output under a specified set of constraints. The rational actor model is based on the assumption that agents' preferences are exogenous, ordered and stable. Rational consumers purchase the amount of goods that maximizes their utility, by choosing the basket of goods on the highest possible indifference curve. Rational firms produce at a point that maximizes profits, by setting marginal cost equal to marginal revenue. Actually, the rational actor model ignores the impact that the agents' environment may have on their preferences, on their decisions and on their behaviors. As emphasized by Granovetter (1985), it is based on an undersocialized view of action.

The rational actor model has influenced the development of economic theories of organization, such as public-choice theory, agency theory or the new institutional economics. All these theories tend to isolate organizations from their societal context and to focus on the analysis of the decisions of "the instrumental, rational individual, whose choices in myriad exchanges are seen as the primary cause of societal arrangements" (Friedland and Alford, 1991: 232).

2.1.2. The contribution of neo-institutional theory to the agency vs. structure debate

Neo-institutional theory suggests that patterns of action and organization are shaped by institutions rather than solely by instrumental calculations (Meyer and Rowan, 1977; DiMaggio and Powell, 1983). It proposes that agents' behaviors are determined by the need for them to be regarded as legitimate in their institutional environment. The key difference between neo-institutional theory and rational actor models has to do with the role that is assigned to the environment in which actors are embedded. While rational actor models tend to neglect the environment's influence on actors' decisions, neo-institutional theory takes the environment's influence into account by assigning a key role to legitimacy considerations in actors' decision processes. Indeed neo-institutional theory is based on the notion that, to survive, organizations must convince larger publics that they are legitimate entities worthy of support (Meyer and Rowan, 1977). To do so, they must conform –at least in appearance– to the institutional norms of their environment. In institutional environments, organizations are rewarded for using acceptable structures and practices, not the quantity and quality of their outputs (Meyer and Scott, 1983).

Therefore, legitimacy has a central role in neo-institutional theory as a force that constrains change and pressures organizations to act alike (DiMaggio and Powell, 1983).

Concerns over legitimacy force organizations to adopt managerial practices or organizational forms that other organizations have. These practices and organizational forms may or may not enable organizations to maximize the quality and/or quantity of their outputs. As Oliver (1991: 148) explains, neo-institutional theory states that "when external norms or practices obtain the status of a social fact, organizations may engage in activities that are not so much calculative and self-interested as obvious or proper." On the whole, neo-institutional theory accounts for the fact that agents' preferences, decisions and behaviors are influenced by the institutional environment in which they are embedded.

2.2. The paradox of embedded agency in neo-institutional theory

During the 1980s, neo-institutional theory was primarily used to explain the observed organizational homogeneity within organizational fields (e.g., DiMaggio and Powell, 1983; Tolbert and Zucker, 1983). These studies emphasized increasing isomorphism among organizations subject to similar institutional pressures. In these early studies (e.g., Meyer, Scott, and Deal, 1983; Tolbert and Zucker, 1983; Zucker, 1983; Tolbert, 1985), it was implicitly assumed that organizations and individuals passively adapt to institutions. Human agency was implicitly viewed as habitual and repetitive. Institutional theorists emphasized the taken-for-granted quality of knowledge and action that makes organizations relatively stable and resistant to change, once their members have adopted institutionalized organizational forms and practices. As Oliver (1991) noted, instutional theorists aimed at demonstrating how behaviors can occur and persist, through the exercise of habit, convention, convenience, or social obligation, in the absence of any ostensible indication that these behaviors serve the actors' own interests. Early neo-institutional studies viewed institutions as external constraints on organizational and human agency. They have been criticized for relying on an oversocialized view of action (Hirsch and Lounsbury, 1997).

As long as neo-institutional theorists mainly concentrated on explaining organizational conformity, the issue of agency was not a central one. Now that institutional theorists have begun to tackle the issue of change, the question of organizational and human agency has become central. Since the 1990s, there has been a tendency among new institutionalists to focus more on the way in which both individuals and organizations innovate, act strategically, and contribute to

institutional change (e.g., DiMaggio, 1988; Leblebici et al., 1991; Greenwood and Hinings, 1996; Kraatz and Zajac, 1996; Barley and Tolbert, 1997; Fligstein, 1997; Karnoe, 1997; Kondra and Hinings, 1998). The special research forum on institutional theory and institutional change, published by the *Academy of Management Journal* in February 2002, gathers contributions that analyze the role of individual or organizational agents in institutional change. The notion of institutional entrepreneurship (DiMaggio, 1988) has progressively emerged as a promising way to account for the active role of individual and organizational actors in institutional change.

2.2.1. Institutional entrepreneurship

Addressing the issue of institutional change, DiMaggio (1988) introduced the notion of institutional entrepreneurship, which he borrowed from Eisenstadt's (1964; 1980) work, in neo-institutional theory. Analyzing the patterns of social change within different historical societies and the conditions which gave rise to the variations among these patterns, Eisenstadt (1980: 848) proposed that institutional entrepreneurs were one variable –among a "constellation" of others– that was relevant to the process of social change. In Eisenstadt's work, institutional entrepreneurs are those individuals and groups who adopt leadership roles in episodes of institution building (Colomy, 1998). By introducing the notion of institutional entrepreneurship in the framework of neo-institutional theory, DiMaggio (1988) put more emphasis on the role of actors and agency in institutional change processes: "New institutions arise when organized actors with sufficient resources (*institutional entrepreneurs*) see in them an opportunity to realize interests that they value highly" (DiMaggio, 1988: 14, emphasis in original). He thus revived dimensions of 'old institutionalism' (Selznick, 1949, 1956) that had been de-emphasized in early neo-institutional studies (e.g, DiMaggio and Powell, 1983, Meyer, Scott, and Deal, 1983; Tolbert and Zucker, 1983; Zucker, 1983; Tolbert, 1985). Institutional entrepreneurs can be either organizations –or groups of organizations– (e.g., Garud et al., 2002; Greenwood, Suddaby, and Hinings, 2002) or individuals –or groups of individuals– (e.g., Fligstein, 1997; Maguire et al., 2004).

Most studies about institutional entrepreneurship rely on DiMaggio's (1988) definition. For example, Maguire et al. (2004: 657) propose that institutional entrepreneurship "represents the activities of actors who have an interest in particular institutional arrangements and who leverage resources to create new institutions or to transform existing ones." It appears that actors must fulfil at least two conditions to be regarded as institutional entrepreneurs. First, only actors who somehow break with the rules and practices associated with the dominant institutional

arrangements and thereby develop alternative practices and rules can be regarded as institutional entrepreneurs. Second, actors must mobilize resources in order to implement changes that break with the dominant institutional arrangements. In other terms, they must actively take part in the implementation of these changes.

Such a definition of institutional entrepreneurship leaves at least two questions unanswered: (1) must actors be willing to change their institutional environment to be regarded as institutional entrepreneurs? and (2) how far do they have to go in the implementation of change to qualify as institutional entrepreneurs? Actors may not be willing to change their institutional environment, they may not even be aware of the fact that they are contributing to changing their institutional environment, however, they may break with the dominant institutional arrangements, and thereby act as institutional entrepreneurs. If they do not necessarily have to be aware of the role that they play, it is clear from DiMaggio's (1988) definition that actors must actively take part in the implementation of changes that break with the dominant institutional arrangements to qualify as institutional entrepreneurs. By doing so, they in fact contribute to the institutionalization of alternative practices. But, these practices do not have to become institutionalized for actors to be regarded as institutional entrepreneurs. In other words, actors do not have to be successful in institutionalizing new practices to qualify as institutional entrepreneurs.

2.2.2. Institutional entrepreneurship and the paradox of embedded agency

All the studies that account for the role of organizations and/or individuals in institutional change face a theoretical paradox. Indeed, if individuals and organizations are assumed to be shaped entirely by their institutional environment, the question to ask is: 'How can actors change institutions if their actions, intentions, and rationality are all conditioned by the very institution they wish to change?' (Holm, 1995). This theoretical paradox between institutional determinism and agency is labelled the 'paradox of embedded agency' (Seo and Creed, 2002). It is inherent in neo-institutional theory and it becomes particularly salient when one deals with the notion of institutional entrepreneurship. For this reason, the notion of institutional entrepreneurship has been a source of controversy among institutional scholars. The controversy revolves around the ability of actors, who are supposed to be institutionally embedded, to distance themselves from institutional pressures and to act strategically. Overcoming the paradox of embedded agency is crucial because it is a prerequisite to setting up the foundations for a theory of institutional

entrepreneurship. To overcome it, it is necessary to explain under what conditions actors are enabled to act as institutional entrepreneurs.

2.3. Overcoming the paradox of embedded agency

A number of studies account for the fact that institutional entrepreneurs are often ushered onto the stage by enabling conditions (Strang and Sine, 2002). To bring out all the enabling conditions for institutional entrepreneurship that have already been identified, I conducted an in-depth review of the literature about institutional entrepreneurship. To identify all the papers that have been published about institutional entrepreneurship, I followed the same procedure as Leca, Battilana and Boxenbaum (2006). I first identified all the papers about institutional entrepreneurship that had been published in peer-reviewed journals. I searched EBSCHOT Business Source Premier and JSTOR databases for entries in peer-reviewed journals that contained at least one of the following keywords in the title, abstract, keywords or full text: institutional entrepreneur, or institutional entrepreneurship. From this pool of articles, I excluded book reviews, editorials and calls for papers, as well as, all articles that made reference to these terms only in passing or that referred to other meanings or theories. I then looked at the reference list of the selected articles to identify recurrent and apparently important references that were published in non-refereed journals or edited volumes. This procedure generated the following articles: DiMaggio (1988, 1991), Fligstein (1997), and Rao et al. (2000). To make sure that no significant piece of work had been missed, I compared the list that I generated to articles that provide partial synthesis of the topic (Rao et al. 2000; Dorado 2005). This resulted in a list of 40 articles (see Appendix 1). In all these papers, I coded the information on enabling conditions for institutional entrepreneurship whenever they were mentioned and/or examined. I found that two categories of enabling conditions have so far received a great deal of attention, i.e., field-level and organization-level conditions.

2.3.1. Field-level enabling conditions for institutional entrepreneurship

Different types of field-level enabling conditions for institutional entrepreneurship have been identified. Far from being mutually exclusive, these different conditions are often interrelated. Precipitating jolts or crises correspond to one type of field-level enabling condition for institutional entrepreneurship (Oliver, 1991; Holm, 1995; Clemens and Cook, 1999; Fligstein and Mara-Drita, 1996; Fligstein, 2001; Greenwood, Suddaby and Hinings, 2002). Relying on the

literature about institutional change, Greenwood et al. (2002) propose that jolts that may take the form of social upheaval, technological disruption, competitive discontinuities, or regulatory changes may enable institutional entrepreneurship because they disturb the socially constructed field-level consensus and contribute to the introduction of new ideas. In their study about the creation of the single market in the European Union, Fligstein and Mara-Drita (1996) show how the economic and political crisis that characterized the European Union in the early 1980's facilitated the action of the European Commission that played a pivotal role as a collective institutional entrepreneur in the creation of the Single Market.

The presence of acute field-level problems that may lead to crises corresponds to another type of field-level enabling condition (Fligstein and Mara-Drita, 1996; Phillips, Lawrence and Hardy, 2000; Wade-Benzoni et al., 2002). For example, Phillips et al. (2000) suggest that the existence of complex and multi-faceted problems, such as environmental issues and diversity in the workplace, enables participants in an inter-organizational collaboration to act as institutional entrepreneurs.

Organizational fields' characteristics correspond to the third type of field-level enabling condition. Among other organizational field characteristics, scholars have particularly highlighted the enabling role of organizational field's respective degree of heterogeneity and of institutionalization. Indeed it has been shown that both the degree of heterogeneity of the organizational field (Sewell, 1992; Whittington, 1992; Clemens and Cook, 1999; D'Aunno, Succi and Alexander, 2000; Seo and Creed, 2002) and its degree of institutionalization (Tolbert and Zucker, 1996) may affect actors' agency and thereby affect institutional entrepreneurship. Relying on Sewell (1992), Clemens and Cook (1999) state that the presence of multiple institutional orders or alternatives constitutes an opportunity for agency and thereby for institutional entrepreneurship. In other terms, the heterogeneity of institutional arrangements, that is, the variance in the characteristics of these different institutional arrangements may facilitate the occurrence of institutional entrepreneurship. When there are heterogenous institutional arrangements in a given organizational field, institutional incompatibilities are more likely to emerge. Such incompatibilities are a source of internal contradictions. A contradiction can be defined as a pair of features that together produce an unstable tension in a given system (Blackburn, 1994). Like other scholars, Seo and Creed (2002) highlight the enabling role of institutional contradictions for institutional entrepreneurship but they go one step further in trying to explain the mechanism by which those contradictions lead embedded agents to act as

institutional entrepreneurs. According to them, the ongoing experience of contradictory institutional arrangments enables a shift in collective consciousness that can transform actors from passive participants in the reproduction of existing institutional arrangements into institutional entrepreneurs.

The degree of institutionalization of organizational fields has also been shown to affect actors' agency (Tolbert and Zucker, 1996) and therefore institutional entrepreneurship. However, there seems to be a debate regarding the impact that the degree of institutionalization of organizational fields has on institutional entrepreneurship. Beckert (1999) suggests that strategic action is more likely to occur in relatively highly institutionalized organizational fields. Relying on Oliver's (1991) argument, he proposes that in relatively highly institutionalized organizational fields, uncertainty is lower and the need for security, stability, and predictability from the persistence of institutionalized rules and norms decreases. As a result, actors are more likely to engage in strategic action. Building on Beckert's (1999) work, Dorado (2005) proposes that substantial institutionalization as opposed to both minimal and extreme institutionalization creates room for strategic agency and thereby for institutional entrepreneurship. In contrast, other researchers suggest that uncertainty in the institutional order may provide opportunity for strategic action (DiMaggio, 1988; Fligstein, 1997). Fligstein (1997: 401) proposes that when the organizational field has no structure, that is, when its degree of institutionalization is very low, 'the possibilities for strategic action are the greatest.' Similarly, Philipps, Lawrence and Hardy (2000) suggest that unstructured or under-organized contexts provide opportunities for institutional entrepreneurship. It is striking to note that so far the majority of empirical studies about institutional entrepreneurship have been conducted in emerging fields that are less structured and that are thereby characterized by higher uncertainty (Rao, 1994; Lawrence, 1999; Rao and Sivakumar, 1999; Garud, Jain and Kularaswamy, 2002; Zimmerman and Zeitz, 2002; Déjean, Gond and Leca, 2004; Lawrence and Philipps, 2004; Maguire, Hardy and Lawrence, 2004).

Taking into account both the degree of heterogeneity and the degree of institutionalization of a given organizational field, Dorado (2005) developed a typology that aims at determining the extent to which fields offer opportunity for action, that is, for institutional entrepreneurship. According to her, organizational fields can adopt one of three dominant forms. When fields are highly institutionalized and/or isolated from the potential influence of other fields and thereby of new ideas, they are 'opportunity opaque,' which means that their characteristics do not provide

any opportunity for action. In contrast, 'opportunity transparent' fields that offer a lot of opportunities for action are characterized both by the co-existence of heterogeneous institutional arrangements and by a substantial level of institutionalization. Finally, 'opportunity hazy' fields that are characterized by minimal institutionalization and many heterogeneous models of practices render opportunities for action hard to grasp for agents who have to deal with a highly unpredictable environment.

2.3.2. Organization-level enabling conditions for institutional entrepreneurship

Apart from field-level enabling conditions, studies about institutional entrepreneurship have also highlighted the enabling role of organizational characteristics (e.g., Leblebici, Salancik, Copay and King, 1991; Kraatz and Zajac, 1996; Rao, Morrill, and Zald, 2000; Garud et al., 2002; Greenwood and Suddaby, 2006). Actually, most of these studies concentrate on one organizational characteristic which is the position of the organization in its organizational field or, even more broadly, in its institutional environment.

It has been shown that organizations and social movements that are at the margins of a given organizational field (Leblebici et al., 1991; Havemand and Rao, 1997; Garud et al., 2002) or at the interstices of different organizational fields (Rao, Morrill, and Zald, 2000; Levy and Egan, 2003) are more likely to act as institutional entrepreneurs. In a historical study about the U.S. commercial radio broadcasting industry, Leblebici et al. (1991) have showed that organizations from the periphery of the field are likely to act as institutional entrepreneurs. Analyzing the evolution of the U.S. broadcasting industry between 1920 and 1965, they found that most new practices were introduced by peripheral organizations that were in fact lower status organizations, such as "shady traders, small independent stations, renegade record producers, weaker networks, or enterprising advertising agencies" (Leblebici et al, 1991: 358). In contrast, higher status organizations mobilized resources to maintain the status quo. Drawing from research on the emergence of the Alternative Dispute Resolution industry (ADR), Rao et al. (2000) described how social movements at the interstices of multiple organizational fields bundled together particular sets of practices into new organizational forms. ADR involved lawyers, social workers, community organization therapists, judges, social work agencies, mental health agencies and community organizations using informal methods to handle minor disputes. Out of those encounters a new field emerged.

2.3.3. What about individual-level enabling conditions for institutional entrepreneurship?

Organizations and social movements are not the only actors that may act as institutional entrepreneurs. Individuals or groups of individuals may also act as institutional entrepreneurs (e.g., Fligstein, 1997; Maguire et al., 2004). For example, individuals who undertake divergent organizational changes, i.e., changes that break with the dominant institutional logic(s) in a given organizational field, fulfil the criteria to be regarded as institutional entrepreneurs. As already explained in the introduction, it is possible to study institutional entrepreneurship at the individual level by analyzing attempts at conducting divergent organizational changes.

However, most studies about institutional entrepreneurship have so far concentrated on the organizational field and organizational levels of analysis. As a result, scholars have tended to neglect the study of the individual-level enabling conditions for institutional entrepreneurship. The question of knowing how individuals are enabled to act as institutional entrepreneurs remains largely unanswered. Though, all individuals are not equally likely to act as institutional entrepreneurs, even when they are embedded in the same environment (Clemens and Cook, 1999). As acknowledged by Dorado (2005), all individuals will not necessarily perceive field-level conditions in the same way. Even though they may be embedded in a field that offers opportunity for action, individuals may not perceive them. A number of individual characteristics may have an impact on individuals' perception of the field, willingness to act as institutional entrepreneurs and ability to do so.

It is all the more important to examine the individual-level enabling conditions for institutional entrepreneurship as it is the only way to completely overcome the paradox of embedded human agency. I argue that this paradox stems from the fact that neo-institutional theorists have never explicitly tackled the issue of human agency. As suggested by Hirsch and Lounsbury (1997), uncertainty about actors' agency raises serious questions about how macrolevel institutional phenomena change. The problem of neo-institutional theory is that it offers organizational level and organizational field level explanations for phenomena that implicitly involve individual behavior without providing a basis for constructing a theory of individual behavior. Without solid microfoundations institutional theorists risk not accounting for institutionalization processes (Zucker, 1991).

Some institutional theorists (e.g., DiMaggio, 1988; Fligstein, 1997; Barley and Tolbert, 1997; AMJ, 2002; Seo and Creed, 2002) conducted studies that took human agency into account and that participated in the development of a theory of action. But, there are still many questions

that remain unanswered especially regarding the role of individuals in institutional change phenomena. In particular, we need to know more about the mechanisms that enable some individuals to break with the existing institutional arrangements and to adopt new ones. In this dissertation, I propose to concentrate on the analysis of the enabling role of individuals' social position.

CHAPTER 3
INSTITUTIONAL ENTREPRENEURSHIP AND INDIVIDUALS' SOCIAL POSITION

3.1. Individuals' social position: An individual-level enabling condition

Individuals' likelihood to act as institutional entrepreneurs is a function of their willingness to act as such and of their ability to do so. Individuals' willingness and ability to act vary from one individual to another. To act as institutional entrepreneurs, individuals must have an interest in doing so and they must have enough resources to do so, as stated in the definition of institutional entrepreneurship (DiMaggio, 1988). Their willingness to act is dependent on their interest, while their ability to act is partly determined by the resources that they hold or to which they have access (Lawrence, 1999). In addition, individuals' ability to initiate divergent organizational change in their organization is also determined by what Greenwood and Hinings (1996: 1035) call the organizational "pattern of value commitments," that is, the extent to which the different organizational groups are committed to the prevailing institutional arrangements. In a given organization, when all organizational groups are committed to the prevailing institutional arrangements, conducting divergent organizational change is particularly difficult. In contrast, when some or all organizational groups are opposed to the prevailing institutional arrangements, conducting divergent organizational change becomes easier.

Building on Bourdieu's conceptualization of fields that DiMaggio and Powell (1983) used when they developed the notion of organizational field, I propose that individuals' social position in a given field is a key variable to understanding how they are enabled to act as institutional entrepreneurs despite institutional pressures. According to Bourdieu (1990), fields are structured systems of social positions within which struggles take place between individuals over resources, stakes, and access. He regards individuals as "agents" as opposed to "biological individuals, actors or subjects" (Bourdieu and Wacquant, 1992: 107) in order to convey that they are both socially constituted as active and acting on their own in the field. Dealing with the importance of agents' social position in a given field, Bourdieu (1994: 28) states that agents' social position determines their point of view about the field, that is, their perception of the field, the stands that they take in the struggles to maintain the status quo or transform the field, and their access to resources. Thus, depending on their social position in the field, agents may, on the one hand, be more or less willing to transform the field, and on the other hand, more or less able to do so.

While most studies about institutional entrepreneurship that take into account the enabling role of actors' social position use organizations as units of analysis, some studies (Dorado, 2005; Maguire et al., 2004) have started analyzing the enabling role of individuals' social position. Dorado (2005: 397) proposes that actors' "social position," that is, "their position in the structure of social networks," which correspond to the set of persons to whom they are directly linked (Aldrich, 1999), affects their perception of their organizational field, and thereby their likelihood to behave as institutional entrepreneurs. Studying institutional entrepreneurship in the field of HIV/AIDS treatment advocacy in Canada, Maguire et al. (2004) suggest that institutional entrepreneurs in emerging organizational fields tend to be actors whose "subject positions" (Foucault, 1972) provide them with both legitimacy in the eyes of diverse stakeholders, and the ability to bridge those stakeholders, enabling them to access dispersed sets of resources. In their study, the notion of "subject position" refers to formal position and to all the socially constructed and legitimated identities available in a field. To complement these studies, and to more systematically analyze the enabling role of individuals' social position, it is necessary to rely on a more precise definition of individuals' social position. In the frame of this study, I restrict myself to the analysis of the impact of individuals' social position in a given organizational field, which is determined by their position in this organizational field on the one hand, and by their position in their organization, on the other hand.

Individuals are embedded in organizations and social groups, both of which are embedded in organizational fields. Social groups transcend organizational boundaries. Professional and occupational groups are examples of such social groups. Depending on the field under study, other types of social groups may play a key role. In France, for example, where degrees are highly valued, there is a clear distinction between the alumni group of the highly respected French schools, *grandes écoles*, and others (Bourdieu, 1989; Manzoni and Barsoux, 2004). Social groups' membership together with organizational membership contributes to determining individuals' position in the organizational field. Organizational fields, which correspond to a "recognized area of social life," comprise "key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products" (DiMaggio and Powell, 1983: 148). They encompass a variety of individuals, social groups and organizations. Just like fields in Bourdieu's definition, organizational fields can be regarded as structured systems of social positions, composed of dominant and dominated agents who attempt to usurp, exclude and establish monopoly over the mechanisms of the field reproduction and the

type of power effective in it (Bourdieu and Wacquant, 1992). In other terms, they are political arenas (Brint and Karabel, 1991). In a given organizational field, any dominant institution and the set of templates, rules and practices with which it is associated imply different access to, and control over, key resources and decision processes within this organizational field, that is, within the organizations and social groups that are embedded in this organizational field. For this reason, one can argue that, depending on the organization and social group(s) to which individuals belong, existing institutional arrangements are a source of power for some of them and not for others in a given organizational field.

Building on Fligstein's (1997) and Hensmans' (2003) work, one can use a rhetoric on 'incumbent-challenger' in order to qualify individuals' position in the organizational field. Incumbents are individuals who belong to organizations and/or social group(s) that are favored by the existing institutional arrangements, which constitute a source of power for them. They are in a privileged situation. It is generally in their interest to maintain the institutional status quo. For this reason, they are likely to use their position of power to buttress the existing institutional arrangements (Covaleski and Dirsmith, 1988). In contrast, challengers belong to organizations and/or social group(s) that are less favored by the existing institutional arrangements. For this reason, they are more likely to be dissatisfied with them and to try to modify them. Thus, depending on whether they occupy an incumbent or a challenger position in a given organizational field, that is, depending on their organizational and their social group(s) memberships, individuals are likely to have different incentives regarding the transformation or the maintenance of existing institutional arrangements. Similarly, they may benefit from different access to key resources. Incumbents are likely to have access to more resources than challengers.

Individuals' social position is not only determined by their position in the organizational field, but also by their position in their organization. In the framework of this study, I concentrate on the main determinant of individuals' position in their organization, that is, their position in organizational hierarchy. I do not take into account individuals' position in informal organizational networks.

Finally, individuals are not only situated in space but they are also situated in time. To comprehensively account for individuals' social position, it is necessary to account for the fact that it is not constant; it changes over time. Individuals may change position within their organization and/or within the organizational field. For this reason, in order to analyze the impact that individuals' social position has on the likelihood for them to conduct divergent

organizational change, i.e., to act as institutional entrepreneurs, it is also necessary to analyze the impact of changes in individuals' social position. To account for such changes, I analyze the impact of individuals' inter-organizational mobility on the likelihood for them to act as institutional entrepreneurs.

In the next section, I develop hypotheses about the impact of individuals' position in their organizational field, individuals' position in their organization and changes in individuals' position on the likelihood for them to initiate divergent organizational change, that is, to act as institutional entrepreneurs.

3.2. The impact of individuals' social position

3.2.1. The impact of individuals' position in the organizational field

The status of both the organization and the social group(s) to which individuals belong indicates whether they are in an incumbent or in a challenger position within the organizational field and therefore is likely to have an impact on individuals' willingness and ability to initiate divergent organizational change, i.e., to act as institutional entrepreneurs.

Organization's status. Other than organizational performance whose influence on the likelihood of occurrence of divergent organizational change has been largely theorized (Oliver, 1992) and tested (e.g., Miller and Friesen, 1980; Tushman and Romanelli, 1985), organizational status may have a key impact on individuals' likelihood to initiate divergent organizational changes. Status refers to a ranking of a social entity in terms of the values of a social system (Nicholson, 1995). In this case, it corresponds to the ranking of a given organization in terms of the values of the organizational field in which it is embedded. We know that the susceptibility of organizations to institutional pressures within a given organizational field varies with the status of those organizations (Podolny, 1993; Phillips and Zuckerman, 2001).

In order to assess the impact that organizations' status differences have on the likelihood for organizational members to initiate divergent organizational change, it is necessary to make a distinction between low and high status organizations. In a historical study on the U.S. commercial radio broadcasting industry, Leblebici et al. (1991) have showed how institutional change can be initiated by the actions of deviant organizations that are low status organizations. Analyzing the evolution of the U.S. broadcasting industry between 1920 and 1965, they found that most new practices were introduced by the less central organizations that were in fact low status organizations, such as "shady traders, small independent stations, renegade record

producers, weaker networks, or enterprising advertising agencies" (Leblebici et al, 1991: 358). In contrast, high status organizations mobilized resources to maintain the status quo. Even though organizations are the unit of analysis of this study, one cannot deny the fact that changes were introduced by organizational members of the different low status organizations. Similarly, other studies (Haveman and Rao, 1997; Palmer and Barber, 2001; Kraatz and Moore, 2002) have showed that peripheral organizations that, most of the time, happen to be low status organizations are more likely to conduct divergent changes.

There are several reasons for these organizational behavior differences when it comes to initiating divergent changes. Low status organizations are less well-embedded in the organizational field compared to high status organizations and they have little to lose by social deviance, insofar as they are less privileged by the existing dominant institutional arrangements. In other terms, individuals who belong to low status organizations are in a challenger position in comparison with individuals who belong to high status organizations in a given organizational field. For this reason, in low status organizations, organizational members are more likely to be willing to transform the existing institutional arrangements. In addition, they can more legitimately raise and promote alternative practices corresponding to new emerging institutions in their organization because it is not privileged by the existing dominant institutional arrangements. In other terms, the "pattern of value commitments" (Greenwood and Hinings, 1996: 1036), that is, the extent to which organizational members are committed to the prevailing institutional arrangements, facilitates the development and the implementation of divergent organizational change. Thus, I hypothesize the following:

H1a: Individuals who belong to low status organizations within a given organizational field are more likely to initiate divergent organizational change.

Social groups' status. Individuals' position in a given organizational field is also partly determined by the status of the social group(s) to which they belong. Depending on the field under consideration different types of social groups may exist and may benefit from different status. As underlined by Lawrence (2004), in organizational fields, interaction rituals among group members and across groups structure the relationships among field members. Interaction rituals that are dictated by the dominant logic(s) in the field correspond to "routinized interactions between two or more actors that are vested with some symbolic significance" (Lawrence, 2004: 118). They contribute to establishing a status hierarchy among social groups. Individuals who

belong to high status social groups most often benefit from the prevailing institutional arrangements, which reinforce their dominance over individuals who belong to low status social groups. In other terms, they benefit from an incumbent position in the organizational field. For example, in multi-professionalized organizational fields, different professions have different status. Abbott (1988) has described how dominant professions establish jurisdictions surrounded by subordinate, less powerful professions. Similarly, Starr (1982) has shown that professionals may play highly conservative parts in order to defend their traditional privileges and autonomy. In the same vein, Ferlie, Fitzgerald, Wood and Hawkins (2005) have showed that the non-spread of certain medical innovations across the National Health Service in the United Kingdom is due to the existence of strong professional boundaries between doctors, who are the high status professionals, and other health professionals, who are low status professionals in comparison with doctors. In this case, some doctors use their power to maintain the status quo. In contrast to individuals who belong to high status social groups, individuals who belong to low status social groups are less favored by the prevailing institutional arrangements. They are in a challenger position. For this reason, they have more incentives to try and modify the prevailing institutional arrangements. Thus, I hypothesize the following:

H1b: Individuals who belong to low status social groups within a given organizational field are more likely to initiate divergent organizational change.

3.2.2. The impact of individuals' position in their organization

In the frame of this study, I focus on the impact that individuals' formal position in their organization has on the likelihood for them to initiate divergent organizational change, that is, to act as institutional entrepreneurs. Individuals who are low in the organizational hierarchy do not have enough legitimacy to initiate divergent organizational change. In addition, they may not be able to access the resources that are necessary for initiating divergent organizational change. In contrast, individuals who occupy higher hierarchical positions are more able to initiate divergent organizational change (Tushman and Romanelli, 1985). The stream of research on top management teams in the strategy literature has highlighted the key role of top managers in organizational change. Some studies (Hambrick and Mason, 1984; Finkelstein and Hambrick, 1996) have showed that top management succession and demography have an impact on organizational changes. When it comes to initiating divergent organizational change, the role of top managers is likely to be even more important. Examining the impact of executive migration

on institutional change among liberal arts colleges during the 1970's and 1980's, Kraatz and Moore (2002) have showed that executives were influential in bringing about divergent change in taken-for-granted practices in a highly institutionalized context. Executives' influence played a key role in the adoption of professional programs in liberal arts colleges. Such adoption was definitely a divergent organizational change insofar as it broke with the taken-for-granted model of liberal art colleges that were thought of "as small, private, independent, undergraduate, residential institutions in education in the humanities and social sciences" (Kraatz and Moore, 2002: 127).

Individuals who occupy higher hierarchical positions can rely on the authority associated with their position to impose divergent organizational changes, even though such changes break with the norms that all other organizations in the field use. Because of their position, individuals who are higher in the organizational hierarchy are also more likely to have access to key resources that may be useful for initiating divergent organizational change. In other terms, they are more likely to be able to initiate divergent organizational change. Thus, I hypothesize the following:

H2: The higher individuals are in organizational hierarchy, the more likely they are to initiate divergent organizational change.

3.2.3. Interaction between individuals' position in the organizational field and individuals' position in organizational hierarchy

While the arguments that I used to justify the impact of individuals' position in the organizational field (H1a and H1b) mainly have to do with individuals' willingness to initiate divergent organizational change, the arguments that I used to justify the impact of individuals' position in organizational hierarchy (H2) mainly have to do with individuals' ability to initiate divergent organizational changes. It is established that individuals' willingness and ability to act are not independent dimensions. As suggested by the expectancy theory (Vroom, 1964), individuals' motivation to engage in behaviors is partly determined by their subjective assessment of the probability of these behaviors to result in positive outcomes. When individuals know that they have the ability to do something, they are more likely to positively assess the probability for them to succeed. As a result, they more easily make the decision to undertake action. For this reason, when individuals are able to do something, they are likely to be even more willing to undertake action. Taking into account this relationship between individuals'

motivation to act and ability to do so, one can expect that the effect of individuals' position in the organizational field will be stronger for individuals who are higher in the hierarchy of their organization because being more able to initiate divergent organizational change, they are likely to be even more willing to do so.

Interaction between the status of the organization to which individuals belong and their position in organizational hierarchy. Even though individuals who belong to low status organizations are more likely to be willing to initiate divergent organizational change (see Hypothesis 1a), they do not necessarily have access to the resources that they need to initiate such changes in their organization. Finding resources may be all the more difficult as their organization is likely to have fewer resources than high status organizations. However, the higher they are in the hierarchy of their organization, the more able they are to initiate divergent organizational change (see Hypothesis 2). Because individuals who are higher in organizational hierarchy are more able to initiate divergent organizational change, they are likely to be even more willing to initiate such a change. For this reason, I hypothesize the following:

H3a: Individuals who belong to low status organizations and who are higher in the hierarchy of their organization are more likely to initiate divergent organizational change.

Interaction between the status of the social group(s) to which individuals belong and their position in organizational hierarchy. Even though individuals who belong to low status social groups are disadvantaged by the existing institutional arrangements, they are not necessarily low in the hierarchy of their organization. Some of them work their way up the organizational hierarchy. For example, in the National Health Service, some nurses and allied health professionals, who are low status professionals in comparison with doctors, occupy high hierarchical positions, such as that of executive directors[2]. Unlike individuals who belong to high status social groups, the prevailing institutional arrangements do not give much power in their organization to individuals who belong to low status social groups that are in a challenger position within the organizational field. Despite their willingness to initiate divergent organizational change, these individuals may lack resources to engage in divergent organizational change. This lack of resources may deter them from initiating divergent organizational change,

[2] Out of the 93 clinical managers in my sample, 25 are non-doctors who occupy high hierarchical positions in their organization. Out of these 25 clinical managers, 7 are executive directors.

insofar as individuals seldom make decisions without considering their access to resources (Stevenson and Greenberg, 2000). In addition, individuals who belong to high status social groups may use their power to block change, so that they must be engaged in the change process for it to succeed (Ferlie et al., 2005). Not having access to key resources and not controlling key decision processes in their organization, individuals who belong to low status social groups may not have the ability to initiate divergent organizational change despite their dissatisfaction with the existing arrangements. In contrast, when individuals who belong to low status social groups are higher in the hierarchy, they are more likely to be not only willing to initiate divergent organizational change (see hypothesis H1b) but also able to do so (see hypothesis H2). Knowing that they are able to initiate divergent organizational change, they are likely to be even more willing to do so. Thus, I hypothesize the following:

H3b: Individuals who belong to low status social groups and who are higher in organizational hierarchy are more likely to initiate divergent organizational change.

3.2.4. The impact of changes in individuals' social position

Individuals' social position in a given organizational field is not constant. It changes over time. There are various types of changes that may occur. Individuals may change position within the organizational field and/or within their organization. Changes in organizational field position correspond to changes in organizational membership and/or social groups' membership. Depending on the status of the new organization and/or social group(s) to which they belong, individuals will be more or less likely to initiate divergent organizational change (see hypotheses H1a and H1b). Changes in organizational position correspond to changes in individuals' hierarchical position. Depending on whether their new position is higher or lower in organizational hierarchy, individuals will be more or less likely to initiate divergent organizational change (see hypothesis H2). While the above cited propositions indirectly deal with the potential consequences of changes in position within the organizational field and the organization, one important dimension of such changes has not yet been considered. In order to account for changes in position, it is necessary to take into account individuals' level of inter-organizational mobility, that is, the number of different organizations in which they worked.

Individuals' inter-organizational mobility. The study conducted by Kraatz and Moore (2002) about the impact of executive migration on the adoption of professional programs in liberal arts colleges has contributed to highlighting the role of inter-organizational mobility in the

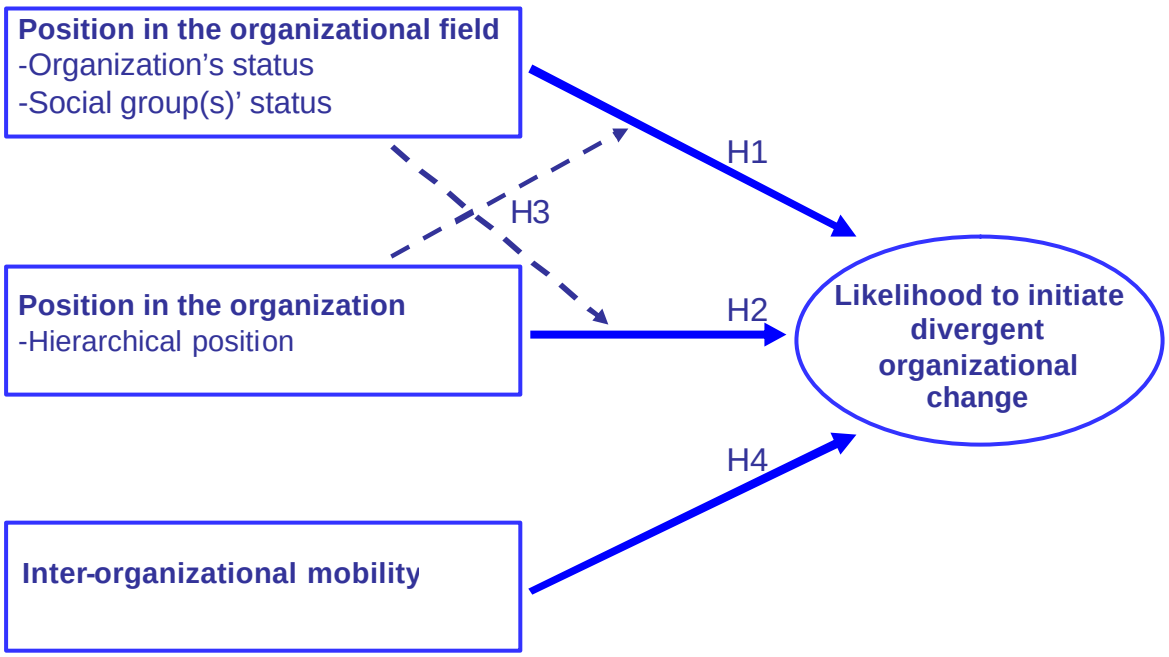
development and implementation of divergent organizational changes. Defining executive migration as the flow of top administrators between organizations and fields, they have shown that, as a result of their past experience, immigrant executives often imported new and very different conceptions from the taken-for-granted model of liberal arts colleges. Similarly, studying the importation of the practice of diversity management from the U.S. to Denmark, Boxenbaum and Battilana (2005) have found that inter-organizational mobility was an important enabling condition for institutional entrepreneurship at the individual level. The two individuals who initiated the importation of diversity management to Denmark, where it broke with the dominant model of human resources management, had previously worked in a number of different international organizations within which they were exposed to the practice of diversity management.

Individuals whose inter-organizational mobility has been higher have been exposed to more different organizational contexts. As a result, they are less likely to take-for-granted the functioning of their current organization. Meanwhile, they are more likely to be aware of the existing opportunities for action in their organizational field. For instance, they are more likely to be aware of the existence of heterogeneous institutional arrangements across their organizational field, if there are any. Such awareness is likely to trigger their reflective capacity (Emirbayer and Mische, 1998; Seo and Creed, 2002; Sewell, 1992). In other terms, they are less likely to see the prevailing institutional arrangements as taken-for-granted. As a result, they are more likely to initiate divergent organizational change. Thus, I hypothesize that:

H4: The higher individuals' inter-organizational mobility, the more likely they are to initiate divergent organizational change

Figure 3.1 summarizes the model that I have just presented.

Figure 3.1: The impact of individuals' social position in a given organizational field on individuals' likelihood to act as institutional entrepreneurs



CHAPTER 4
CHARACTERISTICS OF THE ORGANIZATIONAL FIELD OF THE NHS

To test the hypotheses that I presented in the previous chapter, I use data from change projects that were conducted by ninety-three clinical managers within the National Health Service (NHS) in the United Kingdom between 2002 and 2004. The primary objective of this chapter is to examine the characteristics of the organizational field of the NHS, which is the research setting of this dissertation. Such an analysis is prerequisite, insofar as the characteristics of the organizational field of the NHS may be more or less conducive to action, that is, they may or may not facilitate the development and the implementation of divergent organizational changes. To be able to test the hypotheses, it is therefore necessary to bring out the objective characteristics of the organizational field in which all the members of the sample are embedded. More precisely, I aim to evaluate the degree of heterogeneity and the degree of institutionalization of the organizational field of the NHS. It will enable me to evaluate the extent to which the organizational field of the NHS offers opportunities for action.

In order to do so, it is necessary to understand the nature and the extent of changes that have taken place in the organizational field of the NHS over the last 60 years. To assess the degree of heterogeneity of the organizational field of the NHS, I concentrate on the analysis of institutional logics. I identify the different institutional logics that have characterized the NHS over the last 60 years and I see whether or not they still co-exist in the NHS. Some studies have shown that different institutional logics sometimes co-exist in the same organizational field (e.g., D'Aunno, Sutton and Price, 1991; Kitchener, 2002; Thornton, 2002; Reay and Hinings, 2005). The existence of multiple institutional logics in the same organizational field increases the level of heterogeneity of this organizational field. To assess the degree of institutionalization of the organizational field of the NHS, I analyze the stability through time of the institutions that constitute the core of the NHS.

The remainder of this chapter proceeds as follows. I first present the organizational field of the NHS and its main actors. Then, I present the methodology that I used in order to examine the changes that have taken place in the NHS over the last 60 years and to analyze the different institutional logics. Next, I present the results of my analysis. Finally, I summarize the key

characteristics of the organizational field of the NHS and I explain why it is an appropriate setting for testing the model that I presented in the previous chapter.

4.1. Presentation of the organizational field of the NHS

The NHS came into operation in 1948 under the Labour government of Clement Attlee following the provisions of the NHS Act of 1946. This Act established the post-Second World War pattern of health service finance and provision in the United Kingdom. It introduced the principle of collective responsibility by the state for a comprehensive health service, which was to be available to the entire population free at the point of use (European Observatory on Health Care Systems, 1999). All UK residents are covered by the NHS system, which is primarily funded from general taxation, with a residual element from national insurance contributions. In 2000, private health insurance covered less than 10% of the population and accounted for less than 4% of the total health expenditure in the UK (The OECD Health Project, 2004). Today the NHS has a budget of around £42 billion year (NHS website).

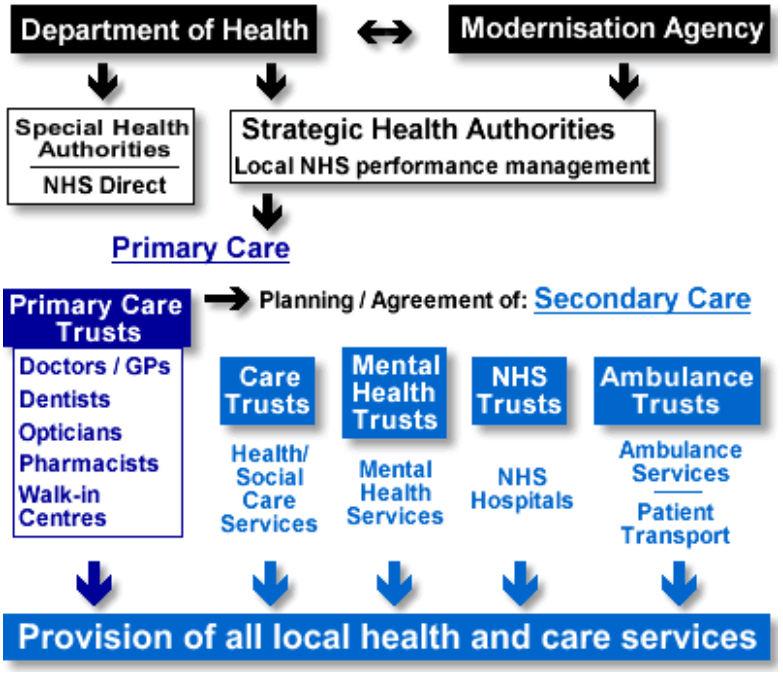
Following DiMaggio and Powell's (1983) definition, the British healthcare sector can be regarded as an organizational field that consists of suppliers working within the NHS (health professionals, community hospitals, acute hospitals and other facilities), resource and product consumers (patients), regulatory agencies (government and professional associations) and other organizations that produce similar services or products (private healthcare service providers). Private healthcare service providers, though, have so far played a marginal role in the UK. For this reason, I concentrate mainly on the role played by the other actors of the organizational field. I focus attention on NHS organizations and professionals, but I also take into account patients and governing bodies, such as government regulators and professional associations. I argue that one can talk about the organizational field of the NHS, insofar as these different actors, i.e., NHS organizations and professionals, patients and governing bodies are involved in the common purpose of commissioning and providing health care services in the UK and interact with each other frequently and fatefully (Scott, 1994).

4.1.1. The current organization of the NHS

The organizational field of the NHS comprises a multitude of organizations that are subject to common regulatory processes that are developed by public authorities and professional associations. One can distinguish three categories of NHS organizations: administrative

organizations, primary care service providers and secondary care service providers. The diagram below (see figure 4.1) shows the structure of the NHS in England. It is slightly different in Scotland, Northern Ireland and Wales. Though, the different types of organizations providing health care services are the same all over the UK.

Figure 4.1: Current organization of the NHS (Source: NHS website 2004: http://www.nhs.uk/england/aboutTheNHS/default.cmsx)



The Department of Health (DoH) under the direction of the Secretary of State for Health is responsible for health and social services in England. It has overall responsibility for the NHS. It is responsible for: (1) setting overall direction and leading transformation of the NHS and social care, (2) setting national standards to improve quality of services, (3) securing resources and making investment decisions to ensure that the NHS and social care are able to deliver services, and (4) working with key administrative partners to ensure quality of services, such as the Modernization Agency and Strategic Health Authorities (SHAs).

The Modernization Agency was established in April 2001 to support NHS clinicians and managers in their efforts to deliver improvements to their services. The best performing organizations are rewarded with more power to make decisions at a local level. The Agency also

supports NHS organizations where services are poor or failing - identifying problems and helping to get these organizations back on track.

SHAs are the local headquarters of the NHS. At the local level, the NHS is run by authorities and trusts. England is split into 28 SHAs, which manage the NHS locally and are a key link between the DoH and the NHS. SHAs were set up in 2002 to develop plans for improving health services in their local area and to make sure that their local NHS organizations were performing well and that the national priorities were integrated into local health service plans. Within each SHA, the NHS is split into various types of Trusts that take responsibility for running the different NHS services in a given local area.

The different types of Trusts provide two main types of services: primary care services and secondary care services. Primary care services correspond to the services that are provided to patients when they first have a health problem. They may correspond to a visit to a doctor or dentist, an optician for an eye test, or just a trip to a pharmacist to have a prescription filled. NHS Walk-in Centers, which give patients fast access to health advice and treatment seven days a week, and NHS Direct, which is a 24-hour line, staffed by nurses, offering quick access to health care advice, are also part of primary care. All the NHS professionals offering primary care services are managed by local health organizations called Primary Care Trusts (PCTs). PCTs are local health organizations responsible for managing health services in a given local area. They work with local authorities and other agencies that provide health and social care locally to make sure the community's needs are being met. PCTs are recent organizations. They were created in 1998. They are responsible for planning secondary care. They look at the health needs of the local community and develop plans to improve health and set priorities locally. They then decide which secondary care services to commission to meet people's needs. Therefore they work closely with the providers of secondary care services that they commission. PCTs have gradually become the budget holders. Despite their central role in the NHS, PCTs are still considered to be lower status organizations than hospitals and administrative organizations. Because they are newer organizations, they are not regarded as being as legitimate as hospitals and administrative organizations that have played a key role in the NHS for decades. In addition, the NHS healthcare system is still an acute episodic healthcare system that places hospitals at the center of healthcare provision. Health professionals working in the primary care sector are often presented as gatekeepers to the secondary care sector, as if their only function was to regulate access to secondary care services. On the other hand, because the NHS is state funded, PCTs –even if they

are the new budget holders– are always dependent on administrative organizations for budget allocation.

If a health problem cannot be sorted out through primary care, or if there is an emergency, it requires secondary care. NHS hospitals normally provide acute and specialist services, treating conditions which normally cannot be dealt with by primary care specialists. Hospitals are managed by NHS Trusts (also known as Acute Trusts), which make sure that hospitals provide high quality health care, and that they spend their money efficiently. They also decide on a strategy for how the hospital will develop, so that services improve. Some Trusts are regional or national centers for more specialized care. Others are attached to universities and help to train health professionals. Trusts can also provide services in the community, for example through health centers, clinics or in people's homes. In addition to NHS trusts, three other types of Trusts provide secondary care services: Mental Health Trusts, Ambulance Trusts and Care Trusts. Mental Health Trusts provide specialist mental care services, ranging from psychological therapy, through to very specialist medical and training services for people with severe mental health problems. The 33 Ambulance Trusts covering England provide emergency access to health care. The NHS is also responsible for providing transport to get patients to hospital for treatment. In many areas it is the Ambulance Trust which provides this service. Finally, Care Trusts are organizations that work in both health and social care. They may carry out a range of services, including social care, mental health services or primary care services. Care Trusts are set up when the NHS and Local Authorities agree to work closely together, usually where it is felt that a closer relationship between health and social care is needed or would benefit local care services. At the moment there are only a small number of Care Trusts, though more should be set up in the future.

4.1.2. The NHS, a multi-professionalized setting

The NHS is the largest employer in Europe with a workforce of over one million people (NHS website, November, 2004). A variety of professionals deliver services in the NHS. They can be classified into seven main professional categories: doctors (be they consultants or general

practitioners (GPs)), nurses, allied health professionals[3] (AHPs), pharmacists, health assistants, managers and support staff (e.g., porter, cleaners). On a typical day in the NHS in 2000, there were approximately 90,000 doctors, 300,000 nurses, 150,000 health assistants, 22,000 midwives, 13,500 radiographers, 15,000 occupational therapists, 7,500 opticians, 10,000 health visitors, 6,500 paramedics, 90,000 porters, cleaners and other support staff, 11,000 pharmacists, 19,000 physiotherapists, 24,000 managers and 105,000 practice staff in GP surgeries (Secretary of State for Health, The NHS Plan, July 2000).

General practitioners (GPs), who run general practices, provide primary care services. Every UK citizen must be registered with a GP in order to avail of the NHS services. Visits to the surgery are free. Over 99% of the population is registered with GPs (European Observatory on Health Care Systems, 1999). GPs look after the health of people in their local community and deal with a whole range of health problems. They also give health education and advice on things like smoking and diet, run clinics, give patients vaccinations and carry out simple surgical operations. If a GP cannot deal with a patient's problem himself/herself, he/she usually refers this patient to a hospital for tests, treatment or to see a consultant with specialized knowledge. Except in the case of emergencies, hospital treatments are thus arranged through GPs' referrals. GPs act as gatekeepers in the NHS healthcare system. Most of them are technically self-employed but they are paid directly by the government through a combination of methods: capitation, fee for service and allowance. GPs usually work with a team including nurses, health visitors and midwives, as well as a range of other health professionals such as physiotherapists and occupational therapists. All the professionals involved in the delivery of primary care services are now gathered in Primary Care Trusts (PCTs). Today primary care is a major employer with, in England, Scotland and Wales, over 100,000 people now working in general practice (Peckham and Exworthy, 2003: 4).

Secondary care is provided mainly through NHS Trusts. Trusts employ most of the NHS workforce, including nurses, doctors (consultants), dentists, pharmacists, midwives and health visitors as well as people doing jobs related to medicine - physiotherapists, radiographers,

[3] Note that Allied Health professions include the following: Art Therapist, Chiropodist/Podiatrist, Dietitian, Drama Therapist, Music Therapist, Occupational Therapist, Orthoptist, Paramedic, Prosthetist & Orthotist, Physiotherapist, Diagnostic Radiographer, Speech & Language Therapist, Therapeutic Radiographer.

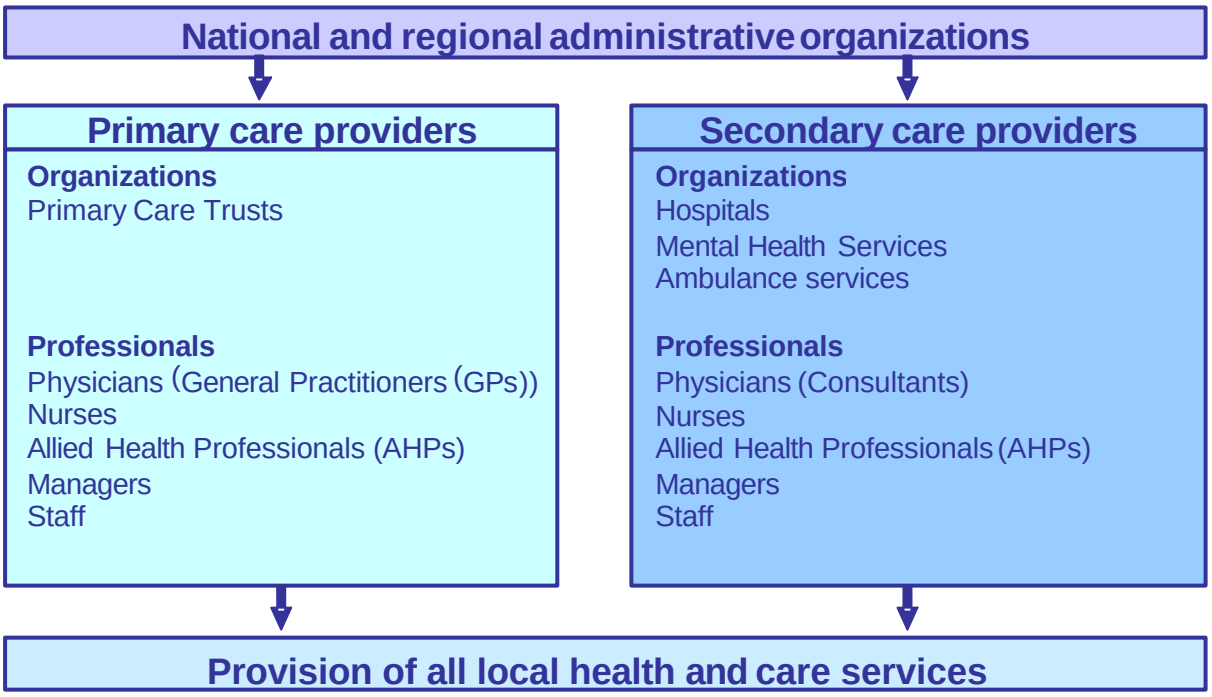
podiatrists, speech and language therapists, counsellors, occupational therapists and psychologists. There are many other non-medical staff including receptionists, porters, cleaners, IT specialists, managers, engineers, caterers and domestic and security staff. Most of the staff members working in secondary care are salaried, including specialist physicians (consultants). Though, consultants are allowed to supplement their earnings by treating private patients.

As observed by Ferlie et al. (2005), in the NHS, there are strong boundaries between the different professional groups, which have been educated and socialized in different ways. There is first a main distinction between health professionals and non medical professionals. Then, within each of these two categories, there also exist strong boundaries between professional groups, especially between the different health professional groups. The different health professions are represented by different bodies. Doctors are represented by the British Medical Association (BMA) which is both the doctors' professional organization and an independent trade union protecting the professional and personal interests of its members. There are several trade unions that represent other health care workers. The regulation of professional standards expected of clinical professionals has traditionally been performed through a system of professional self-regulation. As Ferlie et al. (2005) explain: "self regulatory and uni disciplinary machinery (the Royal Colleges; expert advisory groups) controls entry into and exit from the professional groups, sets and examines training programmes, validates research, and enforces professional standards." Thus, the General Medical Council regulates the education, training and professional standards of doctors, while the UK Central Council for Nursing, Midwifery and Health Visitors performs a similar function for its members. For Allied Health Professional (e.g., occupational therapists, physiotherapists, radiographers, and speech and langage therapists), the Council for Professions Supplementary to Medecine is responsible for registering practitioners.

Analyzing the (non) spread of evidence based practice in the NHS, Ferlie et al. (2005) suggest that membership of a profession creates underpinning social and cognitive boundaries in relation to other professions that may hinder spread. Confirming Abbott (1988), they find that established professional roles and 'jurisdictions' render role redefinitions difficult in the NHS. On the whole, it appears that the NHS is a multi-professionalized setting characterized by the existence of strong social and cognitive boundaries between the different professional groups that work within it.

The figure below presents the key organizational and professional actors of the organizational field of the NHS.

Figure 4.2: Key organizational and professional actors of the NHS



4.2. Methodology

4.2.1. Data collection methods

As Greenwood and Hinings (1996: 1046) suggest, analyzing the evolution of a given organizational field and of the institutional logics that characterize it requires "immersion" within it. I obtained data about the evolution of the NHS over the last 60 years through multiple sources and methods. I first gathered archival data about the NHS using the NHS website. It enabled me to access all the key official documents and Acts that have guided the organization of the NHS over the last 60 years. I also relied on OECD data and publications about healthcare in order to collect comparative data about the NHS and other western healthcare systems.

In addition, I conducted a literature review about the NHS. I read the key books that have been written about the NHS over the last 15 years (e.g., Harrison et al., 1992; Pettigrew et al., 1992; Giaimo, 2002). I also searched for all the papers that have been published about the NHS over the last 15 years in a selection of general management journals (*Academy of Management Journal*, *Administrative Science Quarterly*, *Organization Studies*, *Organization Science* and the

British Journal of Management) and healthcare management journals (*Health Affairs*, *Journal of Health Economics*, and the *Journal of Health Politics, Policy and Law*).

Last but not least, I conducted 46 semi-structured interviews, between 2003 and 2004, with different NHS professionals in the framework of four in-depth case studies on four change projects that I selected among the ninety-three change projects that the clinical managers in my sample initiated. I interviewed nurses, nursing directors, allied health professionals, GPs, consultants, CEOs of Trusts and PCTs, and managers. Some of the health professionals who I interviewed occupied positions of clinical managers, others occupied purely clinical positions. These interviews lasted between 45 minutes and 2 hours. They were all taped and transcribed. I used different interview guides for interviewing these people. However, the different interview guides all comprised one section about the interviewee's trajectory in the NHS and one section about the interviewee's perception of the NHS (see Appendix 2). The latter section comprised questions about the interviewee's perception of the different reforms that have been conducted in the NHS over the last 15 years. I asked them what they thought of these different reforms and to what extent they had an impact on their way of working on the one hand, and on the organization of the NHS, on the other hand. I met with the interviewees in their organization, which enabled me to visit different hospitals, PCTs and general practices and to discuss with patients. I used these in-depth interviews to supplement research by sociologists, historians, economists and analysts of the NHS. They enabled me to gain an in-depth knowledge of the NHS. More importantly, they enabled me to identify the different logics that underlie NHS professionals' perception of their tasks and of the tasks of the NHS. After identifying the dominant institutional logic and two other emerging logics that have co-existed in the NHS over the last decades, I conducted five additional interviews in order to cross-validate my analysis of the organizational field of the NHS with NHS professionals on the one hand, and with academics who are specialists of the NHS, on the other hand.

4.2.2. Analyzing institutional change in the NHS

My interest is in understanding the nature and the extent of changes that have taken place in the organizational field of the NHS over the last 60 years and to highlight the current characteristics of this organizational field. Since its creation, the NHS has undergone many changes. The management of the NHS has been a key public and political issue for almost 60 years in the UK. The reform of the NHS has always stood in a high priority position on the public

agenda. As a result, there have been many changes affecting both the organization of the NHS and the way in which services have been delivered by the NHS.

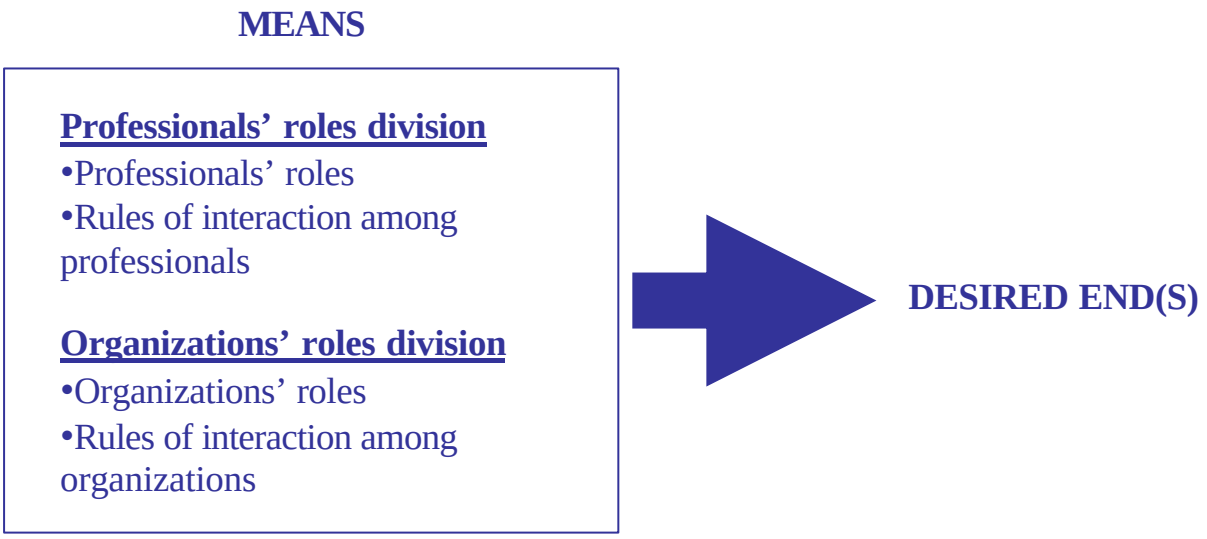
To examine changes in institutional environments, Scott, Ruef, Mendel and Caronna (2000) propose to distinguish between three components: governance systems, institutional actors and institutional logics. I have already presented the key actors of the NHS, i.e., the different categories of NHS organizations and NHS professionals. I now concentrate on the analysis of governance systems and institutional logics. My objective is to show how the different actors were affected by the changes in both governance systems and institutional logics and to see how they participated in those changes. Governance systems are those "arrangements which support regularized control - whether by regimes created by mutual agreement, by legitimate hierarchical authority or by non-legitimate coercive means - of the actions of one set of actors by another" (Scott, 2004: 271). In other terms, governance structures refer to all those arrangements by which field-level power and authority are exercised, variously, formal and informal systems, public and private auspices, and regulative and normative mechanisms (Scott et al., 2000).

Institutional logics are taken-for-granted social prescriptions guiding behavior of actors in a given organizational field. Different characterizations of institutional logics have been proposed. Scott (2001: 139) proposes that they "refer to the belief systems and related practices that predominate in an organizational field" (Scott, 2001: 139). In other terms, institutional logics are collective means-ends designations that represent shared understandings in a field of what goals to pursue and how to pursue them (Scott, 1987, 1994). Collective means-ends designations are the "mundane, taken-for-granted relationships between means and ends that have the tone, 'this is how the world works' " (Dobbin, 1994:13). Overall, institutional logics have two main properties that are very similar to the ones of rationalized myths as Meyer and Rowan (1977) define them. First, they are rationalized and impersonal prescriptions that identify desired ends and specify in a rule-like way the appropriate means to pursue these ends. In other words, they specify who should do what and how in order to achieve the desired ends. Second, they are highly institutionalized and thus widely shared-across at the organizational field level. Therefore, they are taken-for-granted as legitimate at the organizational field level, apart from evaluations of their impact on work outcomes. It is important to make a distinction between institutional logics that are widely shared-across and taken-for-granted at the organizational field level and other logics that correspond to means-ends designations too but that are not widely shared-across and taken-for-granted. These other logics may be emerging logics. Though most fields may contain

multiple logics (Friedland and Alford, 1991; D'Aunno, Sutton and Price, 1991; Thornton and Ocasio, 1999; Schneiberg, 2002; Seo and Creed, 2002), one institutional logic that is widely shared-across and taken-for-granted often tends to hold a dominant position in a field (Dobbin, 1994; Schneiberg, 2002; Reay and Hinings, 2005).

In order to characterize logics, it is necessary to identify the desired end(s) that they bring out and the appropriate means that they specify. Means specify the role identities of the organizational field members (Rao et al., 2003). In other terms, they specify actors' roles division in the organizational field, that is, who should be involved in the organizational field, what they should be doing and how they should interact with each other. One can distinguish two different types of means in multi-professionalized organizational fields, like the NHS. First, logics specify professionals' roles division. Second, they specify organizations' roles division. I propose to use these two dimensions in order to characterize logics (see figure 4.3). Following the same methodology as Thornton (2002), I rely on the information that I collected about the NHS in order to identify the ideal-type (Weber, 1904) of the three different logics that have existed in the NHS over the last 60 years. Ideal types provide an abstract model of complex phenomena that can subsequently be used for theory building purposes (Weber, 1904). The ideal-types that I present in this chapter bring out the means and the desired end(s) that characterize the three different logics that have co-existed in the NHS over the last 60 years. While one of these logics corresponds to an institutional logic that is highly institutionalized across the organizational field of the NHS, the two other logics are emerging ones that are not yet widely shared across the organizational field.

Figure 4.3: Characterization of logics



4.3. Analysis of institutional change in the NHS

I first examine the evolution of the governance system of the NHS over the last 60 years. Relying on this analysis, I identify three distinctive eras, corresponding to the three different systems of governance that have characterized the NHS. Then, following the methodology developed by Scott et al. (2000), I use these eras as the organizing framework for discussing the interplay of governance structures and institutional logics in the NHS over the last 60 years.

4.3.1. Identification of governance systems and associated eras in the evolution of the NHS

Each organizational field is characterized by a somewhat distinctive governance system, composed of a combination of public and private actors employing both regulatory and normative controls over the activities conducted within the field (Scott et al., 2000). In the NHS, the government has always played a central role in the system of governance.

The fact that the NHS is funded out of general taxation means that the Secretary of State for Health is accountable to Parliament for everything that happens in the service. As the creator of the NHS, Aneurin Bevan, put it, "When a bedpan is dropped on a hospital floor, its noise should resound in the Palace of Westminster" (quoted in Nairne, 1983). For this reason, everything that happens in the NHS is likely to be politicized (Klein, 1998). Central government

budget-setting arrangements determine the size of NHS funding, the annual rate of increase, and allocations between major service areas and regions.

As Le Grand (1999; 2002) shows, central control by the government has been maintained since the creation of the NHS, despite some attempts at changing this system. Apart from the government, two other sets of principal players have participated in governance, doctors and managers (be they clinical or non-clinical managers). Doctors have constructed normative frameworks that have provided much of the foundations for the stable conduct of practice in the NHS. They have also actively participated in the development of most healthcare policies. At the time of its creation, the NHS was based on an implicit concordat between the state and the medical profession (Day and Klein, 1992). The former set the budgets within which doctors operated. The latter, however, had complete autonomy to decide whom to treat, and how, within the limits of those budgets. The governance arrangements underpinning the NHS since its establishment combined state hierarchy and corporatism (Giaimo, 2002). It was the *era of combined state hierarchy and medical dominance*.

Starting in the mid-1980's a third set of players, i.e., managers, started participating in the governance of NHS. The set of reforms implemented by the Conservative government of Margaret Thatcher, starting in the mid-1980's with the Griffiths' report (Griffiths, 1983) and continuing with the implementation of the quasi-market reforms in the early 1990s, marked the beginning of a new governance era, the era of *combined state hierarchy and market mechanisms*. More recently, the election of the Labour government of Tony Blair in 1997 opened a third era of governance, the *era of combined state hierarchy and managerial control*.

For each of these three eras, I first describe more precisely the characteristics of the governance system. Then, I highlight the characteristics of the logic(s) that is (are) associated with the system of governance.

4.3.2. The era of combined state hierarchy and professional dominance (1948-early 1980's)

Governance system: Combined state hierarchy and professional dominance. Before the establishment of the NHS, doctors played a key role in the British healthcare sector not only in the delivery of medical services but also in the development of health policy and in the administration of the NHS. The power of the British Medical Association (BMA) had increased since 1911. At that time, in order to induce general practitioners (GPs) to participate in the national health insurance for manual workers, the government of David Lloyd George acceded to

the BMA's demand that GPs have a formal role in health-policy making and administration (Giaimo, 2002). In addition, the medical profession won exclusive jurisdiction over both clinical practice and economic remuneration through the creation of local medical committees, which were composed entirely of the medical profession and dominated by the BMA (Little, 1932). Doctors also reinforced their professional autonomy by securing the principle and practice of free choice of physician (Day and Klein, 1992). Finally, the BMA was recognized by the government as the official representative of the medical profession with the right to negotiate policy matters affecting physicians with representatives of the government. Therefore, the medical profession played a central role both in the functioning and in the administration of the healthcare sector.

The establishment of the NHS was a major change. Under the NHS, the central state played a key role in the governance of the healthcare system. It was responsible for guaranteeing universal free healthcare, financing it through general taxation, and determining the total amount of healthcare spending. The government nationalized hospitals, placed hospital doctors under salaried employment, and created a hierarchical administrative structure to run the NHS (Giaimo, 2002). At the apex there was the Ministry of Health headed by the Minister of Health. The rest of the administrative structure initially comprised Regional Hospital Boards, Hospital Management Committees, Boards of Governors (of teaching hospitals), Executive Councils (holding the contracts of GPs and other family practitioners) and Local Health Committees (Harrison et al., 1992). After the reforms of 1973 and 1982, these administrative bodies were transformed into Regional Health Authorities (RHAs) that were responsible for regional planning, special services and oversight of District Health Authorities (DHAs). DHAs provided hospital care and engaged in health planning for the local population, and local general practitioner services, which fell under the separate purview of Family Practitioner Committees. However, the introduction of this hierarchical command and control system headed by the state did not displace the corporatist arrangements that existed in the British healthcare sector prior to the establishment of the NHS. Rather, the NHS accommodated both forms of governance (Giaimo, 2002: 33-35).

At the time of the NHS creation, the medical profession was initially opposed to some of the proposed features of the established NHS. The Royal Colleges – the professional bodies that represent different medical specialties led by consultants (senior specialists) – and GPs were strongly opposed to any loss of autonomy (European Observatory on Health Care Systems, 1999). Aneurin Bevan had to negotiate with the medical profession to obtain its support for the establishment of a government-run NHS. In order to do so, the government made a number of

concessions to demands for professional autonomy. As a result, GPs were allowed to operate as independent contractors within the NHS, while consultants, although salaried employees of the NHS, were allowed to retain a large degree of control over their conditions of employment. They were also permitted to retain the right to private practice alongside their NHS work. Thus, consultants were allowed to supplement their salaried employment with private practice and private beds in NHS hospitals. An award system of bonus payments was also introduced for consultants. The recipients were to be determined by the medical profession alone (Giaimo, 2002).

The medical profession did not only secure professional autonomy. It also managed to participate actively in the governance system of the NHS. An administrative structure composed entirely of representatives of the medical profession existed alongside the various health authorities and advised them. The administrative reforms of 1974 strengthened the role of the medical profession in the governance system by bringing doctors directly into the NHS bureaucracy. The reorganization created management teams at local, district and regional levels, consisting of a doctor, a nurse and lay managers (Garpenby, 1989), and introduced consensus management, which gave doctors a veto over administrative decisions. In addition, under the NHS, the different governments continued to accord the BMA a privileged position in formulating health policy. The Health Ministry and the BMA were enmeshed in a web of formal and informal contacts, which range from representation on royal commissions to talks with the Secretary of State for Health and the Prime Minister. These arrangements gave doctors direct access to government with the opportunity both to shape official thinking about policy in general and to veto unwelcome developments.

On the whole, it appears that the creation of the NHS ushered in a hybrid arrangement of statist and corporatist governance (Giaimo, 2002). Under an implicit concordat, the government did not question clinical decisions, as long as doctors did not challenge the state's authority to set the global budget for the NHS and rationed resources on its behalf (Day and Klein, 1992).

Associated logic: Medical professionalism. During the era of combined state hierarchy and professional dominance, the dominant institutional logic was medical professionalism. According to this logic, the desired end to pursue was to reduce morbidity and mortality. To reach this end, this logic proposed to rely on two key categories of actors. First, doctors who were the key decision makers both in the clinical and the administrative domains were supposed to

insure the good functioning of the NHS. Second, hospitals that were at the heart of the organizational system were supposed to insure the good functioning of the NHS.

A number of studies have shown how, despite the existence of central policies and priorities, the strategic shape of the NHS was dominated by the medical profession (for a review see Harrison et al., 1992: 30-33). Doctors were the key decision makers in the field, controlling both the organization of the NHS in collaboration with the different governments and the delivery of services. Doctors were powerful both collectively at the national level and individually at a local level (Harrison et al., 1992). Their national associations, i.e., the BMA and the Royal Colleges were well organized and well-resourced. As explained in the previous section, they long ago secured the right to be consulted about all manner of proposed government changes to the NHS (Haywood and Hunter, 1982). As a result, the medical profession played a key role in the administration of the NHS and in the development of healthcare policies between 1948 and 1983.

Doctors were also powerful individually at a local level. Their power had at least three different sources. It has been established that the sources of medical professions' authority and autonomy stem from the social legitimacy of their mission and their exclusive ability to apply expert and esoteric knowledge to particular cases (Friedson, 1986; Abbott, 1988: 99-100). The first source of medical power had to do with doctors' mission. The public supported the medical profession. As a result, doctors acted as patients advocates. The relationship between doctors and patients was the central one in the healthcare system.

The second source of medical power was doctors' expertise. They had expert knowledge upon which members of the public were dependent and which neither NHS administrators, who were responsible for management, nor allied health professionals nor nurses could supply directly. As a result, they enjoyed high social status and respect. The members of the general public were not the only ones to be deferential towards doctors. Most groups of health professionals were similarly deferential. For example, much of the development of the nursing profession had been shaped and conditioned by doctors, and appropriate deference was for long a quite explicit part of nurse socialization (Harrison et al., 1992). In addition to these first two sources of power, formal organizational arrangements had been so designed to leave both consultants and general practitioners free from day to day management.

In hospitals, consultants were the ones controlling the admission and the discharge of patients, the diagnosis of those patients' conditions and the choice of appropriate therapy and care (Harrison et al., 1992). Each of these decisions could have major resource implications for the

health service and consequences for the work of other staff, including allied health professionals, nurses and administrators. Yet because of their power, doctors' decisions were rarely challenged or contradicted by an administrator or by any other occupational group within the NHS. The hospital patient was the patient of a named consultant, not of an administrator, or a nurse, or an allied health professional. Among other health professionals, doctors benefited from a higher status position. As a result, other health professionals did not challenge their decisions. Nurses' work was dependent on direction from doctors. They were expected to act as doctors' assistants. As for allied health professionals, when the NHS was created, they were known as medical auxiliaries. The medical profession had a great deal of influence on the direction, prescription, training and supervision of medical auxiliaries (Jones, 1991). Medical auxiliaries carried out doctors' instruction much in the same way as a pharmacist would dispense a prescription. Most often, they were regarded as technicians to be organized, managed and clinically supervised by doctors. They had little managerial responsibility for even day-to-day running of the departments in which they worked (Jones, 1991).

Similarly, administrators refrained from questioning doctors' treatment decisions and the ways in which they structured their work (Giaimo, 2002). NHS administrators acted as "diplomats" who smoothed internal conflicts in hospital, facilitated the work of doctors and did not question their clinical decisions (Harrison, 1988). Their main tasks were problem-solving, organization maintenance and the facilitation of processes (Harrison et al., 1992). Their role was all the more limited as they most of the time had no power over other clinical professions either, insofar as members of other clinical professions were managed only by other members of their own profession.

On the whole, it appears that consultants were free of any type of control. They benefited from the 'doctrine of clinical freedom', that is, the notion that a fully-qualified doctor cannot be directed in his/her clinical work (Harrison et al., 1992: 24). Except for the most egregious transgressions, medical organizations undertook no peer review of their members' clinical decisions (Harrison, 1988; Pollitt, 1993).

If doctors were the key decision makers in the domain of medical practice, they also played a key role in the administration of hospitals. In hospitals, no one officer was in overall charge of administration, and as the 1960's and 1970's progressed, more and more occupations developed their own exclusive management structures (Harrison, 1988). Hospitals were administered by groups of managers from a mix of professional background. The organizational

reforms of 1974 led to the creation of multidisciplinary management teams of chief officers, taking decisions only by consensus, that is, where no member disagreed. Hospitals were run at the local level by consensus teams consisting of doctors, nurses, finance officers and administrators. The team members had the formal right of veto. Such a system allowed health professions, and especially doctors who were the most powerful, a veto on change within hospitals (Peckham and Exworthy, 2003). By doing so, it further weakened administrators' leverage over doctors, since doctors now had a veto over administrative decisions, while retaining their clinical independence. As a result, administrators played a relatively passive role in initiating and implementing change. However, some studies (e.g., Stewart et al., 1980; Schulz and Harrison, 1983) have shown that, once doctors are disregarded, administrators were the most influential actors in hospitals, despite the formal equality of nurses, who were part of the consensus teams running hospitals. On the whole, through their treatment decisions in hospitals and their involvement in various advisory committees and NHS administrative bodies, consultant constituted the dominant voice in decisions about resource use at local levels (Ham, 1988).

In primary care, GPs dominated the management of practice. Administrators met the needs of GPs rather than instigating changes themselves (Peckham and Exworthy, 2003). Though, the power of GPs was not as strong as the power of consultants. Once they had sent a patient to hospital, consultants were the key decision makers. This status hierarchy between consultants and GPs reflects the status hierarchy that existed between hospitals and primary care organizations. The NHS system was an acute episodic healthcare system. Primary care organizations played the role of gatekeepers to the secondary care sector. Secondary care organizations –in particular acute hospitals– were at the heart of the NHS system. They received the biggest part of the NHS budget that was allocated to them by administrative organizations. Hospitals were both providers and commissioners of services, which gave them the freedom to choose which services to deliver and how to deliver them without being monitored. Hospitals most often benefited from a monopoly position for the provision of secondary care services in their health community. In contrast, they were many general practices in a given health community competing for the provision of primary care services. While hospitals were huge organizations, general practices were small ones.

Therefore, it appears that, between 1948 and the early 1980's, the logic of medical professionalism held institutional dominance, and the organizational field of the NHS was

relatively stable (till 1983). Table 4.1 presents the key characteristics of the logic of medical professionalism.

Table 4.1: Ideal-type of the logic of medical professionalism

	Medical Professionalism Logic
END	**Reduce morbidity and mortality**
MEANS	
Professionals' roles division	
Professionals' roles	**Physicians** as **key decision makers** in the clinical and administrative domains **Nurses** as **physicians' assistants** **Allied health professionals** as **medical auxiliaries** **Managers** (administrators) as **'diplomats'** facilitating the work of physicians
Rules of interaction among professionals	**Physicians hold authority** over all other NHS professionals in the clinical and in the administrative domains
Organizations' roles division	
Organization's roles	**Hospitals** as **both commissioners and providers** of secondary care services **Administrative bodies** responsible for **planning and budget allocation** **General practices** as **gatekeepers** to the secondary care sector
Rules of interaction among organizations	**Hospitals hold authority** over all other NHS organizations

Precursors of change. The system of governance which combined state hierarchy and medical dominance was characterized by a number of weaknesses. For corporatism to be an effective form of governance, the leadership of an interest group must be able to control the behavior of its members and deliver their compliance with the government. The problem was that the BMA was not always able to do so, for several reasons (Giaimo, 2002: 35-38). First, although it had been recognized as the trade union for the medical profession since 1911 (Day and Klein,

1992), the BMA was not the exclusive representative of the medical profession. The Royal Colleges that corresponded to another sort of representative bodies were allies but also rivals of the BMA. Second, the internal structure of the BMA replicated the separation between hospital and office-based doctors, which often made it difficult for the BMA to come up with a policy line that was common to all doctors. Last but not least, the BMA leadership lacked effective sanctions over its own members, which weakened its ability to enter into and keep agreements made with the state.

Another weakness of the governance system had to do with the fact that the Secretary of State for Health often lacked line management control over the NHS (Harrison et al., 1992). Government priorities for healthcare often had to be written in rather vague or general terms, and proved difficult to enforce (Haywood and Alaszewski, 1980). One major problem was the lack of information on what lower levels of the NHS were doing with the money allocated by the government. The Department of Health, for instance, did not know what medical procedures cost and had little information on how hospitals spent their budgets. In addition, there was no central system to evaluate the performance of individual managers. As for managers, they lacked measurement indicators to monitor the actions of physicians in their hospitals (Griffiths, 1983; Klein, 1989; Pollitt, 1993). Therefore, global budgeting proved highly effective in containing healthcare expenditures while relieving the center of the tasks of detailed micromanagement, but it was "a blunt instrument unable to guarantee efficient practices at the level of the individual doctor or manager" (Giaimo, 2002: 40). Even, if the hierarchical administration did not provide governments with the means to control the NHS performance, they were held responsible for NHS performance failures, insofar as the central state played a prominent role in NHS administration.

4.3.3. The era of combined state hierarchy and market mechanisms (early 1980's-1997)

Governance system. The election of Margaret Thatcher in 1979 was a turning point in the history of the NHS. Her government saw public expenditure and state involvement as the source of Britain's economic difficulties and embarked upon a major program of privatization (European Observatory on Health Care Systems, 1999). The 1980s were a decade of financial austerity for the NHS. Continuing on a trend set in the late 1970s, following a series of economic crises, the Conservatives kept health care spending on a tight rein (Day and Klein, 1991). Meanwhile,

advancing technologies, an aging population, and increased patients expectations focused attention on resource shortages.

The government's belief in the superior efficiency of private sector practice led to major changes in the NHS structure and functioning. An inquiry into the management of the NHS was set up in 1983 under the chairmanship of Sir Roy Griffiths, who was a managing director of the food retail chain Sainsbury's. His report was highly critical of consensus management because of the dearth of personal accountability and its tendency to lead to "lowest common denominator decisions" (Griffiths, 1983: 17-22).

Adopting private sector business principles, the Griffiths inquiry (Griffiths, 1983) recommended a move away from the old-style 'consensus' management towards a system of general managers at the unit, district and regional levels. Regardless of discipline, general managers were to carry overall management responsibility for achieving the relevant health authorities' objectives, and were to have substantial freedom to design local organizational structures. Day-to-day decisions were to be taken at unit level rather than higher up in the organization. General managers alone would bear responsibility for their own unit's performance. As for clinical doctors, they were to become more involved in local management. The prime vehicle for this was the allocation of workload-related budgets to consultants. More than 60% of general managers' posts initially went to former administrators and treasurers (Harrison et al., 1992). However, some health professionals also took general managers positions.

General management was an important precursor of market-based reforms which were to follow. By introducing general management, the Conservative government of Margaret Thatcher wanted to shift the balance between managerial and medical authority toward the former. As managerial pressure on the medical profession increased, so did the latter's discontent (Day and Klein, 1991). The medical profession reacted by questioning the budgetary constraints within which it had to work and denouncing the inadequacy of the NHS, which contributed to increasing the British public's dissatisfaction with the NHS. The culminating point of the medical profession's opposition was, in 1987, when the presidents of the Royal Colleges, representing consultants, issued a public statement warning that the NHS was facing ruin. Tensions were exacerbated by the increased media attention to shortages, waiting lists, and other incidents that implied a failure in maintaining NHS standards (Mechanic, 1995). The Labour Party brought the NHS and evidence of resource shortages issues to the front stage during the 1987 election campaign, thereafter putting the Thatcher government on the defensive (Lawson, 1992).

The funding crisis of the winter 1987 and the organized resistance of consultants, prompted Margaret Thatcher to set up a high profile ministerial review of the NHS under her own chairmanship in January 1988. The early deliberations of the group were believed to have centered on alternative ways of NHS funding: ways that would avoid the constant funding crises to which the NHS was prone. However it soon became clear that the existing method of central tax-based funding was particularly effective at containing the growth in health expenditure. As a result attention shifted to the way services were organized, managed and delivered. The Thatcher government considered that the best way to improve the efficiency of the NHS and to make it more responsive to patients was through the injection of market forces. The Conservative government's reform program for the NHS was set out in the White paper, *Working for Patients* (Department of Health, 1989). It proposed a radical reform program. Its review and its recommendations led to the reforms embodied in the NHS and Community Care Act in 1990 which were implemented on 1 April 1991. The document recommended the establishment of market competition and stronger managerialism.

These reforms introduced an internal or quasi-market to the NHS with the claim that competition between providers would increase efficiency, offer wider choice and improve the quality of services. In quasi-markets in healthcare, third-party payers or public agents contract for healthcare rather than the patients themselves (Le Grand and Bartlett, 1993). The state provides the finances but competition exists between independent suppliers to provide the service. The NHS quasi-market or internal market separated the responsibility for purchasing services from the responsibility for providing them.

As under the old system, purchasers were funded by government from general taxation. The main purchaser function was assigned to the district health authorities - that is, the bodies hitherto responsible for running health services (general practice apart) for given geographical populations within budgets devolved from the center- supplemented increasingly by GPs who were given the choice to become budget holders. District health authorities were allocated a budget to purchase secondary care based on the size and characteristics of the district's population. Therefore, as purchasers, health authorities became responsible for assessing the needs of their populations and buying appropriate care. As for GPs, they were encouraged to become budget holders and to take responsibility for purchasing an increasing range of hospital services for their enrolled patients. Volunteering GPs (GP fundholders) received a budget to purchase pharmaceutical and elective care based on past referral activity for the treatment

concerned. The budget was deducted from the budget received by the health authority in which the fundholder was situated. Fundholders (but not health authorities) could keep any surplus they made on their budget, provided that it was spent on services or facilities of benefit to patients. By the time, the internal market experiment came to an end, the Conservative government had concluded that GP fundholders were the more effective purchasers of services and should become the purchasers of choice (Smee, 2000).

The provision of services was made the responsibility of hospitals and community services, which became semi-autonomous trusts but remained publicly owned. They were quasi-independent entities, managing their own budgets and financing them from contracts with purchasers. Indeed trusts were expected to establish prices for care and to compete with each other for service contracts from purchasers, i.e., district health authorities or GP fundholders. In practice, this was largely limited to elective care as emergency services needed to be locally supplied. Actually, the freedom of trusts was limited insofar as they had to conform to central guidelines concerning pricing and investment, and they could not retain any surpluses they might generate (Le Grand, 1999).

The 1991 reforms aimed at substituting a system of governance based on market mechanisms to the combined state hierarchy and medical dominance governance system. The changes were intended to put pressure on providers through limited forms of competition and harder budget constraints and to strengthen purchasers' agency role within the NHS. The main rationale for the introduction of an internal market in to the NHS was to remedy the lack of incentives for efficiency and innovation and to allow money to "follow the patient" (Department of Health, 1989). This echoed some of the ideas put forward by Enthoven (1985), an American expert, in the mid 1980's. The new organizational arrangements were supposed to force providers to be both more efficient and more responsive; if they failed to improve their performance, they would lose income as purchasers switched their contracts (Klein, 1998). But the introduction of market-based approaches to the public sector was controversial and attracted a good deal of opposition. From the outset, health care professionals (i.e., doctors, nurses, and allied health professionals) and the general public were generally seen as opposed to the direction of change. The chief criticism of the reform on the part of its opponents was that the NHS was being privatized and commercialized beyond recognition.

Over the time, possibly as a result of the continuing electoral unpopularity of some of the more radical changes, the government softened its stance. The emphasis on competition and the

internal market was reduced as a system of regulated or managed competition was developed. The term 'purchasing' was increasingly replaced by the term 'commissioning' as attempts were made to move away from models based on spot purchasing to those on a more strategic, planned approach.

Instead of stepping aside and letting competitive forces take over, the state figured prominently in the NHS internal market. The implementation of the quasi-market was a government led initiative. Then, once the market was in place, the government could not really step aside, insofar as it was still responsible for providing and guaranteeing universal care. Because it decided the NHS budget, the government had a direct stake in how that money was spent. It was still held accountable by voters and Parliament for perceived or actual shortcomings in performance of the health service and in the level of resources allocated to it. As a result, it was in fact impossible to separate operational from political decisions or to completely devolve decision making to lower-level managers or freewheeling market forces (Giaimo, 2002). A decade after the publication of the White Paper *Working for Patients* (Department of Health, 1989), a new governance hybrid was emerging in the NHS that blended greater state centralization, market forces, and diminished corporatism (Giaimo, 2002).

Associated logics: the quasi-market logic and the logic of medical professionalism. The Conservative government of Margaret Thatcher tried to develop and impose a new logic in the NHS. This logic can be labelled the quasi-market logic. It was developed through the introduction of general management on the one hand, and of the quasi-market, on the other. According to this logic, the desired end to pursue within the NHS was still the reduction of morbidity and mortality but it also aimed at providing effective and efficient healthcare services. The main difference between the quasi-market logic and the logic of medical professionalism was that they proposed to rely on different means to reach the desired end(s).

The introduction of general management aimed at changing the role identity of administrators, who became general managers. It also aimed at making health professionals more managerially conscious. The composition of the Griffiths Inquiry team was quite unique, insofar as the team comprised only four members and there were no medical interests represented, in contrast with most of the previous commissions and inquiry teams that had been set up. More than previous reforms, the Griffiths changes sought to modify organizational processes and ultimately to change the beliefs and values of NHS actors (Harrison et al., 1992). The objective was to transform healthcare services, so that they would be managerially-driven rather than

profession-led and that they would be sensitive to user preferences. The advent of general management introduced significant changes to the management process and power balance in the NHS, insofar as access to decision-making forums became contingent upon gaining managerial influence (Brooks, 1999). It has been shown that the introduction of general management had some impact on health professionals. Most groups, including doctors, perceived themselves, and others, to be more managerially conscious than in the late 1970s (Harrison et al., 1992).

As for allied health professionals and nurses, their status evolved during this period. Their clinical autonomy and their managerial autonomy were considerably enhanced. AHPs were recognized as having the right to make their own assessments and treatment plans. In addition, they were regarded as responsible for those.

The 1991 reforms aimed at substituting a market-like logic to the medical professionalism institutional logic that had been dominant so far. Competition may have never effectively materialized but the 1991 reforms had an undeniable impact on the organization and the functioning of the NHS. They contributed to changing ways of thinking about healthcare in the UK (Klein, 1998). Consumerism was placed center stage by the white paper, *Working for Patients* (Department of Health, 1989). Patients were regarded as consumers. One of the main objectives of the reform was to give them greater choice and increased involvement in the services provided. The quasi-market was designed to prod doctors and managers toward greater efficiency. Most analysts agree to say that the 1991 internal market reforms induced a considerable degree of cultural change in the NHS (Le Grand, 1999). First, they led to the emergence of a contract culture, with both health authorities and GP fundholders negotiating contracts with providers. The distinction between purchasers or commissioners and providers has been widely accepted and adopted throughout the NHS (Le Grand, 1999).

Second, the development of GP fundholding contributed to increasing the power of GPs, and more broadly of primary care professionals, in the NHS. The introduction of the internal market aimed at changing the balance of power in the NHS by shifting power from hospital consultants to GPs. More generally, it contributed to a growing emphasis on primary care in public policy (Klein, 1998). Not only did government policy statements increasingly stress the role of primary care, but equally, there were a variety of experiments in involving all GPs –not just fundholders– in the process of purchasing (NHS Executive, 1996). A complex mosaic of purchasing emerged as health authorities devolved decision making to groups of local GPs (Mays and Dixon, 1996). At the same time, fundholders were forming themselves into large consortia.

Finally, the government introduced a pilot scheme for "total purchasing," that is, giving fundholders budgets for purchasing the complete range of services required by their patients (Mays, et al., 1998).

In addition, there certainly was a degree of competition, particularly for the provision of elective surgery or new services and in conurbation with a concentration of hospitals (Klein, 1998). The threat of competition–i.e., the fact that the contracts could be switched if providers failed to improve their performance–was in itself quite an important weapon for purchasers (Klein, 1998). Another effect of the 1991 reforms is that they seem to have induced a considerable increase in cost-consciousness throughout the NHS (Le Grand, 1999).

Overall, it clearly appears that between the early 1980's and 1997 (and especially between 1991 and 1997), Conservative governments tried to infuse a new logic in the NHS, i.e., the quasi-market logic. Table 4.2 presents the key characteristics of the logic of quasi-market.

Table 4.2: Ideal type of the logic of quasi-market

	Quasi-market logic
ENDS	**-Reduce morbidity and mortality** **-Provide effective and efficient healthcare services**
MEANS	
Professionals' roles division	
Professionals' roles	**Physicians** as **medical experts also involved in local management** **Allied health professionals** and **nurses** as **quasi-autonomous health professionals** **General managers** as **pro-active managers**
Rules of interaction among professionals	**Physicians still hold authority** over all other NHS professionals **for clinical decisions** (but not for administrative ones)
Organizations' roles division	
Organization's roles	**Trusts** (i.e., acute hospitals) as **providers** **District health authorities** as **purchasers** **General practices** as **gatekeepers and fundholders** (i.e., purchasers)
Rules of interaction among organizations	**Market mechanisms** (purchasers and providers contract with each other)

The period between the early 1980's and 1997 was a period of intense change for the NHS. However, the previous institutional logic of medical professionalism still existed and was still dominant. The new system of governance and the new logic it went with never really materialized. In some organizations, doctors' authority might have been reduced, but their power remained largely intact (Harrison et al., 1992). It varied from one organization to another but consultants were still very powerful. It has been shown that in the post-Griffiths period, doctors still held to a predominantly 'diplomatic' view of the role of management (Harrison, 1988). Managers themselves, when interviewed, acknowledged that they did not themselves expect doctors to change (Harrison et al., 1992). The model of a pro-active management, setting goals,

implementing plans for their achievement, and monitoring progress remained a vision rather than a reality. Reactive management remained the day-to-day norm (Harrison et al., 1992). In fact the general management reform focused on managers but did not touch the core attributes and the position of the medical profession.

As for the 1991 reforms, they curbed medical power in some areas but granted doctors opportunities for influence in other areas of health policy and administration (Giaimo, 2002: 71). Crilly (2000) demonstrated that in the period of the quasi-market, consultants' aims systematically dominated those of managers in determining trusts' behavior. In addition, even though the 1991 reforms contributed to shifting the balance of power from secondary to primary care organizations, hospitals remained the most powerful organizations. Budget was mainly in the hands of administrative organizations that allocated more money to hospitals that were still at the center of the NHS system. Competition between hospitals for the provision of secondary services never really materialized. Acute hospitals still very much benefited from a monopoly position for the provision of most secondary care services in their health community.

Precursors of change. In the UK, like in some other countries (e.g., New Zealand and Sweden) that introduced an internal market into their national healthcare system, the competitive experiments remained short-lived, lasting from 1992 to 1997 (Docteur and Oxley, 2003). The introduction of an internal market into the NHS had a small measurable impact (Klein, 1998; Le Grand, 1999; Smee, 2000). Some indicators of efficiency showed a small improvement. For example, there appears to have been a small acceleration in the growth of hospital productivity and a relative reduction in the pharmaceutical expenditures of GP fundholders (Smee, 2000).

In contrast, there was no sustained improvement in public satisfaction, no sustained decline in waiting lists or waiting times, and no measurable improvement in the clinical quality of care or in health outcomes (Smee, 2000). In fact, waiting times appear to have been shorter for GP fundholders (Mays and Goodwin., 2000), which increased the discontent of part of the British public, who viewed as unfair the fact that the quality of people's healthcare should depend on whether or not their GP had chosen to be a budget holder. In addition, the introduction of the internal market into the NHS induced a significant increase in administrative costs as contractual relationships replaced management systems and provider units took on management and accounting functions that had previously been centralized (Smee, 2000). Moreover, the evidence suggests that choice for patients did not increase under the internal market (Le Grand, 1999). For

instance, a study of the reform's impact on choices offered to patients for cataract surgery found no increase in choice of either procedure or provider for patients of both fundholders and non-fundholders. If anything, choice for both purchasers and patients seemed to have been reduced. However, there was a limited increase in the amount of information given to patients.

The short length of the internal market experience and its weak impact on the improvement of health outcomes have been attributed to a range of factors: a tradition of central budget and regulatory control; the difficulty of developing powerful purchasers, sufficiently expert and well informed to redress the imbalance of information in favor of providers; local provider (i.e., hospital) monopolies; the lack of good comparative information on unit costs and quality of care, leaving purchasers with little reason to change service suppliers; and more generally, an underestimation of the complexity of healthcare markets (Docteur and Oxley, 2003; Smee, 2000). Some have argued that effective competition did not materialize (Le Grand, 1999; Light, 1998; Smee, 2000). By 1996, Chris Ham concluded that competition in British healthcare had 'slipped away.'

Throughout the late 1990s and early 2000s, like most other national healthcare systems, the NHS has faced key challenges. Since its creation, the NHS has been trying to combine universal coverage and rigorous cost control. As a result, the NHS has been facing competing and, in practice, conflicting objectives. Although it has managed to provide comprehensive care at a remarkably low cost and achieved a large degree of equity in access to care, it is perceived to have failed in meeting rising demands, ensuring uniformly high quality of care, and responding to consumers' preferences (Powell, 1997). The increasing waiting times have been a major source of discontent in the United Kingdom as in other OECD countries (Hurst and Siciliani, 2003). A regular public opinion survey has indicated for several years that waiting for specialist assessment and waiting for elective surgery are perceived, respectively, as the first and the second most important failings of the NHS by UK residents (Jowell et al., 2000). In 1990, the waiting time for surgery in the UK was among the highest in Europe. 41, 7% of patients had to wait for surgery (between specialist appointment and surgical intervention) more than 12 weeks (Fleming, 1992). Another survey conducted in 5 English speaking countries (Blendon, et al., 2002) showed that long waiting times were more frequent in the UK than in other countries and that they tended to increase between 1998 and 2001 (see table 4.3).

Table 4.3: Percentage of patients waiting for elective surgery more than 4 months

	Year 1998	Year 2001
Australia	17	23
Canada	12	27
New Zealand	22	26
United Kingdom	**33**	**38**
United States	1	5

Base: Those with elective surgery in the past 2 years (%)

Public concern about the NHS and its alleged mismanagement has been a key factor in Labour's electoral victory in 1997 (Hunter, 2000). For many years, governments imposed strict control on NHS budget, which helped keep its costs down rather more successfully than those in other rich countries. Yet public discontent with an increasingly erratic service prompted today's Labour government to announce a major healthcare policy reorientation just after its election.

4.3.4. The era of combined state hierarchy and managerial control (1997-2004)

Governance system. The election of the Labour government in 1997 was another turning point for the NHS. This newly elected government had to find solutions for key underlying problems that have been highlighted in the NHS Plan (Secretary of State for Health, 2000). The major problem identified was the lack of investment in the NHS, which had become a public concern. Popular discontent culminated in widespread failures to meet some peaks in inpatient demand in the winter of 1999. Prime Minister Tony Blair then issued a pledge that health care spending levels, as a percentage of gross domestic product (GDP), would rise to the average level of the European Union (EU) over a five-year period, implying a massive increase in the NHS budget (Appleby and Boyle, 2000). Spending on the NHS has been scheduled to rise by over 7% a year in real terms until 2007-2008. By then, total health expenditure in Britain will have vaulted to 9.4% of GDP, compared with 6.9% in 1998, the year before the spending spree started.

Regarding the governance system of the NHS, the government claimed that it was seeking a 'third way' in NHS management - neither a return to the hierarchical command and control style of the 1970s nor a continuation of the competitive quasi-market approach introduced by its predecessors. Rather it favored a collaborative approach, encouraging partnership working

(Hunter, 2000, Le Grand, 2002). In the place of the previous governance systems, the government proposed a 'third way' where 'intervention is in inverse proportion to success' (Hunter, 2000: 69). This meant that central government would be progressively relaxed as NHS organizations demonstrate improved performance. The creation of the first Foundation Trusts in April 2004 was supposed to go in this direction. Foundation Trusts are a new type of NHS hospital run by local managers, staff and members of the public which are tailored to the needs of the local population. They have been given more financial and operational freedom than other NHS Trusts and have come to represent the Governments commitment to de-centralizing the control of public services. They have increased freedom to retain any operating surpluses and access a wider range of options for capital funding to invest in delivery of new services. They recruit and employ their own staff. The first 20 NHS Foundation Trusts have been authorized by the Independent Regulator and were established on 1 April and 1 July 2004. However, these Trusts remain within the NHS and its performance inspection system and they will only be able to treat a limited number of private patients.

Even if the government claims that it seeks a third way in NHS management. Some of the reforms it implemented have been characterized by strong elements of central command and control (Le Grand, 2002). The Labour government has developed service frameworks and national treatment guidelines that have provided the substance of command from the central authority. It also created a variety of central agencies to encourage innovation, to promote the spread of good practice, and to enforce implementation. These different agencies are tools of control for the government. Central control has also been exercised through a stream of directives that have been issued by the center to health authorities and primary care organizations (Le Grand, 2002). These directives took the form of health service circulars and, latterly, chief executive bulletins. These documents contain both instructions and advice from the NHS Executive. In 1998 and 1999, health service circulars on specific issues were being sent out at the rate of nearly one every workday. They were replaced in 2000 by chief executive bulletins, which are now being issued at the rate of one a week.

On the whole, it appears that a new system of governance has emerged since 1997. It is based on combined state hierarchy and managerial control.

Associated institutional logics: market managerialism and medical professionalism. As with Conservative governments during the previous era, the Labour government of Tony Blair tried to infuse a new logic in the NHS. Whereas the key words in the 1991 reforms were 'choice'

for patients and 'competition' among providers, the key words in the Labour government's White paper (Department of Health, 1997), which set its priorities, were 'collaboration' and 'cooperation' (Klein, 1998) both across services and across professions. As already explained, the Labour government aimed at developing a third way in NHS management. However, this should not lead us to conclude that the Labour government policy has nothing to do with the previous one. It is necessary to go beyond the political rhetoric. Some of the underlying elements of the 1991 reforms remain in the policy of the Labour government. The new emerging logic combines a managerial and a market approach to the organization and the management of the NHS. For this reason, it can be called the logic of market managerialism. The desired ends that it highlights are the same as the ones that were highlighted by the quasi-market logic, that is, the reduction of morbidity and mortality on the one hand, and the provision of effective and efficient services, on the other. The different means that should be used to achieve these ends have been specified in the two major documents that set the priorities of the Labour government regarding the NHS, the White Paper (Department of Health, 1997) and the NHS Plan (Secretary of State for Health, 2000).

The Labour government's 1997 plans for the NHS, which have been set out in a White Paper (Department of Health, 1997), have been presented as a reaction to the reforms introduced by its Conservative predecessor in 1991 and as a reaffirmation of the fundamental values of the NHS. In the White Paper (Department of Health, 1997), the Labour government proposed the abolition of the internal market and its replacement by a new set of organizational structures. First, the purchaser/provider split was retained, but with an emphasis on cooperative relationships between purchasers –now called commissioners– and providers and between providers, rather than competitive ones. However, as noted by Le Grand (1999), as a last resort, purchasers can switch their purchasing away from their current providers.

Second, the purchaser function was given to Primary Care Groups (PCGs), led by GPs. All GPs were required to join PCGs, which covered populations varying in size from 30 000 to 250 000. PCGs were able to retain surpluses from their budgets, surpluses that could be spent on services or facilities of benefit to patients. Fundholders were absorbed into PCGs. As for Health authorities, they lost their purchasing role, except for certain highly specialized services. PCGs then evolved into primary care trusts (PCTs) in 1998. PCTs are independent trusts. They directly provide primary and community care services while commissioning other services, including hospital care, from specialist providers. They are funded by central government and will

eventually control 75% or more of the NHS budget. All GP practices are required to join PCTs that cover specific geographic area, often serving large population (250 000, or more). Like PCGs, PCTs can retain surpluses.

For secondary services, the White Paper (Department of Health, 1997) stated that they were still provided by hospital trusts that remained independent units as before. Like PCGs and then PCTs, trusts were able to retain surpluses, subject to them being spent in a way that benefited patients. Any community services that hospital trusts used to run have been transferred to PCTs.

Last but not least, following the White Paper (Department of Health, 1997), the central government put in place a new performance "framework," with new performance indicators emphasizing effectiveness and outcomes. To support this framework, it created two new national bodies designed to monitor performance and, if necessary, to intervene. The National Institute for Clinical Effectiveness (NICE) was responsible for setting standards, while the Council for Health Improvement (CHI) enforced them.

The other official document setting the priorities of the Labour government regarding the NHS was the NHS plan (Secretary of State for Health, 2000). It identified a series of central problems that had to be overcome. As already stated, the first major problem identified was the lack of investment in the NHS. Second, the Labour government noted that there was a lack of NHS national standards. Actually, from its creation in 1948, there were no national NHS standards. The assumption was that standards would rise automatically in all parts of the country. It was left to individual health authorities (and during the internal market to individual GP practices) to decide levels and types of treatments. 'The result was a postcode lottery of prescribing and care' (Secretary of State for Health, NHS Plan, 2000).

The third problem identified was the existence of barriers between services, especially between primary and secondary care services. One of the harmful consequences of these rigid boundaries between services was that the needs of individual patients tended to come 'a poor second to the need of the individual service' (Secretary of State for Health, NHS Plan, 2000). They prevented the development of integrated care pathways.

Fourth, 'old-fashion demarcations between staff' (Secretary of State for Health, NHS Plan, 2000), that is, rigid professional boundaries between professions perceived as having different status, were identified as impediments to the good functioning of the NHS. The existence of rigid professional boundaries between the different professions represented in the

NHS resulted in sub-optimal outcomes both for patients and health professionals. Patients often saw a procession of health professionals frequently recounting the same details to the GP, practice nurse, hospital booking clerk, hospital nurse, care assistant, therapist, junior doctor and consultant (Secretary of State for Health, NHS Plan, 2000). The lack of communication and coordination across professional boundaries was identified as a source of increased costs for the NHS (because of repeated investigations) and as a source of discomfort for patients whose care pathways were often tortuous and long. Thus, the existence of rigid professional boundaries was an additional impediment to the development of integrated and coherent patient healthcare pathways. In addition, these rigid professional boundaries held back part of the NHS staff from 'fulfilling their true potential'.

To remedy the lack of NHS national standards, the NHS plan (Secretary of State for Health, 2000) set various targets for the health service, in terms of both performance indicators such as waiting times and inputs such as hospital beds and medical staff. The managers' role is to make sure that their organization will hit the targets set by the government. To do so, they are expected to implement major changes in their organization if necessary.

The NHS Plan (Secretary of State for Health, 2000) also set up other new bodies. Prominent among this was the Modernization Agency, which was intended to help local clinicians and managers redesign local services around the needs and convenience of patients. Others include the National Standards Commission, an inspectorate with a role similar to that of CHI for nursing and residential care, and the National Clinical Assessment Authority, whose role was to provide a support service to health authorities and trusts that had concerns over performance of an individual clinician.

To facilitate collaboration across services and across professions, the government launched a new program "Shifting the Balance of Power." Its aim was to reform the way the NHS worked by designing a service centered around patients, which put them first. To facilitate collaboration across professions, the Labour government has tried to empower nurses and allied health professionals. For example, new positions of AHPs and nurses consultants have been created in the NHS. In addition, like all other NHS employees, consultants are now appraised. They have to respect some clinical standards and guidelines.

To facilitate collaboration across services, social services have become part of the NHS. In addition, the government encourages collaboration across primary and secondary care services. The ultimate objective is to develop a more integrated care system. As explained by Chris Ham,

who is the Director of Strategy at the Department of Health, one of the challenges that the NHS is now facing is to develop a different model of healthcare to respond to the problems raised by chronic diseases whose care is a major source of expenses. The NHS has relied for a long time on the model of the acute hospital that does not fit people with chronic diseases, who need continuing care. The public authorities' objective is to operate a shift from an acute episodic health system to a system that provides continuing care through integration. For this reason, collaboration between primary, secondary and social care providers has become a central issue.

Table 4.4 presents the key characteristics of the logic of market managerialism.

Table 4.4: Ideal type of the logic of market managerialism

	Market managerialism logic
END	**-Reduce morbidity and mortality** **-Provide effective and efficient healthcare services**
MEANS	
Professionals' roles division	
Professionals' roles	**Physicians** as **medical experts** **Allied health professionals and nurses** as **health experts** **General managers** as **pro-active change agents** responsible for hitting targets
Rules of interaction among professionals	**Cooperation** and **coordination** across the different professional groups (team functioning)
Organizations' roles division	
Organization's roles	**Trusts** (i.e., acute hospitals) as **providers** **Administrative bodies** as **providers of guidelines, targets, and standards** and as **inspectors** **PCTs** as **commissioners**
Rules of interaction among organizations	**Cooperation** and **coordination** across the different types of organizations

Despite the rhetorical scorn of the Labour government for the quasi-market experience, most analysts agree to say that the current organization of the NHS has some remnants of the quasi-market (Le Grand, 2002). The logic of market managerialism is not fundamentally different from the logic of quasi-market. The purchaser-provider split remains and the possibility of "contestability" still exists –that is, purchasers can compare the performance of their providers with that of others and, if they are dissatisfied, shift their purchasing as a last resort. Moreover, the changes to the rules on the retention of surpluses are in the direction of improving market-type incentives, as are some of the GP payment reforms.

In addition, the government claims that it aims at facilitating collaboration across services as opposed to competition, but it conducts a policy that is sometimes contradictory. As acknowledged by Chris Ham himself, the introduction of the Payments by Results may, for example, hinder the development of collaboration across services, and thereby the development of a more integrated healthcare system.

As for the institutional logic of medical professionalism, it still exists within the NHS and it still holds dominance. Similar to other healthcare systems throughout the western world (e.g., Kitchener, 2002; Scott et al., 2000, Reay and Hinings, 2005), the NHS has been dominated by an institutional logic of medical professionalism for quite a long time. As healthcare services have become more complex, and the number of professional groups involved has multiplied, the dominance of the medical profession may have been slightly diluted, but its power has remained considerable (Haywood and Hunter, 1982). Even today, doctors, and especially consultants, remain the most powerful actors in the NHS. The interviews that I conducted confirmed that other NHS professionals still consider that doctors benefit from a specific status within the NHS. Mentalities are changing but slowly. Other NHS professionals rarely dare to directly challenge doctors. The study conducted by Ferlie et al. (2005) about the non spread of certain innovations across the NHS suggests that professional and services boundaries still exist and that doctors do not always easily cooperate with other health professionals.

Similarly, even though the primary care sector has been strengthened, acute hospitals are still at the heart of the NHS system and they still very much benefit from a monopoly position for the provision of secondary care services in a given health community. Now that PCTs exist, the primary care sector is less atomized than what it used to be and primary care organizations have more resources than they used to have. But, despite their central role as commissioners in the NHS, PCTs are still considered to be lower status organizations than hospitals and administrative

organizations. Because they are newer organizations, they are not regarded as being as legitimate as hospitals and administrative organizations that have played a key role in the NHS for decades. In addition, the NHS healthcare system is still an acute episodic healthcare system that places hospitals at the center of healthcare provision. Health professionals working in the primary care sector are still presented as gatekeepers to the secondary care sector, as if their only function was to regulate access to secondary care services. On the other hand, because the NHS is state funded, PCTs –even if they are the new budget holders– are always dependent on administrative organizations for budget allocation.

The table below summarizes the changes in both governance systems and institutional logics that have taken place in the NHS over the last 60 years.

Table 4.5: Eras of governance systems and associated logics

Era of governance system	Combined state hierarchy and medical dominance (1948-1983)	Combined state hierarchy and market mechanisms (1983-1997)	Combined state hierarchy and managerial control (1997-2004)
Associated logic(s)	**Medical professionalism**	-Quasi-market -**Medical professionalism**	-Market managerialism -**Medical professionalism**

4.4. Why is the NHS an appropriate setting for testing the model?

Like in many other western healthcare systems (e.g., Kitchener, 2002, Reay and Hinings, 2005), different institutional logics have been co-existing in the organizational field of the NHS over the last 20 years. Until the mid 1980's the dominant institutional logic was the logic of medical professionalism and the NHS was a highly institutionalized environment. Starting in the mid 1980's, different governments have tried to infuse alternative logics in the NHS. These alternative logics have contributed to setting the stage for the possibility of change (Sewell, 1992; Whittington, 1992; Clemens and Cook, 1999; D'Aunno, Succi and Alexander, 2000; Seo and Creed, 2002; Dorado, 2005). However, the logic of medical professionalism has remained the

dominant institutional logic in the NHS so far. Despite the governments' attempts to alter this dominant institutional logic, the NHS is still a rather hierarchical field (Rao et al., 2000), insofar as it is still characterized by a distinct dominance order in which doctors operate at the apex. Actually, it appears that the NHS is a relatively institutionalized organizational field. Indeed the government is still responsible for financing the NHS and guaranteeing universal care. In addition, the distinction between primary care services provided by GPs in general practices and secondary care services provided by consultants in hospitals is still central to the functioning of the NHS. Last but not least, the logic of medical professionalism is still dominant, even if it is challenged by emerging logics infused by governments.

Using the typology developed by Dorado (2005), one can now try to categorize the NHS. Organizational fields can adopt one of three dominant forms. Depending on their degree of fragmentation and of institutionalization, fields can be either 'opportunity opaque,' which means that their characteristics do not provide any opportunity for action, or 'opportunity transparent,' which means that their characteristics offer actors many opportunities for action, or 'opportunity hazy,' which means that their characteristics render opportunities for action hard to grasp. The organizational field of the NHS is characterized both by a relatively high degree of institutionalization and by the co-existence of multiple logics. For these reasons, it can be classified in the category of 'opportunity' transparent fields, that is, it offers opportunity for action that diverges from the dominant institutional logic. Thus, the characteristics of the organizational field of the NHS are likely to facilitate institutional entrepreneurship. In such an environment, if individuals do not act as institutional entrepreneurs, it means that factors other than organizational field characteristics (such as individuals' social position) may also play a key role in the occurrence of institutional entrepreneurship.

CHAPTER 5
DATA AND METHODS

5.1. Sample presentation

I test my hypotheses with data from ninety-three change projects that were conducted by ninety-three clinical managers from the NHS between 2002 and 2004. These clinical managers, who worked in 80 different organizations, attended a two-week strategic leadership executive education program between January 2003 and May 2004. Program participants were required to design and implement a change project in their organizations. During the program, participants developed a comprehensive change project implementation plan. They were required to write a comprehensive description of their change project after two months of implementation, two intermediate reports about their change project after respectively six and nine months of implementation and a final report after a year of implementation. They also had to participate in two conference calls in groups of five to discuss the difficulties that they encountered while implementing their change project after respectively five and eight months of implementation. I was responsible for following up on the change projects that the ninety-three participants implemented in their organization over a two-year period. I had access to all the reports and I took part in all the conference calls. During the program, I gave a brief presentation describing the study and I also gave each attendee a letter requesting his/her participation. Last but not least, study participants agreed to let me use all available information about their change project and granted me access to their curriculum vitae. Although participation was voluntary, all 95 program participants agreed to participate in the study. Data for two participants were incomplete, leaving a final sample of ninety-three observations.

The ninety-three clinical managers ranged in age from 34 to 56 years (average age of 43); of which 71 were women and 22 men. They all had a clinical background. 24% were physicians, 28% were allied health professionals (AHPs), and 48% were nurses. All study participants had managerial responsibilities, but their level of management responsibility varied from middle managers to top managers. They came from a variety of NHS organizations. 44% worked within Primary Care Trusts (PCTs), while 45% worked within hospitals or other secondary care organizations. The remaining (11%) worked within NHS administrative bodies.

At this stage, it is important to specify that all the participants to the program were self-selected. They indubitably had some interest in change insofar as the program was about leading

change. However, there was nothing in the presentation of the program or in the way they were selected to attend the program that had to do with their potential interest in divergent organizational change. In other terms, I did not select these people on the basis of their interest in the dependent variable of my model. In addition, all the participants were completely free to choose the change project that they wanted to implement in their organization. It is important to keep in mind that although the government mandates initiatives for strategic change within the NHS, managers at the regional and organizational level are responsible for implementing changes appropriate to local needs and circumstances. Finally, all the participants had to develop a description of the change project that they wanted to initiate in their organization before they came on campus for the executive program. They refined this description after two months of project implementation after they came on campus for the first week of the executive program. I compared both project descriptions for all participants. None of them fundamentally changed their project after coming on campus.

The different change projects can be classified into five main categories: workforce development (e.g., development of a corporate training programme which supports the personal and professional development of a D to that of an E grade registered nurse), redesign of patient care services (e.g., reconfiguration of stroke services within a health community through the integration of primary and secondary care services), redesign of administrative services (e.g., transformation of the booking system in a General Practice), creation of new patient care services (e.g., creation of an intermediate care service for the elderly in a community hospital), and creation of new administrative services (e.g., creation of an integrated department of bed management and discharge planning in a hospital).

I selected four change projects out of the ninety-three for conducting in-depth case studies. Three of these projects aimed at redesigning an existing patient care service (see the change projects initiated by Deborah Jamieson[Vignette 1], Tracey McErlain Burns [Vignette 2], and Fiona Jenkins [Vignette 3]), while one of them aimed at creating a new patient care service (see the change project initiated by Martin McShane [Vignette 4]). The selection of these four change projects was based on my own assessment of their degree of divergence from the logic of medical professionalism prior to developing a rigorous measure of divergence. Based on the change project descriptions that I had and on the different discussions that I had with the participants to the program, I identified these four projects as being particularly divergent from the logic of medical professionalism. I followed up on these change projects for a two-year

period after their launching. I went on the field to collect data using the interview guides that are available in appendix 2. The four case studies (see Appendices 6, 7, 8 and 9) that I co-authored with Thomas D'Aunno, Mattia Gilmartin and Anne-Marie Cagna provide good examples of the change projects that the participants initiated in their organization.

Vignette 1

Implementing nurse-led pre-admission clinics (see Appendix 6 for a more detailed presentation of the change project)

Deborah Jamieson, who was an American nurse by background, was recruited in February 2002 by the University College London (UCL) Hospitals NHS Trust. This Trust was established in 1994, although its origins dated back over 250 years in the history of various individual hospitals. It was based in London and comprised eight specialist hospitals with the opening of the new University College Hospital (UCH) due in 2005.

Deborah was recruited to set up a nurse-led Pre-operative Assessment Service in the University College London Hospital NHS Trust and to review the already existing day surgery clinic. It was a major change to initiate insofar as traditionally pre-admission clinics had been run by doctors only. By transferring this responsibility from doctors to nurses, the change that Deborah initiated clearly broke with the dominant logic of medical professionalism.

Her first challenge was to recruit nurses who would be willing to take on further responsibility. She also needed to convince the main players that nurse-run pre-admission centres would benefit both patients and staff. In the long-run she knew from her experience in the US that these clinics would free up more time for consultants, reduce cancelled operations thus reducing costs and improve patient care. Her ultimate goal was "to have one large pre-assessment centre with sufficient trained staff, enough nurse practitioners, and sufficient consulting rooms; along with dedicated anaesthetic sessions". Deborah first concentrated on setting up a pilot pre-operative assessment clinic in the Diagnostic & Treatment Centre for major surgery at the University College Hospital. A year after setting up this pilot treatment centre, she turned her attention to improving the day surgery clinics.

In the meantime, Deborah worked on the development of a training program for nurses who would be willing to run pre-admission clinics. A two day course was designed for nurses newly recruited to work in the clinics, as an introduction to clinical examination and pre-operative assessment. Deborah advertised the training throughout the Trust. Nurses were encouraged to attend from different areas of UCLH. The aim of the training programme was to empower the Pre-operative assessor to develop clinical examination skills. An overview would be carried out of all that was required from obtaining the health history of the individual, identifying patients at higher risk, to utilising assessment tools appropriately to assess a patient's condition and act accordingly. The nurses were shown how to perform clinical examinations and obtain a patient's health history, for example listening to the heart and lungs, tasks that were traditionally undertaken by doctors. The nurses were also sent on a two and a half day venepuncture course and certified to take blood. All of the nurses were supervised during patient encounters until deemed competent to perform independently.

Vignette 2

Implementing nurse-led discharge (see Appendix 7 for a more detailed presentation of the change project)

Tracey McErlain Burns was the Executive Director of Nursing of Mid Yorkshire Hospitals Trust. This Trust comprised three hospitals and a total of 1291 beds. In 2003, at the time Tracey launched her change project, the Trust was receiving a lot of adverse media coverage owing to waiting list problems and a £30 million financial deficit. Its credibility within the community was plunging. Something had to be done.

The Trust Board members became aware that the inefficient processing of patients inhibited the hospitals' capability to reduce waiting lists. As part of the broader turnaround strategy, someone needed to drive and accept accountability for improving the performance of the admission-through-to-discharge chain. The Chief Executive asked Tracey, if she would take the lead.

Tracey noted that inefficient practices and poor communication were blocking the release of many patients. There was a need for someone to coordinate the discharge process. For example, a number of patients were simply waiting for test results or a prescription of take home drugs, and did not even need a hospital bed. Another common scenario was that physicians doing their rounds would suddenly pronounce a patient fit to go home – and discharge planning procedures would commence only at that point. This caused unnecessary delays, from simple problems like arranging for relatives to collect or look after the patient for a few days, through to more complex problems of finding suitable residential or nursing home accommodation. Poor communication with Social Services and poor knowledge of the varied and fast-evolving care schemes provided by primary care trusts (and eligibility criteria) further complicated matters.

To try and solve these problems, Tracey decided to implement nurse-led discharge throughout the Trust, which would involve nurses taking over responsibility from specialist physicians for making the final decision to discharge a patient. By transferring this decision from physicians to nurses, Tracey was clearly breaking with the dominant model of medical professionalism. She wanted nurses to be responsible for coordination across services, organizations and professionals so that patients would be discharged more efficiently.

Vignette 3

Redesigning strokes services in a health community (see Appendix 8 for a more detailed presentation of the change project)

Fiona Jenkins was employed as Head of Physiotherapy Services for the South Devon Health Organization. She was officially employed by a Primary Care Trust. In addition to her role as head of physiotherapy services, she was also the lead of her Primary Care Trust's Service Improvement. She was responsible for a complete review and redesign of South Devon stroke services.

In 2003 when Fiona initiated the redesign of stroke services the stroke unit for the South Devon community was centralized in the acute hospital, Torbay General Hospital, with 24 beds available. Both acute care and rehabilitation took place in the acute hospital on the same ward. Patients stayed on the acute ward for both parts of the care. As a result, patients' average length of stay on the acute unit was 3 weeks. The problem was that there were insufficient beds to admit all stroke patients on the ward as many beds were being used for patients who were post acute undergoing rehabilitation. Other patients were just waiting to be placed in long term residential or nursing care. There were an estimated 600 admissions per year to the ward. In 2003 less than half of the patients admitted with a stroke had access to the Torbay acute unit and hence the specialist stroke service. With limited bed space individuals admitted with stroke often found themselves on other non-stroke wards without the appropriate staff and skills required for their care.

To solve this problem, Fiona decided to create a stroke unit in the primary care sector in a community hospital of South Devon Health community. Her objective was to maintain the acute unit in Torbay General Hospital and develop a specialist rehabilitation service within the community hospital in the primary care sector. After a stay at the rehabilitation centre individuals would be sent home or placed in nursing homes by social services. Fiona also recommended a reduction in the length of time patients were placed on the acute unit to an average of seven days. Patients would be transferred to the community hospital once they were medically stable and ready for rehabilitation. This would ensure that the acute unit would only deal with patients that were really "acute" patients, thus increasing the number of patients receiving specialist care.

Fiona transferred rehabilitation services from the secondary care sector to the primary care sector where she created an intermediate care unit. In other terms, she contributed to the development of a more integrated and less centralized healthcare system in her health community. In addition to creating a rehabilitation unit in the primary care sector, Fiona's intention was to have the rehabilitation unit run by an Allied Health Professional or a nurse rather than a physician. Among the responsibilities of this person would be the community hospital rehabilitation ward, in addition to coordinating all the different organisations involved in the stroke care pathway from the acute unit to the social services. By creating this position, Fiona clearly aimed at empowering non-physicians. Her change project was thereby breaking with the dominant logic of medical professionalism.

Vignette 4

Creating an intermediate care service for the elderly (see Appendix 9 for a more detailed presentation of the change project)

Martin McShane was a GP in a medical practice that was part of the North Eastern Derbyshire Primary Care Trust and he was also the Professional Executive Chair of this PCT. His objective was to improve care for the erderly in his health community. It was a timely issue as demographics forecast a rise in life expectancy in the UK and Europe that inevitably would lead to an increase in elderly patients. Within his health community there was already a higher proportion of older patients than the national average with fragmented care and lack of coordination between the different services involved.

Martin's goal was to facilitate continued care, reduce hospital stay and decrease readmission for the elderly patients in his health community. To do so, he implemented a nurse-led pilot scheme that aimed at monitoring the condition of the elderly patients and at following up when they were admitted to the acute hospital. For this new pilot to work out, primary and secondary care organizations had to efficiently exchange information about the elderly patients. In order to facilitate communication, Martin decided to create a Discharge Liaison team that was located in the acute hospital. This team was a multi-disciplinary team comprising staff from the primary care sector. They had to liaise with the hospital staff to smooth and facilitate the discharge process. Martin was clearly trying with this change project to develop cooperation between primary care and secondary care organizations and to strengthen the role of primary care organizations in the follow up and treatment of elderly patients.

Martin hoped that this pilot scheme would ensure smooth discharge for people that were already in hospital, or ideally prevent them from being admitted in the first place. Hospital stays were not always the appropriate care for elderly people and it was clear that individuals did not necessarily want to remain in hospital. In addition, with infections such as Methicillin-Resistant Staphylococcus Aureus (MRSA), it was often putting them at unnecessary risk. Martin's ultimate ambition was to expand the pilot scheme throughout his health community.

5.2. Independent variables

Here is how I operationalized the different predictors of my model:

Low status organizations. In the NHS, PCTs that are the primary care organizations are the most recent organizations. They were created in 1998. Since the creation of the NHS, hospitals have traditionally played a central role in its functioning. The NHS system has been organized as an acute episodic healthcare system, within which hospitals benefit from a monopoly position for the provision of secondary healthcare services in their health community. Primary care organizations that have always been much smaller organizations than hospitals have traditionally played the role of gatekeepers to the secondary care sector. Despite their central role of commissioners of secondary care services in the NHS, PCTs are still considered to be lower status organizations than hospitals and administrative organizations. Because they are newer organizations, they are not regarded as being as legitimate as hospitals and administrative organizations that have played a key role in the NHS for decades. Health professionals working in the primary care sector are still very often presented as gatekeepers to the secondary care sector, as if their only function was to regulate access to secondary care services. On the other hand, because the NHS is state funded, PCTs –even if they are the new budget holders– are always dependent on administrative organizations for budget allocation. For all these reasons, PCTs are regarded as low status organizations in comparison with hospitals and administrative organizations. Organizations' status was measured with a dummy variable, where 1=low status organizations (i.e., PCTs), and 0=high status organizations (i.e., non PCTs).

Low status social group. In the NHS, professional groups are the most salient social groups. As observed by Ferlie et al. (2005), there are strong boundaries between the different professional groups, which have been educated and socialized in different ways. Like in most other healthcare systems, physicians benefit from a high status position in comparison with other healthcare professionals. It has been established that the sources of medical professions' authority and autonomy stem from the social legitimacy of their mission and their exclusive ability to apply expert and esoteric knowledge to particular cases (Friedson, 1986; Abbott, 1988: 99-100). Physicians have expert knowledge upon which members of the public are dependent and which neither managers nor other health professionals can supply directly. As a result, the members of the general public are not the only ones to be deferential towards physicians; other health professionals are similarly deferential.

A number of studies have shown how, despite the existence of central policies and priorities, the strategic shape of the NHS has been dominated by the medical profession since the creation of the NHS (for a review see Harrison et al., 1992: 30-33). Physicians have been the key decision makers in the field, controlling both the organization of the NHS in collaboration with the different governments and the delivery of services. Thus, there is a clear status hierarchy between doctors who are high status professionals and non-doctors who are the low status professionals in the NHS. Like organizations' status, professional groups' status was measured with a dummy variable, where 1=low status professionals (i.e., non-doctors), and 0=high status professionals (i.e., doctors).

Hierarchical position. I measured an individual's hierarchical position by a rank-ordered categorical variable representing his/her position in the organizational hierarchy (1=Deputee head/assistant director, 2= Head of service; 3=Non executive directors; 4=Executive directors). It is important to note that in my sample, the individuals who are the lowest in the hierarchy are still middle managers. In other terms, managers in my sample range from middle managers through to top managers. Two thirds of the sample correspond to executive and non executive directors.

Interaction terms. The first interaction variable is the product of low status organization and hierarchical position, while the second interaction variable is the product of low status social group and hierarchical position.

Inter-organizational mobility. Individuals' inter-organizational mobility was measured as the number of different organizations within the NHS in which individuals worked.

5.3. Dependent variables

Instead of adopting a binary approach to assess the divergence of organizational changes, I developed a rank-ordered categorical measure of the degree of divergence of the ninety-three change projects from the dominant institutional logic of medical professionalism. To do so, I developed a questionnaire and associated coding instructions (see Appendices 3 and 4) that were used to code the different projects. In order to develop this questionnaire, I relied on my analysis of the organizational field of the NHS. I showed in chapter 4 that the institutional logic of medical professionalism specifies which organizations' roles division and professionals' roles

division should be used to reach the desired end that is the reduction of morbidity and mortality (see Table 4.1 in chapter 4). I came up with four items (items 1 to 4 in the questionnaire) that aimed at capturing the degree of divergence of the change projects from the institutionalized model of professionals' roles division that characterizes the logic of medical professionalism. The six additional items in the questionnaire aimed at capturing the degree of divergence of the change projects from the institutionalized model of organizations' roles division that characterizes the logic of medical professionalism. For all 10 items, I used a rank-ordered 3-point scale. Then, I developed coding instructions (see appendix 4) and I hired two external raters to code the ninety-three change projects.

The coding was based on the project descriptions that all the program participants wrote after two months of project implementation. These projects descriptions were three-page long on average and they all followed the same template**:** (1) Brief description of the change project, (2) Goals and objectives of the change project**,** (3) Required resources to implement the change project**,** (4) Measurement of the outcomes of the change project**,** (5) Key factors for success in implementing the change project**,** (6) People involved in the change project. Because I followed up on the ninety-three change projects over a two-year period, I had the possibility to check whether the participants actually initiated their change project in their organization. They all did but it obviously does not mean that they all succeeded in implementing the change that they initiated.

Three different raters (two external raters and myself) coded the ninety-three change projects. Each rater coded two pilot change projects to become familiar with the coding scheme and compare codings for calibration purposes. To facilitate discrepancy resolution, raters were asked to note passages in the change project descriptions that they viewed as important for their codings (Larsson, 1993). After the three raters coded the ninety-three change projects on their own, I assessed interrater reliability by comparing their coding results. I used the kappa correlation coefficient, which corrects for the level of correlation that would be expected by chance. Values exceeding .75 are typically thought to indicate excellent agreement, and values between .40 and .75 indicate fair to good agreement (Landis and Koch, 1977; Fleiss, 1981). I obtained a kappa value of 0.90, which accounts for a very high degree of agreement among raters.

After checking interrater reliability, I then proceeded to run factor analysis on the results of the coding in order to explore whether the ten items in the questionnaire had common

underlying factors. One complication with my data was due to the fact that they were rank-ordered categorical. When the data are discrete the normality assumption underlying the principal component analysis is violated. One good option to overcome this problem is to use the polychoric correlations (Kolenikov and Angeles, 2004). This approach originated in Pearson (1901) and was furthered developed in Pearson and Pearson (1922) and Olsson (1979). A polychoric correlation extrapolates what the categorical variables' distributions would be if continuous, adding tails to the distribution. As such it is an estimate strongly based on the assumption of an underlying continuous bivariate normal distribution[4]. Using polychor macro in SAS, I obtained the polychoric correlations (see table 5.1).

Table 5.1: Polychoric correlations

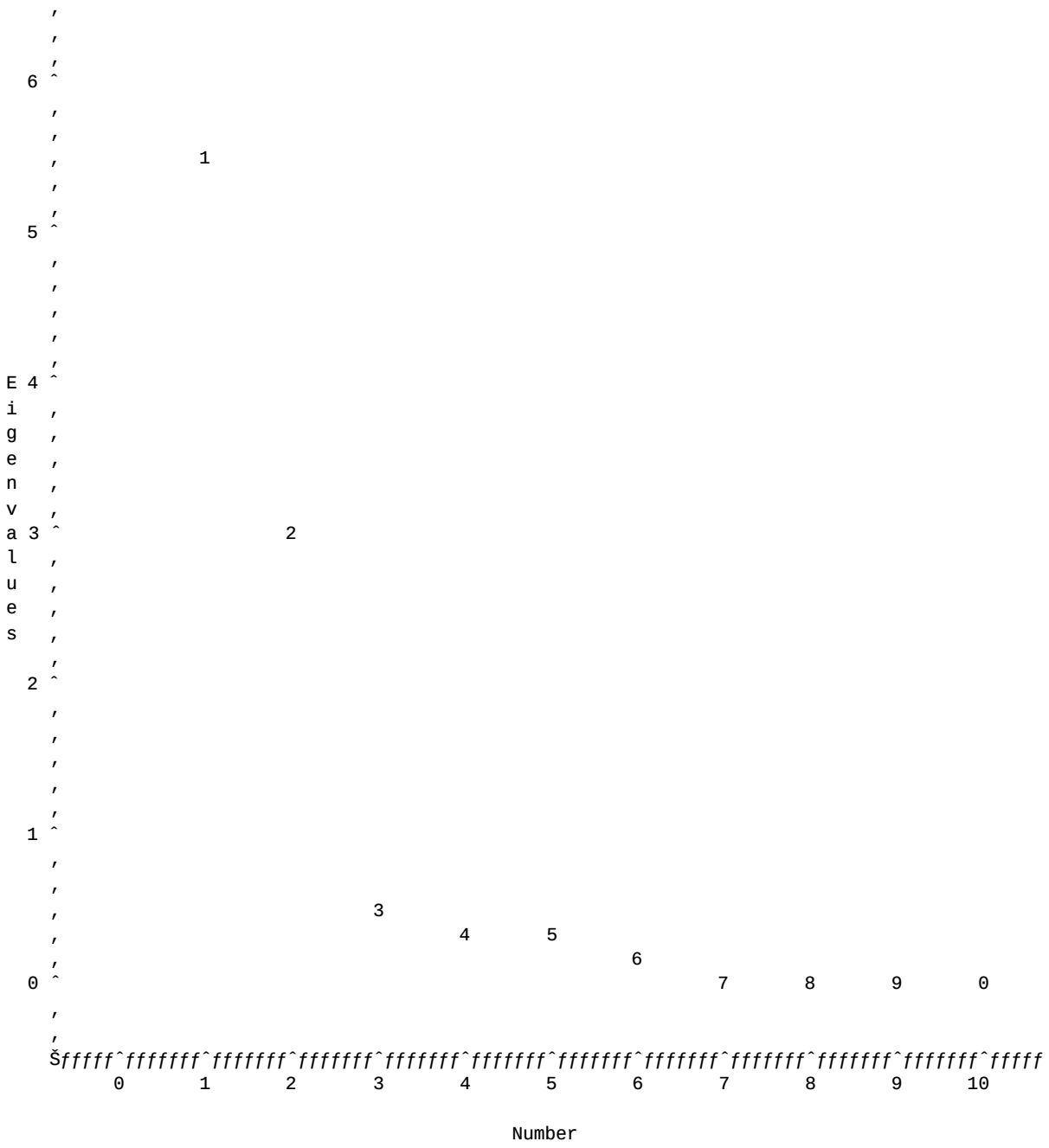
		Mean	S.D.	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
[1]	Item 1	1.753	0.917	1.000									
[2]	Item 2	1.548	0.651	0.702	1.000								
[3]	Item 3	1.333	0.518	0.974	0.619	1.000							
[4]	Item 4	1.161	0.370	0.801	0.652	0.753	1.000						
[5]	Item 5	1.323	0.694	0.200	-0.135	0.257	0.398	1.000					
[6]	Item 6	1.376	0.721	0.067	-0.097	0.149	0.315	0.888	1.000				
[7]	Item 7	1.215	0.463	0.276	-0.070	0.349	0.485	1.000	0.878	1.000			
[8]	Item 8	1.215	0.413	0.140	-0.061	0.197	0.363	0.931	0.969	0.962	1.000		
[9]	Item 9	1.570	0.713	0.058	-0.224	0.109	0.240	0.701	0.714	0.728	0.746	1.000	
[10]	Item 10	1.624	0.806	0.218	-0.163	0.204	0.396	0.820	0.602	0.858	0.663	0.645	1.000

N=93

[4] The polychoric correlation of two ordinal variables is derived as follows. Suppose each of the ordinal variables was obtained by categorizing a normally distributed underlying variable, and those two unobserved variables follow a bivariate normal distribution. Then the (maximum likelihood) estimate of that correlation is the polychoric correlation. If each of the ordinal variables has only two categories, then the correlation between the two variables is referred to as tetrachoric. This method is based on the assumption that observed rank ordered categorical variables are indeed latent continuous variables following a multivariate normal distribution.

Using the resulting correlation matrix, I ran a principal component analysis (see, Kim and Mueller, 1978; Selvin, 1995) in order to identify underlying constructs. I used varimax rotation (Kaiser, 1958) to increase the distinctiveness of clusters of intercorrelation among factors (see Rummel, 1970 for an in-depth discussion of rotation criteria). I retained two factors whose eigenvalue was greater than 1 (see figure 5.1).

Figure 5.1: Scree plot of Eigenvalues of the Correlation Matrix



As reported in table 5.2, the first four items in the questionnaire load on factor 2, while the next six items load on factor 1. These two factors correspond to two dimensions on which change projects may diverge from the dominant logic of medical professionalism. The first factor (factor 1) corresponds to the development of a more integrated healthcare system that breaks with the institutionalized model of organizations' roles division that characterizes the logic of medical professionalism, while the second factor (factor 2) corresponds to the empowerment of non-physicians that breaks with the institutionalized model of professionals' roles division that characterizes the logic of medical professionalism. The two-multi items scales corresponding to these two factors exhibited acceptable reliability values, ranging from 0.79 for the empowerment of non-physicians to 0.88 for the development of a more integrated health care system.

Table 5.2: Factor analysis results

	Factor 1	Factor 2		Communality
Item 1	.093	**.964**		.938
Item 2	-.226	**.843**		.763
Item 3	.155	**.922**		.875
Item 4	.331	**.856**		.843
Item 5	**.968**	.111		.949
Item 6	**.919**	.025		.845
Item 7	**.976**	.198		.992
Item 8	**.953**	.082		.915
Item 9	**.827**	-.044		.686
Item 10	**.828**	.110		.698
			Total	8.505
Eigenvalue	5.487	2.468		

All change projects have been assigned a score on each of the two dimensions, i.e., the development of a more integrated healthcare system and the empowerment of non-physicians. To calculate these two scores, I took the averages of corresponding items for each factor (i.e., items 1 to 4 for the empowerment of non-physicians and items 5 to 10 for the development of a more

integrated healthcare system). All scores range from 1 to 3 insofar as they correspond to the averages of three-point scale items. These scores measure the extent to which the change projects diverge from the dominant logic of medical professionalism, that is, the extent to which they aim at either developing a more integrated healthcare system or empowering non-physicians (where 1=no extent; 2=some extent and 3=great extent). Some projects rate high on only one of the two dimensions, while others do not rate high on any of the two dimensions. Only a few of them rate high on both dimensions simultaneously. 73% of the projects have scores that are smaller than 2 on both dimensions. These projects are not divergent on any of the two dimensions. In other terms, they neither aim at developing a more integrated healthcare system nor at empowering non-physicians. A change project that aims at reorganizing the booking system in a General Practice by hiring a new assistant and implementing a new work schedule is a good example of a change project that is not divergent on any of the two dimensions. 21% of the projects have scores that are strictly superior to 2 for one of the two dimensions. More specifically, 11% of the change projects diverge from the dominant model of organizations' roles division and 10% diverge from the dominant model of professionals' roles division. A project that aims at creating a new intermediate care service in the primary care sector is a good example of a project that diverges from the institutionalized model of organizations' roles division. The projects initiated by Deborah Jamieson and Tracey McErlain Burns (see Appendices 6 and 7) that respectively aimed at implementing nurse-led preadmission clinics and nurse-led discharge in hospitals are good examples of change projects that diverge only from the dominant model of professionals' roles division. After the coding procedure, both change projects were assigned a score that was strictly superior to two on the empowerment dimension but smaller than two on the other dimension. Finally, only 6% of the projects have scores that are strictly superior to 2 on both dimensions. These projects are divergent on both dimensions. The change projects that Fiona Jenkins and Martin McShane respectively initiated are good examples of such projects. They aimed both at developing a more integrated healthcare system and at empowering non-doctors.

On the whole, it appears that there are two dimensions on which a change project may diverge from the logic of medical professionalism:

(1) Organizations' role division: Development of a more integrated healthcare system (i.e., development of a healthcare system in which primary and secondary care organizations collaborate more)

(2) Professionals' role division: Empowerment of non-physicians (i.e., nurses, allied health professionals and managers)

These two different types of divergent organizational changes correspond to two different dependent variables for which the model that I developed needs to be tested.

5.4. Control variables

Managers may initiate divergent organizational changes for reasons other than their social position in a given organizational field. I controlled for the potential impact of a number of demographic (age and gender), career specific (educational background, highest clinical degree achieved, highest management degree achieved, seniority in a management position and duration of tenure in the current formal position) and organizational characteristics (organizational budget and organizational performance). Out of all these variables, only two career specific variables, i.e., seniority in a management position and duration of tenure in the current formal position ended up being significant. Both variables have been shown to have an impact on individuals' ability and willingness to initiate change.

Seniority in a management position. First, seniority in a management position (which I measure by the number of years spent in a management position) may affect individuals' likelihood to initiate divergent organizational changes. Individuals who have more seniority in a management position have more management experience. Such experience is useful whenever it comes to initiating change. It is likely to be even more useful when managers initiate divergent organizational changes that break with practices that are widely used and accepted not only in a given organization but throughout the organizational field. People with more seniority in a management position may be more confident that they will manage to conduct divergent organizational changes. As a result, they may be more likely to initiate divergent organizational changes than others.

Duration of tenure in a position. Another potential explanation for individuals' likelihood to initiate divergent organizational changes is their duration of tenure in a position (which I measure by the number of years spent in the current position). To convince other organizational members to abandon practices that are widely accepted and used not only in their organization but throughout the organizational field, managers must be regarded as legitimate by other organizational members. In addition, they need to have a good knowledge of their organization in order to overcome the obstacles that they may encounter while implementing

divergent organizational change. Managers with longer tenure in their position usually have built up more legitimacy in the eyes of both their subordinates and their superiors and have a better knowledge of the specificities of their organization (Huber, Sutcliffe, Miller, and Glick, 1993). For these reasons, longer tenure is likely to be positively related with the ability to initiate divergent organizational change and thereby with the likelihood for individuals to initiate divergent organizational change.

5.5. Estimation

Because my dependent variables are categorical and rank-ordered, I used ordered logit estimations in all models. Several of my observations (13 out of 93) correspond to managers who belong to the same organization. For this reason, I adjust baseline ordered logit estimations by clustering data with repeated observations on organizations. Without adjustment, estimates may be biased as these observations will probably be independent across, but not necessarily within, groups. In all models, I report heteroskedasticity-adjusted (i.e., robust) standard errors.

CHAPTER 6
RESULTS

An important intermediate result associated with the measurement of the degree of divergence of change projects from the dominant logic of medical professionalism is that there are two dimensions on which a change project may break with this logic. The first dimension has to do with organizations' roles division. Change projects that diverge from the logic of medical professionalism on this dimension aim to develop a more integrated healthcare system. The second dimension has to do with professionals' roles division. Change projects that diverge from the logic of medical professionalism on this dimension aim to empower non-physicians. Below I report the results associated with these two dependent variables, i.e., the development of a more integrated healthcare system and the empowerment of non-physicians. It appears that the impact of individuals' social position on the likelihood for them to initiate divergent organizational change, that is, to act as institutional entrepreneurs, is not the same depending on the dimension on which a change project breaks with the dominant institutional logic of medical professionalism.

Table 6.1 reports means, standard deviations, and correlations. There are no critically collinear variables (i.e. over .8 in absolute value [Kennedy, 1998]) in my data set.

Table 6.1: Summary statistics and bivariate correlations

		Mean	S.D.	Min	Max	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]
[1]	Development of a more integrated healthcare system	1.387	0.520	1.000	2.833	1.000							
[2]	Empowerment of low status professionals	1.449	0.509	1.000	2.500	0.106	1.000						
[3]	Seniority in a management position	11.624	4.917	2.000	26.000	-0.009	0.237	1.000					
[4]	Duration of tenure in current position	2.677	2.102	0.000	11.000	-0.142	0.101	0.032	1.000				
[5]	Interorganizational mobility	4.796	2.577	1.000	14.000	0.152	0.046	-0.055	-0.137	1.000			
[6]	Low status organization	0.441	0.499	0.000	1.000	0.313	0.025	-0.171	-0.143	-0.014	1.000		
[7]	Low status social group	0.763	0.427	0.000	1.000	0.009	0.169	0.542	-0.037	-0.104	-0.117	1.000	
[8]	Hierarchical position	3.022	1.000	1.000	4.000	-0.020	0.125	-0.215	-0.064	0.331	0.046	-0.344	1.000

N=93

6.1. Diverging from the institutionalized model of organizations' roles division: Developing a more integrated healthcare system

Table 6.2 shows results from five equations that enter variables in different combinations. In column 1 are results from an equation with only the control variables (seniority in a management position and duration of tenure in a position); column 2 shows results from an equation with control variables and the variables that characterize individuals' position in the organizational field (organization status and social group status), and individuals' position in the organization (hierarchical position), and changes in individuals' position (inter-organizational mobility). This column corresponds to the main effect model. In column 3 are results from an equation with control variables and all the above cited main effect variables plus the first interaction term (organization status x hierarchical position); column 4 shows results with the same control variables and main effect variables plus the second interaction term (social group status x hierarchical position), and, finally, in column 5 are results from an equation with all variables. The contribution of one or more variables was assessed with the likelihood ration test, which compares the goodness of fit of a pair of nested models distinguished by one or a set of variables (Bishop, Fienberg and Holland, 1975).

There is support for H1a, that individuals who belong to low status organizations are more likely to initiate divergent organizational change, that is, to develop a more integrated healthcare system (see column 2). In contrast, social group status is not significantly related to the likelihood to initiate divergent organizational change that breaks with organizations' roles division (see column 2). Thus, results do not support H1b, that individuals who belong to low status social groups are more likely to initiate divergent organizational change. There is a statistically significant relationship between individuals' hierarchical position and their likelihood to initiate a change that aims to develop a more integrated healthcare system (see column 2). However, the relationship is the opposite of the one hypothesized in H2. Indeed results show that the higher individuals are in the hierarchy of their organization, the less likely they are to break with the institutionalized model of organizations' roles division. H4, that the higher individuals' inter-organizational mobility, the more likely they are to initiate divergent organizational change that aim to develop a more integrated healthcare system is supported (see column 2). H3a and H3b concern the interaction between individuals' position in the organizational field and in the organization. H3a, that individuals who belong to low status organizations and who are higher in organizational hierarchy are more likely to conduct divergent organizational change is not

supported (see column 3). In contrast, the results show support for H3b, that individuals who belong to low status social groups and who are higher in organizational hierarchy are more likely to initiate divergent organizational changes that break with organizations' roles division (see columns 4 and 5). As for the control variables, neither seniority in a management position nor duration of tenure in a position have a significant impact on individuals' likelihood to initiate divergent organizational changes that aim at changing organizations' roles division (see column 1). The results thus provide mixed support for the impact of individuals' social position on their likelihood to break with the institutionalized model of organizations' roles division.

Table 6.2: The impact of individuals' social position on individuals' likelihood to initiate a change that aims to change organizations' roles division

	(1)	(2)	(3)	(4)	(5)
Seniority in a management position	-0.002 (0.037)	0.039 (0.043)	0.038 (0.043)	0.049 (0.042)	0.046 (0.042)
Duration of tenure in current position	-0.088 (0.078)	-0.052 (0.075)	-0.050 (0.073)	-0.084 (0.076)	-0.080 (0.074)
Inter-organizational mobility		0.165 *** (0.065)	0.166 *** (0.064)	0.148 ** (0.073)	0.149 ** (0.072)
Low status organization		1.145 *** (0.441)	0.959 (1.462)	1.133 *** (0.434)	0.703 (1.488)
Low status social group		-0.459 (0.563)	-0.441 (0.570)	-5.140 ** (2.605)	-5.217 ** (2.617)
Hierarchical position		-0.307 * (0.203)	-0.324 ** (0.188)	-1.502 ** (0.689)	-1.573 ** (0.701)
Hierarchical position x Low status organization			0.062 (0.466)		0.143 (0.474)
Hierarchical position x Low status social group				1.297 ** (0.704)	1.330 ** (0.714)
Log pseudolikelihood	-172.54	-165.67	-165.66	-164.43	-164.38
Wald chi-squared	1.32	17.67 ***	17.99 **	17.64 **	17.89 **
Δ LR-test		13.75 ***	13.77 **	16.22 ***	16.33 **

N=93; Robust standard errors in parentheses
* significant at 10%; ** significant at 5%; *** significant at 1%
Statistical significance based on one-tailed tests for all independent variables and interaction terms
Δ LR-test based on comparison with model (1)

6.2. Diverging from the institutionalized model of professionals' roles division: Empowering non-physicians

The columns in table 6.3 correspond to the same models as the ones presented in table 6.2 except that the dependent variable is the empowerment of non-physicians. H1a, that individuals who belong to low status organizations are more likely to initiate divergent organizational change is not supported (see column 2). In contrast, there is support for H1b, that individuals who belong to low status social groups are more likely to initiate divergent organizational change, that is, to empower non-physicians (see column 2). Results support H2, that the higher individuals are in organizational hierarchy, the more likely they are to initiate divergent organizational changes that aim to empower non-physicians (see column 2). H4, that the higher individuals' inter-organizational mobility, the more likely they are to initiate divergent organizational changes that aim to empower non-physicians is not supported (see column 2). None of the two hypotheses (H3a and H3b) that concern the interaction between individuals' position in the organizational field and in the organization are supported (see columns 3 and 4). However, there is a statistically significant relationship between individuals' likelihood to break with social groups' roles division and the interaction term between the status of the social group to which individuals belong and their hierarchical position (see column 4). This relationship is the opposite of the one hypothesized in H3b. Indeed there is a negative relationship between individuals' likelihood to break with social groups' roles division and the interaction term between the status of the social group to which individuals belong and their hierarchical position. As for the control variables (see column 1), individuals' seniority in a management position has a positive and significant impact on individuals' likelihood to initiate changes that aim to break with the institutionalized model of social groups' roles division. Insofar as changing social groups' roles division has important power implications, management experience is very helpful for initiating such changes. Having more experience, people with more seniority in a management position are more likely to dare to initiate such changes. Finally, there is no statistically significant relationship between individuals' duration of tenure in a position and their likelihood to act as institutional entrepreneurs. Similarly to the results obtained for changes that break with the institutionalized model of organizations' roles division, the results provide mixed support for the impact of individuals' social position on their likelihood to break with the institutionalized model of professionals' roles division.

Table 6.3: The impact of individuals' social position on individuals' likelihood to initiate a change that aims to change professionals' roles division

	(1)	(2)	(3)	(4)	(5)
Seniority in a management position	0.082 ** (0.032)	0.082 ** (0.039)	0.092 ** (0.042)	0.075 * (0.039)	0.087 ** (0.043)
Duration of tenure in current position	0.058 (0.072)	0.102 (0.075)	0.094 (0.077)	0.129 (0.087)	0.123 (0.092)
Inter-organizational mobility		-0.020 (0.078)	-0.033 (0.084)	0.012 (0.082)	-0.001 (0.086)
Low status organization		0.264 (0.461)	1.564 (1.623)	0.268 (0.463)	1.768 (1.618)
Low status social group		0.777 * (0.556)	0.635 (0.601)	7.766 ** (4.482)	7.995 ** (4.564)
Hierarchical position		0.531 ** (0.236)	0.672 *** (0.263)	2.290 ** (1.136)	2.551 ** (1.189)
Hierarchical position x Low status organization			-0.428 (0.521)		-0.492 (0.514)
Hierarchical position x Low status social group				-1.869 * (1.188)	-1.977 * (1.220)
Log pseudolikelihood	-146.11	-142.81	-142.34	-141.36	-140.74
Wald chi-squared	8.54 **	13.29 **	14.20 **	20.88 ***	20.90 ***
Δ LR-test		6.60	7.53	9.51 *	10.74 *

N=93; Robust standard errors in parentheses
* significant at 10%; ** significant at 5%; *** significant at 1%
Statistical significance based on one-tailed tests for all independent variables and interaction terms
Δ LR-test based on comparison with model (1)

CHAPTER 7
DISCUSSION AND CONCLUSION

In this dissertation, I investigate the question of the impact of individuals' social position in a given organizational field on their likelihood to initiate divergent organizational change, that is, to act as institutional entrepreneurs. The study that I conducted provides insight into the different types of divergent organizational change that exist. It shows that depending on the type of divergent organizational change that is considered the profile in terms of social position of individuals' who are more likely to act as institutional entrepreneurs is not the same.

In this chapter, I first discuss the findings associated with the different characteristics of individuals' social position that are taken into account in the model. Then, I highlight the theoretical contributions of this study. Next, I present the different avenues for future research that it contributes to opening up. Finally, I highlight its managerial implications.

7.1. The impact of the different characteristics of individuals' social position

7.1.1. The impact of individuals' position in the organizational field

To begin with, the results show that the characteristic of individuals' position in the organizational field that affects their likelihood to act as institutional entrepreneurs is not the same depending on the dimension on which they break with the dominant institutional logic. When it comes to breaking with the institutionalized model of organizations' roles division, individuals who belong to low status organizations (i.e., PCTs in the study) are more likely to act as institutional entrepreneurs. Alternatively, when it comes to breaking with the institutionalized model of social groups' roles division, individuals who belong to low status social group(s) (i.e., low status professionals in the study) are more likely to act as institutional entrepreneurs. In contrast, the relationship between the status of the organization to which individuals belong and their likelihood to act as institutional entrepreneurs is not significant when it comes to breaking with the institutionalized model of social groups' roles division. Similarly, the relationship between the status of the social group(s) to which individuals belong and their likelihood to act as institutional entrepreneurs is not significant when it comes to breaking with the institutionalized model of organizations' roles division. These results suggest that individuals act as institutional entrepreneurs when they are disadvantaged by the existing institutional arrangements. They are

consistent with results of studies (Leblebici et al., 1991; Havemand and Rao, 1997; Garud et al., 2002) that were conducted at the organizational level of analysis and that showed that organizations that are disadvantaged by the existing institutional arrangements are more likely to act as institutional entrepreneurs. These results also show that there are at least two different categories of institutional arrangements (i.e., institutional arrangements that have to do with organizations' roles division and institutional arrangements that have to do with social groups' roles division). Individuals may be advantaged by one category of institutional arrangements and disadvantaged by another one. As a result, depending on their position in the organizational field, individuals may act as institutional entrepreneurs when it comes to breaking with organizations' roles division but not when it comes to breaking with social groups' roles division (or vice versa).

7.1.2. The impact of individuals' position in the organization

In addition to individuals' position in the organizational field, it is clear that their position in organizational hierarchy has a key impact on their likelihood to act as institutional entrepreneurs. But the impact of individuals' hierarchical position is not the same depending on the dimension on which institutional entrepreneurs break with the dominant institutional logic in the organizational field. When it comes to breaking with the institutionalized model of social groups' roles division, the higher individuals are in the hierarchy of their organization, the more likely they are to act as institutional entrepreneurs. In contrast, when it comes to breaking with the institutionalized model of organizations' roles division, the higher individuals are in the hierarchy of their organization, the less likely they are to act as institutional entrepreneurs. This radically different impact of individuals' hierarchical position on their likelihood to act as institutional entrepreneurs may be due to the fact that one type of divergent organizational change (change in social groups' roles division) implies mainly changes that are internal to the organization, while the other type of divergent organizational change (change in organizations' roles division) implies changes that are also external to the organization. Individuals who are higher in the hierarchy of their organization are more able to initiate divergent organizational change within their organization because they have more legitimacy and they have access to more resources than others ((Tushman and Romanelli, 1985). For this reason, they are more likely than others to change social groups' roles division within their organization and thereby to break with the institutionalized model of social groups' roles division in the organizational field. Meanwhile, individuals who are higher in organizational hierarchy are more likely to conform to

inter-organizational rules of interaction. For this reason, they are less likely to change organizations' roles division.

7.1.3. Interaction between individuals' position in the organizational field and individuals' position in the organization

The impact of the interaction effect between the social group to which individuals belong and their position in organizational hierarchy is also radically different depending on the dimension on which institutional entrepreneurs break with the dominant institutional logic. This difference may be caused by the fact that when they get higher in the hierarchy of their organization, individuals may not only have access to more resources, but they may also position themselves differently with regard to both their social group and their organization. Indeed they may identify more with their organization or the group of top managers in their organization and less with their social group, which is likely to have a different impact on their willingness to act as institutional entrepreneurs depending on the type of divergent organizational change that is considered.

To adequately interpret the impact of the different interaction terms on individuals' likelihood to act as institutional entrepreneurs, it is necessary to keep in mind the findings that are associated with the variables involved in these interaction terms. To begin with, the findings suggest that the higher individuals get in organizational hierarchy, the less likely they are to act as institutional entrepreneurs when it comes to breaking with the institutionalized model of organizations' roles division. However, the results associated with the interaction term between the social group to which individuals belong and their position in organizational hierarchy suggest that this effect is relatively stronger for individuals who belong to high status social groups than for individuals who belong to low status social groups. In other terms, the dampening effect of higher hierarchical position on individuals' likelihood to act as institutional entrepreneurs is less pronounced for those who belong to low status social groups than for those who belong to high status social groups. It may be due to the fact that individuals who belong to low status social groups have more experience when it comes to fighting against the status quo because of their social group belonging. As a result, even when they get higher in organizational hierarchy, they may be less likely to conform with the existing rules of inter-organizational relationship than individuals who belong to high status social groups.

We know that when it comes to breaking with social groups' roles division, individuals who belong to low status social group(s) are more like to act as institutional entrepreneurs because they are less favored by the existing institutional arrangements than individuals who belong to high status social groups. However, the results associated with the interaction term between the social group to which individuals belong and their position in organizational hierarchy suggest that once they made it to the top of the hierarchy of their organization individuals who belong to low status social groups are relatively less likely to initiate changes that aim at changing social groups' roles division. In other terms, the positive impact of higher hierarchical position on individuals' likelihood to act as institutional entrepreneurs is less pronounced for those who belong to low status social groups than for those who belong to high status social groups.

A very similar phenomenon has been observed in studies about both women and ethnic minorities in the workplace. It has been shown that women who made it to the top of organizational hierarchy sometimes display the "queen bee" syndrome (Kanter, 1977a, 1997b; Cohen, Broshak and Haveman, 1998) considering that the inclusion of other women threatens their special status. In the same vein, studying the conditions that enable black, urban, poor job seekers to mobilize their network of relations for job-finding assistance, Smith (2005) shows that the black urban poor's difficulty to find jobs is not only due to social isolation from mainstream ties and institutions but also to the fact that within this community job contacts often express great reluctance to assist their job seeking ties because they perceive pervasive untrustworthiness among their job-seeking ties and choose not to assist. One reason for this phenomenon is that job contacts think of the potential damage job seekers might do to their own reputation, if they do not perform well. The findings of the study that I conducted are similar to the above cited ones insofar as they suggest that individuals who belong to low status social groups are more reluctant to promote other individuals who belong to low status social groups when they get higher in organizational hierarchy.

There are different possible explanations of such behavior. It may be that once they made it to the top, they feel that it is not necessary to fight anymore since they reached their personal objective. In other terms, they may have a very individualistic approach. In the same vein, they may feel that other people who belong to low status social group(s) are a potential threat for them. For this reason, they may prefer not to empower people who belong to low status social group(s) in order to protect their hierarchical position. This explanation is equivalent to the

"queen bee" syndrome explanation of the prejudice of some women against other women in the gender literature. Another possible explanation has to do with the fact that when they get higher in organizational hierarchy, individuals may identify more with their organization and less with their social group. As a result, they may have less incentive to empower individuals who belong to low status social groups. Finally, an alternative explanation that is related to the latter one is that in order to be regarded as legitimate members of the group of top managers, they do anything that they can to make other organizational members forget that they belong to a low status social group. In particular, they avoid empowering people who belong to low status social groups. This type of behavior is a way for them to demonstrate loyalty to the group of top managers. Note that this explanation corresponds to one of the explanations that Kanter (1977a, 1977b) provides for the "queen bee" syndrome.

The other interaction effect which is the interaction effect between the status of the organization to which individuals belong and their position in organizational hierarchy has no significant impact either on individuals' likelihood to break with the institutionalized model of organizations' roles division or on their likelihood to break with the institutionalized model of social groups' roles division. The type of organizational setting (i.e., low status organizations vs. high status organizations) neither reinforces nor dampens the impact that individuals' position in organizational hierarchy has on the likelihood for them to act as institutional entrepreneurs.

7.1.4. The impact of changes in individuals' social position

Finally, the results show that individuals whose inter-organizational mobility has been higher are more likely than others to act as institutional entrepreneurs when it comes to breaking with the institutionalized model of organizations' roles division. Individuals who have been working in different organizations are more likely to have been exposed to different models of organization if there are any in the organizational field. As a result, they are more likely not to take-for-granted the current functioning of their organization and thereby to take a reflective stance toward it. In addition, these individuals are more likely to know what the needs for inter-organizational cooperation are and who should cooperate with whom in order to fulfil these needs. For these reasons, individuals whose inter-organizational mobility has been higher are more likely to try and change organizations' roles division within a given organizational field. In contrast, there is no significant relationship between inter-organizational mobility and individuals' likelihood to initiate changes that aim to change social group(s)' roles division.

Taken together these results suggest that individuals' social position in a given organizational field is an important enabling condition for institutional entrepreneurship but that its impact varies depending on the dimension on which individuals break with the dominant institutional logic. Thus, when dealing with institutional entrepreneurship, it is essential to analyze the type of divergent organizational change that individuals initiate. People with different profiles in terms of social position will be more likely to initiate different types of divergent organizational changes. One should stop talking about divergent organizational change in general. Instead, one should specify the dimension on which a divergent organizational change diverges from the dominant institutional logic in a given organizational field.

7.2. Theoretical contributions

There are a number of contributions associated with this study. First, the focus on individuals' social position contributes to the development of neo-institutional theory by linking the individual level of analysis back to the organizational and organizational field ones. Of course, such an approach does not imply that individuals' actions are the only sources of institutional change. As already explained in the introduction, I agree with Jepperson (1991) when he states that successful influence attempts by a delimited agent, carrying a specific interest, represent only one category of possible social change explanations. Institutional change processes are complex processes, in which different types of forces and agents are involved. However, individual change agents' actions, which have so far received scant attention, correspond to one type of force that might affect the institutional order. In the layered model of institutions that he proposes, Scott (1994: 57) includes human agents and highlights the interactions that exist between human agents and institutional elements. Briefly describing the role of human agents, he states:

"Although the focus of institutional theory is on symbols and meanings and rules, I believe that it is essential that we not lose sight of the human agents that are creating and applying these symbols, interpreting these meanings, and formulating, conforming to, disobeying, and modifying these rules" (Scott, 1994: 60).

This study contributes to not losing sight of human agents.

It also contributes to better accounting for the nature of institutional change processes. To comprehensively account for these processes, it is necessary to rely on a multi-level approach that aims at capturing the interactions that exist between the different levels of analysis. Actors, be they organizations or individuals, are both constrained and enabled by their institutional

environment (Sewell, 1992). In other terms, the nature of institutional processes is both isomorphic and constitutive (Strang and Sine, 2002). Multi-level research, taking into account the individual, organizational and organizational field levels of analysis, has been suggested as a promising avenue of research for studies dealing with institutional change and thereby aiming to account for the dual nature of institutional processes (Occasio, 2002; Palmer and Biggart, 2002; Strang and Sine, 2002). However, there has been little work so far in this direction (Reay and Hinings, 2005). One reason for this may be that the relevant temporal and spatial dimensions for studying variation in institutions and individual actions are not the same. This paper contributes to overcoming this obstacle by focusing on divergent organizational change. Such focus is a methodological device that renders multi-level research feasible within the theoretical framework of neo-institutional theory.

A third contribution that is related to the previous ones has to do with the fact that this study highlights the role of individuals in institutionalization processes. These processes have already been studied quite extensively. Neoinstitutionalists (e.g., Meyer and Rowan, 1977; DiMaggio and Powell, 1983; Meyer and Scott, 1983) have insisted on the central role of legitimacy in such processes. They argue that concerns over legitimacy force organizations to adopt managerial practices and/or organizational forms that other organizations have. The problem with most of these studies is that they do not account for the behavior of early adopters who adopt practices and/or organizational forms that are not yet regarded as legitimate in a given organizational field. As Greenwood and Hinings (1996: 1044) note, there is a need for more in-depth studies of 'early movers.' In their well-known study on civil service reform in US municipalities, Tolbert and Zucker (1983) examine the behavior of both early and late adopters. They find that early adopters are driven to change by technical-competitive reasons, while late adopters are driven by the necessity to conform to what has become best practice in order to be regarded as legitimate. However, Tolbert and Zucker (1983) do not explain how early adopters are enabled to diverge from the institutionalized practice. In addtion, it is striking to note that most of the studies about institutionalization processes have concentrated on the organizational level of analysis. Only few studies have taken into account the individual level of analysis. Some of them (e.g., Davis, 1991; Davis and Greve, 1997) have shown that diffusion processes are mediated by inter-personal networks that connect organizational decision makers (executives, board members) through profesionnal and business associations and interlocking memberships. Others (e.g., Abernethy, 2000; Kraatz and Moore, 2002) have highlighted the role of movements

of people in the diffusion of new practices and/or organizational forms that break with the dominant institutions in a given organizational field. This dissertation complements the existing studies by focusing on the role of early individual adopters in the diffusion of practices and/or organizational forms that diverge from the dominant institutional logic in a given organizational field.

From a theoretical perspective, the model that I developed and tested in this dissertation also participates in the development of the body of research about institutional entrepreneurship by highlighting the enabling role of individuals' social position. Researchers have already identified field-level and organizational-level enabling conditions for institutional entrepreneurship. I complement their work by highlighting the impact of an individual-level condition on the likelihood of the occurrence of institutional entrepreneurship. The focus on the enabling role of individuals' social position provides new guidelines for overcoming the paradox of embedded human agency. Overcoming this paradox is crucial because it is a prerequisite to setting up the foundations for a theory of institutional entrepreneurship which, in fact, corresponds to the theory of action of neo-institutional theory. In the introduction of their famous book *New Institutionalism in Organizational Analysis*, DiMaggio and Powell (1991) called for the development of such a theory of action. The lack of an explicit and coherent theory of action is at the core of neo-institutional theory's weakness when it comes to explaining change, since it does not make clear the role of actors and action in the creation, diffusion, and stabilization of institutions (Christensen, Karnoe, Pedersen and Dobbin, 1997). The problem of neo-institutional theory is that it offers organizational-level and organizational field-level explanations for phenomena that implicitly involve individual behavior without providing a basis for the construction of a theory of individual behavior. By offering guidelines to overcome the paradox of embedded human agency, the model contributes to setting up micro-foundations for the development of such a theory of individual behavior within the theoretical framework of neo-institutional theory.

Finally, this study makes an important contribution to the organizational change literature by suggesting that divergent organizational change should be treated as a multi-dimensional concept rather than a uni-dimensional one. The findings suggest that, in multi-professionalized fields such as the NHS, there are at least two different dimensions on which a change project may break with the dominant institutional logic. Therefore, there are at least two types of divergent organizational change, i.e., changes that break with the institutionalized model of organizations'

roles division and changes that break with the institutionalized model of social groups' roles division. When dealing with divergent organizational change, one should systematically identify the dimension on which the change under study breaks with the dominant institutional logic, instead of talking about divergent organizational change in general.

7.3. Future research directions

This study opens up a number of paths for future research about divergent organizational change and institutional entrepreneurship. First, it would be interesting to test the model in different empirical settings. It will enable researchers to draw comparison across different contexts. It may be that the impact of individuals' social position on their likelihood to initiate divergent organizational change is not the same depending on the characteristics of the organizational field under study. The organizational field of the NHS is quite mature and conducive to action. It has reached some degree of maturity insofar as it represents relatively well-structured configurations of actors (be they organizations or individuals) that are aware of their involvement in a common enterprise, and among which there are identifiable patterns of interaction such as domination, subordination, conflict and cooperation (DiMaggio and Powell, 1983). In addition, I showed in chapter 4 that the characteristics of the NHS are conducive to action. It may be that, in environements that are less mature or less conducive to change, social position does not have the same impact as the one described in this study. For example, under certain circumstances, actors who are favored by institutional arrangements, i.e., individuals who belong to high status organizations and/or high status social groups, may act as institutional entrepreneurs. Some studies (Sherer and Lee, 2002; Greenwood and Suddaby, 2006) have showed that in certain situations high status organizations may act as institutional entrepreneurs. It is necessary to figure out whether the same phenomenon can be observed at the individual level and if so, to highlight the circumstances under which individuals who belong to high status organzitions and/or high status social groups are more likely to act as institutional entrepreneurs. It would enable researchers to develop a contingent model of the impact of individuals' social position on the likelihood for them to act as institutional entrepreneurs.

Second, it would be worth analyzing the impact of other aspects of individuals' social position, such as individuals' position in informal organizational networks and individuals' position in multiple organizational fields, on the likelihood for them to act as institutional entrepreneurs. Individuals' position in informal organizational networks is out of the scope of this

study but it may have an impact on individuals' likelihood to act as institutional entrepreneurs. Some studies (e.g., Valley and Thompson, 1998) have explored the influence of intra-organizational networks on the adoption of organizational changes. Analyzing the tension between management's power to prescribe organizational structure and employees' resistance in a metropolitan newspaper undergoing a change in organizational structure, Valley and Thompson (1998) have showed that employees' degree of resistance to change was partly determined by their position in intra-organizational networks. This finding suggests that certain types of ties may contribute to undermine people's resistance to organizational change. In particular, it may be that, depending on their position in intra-organizational networks, individuals belonging to low status social groups are able to undermine the resistance to divergent organizational change of individuals belonging to high status social groups. Specifically, among individuals who belong to low status social groups, those who have strong ties with individuals belonging to high status social groups in their organization may rely on those ties to conduct divergent organizational changes. The strength of tie is a combination of "the amount of time, the emotional intensity, the intimacy (mutual confiding) and the reciprocal services which characterize the tie" (Granovetter, 1973: 1361). Strong ties promote trust and reciprocity and facilitate the transfer of private information and critical resources (Gulati, Dialdin and Wang, 2002). Individuals who belong to low status social groups may rely on strong ties with individuals who belong to high status social groups to undermine their potential resistance and to gain access to the key resources that they need to initiate divergent organizational change. Knowing that they can mobilize these ties and having strong incentives to conduct divergent organizational change, individuals who belong to lower status social groups may be more likely to initiate divergent organizational change.

Another aspect of individuals' social position that I do not account for in the model that I developed and tested corresponds to multiple embeddedness. Most often individuals are simultaneously embedded in multiple organizational fields. For this reason, they are likely to be aware of the existence of different institutional arrangements, if they are any in the different organizational fields in which they are embedded. Such awareness is likely to trigger their reflective capacity (Emirbayer and Mische, 1998): knowing that other institutional arrangements exist, they are less likely to take-for-granted the institutional arrangements that characterize a given organizational field. In addition, because institutional arrangements are transposable (Sewell, 1992), individuals who are embedded in multiple organizational fields may act as institutional entrepreneurs by transposing institutional arrangements from one organizational field

to another. A number of questions about the impact of multiple embeddedness on individuals' likelihood to act as institutional entrepreneurs still need to be addressed. Are individuals more likely to act as institutional entrepreneurs, the higher the number of organizational fields in which they have been embedded? Is the likelihood of individuals to act as institutional entrepreneurs dependent on the degree of similarity of the different organizational fields in which they are embedded?

Apart from individuals' social position, other individual factors may be conducive to institutional entrepreneurship but analyzing their role without accounting for the fact that individuals are embedded in a social position corresponds to the trap of methodological individualism and, thereby, is in contradiction with the premises of neo-institutional theory. Now that this study has highlighted the key role of individuals' social position, future research may explore the impact that other individual factors, such as psychological factors and individuals' social skills, have their likelihood to act as institutional entrepreneurs. A number of studies (e.g. Dorado 2005; Fligstein, 1997, 2001; Seo and Creed 2002) have started exploring this new path of research. Fligstein (1997, 2001) considers that institutional entrepreneurs are socially skilled actors. Social skills revolve around empathy. Institutional entrepreneurs are able to relate to the situations of other actors and, in doing so, are able to provide those people with reasons to cooperate. Fligstein (1997, 2001) considers these social skills as distinctive for institutional entrepreneurs. On the other hand, Dorado (2005) and Seo and Creed (2002) emphasize the importance of individuals' temporal orientation for institutional entrepreneurship. They argue that one condition for institutional entrepreneurship is the ability to envision the possibility of change. Relying on the work by Emirbayer and Mische (1998) about human agency, both Dorado (2005) and Seo and Creed (2002) have highlighted that to act as institutional entrepreneurs, individuals must display a projective capacity that is the capacity to imaginatively generate possible future trajectories of action that may lead to the creative reconfiguration of existing structures of thought and action. In other terms, institutional entrepreneurs are oriented toward the future. This temporal orientation toward the future favors the emergence of Praxis – i.e. the free and creative reconstruction of social arrangements on the basis of a reasoned analysis of both the limits and the latent potentials of present social forms (Seo and Creed, 2002). Individuals' social position may of course affect their social skills development and their temporal orientation but other individual-level conditions may play a key role. Future research may explore the impact that psychological factors have on individuals' social skills and temporal orientation, and thereby on

the likelihood for them to act as institutional entrepreneurs. This line of inquiry, although promising, is very demanding because it requires researchers to control for the impact of other identified enabling conditions to avoid the trap of methodological individualism. One way to avoid this trap is to examine the role of psychological factors in relation with individuals' social position. Such an approach will more comprehensively account for individual-level enabling conditions for institutional entrepreneurship.

Finally, future research should highlight the profile of individuals who are more likely to succeed when acting as institutional entrepreneurs. In the frame work of the research that I conducted, the individuals who succeeded were the ones who managed to institutionalize their change project in their organization. I developed a questionnaire (see Appendix 5) with two of my colleagues of the Healthcare Management Initiative research team, Jeffrey Alexander and Mattia Gilmartin, in order to assess the degree of institutionalization of the change projects. This questionnaire aims to gather information not only about the degree of institutionalization of the change projects but also about the strategies that the ninety-three clinical managers used while implementing their change project. It was administered by phone to all the participants after one year of change project implementation. The next step in my research program is to use these data to highlight the profile of the successful institutional entrepreneurs and the type of strategy that they used to implement their divergent organizational change project. I would like to supplement quantitative research methods with qualitative research methods for the analysis of the different strategies that individuals acting as institutional entrepreneurs used to conduct divergent organizational change in their organization. To do so, I will use the four in-depth case studies that I conducted. The four managers who implemented these change projects all behaved as institutional entrepreneurs but they used different strategies to conduct their change projects.

7.4. Managerial implications

The model that I presented and tested in this dissertation has some key managerial and policy implications. In particular, it helps to identify the individuals who are more likely to be leaders in implementing organizational changes that challenge well-established, traditional models and practices. Such identification may be crucial. In any society, one can see organizations that go on using institutionalized practices even though they are permanently failing the organization (Meyer and Zucker, 1989). To break this vicious circle, it is necessary to know how to change institutionalized practices. One possible source of change, among others, is

the action of individuals acting as institutional entrepreneurs. For this reason it is important to be able to identify individuals who are more likely to act as such.

When CEOs want to implement changes that break with the existing institutions in a field, they need to identify the people on whom they can rely to locally initiate these changes. Similarly, when governments are facing reform challenges that require a break with the dominant models of organization in their country, the question of being able to identify the individuals who are more likely to be among the first to implement such reforms locally (i.e., in their organization) is a very important one for policy makers. The problem for governments is not only to develop and propose new organizational designs, but also to persuade the different actors involved in public organizations to actually put into practice and adopt those new organizational designs. It takes quite a long time before a change is institutionalized (Greenwood and Hinings, 1996), especially in public organizations, which are well known for their structural inertia. Governments can of course rely on coercive pressures to force the different actors to adopt organizational changes. However, the institutionalization process does not only rely on coercive pressures stemming from governments. Such a top-down approach is simplistic and misleading. For changes to be adopted and then institutionalized within public organizations, they also have to be supported and promoted locally (i.e., within each public organization) by some organizational members who become the local champions of the reform. Thus, highlighting the profile of individuals who are more likely to act as institutional entrepreneurs will help CEOs or government to identify these local champions on whom they can rely when they need to implement major changes that break with institutionalized practices.

The results of this study suggest that there is not one single profile of individuals who are more likely to act as institutional entrepreneurs. Depending on the type of divergent organizational change that is considered, the profile in terms of social position of individuals who are more likely to act as institutional entrepreneurs is not the same. When a CEO or a government wants to initiate major reforms, they should first think of the nature of these reforms in order to identify the type of divergent organizational change that early adopters will have to locally initiate. Then, taking into account the type of divergent organizational change, they should try to identify the profile in terms of social position of the individuals on whom they can rely to locally initiate it.

7.5. Conclusion

Who are the individuals who are more likely to act as institutional entrepreneurs? The results of this study show that, among other variables, the individuals' social position influences their likelihood to act as institutional entrepreneurs. The results further suggest that depending on the dimension on which institutional entrepreneurs break with the dominant institutional logic, the profile, in terms of social position of the individuals who are more likely to act as institutional entrepreneurs, is radically different. Such findings have important implications insofar as they contribute to better identifying the individuals who are more likely to locally initiate major reforms in the private as well as in the public sector, that is, to act as local champions of reforms.

This study is a first step toward the identification of these local champions. It is now necessary to analyze the impact that individual factors other than individuals' social position may have on individuals' likelihood to act as institutional entrepreneurship. Future research may explore the impact that psychological factors and social skills have on the likelihood for individuals to act as institutional entrepreneurs. Another important avenue for future research is the profile(s) analysis of the individuals who are more likely to succeed when acting as institutional entrepreneurs. In other terms, we need to know more both about the characteristics of the local champions of reforms and about the characteristics of the successful local champions who manage to institutionalize divergent organizational changes.

Among the indicators of progress of neo-institutional theory over the last 15 years that Scott (2001) considers, agency occupies a prominent position. The model that I developed and tested in this dissertation further examines the issue of agency in neo-institutional theory. It provides new guidelines to overcoming the paradox of embedded human agency. By doing so, it contributes to setting up micro-foundations for the development of a theory of institutional entrepreneurship. The development of this theory is all the more important as it will render neo-institutional theory more actionable by explaining how, in some situations, individuals may shape institutions. Far from being reductionist, this approach aims at accounting more comprehensively for institutional change phenomena by exploring the interactions that exist between the different levels of analysis.

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APPENDICES

APPENDIX 1: ENABLING CONDITIONS FOR INSTITUTIONAL ENTREPRENEURSHIP: A LITERATURE REVIEW

	Reference s	**Enabling conditions for institutional entrepreneurship**
1	Munir and Phillips, 2005.	
2	Demil and Bensédrine, 2005.	
3	Suddaby and Greenwood, 2005.	
4	Dorado, 2005.	Degree of fragmentation and institutionalization of the organziational field Actors' network position
5	Durand and McGuire, 2005.	Scarcity of resources and challenges in the existing domain
6	Lawrence, Mauws, Dyck and Kleysen, 2005.	
7	Maguire, Hardy and Lawrence, 2004.	
8	Phillips, Lawrence and Hardy, 2004.	
9	Lawrence and Phillips, 2004.	Actors draw from multiple pre-existing institutional fields and the ambiguous and contested macro-cultural discourse. They adapt and modify these institutions to fit their own purposes.
10	Déjean, Gond and Leca, 2004.	Emerging fields provide opportunities for action (need to reduce uncertainty, ensure legitimacy toward external stakeholders)
11	Anand and Watson, 2004.	
12	Levy and Egan, 2003.	Actors' position (institutional entrepreneurs can be positioned at the the margins and interstices of organizational fields).
13	Creed, Scully and Austin, 2002.	
14	Zimmerman and Zeitz, 2002	Emerging fields provide opportunities for action
15	Seo and Creed, 2002.	Contradictions among institutional logics, i.e. ruptures and inconsistencies both among and within the established social arrangements are the fundamental driving force of institutional change.
16	de Holan and Phillips, 2002.	
17	Dacin, Goodstein and Scott, 2002.	Pressures to change are either functional, political or social (Oliver, 1992).
18	Greenwood, Suddaby and Hinings, 2002.	-Social, technological and regulatory jolts bring about deinstitutionalization. -Actors' position (being at the intersice of different fields favors the awareness of emerging opportunities).

	Reference s	Enabling conditions for institutional entrepreneurship
19	Garud, Jain and Kumaraswamy, 2002.	-New technologies favors institutional entrepreneurship (emerging technological fields offer opportunity for action). -Actors' position in the field
20	Zilber, 2002.	Actors' position in the field
21	Lawrence, Hardy, and Phillips,2002.	
22	Fligstein, 2001.	Crises/ external jolts
	Wade-Benzoni, Hoffman, Thompson, Moore, Gillespie and Bazerman, 2002.	-Acute field-level problems -Activist groups connect the values of their cause with their personal identity, creating a value congruence that is a potent force for social change.
24	Rao, Morrill and Zald, 2000.	Opportunities arise from market failures: failure of trade associations, inadequacy of 'normal' incentives, failure of market mechanisms to reduce social costs, the exclusion of actors from traditional channels.
25	Phillips, Lawrence, and Hardy, 2000.	- Complex and multi-faceted problems not previously addressed - Collaboration with actors from other fields allows translation of institutions.
26	Beckert, 1999.	Institutional stability is the basis for strategic agency of institutional entrepreneurs.
27	Lawrence, 1999.	The potential for organizational actors to manage institutional structures depends both on the nature of the institutional context and on the resources held by the interested actors.
28 29	Rao and Sivakumar, 1999. Hardy and Phillips, 1999.	Institutional entrepreneurs develop discursive strategies based on discursive material available in the field and at the societal level.
30	Clemens and Cook, 1999.	Three conditions facilitate institutional entrepreneurship: (1) Mutability of the rules, (2) Internal contradictions of institutional arrangements, (3) Multiplicity of competing institutions constitutes an opportunity for agency. Exogenous events may also play a key role in initiating institutional change.
31	Rao, 1998.	Political support from the state, professions, key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar goods and services.
32	Haveman and Rao, 1997.	Technical requirements of consumer demands.
33	Fligstein, 1997.	"When the organizational field has no structure, the possibilities for strategic action are the greatest" (p. 401).
34	Fligstein and Mara-Drita, 1996.	External jolt that generate acute field problems that cannot be fixed generate a political opportunity for institutional entrepreneurs.

	Reference s	Enabling conditions for institutional entrepreneurship
35	Holm, 1995.	Enabling conditions include a market crisis, relative bargaining position of actor groups, conditions for collective action, and the access structure of the political system.
36	Suchman, 1995.	A weak technical or institutional environment facilitates the task of institutional entrepreneurs.
37	Rao, 1994.	Ambiguity, field emergence, lack of standards in field.
38	DiMaggio, 1991.	Ideological fit between institutional entrepreneurs and strategically positioned groups in the sector.
39	Leblebici, Salancik, Copay, King, 1991.	-Inconsistency or conflict between social order at the macro and micro level (p.337). -Actors' position in the field (peripheral actors are more likely to act as institutional entrepreneurs).
40	DiMaggio, 1988.	-Actors' position in the field -Transformation of an existing field/ contradictions in the field.

APPENDIX 2: INTERVIEW GUIDES

Interview guide for change agents

This interview guide has 4 different foci: (1) the interviewee's trajectory within the NHS, (2) the development of the change project, (3) the implementation of the change project, and (4) the interviewee's perception of the NHS and of its evolution.

The interviewee's trajectory within the NHS

Which jobs did you have before joining the NHS?

For how long have you been working in the NHS?

Which jobs have you had in the NHS?

For how long have you been working in your organization?

Could you tell me more about your current job?

Who are you reporting to?

What type of relationship do you have with your supervisors?

Who is reporting to you?

How many people are working for you?

What type of relationship do you have with your subordinates?

The development of the change project

How did you get the idea for your change project?

Why did you decide to implement such a change project? What were your objectives?

Was your change project inspired by a wider NHS initiative or policy?

Had the same kind of change project been implemented in other NHS organizations when you started implementing yours? Which ones? Did you contact them?

Did you rely on a model to implement your change project?

Why wasn't such a project implemented earlier in your organization?

How did you present your change project to your colleagues?

Did you discuss your change project with your colleagues before starting to implement it? Did these discussions lead you to modify your change project?

The implementation of the change project

Did you expect to encounter obstacles before starting to implement your change project? Which ones?

Which obstacles have you actually encountered while implementing your change project?

Have some moments been particularly difficult? Which ones?

How did you manage to overcome these difficulties? Who did you rely on do so?

How did the members of your organization react to your change project?

Did some people resist your change project? If so, who and why?

What are the outcomes of you change project?

Did your change project have unexpected consequences?

Are you satisfied with the outcomes of your change project?

How satisfied do you think the members of your organization are with the outcomes of your change project?

What would you do differently, if you had to implement your change project again?

Did your change project make a difference within your organization?

The interviewee's perception of the NHS

If the interviewee was already working within the NHS in 1990:

Since its creation the NHS has undergone a series of reforms. One of the major set of reforms is the 1991 reforms, which introduced an internal or quasi-market to the NHS. What did you think of the 1991 reforms?

Did these reforms change anything in your way of working?

Did they change anything in the way of functioning and/or in the organization of the NHS organization within which you were working at that time?

For all interviewees:

NHS organizations have many targets to reach. Isn't it complicated to deal with some many targets? Is it possible to comply with all of them? Which ones are the most important ones? Is there a hierarchy among the existing targets?

In the same way, there are many different NHS guidelines. Isn't it complicated to comply with these different NHS guidelines? Is there a hierarchy among the existing guidelines?

What do you think of the new NHS guidelines, which have been developed since 1997?

Did they change anything in your way of working?

Did they change anything in the functioning or in the organization of the NHS organization within which you are working?

Do you consider that the NHS has a clear policy? What are the main features of this policy?

What do you think of this policy?

Do you consider that your organization is in accordance with the NHS policy?

Do you feel that your project makes a difference within the NHS? If so, how?

Did you intend to change something across the NHS when you developed your change project?

Is the same kind of change project now implemented in other NHS organizations?

Omnibus questions

What did you learn from this experience from a personal point of view?

More generally, what are the rewarding aspects of your job? What is it that you like in your job? What are the less interesting aspects of your job?

Interview guide for interviewees whose work has been influenced by the change project

This interview guide has three different foci: (1) the interviewee's trajectory within the NHS, (2) the impact of the change project on his/her work, and (3) the interviewee's perception of the NHS and of its evolution.

The interviewee's trajectory within the NHS

Which jobs did you have before joining the NHS?

For how long have you been working in the NHS?

Which jobs have you had in the NHS?

For how long have you been working in your organization?

Could you tell me more about your current job?

Who are you reporting to?

What type of relationship do you have with your supervisors?

Who is reporting to you?

How many people are working for you?

What type of relationship do you have with your subordinates?

The impact of the change project

When did you first hear of the change project?

What was your reaction when you first heard of the change project?

Have you been consulted by the change agent and his/her team while they were developing and implementing the change project?

Have you done anything to support or resist the change project?

How did the change project impact your way of working? Is your way of working different than what it was prior to the implementation of the change project?

How did your colleagues react to the change project?

Did some people resist the change project? If so, who and why?

What are the consequences of the change project for you? For your organization?

What do you think of the outcome of the change project?

How satisfied do you think the members of your organization are with the outcome of the change project?

The interviewee's perception of the NHS

If the interviewee was already working within the NHS in 1990:

Since its creation the NHS has undergone a series of reforms. One of the major set of reforms is the 1991 reforms, which introduced an internal or quasi-market to the NHS. What did you think of the 1991 reforms?

Did these reforms change anything in your way of working?

Did they change anything in the way of functioning and/or in the organization of the NHS organization within which you were working at that time?

For all interviewees:

NHS organizations have many targets to reach. Isn't it complicated to deal with some many targets? Is it possible to comply with all of them? Which ones are the most important ones? Is there a hierarchy among the existing targets?

In the same way, there are many different NHS guidelines. Isn't it complicated to comply with these different NHS guidelines? Is there a hierarchy among the existing guidelines?

What do you think of the new NHS guidelines, which have been developed since 1997?

Did they change anything in your way of working?

Did they change anything in the functioning or in the organization of the NHS organization within which you are working?

Do you consider that the NHS has a clear policy? What are the main features of this policy?

What do you think of this policy?

Do you consider that your organization is in accordance with the NHS policy?

Do you feel that the change project makes a difference within the NHS? If so, how?

Is the same kind of change project now implemented in other NHS organizations?

Omnibus questions

What did you learn from this experience from a personal point of view?

More generally, what are the rewarding aspects of your job? What is it that you like in your job? What are the less interesting aspects of your job?

Interview guide for the change agent's supervisors

Like the previous one, this interview guide has four different foci: (1) the interviewee's trajectory within the NHS, (2) the development of the change project, (3) the implementation of the change project, and (4) the interviewee's perception of the NHS and of its evolution.

The interviewee's trajectory within the NHS

Which jobs did you have before joining the NHS?

For how long have you been working in the NHS?

Which jobs have you had in the NHS?

For how long have you been working in your organization?

Could you tell me more about your current job?

Who are you reporting to?

What type of relationship do you have with your supervisors?

Who is reporting to you?

How many people are working for you?

What type of relationship do you have with your subordinates? With the change agent?

The development of the change project

Were you involved in the development of the idea for the change project that has been implemented by the change agent? If so, how did you get the idea for this change project?

If not involved:

When did you first hear of the change project?

What was your reaction when you first heard of the change project?

How did the change agent present you the change project?

Did you support this project? Why?

What did you expect from this change project?

Was this change project inspired by a wider NHS initiative or policy?

Why wasn't such a project implemented earlier in your organization?

The implementation of the change project

What was your role in the implementation of the change project?

Did you participate actively in the implementation of the change project?

Have you been more active at certain moments? When?

Prior to the implementation of the change project, did you expect that the change agent would encounter obstacles? Which ones?

Which obstacles has the change agent encountered while implementing the change project?

What did you do to help him/her?

How did the members of your organization react to the change project?

Did some people resist the change project? If so, who and why?

What are the outcomes of the change project?

Did the change project have unexpected consequences?

Are you satisfied with the outcomes of the change project?

How satisfied do you think the members of your organization are with the outcomes of the change project?

What do you think of the change agent's performance?

What do you think he/she could have done better?

Was it worth implementing this change project?

Did the change project make a difference within your organization?

The interviewee's perception of the NHS

If the interviewee was already working within the NHS in 1990:

Since its creation the NHS has undergone a series of reforms. One of the major set of reforms is the 1991 reforms, which introduced an internal or quasi-market to the NHS. What did you think of the 1991 reforms?

Did these reforms change anything in your way of working?

Did they change anything in the way of functioning and/or in the organization of the NHS organization within which you were working at that time?

For all interviewees:

NHS organizations have many targets to reach. Isn't it complicated to deal with some many targets? Is it possible to comply with all of them? Which ones are the most important ones? Is there a hierarchy among the existing targets?

In the same way, there are many different NHS guidelines. Isn't it complicated to comply with these different NHS guidelines? Is there a hierarchy among the existing guidelines?

What do you think of the new NHS guidelines, which have been developed since 1997?

Did they change anything in your way of working?

Did they change anything in the functioning or in the organization of the NHS organization within which you are working?

Do you consider that the NHS has a clear policy? What are the main features of this policy?

What do you think of this policy?

Do you consider that your organization is in accordance with the NHS policy?

Do you feel that the change project makes a difference within the NHS? If so, how?

Is the same kind of change project now implemented in other NHS organizations?

Omnibus questions

What did you learn from this experience from a personal point of view?

More generally, what are the rewarding aspects of your job? What is it that you like in your job? What are the less interesting aspects of your job?

Interview guide for the members of the change project team

Like the previous one, this interview guide has four different foci: (1) the interviewee's trajectory within the NHS, (2) the development of the change project, (3) the implementation of the change project, and (4) the interviewee's perception of the NHS and of its evolution.

The interviewee's trajectory within the NHS

Which jobs did you have before joining the NHS?

For how long have you been working in the NHS?

Which jobs have you had in the NHS?

For how long have you been working in your organization?

Could you tell me more about your current job?

Who are you reporting to?

What type of relationship do you have with your supervisors?

Who is reporting to you?

How many people are working for you?

What type of relationship do you have with your subordinates?

The development of the change project

When did you first hear of the change project?

What was your reaction when you first heard of the change project?

When and by whom were you contacted to work on the change project?

How did the change agent present you the change project?

Did you participate in the development of this change project?

Why did you agree to participate to the implementation of this change project?

What were your objectives when you started implementing this change project?

Was this change project inspired by a wider NHS initiative or policy?

Why wasn't such a project implemented earlier in your organization?

The implementation of the change project

What was your role in the implementation of the change project?

Did you expect to encounter obstacles before starting to implement the change project? Which ones?

Which obstacles have you actually encountered while implementing the change project?
Have some moments been particularly difficult? Which ones?

How did you manage to overcome these difficulties? Who did you rely on do so?

How did the members of your organization react to the change project?

Did some people resist the change project? If so, who and why?

What are the outcomes of the change project?

Did the change project have unexpected consequences?

Are you satisfied with the outcomes of the change project?

How satisfied do you think the members of your organization are with the outcomes of the change project?

What would you do differently, if you had to participate in the implementation of the change project again?

Did the change project make a difference within your organization?

The interviewee's perception of the NHS

If the interviewee was already working within the NHS in 1990:

Since its creation the NHS has undergone a series of reforms. One of the major set of reforms is the 1991 reforms, which introduced an internal or quasi-market to the NHS. What did you think of the 1991 reforms?

Did these reforms change anything in your way of working?

Did they change anything in the way of functioning and/or in the organization of the NHS organization within which you were working at that time?

For all interviewees:

NHS organizations have many targets to reach. Isn't it complicated to deal with some many targets? Is it possible to comply with all of them? Which ones are the most important ones? Is there a hierarchy among the existing targets?

In the same way, there are many different NHS guidelines. Isn't it complicated to comply with these different NHS guidelines? Is there a hierarchy among the existing guidelines?

What do you think of the new NHS guidelines, which have been developed since 1997?

Did they change anything in your way of working?

Did they change anything in the functioning or in the organization of the NHS organization within which you are working?

Do you consider that the NHS has a clear policy? What are the main features of this policy?

What do you think of this policy?

Do you consider that your organization is in accordance with the NHS policy?

Do you feel that the change project makes a difference within the NHS? If so, how?

Is the same kind of change project now implemented in other NHS organizations?

Omnibus questions

What did you learn from this experience from a personal point of view?

More generally, what are the rewarding aspects of your job? What is it that you like in your job? What are the less interesting aspects of your job?

APPENDIX 3

QUESTIONNAIRE FOR THE CODING OF THE CHANGE PROJETCS

Professionals' roles division:

1. To what extent does the project aim to increase nurses'/AHPs'/managers' decision making power in the clinical domain?

No extent	Some extent	Great extent
☐	☐	☐

2. To what extent does the project aim to increase nurses'/AHPs'/managers' decision making power in the administrative domain?

No extent	Some extent	Great extent
☐	☐	☐

3. To what extent does the project aim to decrease doctors' decision making power in the clinical domain?

No extent	Some extent	Great extent
☐	☐	☐

4. To what extent does the project aim to decrease doctors' decision making power in the administrative domain?

No extent	Some extent	Great extent
☐	☐	☐

Organizations' roles division:

5. To what extent does the project aim to increase the influence of the primary care sector in the clinical domain?

No extent	Some extent	Great extent
☐	☐	☐

6. To what extent does the project aim to increase the influence of the primary care sector in the administrative domain?

No extent	Some extent	Great extent
☐	☐	☐

7. To what extent does the project aim decrease the influence of the secondary care sector in the clinical domain?

No extent	Some extent	Great extent
☐	☐	☐

8. To what extent does the project aim to decrease the influence of the secondary care sector in the administrative domain?

No extent	Some extent	Great extent
☐	☐	☐

9. To what extent does the project aim to improve cooperation across organizations (especially across primary, secondary and social care organizations)?

No extent	Some extent	Great extent
☐	☐	☐

10. To what extent does the project aim to promote continuous care through integration of services?

No extent	Some extent	Great extent
☐	☐	☐

APPENDIX 4

CODING INSTRUCTIONS FOR THE RATERS

All the project descriptions that you will read display the same structure. They fall into 6 parts:
(1) Brief description of the change project
(2) Goals and objectives of the change project
(3) Required resources to implement the change project
(4) Measurement of the outcomes of the change project
(5) Key factors for success in implementing the change project
(6) People involved in the change project

The objective of this coding is to assess the extent to which the different change projects diverge from the dominant model of organization and care provision used in the NHS, i.e., the model of medical professionalism (see the doc that you read about the NHS). For each category of items, I provide a framework and precise coding instructions.
I do not ask you to think of the potential consequences of the projects that you are going to code. Your coding should be based only on the information that is available in the different change project descriptions.

Professionals' roles division

Professionals' roles division specifies what each category of professionals should do, i.e., their scope of practice and the rules of interaction among these professionals.
In any healthcare organization, one can distinguish two domains: the clinical and the administrative domains. The clinical domain focuses on the organization, coordination and delivery of care for individual or groups of patients (e.g., services for Mrs Jones who has just delivered a baby on the maternity ward). The administrative domain has to do with the management of organizational and clinical resources (e.g., beds rotation, machines purchase, staffing, physical plant). For this reason, it is necessary to distinguish between the roles that each category of professionals has in the clinical domain, on the one hand, and in the administrative domain, on the other hand.
According to the dominant model, i.e., the model of medical professionalism, doctors play a key role in decision making both in the clinical and in the administrative domains. Allied Health professionals and nurses carry out the medical plan of care as prescribed by doctors. As for general managers, their role is to facilitate doctors' activity and to act as diplomats to reach a consensus anytime there is some disagreement among organizational members.

1. ***To what extent does the project aim to increase nurses'/AHPs' decision making power in the clinical domain?***

If the project has nothing do to with the role that nurses/AHPs play in decision making in the clinical domain or if it aims to either maintain the status quo regarding their decision making power in the clinical domain or decrease their decision making power in the clinical domain, then the answer should be NO EXTENT.

If the project aims to enable nurses/AHPs to perform medical procedures or examinations that they usually do not perform without giving them the power to participate more in decisions regarding patients' treatment, then the answer should be SOME EXTENT.
E.g.: nurses are enabled to make ultrasounds but they do not participate in their interpretation.

If the project aims to enable nurses/AHPs to participate more in decisions regarding patients' treatment, then the answer should be GREAT EXTENT.

2. ***To what extent does the project aim to increase nurses'/AHP/managers' decision making power in the administrative domain?***

If the project has nothing do to with the role that nurses/AHPs/managers play in decision making in the administrative domain or if it aims to either maintain the status quo regarding their decision making power in the administrative domain or decrease their decision making power in the administrative domain, then the answer should be NO EXTENT.

If the project aims to enable nurses/AHPs/managers to participate more in administrative decisions about the management of their ward/service, then the answer should be SOME EXTENT.

If the project aims to enable nurses/AHPs/managers to participate more in administrative decisions about the management of their organization as a whole, then the answer should be GREAT EXTENT.

3. ***To what extent does the project aim to decrease doctors' decision making power in the clinical domain?***

If the project has nothing do to with the role that doctors play in decision making in the clinical domain or if it aims to either maintain the status quo regarding their decision making power in the clinical domain or increase their decision making power in the clinical domain, then the answer should be NO EXTENT.

If the project aims to force doctors to make a decision collegially with other health professionals regarding some aspect of patients' treatment, then the answer should be SOME EXTENT.

If the project aims to transfer the decision making power from doctors to other health professionals regarding some aspects of the patients' treatment, then the answer should be GREAT EXTENT.

4. ***To what extent does the project aim to decrease doctors' decision making power in the administrative domain?***

If the project has nothing do to with the role that doctors play in decision making in the administrative domain or if it aims to either maintain the status quo regarding their decision

making power in the administrative domain or increase their decision making power in the administrative domain, then the answer should be NO EXTENT.

If the project aims to decrease the role or influence of doctors in administrative decisions about the management of their service, then the answer should be SOME EXTENT.

If the project aims to decrease the role or influence of doctors in administrative decisions about the management of their organization as a whole, then the answer should be GREAT EXTENT.

Organizations' roles division:

Organizations' roles division specifies what each category of organizations should do and the rules of interaction among these organizations. In the NHS, one can distinguish two main categories of organizations: primary care organizations and secondary care organizations. As already explained, there are two different decision making domains in the healthcare sector: the clinical domain that has to do with patients' treatment and the administrative domain that has to do with the management of organizational and clinical resources. For this reason, it is necessary to distinguish between the role that each category of organizations has in the clinical domain on the one hand, and in the administrative domain, on the other hand.
According to the dominant model, i.e., the model of medical professionalism that focuses on treating diseases, secondary care organizations have more influence than primary care organizations both in the clinical and in the administrative domains. Secondary care organizations provide most of the healthcare services and get most of the resources. In addition, each type of organizations delivers its services in a quite isolated way. In the dominant model of medical professionalism, a person's care is focused on treating acute episodes of disease in the hospital setting without providing follow up and preventative services in the home or community setting. As a result, this model of care is characterized as episodic and fragmented. Opposed to this model is a model of continuous care through integration of services. This model relies on integrated care pathways which reduce fragmentation by setting out the interventions to be carried out by different services and/or organizations for the treatment of specific diseases.

5. ***To what extent does the project aim to increase the influence of the primary care sector in the clinical domain?***

If the project has nothing do to with the influence of the primary care sector in the clinical domain or if it aims to either maintain the status quo regarding its influence in the clinical domain or decrease its influence in the clinical domain, then the answer should be NO EXTENT.

If the project aims to involve jointly the primary and the secondary care sectors in the provision of healthcare services that are usually provided only by the secondary care sector, then the answer should be SOME EXTENT.

Similarly, if the project aims to involve jointly the primary and the secondary care sectors in the provision of new healthcare services, then the answer should be SOME EXTENT.

If the project aims to either transfer responsibility for the provision of a healthcare service from the secondary care sector to the primary care sector or to create new healthcare services within the primary care sector, then the answer should be GREAT EXTENT.

6. ***To what extent does the project aim to increase the influence of the primary care sector in the administrative domain?***

If the project has nothing do to with the influence of the primary care sector in the administrative domain or if it aims to either maintain the status quo regarding its influence in the administrative domain or decrease its influence in the administrative domain, then the answer should be NO EXTENT.

If the project aims to jointly involve the primary and the secondary care sectors in administrative tasks that are usually performed only by the secondary care sector, then the answer should be SOME EXTENT.

Similarly, if the project aims to involve jointly the primary and the secondary care sectors in new administrative tasks, then the answer should be SOME EXTENT.

If the project aims to either transfer responsibility for some administrative tasks from the secondary care sector to the primary care sector or to give new administrative responsibilities to the primary care sector, then the answer should be GREAT EXTENT.

7. ***To what extent does the project aim to decrease the influence of the secondary care sector in the clinical domain?***

If the project has nothing do to with the influence of the secondary care sector in the clinical domain or if it aims to either maintain the status quo regarding its influence in the clinical domain or increase its influence in the clinical domain, then the answer should be NO EXTENT.

If the project aims to involve primary care organizations in the provision of health services that are usually provided only by secondary care organizations, then the answer should be SOME EXTENT.

If the project aims to transfer the provision of healthcare services from secondary care organizations to primary care organizations, then the answer should be GREAT EXTENT.

8. ***To what extent does the project aim to decrease the influence of the secondary care sector in the administrative domain?***

If the project has nothing do to with the influence of the secondary care sector in the administrative domain or if it aims to either maintain the status quo regarding its influence in the administrative domain or increase its influence in the administrative domain, then the answer should be NO EXTENT.

If the project aims to involve the primary care sector in administrative tasks that are usually performed only by the secondary care sector, then the answer should be SOME EXTENT.

If the project aims to transfer responsibility for administrative tasks from the secondary to the primary care sector, then the answer should be GREAT EXTENT.

9. ***To what extent does the project aim to improve cooperation across organizations (especially across primary, secondary and social care organizations)?***

If the project has nothing to do with cooperation across organizations or if it aims to maintain the status quo regarding such cooperation or to prevent it, then the answer should be NO EXTENT.

If the project, while not explicitly aiming to improve cooperation across organizations, involves different organizations, then the answer should be SOME EXTENT.

If the project aims to develop cooperation across organizations on an ongoing basis, then the answer should be GREAT EXTENT.

10. ***To what extent does the project aim to promote continuous care through integration of services?***

If the project has nothing to do with the promotion of continuous care through integration of services, or if it aims to either maintain the status quo regarding the provision of care or prevent the promotion of continuous care, then the answer should be NO EXTENT.

If the project aims to develop integrated care pathways in a given organization, then the answer should be SOME EXTENT.

If the project aims to develop integrated care pathways across organizations, then the answer should be GREAT EXTENT.

APPENDIX 5

FOLLOW UP PHONE SURVEY

During your session at INSEAD for the Clinical Strategists Program you were asked to undertake a program of change in your home organization. Our records indicate that your proposed project was (*read description or title of project*). The NHS Modernization Agency Leadership Centre has asked that we follow up with you to learn about that experience and your current career situation. This is not an evaluation, and we are not concerned with whether or not your change program was a success. We are primarily interested in learning from you about the process and experience of managing change in organizations. Because there is more than one way to manage change, there are no right or wrong ways to approach these questions. The important thing is that your answers reflect your own experience, not what you think your experience should have been.

First, we have three questions about your current career situation:

1. Since completing the Clinical Strategists Programme in (*March 2003 for cohort 1/ September 2003 for cohort 2/December 2003 for cohort 3*) have you:
    a. Stayed in the same job
    b. Taken a new job?

2. If a. to 1: In your job, do you have:
a. the same amount of authority or responsibility as before?
b. less authority or responsibility than before?
c. more authority or responsibility than before?

If b. to 1: In your new job, do you have:
a. the same amount of authority or responsibility as before?
b. less authority or responsibility than before?
c. more authority or responsibility than before?

3. If b. to 1: Is this new position at a different organization?

4. If b. to 1: What is your current title/position?

Now, we have two general questions about your change project:

1. About how much time in total did you spend on the change project? *(Let me remind you that you first came on campus in January 2003 for cohort1 / in June 2003 for cohort 2 / in October 2003 for cohort 3)*

Less than a month
1-6 months
7-12 months
13-24 months
25 months or more

2. On a scale of 1-5, how far did you progress toward completing the change project, where 1 is defining the project for the clinical strategists program and 5 is institutionalizing the implemented change as part of standard practice in your organization.

We are next going to read to you a series of 29 statements about change processes in organizations. After each statement we will ask you to assess how much you agree or disagree with the statement as it applies to your experience with the change project. If there is a question that pertains to an aspect of the change process that you did not experience, please answer as best you can.

Questions are to be answered on a 5 point disagree-agree scale (1 is strongly disagree, 2 is disagree, 3 is neither agree nor disagree, 4 is agree and 5 is strongly agree). Please write down this scale in front of you. It will help you to more easily assess the following statements.

	Strongly disagree	***Disagree***	***Neither agree nor disagree***	***Agree***	***Strongly agree***
1. Even before introducing the change in my organization, I had a very clear vision of what I wanted my organization to look like after the change had been completed.	☐	☐	☐	☐	☐
2. I specifically sought out others in my organization to help shape the vision of the organization following the change.	☐	☐	☐	☐	☐
3. To me, having a vision for change was much less important than other aspects of the change process.	☐	☐	☐	☐	☐
4. Communicating the vision for change was a critical aspect of the change process.	☐	☐	☐	☐	☐
5. Relative to other aspects of the change process, I devoted a significant amount of time and energy in developing a vision for the outcomes of the organizational change.	☐	☐	☐	☐	☐
6. The change was initiated largely because of my own understanding of a need in the organization versus a widespread consensus on the need for change.	☐	☐	☐	☐	☐

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*
7. Relative to other aspects of the change process, I devoted significant time to communicating the need for change among other organizational members.	☐	☐	☐	☐	☐
8. To me, the perceived need for change was different for different groups in my organization, making the job of communicating the need for change more challenging.	☐	☐	☐	☐	☐
9. To me, effectively communicating the ideas behind the change was much more important than other aspects of the change process.	☐	☐	☐	☐	☐
10. The ideas I had about the change going into the process were quite different from those that emerged at the end of the process.	☐	☐	☐	☐	☐
11. I worked on this change project with considerable help and input from others in the organization.	☐	☐	☐	☐	☐
12. The change was accomplished largely through efforts of a few key members of my organization.	☐	☐	☐	☐	☐
13. Relative to other aspects of the change process, I spent a significant amount of time analyzing the problems and issues associated with the organization.	☐	☐	☐	☐	☐
14. To me, the analysis of problems and issues associated with the organization were much less important that other aspects of the change process.	☐	☐	☐	☐	☐
15. I used "hard" data (financial and other) as a central feature to analyse the need for change.	☐	☐	☐	☐	☐
16. To me, systematic analysis of the problem associated with the change was a critical element in the change process.	☐	☐	☐	☐	☐

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*
17. I relied primarily on few trusted colleagues for input on the proposed change recommendations before introducing them.	☐	☐	☐	☐	☐
18. To me, seeking input from a wide variety of stakeholder groups in the organization was a key factor in smoothing the way for the introduction of the change.	☐	☐	☐	☐	☐
19. For my change project, I pilot tested the change, or aspects of the change, before rolling it out to the entire unit or organization.	☐	☐	☐	☐	☐
20. I felt that pilot testing would not provide any useful, additional information about the change.	☐	☐	☐	☐	☐
21. I felt that pilot testing was risky because it could generate more anxiety in the organization.	☐	☐	☐	☐	☐
22. I spent a significant amount of time in preparing my organization for the change before it was officially rolled out.	☐	☐	☐	☐	☐
23. Relative to other aspects of the change process, preparation for rollout was a critical element of the change.	☐	☐	☐	☐	☐
24. For my project, rollout of the change was done differently in different units in the organization to accommodate different situations.	☐	☐	☐	☐	☐
25. In my view, the change is now part of the standard operating practice of the organization.	☐	☐	☐	☐	☐
26. In my view, it was necessary to continuously reinforce the change once it had been implemented in my organization.	☐	☐	☐	☐	☐
27. In my view, the change was not adopted in the organization.	☐	☐	☐	☐	☐

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*
28. We utilized a formal system of measurement to evaluate the impact of the change.	☐	☐	☐	☐	☐
29. We used a formal system of measurement to evaluate the need for possible refinements in the way the change was implemented in the organization.	☐	☐	☐	☐	☐

30. Could you give us the name and the coordinates of two people who we could contact in your organization to get their perception of the change?

31. What was the total budget for your change project?

Thank you very much for participating in this survey!

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APPENDIX 6

Empowering Nurses at University College London Hospitals

This case was written by Julie Battilana, Doctoral Candidate at INSEAD, Anne-Marie Cagna, Research Associate and Tom D'Aunno, Professor of Organizational Behavior INSEAD, as a basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

The project was supported by the Johnson & Johnson-INSEAD HMI Partnership, The National Health Service Modernization Agency, Leadership Centre and the INSEAD Alumni Fund.

Deborah Jamieson, Advanced Practitioner at the University College London Hospital (UCLH) National Health Service (NHS) Trust, knew that developing pre-operative assessment trust-wide was a huge task, but also essential to improve the quality of patient care, reduce cancellations, and increase efficiency and utilization.

Within just a short period of time several pre-assessment centers were opened and day surgery clinics improved. Deborah was also finally beginning to change the mindset of many of the key players at the Trust (managers, consultants and anaesthetists) some of whom had initially opposed the nurse-run clinics. The staff were also more motivated and patient satisfaction had increased. Nevertheless, there was still much work to do: further developments, additional training for nurses and increasing the number of clinics throughout the trust were dependent on additional financing. As Deborah knew, funding was always a key issue in completing NHS projects. She had witnessed many such endeavors fail because managers could not obtain further investment after a project's initial funding. Deborah, however, was confident this would not be the case for this project as one of the NHS's top ten impact changes announced was to pass 75% of operations through as day surgery and she was convinced that pre-operative assessment would play a vital role. In addition the government revealed that in 2003, that it would be investing £50million in training nurse practitioners and advanced practitioners, an encouraging sign that her project might successfully obtain financial support in the future.

An American national, Deborah was recruited in February 2002 to set up a nurse-led Pre-operative Assessment Service in the University College London Hospital NHS Trust and to review the already existing day surgery clinic. Traditionally pre-admission clinics had been run by doctors. Her first challenge was to recruit nurses who would be willing to take on further responsibility. She also needed to convince the main players that nurse-run pre-admission centers would benefit both patients and staff. In the long-run she knew from her experience in the US that these clinics would free up more time for consultants, reduce cancelled operations thus reducing costs and improve patient care. Her ultimate goal was "to have one large pre-assessment centre with sufficient trained staff, enough nurse practitioners, and sufficient consulting rooms; along with dedicated anaesthetic sessions".

University College London Hospitals (UCLH) NHS Trust

University College London (UCL) Hospitals NHS Trust was established in 1994, although its origins dated back over 250 years in the history of various individual hospitals, some of which by 2004, formed part of the Trust while others had been closed down.[5] It was based in London and comprised eight specialist hospitals with the opening of the new University College Hospital (UCH) due in 2005. It provided care and treatment for local people, commuters and visitors to London. In addition it supplied highly specialized services for individuals throughout the UK and almost every country in the world.[6] Links with the Royal Free & University College London Medical School made it one of the country's leading hospitals for education, training and research. As its mission stated "University College London Hospitals

[5] Website www.uclh.org/about/history/
[6] Annual Report 2003/2004

NHS Trust is committed to delivering top quality patient care, excellent education and world class research."[7] In July 2004 the Trust received the maximum three star rating in the Healthcare commission's annual ratings. The same year it employed 6,000 people, recruited 1,000 new staff, of which 400 were nurses, midwives and health care assistants. Staff turnover rate for the year was reduced from 20% to 18% and the absence rate was reduced from 5% to 3.5%.

On 1 July 2004 the UCLH NHS Trust became one of the first major teaching hospitals to become a Foundation Trust. Foundation status meant that UCLH could enjoy more freedom from central government control in terms of managing its own budgets and shaping the services it provided to reflect the needs and priorities of its local community. Foundation Trust status also ensured that there was greater involvement of the local people in the future development of the Trust. Local annual elections were held for seats to the Members' Council; it comprised 17 patients and members of the public, and 16 staff and stakeholders. The Members' Council role was to work with the Board of Directors to look at the strategic developments within the Trust with a minimum of three formal meetings a year that were open to all its members.

Deborah Jamieson

Prior to joining the NHS in February 2002, Deborah Jamieson had worked in the private sector in the UK for three years in Theatre and Recovery and as a Pre-operative Visiting Nurse at the King Edward VII's hospital in London, while completing further legal studies. Before her arrival in the UK she had been a Practice Director and Physician Agent for 11 years in the US. As she explained:

> *"I worked with general vascular thoracic, abdominal and trauma surgeons who covered many different specialties. I was approved by two hospitals to be a Physician Agent. This meant that I could do the history and physical examinations, and I could also admit patients into hospital. In addition I made rounds daily to see the patients, on the ward and in the Intensive Therapy Unit (ITU). I wrote hospital orders, medication orders, requested X-rays, carried out diagnostic tests among other tasks. Once I made the order the surgeon would sign it off within 24 hours."*

In addition to Deborah's four year bachelor degree in nursing she held post graduate qualifications in law, business, and was an International Commercial Arbitrator. She frequently lectured on topics such as 'Law and Nurse'. Her qualifications in nursing meant that Deborah was considered a professional nurse in the US, unlike most UK nurses the majority of whom at the time did not follow either a bachelor or masters degree. She had also published many articles in various medical and legal journals on this subject.

When she began at the NHS Deborah had a limited knowledge of how the organization was run and was surprised at the great differences between the US and UK healthcare systems.

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[7] Annual Report 2003/2004 – UCLH NHS Trust Mission statement.

> *"I thought the whole concept that every patient has access to medical care was great. It was really important to me. I was pleasantly surprised by how hard people work in the NHS and especially behind the scenes and a great deal of the time without recognition, support or gratitude. On the other hand things have been done a certain way for so long that change was difficult to accept and even the idea of development made some people adamant that they would not change."*

As Deborah Jamieson explained in the US she had many more medical responsibilities than nurses in the UK:

> *"Most of the time nurses in the UK do not feel that they are appreciated or recognized that they are knowledgeable. The roles and responsibilities are quite different in the US and the UK. There are many differences between doctors and nurses whereas in the US it is more across board and you would see nurse practitioners in almost every surgical practice. For example in the US I had to know clinical examination skills. I was expected to know how to check everything from the cranial nerves down to the abdomen. In the UK they don't normally teach this in the nursing curriculum. It's also something that doctors are uncomfortable with nurses doing."*

Deborah soon realized that recruiting nurses for pre-admission assessment would be more challenging than she had first anticipated. She would not only have to change the attitude of the managers and doctors, but also convince nurses to take on more responsibility.

> *"If you have nurses that are leading clinics you also need to check with the hospital ward or Trust to make sure they are happy for you take on those responsibilities and it's also important to have a policy approved. The nurse can be held accountable if negligence is established, with vicarious liability extended to the hospital or Trust employing the nurse."*

It was commonplace in the US for nurses to take out their own insurance to cover against malpractice claims. In the UK, however, this practice was rare, but Deborah was convinced that it was an area "whereas nurses take on more roles; more responsibilities, they do need to have the knowledge of who is accountable, what they need to do to prevent problems and safeguard the patient, such as documenting properly." In addition it soon became clear that many nurses were not aware that they were in fact legally accountable for their actions. Deborah used her experience in law to give lectures on nurses' legal accountability in the UK, and covered other relevant topics such as informed consent. In 2003 NHS malpractice claims had increased from £2.9 billion to £6.2billion, and was thus becoming a serious issue, increasing the need for raised awareness and preventive measures. After attending Deborah's lectures on the subject many nurses were astonished at the extent that medical malpractice claims had rocketed in the UK over previous years.

Training for Nurses in the UK

Student nurse training in the UK had witnessed many changes since the introduction of Project 2000 in the early 1990s. Prior to this nursing and midwifery training was carried out within a school of nursing based in a hospital. Practical ward work and studying were

combined as part of the nurses' education. However, a move towards establishing nurses and midwives more "professionally" led to an academic approach in their training. Nurses began to study for diplomas or degrees within a university environment. "Hospitals started to pay universities for the education and training of student nurses, who in turn would provide nurses that were academically sound and 'fit for practice'."[8] One of the outcomes of this move to the higher education sector was a reduction in nurse-teacher contact within a clinical environment. However, some observers believed that nurses required a "greater depth and different type of knowledge."[9] By 2005 education in nursing had developed with some universities offering post graduate degrees and doctoral programs reflecting a move towards the US professional nursing model. As Nicky Besag, Service Improvement Facilitator, noted:

> *"In the UK nurses do not get the training I received in the US. We need to tell nurses how to communicate especially with the doctors. We should give them very precise information; they need to be logical when they present a patient. Today's nurses are not intellectually equipped to know how to talk about a patient. It should be part of their initial training."*

The US Model

Nurse education in the US followed a different path from the UK. From as early as 1899 a post-diploma hospital economics program was offered at Teachers College, Columbia University. Until the 1920s hospitals in the US still had student nurses on the wards primarily to reduce costs. In the 1930s with the great depression many nursing schools within hospitals were closed. New degree and diploma courses at universities opened and by 1965 the American Association of Nursing (ANA) recommended that the minimum education level for nurses was baccalaureate (it has recently been considered to be higher). Throughout the 1970s and 1980s the role of professional nurses expanded in response the Federal government funding the education of nurse practitioners. Further developments in healthcare meant nurses were seeking higher education to become nurse practitioners and clinical nurse specialists.

[8] www.nursingnet.uk.com 2005
[9] www.RCN.org.uk: The Future Nurse: the Furture for Nurse Education: A Discussion Paper, 2005

Getting Started - Pre-Admission Service

> *"When I was recruited Elizabeth Hewson-Hesketh, the Theatre Manager and my supervisor, were extremely supportive of the Preadmissions Service. There was less encouragement from some of the doctors and anaesthetists, however. It was a challenge at the beginning as I had no administrative help, no staff and no dedicated office for a long time, so we had to start from the bottom up. Before I started the Trust had been trying to employ someone for this specific task for about 18 months."* Deborah explained.

Deborah first concentrated on setting up a pilot pre-operative assessment clinic in the Diagnostic & Treatment Centre for major surgery at the University College Hospital. As she explained:

> *"The Treatment Centre was due to open within several months of my role starting, and therefore it was necessary to prioritize the Treatment Centre. As it was a new facility, it offered a brand new way of working and opportunities to start with a new approach. Treatment Centers were being developed and rolled out nationally to decrease waiting times for elective surgery."*

The UCLH Management initially set Deborah's priorities, with support and encouragement from the Chief Nursing Officer, Louise Boden, the CEO, and Director of the Board, the General Manager, Service Improvement Facilitator among others. It was critical for Deborah to have these people supporting the project, as Louise Boden noted: "I was a breeze in the background and encouraged people to take the project forward."

She began by meeting all the staff involved in the Pre-admission process. This included visits to the pathology lab, microbiology, dietician, physiotherapy, imaging for X-rays among others, to see how they could collaborate to improve existing services. When she arrived at the hospital there was just one nurse working part-time in pre-admission assessment. In the majority of cases pre-assessment or 'pre-clerking' was performed by junior doctors, House Medical Officers or registrars. She studied the pre-admissions services and through a mapping and redesign exercise an 80 year-old female patient was followed through the existing pre-clerking experience. As she noted: "we did an exercise where we had to map and redesign the service. It emerged that there were 56 different steps involved and that was just not satisfactory for the patients involved." This long process meant that resources were not being optimized; patients had to be transported to various different hospitals to undergo a variety of examinations, for example, a visit to one hospital for a blood test and another appointment at a different hospital for an ECG.[10] The process was long and costly and there was much duplication in the work that was a great source of dissatisfaction among the patients and staff. The experience was not only expensive for the Trust, but time consuming for the individual with sometimes up to five or six appointments at the same hospital on different days.

As one of the Trust's employees noted:

[10] Electrocardiogram - a test that measures the electrical activity of the heartbeat.

"It's been obvious for a number of years that we should do something to make the processing of our patients a much more useful experience not only for the patients but also in terms of organizational capacity. Our previous way of working was sloppy and hap-hazard, hit and miss. It was clear to me when I began at the Trust that the only way to deal with this properly was pre-assessment and pre-admission."

Taking action – Treatment Centre

Deborah intended to introduce 'fast track' pre-operative assessment services by centralizing the examinations in one hospital, offering a 'one-stop-shop' thus reducing transport costs and improving the experience for the patients. This was for multi-specialty patients including orthopaedics, urology, and general surgery that had predictable outcomes and discharge. She set out to see approximately 4,000 patients annually. The Pre-admission team was centralized and based at UCLH with three newly purchased ECG machines located there. She also visited other parts of the Trust to identify where clinics were needed and how many patients were typically seen. Patients initially were referred from outside trusts, later becoming 'a patient choice' initiative.' A referral system was set up between different departments such as oncology, and meetings with outside trusts were commonplace.

After just a month in the job Deborah began to hire staff. By December 2002 the first four nurses had been trained and the Diagnostic and Treatment centre opened. As she further explained she drew on her experience in the US to plan the clinic:

"I blended what I had learnt in the US and in the UK private sector – emphasis on patient satisfaction and patient delivery of services, so I mixed that with trying to deliver it from the UK model rather than just the US one. In the US all patients are pre-assessed by a nurse or anaesthetist depending on the type of surgery. It makes the process better for patients and you can detect problems in advance and so hopefully resolve them."

The pre-admission clinic was designed around the patient and was 'patient-centered'. "Social needs, patient education needs, and healthcare needs were examined individually and care was coordinated encompassing physical therapy, occupational therapy, social services, transport, translator service, community nursing, 'meals on wheels' for example in a team response."[11] The result was that the process was reduced from 56 steps to two (Exhibit 1).

A steering committee was created and included Elizabeth Hewson-Hesketh, General Manager, Theatres and Anaesthetics and Nicky Besag Service Improvement Facilitator with Mr. Fares Haddad, Consultant Orthopaedic Surgeon, as the clinical lead. The group met monthly and was later expanded to include a wider range of stakeholders, clinicians, managers, and service providers, including areas such as Physiotherapy and Imaging. In

[11] Patient's first; Nurse-led Pre-admission Clinic – Post Implementation Review, Deborah Jamieson, July 2003.

March 2004, Deborah visited and lectured at St. Mary's Hospital in the Isle of Wight and was impressed with what she found there.

> *"The model I saw in the Isle of Wight was great. When they assessed the patients and there was a problem identified, then an anaesthetist was available on site and he/she would see them."*

The Isle of Wight hospital had a large pre-assessment centre with seven consulting rooms. Admissions were also part of the pre-assessment department, with several anaesthetic sessions per week, and over 18 nurse practitioners. These practitioners saw both in-patients and day surgery patients, and were located with the admissions department. Some of the staff were part-time, and others were allocated by specialty and background such as orthopaedics. The Centre was built, from an already existing day surgery centre. On her return Deborah presented this model to the steering committee as an example of a successful UK clinic. Other models were discussed, but it was agreed that the type of service offered at the Isle of Wight centre would be the one adopted for the Pre-assessment services at UCLH NHS Trust.

Staff for the treatment centre were recruited primarily by Deborah, although some of the nurses were reallocated from different parts of the Trust. The new recruits were trained to perform pre-assessment for day surgery as well as major surgery. The pilot centre was based at University College Hospital, originally with four nurses but within three years this number increased to eight.

Moving on with the Day Surgery Clinics

In 2003, a year after setting up the pilot treatment centre Deborah turned her attention to improving the day surgery clinics. She found herself confronted with poor facilities and de-motivated staff. She described the space where the day surgery was carried out as "a closet." Unlike the Pre-admission clinic in the treatment centre, Deborah's team of nurses had already been recruited by hospital managers and she was informed that these nurses were not always the "best performers, nor the most motivated". The managers hoped that by allocating these people to pre-assessment, and encouraging them to take on more responsibility it would encourage the nurses. Another challenge for Deborah was that most of the nurses allocated were not mother tongue English and thus this presented cultural challenges, including language and communication skills.[12] Most notably was the reluctance to confidently approach doctors and senior nurses, or make decisions on their own. Deborah was also astonished when she first spent time with the nurses to find out how unconfident they were and that they often considered they were unappreciated for the tasks they performed – they had never felt they had been thanked for their work. They were also suspicious of her role, and whether she was there to supervise them or criticize their work. She realized that she had to find a way of motivating them and quickly, if the day surgery clinics were going to be successful.

[12] The nationalities included German and Filipino

> *"I sat in with them and watched them with their patients and explained to them what I was there to do. I also asked them what they felt needed to be changed, or could be worked on, what they were happy and unhappy about."*

Despite the staff's lack of self-confidence they all worked well as a team, something that Deborah knew would be essential to the clinics' success. She tried to encourage the team by thanking them as much as possible and explaining clearly when they had any problems or difficulties with pre-assessment. They began working more successfully and teamwork improved further. As Deborah described:

> *"From October 2003, I was located in the Day Surgery Unit, to try to improve existing services, and train additional nurses. I have now trained eight nurses, and started with a baseline measurement of employee satisfaction through staff surveys. Employee satisfaction was consistently low in communication/support from management. The majority of the nurses were from other countries, and cultural differences seemed to contribute to dissatisfaction with current roles and responsibilities. All of the nurses worked in several areas including Theatres and Recovery. After consultation with the Day Surgery Manager and the Manager of Theatres & Anaesthetics, the Education Department was asked to evaluate the nurses in Day Surgery, and develop a competency/training package for Theatres & Recovery. In addition, I trained and deemed competent pre-assessment skills. All of the nurses have increased their skills and confidence, and since October 2004, three have also been promoted to a senior grade, while patient satisfaction has been consistently high, based on patient questionnaires."*

Staff satisfaction was of up most importance for the team and surveys were completed throughout the pre-assessment employees. These questionnaires indicated that for the staff "career development/promotion was as important as a competitive salary."[13] Communication between managers and subordinates was essential for smooth running of the clinics. In October 2003, overall staff satisfaction was low on a scale of 1:7 between 'not at all satisfied and very satisfied'; all responses received were between 2 and 3 on the scale. In response to this teaching sessions and competency evaluation in theatre and recovery were provided, with Deborah herself introducing additional training. As there was no specific funding identified for pre-assessment in Day Surgery, existing staff had been allocated, as a result Deborah actually carried out the majority of pre-assessment herself, something that she had not anticipated doing at the out set.

Training

A two day course was designed for nurses newly recruited to work in the clinics, as an introduction to clinical examination and pre-operative assessment. Deborah advertised the training through the internal e-mail system and also discussed it at the Nursing and Senior

[13] Extract form Deborah Jamieson, Advanced Practitioner, University College London Hospitals, Final Project Report, 2003

Sisters meeting. Nurses were encouraged to attend from different areas of UCLH, including the Heart Hospital. The aim of the training program was to empower the Pre-operative assessor to develop clinical examination skills of the cardiovascular and respiratory systems; to develop the ability to conduct a head, neck and airway assessment and provide an opportunity to acquire new skills that support a higher level of practice. An overview would be carried out of all that was required from obtaining the health history of the individual, identifying patients at higher risk, to utilizing assessment tools appropriately to assess a patient's condition and act accordingly. The nurses were shown how to perform clinical examinations and obtain a patient's health history, for example listening to the heart and lungs, tasks that were traditionally undertaken by doctors. The nurses were also sent on a two and a half day venepuncture course and certified to take blood. All of the nurses were supervised during patient encounters until deemed competent to perform independently. An advanced practice competency manual was developed in 2002 for pre-assessment to use as a tool. Senior staff nurses were sent to relevant management courses to further improve leadership skills. There was a comprehensive ECG course at the Heart Hospital, that the nurses completed so that they could perform ECG's, which meant the transfer of patients to different clinics was eliminated.

As Deborah explained:

> *"I used a lot of my experience in the US in developing the training program as well as what I had observed in the UK. We do case studies including cardiac case studies. When I teach, the students have to perform a complete history and clinical examination on a fellow student. By the end of the two days they have to document and perform a full history and physical examination of the other person."*

Although the training course had been approved by the Trust, Deborah still had to contend with opposition from many of the clinicians. She defended the pre-assessment project by referring to the NHS Modernization Agencies National Guidelines on Pre-operative Assessment for In-Patients and for Day Surgery Patients, which stated that "each patient should be assessed two or three weeks before surgery." She also quoted The National Institute for Clinical Excellence (NICE) pre-operative testing guidance.[14] However, as Deborah noted: "some people, particularly physicians think these NICE guidelines are not always optimal and that they should be challenged."

Some of the doctors, notably the older ones, also argued that nurses could not be qualified after two days training to carry out examinations that, only after years of study, the physicians were capable of performing. On one occasion when Deborah lectured at the Royal College of Surgeons she mentioned that some nurses in the UK were now trained to do some minor surgery. "Some of the doctors were astounded, they just could not believe it." Other physicians, however, welcomed the extra time that was freed up for them with nurses taking on these pre-assessment examinations and the reduction of cancelled operations. Several consultants became very supportive of the pre-assessment process. As one doctor explained:

[14] http://www.nice.org.uk/pdf/PreopTests_Apps.pdf

> *"When I started three years ago Nurse pre-admission did not exist – as a result, we would only see the patients the day before the surgery or the day of the operation which resulted in many operations being cancelled."*

The nurses also appreciated the training, as Natasha, one of the first nurses to be benefit from the course explained:

> *"The training was very helpful, even though I was already working in pre-admission; the two day training meant that I could take on other tasks. Now I can answer patients' questions with more authority and knowledge."*

Natasha also provided additional information for individuals waiting for operations and organized group sessions to discuss their forthcoming surgery to share concerns as well as a rehabilitation service.

With the input from the steering group, Deborah developed a detailed protocol and operational policy that explained each stage of the pre-admission process. The pre-operative process established that the individual due for surgery was fully informed about the processes and it ensured that the patient was fit for surgery and anaesthetic.

Building the Services in both Day Surgery and Major Surgery

By 2003 eight nurses had been trained to run the pre-admission services. The nurse led-diagnosis for pre-admission assessment led to improved patient care and optimized theatre time. Both medical and psychosocial assessment was encompassed and patients were identified that had pre-existing medical conditions or a change in condition. Pre-screening meant that waiting lists were cut and procedures were accelerated by using nurses to free up time for doctors. In addition with the introduction of the European Working Time Directive, junior doctors hours were reduced, meaning they would be less available for services such as pre-clerking. It was also beneficial for the patients, as Louise Boden noted, "Nurses are better than junior doctors at talking to people and alleviating anxieties they may have. In pre-assessment the nurses are doing all the things they are good at, it plays on the strengths of the nursing force."

Cancelled operations were also reduced. In 2004 three pilots were launched in Day Surgery; the first a pre-screening tool, designed to identify patients undergoing minor surgery that did not need to attend a face-to-face pre-assessment. An audit was conducted to follow the patients identified, of the 31 patients, no clinical problem resulted. The pre-screening tool also helped to identify risk factors in patients, and identify the patients not suitable for Day Surgery. A new Day Surgery care pathway was drafted and piloted, based on Modernization agency guidance.

Satisfied?

To gauge patient satisfaction a questionnaire was designed, with ten key questions that included the following

- what the individuals thought of their clinic visits;
- if the appointment was delayed;
- if the duration of the visits was sufficient;
- if the information given was useful and if the handouts were helpful;
- were all the questions answered effectively;
- was the examination procedure explained and;
- How useful was the visit to the clinic in preparing for surgery.

By July 2003, 746 completed questionnaires had been returned from the Treatment Centre. These indicated that in 99% of cases patients "felt better informed about their operation...[and] 99.8% believed the information (both verbal and written) was helpful and easy to understand with 100% of the patients stating that their questions were answered effectively, and over 40% remarked that it was excellent."[15] Patients were more confident in the care they received and less anxious about their forthcoming operations. In response to patients' remarks a tea and coffee machine was installed in the reception to make the visit more comfortable. The Heart Hospital and the Day Surgery clinic also conducted patient satisfaction surveys over a period of three years with similar results.

In addition to this questionnaire a two-week post-hospital discharge telephone survey was conducted. Sixty-nine patients took part in the survey and all of them felt that the pre-admission clinic helped with their hospital experience. Only 1% of the people surveyed were not completely satisfied with the stay. Patients were encouraged to comment on the experience from pre-admission to discharge. As one nurse mentioned; "Doctors say that patients are more relaxed."

Goals Achieved?

By mid 2004 the clinics were expanding, and more nurses were being trained. Cancelled operations were declining; patients seemed to be more satisfied according to the surveys. However, key now for the project to continue to be successful was securing further funding. On the process side the 56 steps had been reduced to just two thus saving money and time for both patients and staff.

However, some of the nurses were becoming frustrated as they were not allowed to perform certain medical procedures. Deborah also knew that to further improve the services she needed to find ways of maintaining the nurses' motivation. She also wanted to see nurses gain more recognition and "feel better about themselves" and increase their confidence.

As Louisa one of the nurses working with Deborah pointed out "there is still a hierarchy mentality within the NHS. The consultants are at the top and the nurses are somewhere near the bottom. I think now they have to get used to us working with them and have more respect

[15] Extract form Deborah Jamieson, Advanced Practitioner, University College London Hospitals, Final Project Report, 2003, INSEAD

for us." There was still some resistance to nurse-led clinics stemming from consultants and Deborah knew it would be a continued struggle to convince them all of the benefits these teams could yield. However, the optimal pre-operative assessment was a team approach between nurses, doctors, physio/OT, etc, rather than just nurses. All staff involved needed to work together closely so that it would become normal practice through the NHS. As Louise Boden explained: "we are about to move into a new hospital and hopefully all the practices that we have set up here will be embedded. It will no longer be a case of fast tracking a patient through the system, it will become the norm."

New Opportunities – the Way Forward

The pre-assessment centre was due to move into the new University College Hospital building in Autumn 2005 and Deborah had just heard that there were seven consulting rooms proposed assigned to pre-admission with 13 dedicated staff planned. Pre-admission would be centralized there with specialized clinics at the Heart Hospital and the National Hospital for Neurology and Neurosurgery. The new hospital was opened in 2005 and was situated on the Euston Road in central London. It promised to be "a healthcare facility fit for the 21st century (…) with services [that] reflect our surroundings."[16]

Further Empowerment for Nurses in the UK?

Just three years after beginning the change project Deborah and her team were pleased with the way the clinics was heading. However, there was still the concern that additional funding was required to fully implement the project and increase the services Trust-wide. In Summer 2005 the request for extra funding had been submitted and it was just a waiting game for approval of the plan. Deborah, however, was confident this project would be successful in obtaining further investment, as one of the NHS's top ten impact changes announced was 75% of all elective operations should go through as day surgery procedures and she knew that pre-admission assessment would play a vital role. She was optimistic for the future and was confident that empowering nurses throughout the NHS would play a vital role in the organization's future development.

Louise Boden also noted that:

> *"It was not just in pre-admission that the empowerment of nursing was developing but throughout the NHS. What we've being doing in pre-assessment is what we've doing throughout the trust in developing and expanding nursing and midwifery roles. We are pushing them to takeover areas of responsibility that were previously the roles of the medical staff."*

As pre-assessment was just beginning to be rolled-out nationally, Deborah was increasingly contacted about setting up nurse-led clinics, developing training, and expanding nursing roles

[16] University College London Hospitals NHS Foundation Trust Annual Report and Accounts 2003/2004, Extract from the Chief Executives and Chairman's introduction. Trust, 2004

throughout the UK. She had lectured at the RCN, Royal College of Surgeons, and visited hospitals throughout England, Scotland, Wales, and Ireland. The Modernization Agency had also asked her for advice on how to expand nurses' role nationally, and she was made an associate. As she noted:

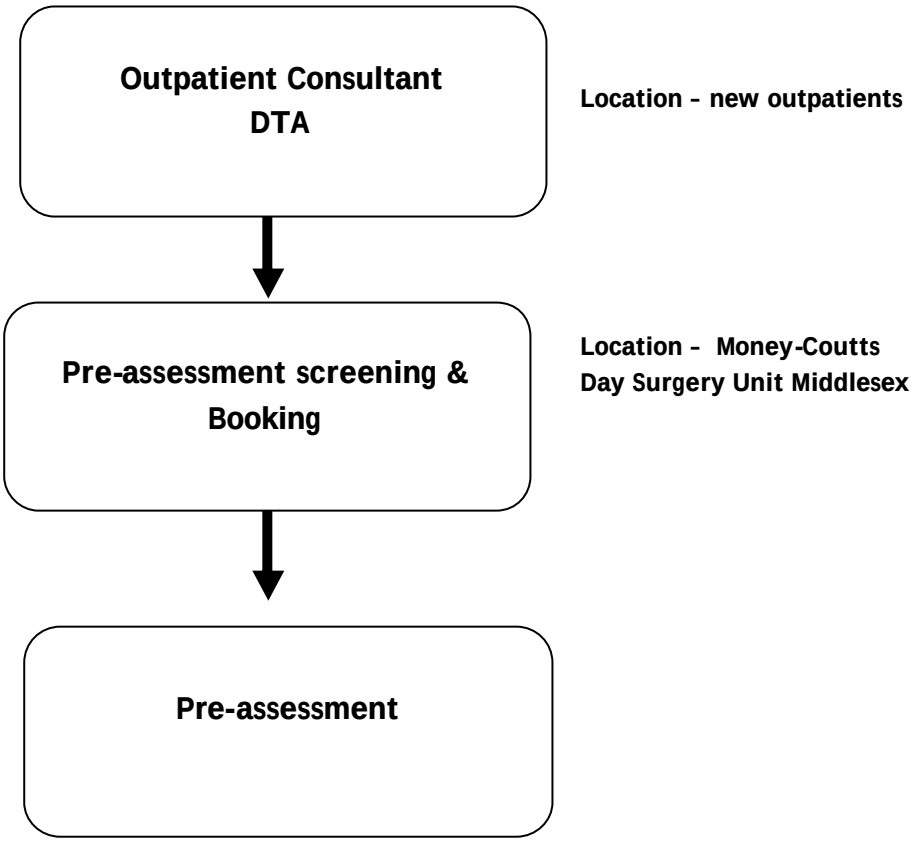
> *"When I joined the NHS the position of nurses was completely different than it is today, it was rare to hear of nurses leading in different areas, now you hear more and more."*

By the beginning of 2005 the results were encouraging. Cancellations cost the NHS approximately £211 million annually and DNA's (Did not keep appointment) cost at least £50.00 per patient.[17] Deborah's goal had been to reduce these rates by 20%. By 2005 this had been achieved and in some categories of cancellations it was greater than 50%. Further cost reduction had been achieved with the presence of two consultant anaesthetist sessions on Tuesdays and Thursdays. Previously patients only met with the anaesthetists the day before surgery was due, leading to many cancelled operations. With the move to the new hospital this would be a daily service with a dedicated anaesthetic session each day. New processes were piloted to improve services such as pre-screening immediately after a decision has been made to operate. This allowed for 'walk-in' immediate services, and assisted in identifying patients at an early stage that have complicated medical histories, elevated blood pressure, or may need to be seen by an anaesthetist. It also helped to stream-line services significantly.

The future of the pre-assessment clinics was looking healthy as was the future empowerment of nurses within the NHS.

[17] Deborah Jamieson's final report to INSEAD

Exhibit 1
New Process Map 2004 – two steps



Consultant Anaesthetics pre-assessment every day

In-Patients
TCI date will be obtained from the surgical speciality for in-patients or the Consultant to put on TCI form. Pre-assessment date will be supplied by Pre -assessment administration.

Day Surgery
TCI date will be obtained from Day Surgery administration team.
All Day Surgery patients will have their demographics put on the Care Cast system at the time of attending after out-patients appointment. This will **not** be done at a later time. This is to ensure all patients are captured on the systems and **do not** slip through the net. The patients Pre-asesement and TCI date will also be recorded on the system at this time.

All details will simultaneously be recorded in the diaries; this part of the admin process **will not** be left until a later time.

Source: Deborah Jamieson, UCL Hospital 2004

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APPENDIX 7

Leading Organizational Change: Improving hospital performance

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This case is intended to be used as a basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

Disturbing Symptoms

In April 2002, under government pressure to improve services and reduce duplication, three hospitals merged to form the Mid Yorkshire Hospitals Trust. One year on, the Trust was receiving a lot of adverse media coverage owing to waiting list problems and a £30 million financial deficit. Its credibility within the community was plunging. Something had to be done.

A wide range of problems were discussed by the Trust Board at its monthly meeting in March 2003, including: increased trolley waits for patients in the accident and emergency (A&E) department, bottlenecks in the medical admissions ward, high admission rates, patients being placed on the wrong wards, increased lengths of stay, delays in discharges, poor relationships with social services and more patient complaints.

As the 11-member Board debated these topics, it became clear that many of them concerned the inefficient processing of patients, which inhibited the hospitals' capability to reduce waiting lists. Given government scrutiny of long waiting lists – and the autonomy repercussions for Trusts – sorting out these capacity and throughput problems was deemed a priority. As part of the broader turnaround strategy, someone needed to drive and accept accountability for improving the performance of the admission-through-to-discharge chain. Roger French, the Chief Executive, asked Tracey McErlain-Burns, the Executive Director of Nursing, if she would take the lead.

As a former matron-turned-director, McErlain-Burns was acutely aware of these problems. Although her responsibilities were entirely managerial, she still did occasional hands-on nursing, and she knew that hospital beds were often blocked by patients who were medically stable but had nowhere else (such as a nursing home) where they could go. In fact, a study conducted in her hospital in March 2000 indicated that as many of 30% of patients were medically fit. She also knew that the necessary changes in systems, performance measures and procedures would amount to something of a culture shock and were liable to elicit resistance, both from specialist physicians and nurses.

On the other hand, McErlain-Burns welcomed the opportunity on two counts. First there was the professional carer's gut reaction to an unacceptable situation: "I was trying to put myself in the patient's position, having to spend up to 12 hours on a trolley in an A&E department when you've had nothing to eat or drink and you've probably got a sore bottom because you're laid on a tiny little thin mattress with no dignity. For me, it was about saying we can make a change to that now by just moving some of the systems."

Beyond the patient perspective, she also saw an opportunity to extend the role of nurses in an environment very much dominated by the medical profession. She wanted "to try to increase the nursing voice and to try to demonstrate how nursing could contribute to the agenda." Empowering the nurses might help to recruit and retain nurses in what was a very tight labor market. With its additional potential for relieving waiting lists, this was a high stakes project.

She had in mind a more systemic approach to patient discharge, starting right back at the pre-admission stage. More controversially, she also nurtured plans to introduce nurse-led discharge – which would involve nurses taking over responsibility from specialist physicians, for making the final decision to discharge a patient.

The Waiting Game

Starting with the decision to merge, the prevailing climate and priorities within the Trust were heavily influenced by the program of National Health Service (NHS) reform launched by the Labour Government. At the heart of the Government's NHS Plan, unveiled in July 2000, was an ambitious pledge to cut maximum waiting times – regarded as the public's main concern about the NHS and a striking symbol of hospital inefficiencies. Under the new guidelines, for example, individuals previously waiting up to 18 months for treatment would not be expected to wait longer than nine months by 2004, and three months by 2008. Similarly, cases of patients waiting more than 12 hours in the A&E department would have to be reported to the Strategic Health Authority, which would inform the Department of Health.

On the basis of these and other metrics (such as financial performance, cleanliness, staff morale, and patient satisfaction levels), hospital trusts were then awarded stars, like Michelin restaurants, to indicate how well they were run. Those awarded three stars received full funding and were free to spend the money as they chose. In contrast, the zero-rated trusts would have to submit performance improvement plans to the NHS Modernization Agency and would be subjected to close scrutiny, particularly in the way they spent their money. Based on its performance up to March 2003, the Mid Yorkshire Hospitals Trust was awarded one star – a moderate fail – signifying that it had not performed well across the key targets.[18]

The star ratings were seen as a means of driving up standards and reducing the wide variations in the performance of NHS trusts, while at the same time making managers more accountable to the public. Yet, the intense political pressure on NHS trusts to meet waiting list targets also generated some unwanted side effects. For example, there were several cases of waiting list figures being "misreported".[19] There were also question marks about how the hospitals were meeting their targets, with some hospitals drafting in extra physicians, nurses and radiographers into A&E departments to raise performance during the crucial assessment week.[20] A spokeswoman for one of the top-performing trusts explained: "We wanted to maintain our three stars... We did probably what most other trusts did and brought in extra staff."[21]

Unfortunately, the option of pouring in extra resources to hit targets was not available to the cash-strapped Mid Yorkshire Hospitals Trust. It was forced to meet its targets as best it could. Occasionally that had given rise to expedient measures that produced difficulties downstream. For example, when patients had been waiting in casualty for approaching 12 hours, pressure mounted on the medical admission ward to assign a patient to a ward – to avoid breaching the 12-hour ruling – which meant that the patient might be dispatched to wherever a bed was available. Typically, that would increase the length of stay, since patients on inappropriate wards would not be seen by the relevant specialists during their rounds.

There was also evidence, from Department of Health figures, that target-pressures might be distorting clinical priorities, as suggested by the national surge in emergency re-admissions – that

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[18] Of the nine key targets, the Trust had failed on three: 1) financial management; 2) three patients had waited longer than the 12-month standard; and 3) 10 patients waited longer than the 26-week outpatient standard (*Source*: Annual Report 2002-2003).
[19] Anon. (2002) "Waiting list targets criticised," *Health Newswire Consumer*, September 18.
[20] Revill, J. (2003) "Hospitals faking cuts in casualty wait times," *The Observer*, May 11: p. 1.
[21] Revill, J. (2003) "Hospitals faking cuts in casualty wait times," *The Observer*, May 11: p. 1.

is, patients sent home early who had to be rushed back to hospital.[22] Given these risks, McErlain-Burns knew that they would have to monitor re-admission trends closely.

McErlain-Burns had actually taken initial steps to review the discharge process in October 2002 when interviewing Sue Edwards for one of the three Assistant Director of Nursing positions. If successful, Edwards had been told, the Chief Executive would want her to use her training experience (and her work with different agencies) to run a workshop at the Pinderfields hospital with the key stakeholders so as to address the discharge problems. Edwards got the job and three weeks later organized a workshop to try to get everybody thinking about improving – but in an atmosphere of widespread anxiety and change fatigue, nothing came of it. Edwards was particularly disappointed by evidence of a "blame culture" which had permeated the workshop – the sense of "what more can we do?" and the tendency to hold Social Services responsible for all the discharge problems because of their inability to propose timely solutions for patients.

The Case for Treatment

In April 2003, the Chief Executive announced a series of key performance objectives, which he dubbed "golden bullets". The first of these required an energetic investment in improving and overhauling discharge performance. Shortly afterwards, during a lunch meeting with the Chief Executive, McErlain-Burns secured a pledge that if nursing took discharge planning forward, matrons would be relieved of their onerous bed management duties, which would be picked up by general management.

On the back of her strong mandate from the top, McErlain-Burns decided to organize a workshop on improving the discharge process. Working closely with Sue Edwards, they invited the entire body of matrons, each in charge of a group of wards, and 20 of the 22 attended. The workshop was essentially meant to launch the project and get buy-in from the matrons, as many seemed unsure why nursing had taken on this "medical issue". The idea was to underline that nursing had both the authority and expertise to "sort out the production lines".

While introducing the purpose of the workshop, McErlain-Burns also announced the concessions obtained in terms of reduced duties, effective from July, which received an enthusiastic reception. Then, speaking from experience, she proceeded to evoke a number of areas where there seemed to be room for improvement in the discharge process. She started by reminding the matrons that the Trust's biggest hospital (Pinderfields) actually had the third highest admission volume in the country. She conceded that, to some extent, this reflected the lack of adequate alternative healthcare facilities in the community. But there were other factors too: after initial triage by an experienced A&E nurse, the actual admission decision was made by very junior physicians who tended to err on the side of caution. That generated an immediate bottleneck in the A&E department. Those patients then moved on to the medical admission ward, and again, the lack of a senior medical presence meant that patients were not getting moved out fast enough, causing more backup in the A&E department – which occasionally resulted in patients waiting upwards of 11 hours. And on some wards, capacity was so stretched that it would only require a power cut in the operating theatres and a few cancelled operating sessions to breach key waiting list standards.

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[22] Anon. (2002) "Blocked thinking," *Yorkshire Post*, February 21: p. 3.

In addition, pressures on capacity meant that surgeons sometimes took precautions to ensure that their scheduled patients were admitted. For example, there were instances of patients due to have an elective procedure being called in early by surgeons anticipating a likely squeeze on bed space. Patients could end up waiting as long four days before their actual intervention. That, of course, only compounded the capacity problems.

At the other end of the process, McErlain-Burns also noted that inefficient practices and poor communication were blocking the release of many patients. For example, a number of patients were simply waiting for test results or a prescription of take home drugs, and did not even need a hospital bed. Another common scenario was that physicians doing their rounds would suddenly pronounce a patient fit to go home – and discharge planning procedures would commence only at that point. This caused unnecessary delays, from simple problems like arranging for relatives to collect or look after the patient for a few days, through to more complex problems of finding suitable residential or nursing home accommodation. Poor communication with Social Services and poor knowledge of the varied and fast-evolving care schemes provided by primary care trusts (and eligibility criteria) further complicated matters.

Nor were the hospitals making effective use of their discharge lounges. Patients due for discharge would remain on the ward until ready to leave, which did not ease pressure on beds or allow early call up of new patients. Often, it was the nurses themselves who would notice the patient's stable condition and who would call the physician to authorize the discharge – but typically that meant waiting until physicians had completed their afternoon rounds, which was too late to call in a new patient that day. And to cap it all, increased lengths of stay exposed patients to higher risks of hospital acquired infections – particularly amongst the elderly – which put additional strain on the system.

To reinforce her message, McErlain-Burns invited Sue Edwards to share the preliminary findings from a bed occupancy exercise she had just conducted. Edwards had applied a methodology designed to identify the number of stable patients occupying hospital beds – an approach known as "point prevalence" in which she had recently been trained. The technique involved sending a team – comprising a ward sister, an occupational therapist, a physiotherapist and a social worker – to assess the medical stability of patients on each ward. The early results, presented at the workshop, suggested that over 17% of patients did not need to be in an acute hospital bed and could have been cared for in a different environment. Edwards emphasized the need to provide expected dates of discharge on admission, with daily updates, as a platform for more effective discharge performance.

The remaining third of the day was devoted to group work, facilitated by McErlain-Burns and the three Assistant Directors of Nursing. The four groups, each focusing on a different aspect of the discharge process, came up with a number of action recommendations. One group proposed introducing a "scaled down" version of the point prevalence approach to track performance improvements on a monthly basis; and also came up with a list of relevant performance indicators. Another group proposed adopting as pilot sites, those wards which had scored poorly on the point prevalence study, and highlighted the need to develop an education program to help the nursing staff understand and implement effective and timely discharge planning. A third group looked at how to integrate these new responsibilities and objectives for matrons into their annual performance evaluations, and proposed allocating three fixed sessions per week to the management of discharge performance (to allow matrons to lead this activity). And a fourth group looked at nurse-led discharge, noting that it had been in operation for 5 years on one of the

maternity wards, proposing ways of introducing it more broadly, and stressing the need to define clear discharge criteria, for each ward – as well as criteria for 'hand back' to a medical practitioner.

At the end of the session, McErlain-Burns and Edwards asked who would be interested in working on some of these initiatives. A number of matrons, including Helen Green and Nikki Ryan, volunteered. Yet not all were enthused by the prospect, as evidenced by the reaction of one matron who attended: "I just thought, 'Oh no!' Discharge planning is boring. And the fact that if you're pushing patients out quicker [creates] more workload because you get another acute admission that's poorly… You have a lot of paperwork to do on a new admission."

McErlain-Burns realized that she would have her work cut out to get all the nurses behind this initiative. To try to maintain the momentum, she shared the action plan from the workshop with her colleagues on the Executive Director Group and asked them to sign off on it. She then made three presentations to gain the support of the general managers, the medical staff committee and the medical directorate – and, via the hospital general managers, she invited all the senior physicians to a meeting where the Chief Executive himself had agreed to endorse the initiative. There was a 6-weeks notice period to observe in order to allow the senior medical staff to cancel or re-arrange their clinics.

McErlain-Burns also co-opted the Director of Information Management and Technology (IM&T) to help develop the information systems needed, working alongside the Assistant Director of Practice Development who would provide the baseline data needed to monitor progress (in length of stay, re-admission rates and so on). Finally, she named Sue Edwards to chair the steering group, which would meet weekly to oversee the initiative. Both being based at the Pinderfields hospital, Edwards and McErlain-Burns interacted regularly, both formally and informally.

Having dedicated about 20% of her time to launching the project for the past two months, McErlain-Burns felt it was time to step back a little, explaining: "It needed to be done right at the very beginning. We needed to be able to demonstrate that we'd done the diagnostics, that we understood the operational problems. I needed to go into the senior medical staff committees and to reassure them that we would share the information with them, [and keep] them regularly up to date. So valuable time was spent." From now on, she would be saving her time more for developing the links with the external agencies – as more efficient throughput needed to be matched by exit improvements, or it could prove counterproductive.

Toward a More Effective Operation

Following on from the matron's first workshop, the discharge performance steering group started its meetings in June 2003, occasionally attended by the Chief Executive. For half an hour each week, one of the Hospital Managers (Pinderfields), the Assistant Director of Practice Development and the Director of IM&T, joined Sue Edwards and the matrons in charge of discharge projects, to review developments. At one of the first meetings, the Chief Executive conceded that he was unhappy with the input from their Social Services colleagues but stressed that he wanted the Trust to get "its own house in order" before complaining to the Social Services about their inefficiencies.

Also participating in the steering group was the newly appointed "discharge manager", a position created exclusively to facilitate the discharge process and to liaise with outside agencies, such as Social Services. This person would be supported by a discharge co-ordinator, whose job would be to handle complex discharges, to be piloted immediately and to be cascaded out once further funding could be secured. Another new role which would support the discharge process, albeit indirectly, was the position of "site manager" (six per hospital providing 24-hour cover 7-days a week). The appointment of senior nurses to these positions made it possible to change the bed management duties – and to make sure that patients were placed on appropriate wards – while at the same time, alleviating matrons of that responsibility, as promised.

As the date approached for the meeting with the senior physicians, it became clear that a lot of them had not been warned or invited by their general managers – and for many of them, it was too late to cancel their clinics. So, at that point, the decision was made to cancel the meeting.

Meanwhile, Edwards was investing her time in several ways. Her main priority was to support the matrons and maintain their focus on discharge improvements: "I am continually having to motivate them and make sure that [it stays] high on their agenda, so I don't let them forget it." To achieve that, however, Edwards also had to work on the general managers, over whom she had no authority: "I have to get the general managers on board to support them working with me on [the project] and agree it's a priority. So it's very important that I develop good relationships with the general managers… and that I have credibility with them. I've got to convince them of the importance of the outcomes that we can deliver for them and get them to agree to provide the time for the matrons to work with me." Prior to the workshop, matrons did not have weekly timetables, so these were introduced in order to help allocate three fixed sessions per week to discharge activities. As for the *lead* matrons, the seven who were driving the various discharge improvement projects, they were dedicating 30% of their planned time to the issue, causing occasional tensions with their line managers.

Edwards also knew that she had to involve and support the front line nurses. Through regular presentations to the nurses' forum and via the matrons, but also through her physical presence on the wards, she needed to ensure "that sisters on every ward are monitoring on a monthly basis the percentage of patients that are medically stable, making sure that all have discharge plans, making sure that we communicate well with the relatives and patients, that they understand the care plans, that the plans get reviewed on a daily basis, that all staff understand the schemes." Edwards was also busy training the matrons and ward sisters to conduct 'mini' point prevalence assessments, due to start on a monthly basis in July.

It was not an easy context in which to drive such an initiative. For about ten years already, nurses had increasingly been asked to take on work, including medical tasks, previously performed by physicians. Indeed, this had intensified with the recent push to reduce the number of hours that junior physicians were working. Some nurses were reluctant to take on this extra work as it involved additional training, and reduced the time available for more traditional nursing roles, like talking to patients, counselling them and working with the relatives. It also raised key issues of liability if anything went wrong.

The context was further complicated by the fact that there were a variety of change initiatives running in parallel. Some of these initiatives were potentially complimentary to the discharge effort, such as the Emergency Care Collaborative, which promoted benchmarking visits and

where one member of the benchmarking team could be asked to collect information on specific discharge practices. There was also the Transfer of Care scheme, launched by Social Services, designed to achieve a better understanding of the patient's needs on discharge. Other initiatives were less obviously complimentary. For example, there was a large-scale initiative called the Premier Project, which looked for potential cost savings, particularly through the rationalization of purchasing – but it meant that matrons were heavily involved in the pilot testing of new supplies.

Meanwhile, with new discharge legislation on the horizon, McErlain-Burns had spent much of July and August leading the discussions with Social Services and local politicians regarding the Community Care Act. This legislation proposed resolving the problem of delayed discharges by fining Social Services about £100 for every day that a patient waited unnecessarily for a care package to be put into place. Many observers predicted that the Bill would sour an already strained relationship between hospital trusts and social services.[23] But in the Mid Yorkshire region, the parties took a different approach to the problem. First they established a common definition of what constituted a "delayed discharge". Then, instead of sanctioning delays, they agreed to *invest* some of the Social Services' annual reimbursement funding (£300,000) into trying to *avoid* delays – through improved discharge systems, earlier notification and financial support for the hospitals' six discharge co-ordinators. Access to this funding would provide much needed assistance to McErlain-Burns and her team who had no formal budget allocated to improving discharge performance. In order to be ready for the legislation, a shadow version of the Reinvestment Plan was put into place in October 2003.

The timing coincided with a second matrons' workshop, organized this time by Sue Edwards, but also open to staff from external agencies. Its purpose was to take stock of the progress on two fronts: in terms of the discharge planning process as a whole, and more specifically in terms of the drive to introduce nurse-led discharge.

Discharge Planning

The discharge planning initiative benefited from the fact that the lead matron, Helen Green, had previously been her hospital's link matron for issues around discharge. It was natural for her to build on that experience – and within a couple of weeks of the first matron's workshop, she had already produced a report entitled, "Changing Culture & Improving Discharge Performance", outlining the scope of the initiative to all the ward sisters and nurses. The report stressed this was a major priority for the Trust and that discharge planning started from the moment a patient was admitted.

The report cited a number of preliminary measures already under way: a review of the "Going home from hospital" information booklet, the introduction of discharge planning notice boards for patients and carers on each ward, as well as a poster campaign advising patients that they should not expect to stay in an acute bed once their acute episode of illness had passed. Ward staff were also encouraged to make better use of the discharge lounge – the centralized waiting

[23] A health select committee consultation paper found that 80% of 250 affected organizations – councils, primary care and NHS trusts – said it would harm relations between the NHS and social services. (Batty, D., "Who cares," *The Guardian*, 13 February 2003, p. 21)

area for patients about to be released – and matrons were given monthly reports on the use of the lounge by ward area.

Green also made up cartoon posters of the golden bullets showing how discharge planning fitted into the Trust's overall priorities. She shared these with all the ward sisters reporting to her and asked them to display them so that the staff would also become familiar with them. Very quickly, other ward sisters not reporting to her started contacting her to ask if they could also have them. Within two weeks they were displayed on every ward in her hospital.

At the same time, Green and the newly appointed discharge manager were organizing the first full-day workshop to promote ownership of discharge planning. Starting in July 2003 with all the ward sisters, to ensure they understood their pivotal role in the process, the monthly workshops involved group work and discussion around discharge planning – such as encouraging ward sisters to attend ward rounds and to challenge discharge planning practices on their wards, but also including discussions about how the performance objectives of ward sisters would be modified to incorporate this new issue. The ward sisters were then encouraged to send their staff to the workshops, and Green was surprised at the enthusiastic response from the nurses. In fact, there were only a couple of negative reactions. One actually involved a nurse from Green's own staff who saw this as an unwelcome supplement to an already heavy workload. Green was angry, stressing that this initiative was about working smarter rather than harder, but she suggested that he come and shadow her to see the bed situation for himself: "I took him to A&E where there were trolley waits, there were children, older people and he was just, well, amazed… I took him to the bed bureau and he looked at the list of people needing to come in and, to be honest, he just went completely the other way! Now, he'll ring the bed bureau himself when he has a free bed so that they send a new patient down."

The success with the nurses persuaded Green to open up the workshops to medics, social workers and therapists to raise awareness of this as a joint problem. Flyers were sent out to emphasize the multi-disciplinary nature of these workshops, and although one therapist attended, there was no uptake from Social Services or the medical side.

Despite having a good relationship with the physicians in her hospital, Green was not entirely surprised by the negative medical response: "They'll stamp their feet and dig their heels in and say no we're not doing this but ultimately it's about selling it to them and it takes quite a bit of time." For example, the senior physician on one of the three wards for which Green had direct responsibility, had initially been very resistant toward the whole effort, but she had persuaded him to pilot the discharge co-ordinator scheme. In the process, that physician had become an advocate of discharge planning, supporting Green when she later spoke to his two junior colleagues. One of the junior physicians agreed to provide an estimated date of discharge for his patients, but said that he didn't see the point. The other said that he definitely would not be doing so because "it was increasing his workload and a waste of time" – he refused to "pluck a discharge date for somebody who might deteriorate." Yet, it was for this reason that daily reviews were also being introduced.

So Green asked the two ward sisters to "keep badgering him" and in fact to set estimated dates of discharge themselves, if he didn't mind. His response was "You can do what you want, but I'm not doing it!" They pushed back repeatedly, showing him that the other two physicians were now cooperating and asking him again to give it a try. At which point, he wrote to the Chief Executive, telling him that he thought it was a waste of time, with Green and the ward sister on

copy. The Chief Executive fired back a response essentially saying that "resistance was futile", that nursing had his full support and listing the reasons why.

In September 2003, Green received the results of a "utilization management" exercise launched by McErlain-Burns two months earlier. The assessment showed that up to 30% of the patients did not need admission to an acute hospital – though for half of them, there was no suitable alternative in the community. It confirmed Green's suspicions that admissions' procedures needed tightening up – and that capacity gains from slicker throughput might actually be contributing to the problem, in that they reduced the pressure on junior physicians to screen out inappropriate admissions. More efficient discharge was one thing, but they also had to "sort out the front door".

Green was able to secure some funding from the recently agreed Reinvestment Plan and to put senior physicians and physiotherapists into the A&E department to help assess patients. In parallel, and under pressure from nursing, the physicians set up the Acute Care Pathway group to redesign the admission pathways – and matrons were often solicited to be part of the various project groups. A related change was the renaming of the *medical admissions ward*, which became the *emergency assessment unit*.

At the same time, some of the wards had been trying to pilot the "single assessment process", a national recommendation, intended to reduce duplication in the collection of patient information. This was proving a complex procedure to implement, as it involved a multidisciplinary team – and so its implementation was put on hold by Tracey McErlain-Burns until the on-going changes were better established. Similarly, the Transfer of Care scheme was discontinued in October 2003 after the pilot phase. Although Social Services came back proposing a modified version, McErlain-Burns turned down their request, explaining: "There are just too many things going on. We're going to be good at those we've put in place and then we'll consider another stage."

Amongst other things, there was the shadow form of the Community Care (delayed discharge) Act coming on stream in October 2003 – and this involved new communication procedures between the hospitals and Social Services. For any patient likely to require Social Services input upon discharge, the hospital had to send out official notification on admission, to allow Social Services to prepare. This was followed by another official notification, 24 hours before the patient's expected discharge.

By the time of the second matrons' workshop in mid October 2003, there were signs of progress on several fronts. For example, the discharge co-ordinators had quickly proved a success. One ward sister who had been particularly negative at the start, saying she would rather have an additional nurse, had seen the benefit that the other wards were deriving from having someone dedicated to co-ordinating and planning the discharge process. Green was also able to report improvement in lounge usage and pilots under way to analyze the further impact of extended opening hours. Furthermore, the monthly point prevalence assessments showed that the numbers of patients inappropriately occupying hospital beds was dropping steadily in two of the three hospitals. And the percentage of patients with estimated dates of departure was climbing rapidly – even on the ward with the recalcitrant junior physician, it had risen to over 90% from around 10% only a few weeks previously. Green noted wrily: "He doesn't like doing it and they do have to prompt him with a cattle prod sometimes, but he *is* doing it." There was much cause for celebration. Conversely, on the nurse-led discharge initiative, progress had not been so smooth.

Nurse-Led Discharge

On the back of the first matron's workshop, back in April 2003, the immediate challenge for the Nurse-led Discharge (NLD) project had been policy development. There was a need for a set of guidelines to establish clearly the remit of nurses in terms of discharging patients, as well as the education and training requirements, the necessary competencies and the extent of nurses' responsibility – a document that could be formally approved by the Board. With her extensive experience of procedure writing, the Assistant Director of Nursing from the Dewsbury hospital had volunteered to take overall responsibility for the initiative, along with one of her matrons from the maternity unit in the same hospital.

Over several weeks, they did a literature search to see what was happening, but identified only a few isolated pockets of practice in the UK, mostly in maternity and gynaecology units. They also made contact with other trusts to see if they had anything to share, including one in Manchester, which had been wrestling with policy development for close to a year. But, for Sue Edwards, "That was too slow. We wanted to move more quickly and, at that point, we decided, forget about what other people are doing, let's just sort out what we think is right." A relatively short set of policy guidelines was prepared and the Executive Director Group signed off on them in August 2003, providing vicarious liability if anything went wrong.

By the time of the second workshop in October 2003, it was evident that the NLD project had not developed sufficient momentum. In part, this was a consequence of the absence of bed pressure problems on the Dewsbury site, which was not fostering a strong sense of urgency. It was also related to the dominance of the midwifery perspective, which contributed a strong sense of accountability, but was less adapted to thinking about new ways of planning and executing the discharge of patients with complex medical and social problems. Sue Edwards asked for a volunteer to take the lead on the training and piloting stage of the NLD project. Nikki Ryan, a matron from Pinderfields who was already closely involved with the project, volunteered and knowing that she was "very much an activist", Edwards was happy for her to drive the project.

Ryan's first priority was to develop a training program for all the nurses going through NLD. In late October 2003, she proposed the first of her monthly training sessions, inviting nurses from all wards to attend but having no idea what kind of response she would get. As it turned out, she averaged 20 nurses per session. The first two hours of training involved Ryan herself providing information on issues like record keeping, history taking, patient consent and accountability. The next two hours were spent developing competencies, with nurses from each different specialty drawing up a list of the medical criteria that a patient in their area would need to fulfil in order to be considered fit for discharge. This work was essential in order to have something to show the physicians and to gain their approval.

After three training sessions, Ryan had covered the full range of specialties and decided to write to each physician in the three hospitals explaining the whole process. Unfortunately, the timing coincided with a reshuffle in matrons' responsibilities within her hospital and the secretarial support, which Ryan had been using for the NLD project, was removed by her general manager. By the time Edwards heard about it and could offer some assistance, Ryan had already done the secretarial work herself: "I found that hard, trying to do my day job and trying to get the clerical side sorted. But all the physicians were sent a copy of the policy and a list of the proposed discharge criteria for their area, with a request to contact me if they had any problems."

Ryan's proposals went unchallenged: "Nobody got in touch, so I assumed that everything was going to be okay." The next stage was to get the physicians involved, first in showing the nurses what to do, then observing them and finally signing the certificate to say that a nurse was competent to carry out nurse-led discharge. It was at this point, that the objections began to surface. It started with one of the respiratory nurses who, after attending the training, had approached the physician to ask him how he thought they might approach this – only to be told that: "Under no circumstances was a nurse going to discharge his patients."

Besides the respiratory specialist and a cardiologist who were refusing to participate, there were other physicians who had clearly not read what Ryan had sent them or had assumed it would not affect them: "It was only when the nurses started trying to identify suitable patients for nurse-led discharge that they said, '*What do you mean by nurse-led discharge?*'"

This was a serious setback, in that physicians formed a very powerful group within the organization and could easily block any change initiative they did not like. Ryan asked two specialist physicians, a neurologist and geriatrician, who had signalled their interest in the project to put down in writing why they were supporting it – and they wrote that it promised to reduce the workload for junior physicians, as well as ensuring quicker patient turnover which, for specialists with long waiting lists of patients, had an obvious benefit.

The main problem, Ryan felt, was with the specialists who dealt mainly with emergency admissions – as it was the emergency admissions that really needed to improve because of all the trolley waits in A&E: "The physicians that covered emergency medicine and the acute admissions didn't seem all that bothered by the process whereas the surgery side of it were really keen on it."

Ryan's response was to identify two senior physicians, one from surgery and one from medicine, who might support the project. She chose "the ones I got on well with and the ones I thought were going to be strong enough to deal with their colleagues." She asked them to bring up the issue of NLD at their fortnightly medical group meetings and to be clear that, "This is going to happen whether they like it or not and if one physician doesn't like it, there's going to be another physician who's going to sign off those nurses anyway."

With more of the physicians showing signs of coming round and some participating in the observation of nurses, Ryan encountered another wave of resistance, this time from a less expected quarter. Two or three weeks after they had enthusiastically participated in training, Ryan was following up on a group of nurses, asking how the NLD was progressing. "Oh, well we haven't really done any yet," she was told. When she probed, they admitted that they were concerned that the Trust would not support them in cases of re-admission, although they had not raised any questions about liability when the issue had been covered in training. "I don't know where it's come from," explained Ryan. "Some say it's from the physicians but I have no evidence of that."

Ryan reassured them that the Trust would support them "absolutely and completely… provided the nurse could justify her decision." She also wrote to all the matrons, giving them a list of the nurses who had undergone NLD training and telling the matrons, "When you go in on your wards, try to support them [to take the next step]… because I can't physically support all of them." In addition, Ryan decided to put in place a clinical incidence reporting system, in order to

"pick up re-admissions and look at why they've come in," and to determine whether or not this was related to the patient's previous problem.

By April 2004, over 120 of the 2,500 nurses and midwives had gone through NLD training and at the professional forum meeting, two of the ward sisters gave an account of how NLD had changed their jobs. They acknowledged that making their first discharge decision had been quite a trial, but that they had quickly grown in confidence – and had released 40 patients in the previous month alone. They explained how they would identify patients as suitable for NLD on admission (or even pre-admission in the case of a scheduled procedure), before outlining the NLD procedure to the patient and requesting the patient's consent. The ward sisters felt that this now enabled them to build up more of a relationship with the patient – and gave them a sense of providing "total patient care". After the intervention, the patient would return to the ward with a treatment plan and notes from the physician, so that the nurse could proceed with discharge, provided that convalescence followed the expected trajectory.

In cases where the patient needed take home drugs, the nurses would get the physician to prescribe these on the previous evening, making it possible to discharge the patients the next morning at 7am, and allowing the hospital to call in a new waiting list patient or accept an acute admission the same day. Prescription was, in fact, the last remaining hurdle for NLD. While there were prescription courses for nurses, the Trust was too stretched, both financially and in terms of staffing, to release nurses for the necessary 6-month training period.

Ryan's immediate concern was to get more nurses signed off as competent to do NLD. She decided to call a temporary halt to the training sessions, explaining: "I don't want to get more and more nurses through training when they can't really get their competences signed off because the physicians haven't got the time." Her idea to get round this problem, once enough nurses were experienced in NLD, was to have nurses signing off other nurses.

Taking a Health Check

Back in October 2003, the initiative had experienced a potentially devastating blow when Roger French, the Chief Executive who was strongly behind the discharge effort, had been forced to take sick leave. An acting CE had taken over, but there was not the same impetus to make progress reports to the general management forum that had existed under French. A new Chief Executive, John Parkes, was not appointed until April 2004. Three weeks into Parkes' tenure, the four members of the senior nursing team were invited to share their thoughts regarding the past and the future of the discharge project.

Matron Nikki Ryan had several satisfactions. She pointed to the number of nurses who were well on the way to becoming competent to discharge patients, especially in the surgical specialties. She highlighted the fact that, so far, not one patient had refused to give consent for NLD, nor had there been any cases of re-admission linked to early discharge. Most encouragingly, she reported the mounting interest from other Trusts, eight of which had contacted her for details, advice or training on NLD.

Ryan also noted the beneficial side effects of her project in terms of integrating the work of matrons across the three hospitals, and in terms of enhancing the status of nurses: "Generally I

think nurses are being given more respect and an acknowledgment for the knowledge and the ability they bring to what they're doing, which has been a long time coming really."

She was a little perplexed at the disparity of uptake between the wards, noting for example, that the initiative was up and running extremely well in one neurology ward, but meeting much more resistance in another neurology ward. Looking back, she realized that she had underestimated the amount of support needed by ward staff when making discharge decisions and could have made a better job of "making sure the support structures were in place", prior to initiating training.

As a next step, she envisaged "getting the physicians on board, getting the nurses on board, where the successes have been, and doing a presentation to the wider medical community. So they can sell it… let the champions sell it to the others." Looking ahead, she remained very upbeat: "I think that within 3 months we'll see a massive upsurge. At least three quarters of the nurses, that's my goal, are going to be carrying out nurse-led discharge… At least one in each ward, on each shift."

Matron Helen Green was particularly proud of the changes both in work practices and attitudes, which had resulted in more proactive, energized discharge planning: "Now, you can ask nurses what's happening with the patient and they'll know. Their care plans are reviewed daily. The mini Points Prevalence that we do each month is done by the ward sisters and the results speak for themselves." The percentage of stable patients in acute beds was down to 7.5%, while usage of the discharge lounges had improved 100%. The Trust was also closing in on several other discharge targets. And a proposal had just been launched to obtain money from the King's Fund in order to refurbish the discharge lounges (part of the *Enhancing the Healing Environment* project).

Green was somewhat frustrated by the fact that Social Services were still operating at a slower pace than the project required: "When they're called in, they do step up a level. But we want them to step up a level 24 hours a day 7 days a week. Having said that, our understanding of each other's ways of working has improved a lot."

Her forthcoming challenges, she felt, would be to try to link up better with Nikki Ryan in terms of helping nurses become discharge competent and, more generally, consolidating the improvements obtained: "[Discharge planning] overtook a lot of other issues that I was dealing with. It was a chief priority for my workload but now, it's like, dare I let go of these reins and step back? But I don't think I can take my eye of it yet, because although people are more motivated, it's easy for them to slip back."

Assistant Director of Nursing, Sue Edwards welcomed the much-improved relations with external agencies, partly as a result of joint schemes, notification procedures and multi-disciplinary meetings: "Things are better. It doesn't feel so much like a blame thing. There's more joint-ownership of problems." She noted, for example, that the reimbursement protocol had been implemented successfully with no disputes or appeals. She was also satisfied that she had managed to keep the energy of the staff focused around improving discharge planning, beyond the first exciting months of the project, and despite many other competing pressures.

On the other hand, she regretted the poor performance of Dewsbury hospital on several of the KPIs, which was dragging down the Trust's overall performance. Asked to comment on this lag, she offered two explanations:

Dewsbury had never experienced the same kind of admission pressure as the other two hospitals. It had always had a slightly more efficient casualty service and it did not have a problem with bed utilization: "So, when we merged, some of the response from Dewsbury was "We really don't need this project quite as much". But the reality was that we were trying to implement some standardization across the Trust and bring the different hospitals together." The problem was probably compounded by the fact that Roger French, who had been in charge at Dewsbury before the merger, systematically stressed the problems at the Pinderfields and Pontefract sites.

"Also Tracey's visibility is mainly on the Pinderfields site. She spends 3 days a week there. Myself and Helen are also based at Pinderfields, though both of us worked at Pontefract before the merger, and therefore we still had the networks and the tentacles into Pontefract and to be honest we abused those and played on them… And, of course, Nikki is the matron for A&E for both Pinderfields and Pontefract. So there's something, I think, about visible presence keeping the project going."

Looking forward, she was cautiously optimistic: "Some of the new physicians that come through are great. They come in with super ideas and want to change the world. But we've also got a number of dinosaurs within the organization who are very powerful still… and we don't yet have a critical mass of the younger, more dynamic physicians." She echoed Helen's concerns: "Although discharge planning is now a reality and everybody's very much aware of how important it is and they're all doing what we ask of them, I just feel that if I started to prioritize something else, it would start to slide again. So it's not yet the right time [for me] to withdraw from this project."

Director of Nursing, Tracey McErlain-Burns, drew special satisfaction from the reinvestment plan agreed with Social Services, "despite the politics", and from helping maintain the discharge project on track, in-between Chief Executives. She also felt that their efforts had helped to raise the profile of nursing as she had hoped it would: "Helen had to come to Trust Board last Friday to do a presentation to the Board. To have matrons coming in to Trust Boards is another visible sign of what nursing is doing."

Her regrets revolved primarily around the failure to get the medical side involved in the project – and particularly allowing the early meeting with senior clinicians to be cancelled: "I often reflect on whether I should have tried to manage it in partnership with the Medical Director and whether that would have given us any different results? Would they have led on the changes at the front-end admissions, sooner? It might have generated a system solution." Taking a wider perspective she conceded that: "Perhaps it would have been a good way to demonstrate how physicians and nurses can work together. That's probably been a lost opportunity."

McErlain-Burns was also frustrated that after identifying the right metrics, they had not succeeded in establishing clear baseline data for re-admission rates or length of stay, making it difficult to assess progress. The Assistant Director of Practice Development had left the organization before completing the project and boking back, McErlain-Burns felt, "We weren't hard enough on her to deliver." The number of patients with an estimated date of discharge and other key metrics had been collected manually. And with a new patient administration system coming on stream in 2005, it no longer seemed worthwhile investing in a provisional system.

Another lesson that McErlain-Burns would take away from the experience was that complex organizational change typically resulted in a variety of processes running in parallel. Looking back, she felt that she could have done a better job of mapping the change processes to avoid some duplication. She also felt that she had occasionally allowed external agendas to become distracting, notably by letting the Transfer of Care scheme go ahead: "It was too much, too soon, rushed and ill-thought through."

Looking ahead, she considered that the essential challenges lay around juggling different demands and priorities: "The targets are often competing in different directions so you're told you *must* hit your waiting list targets, but at the same time you *must* bring down the expenditure by £20-odd million within 12 months and you *must* streamline activities. And streamlining clearly means moving staff across sites. There's all the staff consultation that needs to be undertaken, you need to train them so if you're moving nurses from surgery into orthopaedics you need orthopaedic training… and doing all of those things at the same time is exhausting."

On the other hand, she felt that what they had achieved in the past 12 months demonstrated what kind of contribution nursing could make as a professional group – and hoped that nurses' enhanced influence over the patient journey would show through in higher job satisfaction and retention rates. Longer term, she also felt that their efforts to introduce nurse-led discharge Trust-wide would help set the stage for the process to become a standard throughout the NHS in the future.

Epilogue: The risk of relapse

> In spite of the significant improvements across a broad range of discharge measures, the gains were not reflected in public opinion about the Trust. The situation was made even worse, in August 2004, when the Trust lost its only star in the annual ratings. This score put it among the nine worst performing trusts in the country, with almost 1 in 5 people having to wait more than five hours in A&E admissions for a bed, with twice as many cancelled operations as the national average and delays in outpatient appointments.

Facing the press, John Parkes, the new Chief Executive tried to remain upbeat: "We have taken a firm grip on our finances and are putting in place measures that will enable us to move towards financial stability by March 2006… Staff have worked extremely hard to ensure that over 90 per cent of patients who arrive at Accident and Emergency are seen within four hours and we continue to work hard across the Trust to improve this figure." He concluded: "We must now look to the future. This year's rating is an opportunity for us to draw a line in the sand and move forward."[24]

The Royal College of Nursing had previously warned that a no-star rating could seriously exacerbate recruitment and retention problems, creating "sink" hospitals where nobody wanted to work or be treated.[25] And Tracey McErlain-Burns clearly understood that the zero-rating would make her job more difficult and suspected she would have to start monitoring job satisfaction

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[24] Waugh, R. (2004) "Health turst fails to shine in ratings," *Yorkshire Post*, July 21: p. 1.
[25] Batty, D. (2003) "Q&A: NHS star ratings," *SocietyGuardian.co.uk* , July 16.

among nursing staff: “It’s tough not only because you have to maintain the public confidence and staff morale, but also because, as one of only two acute trusts in the country not to have a star, we have an awful lot of public scrutiny now. It’s like working in a fish bowl. Everybody is looking in. Everybody is questioning.”

The financial recovery program put into place had involved two ward closures at Dewsbury hospital. Perhaps the only bright spot to emerge from this was that, by November 2004, Dewsbury had become “very positively engaged” on the discharge issue. As McErlain-Burns noted: “Even though they had efficient procedures in casualty, those procedures were very severely challenged once they had fewer beds to admit patients and therefore they have now fully embraced all of the discharge initiative.”

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APPENDIX 8 (PART A)

Redesign of Stroke Services in South Devon Health Community (A)

This case was written by Julie Battilana, Doctoral Candidate at INSEAD, Anne-Marie Cagna, Research Associate, Tom D'Aunno, Professor of Organizational Behavior and Mattia J. Gilmartin RN, PhD, Senior Research Fellow, INSEAD, as a basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

The project was supported by the Johnson & Johnson-INSEAD HMI Partnership, The National Health Service-Modernization Agency, Leadership Centre and the INSEAD Alumni Fund.

The case was developed in collaboration with Fiona Jenkins and Dr Robert Jones.

Fiona Jenkins, Head of Physiotherapy for the English National Health Service (NHS) South Devon Health Services had just four months to review and redesign the stroke unit for the region. In 2001 The National Service Framework (NSF) guidelines stated that all individuals admitted to hospital suffering from a stroke must be seen by a stroke specialist service.[26] Jenkins realized immediately that the stroke service for South Devon, situated in Torbay General hospital, simply did not have the capacity to meet the NSF guidelines. One solution was to increase the number of beds in the unit. This, however, was not feasible, as the unit had recently moved to a new ward with additional beds and clearly would not be allocated more in the future. Furthermore the unit was not designed for rehabilitation and could not provide the services required as it was dedicated to acute care.

An alternative way of handling the capacity problem needed to be found and so Jenkins looked outside of the acute unit to other sectors of the organization that dealt with stroke. Patients were admitted for an average of three weeks into the stroke unit, a length of stay Jenkins considered too long. This was due to stroke patients staying in the acute unit for rehabilitation. Reducing the time a patient occupied a bed could be one way of increasing bed capacity. If rehabilitation could be handled outside of the acute unit in primary care it would make more beds available for acute care. It would also mean an overhaul of stroke patient care. Jenkins knew that it would be a challenge to convince all the different stakeholders to adopt the new structure and change their mindsets. Coordination between the different players involved in stroke care was going to be key, but also one of the largest hurdles to overcome, as treatment of stroke involved not only primary and secondary care but also social services.

South Devon Health Community

During the 1990s the South Devon Health Care Community developed considerably with a reputation for high quality primary and secondary healthcare and a good track record for service improvement. In 1991 it became one of the first National Health Trusts with the responsibility for providing acute mental health and community health services for its population. In 2001 the population it served had increased from 240,000 to 270,000 and was expected to reach 280,000 by 2010. The South Devon Care Community was made up of many different health organizations including the South Devon Healthcare Trust. Acute trusts were part of this and incorporated general hospitals one of which was Torbay General Hospital.[27] In addition there were three Primary Care Trusts that came under the responsibility of the South Devon Health Care Trust: Teignbridge, Torbay and part of South Hams and West Devon. There were nine community or cottage hospitals that were accountable to these PCTs. Social care organizations in the region were separate from the Trust and were linked to district authorities.

The area the Trust covered included a high percentage of elderly people (65 years and over) - 24% compared to the national average of 16%. This older population placed significant strain on the Trust's resources to meet their healthcare needs. Elderly patients represented 45% of patients

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[26] These guidelines were based on the The Royal College of Physicians Guidelines that were drawn up in 2000.

[27] Torbay General Hospital had a star rating of three.

admitted in the hospitals and 74% of bed use. Stroke was just one of the chronic illnesses that affected this aged population and was therefore one of the Trust's priorities for improvement.

In 2003, both the acute trusts and PCTs were given the maximum three-star rating based on indicators such as low numbers of emergency readmissions; after treatment for strokes or timely breast cancer treatment. The different organizations employed 3,500 staff including doctors, nurses, allied health professionals (AHP) physiotherapists and occupational therapists among others.

Stroke Targets in the National Health Service

> *"Stroke services in the National Health Service have been 'Cinderella services' for a long time before public authorities tried to improve them. This began in 2000 when some national stroke targets were defined within the NHS."* Explained Fiona Jenkins.

The national clinical guidelines for stroke care were first drawn up in 2000 by the Intercollegiate Working Party (IWP), revised in 2002, and were included in the National Service Framework (NSF) for Older People. The guidelines addressed the care and management of an individual experiencing a stroke from the acute illness to longer-term challenges including carer support and secondary prevention. The guidelines clearly stated that organizations should develop specialist stroke services:

> *"Every organization in the care of stroke patients over the first six months should ensure that all stroke patients are the responsibility of, and seen by, services specializing in stroke and rehabilitation."*[28]

The NSF introduced standards for treatment and care of stroke sufferers that included both health and social services. Treatment for strokes differed depending on the type of stroke an individual suffered. It was also acknowledged that stroke patients were not uniquely elderly people and so the standards and models would be applied to all stroke patients regardless of age. There was evidence that individuals that suffered stroke were more likely to survive and recover ability if they were admitted promptly to a hospital-based specialized stroke unit. However, the report also stated that "these benefits can be achieved at no overall additional cost to health and social care."[29] Jenkins knew that it was an impossible task and she would have to secure funding in order to improve the service. Four main components for the development of integrated stroke services were identified: prevention, immediate care, early and continued rehabilitation, as well as long term support. The NSF also defined the milestones for the implementation of these services.

The guidelines also specified that specialist stroke services should be delivered to patients equally and effectively in a hospital or in the community provided that services were resourced appropriately such as suitable staff to look after the patient on discharge. The patient should be seen regularly by a specialized multidisciplinary stroke team on returning home.

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28 National Clinical Guidelines for Stroke, 1999. updated 2002.

29 Department of Health 2001.

Stroke care accounted for 4% of the total NHS expenditure with annually close to 60,000 deaths. It was the third highest cause of death in the UK after heart disease and cancer. Stroke was also the largest single cause of major disability with 250,000 people being affected at any given time. In 2002 the Stroke Association[30] estimated that spending on stroke services would increase 30% by 2008. Each year over 130,000 people in England and Wales experienced a stroke with approximately 10,000 sufferers under retirement age. It accounted for over 8% of all deaths in men and 13% of deaths in women in England. Around 20% of all acute hospital beds were occupied by stroke patients and 25% of long term beds.

Under pressure…

Until September 2003 the stroke unit for the South Devon community was centralized in the Elisabeth ward in Torbay General Hospital with 18 beds available. There were an estimated 600 admissions per year to the ward. It was moved to the George Earle ward in September with an increase to 24 beds. The new ward was better equipped than its predecessor as it was refurbished to accommodate stroke patient needs unlike the Elisabeth that was designed for general care of the elderly. The George Earle ward had 24 beds, where acute care and rehabilitation took place. Prior to the stroke review patients stayed on George Earle for both parts of the care. However, there were insufficient beds to admit all stroke patients on the ward as many beds were being used for patients who were post acute undergoing rehabilitation. Others were just waiting to be placed in long term residential or nursing care.

The stroke service at Torbay hospital was led on a part time basis by Peter Sleight, a Care of the Elderly Consultant who had a special interest in stroke. In addition to his work on the stroke unit he had a case load of general care for the elderly in Torbay hospital, ie, Acute Trust. He was assisted in the stroke centre by a full time physician. Decisions regarding a patient's care and transfer were made by a multidisciplinary team that met weekly to discuss each person case by case. The Torbay acute unit was the only dedicated facility for stroke in the South Devon health community. There were, however, ten beds dedicated to care for the elderly at one of the community hospitals at Newton Abbot that could be occupied by stroke patients. In reality these beds were mainly used for patients waiting to be placed by social services in a residential or nursing home. The majority of the patients were admitted with other conditions than stroke.

In 2003 less than half of the patients admitted with a stroke had access to the Torbay acute unit and hence the specialist stroke service. With limited bed space individuals admitted with stroke often found themselves on other non-stroke wards without the appropriate staff and skills required for their care. There were even cases of patients suffering from stroke admitted to maternity wards. In addition only the consultant could discharge patients that ultimately led to delays in beds being freed up for needy stroke patients. If, however, an individual was fortunate enough to be admitted to the stroke ward they stayed in as long as three weeks for rehabilitation. As Jenkins explained:

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[30] The Stroke Association is an organisation run by volunteers that improves services for stroke sufferers. They provide some support for patients suffering from stroke for example retired teachers help individuals who have speech difficulties to overcome them.

"With an average length of three weeks, the acute units were keeping patients in the hospital far too long and not passing them on to the appropriate community services for rehabilitation."

In addition to beds being "blocked" by patients undergoing rehabilitation, the stroke unit was the only inpatient service for other neurological patients and so often the beds were filled with other non-stroke patients. The situation meant that often patients requiring specialist care at the Torbay Stroke unit were either sent home, to one of the community hospitals or a nursing home within the South Devon area and thus did not receive appropriate care. It also became clear that the three primary care trusts that worked with the acute stroke unit were unaware of what care was available for stroke patients throughout the entire care community.

Social services were responsible for ensuring the care of the patient once they left rehabilitation or hospital. They worked with the care homes to place individuals requiring long term care that could not be looked after at home. There were often difficulties with commissioning places in care homes due to the unavailability of space. As patients were given a choice of the care home according to their financial status, this often led to beds being blocked while patients waited for a place in their chosen home to be made available. This placed a certain amount of strain on social services and acute care. Another issue arose as it emerged that the two social service departments within the South Devon community had different referral systems and services in place, hence further complicating the situation.

Getting started...

Jenkins was employed as Head of Physiotherapy Services for the South Devon Health Organization and lead of the Teignbridge Primary Care Trust's Service Improvement. She was responsible for a complete review and redesign of South Devon stroke services. She had a wide knowledge of the services that would be vital in convincing all key stakeholders of the importance in changing processes. She was also a member of the steering group that looked at how the NSF requirements would be implemented across South Devon. As she noted:

"Having the responsibility to work in more than one organization gives you many advantages. Where as if I came from an external organization, people will think 'who is she? What does she think she's doing?' whereas I have always been part of the acute trust and primary care."

In addition she was the lead of the modernization project for the South Devon Care Community. With just four months to complete the review, according to the targets fixed by the National Service Framework for Older People Jenkins' task was not going to be easy. As she explained:

"If we need to alter the acute unit and develop the community services I cannot envisage that it isn't going to have to require some investment."

The overall aim of the review was to improve quality and care for stroke patients in the stroke health community. She had four main goals when taking on the redesign of the stroke care services: to increase the number of patients that were diagnosed with stroke to be admitted to the

acute unit; to improve community rehabilitation services; to develop integrated work practices and collaboration across the different services and; finally to change discharge practices.

Steering the Way – Process mapping

In September 2003, Jenkins began by reviewing the stroke service process map. She set up a steering committee with members from all areas of the health community that dealt with stroke care. This included patients, nurses, social services representatives and the stroke association regional co-ordinator among others. The "Process Map" took two sessions of two and a half days to create and involved 40 staff. It plotted the stroke service from an individual's initial consultation through the health and social care system. As Jenkins explained:

> *"Although it was very time consuming, it was probably one of the best strategies, especially for the acute unit staff as they could now see how complex the pathway was."*

This steering group was key as Jenkins not only needed the main stakeholders' buy-in but valued their input and suggestions. As she noted "It makes everyone feel that they are part of something." Coordination between the social services, the community hospitals, the General Hospital and the General Practitioners (GPs) was critical for Jenkins's redesign strategy to be successful. However, it was also one of her greatest challenges as the different parties did not have the same needs and did not always work together. She knew she had a difficult job to convince these different organizations involved in stroke care of the importance of collaboration and communication. Jenkins explained the implications of the NSF and tried to cover all the issues that occurred during the stroke patient treatment process. She believed that if care was to be improved for stroke patients social services would need to be integrated into the pathway and this would be tricky as they were not part of the same overall organization – South Devon Heath Care, but fell under district authority's responsibility.

As part of the review process the steering committee visited a stroke centre that was considered a centre of excellence for care. As Jenkins explained not only was the visit an inspiration for the steering committee it also helped with communications between the different members:

> *"One of the interesting things we did was to hire a mini bus and take everybody for a six-hour journey to the centre of excellence for stroke care. It was quite obvious that a lot of people had not even met each other before. The fact that the people got to know each other would be very useful when the system would be up and running."*

Jenkins not only looked at other stroke services in the UK but also other healthcare systems including the US Kaiser Permanente model. This linked hospitals, physicians, pharmacies, long-term care, and payment under a single corporate structure. It used a system of "managed care" that maintained patient flow through all the different channels of health care. This reduced the use and length of stay in hospitals. Nurses and therapists were employed to allow patients to be discharged from the hospital as early as possible. Even though it was recognized that the US Kaiser healthcare system differed from the NHS Jenkins was convinced that the Kaiser method would "undoubtedly bring benefits as the NHS required a major re-engineering and could be helpful in developing the South Devon stroke care services."

By October 2003, all key areas in the care pathway that needed improvement were identified, these included:

- looking at demand
- referral routes
- hand-offs between, professions – transfer from acute unit to community
- waiting times and delays
- bottlenecks in the system increasing delays
- adherence to evidence based practice

The Steering committee drew up a list of what the NHS Modernization Agency termed "Improvement Opportunities." They looked specifically at the areas in the stroke pathway that did not comply with best practice and that were realistic to improve in the time frame. Eight pilot schemes were set up consisting of one lead person from the steering committee with support from other staff members. These groups began to collect data, such as how often a patient was weighed - one indication that patients were not recovering was weight loss. Another group focused on the TIA booking clinic. An individual that suffers a TIA runs a high risk of a full blown stroke, therefore GPs needed to send patients quickly to the clinic. An electronic pro-forma was introduced to speed up the process with emails used to send patient information and to ensure there was sufficient space at the clinic. These were just some examples of what was tested in the pilot schemes to achieve improved service (Exhibits1 & 2).

Another part of the review process plan was developed that focused on health promotion, prevention, education and treatment. According to Jenkins

> *"This shift from disease treatment to disease prevention would lead to fewer emergencies. The ability to share clinical information (patient history, test results, medical imaging) would provide all health-care providers (GPs, hospital, community-based services) with a common mechanism."*

Difficult Choices...

It soon became clear that Jenkins had several options to improve the stroke service. One solution was to expand and develop the rehabilitation unit in Torbay General Hospital. The unit had been allocated more beds and the advantage for patients would be early care and rehabilitation carried out by one care provider – Torbay General Hospital. However, it was unlikely that the unit would be able to accommodate the estimated 625 stroke patients per year even with the extra beds.

An alternative was to maintain the acute unit in Torbay General Hospital and develop a specialist rehabilitation service within the PCTs. Either each PCT could establish its own rehabilitation service or there could be one central service for the whole of the South Devon Care Community. The latter option was chosen due to the economies of scale in staffing – one team in one place. It was decided to redevelop one of the community hospitals at Newton Abbot. However, there was concern among staff as the facilities at this hospital were not adequate to provide the required

rehabilitation services. In addition the building was rundown and in urgent need of renovation. As Peter Sleight noted:

> *"There are lots of improvements to be made at Newton Abbot Hospital. Patients will just burst into tears if they are transferred from Torbay with all its modern facilities to Newton Abbot. The other concern in that hospital is providing medical cover for the standards that fulfill people's needs."*

Despite opposition from Sleight and other staff, Jenkins was convinced that this was the best solution. She made it clear in her final report to the Older Person's Strategic Implementation Group, however, that it would only be for a transitory period as the Newton Abbot hospital was due to be replaced in 2008. The new hospital promised improved services and equipment as well as accommodating Social Services under the same roof as part of the Integrated Care Network development and would thus facilitate coordination between the different organizations.

The first task was to transform the Tudor ward in the Newton Abbot hospital into a community stroke rehabilitation centre. Jenkins' intention was to have the centre run by an Allied Health Professional or a nurse rather than a physician. After a stay at the rehabilitation centre individuals would be sent home or placed in nursing homes by social services. Jenkins also recommended a reduction in the length of time patients were placed on the acute unit to an average of seven days. Patients would be transferred to Newton Abbot Community hospital once they were medically stable and ready for rehabilitation, with an average stay of three weeks. This would ensure that the acute unit would only deal with patients that were really "acute" patients, thus increasing the number of patients receiving specialist care. Sleight was not convinced:

"Our patients don't quite fit the quick in-and-out. Most of the patients I deal with are pretty disabled and very ill with swallowing problems etc. We have to try and accommodate that in the most suitable surroundings. It is more a question of us discussing it and actually deciding case by case when someone was ready to move to Newton Abbot rather than setting a time limit. In addition this would set the stage of inadequate diagnostic for complicated cases."

Unhappy Staff

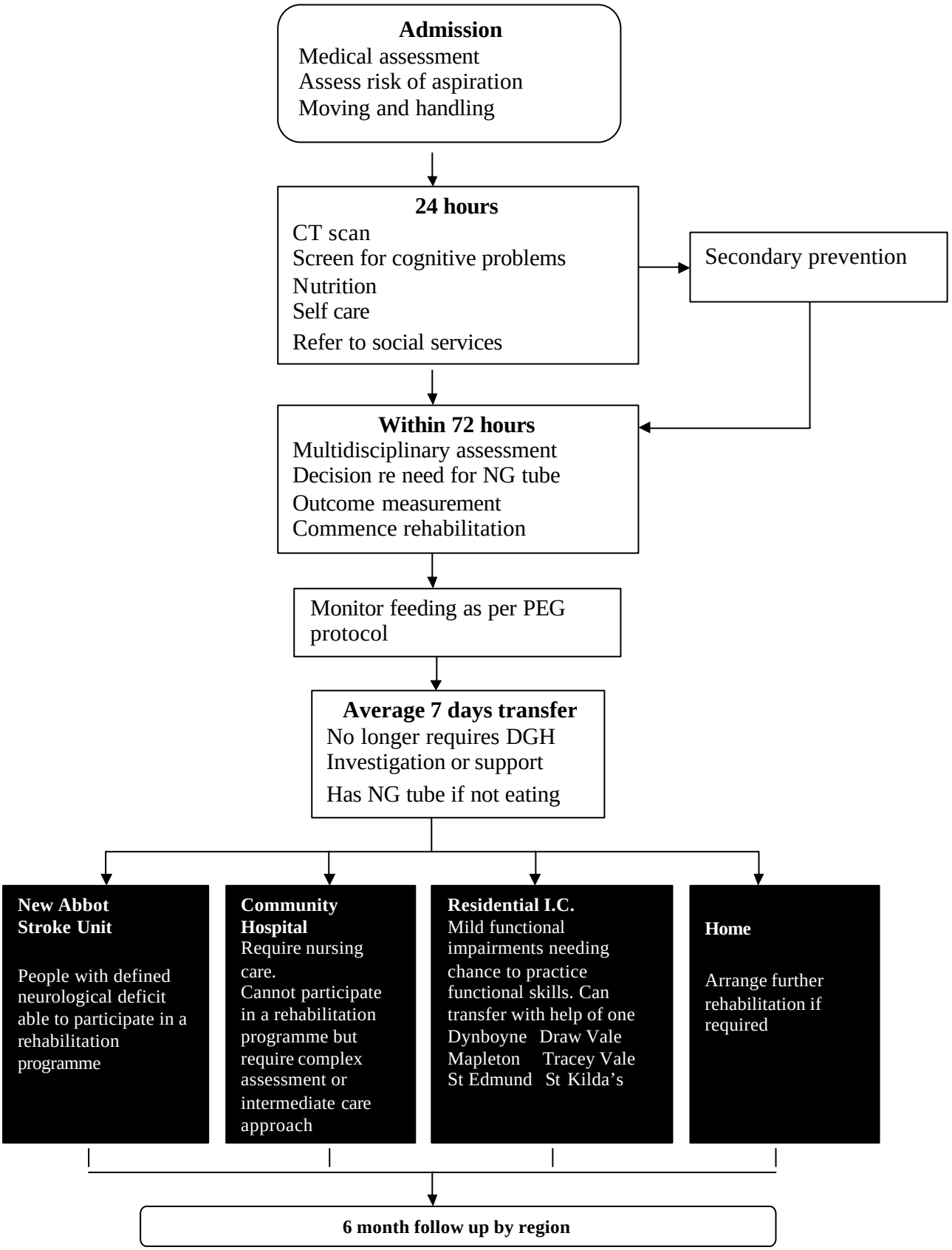
Sleight was not the only person concerned with the proposal, staff from both Torbay General Hospital and Newton Abbot were also worried, but for different reasons. Staff from Torbay hospital felt threatened by the redesign project as they knew that their jobs would change considerably. Jenkins believed that the staffing levels on the stroke ward were too heavy and proposed transfers of some of the Torbay staff to Newton Abbot. The idea was to then rotate the people working in the stroke unit between the general hospital and the community hospital. However, staff were unhappy as the Newton Abbot hospital was an old run down hospital and its facilities a far cry from those in Torbay. In addition they would have to care for acute patients with no rehabilitation work – part of their job satisfaction was seeing patients recover. Some staff from the Newton Abbot Community hospital were equally anxious about the inevitable change in the type of work they would be expected to carry out. They knew that caring for stroke patients would be more challenging and were not confident that they had the required skills and training. Until then They had been dealing with a range of elderly patients, however these did not include

people who had recently undergone a stroke, with swallowing, feeding difficulties and significant impairment in balance, mobility and speech.

It was also unclear to employees in both the primary and secondary care sectors who would take responsibility once the patients were transferred to Newton Abbot. Who would liaise between Torbay and Newton Abbot? How often would they meet? There was also concern as to how primary and secondary care services would coordinate with social services. In response Jenkins recommended the appointment on a non-medical consultant that would be based at Newton Abbot and coordinate with the medical staff and social services to ensure seamless care. By January 2004 it was a waiting game to see if the review and recommendations would be accepted by the Older Person's strategic Implementation Group. If the review was accepted she would then need to implement the plan and that would be a further challenge given the opposition she was up against.

Exhibit 1

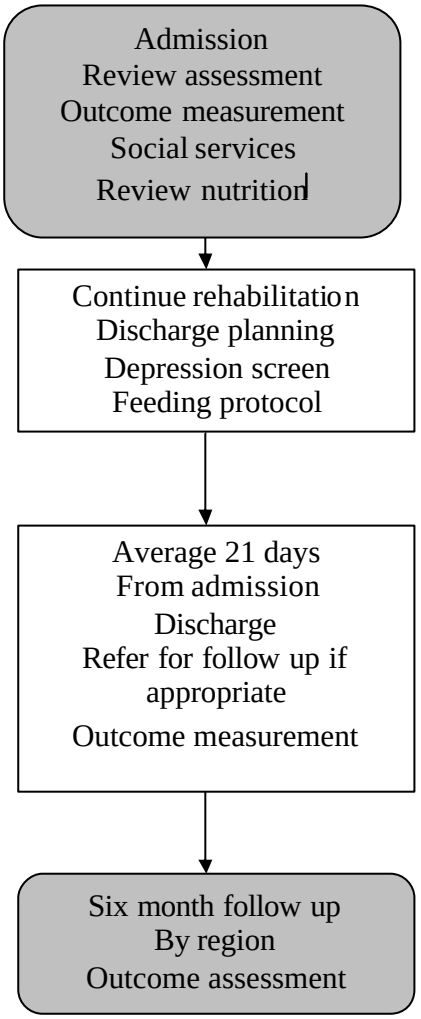
Stroke Pathway Redesign Proposal South Devon Guidelines for Immediate Inpatient Management of Stroke (George Earle ward)



Source: South Devon Health Community, 2005.

Exhibit 2

The Newton Abbot Pathway



Source: South Devon Health Community, 2005.

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APPENDIX 8 (Part B)

Redesign to Implementation – Stroke Services (B)

This case was written by Julie Battilana, Doctoral Candidate at INSEAD, Anne-Marie Cagna, Research Associate, Tom D'Aunno, Professor of Organizational Behavior and Mattia J. Gilmartin RN, PhD, Senior Research Fellow, INSEAD, as a basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

The project was supported by the Johnson & Johnson-INSEAD HMI Partnership, The National Health Service-Modernization Agency, Leadership Centre and the INSEAD Alumni Fund.

The case was developed in collaboration with Fiona Jenkins and Dr Robert Jones.

Fiona Jenkins' review and recommendations to improve stroke services for the South Devon care community were accepted in April 2004 by the Older Person's Strategic Implementation Group. She now had the task of actually implementing it and this, she knew, would be even more of a challenge than developing the plan. There were 18 recommended actions in order to improve stroke service care. The first and key for the plan to be successful, was the appointment of a non medical consultant (either AHP or Nurse). This person would be lead of the community specialist stroke service and a key figure in implementing the stroke review across all the different care organizations.

In November 2004 Jenkins appointed Rhoda Allison as the Allied Health Professional Stroke Consultant. Allison had been involved from the start of the project and had helped Jenkins with various areas of the redesign plan. Among her many responsibilities would be the Newton Abbot rehabilitation ward, in addition to coordinating all the different organizations involved in the stroke care pathway from the acute unit to the social services. It was a challenging job but Jenkins was confident that Allison would be successful and overcome any difficulties that would undoubtedly occur given all the different stakeholders involved.

Within just two months of Allison's appointment progress had been made on improving the service. Funding from Teignbridge PCT was obtained to renovate the Tudor ward at Newton Abbot community hospital and in January 2005 opened as a 17 bedded stroke rehabilitation ward. Stroke patients from Torbay hospital that required rehabilitation were referred to the Tudor ward by the Torbay Hospital stroke team led by Dr Peter Sleight once they were considered suitable for rehabilitation. By November 2005 the length of stay on the George Earle ward had been reduced over an 18 month period from 19 days to 11 days. However there were still some case of patients waiting placement and remaining on the George Earle ward but usually after a long period of medical instability.

Improvements were also being made throughout the whole service. The delayed discharge working group and social services were beginning to coordinate to ensure that admissions transfer criteria met the requirements of individuals who had suffered stroke. Guidelines for the stroke services had been reviewed and updated as a guide for all staff dealing with stroke patients. Approval had been given for additional staff on the Tudor ward. Patient satisfaction had improved according to surveys undertaken. Implementation appeared to be going according to plan by November 2005, but Jenkins and her team knew there were still many hurdles to overcome before the service met with all the NSF directives.

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APPENDIX 9

In Reach Care of the Elderly: Moss Valley Medical Practice

This case was written by Julie Battilana, Doctoral Candidate, Anne-Marie Cagna, Research Associate and Tom D'Aunno, Professor of Organizational Behavior at INSEAD as a basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

The project was supported by the Johnson & Johnson-INSEAD HMI Partnership, The National Health Service-Modernization Agency, Leadership Centre and the INSEAD Alumni Fund.

"This is fantastic it's just how it should be - we've got ownership of the process."

Martin McShane, the Professional Executive Chair of the North Eastern Derbyshire Primary Care Trust and Partner in the Moss Valley Medical Practice had just left the Friday weekly meeting pleased that new action was being taken to improve care for the elderly[31] in the health community. The General Practitioners (GPs) in the practice were now fully on board and beginning to see the benefits of the nurse-led pilot scheme that had been introduced in the centre. In just a few months, with the help and coordination of key players involved in the care of the elderly, new processes had been set up and old ones improved. The nurse that was in charge of the new systems that aimed to track admission, readmission and discharge, was based at the Moss Valley practice. The goal was to facilitate continued care, reduce hospital[32] stay and decrease readmission for its elderly patients. Weekly meetings were introduced at the practice with all parties involved in care for elderly encouraged to attend to discuss particular patients. Martin hoped that this would ensure smooth discharge for people that were already in hospital, or ideally prevent them from being admitted in the first place. Hospital stays were not always the appropriate care for elderly people and it was clear that individuals did not necessarily want to remain in hospital. In addition, with infections such as Methicillin-Resistant Staphylococcus Aureus (MRSA), it was often putting them at unnecessary risk.

Improvements had also rapidly been made with the out of hours service, ensuring better care for patients when the surgery was closed. Martin knew, however, that despite great support from his colleagues there were still many obstacles preventing the service from developing further. Coordination and communication with the hospitals would be key and yet posed the team's greatest challenge. His ultimate ambition was to expand the pilot scheme throughout the North Eastern Derbyshire Primary Care Trust. It was a timely issue as demographics forecast a rise in life expectancy in the UK and Europe that inevitably would lead to an increase in elderly patients. Within Moss Valley there was already a higher proportion of older patients than the national average with fragmented care and lack of coordination between the different services involved. Although a long way from this goal, progress had been made and the future looked promising for the continued success of the project.

Moss Valley Medical Practice

Moss Valley Medical Practice was part of the North Eastern Derbyshire Primary Care Trust that came under the Trent Strategic Health Authority. The PCT was divided into six localities with a total of four practices in the Moss Valley district. It had a two star rating in 2003/04 and as its mission stated 'the aim of North Eastern Derbyshire Primary Care Trust is to improve the health and well being of the local population". The PCT was located in the North of England around Chesterfield and close to Sheffield. In 2004 the Moss Valley Practice had approximately 8,550 people on the list of potential patients with almost 20% of these over the age of 65. Also counted within the practice were patients from two nursing homes and one residential home plus a learning disabilities residential unit that was registered with the

[31] An "elderly" person is defined as 65 years of age and over.
[32] "Hospital" refers to both community hospitals within primary care sector and acute hospitals in secondary care.

practice. It was a purpose built modern facility with five partners, and was also a teaching practice with registrars, pre-registration house officers and medical students regularly rotating through attachments[33]. In addition to practice nurses and healthcare assistants, the centre shared a practice manager and information officer with a similar-sized practice within the same area. It was fully computerized with medical records in digital format. The surgery was open from 8.30am to 6pm Monday to Friday and from 9-11am on Saturdays[34]. There was also an out of hours service provider for people that required care when the surgery was closed.

Other staff were attached to the practice as part of the extended primary care team. These included District Nurses, Health Visitors, Physiotherapy, Occupational Therapy, Community Psychiatric Nurses and Podiatry among others. There were also links with the local social services and a crisis intervention service was available to care for people at home if they did not require admission to hospital.

The physical location of the practice meant that there was good access to the acute hospitals in the region with particularly close links at the acute Chesterfield Royal Hospital. This ensured that the majority of referrals, both scheduled and unscheduled were made there. However, the geographic location of the community hospitals and associated transport systems meant that the practice had little, if any, interaction with the PCT's community hospitals.

Making a Start

Before drawing up a plan to improve care for the elderly within the practice, Martin began by looking at different standards worldwide in particular the American United Health Care model known as Evercare. In November 2002 the United Health Group (UCG) was engaged by the NHS to work with the nine PCTs that were part of the UK's National Primary and Care Trust Development Program (NatPaCT) with the possibility of adapting and implementing the Evercare model to the treatment of the PCT's elderly population. There was little experience of implementing this model in the UK at the time but the concept seemed particularly applicable and relevant to UK General Practice. The PCTs that worked with the UCG found that 2% of the high risk group was actually driving 30% of unplanned admissions for patients over 65 years. There were also a high number of people (up to 40%) that did not have contact with relevant services such as district nursing and social services. It became clear that many of the admissions were for conditions that were treatable or avoidable if action had been taken in primary care.

In the US the Evercare model had shown a 50% reduction in hospitalization rates, a significant reduction in prescription drugs issued and a 97% satisfaction rate from relations of

[33] As part of their training medical students are assigned to a practice. These assignments occur at different years in their schooling therefore, students can be at the practice early in their training or later for up to two to three months.

[34] With the introduction of a new contract in April 2004 the practice no longer had to offer Saturday morning surgeries or ensure out of hours care for the registered list. Out of hours care became a PCT responsibility.

the patients.[35] The model was based on the development of care teams led by nurses working in partnership with General Practitioners and other care staff including primary care workers. The emphasis was on prevention rather than cure with avoiding hospital admission whenever possible. Illnesses should be caught early and deterioration of the condition prevented. If hospital admission was inevitable, then the goal was safe and early discharge.

Implementing the model involved:

- Identifying high risk elderly patients: The early Evercare criterion was two or more unplanned admissions to hospital in 12 months.
- Establishing an extended nurse role to proactively manage the high-risk caseload.
- Introducing systematic tools and processes such as retrospective analysis of avoidable admissions, pharmacy review and early alert processes. [36]

The Evercare model appealed to Martin as it "bridged a gap between the community services (GPs, Community Services and Social Services) and the hospital based services – especially those in an Acute Trust." He looked at other models such as the American Kaiser model but as he noted "The Kaiser model would have required complete restructuring of the local health service! The advantage of the Evercare model is that it seemed to 'fit' the NHS quite neatly."

The first task for Martin and his team was to carry out a retrospective audit in the Moss Valley Practice. The criteria was all patients over the age of 65 admitted to hospital more than once in a 12 month period and taking four or more drugs. Forty-three patients were identified with an average age of 75. The median number of drugs they were taking was six with a range from 4-17. These people accounted for 119 admissions and 1,131 bed days. Chronic Obstructive Pulmonary Disease (COPD) accounted for 22 admissions and consumed 220 bed days. However, what was not counted in the preliminary audit was accident and emergency (A&E) attendances, all the bed days (not available for some admissions) and the full use of community hospital beds.

He presented the results and his initial project plan that he had drawn up to the practice, the health community and the hospitals to illustrate the extent and scale of the issue. He used this to set the scene so "that people could understand why this was needed and what the likely impact would be". There were a small number of patients consuming a large number of hospital admissions and bed days. "When I looked through the case records I realized that poor care coordination was the main culprit." The audit also revealed that robust records and information were required to improve clinical management in order to create systems and processes to alert professionals to high risk patients. It emerged that data on the use of the hospital beds was not accurately recorded and thus bed day usage was underestimated. Improving communications between the hospitals and other sectors of primary care would be

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[35] Further reading: "The Effect of Evercare on Hospital Use. Robert L. Kane, Gail Keckhafer, Shannon Flood, Mir Said Siadaty. *Journal of the American Geriatric Society*. Volume 51, N°10, October 2003.

[36] Martin McShane final Report INSEAD Care of the Elderly Project Report, NHS Clinical Strategist Course May 2004.

essential. In addition it appeared Primary Care had no systematic process for identifying patients at risk and so could not ensure proactive care and follow up.

In response Martin approached a district nurse at the practice, Fiona Chisnell, to take the lead on the pilot scheme he decided to implement. Martin believed that she would be key to the success of the project. One of her tasks would be to follow up with the hospitals when a patient was admitted. When he approached her with the proposal she was surprised as she explained:

> *"I was actually already doing some of the work that Martin suggested for the scheme. I often rang through to the hospitals to check on some of the elderly patients that were on my case load, so the actual concept wasn't entirely new and some of the systems existed but weren't being used to their full potential."*

As a District Nurse in the Moss Valley practice, Fiona had a case-load of approximately 200 people that required care in the home for various conditions. The majority of these were elderly patients. One of Fiona's jobs was to carry out an initial evaluation of patient's needs within the home environment and when appropriate, risk assessments. She was responsible for care planning that detailed agreed nursing care intervention and on going evaluation of that care.[37] Among the patients on her caseload were people suffering from chronic diseases and long term conditions.

Fiona agreed to lead the project and coordinate between the different parties involved: hospitals, Primary Care and Social Services. Additional funding was provided by the PCT to support her. As Fiona explained: "the extra financing provided me with an additional 8 hours E grade staff nurse, but as the project got underway I realized it was clearly insufficient. However, my existing team supported the extra time needed." The Lead Clinician, District Nurse and Information Officer helped her with the pilot scheme.

Patients at Risk – Alert System

Martin knew that a fool proof, reliable alert system for primary care staff would be essential for the success of the project. As he noted: "a system already existed but it was not being exploited fully." The PCT had funded an Admission, Transfer and Discharge Team (ATD) that was located in the Chesterfield Royal Hospital. The team consisted of nurses, administration and clerical staff who worked full time. Their role was "through liaison, partnership working, negotiation advice and practical support to achieve the safe and effective transfer and discharge of patients to community hospitals and their homes." They had access to communications and information systems within the hospitals but not GP services. When a patient was discharged a fax would be sent to the District Nurse in the relevant medical practice to inform them. This could be prior to their discharge, on the day, or in some cases

[37] Fiona's other tasks included : crisis intervention; minor injuries; carer fatigue; providing health advice; health promotion; and palliative care services. She supplied physical, psychological and spiritual care to patients and their families. She dealt with hypertensives, diabetics, rheumatoid patients. She was responsible for co-ordination of complex care packages, with close liaison with social services. Fiona was also in charge of leg ulcer assessment and prevention as well as post leg ulcer monitoring and prevention.

after they had left the hospital. The GPs were not contacted directly and were unaware that such a process existed. As Fiona continued:

> *"I received a fax from the hospital when a patient was discharged, if I had contact with the person I would follow up but if I did not know them the fax was shredded! If I wasn't alerted specifically by the hospital that I needed to be involved I wouldn't take action. Because of this many patients that required further care may have slipped through the net."*

As a result the Moss Valley Practice requested that the fax be sent to them from the hospital when a patient was admitted rather than being dependent on receiving discharge information. This was usually a handwritten note in the first instance followed by a typed summary many weeks or even months later. The Practice Information Officer, Christine Shone would then collate all admissions for patients over 65 even if they had only been admitted once, so that they could be assessed for risk. Fiona Chisnell explained:

> *"With the new system I am dealing with patients that I haven't had any contact with - who haven't previously required care services. Now instead of being informed when the patient leaves hospital we are told as they go in. Once the patients are admitted we can start planning their discharge. "*

Standing Room only…

As part of the pilot scheme weekly meetings were introduced every Friday for all the key stakeholders such as Social Services and members of the Moss Valley practice, so that patients records could be assessed and care coordinated for individuals that had been admitted as emergencies. Christine Shone, the Information Officer, gathered information on all the patients for a given week to be discussed case by case. She downloaded details of the patients from the clinical IT hospital system that gave an overview of the person's current problems and medication. This was then sent to Fiona. The names of those people that had been admitted to hospital in the previous week were also listed on a whiteboard in the room where the discussions took place. This list was updated daily if necessary. As Christine worked part time between two practices, it ensured that the information was readily available even in her absence for all staff members concerned.

The first meetings were attended by just three people, Martin McShane the lead GP, Fiona Chisnell, Nurse and the Information Officer, Christine Shone. As other people in the practice heard of the benefits of attending, the meetings rapidly escalated into "standing room only". As Martin explained:

> *"I didn't try and force people to join us but rather to entice them to attend by saying 'we had this meeting Friday' and not 'we had this meeting, why didn't you turn up?' I am a change merchant but I also recognize change fatigue can set in. There have been many major developments in the practice over the last few years. For example I would ask them if they were aware of the alert system etc. Once colleagues actually began to experience it they started coming on their own*

accord and they asked for the process to be continued beyond the end of the project."

Within weeks regular attendees included Doctors, Social Services, Discharge Liaison Team members PCT Locality Manager, Occupational Therapist and Palliative Care Nurses among others. However apart from the DLT members[38] there were no other staff representatives from the hospitals. As Martin explained "This was a failing we needed to overcome at Moss Valley, but there was also the practical side: how could they attend 60 meetings if every practice in North Derbyshire took this up?"

The meetings soon developed from simply identifying patients at risk to the discussion of more complex care problems. Martin noted:

"The meeting facilitated the problem solving for many difficult and complicated cases. I think this is why attendance grew. An unexpected spin off has been the improvement in coordination of care for all terminally ill patients."

The idea was to identify patients as they were admitted and start the process of coordinating discharge planning with the hospitals so we could reduce length of stay, the likelihood of readmission and understand what changes had been made to their care whilst inpatients. Often the first we would know was when a patient reappeared in the community on a Friday afternoon with new medication not having a clue what the care plan was, what investigations had been done or even, in a lot of cases, what the diagnosis was. The multidisciplinary case discussions quickly flushed out numerous quality issues."

Originally the meetings were scheduled to last 15 minutes but more often took 30 minutes. Prior to the introduction of these discussions patients "were just sent into hospital and when they reappeared in the community people reacted to it."

During the first weekly meetings the members discussed how they could communicate simply to hospital staff important information that was held concerning the patient in the Practice, District Nursing and Social Service records. As a result Fiona developed a pro-forma with information relevant to the patient that would be sent to the hospital where the person had stayed. Details included the next of kin, that was of particular importance for elderly, the date, where, when the individual had been admitted, and a short resume from a nursing view point. She completed these forms using her personal knowledge of the person, if she knew them, information received from Christine, and patient notes from the GPs. Also included were comments that the different attendees wanted to impart to the hospital and social services. It was then typed up to avoid errors by handwriting being misread and faxed to the relevant hospital. A follow-up phone call was made to ensure that the fax had been received. Fiona was the main person who liaised with the hospitals unless a doctor specifically decided to intervene.

However, Fiona soon realized that she was not receiving any feedback from the hospital unless it was to notify her that a patient had been discharged. She decided to include a

[38] The DLT team was based in the hospital (funded by the PCT) and sent faxes to the District Nursing Teams.

communication sheet on the reverse of the pro-forma to track "who I talked to at the hospital, the date and what was discussed."

Taking a Risk– the Palliative Care Pack

During the care of the elderly meetings it also became apparent that some terminally ill patients were being admitted to hospital because the out of hours service could not provide appropriate treatment.[39] The provider of this service often could not make contact with the appropriate District Nurse, despite receiving the information. In response, Dr Kinghorn, Senior Partner, and Fiona developed an emergency palliative care pack made up of already prescribed drugs. The medication pack was accessible in the individual's home for whoever needed to use it, such as a doctor. Community Nurses were also given signed authority by the Doctors to administer the drugs if required. This diminished requests for "emergency" Doctors and reduced inappropriate hospital admission in some cases. As Martin noted:

> *"There is a high element of risk as anyone could access the care pack, but then again so what? We do this all the time. If someone is dying at home and there's diamorphine in the houses and a syringe driver we use them. It's about removing the mental block of thinking we 'can't put that drug in until they need it'. Well they are going to need it so let's put it in, let's be proactive rather than reactive."*

In addition to the care pack the practice, developed an information leaflet for patients and carers. It included clear instructions on what drugs were available, how to make contact with the out of hours service and telephone numbers for other community services. This helped to reassure the patients that both the treatment and nursing services were available quickly.

Communications

From the beginning Martin knew that the success of the pilot scheme would depend on support from all the main parties involved in care of the elderly and that good communications between them would be crucial. However, as Fiona noted:

> *"Communications with the hospitals were improved a little when we established a pro-forma. However it still tended to be one way. A comprehensive assessment and case of need for discharge planning would be sent into acute services. There was little or no input in the majority of cases. One has to acknowledge this was a small study, and with persistence on my part things may have improved"*

Martin also commented:

> *"If I had to do this project again I would have spent more time communicating – talking to people and thinking through the network. I should have thought more clearly about the social network that I needed to create and facilitate the process. My 'wicked stepmothers' were the community hospitals, but they were also*

[39] This was for all terminally ill patients not just elderly ones.

crucial. I forgot to talk to them about the project. So inevitably when Fiona rang a community hospital and asked them to give us information on a patient from our practice they would say 'why are you telling us this? What's it to do with us? This is just extra work for us etc.' So, I realized I should have prepared the ground better and not, 'ploughed it up before throwing the seeds out.'"

Martin, however, did use his contacts in the acute hospital, that he had made when he set up a Clinical Leaders Group in North Derbyshire; "it was an open door for me". He approached Ron Clarke, the Nurse Director, at the Chesterfield Royal Hospital; the acute care unit that served the region and was located near to the Moss Valley Practice. Martin knew he would be an important person to involve for help on the operational part of his project. Ron invited Martin to talk at the Emergency Care Directorate Meeting where he sought advice from the members on how he should go about reorganizing the processes. "I asked people what they thought I should be doing to make it work and found my way through the pattern of contacts and networks that exist in every organization however, large or small." Martin was also invited to brief senior managers on his project at the Health Communities National Service Framework (NSF) for Older People Group. At this meeting one of the Consultants, Martin Cooper, reflected that getting the sort of information on the pro-forma from Primary Care was exactly what he had been asking his junior staff to obtain for years. As Martin noted "Amongst professionals there is an appetite for better communication but there is a lack of support and the processes to deliver it"

Fiona, too, realized from the outset that the greatest challenge would be communicating with the different groups involved in care of the elderly and in particular the hospitals. As she explained:

"Quite often I would phone the hospital and talk to several different staff members. They didn't seem to speak to each other because of the rotation of shifts and the very nature of nurse work. This made it difficult to obtain the information I was looking for."

There were still many hurdles to overcome in communicating with both community and acute hospitals. A culture of blame had developed between the primary care sector and the hospitals, as Jan Raynor, Bed Manager at Chesterfield Royal Hospital, remarked:

"There needs to be a greater interface between primary and acute care and for both of them stop blaming each other. From the acute point of view it has to be questioned why patients are being assessed once they are admitted to hospital it should be done before. So this project is a start but it needs to be nurtured and built on. It's working well for one practice but it needs to expand into other practices and that will be a greater challenge."

A Success?

Care for the elderly was a complex process as it involved many different organizations and coordination was a huge challenge. However, within just a short period of time improvements had been made at the Moss Valley practice in the care of the elderly, as Martin noted:

"I think the multi-disciplinary meetings on Friday have created a change in the way we deal with patients. One example a couple of partners approached me and asked if they could discuss particular patients even though they hadn't been admitted as they were having real problems with them. This was an exciting moment as it represented a step further towards pro-active care."

The palliative care packs had been introduced and were being used successfully to relieve unnecessary suffering for all terminally ill patients and their relatives. It "enabled a patient to fulfill their desire to die at home with dignity and comfort provided by their family and healthcare professionals"[40]. Relatives also appreciated the introduction of the packs, as one patient's daughter noted "my Mother achieved a goal to die in her own bed peacefully surrounded by her whole family."[41] There was still much work to be done, however, to expand the pilot project to other practices within the PCT.

Next Steps

Martin understood that it was difficult for the hospitals to provide what the practice required as they were dealing with an average of 75 practices. He decided that for the project to expand he would approach the Professional Executive Committee (PEC)[42] and the PCTs to explain that to deliver the agenda it had to be implemented throughout the whole network. He was waiting for buy-in from the PEC before approaching other GPs about the scheme. The admissions and length of stay were being monitored proactively in the second phase of the project and the results indicated a reduction in readmission rates.

Further expansion would require a review of IT systems. As one employee remarked: "there would be a need for a central repository of information that could be accessed by everyone no matter where they were based." The solution seemed to be on the horizon with the introduction of the NHS's National Information System that was due to be on stream within the next couple of years. Although Martin believed this was an optimistic time frame and would take a lot longer to come on line.

Despite the apparent success Martin was still frustrated:

"The biggest failure I've had was that I wanted to develop care plans, but I haven't found the model for primary care that works. The 'care plan' has long been the remit of the nursing profession. Essentially what we need is a single care plan that all the members of the team can access, read, contribute to and keep up to date and relevant. The NHS intends to deliver this through the "Single Assessment Process" or SAP. However to make this really work we need an electronic record that social services and NHS staff can access wherever they are.

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[40] Dr Sheila Kinghorn, "Palliative Care – Working together in the Community to Ease Symptoms of Terminal Illness" Report submitted to NHS in Trent – Inspiring Success 2006.
[41] Dr Sheila Kinghorn, "Palliative Care – Working together in the Community to Ease Symptoms of Terminal Illness" Report submitted to NHS in Trent – Inspiring Success 2006.
[42] The PEC is a statutory body that is part of the PCT where management and clinicians meet to agree on how to move service improvement and redesign.

The National Programme for IT is making strides towards this single care record but there is a way to go yet. Some GP practices won't let Community staff access their systems. NHS and Social Care systems don't talk to each other. And the problems associated with a paper record are huge – where is it kept, how is it accessed and do people really want to maintain a double entry system?"

Challenges?

The scheme that was introduced occurred during a period when the NHS began to switch focus from dealing with problems that surrounded elective case management[43] to a fuller understanding of the impact of chronic diseases on the use of resources. There was a need in the NHS to obtain better information on the small number of patients that used the greatest proportion of hospital beds and thus look at how to care for these people more appropriately. Elderly people did not necessarily want to be in hospital but, as Martin noted:

"Neither did they want to be left isolated at home, ill and neglected by the services that are supposed to support them. During this study it became apparent that there is a huge moat between the community services and hospital services, and this moat is phenomenally difficult to bridge."

Further improvements in care for the elderly nationally still had many barriers to overcome. Martin cited the following as the greatest challenges:

"Abdication of responsibility: both by primary care when a patient is admitted and secondary care when discharged.

Communication: the traditional methods of communication do not address the complex needs of these patients.

Care planning: there isn't any.

Organizational and professional cultures: Doctors, Nurses, Social Workers have different ways of working and attitudes. Practices, Social Services, Community Teams and Hospitals have their own regulations, rules, methods of working.

The NHS culture is to provide a 'cure': if people cannot be cured then nothing can be done. All the targets and measures are geared towards this culture. Until measures for improving quality of life and patient experience are introduced there is no incentive to address the needs of people with enduring essentially incurable conditions."

However, all the necessary resources and services were in place "to provide a high quality holistic care for elderly patients with complex needs." Yet, as he remarked "the problem was how can these be linked together to provide what patients need."

[43] For example access and waiting times for operations etc.