

Managing Change and Role Enactment in the Professionalised Organisation

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Executive Summary

Introduction

This section summarises the content and key learning points of the full final report on a project funded by the National Health Service (NHS) Service Delivery and Organisation (SDO) R&D Programme: *Managing Change and Role Enactment in the Professionalised Organisation*.

The lead question of the study was: 'How do clinical directors and service managers from non-clinical backgrounds interpret and enact their roles and use them to implement service change?'

Overview of the report

The overall plan and structure of the report is summarised in Section 1.

Section 2 reviews key recent academic literature, in particular developments within role theory (where we focus on literature on doctor/manager relations, inter-professional relations, hybrid and portfolio roles), the literature on organisational change in health care (where we stress conditions of high complexity, strong professionalisation, the role of local context and the increasingly important role of the network based form of management), and facilitation and change agency (where the literature stresses the key role of opinion leaders and change agents and also conditions of dispersed leadership). This chapter also considers the NHS policy framework, outlining the modernisation change agenda, as seen in the National Service Frameworks (NSFs) published by the Department of Health between 1998 and 2005, and also in the associated service improvement activity tasks.

Section 3 outlines our methodology. This is a qualitative study based on 11 comparative case studies of processes of service change in key clinical areas. The clinical areas were all chosen as national service priorities. Six cases were from the acute sector (three from cancer and three from maternity) and five from primary care (diabetes). We outline how the case study design was operationalised and how data were collected and analysed.

Sections 4, 5 and 6 contain the empirical case material. We present a comparative analysis of the groupings of cases: starting with cancer, then maternity and finally diabetes. A similar structure is used to aid

comparison. We draw out very preliminary themes within each of the three clinical areas.

Section 7 considers the overall themes which emerge across the 11 case studies. We found that:

- There was variation between acute and primary care sites in their capacity to enact clinical service change. Specifically, the base in primary care seemed narrow and fragile.
- The influence of the local organisational context was important. We introduce Appendix 5 which is our key empirical typology summarising evidence of differential change capability across the cases. Specifically, we saw configurations of characteristics emerging across the cases which shaped rates of progress. We identify a number of specific positive and negative forces.
- Some sites were distracted onto other competing agendas and this negatively affected clinical service improvement.
- Formal frameworks and service standards do not by themselves guarantee change but much depends on how they are enacted in the sites.
- There was an increase in hybrid clinical managerial roles, but we noted that these could be problematic and require senior management and human resource (HR) management attention to ensure they fulfil their potential;
- In the acute sector, clinical managers were evident as leads, but in the primary care sites, general manager leads were more evident. There was some evidence of poor GP engagement.
- There was also evidence of 'portfolio' (or multiple) roles, where there was a need for role clarity but not rigidity.
- The prior nature and quality of relationships in the sites was important. In general the relations between clinicians and general managers could be seen as good, if slightly distant. Intra-clinical relations were more problematic. The poor levels of direct contact between clinical and managerial blocks was concerning.
- There was evidence of dispersed leadership patterns for change in a number of the sites, rather than individualistic leadership. This pattern might include committed duos or trios of change leaders, supported by a wider network of pro-change forces.
- There was a growth of network based approaches to service change management, of both mandated and organic subtypes which represent distinctive forms. The important role of network strategy boards was evident.
- There is at present a poor level of HR and education and training support for the development of these change roles. We argue that new programmes are needed.

Finally in Section 7 we argue that while the substance of change may appear simple, its enactment is complex. There are simple targets for

sites to meet but achieving these targets involves complex change processes which need to be recognised in terms of credible timescales.

Section 8 then outlines the main implications for policy, management and research commissioners which arise from the study. These include:

- the impact of change overload and the negative effects of multiple changing policy directives and policies
- a shift in policy focus from narrow change management techniques to fundamental change capacity building
- the critical importance of hybrid roles which facilitate and bridge between professionals and other groups
- the need for better role definition for people in hybrid positions coming into post
- the need to work on systems to increase user influence at local level
- the substantial agenda facing HR management functions, which need to work to support general managers and clinical directors (we propose a new business partnership model where HR supports clinical service improvement more)
- [separate bullet] the need to develop inter-professional fora

Our recommendations for **policymakers** include the need to:

- reduce change overload and policy shifts
- allow for realistic timescales for change
- work on fundamental capacity building
- introduce strategic interventions to develop the role of general managers and HR functions.

Our recommendations for **management** include the need to:

- focus senior management attention and dedicate project management time to areas of key clinical service improvement
- develop dispersed leadership and clinical involvement
- develop of hybrid spanning roles
- introduce better role definition and review for new clinical directors
- review and redirect the HR function.

Our recommendations for **research commissioners** include the need to:

- value development as well as research activity
- some specific proposals for possible future research which are outlined in Section 9.

Finally, Section 9 contains a note on planned dissemination activity from the project, both in terms of future academic papers and also

policy and practice-based outputs (through briefing papers). We also outline a possible future research agenda, covering:

- further study of organisational change in primary care, which was a sector which raised some particular concerns in this study
- clinical directors' careers and identities;
- the nature of portfolio roles.
- different models of the HR function and how they can support clinical service improvement activity better
- the development of more inter-disciplinary fora to diffuse knowledge and best practice across traditional boundaries
- the development of clinical management as a new profession – why is it so slow to develop?

The Report

Section 1 Introduction

This report presents the analysis of the empirical data from an SDO-funded project which focused on the roles and relationships of clinical managers and their colleagues in periods of change.

The primary research question was: 'How do clinical directors and service managers from non-clinical backgrounds interpret and enact their roles and use them to implement service change?'

The project focuses on 11 case studies across the acute and primary care sectors of health care and ran from 2002-2005. Full details of the stages of the methodology are set out in Section 3.

The report covers the background literature relevant to the areas under study and an analysis of the empirical data from all of the sites. It includes comparisons between the sites and concludes with a selection of the generalisable themes emerging from these data. Finally, we offer ideas on the implications of this research for policy and practice.

The format of the report starts with a section on the literature (Section 2) relevant to the areas under study. The literature review includes the background literature available to the team at the commencement of the study and upon which the study was built. Alongside this, this report also includes more recently published literature, selectively included because it helps to illuminate our findings in some way. For the sake of clarity, the literature has been divided into four sub-sections. The first sub-section introduces general literature on roles; the second draws together some of the more relevant literature on organisational change, while the third brings these two themes together, by reviewing the literature on change facilitation and change agents. The final sub-section in the literature shifts to a brief resumé of the national policy context against which the activities reported in the cases occur.

Section 3 details the methods used in the study and reports aspects of the feedback from the 'workshop' phase of the study. Sections 4, 5 and 6 are the major sections of the report. They present the analysis of the empirical data from the project. Here we present consecutively, the comparative analysis of the cancer cases; the maternity cases and finally the diabetes cases. Section 7 draws conclusions and illustrates the themes emerging from the data. In Section 8, the policy implications of the research are discussed and finally, in Section 9 we

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outline the strategy for further dissemination and some future research directions.

Section 2 Review of the literature

2.1 Roles and relationships in the NHS

This literature review provides an overview of research and commentary publications pertaining to the roles and relationships of clinicians, clinical managers (hybrids) and managers. It opens with a discussion of role theory as a valuable theoretical framework, which is followed by an overview of the developments within the NHS which have shaped and influenced the current configuration of roles and relationships. Recognising that roles are defined via social interaction and cannot be addressed in isolation from relationships, the general dynamics of interprofessional relationships are explored as precursors to examining specific key relationships. Finally, the literature review closes with a critical discussion regarding what was notable for not being emphasised in the literature, as well as the key themes emerging. These are the emergence of portfolio managers, the roles and relationships of clinical managers and the emergence of professional clinical managers. The following section details role theory which provides a theoretical frame for and insight into, the issues addressed within the study.

2.1.1 Role theory

Role theory has been popular among social scientists for over three decades. However it is only recently that its attention has turned to autonomous and power-devolved organisational structures, such as the NHS. Although there are five approaches to role theory (Biddle, 1986), two have particular resonances with this study. Organisational role theory is made pertinent by its focus on multiple sources of norms and role conflicts, while the symbolic interactionist perspective is made relevant by its focus on the evolution of roles via a combination of social interaction, contextual demands, norms and attitudes. The latter's contextually-embedded focus on role enactment provides a link to one of the key research questions in the study: 'How do clinical directors, hybrid managers and service managers from non-clinical backgrounds interpret and enact their roles, and use them to implement effective service change?' Within these parameters, role theory can provide significant insight into role definition, role management and the relationships related to these activities.

A role is a position occupied by an individual in the context of a social relationship, making role definition a social process (Banton, 1965) based on the interactions and expectations of a role holder and their role set. Role sets refer to those individuals who interact with the role holder in the context of their work. Although role sets can be uni-professional, they cross professional and hierarchical boundaries in the

NHS. Importantly, Willcocks (1994) indicates that patterns of behaviour result from both the role itself and the personality of the incumbent. However problems can arise in this process. Those most likely in the NHS are role ambiguity, incompatibility and overload.

Role ambiguity refers to a lack of clarity regarding a particular role. Research (Bedeian and Armenakis, 1981; Jackson and Schuler, 1985; Breaugh and Colihan, 1994; Singh *et al.*, 1996) has led to consensus on the four major dimensions of role ambiguity, which pertain to goals, process, priority and behaviour. These are the 'what, how, when and in what manner' questions. Crucially, role ambiguity has been linked with higher levels of role conflict, role stress and role overload (Kahn *et al.*, 1964; Miles, 1974) and is also negatively correlated with variables such as job satisfaction and job performance (Rizzo *et al.*, 1970; Singh, 1998). However, Willcocks (1994) indicated the contingent nature of appropriate role ambiguity. For some, this can act as a challenging and empowering experience, while for others it is a source of stress and frustration.

A related, but separate issue is role incompatibility. This occurs where there are multiple and contradictory expectations on the role holder (Willcocks, 1994). This is a particular concern across the NHS, where diverse professional groups with different cultures interact to achieve goals or when clinicians have the competing and sometimes incompatible responsibilities of manager and clinical provider. Willcocks found evidence of role incompatibility among clinical directors, where the presence of clinicians and managers in the role set led to conflicting expectations. Reflecting this issue, Bruce and Hill (1994) question whether there is a need for managers to be more selective in what they hope to achieve via doctor involvement in management. Role incompatibility is one of the several causes of role overload. At base, role overload is caused by an over-abundance of roles or differences in expectations which lead to a highly demanding workload. Role overload has been associated with decreased job satisfaction in acute and primary care (Pearson *et al.*, 2004), and particularly among clinical directors (Willcocks, 1994). The latter encountered conflicting expectations from a diverse role set. This was underpinned by the felt need to maintain a substantial clinical load to maintain respect among their peers (Bruce and Hill, 1994). This indicates that role incompatibility is an affliction likely to affect the broader community of hybrid managers. It is also more likely in contexts of change, where role overload is liable to be exacerbated by extra responsibilities, while day-to-day operations continue. The extent to which role ambiguity, incompatibility and overload are an issue among all forms of clinical managers, and indeed all role groups, is an important consideration in this study.

2.1.2 Context

Role theory is a useful heuristic for conceptualising roles and for exploring the key issues which arise between role definition and

execution. It particularly focuses attention on the interpersonal aspects of role evolution. However it simplifies role emergence into a dyadic process between the role incumbent and role set. In reality, the internal and external contexts influence the evolution of roles. Within the NHS historical role relations have been challenged by the advent of 'new public management', with its associated developments of 'managerialism' and 'marketisation'. These have had implications for service delivery, organisational structures and work practices, which have, in turn, influenced the configuration of roles and responsibilities. Historically, managerialism has had particularly significant implications for roles and relationships in the acute context via the introduction of hybrid roles and clinical directorate structures. More recently managerialism has extended into primary care with the development of various hybrid roles within primary care trusts (PCTs). In contrast, marketisation has had particularly marked effects on sectoral roles and the relationships between primary and acute care. Similarly, more specific policy developments at a variety of levels have been of influence. Although the study is based within the United Kingdom (UK), authors (Ferlie *et al.*, 1996; Davies and Harrison, 2003) have emphasised that these changes are part of an international phenomenon which is rooted in a perceived crisis in healthcare funding and subsequent attempts to improve efficiency. Within the UK, the three main developments have been identified as the introduction of general management in 1984, the creation of an internal market in 1991 and the limited replacement of the market with performance and accountability measures after the Labour government was elected in 1997. These are reflective of a general increase in the systematisation of medical knowledge, an increasing focus on providing incentives for clinical work and changes in state regulation of medicine (Davies and Harrison, 2003). In addition, they outline an erosion of professional dominance and autonomy over the past 30 years.

Although these reforms are rooted in attempts to create a more efficient health service, much research has drawn attention to their implications for the balance of power and relationships between managers and healthcare professionals (Griffiths and Hughes, 2000). Key themes concern the declining autonomy of professionals (Schneller, 2001), an increased managerial mandate, a rising emphasis on interprofessional working (Braithwaite and Westbrook, 2005), shifting role boundaries (Humphris and Hean, 2004) and tensions in the clinician/manager interface (Ferlie *et al.*, 1996). Within primary care, key themes pertain to fundholding, which led to an apparent shift in the balance of power from secondary to primary care (Ferlie *et al.*, 1996; Baeza, 2005) and a shift from individuality to collegiality among general practitioners (GPs) (Hudson and Hardy, 2001). However, questions remain regarding some of these themes. In particular, there is little consensus regarding decreasing autonomy. In addition, questions have been raised regarding whether clinical directorate structures have increased interprofessional working (Braithwaite and Westbrook, 2005) and the extent to which there has

been success in getting clinical directors or other hybrids to buy into managerial values (Hoque *et al.*, 2004). While such questions remain, there is broad agreement that the search for flexibility in the workforce has led to change in the division of labour, and hence role responsibilities and relationships, in the NHS (Humphris and Hean, 2004). Specific changes are outlined in the next section.

2.1.3 Key roles

Boss (1989) asserted that doctors and managers were among the four most powerful role groups in healthcare organisations (the others being nurses and boards of trustees). However, it is now important to consider the extent to which hybrids have emerged as influential in the context of day-to-day organisational life, as well as in implementing change. As well as these core role groups, the pivotal roles of clinical director and medical director are also discussed.

Managerial roles in acute and primary care: Managerial roles are characterised by a rise in complexity and number. In the acute sector, middle management has expanded from a traditional focus on operational concerns to incorporate strategic involvement. Ashmos *et al.* (1998) relate this to the introduction of contracting for services. Managers at all levels have also seen a rise in their change related activities, given the extent of recent changes in the NHS. Bradley *et al.* (2003) outlined the centrality of senior management involvement in quality improvement, which entails multifaceted roles. Key developments in managerial roles in acute care therefore include the expansion of strategic involvement among middle managers, a general expansion of roles and a specific increase in change related activities. Within primary care, practice management responsibilities have also changed from being operational in nature to incorporating tactical and strategic management components (Fitzsimmons and White, 1997).

Doctors' roles: There has been a general trend towards expanding doctors' involvement in management within the NHS (Davies and Harrison, 2003), with involvement at strategic level advocated by Ashmos *et al.* (1998). These developments have occurred concurrently with the reduction in junior doctors' hours, which Bridges (2004) notes has led to the adoption of new responsibilities by the nursing profession. This is reflected in the rise of practice nurses employed in primary care, which doubled between 1988 and 1990. Although doctors have traditionally engaged in some forms of administrative management, the evolution of hybrid clinical managers is a key role development among physicians. Due to its significance, it is discussed in detail below. However this development can potentially be related to fragmentation of roles among doctors themselves. Montgomery (2000) highlights Freidson's restructuring thesis, which suggests that traditional intra-professional divisions based on clinical specialities may become less important than divisions among clinicians providing care, those conducting research and education and those involved in managerial activities. These are classed as the producers, the

knowledge elite and the administrative elite respectively. Thus key developments in doctors' roles include the expansion of involvement in management and a potential fragmentation of roles within the profession itself. There is evidence to suggest that doctors are now beginning to derive status and prestige both from their clinical expertise and their managerial skills (Harrison and Ahmad, 2000; Baeza, 2005).

Hybrid roles: Within the UK, the roles adopted by hybrid managers are often large and complex, and include significant change management as well as operational functions (Ferlie *et al.*, 1996). Although Schneller *et al.* (1997) identify the development of hybrid responsibilities in the United States (US) from internal and operational, to more external and strategic roles, there has not been equivalent research in the UK. US-based research has also indicated role expansion among hybrids, without mention of reduction in pre-existing responsibilities. Betson and Pedroja (1989) indicated that in addition to practising medicine, clinical managerial roles encompassed three broad categories of tasks, which can all be classified as 'boundary-spanning' activities. These are quality assurance, communication and conflict mediation. In addition, Montgomery (2000) cites Schneller *et al.* (1997), who highlights the rise of the negotiator role among clinical managers, as well as an expansion in strategic planning and capital decision-making roles (Bodenheimer and Casalino, 1999, Scherer, 1999, Kirschman, 1996). However these responsibilities remain residual to the more prevalent boundary-spanning activities outlined above.

Among hybrids a key and recurring theme is the desirability of maintaining clinical practice (Fitzgerald and Dufour, 1997; Schneller *et al.*, 1997). Although hybrid roles appear, by definition, to be held by individuals with clinical and managerial roles, Hoff's (1999, 2001) US-based survey found that over half of the respondents did not currently practise medicine, and that of those who did, approximately 85 per cent practised for only one or two days per week. Hoff (1999) also found that being in a primary care speciality decreased the likelihood of clinical managers practising medicine. This may be reflective of overly high time demands on hybrids, and is not congruent with Hoque *et al.*'s 2004 finding of a lack of commitment to management roles among hybrids.

Prior research into the construction and enactment of hybrid roles in the UK (Harwood and Boufford, 1993; Fitzgerald, 1994; Marnoch, 1996; Fitzgerald and Dufour, 1997, Buchanan *et al.*, 1997; Thorne, 2000; Fitzgerald and Ferlie, 2000) has also raised questions regarding the nature of power and legitimate authority and autonomy; demarcation between professions and the colonisation of key roles by doctors. Problematic relationships between clinical managers and colleagues who are peers have also emerged as an area in need of further investigation (Fitzgerald, 1994; Thorne, 2000; Montgomery, 1990) In particular, Montgomery (1990) raises the question of

whether hybrid roles are becoming isolated and institutionalised. An important issue is that while broad reference is made to 'physician executives' and 'clinical managers', research tends to address this group either as a whole, or to specifically examine doctors in management. A key issue is the extent to which nurses and the allied health professionals are involved in hybrid posts, and whether they have similar experiences; are hybrid roles limited to doctor-managers? Another group that has been somewhat neglected by researchers are managers who have previously held clinical posts in nursing or the allied health professions; how will their roles develop? The next section outlines the key aspects of the clinical director as a key hybrid role.

The clinical director as a hybrid role

The clinical director role was introduced as a part-time management post, which was to be held by a practising clinician, and was predominately taken on by medical consultants. It was initially envisaged as a general management post for the directorate (Harwood and Boufford, 1993; Willcocks, 1994). However, the part-time nature of the role requires a more limited role focus. Within Willcocks' study, managers at trust level asserted that the clinical director should focus on strategy, clinical policy, quality improvement and meeting external targets. Managers were particularly clear about the need for clinical directors to influence consultant and medical staff with regards to meeting targets and delivering contract requirements. However, there was recognition of the limited capacity and willingness of role incumbents to influence their peers. The majority were highly uncomfortable with this aspect of their role. Importantly, Willcocks (1994) found some evidence of misunderstanding between managers and clinical directors regarding the extent of devolution of authority and responsibility.

Given the dynamic and unstructured nature of role negotiation, it is important to consider the extent to which the original responsibilities and structures of the role have changed across organisations. Differentiation among trusts is to be expected, particularly given the initial uncertainty regarding the nature of the role and its responsibilities (Willcocks, 1994). This is also to be expected with other newly introduced posts and hybrid roles in general.

The medical director role

Another key role within the hospital hierarchy is that of the medical director. Although filled by a clinician, the medical director post differs from that of the clinical director by being full time in nature, normally necessitating the abandonment of clinical commitments (Bruce and Hill, 1994). This role attempts to bring doctors and managers together in the development of strategic objectives. In addition, the medical director provides medical input to trust boards (Bruce and Hill, 1994). Ferlie *et al.* (1996) demonstrate in their study of trust boards that the

medical director's role can form a crucial strategic link between management and clinical staff and ensure medical perspectives are incorporated and respected. However, this is dependent on the capacity of the medical director and Bruce and Hill found wide variations in the scope and nature of medical director's responsibilities. While some were clearly part of the managerial hierarchy, others fulfilled a primarily advisory role. In addition, the clinical directors and consultants often disagreed with managers as to the role of the medical director, and who they were to represent.

The issue of remuneration has been raised as a key consideration in encouraging experienced clinicians to move into management. A related question is whether doctors are merely very expensive and inexperienced managers. In particular, some clinicians indicated that they felt that the post may shift towards a more management orientation in the future. Ten years since Bruce and Hills study, it may be time to re-evaluate.

Overview

At the heart of all of the major concepts in role theory is the individual role incumbent's perception of their own role, and whether it is manageable. The volume of the role and the extent of role change are also key issues for concern in the NHS. Although role expectations underpin the issues outlined above, many studies on roles and role development are decontextualised from the wider socio-political context (Bridges, 2004). This is a key omission.

Discussion of the key role groups and specific positions in the healthcare domain has been characterised by mention of role development, expanding responsibilities, clarity of role descriptions, shifting role boundaries and questions regarding appropriate autonomy, the nature of power and legitimate authority, the demarcation between professions, the colonisation of key roles by doctors and appropriate accountability arrangements. The extent to which these developments have affected interprofessional working and key relationships in acute and primary care are important considerations, explored in the next section.

2.1.4 Interprofessional relationships

To date, research on interprofessional relationships and collaboration has tended to look at relationships between clinical groups (Reeves and Lewin, 2004), or between doctors and managers (Bruce and Hill, 1994; Griffiths and Hughes, 2000; Davies *et al.*, 2003). There is little research describing or explaining the relationship sets or patterns of hybrids.

On aggregate, interprofessional relationships are hindered by social and cognitive boundaries between groups (Ferlie *et al.*, 2005a). While social boundaries are 'created by well-developed professional roles, identities and traditional work practices' (Ferlie *et al.*, 2005a: 128),

cognitive boundaries are underpinned by different research traditions and knowledge bases. In spite of the fact that these groups must interact to achieve organisational goals, Ferlie *et al.*'s study noted strong social boundaries between doctors, nurses, midwives, and physiotherapists, even where they shared multi-disciplinary team membership. There is also a large body of literature which explores the, at times, uneasy relationship between clinicians and managers. Braithwaite and Westbrook (2005) found no consensus in an Australian context that clinical directorate structures had increased the quality of relationships between groups. However, an interesting consideration is the extent to which the UK situation is similar, and whether clinical directorate structures have broadened pre-existing sets of relationships.

Reeves and Lewin (2004) assert that in the context of service provision, and particularly in acute care, many interprofessional relationships are of short duration and recurrently shift between individuals and organisations. They follow Engelstrom *et al.* (1999) in describing interprofessional relationships as 'knotworking', based on establishing and re-establishing links via brief interactions. Reeves and Lewin (2004) also described interprofessional relationships in the context of service provision as 'fragmented'. With collaboration premised on short, unstructured and opportunistic interactions, they asserted that clinical professionals formed loose and transient groups around a purpose, rather than adopting sustained and purposive collaboration. In addition, they noted that intra-professional links were based on focused interactions rather than sustained relationships. Most interaction occurred within professional groups, although collaboration between nurses and allied health professionals was based on longer more friendly interactions. Reeves and Lewin (2004) also highlighted the use of care-coordinators and nurses as boundary spanners between professionals, passing information between those who could not interact in person. A key issue is whether this goal-focused, transient and superficial relationship structure is also evident in the context of change, and whether project groups are more structured than those evident in service provision. Similarly, the issue of whether hybrids serve a similar boundary-spanner role between managers and doctors as care co-ordinators and nurses is raised.

Bate (2000) asserts that as an active manifestation of paradigmatic differences, tribalism is an innate element of hospital culture. However, for him, what differentiates effective from ineffective professional organisations is the extent to which such tribalism is contained. Nonetheless, for Bate, health care culture remains paternalistic and authoritarian, with ramifications for interprofessional relationships. In addition, the fact that relationships often span organisational, geographic and indeed sectoral boundaries makes establishing interprofessional relationships even more challenging.

Acute/primary care relationships

Relationships between acute and primary care span organisational and sector boundaries. Williams (2002) identifies three underlying reasons for interorganisational relationships; hegemony, resource opportunity and mandate. Collaboration as hegemony is centred on interorganisational working as a response to complex problems that cross organisational boundaries. Collaboration as resource opportunity is based on the resource exchange model, where organisations attempt to realise their own goals with the aid of resources from other organisations.

The third source of collaboration is mandated, typically from centralised governance. Within the NHS, collaboration as mandate has led to a rise in collaboration as resource opportunity and hegemony, for example the 'breakthrough collaboratives' (Department of Health, 2002b). However, the concern raised by Williams is that where collaboration is based on mandate, the underlying motivation may be insincere and ensuing relationships may be fragile. The literature reviewed by Goodwin *et al.* (2004) for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D Programme indicates that mandated networks will only succeed if the network priorities coincide with those of the professionals or organisations involved. However, they also point out the danger to such an approach; namely that the professionals (doctors) or organisations (hospitals) become so powerful within a network that they manoeuvre the network to meet their own needs. Others have also raised other difficulties associated with such collaborations in the NHS. Bate and Robert (2002) who studied NHS collaboratives suggested three potential difficulties to such initiatives: creating and sustaining horizontal relationships across organisations; maintaining motivation and commitment from staff over time; and identifying staff that are willing to lead and participate in change programmes. The success of these initiatives needs the strong support from the senior managers and clinical staff in all the organisations and their ability to secure support and acceptance from the wider staff population (Bate and Robert, 2002; Powell and Davies, 2001; Ham, Kipping and McLeod, 2003). These are key concerns within the context of current acute – primary care relationships.

2.1.5. Key relationships

This section provides an overview of doctor/manager and hybrid relationships.

Doctor/manager relationships

Inherent in recent policy changes has been the notion that doctors should become more integral to healthcare management (Riordan and Simpson, 1994). Although clinical directorate structures attempted to integrate clinicians into management, this has led to disenchantment

among clinical directors (Davies *et al.*, 2003). Bruce and Hill (1994) explored the extent to which managers should have some capacity to challenge the medical profession in their areas of expertise. Griffiths and Hughes' (2000) study explored relationships between clinicians and managers in the context of the Welsh internal market. A key finding was that neither group tended to encroach on the other's areas of expertise, but rather that groups attempted to define problems in ways that placed them as their specific area of concern. Such a strategy makes it more difficult for managers to challenge clinicians, especially as they found that clinical arguments continue to have prime legitimacy for clinicians. Their work emphasised the importance of hybrid boundary spanners, as clinicians on the contracting team spend a significant amount of their time mediating and translating between managers and clinicians. Similarly, Bate's (2000) case study indicated that by not accepting the legitimacy of management, consultants can undermine managerial power, confirming Pettigrew *et al.*'s (1992) earlier findings that reorganisations of the NHS had failed to shift power away from doctors. Similarly, Hoque *et al.* (2004) indicate that traditional NHS doctor/management relationships were characterised by the veto held by consultants. Their case study illustrates that both hybrids and managers articulated frustration with the divide caused by professional boundaries.

Management capacity to challenge clinicians is undermined by:

- 1 the underdeveloped nature of medical performance, with monitoring still embryonic
- 2 the question of legitimate authority in the clinical realm.

Thus, in reality the doctor/manager relationship is not one of equal or balanced power bases. Recent work on hybrids is explored in the next section.

Relationships: hybrids

To date, there is little understanding of how clinical managers interact with other clinicians and managers, and whether the management and relationship styles of hybrids are different from those of general managers (Hoff, 1999). However, problematic relationships between clinical managers and clinical colleagues have emerged as an area in need of further investigation (Fitzgerald, 1994; Thorne, 2000; Montgomery, 1990; Riordan and Simpson, 1994). Conflicting relationships are related to the difficulty of simultaneously establishing trust between clinicians and managers, which is a critical characteristic of success for hybrids (Guthrie, 1999). Some clinicians may be predisposed not to trust clinical managers, which can be attributed to a sense of threat from environmental changes in healthcare (Fitzgerald, 1994; Montgomery, 2000), as well as a wish to avoid contentious decisions which might have been previously ignored (Fitzgerald and Dufour 1997; Riordan and Simpson, 1994). Importantly, Hoff (1999) indicates that negative experiences are more

prevalent among clinical managers who have ceased to practise medicine. At the polar end of the spectrum, he asserts that practising clinical managers are accorded enhanced credibility by their clinical colleagues.

Relationships between hybrids, clinicians and managers are influenced by the medical management culture in the hospital. Riordan and Simpson (1994) assert that clinical managers may be perceived as working with the enemy. Thus they assert that there is the risk of professional isolation, a concern also articulated by Schneller (2001) and Montgomery (1990). Montgomery (2000) identifies fairness as a source of tension within medical/managerial relationships, with associated implications for hybrid/clinician relationships. For clinicians, fairness is defined at micro level, while for managers definitions of fairness pertain to populations of patients. For Montgomery, it is in this context that the hybrid boundary-spanning roles of negotiation, communication and conflict mediation are most valuable. Finally, there is a need to consider whether clinical managers have relationships which merely span or actually integrate disparate professional groupings.

Given the differences between professions, the issue of how to generate productive interprofessional relationships is vital. Coghlan and McAuliffe (2003) assert that dialogue is central to the basic functioning of interprofessional relationships. A similar orientation is adopted by Bate (2000), as professional allegiances are too strong to facilitate an overarching hospital or health care culture, there is a need for regulated pluralism, where regulation is not premised on rules, but on shared meanings and values, leading to common goals and a shared sense of responsibility. However, Ferlie *et al.* (2005a) demonstrate that opportunities for genuine interprofessional dialogue are rare. The next, and final, substantive section explores four themes which were raised during the review. These are portfolio roles, hybrid managers, the emergence of professional clinical managers and training and capacity for the future.

2.1.6 Key themes

Key theme 1: portfolio roles

In this context portfolio roles are defined as the possession of multiple roles, which may include managerial and clinical roles, inside and outside the trust. Given the emergence of hybrid managers a rise in the number of individuals holding a portfolio of roles is to be expected. However, to date, there is little extant research on the nature or number of such roles, or their prevalence. Neither has any attention been paid to the residual training needs of such individuals, nor to the degree to which such roles are manageable, empowering or motivating.

Key theme 2: hybrid managers

'It's a great role for a masochist because you're not loved by anybody.'

(Bate, 2000: 493)

Hybrid managers have been discussed as a strategy to extend managerial control over professions, as well as being perceived as a method to reconcile the professional and organisational agendas. The legitimacy and capacity of clinical managers is premised on two assumptions (Hoff, 2001). Firstly, that clinical managers make different and valuable offerings when compared with clinicians and managers, and secondly that the core skills required to be a manager and to be a clinical manager are similar. Hoff raises several interesting questions. Firstly, the issue of whether a coherent body of professional clinical managers is emerging needs to be considered. Secondly, the extent to which hybrids are continuing to practise within the UK needs to be explored. Thirdly, the nature and need for management training needs to be more specifically addressed.

Within the UK, there is some debate over the extent to which clinical managers are committed to managerial goals. Although Fitzgerald (1994) asserts that clinicians perceive a shift into management as an opportunity to influence the direction of change, Dopson (1993) found that clinicians were often reluctant to enter into management. Another recurring theme in the literature is a lack of management training among hybrids (Hoque *et al.*, 2004, Ferlie *et al.*, 1996, Willcocks, 1994). Given this, Hoque *et al.* (2004) question the wisdom of providing further autonomy to clinical managers. However, Willcocks found that some clinical directors did not have sufficient authority to execute their responsibilities, although they were accountable for results.

A further key issue is the sparse evidence regarding the organisational or professional outcomes or benefits which are associated with clinical managers (Schneller, 2001). In spite of anecdotal claims that clinical managers are of benefit, Montgomery (2000) asserts that such statements are not based on comprehensive data. This can be related to the difficulty of separating their mediating effects from all other organisational influences. Nonetheless, the issues of capacity, willingness, and training touched on above provide grounding for the debate regarding whether professional clinical directors are emerging in the UK.

Key theme 3: the emergence of professional clinical managers

Within the US, there has been a rise in demand for clinical managers, and there is debate over the extent to which this augmented demand can be perceived as the emergence of a profession of clinical managers. In the US, there are many more clinical managers with appropriate qualifications than in the UK and the figure is rising. However, for Montgomery, the fragmentation of management

education has thwarted embryonic efforts to establish a speciality in medical management in the US, and has stalled the recognition of professional hybrid managers by the American Board of Medical Specialities in that context. But her studies suggest that contrary to macro indications, professional clinical managers are being encouraged at micro level.

Hoff (1999) asserts that the pursuit of graduate degrees by clinical managers is indicative of the groups' intention to secure status as a distinct professional area. For him, physician executives possessing graduate management degrees are a source of legitimacy for the group as a whole. Although the current figure stands at only twenty four percent, it is four times higher than the figure in 1980 (Hoff, 1999). In spite of these barriers at aggregate level, Montgomery (2000) cites numerous studies which indicate particularly attractive packages for clinical managers, which can exceed those for physicians, and particularly in primary care.

Attempts to provide systematic training have been led by the British Association of Medical Managers (BAMM) in the UK context. However, although such efforts suggest a desire to facilitate the emergence of professional clinical managers, the extent to which career trajectories provide sufficient opportunities, and whether hybrid posts are being adopted for limited periods of time, have yet to be explored in the UK. The underlying motivations of clinical managers in entering hybrid posts could also provide insight into aspirations towards professional managerial roles. A key distinction may be whether clinical managers see themselves as *traditional* or *medical* managers. One issue is retaining the distinctive characteristic of medical practice while gaining legitimacy.

2.2 Processes of organisational change in health care

This section of the literature review focuses on the literature relating to organisational change in health care. It commences with a brief review of theoretical approaches to understanding organisational change in order to place the current project within a theoretical framework. This short section illuminates a number of core themes emerging from the organisational change literature, which are relevant to our work. The second part of this section reviews the current literature on organisational change in health care and draws out key themes and outstanding issues.

2.2.1 Models and theoretical approaches to organisational change

While we understand many aspects of the implementation of organisational change, much of the prior work has been done in

commercial organisations. We intend to build on this work, but to examine what is similar and different about health care organisations.

Poole (2004) argues that organisational change theories can be grouped under four main headings which offer models and theories of the basic motors for change:

- 1 life cycle
- 2 teleological
- 3 dialectical
- 4 evolutionary.

A life cycle model depicts the process of change as progressing through a necessary sequence of stages, the specific content of which is prescribed and regulated.

A teleological model sees development as a cycle of goal formation and implementation, which emerges through the purposeful enactment of a planned end state.

In dialectical models of development, conflicts emerge between opposing forces and collide to produce synthesis and progression.

An evolutionary model consists of a repetitive sequence of variation, selection and retention, and is generated by competition for scarce resources.

Defining these models draws attention to the variations between them in terms of the unit of analysis, that is, an organisation or a collection of organisations within a field or sector and whether developments are prescribed or constructed. Based on this discussion of the motors for change, Poole distinguishes between variance and process approaches to the study of change. The former implies that one can explain change in terms of the relationships between independent variables and dependent variables and would include deterministic explanations of organisational change. The latter approach explains change as a sequence of events which lead to an outcome (but not always the intended outcome!). Another crucial difference lies in the extent to which human agency can guide or control the process.

This broad overview provides a useful starting point for this discussion of organisational change in health care as it enables us to position our thinking within a wider theoretical framework. Our current work builds on an empirically-based body of prior work which has developed influential theoretical accounts of change and has developed processual-contextual theory (Pettigrew, 1985; Pettigrew and Whipp, 1991). Thus it falls within the process approach as described by Poole (2004). Processual-contextual accounts advocate a multi-layered, longitudinal perspective, which may inhibit the ready generation of prescriptive advice for the practitioner, since it does not assume a single driver for change. The approach has also been criticised for marginalizing the role of the individual change driver (Buchanan and Boddy, 1992). However, a contextualist analysis of a social process

draws on the phenomena at vertical and horizontal levels of analysis and the interconnections between those levels through time. Based on a comparative study of organisations in different sectors, Pettigrew and Whipp (1991) indicate that there are five core factors in implementing successful organisational change. These are environmental assessment; coherence of strategy; leading change; linking strategic and operational change; and HR management assets and liabilities. They point out that these factors are interlinked and need to be understood in context. However, it may be argued that these factors are sufficiently specific to offer guidance to senior managers wishing to prioritise areas for development and build competence. Dawson (2003) has developed Pettigrew's work - he typifies the organisational change process as untidy and complex, and not one which can be reduced to a series of linear events. He argues for an even wider version of 'context', with more emphasis on the substance of change itself (scale, characteristics, perceived centrality and timeframe) and on the politics of change. Buchanan and Badham (1999) have also raised the issues concerned with power and politics and argued that a change in context changes the role of political behaviour.

There is also a large literature on the management of change in the private sector. For the sake of brevity, a few examples only will be mentioned here (Lawrence and Lorsch, 1967; Dunphy and Stace, 1988; Senge, 1999; Buchanan and Badham, 1999). This literature has been recently reviewed by Illes and Sutherland (2000) who underline a number of generic issues in the effective management of change, such as the need for consistency in strategy; the critical importance of communication strategies and the need to gain commitment from staff. Despite our knowledge of these issues, there remain many enduring problems (Manzoni 2001); this literature is fragmented, and rarely differentiates between sectors or countries. Pascale, Millemann and Gioja (1997) argue that the literature of change is either too conceptual and impractical, or too company-specific.

In particular, the implementation literature fragments into accounts which emphasise either 'best practice', or theory development. A considerable part of the literature on 'best practice' is based on individual case histories, while many other authors provide normative advice, which is not empirically well-founded. Most of these commentators develop 'step guides', for example, Kotter (1995) offers an eight-step guide. These generic guides are offered with limited attention being paid to either the impact of context or of culture.

One helpful source for clarifying some of the sources of variation and fragmentation is to be found in the innovation literature. There, authors (Damanpour, 1991; Fiol, 1996) have helpfully drawn attention to the need for researchers to distinguish between:

- the varied substance or content of change

- the stages in the change process at which events are occurring, for example the initiation of change or the implementation of change
- the differing participants.

Research focusing on different elements is clearly likely to produce different results.

Overview

A core issue emerging from this literature is the difficulty in understanding and explaining the variability of change processes and outcomes from one sectoral context to another and, within a sector, from one organisation to another. The evidence to date suggests that context has to be perceived as crucial element which affects the progress and form of organisational change. Thus, understanding the impact of context is crucial. In addition, the literature highlights debates on the relative importance of deterministic factors, in driving change, as compared to agency and human interventions. Finally, the processual contextual theoretical approach seeks to comprehend the interconnections between variables and to adopt the concept of configurations as a means of understanding complexity and variability.

2.2.2 Organisational change in health care

As suggested in the last paragraph, a more specific literature on the management of change within the health care sector also exists. Building on this foundation of empirical work and in particular, on research in the organisational process perspective (for example Pettigrew, Ferlie and McKee, 1992), a number of researchers have elaborated key facets of change processes as they occur within health care. Authors (Ferlie *et al.*, 1996; Kitchener and Whipp, 1997) have demonstrated the complex nature of health care delivery as a service and therefore the complex character of health care organisations. These authors distinguish health care as an arena of multi-professional membership, with power and autonomy resting with the professions and draw attention to the embedded nature of these organisational features which impact on the capacity of the organisation to change. Denis *et al.* (1996; 1999) illustrate that leading successful change in health care requires an understanding of the multiplicity of stakeholders and has greater probability of success if a collective leadership approach is adopted. We shall return to this issue again in Section 2.3. More recent work, (Packwood, Pollitt and Roberts 1998; Locock 2001; McNulty and Ferlie, 2002) discusses the impact of programmed attempts at transformation and redesign and helps to explain the variability of responses to change by differing parts of an organisation or parts of the overall health care sector. Again the crucial role played by the professionals is reinforced, as are the limitations of radical or 'top down' approaches to change. Following the work of Greenwood and Hinings (1996), McNulty and Ferlie argue

that the 'reproduction' of existing organisational arrangements can be explained as the outcome of institutional and organisational dynamics. Most recently Ferlie *et al.* (2005a) demonstrate the manner in which cognitive and social boundaries within and between professions impede the diffusion of innovation and change. These findings also have clear implications for the diffusion and spread of improvements across professional groups and across organisational boundaries. The issue of the diffusion of 'best practice' and the spread and sustainability of improvements is one which has exercised the policymakers and the work of the Modernisation Agency in health care in the UK, as we shall see in Section 2.4.

A further and interconnected field of literature relates to the role of organisational culture in facilitating or even encouraging, organisational improvements and higher performance. Section 2.4 will demonstrate that current, national policy in health care in the UK has placed considerable emphasis on the need to bring about 'cultural change' in health care (Department of Health 2000; 2003a). The concept of organisational culture and its relationship to organisational change has been hotly debated (Peters and Waterman, 1982; Kanter, 1983; Beer *et al.*, 1993). These arguments revolve around whether attempting to change organisational culture is achievable and will improve performance or whether changing peoples' behaviour will produce the desired changes in attitudes. Work in the NHS has sought to elucidate the relationships between culture and performance (Marshall *et al.*, 2003; Scott *et al.*, 2003; Mannion *et al.*, 2004) and suggests that culture is an 'elusive' concept. However, this work provides evidence that poor performance data and poor measures of performance can have perverse consequences. The core cultural attributes of high performing acute trusts are identified. Finally, this work confirms the importance high quality managers and of an active HR management function to select and train staff. Hyde and Davies (2004) further argue that the relationships between culture and performance are modulated by local design of health services. Their work proposes that organisational culture emerges from a complex interplay between the service design in organisations, staff and users.

A more recent focus of research attention (Pettigrew and Fenton 2000; Hartley *et al.*, 1997) has been the concept of the 'network organisation' which has many properties which might seem attractive to professionalised organisations, such as flexibility and responsiveness. In health care, this concept has only recently been researched (Ferlie and Addicott, 2004) but it may prove a topic of growing importance since government policy is advocating the wider use of networks in health care (Department of Health 2004a; 2005b). Goodwin *et al.* (2004) carried out a systematic review that focused on the management of diverse networks of care by reviewing the literature from both the public and private sector and across a variety of different industries. Their review illustrated how vast the network literature is in other sectors and drew out various lessons for the

management, leadership, governance and policy in the health care sector. This review reported on a number of different network practices and network forms that operated across the various sectors studied and, unsurprisingly, did not find an 'ideal type'. Instead, the review suggested that network models had to fit the problems and tasks that were being addressed and since the health care sector needs to respond to a variety of different tasks there needs to be what they call an 'intelligent crafting of networks' and they need to be capable of 'strategy switching' between the various basic forms of networks (Goodwin *et al.*, 2004: 374). Goodwin *et al.* argue that there is support in the literature that they reviewed that suggests that NHS managers should adopt a hybrid approach to network management that combine the four core network elements of hierarchy, individualism, enclave and isolate.

These studies elucidate how generic change processes occur within health care and also demonstrate variability when compared with results from commercial organisations.

A number of similar issues in the management of change issues arise within a grouping of professionalised organisations which includes, but goes beyond health care (for example Mintzberg, 1989; Greenwood and Hinings, 1996; Brock *et al.*, 1999). This literature emphasises key differences between professionalised organisations, including health care and other types of organisation and other organisational forms. Professionalised organisations are depicted as complex, knowledge-based organisations where power is derived not solely from position or hierarchy, but from professional knowledge. Thus the recent changes to managed professional businesses are seen to result from the interplay between the structural form of professional firms, as partnerships and the external influences from the global marketplace (Powell *et al.*, 1999; Flood, 1996). Professional firms display multiple interest groups which may limit the scope and pace of change and mean that change occurs in some areas of the organisation, while continuity persists in others (Hinings *et al.*, 1991; Morris and Pinnington, 1999). Evidence of similar phenomena has been detected in health care organisations (McNulty and Ferlie, 2002).

Another characteristic of change in professional firms, similar to findings within health care, is the impact and influence of historical and institutionalized relationships both within the organisation and with the professional bodies. Analysis suggests that these result in 'sedimented' change processes (Cooper *et al.*, 1996; Greenwood and Hinings, 1996).

The literature also highlights many important, pragmatic issues. These include the extent of managerial knowledge and the managerial training of clinical professionals; the part-time nature of clinical management roles; the appropriate structures to support clinical management in different specialisms and in different organisational

contexts and the definition of the roles of supporting general managers.

Overview

Within the literature on organisational change in health care, a number of themes emerge:

- 1 Health care organisations as a particular form of complex organisation. This complexity can be perceived in at least three characteristics of the organisations: structures, functions and personnel. Each of these aspects individually impact on the change process and collectively have a profound impact.
- 2 Complexity is also apparent in range and rapidity of change in the policy arena; a particular feature of these changes is their 'top down' approach to change. The rate of change is also perceived as an issue.
- 3 One key finding is the critical role played by the organisational context in shaping and affecting the pace of change (Pettigrew, Ferlie and McKee, 1992; Ferlie *et al.*, 1996). The manner in which factors affect the change process requires further elaboration.
- 4 The crucial role of the professions and professional boundaries in change processes is noted. The ambiguous and uncertain nature of professional judgments and decision making is highlighted (Denis *et al.*, 1996; Fitzgerald and Ferlie, 2000; Ferlie *et al.*, 2005a). A key issue therefore is to understand how to manage change when professionals hold a considerable amount of the power.
- 5 Another important finding is the collective nature of change leadership in health care contexts (Denis *et al.*, 1996; Denis *et al.*, 2001).
- 6 Most recently, the emergence of network forms of organisation as a means of collaboration in health care is noted (Ferlie and Addicott, 2004). The full impact of this development remains to be explored.

The interplay of structures, managerial roles and the processes of management in such organisations are therefore different and remain a relatively under-researched area. Using the concept proposed by Weick (1979), one can describe the processes of influence and management as the 'enactment' of a negotiated order. This concept may provide a theoretical framework for understanding the management of peers and others in complex and ambiguous settings. The project will also draw on the specific literature on influence and influencing processes (Cialdini, 2001).

2.3 Change facilitation and change agency

Broadly speaking, the literature on change capabilities could be classified into two perspectives:

- corporate or organisational characteristics
- individual agency and individual qualities.

In this section, we are largely concerned with the latter perspective, but it can be noted that the notion of corporate capabilities relates to ideas of culture (Kanter, 1983) and to the idea of receptive contexts for change (Pettigrew and Whipp, 1991; Pettigrew, Ferlie and McKee, 1992) which have been mentioned in previous sections.

The individual capabilities' perspective is personal, and concerns individual roles, skill, knowledge, and attributes. The literature tends to divide into a focus on the role and on 'change agency' as it is often termed or, alternatively, to focus on the skills and capabilities required of the individual. There is now a substantial literature, considered in more detail below, exploring the roles and competencies of effective change agents, project managers, and those in related organisational change roles. Much of this research has been carried out in commercial settings, and comparatively less attention has been paid, until recently, to public sector contexts. Interestingly, Locock (2001) proposes on the basis of her work in health care that the term 'opinion leaders' would be more appropriate as her data demonstrate that change agents may both facilitate *and* impede change efforts.

In considering the literature on 'change agency', Ottaway's (1983) taxonomy makes a useful starting place. He identifies ten change agency roles in three broad categories; 'change generators' (key agents, demonstrators, patrons and defenders), 'change implementers' (external and internal), and 'change adopters' (early adopters, maintainers and users). This categorisation has resonance with the work of Rogers (1995) on the diffusion of innovation in which he identifies early and late adopters, with differing characteristics. Stjernberg and Philips (1993) argue that change relies on a small number of committed individuals called 'souls-of-fire', from the Swedish 'eldsjälar' meaning 'driven by burning enthusiasm'. Buchanan and Storey (1997) identify a broader range of change agency roles, including initiators, sponsors, drivers, and subversives. They argue that these are not static positions, and that 'role taking and role switching' is an organisation political skill central to change management expertise. But on the whole, these taxonomies tend to focus on a relatively narrow range of senior and middle managers. This focus is significant because recent research suggests that the change management role has become more widely dispersed, in public and private sector organisations, to involve staff from all organisational levels in substantive change design and implementation roles (Buchanan *et al.*, 1999).

A further tranche of literature explores the competencies required of a change agent. This literature must address the fact that most managers now combine change responsibilities with their regular duties, as well as identifying the skills required of specialist project managers and change consultants. Much of the literature adopts a competency based approach. Howell and Higgins (1990) found that change champions use transformational leadership behaviours; exhibit higher levels of risk taking, innovation and influencing; and use a variety of influence tactics. Beatty and Gordon (1991) and Beatty and Lee (1992) argue that the change evangelist must combine a number of skills and behaviours which they describe as pathfinding, problem-solving, vision, determination, technical expertise, interpersonal skills and political skills. From research with senior project managers, Buchanan and Boddy (1992) identify the 15 competencies in five categories, which relate to goals; roles; communication; negotiation and managing up. The majority of this literature, with the exception of individual case studies is de-contextualised. As a result, any literature review which examines this work produces a long list of commonly agreed competencies, but with virtually no evidence as to their relative utility or effectiveness in different organisational contexts.

A number of authors (Nadler, 1998; Burke, 1987) underline the importance of the motivation and the values held by change agents. This aspect of change management was a critical feature of the early work on organisation development which was premised on the idea that the organisation development consultant's role was conducted in a unique manner, based on a collaborative relationship with the client organisation (French and Bell, 1995). The organisational development practitioner is 'a facilitator, catalyst, problem solver, and educator'. The traditional approach to management consultancy is based on a medical model, in which the consultant is the expert diagnostician who investigates and prescribes a cure. In contrast, the organisational development consultant works collaboratively with clients, designing interventions that help organisation members to diagnose and resolve their own problems more effectively. This approach to change facilitation emphasises knowledge of action research methods and organisational development theory as well as consultation and involvement. These ideas may be seen to have particular relevance to this research since the Modernisation Agency adopted many of the basic ideas and utilised them in advising health care staff on how to manage change (NHS Modernisation Agency, 2002a).

Only a limited part of this volume of work focuses specifically on change agency within the public sector organisations in the UK. While there is a substantial body of work on implementing organisational change in the public sector (see for example, Davis *et al.*, 2001; Boyne, 2004), empirical based research on the roles of change agents and change agency is limited. Wooldridge and Wallace (2002), drawing on work in local government point to the need to equip civil servants and other public-sector workers with delivery skills and an

understanding of the approaches to organisational change. They identify 'nine habits of successful change leaders' including focus on the strategic purpose and on achieving results, listening to staff, developing partnerships, working across organisational boundaries, developing others, open use of information, developing teamworking, and helping others to make sense of complexity. Specifically, within this focused literature, some attention has been paid to the particular issue of change agency within the health care context. It is evident from this research that clinical leaders can play an influential role, both as the promoters of change and as the inhibitors of change (Pettigrew, Ferlie and McKee, 1992; Fairhurst and Huby, 1998; Locock, 2001). This literature also demonstrates that change agents may play a variety of roles, both as instigators of change and as implementers depending on their position and personal skills. These data suggest that in complex, multi-professional organisations the credibility of the individual change agent will be closely associated with their professional membership and their specialist clinical, as well as managerial expertise.

Finally, in this section, attention is drawn to the growing body of evidence which proposes that effective change agency in health care depends on collective or even dispersed leadership (Pettigrew, Ferlie and McKee, 1992; Denis, Langley, and Cazale, 1996; Brooks, 1996; Denis, Lamothe and Langley, 2001). This focus links the literature on change leadership with that on change agency. It discusses change agency within the specifics of current organisational contexts and changing organisational forms, including a growth in network forms. In flatter organisation structures, with team-based working, the growth of knowledge work, and networked organisational forms (the latter increasingly common in healthcare), traditional leadership positions based on hierarchy and organisational symbolism are weakened.

From their research in Canadian hospitals, Denis *et al.* (1996) and Denis *et al.* (2001) argue that strategic change in organisations characterised by shared and ambiguous leadership roles, divergent objectives, and diffuse power (such as health care organisations) depend on a collective leadership group whose members play fluid, fragile and complementary interlocking roles. They consequently use the term 'leadership role constellation'.

Overview

The literature on change agency and change leadership is, in general, relatively underdeveloped, with limited evidence of effectiveness of the roles within particular contexts. The literature remains at the stage of descriptively mapping roles and of defining the competencies and skills required to succeed in these roles.

Increasingly, there is evidence that change agency may embrace a variety of roles with differing foci. And this line of enquiry suggests

that we may need to acknowledge the positive and the negative 'opinion leader'.

A focus on change agency within the public sector in the UK suggests that complex organisations characterised by ambiguity and diffuse power may need to ensure that they have a diffuse, collective capability for change leadership and change agency. Since this finding links to research in the private sector in networks forms of organisation, this is an especially interesting line of future enquiry for health care, where services are increasingly being delivered via networks, for example cancer networks.

2.4 The national policy context: a resumé

This section of the report will consider the national health policy context over the past ten years, particularly prior to the empirical fieldwork and consider New Labour's modernisation agenda. This will provide an important basis for framing the forthcoming empirical results and conclusions. This policy outline is not intended as an exhaustive review of all government health care policy over the period of the Labour government, but rather a broad introduction to issues relating to this research. Neither are we offering here a critique of current policy initiatives. A more detailed review of relevant policies in relation to each of the three care areas under study is given at the start of the comparative analysis of empirical data on each care group.

The modernisation agenda

When the Labour government was elected in the UK in 1997, following many years of Conservative rule, 'modernisation' of public services was central to their policy manifesto. Modernisation, as used by New Labour, is a loose term to describe a range of *strategies* (rather than a *phase*) of public sector reform. The Modernisation Agency of the Department of Health was formed in 2001 to facilitate this strategy.

With the change of government, the internal market model was abolished; however New Labour did maintain essential features of the reform – retention of the NHS trust model and separation of purchasers and providers, not as a means to sustain competition between providers but rather to ensure that trusts were held accountable for their performance. This period saw the further growth of performance management in the NHS, combined with the development of associated agencies, such as the Commission for Health Improvement (CHI) and the National Institute for Clinical Excellence (NICE).

In 2001, commissioning responsibilities were allocated to the newly formed PCTs, reflecting the Department of Health's intention of their paper, *Shifting the Balance of Power within the NHS* (Department of Health, 2001a) - known as 'StBOP' - whereby decision-making and financial responsibility were to be devolved to a local level. This

document further advocated linking groups of health professionals and organisations in a co-ordinated manner, unconstrained by existing boundaries. Its primary message was that the NHS required a shift in the balance of power towards service users and frontline staff, who most understand the needs and concerns of patients. Thus PCTs, as independent trusts, serve a localised population and now control up to 75% of the NHS budget (Le Grand, 2003).

With PCTs responsible for commissioning NHS services, the role of newly developed strategic health authorities (SHAs) was to provide leadership and ensure delivery of improvements in health services (Department of Health, 2001a). SHAs each cover a population of around 1.5 million people (and are roughly aligned with cancer network boundaries). SHAs are responsible for ensuring that all aspects of the health economy – primary, secondary and tertiary care – work together to deliver on the recommendations of the *NHS Plan* (Department of Health, 2000a). Over time, SHAs have taken on greater performance management of all health services. Service improvement initiatives purported through the modernisation agenda have been conceptualised through the series of NSFs which, According to the Department of Health:

- set national standards and identify key interventions for a defined service or care group
- put in place strategies to support implementation
- establish ways to ensure progress within an agreed time scale
- form one of a range of measures to raise quality and decrease variations in service, introduced in *The New NHS: Modern, Dependable* (Department of Health, 1997) and *A First Class Service: Quality in the NHS* (Department of Health, 1999a). The *NHS Plan* re-emphasised the role of NSFs as drivers in delivering the modernisation agenda.

Cancer, diabetes and maternity services are now covered by NSFs. The NSF for cancer follows a different framework, where the Calman-Hine report (*A Policy Framework for Commissioning Cancer Services*) set out a framework for care provision in 1995. The *NHS Cancer Plan* (Department of Health, 2000b) then provided a more specific statement of the government's comprehensive national programme for investment and reform of cancer services in England. The framework for cancer is referred to as the *Cancer Plan* throughout the rest of this document.

The NSF for diabetes was more formalised and, published in 2001 (Department of Health, 2001b), set out a ten-year programme of change to deliver world class care and support for people with diabetes. The NSF for diabetes is referred to as the *Diabetes NSF* throughout the rest of this document.

The NSF for children, young people and maternity services, published in 2004 (Department of Health, 2004a), sets standards for children's

health and social services, and the interface of those services with education. In all three cases, the NSFs carried with them particular targets for improvement. Specific details of national policy relating to the three particular clinical areas will be provided in Section 4 of this report. The NSF for children, young people and maternity services is referred to as the *Children's NSF* throughout the rest of this document.

More recently, foundation trusts represent a potentially conflicting modernisation initiative, again designed to decentralise public services. Foundation trusts are acute trusts that have been granted responsibility to generate their own funds and have unprecedented freedom from centralised political control. They are instead accountable to their local members – residents, patients and staff. In early 2005, there were 31 foundation trusts across England, drawn from high-performing trusts, as judged by the Healthcare Commission (Lewis, 2005). As a new organisational and governance structure, the impact of foundation trusts is as yet unknown. However, they further appear to contradict the collaborative intention of the modernisation agenda and the aim to develop primary care as a significant actor in the planning and delivery of health care. Foundation trusts bypass other local purchasers and authorities and relate directly to the Secretary of State. This model also presents a challenge to the 'whole systems' approach that has been promoted through collaborative, network approaches to the delivery of health care. Instead, they present a potential boundary to integrated care and indicate a return to competitive organisational silos.

On the surface, this initiative might be perceived as a radical structural change that reduces centralised 'micro management' over the provision of health care. However, Hunter (Hunter, 2003: 211) suggests that 'what finally emerges from the legislative process may be so emasculated as virtually to nullify the original intention'. As with other modernisation initiatives, such as 'managed networks' and 'managed choice', it is unlikely that the government will loosen the managerial reigns of these foundation trusts.

The NHS London patient choice project operated between 2002 and 2004 and represented a novel experiment with managed choice in the UK, which potentially conflicts with collaborative initiatives of the modernisation agenda. The project offered London patients waiting longer than six months for surgery the choice of alternative providers in order to reduce surgical waiting lists. This pilot initiative has since been formally disbanded and absorbed by PCTs, reflecting devolved NHS commissioning. However, there remains concern regarding how PCTs are likely to recognise and develop formalised arrangements with alternative providers, who may be outside their commissioning boundaries (Ferlie *et al.*, 2005b). Nevertheless, the London patient choice project represents a modernisation agenda initiative that has the potential to undermine the ethos of collaborative initiatives. Although predominantly confined to elective conditions (such as

cataract and orthopaedic surgery), the government has stated that 'by 2008, every patient referred by their GP will be able to choose to be treated at any facility in England' (Department of Health, 2004b). Most recently, the choice initiative has been extended to the delivery of diagnostics (Department of Health, 2005a) – which could have more significant impact on health care delivery. This managed choice approach offers patients the opportunity to be referred to an institution in another part of the UK or potentially in a different country. These contracts between referring and 'receiving' hospitals raise questions regarding their compatibility with the cancer network focus on quality and continuity of care (Ferlie *et al.*, 2005b). This choice initiative disregards the guidelines and bounded referral pathways that have been established by cancer networks.

Section 3 Methodology

This section sets out in detail the research design and the methods adopted to conduct the research. The section is divided into a discussion of the aims and objectives of the project; followed by an in-depth discussion of the research approach and the section ends by detailing the workshop phase of the project.

3.1 Aims and objectives

The aims of this project were to address the following research questions:

Primary research question:

How do clinical directors and service managers from non-clinical backgrounds interpret and enact their roles and use them to implement service change? [Where enactment is defined as the activities, tasks and decisions, which are actually undertaken by the role holder in the organisational context.]

Secondary research question:

Beyond role interpretation and enactment, what additional factors account for individual or organisational differences in the effectiveness of change implementation?

This bid addressed a number of the core questions set out in the initial SDO call for proposals. As mentioned above, the primary focus of the research was to explore the defined roles of clinical managers and managers from non-clinical backgrounds (i.e. general managers) and to examine the manner in which those roles are interpreted and enacted in the context of change implementation. Recognising that 'effective' change management remains poorly understood, we utilised an exploratory approach, which enabled us to examine the enactment of these roles within given situations, and compare data. The context is an important component and we carefully selected contexts in relation to key components of the *NHS Plan*. This will be explained in further detail later in this section of the report. This research provides:

- a current comparison of the prescribed and locally enacted roles and responsibilities of clinical and non-clinical managers in the acute and primary health care sectors and their relations with each other and with key external others
- an analysis of the similarities and differences in the factors which contribute to effective change management by clinical managers and non-clinical managers

- evidence on how clinical managerial roles are being reshaped and redefined by current developments
- explication and delineation of 'effective' change management in a professionalised organisation.

This research builds on prior research on the construction and enactment of the roles of hybrid, clinical managers in the NHS (Harwood and Boufford, 1993; Buchanan *et al.*, 1997; Fitzgerald, 1994; Fitzgerald and Dufour, 1997; Marnoch, 1996; Thorne, 2000). The construction of clinical director roles within the acute sector, and more recently the primary care sector, is a significant development over the last decade. Issues emerging from this research include the nature of power and the extent of legitimate autonomy; demarcation between professions and the colonisation of key roles by doctors. Problematic relationships between clinical managers and colleagues who are peers, emerges as one area for further investigation (Fitzgerald, 1994; Montgomery, 1990; Thorne, 2000). Some of these issues mirror research in other health care systems outside the UK (Denis *et al.*, 1999; Hoff and McCaffrey, 1996). Montgomery's (1990) work raises the interesting question of whether such hybrid roles are becoming isolated and institutionalised.

This literature also highlights many important, pragmatic issues. These include the extent of managerial knowledge and the managerial training of clinical professionals; the part-time nature of clinical management roles; the appropriate structures to support clinical management in different specialisms and in different organisational contexts and the definition of the roles of supporting general managers.

3.2 Research approach: comparative case studies

On the basis of the nature of the aforementioned aims and objectives, the approach employed was a predominantly qualitative one, comparing across multiple sites (or cases). Qualitative methods are typically utilised in case study research because of the nature of the 'how' and 'why' questions under consideration and the need to thoroughly explore concepts in-depth (Yin, 1994). Yin suggests that discovery should occur through the research process, rather than following a rigid design – however, bias and selectivity need to be avoided.

Yin (1999) also suggests that case studies are particularly suited to the complex nature of health service systems, which are characterised by continual and rapid change. Pettigrew *et al.*'s (1992) use of comparative case studies in analysing organisational change in the NHS, allowed for the analysis of retrospective change, real time analysis and prospective or anticipated change. We learn from singular cases by comparing them to other cases (Stake, 2000).

A comparative case study design was used to facilitate the construction of a large-scale database with both internal and external validity (Eisenhardt, 1989; Langley, 1999). Both these authors argue that with sets of eight to ten cases, one can generate low level patterns and develop generalisations. The approach adopted was an inductive one, since there were some indicators of the characteristics of 'effective' change management within complex health and social care settings, but these data were embryonic and fragmented. With such a small foundation of prior research, it was inappropriate to attempt a quasi-experimental design.

While we adopted an overall inductive design, the cases were purposefully selected. Since theoretically, it is known that context is an important factor in our understanding of effective change management (Kimberly, 1981; Van de Ven *et al.*, 1999), the contextual frames of the fieldwork were also purposefully selected. Firstly, we took into account the degree of complexity within the context and devised site selection criteria, which enabled us to select specific sites against these criteria (these criteria are discussed further below). Secondly, we examined the *NHS Plan* and the priorities, which were laid out in this plan. As a result, our research design focused on three areas of clinical care, which were critical to the effective implementation of the changes set out in the *NHS Plan*. These clinical areas were cancer care in the acute/tertiary care sector; maternity care in the acute/community care sector and diabetes care in primary care. The design deliberately incorporated specialities in which the targets set in the *NHS Plan* were creating pressures for change, which could broadly be defined along three different dimensions, all of which were captured in our design. These are clinically-led change; resource-led change and organisationally-led change. Selection across this spectrum allowed the researchers to investigate the interplay of contextual variation and internal role and relationship characteristics. The indications are that higher levels of complexity affect the required skill levels and influence the capacity necessary to generate a receptive context for change (Pettigrew *et al.*, 1992).

3.2.1 Case study selection

Eleven cases were ultimately selected, six from the acute sector (cancer or maternity) and five from the primary care sector (diabetes). Cases were purposefully selected. The overarching aim was to study role relationships at sites of varying levels of complexity. However, there are multiple drivers of complexity and establishing accurate and unambiguous measures for many of those drivers was complicated, and some displayed levels of high instability.

In order to accomplish the site selection process, we decided to use factual, but proxy data for complexity as the first stage filter. These are set out below and included the Jarman index (an index of deprivation), for which data was more readily available. We built extensive candidate lists of potential sites in the Midlands and London

region in acute and primary care, based on these data only. We then undertook a secondary screening process, which proved more difficult. We considered other potential drivers of complexity, focusing especially on factors which might create demand on managers. Again, the list of factors considered is set out in the next paragraph. However, in retrospect, it is evident that these drivers are highly unstable. One example of this would be financial deficit, where a site might be in a sound financial position at the start of the study, and be judged of 'lower' complexity on this dimension as a result, but fall into deficit during the course of the study. The secondary site selection factors or potential complexity drivers were viewed as a total candidate list and we then searched for sites which had several, but not all of the dimensions for the 'complex' category of sites. The 'lower complexity' sites, by contrast, had fewer of these characteristics.

Site selection was thus based on a two-stage process. First, relatively stable and clearly operationalisable criteria were deployed:

- i the Jarman index and predicted workforce shortages for primary care organisations
- ii the scale, the number of sites and whether it was a tertiary referral centre for secondary care organisations.

These heuristic criteria served as a proxy for other potential complexity drivers. A PCT operating in an area with relatively high deprivation levels and workforce shortages could be expected to display more organisational complexities than one operating in an area of little deprivation. A large-scale acute trust operating as a tertiary referral centre, from three or more sites could be expected to display more organisational complexity than one operating on a single site. Second, having first identified potential research sites on those criteria, secondary site selection justification was based on consideration of a number of other potential complexity drivers. These included: recent senior management team changes; recent or current merger activity; current financial deficit; major restructuring/service reconfiguration; named as underperforming; major workforce shortages; pilot site for one or more *NHS Plan* initiatives. Site selection was thus based on an informed judgement, taking a number of factors into account in a systematic manner. The complexity drivers identified as 'secondary' in this approach may of course be highly significant within the organisations under analysis, and these are factors which attracted focused attention during data collection.

On the basis of this selection process, this study analysed 11 case study sites, across the three different clinical areas identified. For pragmatic reasons, the selection of cases was initially narrowed to a broad geographical area of London and the Midlands, to correspond with the general localities of the research team. There was then a more detailed consideration of the previously-mentioned complexity drivers, in contrast to the characteristics of institutions within the specified geographical areas. A final selection process was undertaken,

where sites were chosen to represent opposite extremes on the complexity criteria. The principle investigators made contact with each of the selected sites and established their interest in participating in the research. In two cases, members of the research team had had some contacts at the proposed sites and these representatives were contacted in the first instance. In all other cases, site contact was established through the research and development (R&D) director or similar and access was gradually negotiated. There were no case study sites that refused to participate. In the case of one of the studied diabetes cases, the PCT approached the research team with an interest in participating as a case study site. This represents an additional case to the proposed ten case study methodology. Table 1 provides a list of the final 11 sites under the chosen clinical areas.

Table 1 Case study sites by clinical care group

Cancer care in acute care:

Higher complexity : one acute trust in London

Lower complexity: two acute trusts - one in Midlands and one in London

Maternity care in acute/community care:

Higher complexity: two acute trusts - one in Midlands and one in London

Lower complexity: one acute trust in Midlands

Diabetes care in primary care

Higher complexity : two PCTs - one in Midlands and one in London

Lower complexity : two PCTs - one in Midlands and one in London

Self-selected : one PCT, in Midlands/North

3.2.2 Tracer issues

Pettigrew *et al.* (1992) suggest that the first step in beginning data analysis should be to choose the key dimensions under consideration. However, this study utilised a much more emergent and individualised approach to identifying these specific 'tracers' (or dimensions). Tracer issues were identified as significant service improvement initiatives enacted within the particular clinical area selected. Each case study site was found to be focusing on different service improvement initiatives, and as such the tracer issue (or issues) that were analysed differed for each case study site, but all pertained to changes in the particular identified clinical area. Details of the tracer issues under investigation in each case study site will be explored in more detail later in the report.

3.2.3 Approach to data collection

Using multiple data sources, or 'triangulation', is an important method to generate complex theory and strengthen the empirical grounding of research. Stake (2000) proposes that these multiple perceptions

clarify meaning and verify repeatability of an observation or interpretation. Three methods were utilised to gather data necessary for this analysis:

- 1 semi-structured interviews
- 2 document analysis
- 3 observation at meetings.

These multiple data sources addressed a wide range of issues and provided a more convincing and accurate contextual account.

Detailed stages of data collection

Because of the scale of the work and the need for ongoing analysis, the data collection was approached in stages, allowing the accumulation of data within care groups.

The data collection stages are outlined below:

- Stage 1: Baseline data (in stages, five to six sites at a time).
- Stage 2: Qualitative data collection; construction of case study.
- Stage 3: Interim analysis begins.
- Stage 4: Preparation of case reports; analysis of comparative data, by care group.
- Stage 5: Preparation for feedback workshops with user groups and advocacy groups; feedback and dissemination workshops.
- Stage 6: Collation of data from the feedback at the workshops; final analysis and review of cross case comparisons.

The three main sources of data were:

i) Semi-structured interviews

As a means of not limiting the research participants to pre-defined categories of investigation, and to produce codable data, semi-structured interviews were used. In order to understand complex issues, it was important to be able to fully explore a topic with the participants. Semi-structured interviews were favoured, as this allowed for more flexibility and interpretation. Appendix 1 details the spine of interview questions.

Semi-structured interviews formed the basis for the majority of the data collection in this study and were conducted with 175 representatives across all the 11 case studies. These representatives were from primary, secondary and tertiary care organisations, PCTs, SHAs and the network management teams. Table 2 provides a breakdown of the number of interviews by case study site and professional categorisation. Appendix 2 provides a full list of all interviewees. In some cases, there is variance between case study sites in the number of interviewees and this reflects low representation within this site and negative responses from some of those who were approached. For instance, there were a greater

proportion of non-respondents (approximately 30%) at the Diabetes 4 and Cancer 2 sites. In these cases, the researchers relied more heavily on observational and documentary data sources. Overall, an average of 77% of those who were approached agreed to be interviewed across the 11 case study sites. Each interview lasted for approximately one hour.

Table 2 Interviewees by case study site and professional group

Case study site	Managerial	Clinical	Hybrid	Total
<i>Cancer</i>				
Cancer 1	9	1	6	16
Cancer 2	6	1	6	13
Cancer 3	11	2	5	18
<i>Maternity</i>				
Maternity 1	4	3	8	15
Maternity 2	6	5	5	16
Maternity 3	10	2	5	17
<i>Diabetes</i>				
Diabetes 1	6	4	6	16
Diabetes 2	8	0	9	17
Diabetes 3	9	7	4	20
Diabetes 4	4	0	8	12
Diabetes 5	6	2	7	15
Total	78	27	69	175

Document analysis

Key organisational documents, such as meeting minutes and terms of reference, strategic planning documents, discussion papers and job descriptions, were analysed to provide a historical narrative of organisational context and a textual indication of the tracer issues and role interpretation. It was also important to utilise this documentary information to corroborate that collected through interview and observational methods.

Observation at meetings

Thirty-five meetings were attended across the 11 case study sites to gain further insight into role enactment, relationships between professionals and the tracer issues, and to provide further support for the interview and documentary data collected. Table 3 details the range of meetings that were attended. As with the interviews, the variance in the number of meetings attended reflects the disparate focus of each of the sites. Meeting notes were taken regarding the content of the interactions, in conjunction with observations of group

dynamics, decision-making, attendance and the time devoted to particular agenda items. Observation provided a more 'authentic' image of group dynamics, which was likely to be different than behaviour observed in one-on-one interviews (Pettigrew *et al.*, 1992). Further, observation at meetings was used to identify key network stakeholders, who were then approached for interview.

Table 3 Meetings attended across all case study sites

Meeting	Occasions
<i>Cancer</i>	
Trust cancer management meeting	5
Network urology meeting	3
Network board meeting	3
<i>Maternity</i>	
Trust maternity liaison meeting	3
Trust maternity risk management meeting	1
Trust women and maternity directorate meeting	4
<i>Diabetes</i>	
PCT diabetes priority action group meeting	4
PCT professional executive committee (PEC) meeting	5
PCT board meeting	5
Clinical governance and risk committee	1
BLODSAG (local diabetics working party)	1
<i>Total</i>	<i>35</i>

Workshop phase

Data verification and action planning

A number of workshops were conducted, both within and across the care groups studied. These workshops served two key purposes. Firstly, they acted as a final and important stage of data verification and collection, testing data for face validity, with a wider audience than the research subjects. Secondly, their purpose was action orientated and they engaged health care staff and users in proposing responses to the issues raised. These workshops provided an opportunity to feed back the findings of the research to the research participants and to wider clinical, managerial and policy communities. In order to fulfil these objectives, we designed the workshops specifically to engage with user groups/advocacy groups, (as proposed in the protocol). In some instances, we discussed the design options prior to the workshops with user representatives, as well as inviting users to attend the workshops. We also targeted a range of national conferences, with clinical, managerial and user representatives in the

audiences, in order to create debate on the findings. All of the workshops entailed a detailed, but customised overview of the research findings, built around five core themes:

- the impact of context on change processes
- change leaders in clinical service improvement
- capacity and training
- relationships between managers and professionals
- managing change through networks.

The workshops were all interactive and to use the time effectively, workshop participants were asked to discuss a range of particular posed questions in sub-groups and report back to the wider group. A sample list of these questions is provided in Appendix 3. The findings presented at all of these workshops were extremely well-received, and validated as representing a 'familiar' picture to the workshop participants. Appendix 4 illustrates some of the participants views on changes and improvements required. Positive feedback was received from these workshops, including invitations to submit articles to journals, based on the presentations.

The responses and emergent discussions in the workshops most significantly acted as further data that was ultimately collated and analysed. These data related particularly to the proposals for action, detailed later in this report. The discussions at each workshop produced further proposals for action that were then presented and validated at subsequent workshops. The researchers have, so far, conducted or contributed to eleven site-specific, regional and national workshops, with one further one planned. We also intend to disseminate our findings by presenting at a number of academic conferences which are detailed in Section 7. Table 4 provides a list of all the workshops that were conducted.

Table 4 Local, regional and national workshops

Local site feedback (*individualised feedback was offered to each site*)

Acute cancer trust

Three PCTs

Regional workshops

Diabetes – Midlands

Cancer – London

Maternity – Midlands / London (combined) – still under planning.

National conferences

SDO Programme national conference, April 2004

British Association of Medical Managers, May 2005

NHS Confederation, June 2005

SDO Commissioning Board, June 2005

Cancer Network Development Programme, July 2004

British Academy of Management, September 2005

3.2.4 Ethics

We were particularly conscious of research ethics in conducting this study. It is a requirement of all research involving NHS patients or staff that ethics approval is granted through their associated research ethics committee. National multi-site ethical approval for this study was granted.

In practice, there were two ethical issues of particular importance – informed consent and confidentiality. Each interviewee signed a consent form acknowledging that they were sufficiently informed about the nature of the research and the interview specifically, they consented to being tape-recorded and that they had been informed that they could withdraw from the study at any time. Secondly, the confidentiality of all research material gathered was assured. Each transcript was assigned with a code that related to the case study site, researcher, transcript number and date of interview (for example SDOBRERA01_120404). Case study reports and data reported at the study workshops were all anonymised. Tapes and their transcripts were all stored in a locked filing cabinet at DeMontfort University and Royal Holloway College, and electronic files were password protected.

3.2.5 Approach to data analysis

Coding was the initial stage of data analysis. All of the primary data collected – interview transcripts and observational notes – were coded using the NVivo software package (QSR International). The research team collectively identified a range of pre-formulated codes, on the basis of the original research questions outlined in the initial research

proposal and the subsequent themes for analysis. These analytic themes were reflected in the interview questions (see Appendix 1), and the initial coding framework generally followed this structure. For example, question one of the interview schedule (What positions do you currently hold in the trust?) was coded as 'role definition' and again responses were coded separately depending on the professional designation of the respondent – clinical, managerial or hybrid. The coding framework was then developed collaboratively between the principle investigators and the two project researchers, maintaining an awareness of the initial research questions and intention of the overall study. The two researchers were then responsible for coding the data from the 11 case studies, with a continual, iterative discussion regarding the coding framework. The researchers who were coding the data were aware of emergent themes, which were noted. These were then discussed by the whole research team at regular team meetings and provided inductively developed codes. The coding framework was thus elaborated and extended. The data coding process continued throughout data collection and analysis, until the final research findings were derived.

Following this coding process, the data was then organised and compressed to draw broad conclusions regarding the research findings. This process then formed the basis for detailed, individual case studies that have been continually developed on the basis of cumulative data collection and emergent themes.

The final stage in the data analysis process was conclusion drawing and verification. Through an iterative process of data coding, final conclusions developed and became more explicit. As mentioned previously, data was verified through discussions at the various workshops that were conducted and also through discussions of the coding framework between members of the research team.

The 11 individual case study reports were then integrated to provide in-depth, comparative case studies across the identified clinical areas. This final report presents the research findings on the basis of these comparative analyses. This is evidently a more structured approach than other qualitative modes of analysis – for example ethnography, which follows a more inductive approach allowing themes to emerge from the data. The structured approach utilised here, based on Miles and Huberman's (1994) approach to qualitative data analysis, was deliberately chosen to assist in demonstrating transparent data analysis and extracting valid findings and proposals from a large volume of data. This was especially important in assuring a structured approach to data analysis between different researchers. Although there is a danger with such a structured approach of 'losing' data which does not fit with the pre-formulated codes, the researchers who were coding the data remained open to emergent themes which were immediately discussed between the two researchers and the principle investigators and added to the coding framework.

Section 4 Comparative analysis of cancer case study sites

This section, and the two which follow it, cover the main empirical findings from the research project. The intention is to provide the reader with a presentation of the data and with preliminary analysis across the cases within each care group. Each of these care groups are covered in turn, starting with the three cancer cases in this section. These are followed by an examination and analysis of the three maternity cases (Section 5). In Section 6 we present the five diabetes cases. In order to aid the reader, each group of cases is presented in a similar form and sequence. After the presentation of each of the sets of data on cancer, maternity and diabetes respectively, we draw out the preliminary themes which have emerged from this particular set. Overall themes across all the cases are presented in Section 7.

4.1 National policy context: cancer

This section considers the national policy context relating to cancer services in the UK.

4.1.1 Cancer services in the UK: the development of managed clinical networks

During the mid 1990s, there was a shift towards more network-based models of management in cancer services in the UK, predating the abandonment of the internal market in 1997. At the time, survival rates for many major cancers were poorer than the rest of Europe and there was significant variation in access to treatment and care across the country (National Health Service, 2000). Traditional referral patterns have historically worked well for individual patients but not for providing equitable services for the entire population (Baker and Lorimer, 2000). Cancer represents a clinical condition that required patients to move across organisational and professional boundaries. The ethos of the modernisation agenda indicated that professional and managerial co-operation across these boundaries was necessary to lessen the 'postcode lottery' of care. Co-ordination was to be based on co-operative agreement rather than hierarchical structure, with contracts replacing command as the mode of co-ordination (Ferlie and Pettigrew, 1996).

The Calman-Hine report (1995) was a significant precursor to these developments in cancer care, and proposed the initiation of service improvements through a process of organisational and cultural change. The report proposed that cancer centres and units of primary

care teams should work in partnership, through a network organisational form, to provide patient care at the most appropriate level. This was consistent with the way that some health professionals in the UK were already operating, but traditionally in a more informal and less multi-disciplinary way. The report recommended local level changes in cancer services in England and Wales and made specific recommendations on three levels of care:

- 1 Primary care: this was to be the central focus of attention. Primary care was to be responsible for referral and follow-up, to ensure best outcomes.
- 2 Designated cancer units in district hospitals to support clinical teams to focus on more common forms of cancer.
- 3 Designated cancer centres providing expertise in the management of all cancers, to offer specialist diagnostic and therapeutic techniques.

At the time of its publication, the Calman-Hine report was radical, suggesting that managerial and clinical relationships develop across and within organisational boundaries, promoting both vertical and horizontal integration. The report was published prior to the election of New Labour and was the first step away from the internal market model, towards a more collaborative framework and the ultimate development of managed cancer networks. The report recognised the importance of building on pre-existing patterns of referral and care and downplayed the role of managers in the reconfiguration.

Managed cancer networks comprise 'linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner, unconstrained by existing professional (and organisational) boundaries to ensure equitable provision of high quality effective services' (Edwards, 2002: 63). The Calman-Hine report saw managed cancer networks as an opportunity to foster the flow of knowledge and clinical expertise across organisational and professional boundaries, in contrast to the competitive pressures engendered by the internal market in health care. It was hoped that the networks would diffuse evidence based and 'good practice' forms of treatment.

In 2000, the *Cancer Plan* was published as a derivative of the *NHS Plan* and focused on improving prevention, acting on health inequalities, earlier detection, faster diagnosis and treatment, providing consistent high quality services, and improving quality of life through better care. The *Cancer Plan* did not dictate a specific network management structure, but did favour networks more generally as an organisational form. As such, these networks initially developed in different ways according to local personalities and needs. The Department of Health were not averse to this divergence as the managed cancer networks were still learning the best ways of working. However, shortly afterwards the *Manual of Cancer Services Standards* (NHS Executive 2000: 9) outlined the national standards for

cancer care in England, on which managed cancer networks were required to deliver – demonstrating a high degree of performance management. The standards were based on recommendations of the Calman-Hine report and primarily focused on the development of specialist multi-disciplinary teams, education, training and continuous professional development, and communication between primary, secondary and tertiary sectors. The manual most fundamentally mandated the appointment of network management teams. These teams are comprised of a number of core staff, largely independent of the member organisations, who are to ‘develop and implement the strategy for the network in line with national policy’. Adherence to these standards is monitored through a formal peer review process. Alongside these developing networks, a separate service improvement programme was also being implemented across cancer services in the UK and represents an early attempt at formalised service improvement in cancer services.

4.1.2 Service improvement in cancer

The Cancer Services Collaborative was first led by the National Patients’ Access Team, and subsequently the NHS Modernisation Agency, formed in 2001 (Cancer Services Collaborative, 2003). This initiative was the first attempt to introduce a collaborative service redesign and improvement approach to the NHS, and was an adaptation of the American Institute of Healthcare Improvement ‘breakthrough’ methodology, which aims to share learning from continuous improvement across a network of services and professionals. The emphasis is on clinical leadership, multidisciplinary working, and on exploring the process of care across traditional organisational and professional boundaries. In 1999, nine pilot collaboratives were developed across England and Wales (bounded approximately by the same geographical areas as the managed cancer networks) and focused on five cancer types – breast, lung, ovarian, prostate and colorectal. The aim of the collaboratives was to make localised improvements in the delivery of cancer services on the basis of the targets laid out in the *Cancer Plan* and to gather managers and professionals together to review the system of care (Modernisation Agency, 2002a). The original handbook (National Patient Access team, 1999) explains that the goals of the collaboratives would be achieved by:

- providing certainty and choice for patients across the process of care
- predicting patient requirements and pre-planning and pre-scheduling their care at times that suit them
- reducing unnecessary delays and restrictions on access
- improving patient and carer satisfaction by providing a personalised, consistent service

- ensuring patients receive the best care, in the best place, by the best person or team.

These laudable but imprecise goals (ensuring, improving, reducing, predicting, providing) were given significantly increased precision and clarity by the series of targets specified in the *NHS Plan* and the *Cancer Plan*. The main targets identified at that time were:

- by December 2000 all urgent referrals with suspected cancer to be seen within two weeks
- maximum one month wait from diagnosis to treatment for breast cancer by December 2001.
- maximum one month wait from urgent referral to treatment for children's cancer, testicular cancer and acute leukaemia by December 2001
- maximum two month wait from urgent GP referral to treatment for breast cancer by December 2002
- every patient with a diagnosed cancer to have pre-planned and pre-booked care by December 2004
- maximum two month wait from urgent GP referral to treatment for all cancers by December 2005
- maximum one month wait from diagnosis to treatment for all cancers by December 2005.

The Cancer Services Collaborative programme moved into its second phase in 2001 and spread to include all 34 cancer networks in England. At this stage, the NHS Modernisation Agency (2002b: 2) reported that clinical engagement and multiple agendas were the most significant challenges for the collaboratives, which had different priorities to trust personnel. At the time it was reported that 'middle managers had not been fully engaged in the initiatives and only a few organisations have widely adopted improvement methodology'.

In 2003, the programme entered its third and current phase and was re-branded as the Service Improvement Programme. Its boundaries are now officially designated by the managed cancer network; a service improvement lead has been appointed to each network management team and its agenda now covers all types of cancer. The objective of the third phase is to move from a centrally-driven programme, 'to service improvement which is locally owned and driven but supported from the Modernisation Agency' (Cancer Services Collaborative, 2003: 3).

Throughout phase three, there has been a return to the format of phase one, where specific service improvement initiatives are co-ordinated within individual trusts, rather than across each network. Although the service improvement lead posts form part of the core network management teams, service improvement activities are not incorporated in the primary managed cancer network remit, are not funded through network-based cancer service commissioning and are not necessarily multi-disciplinary or interorganisational. A service

improvement 'facilitator' is appointed to each trust and the service improvement lead is responsible for co-ordinating the activities of each of the facilitators – although they are line-managed through their individual institutions. The 'network' aspect of service improvement and knowledge sharing has been largely removed and re-subsumed within the organisational boundaries of individual trusts. The development of the Cancer Services Collaborative and Service Improvement Programme initiatives represented an initial move towards service improvement across organisational boundaries (which was not entirely successful), and more recently a return to a traditional hierarchical representation, restricted within organisational boundaries.

4.1.3 Current reflections on the Modernisation Agenda

The NHS Confederation (2001) consider that it is important that managed cancer networks demonstrate characteristics of organic development – bottom-up and participative decision-making and local autonomy. This requires considerable resources and investment in communication. To create a formal, focused and successful network, member organisations need to develop shared values, objectives and rules for behaviour. Managed cancer networks are different than policy networks, where actors co-exist but are not performance managed. Central government retains a directive role in relation to the development and function of the managed cancer network. These networks are created and managed from above, with few organic or emergent components.

The Commission for Healthcare Improvement and the Audit Commission (2001) assessed the implementation of the recommendations of the Calman-Hine report and concluded that although there have been significant changes to practice, progress has been inconsistent and there is still much room for improvement. The report proposed that cancer services in the UK were not yet fully patient-centred, professionals were not operating in a completely multi-disciplinary manner and the service lacked a broad level focus. While there was some evidence of interclinician co-operation, management did not tend to transcend traditional ways of operating. From the networks considered, the report found that real progress had occurred in networks where local professionals had been involved in the development process, while there was less success with a more directive approach. This provides further evidence to suggest that organic, rather than managed, network development may be more successful for sustaining significant service improvement. Within the NHS, there has been limited historical evidence of organisations working together towards a common goal. Supporting clinicians and organisations to work together may be one of the most important methods of achieving an effective cancer network. The report concluded by calling for more knowledge about the operation of

managed cancer networks and recommended that further research be conducted in this area.

This network model should represent a major transition from traditional top-down approaches, to a more local, self-regulating model. However, although the NHS experiments with decentralisation, it typically reverts to top-down models (Kewell *et al.*, 2002). Since their inception, managed cancer networks have evolved to become more managerialised, formal and structured. Prevailing competition for resources has ensured that the focus on sharing knowledge has been marginalised. Despite the modernisation intention of decentralised accountability, managed cancer networks have ultimately not been delegated with any budgetary or governing responsibilities. Networks are increasingly required to relate to PCTs for service commissioning and to SHAs for performance management.

An emerging issue is that of private sector provision of cancer services in London. The private sector has ultimately been marginalised in the evolution of managed cancer networks, despite the initial intention of the *Cancer Plan*. However, more recently this has been highlighted as a significant limitation by those who advocate greater marketisation of cancer care: 'While other areas of care are benefiting from greater pluralism, cancer services are still in the era of complete NHS monopoly within which cancer networks are promoting cartels to block out competition' (Sikora *et al.*, 2005: 5). HCA International (part of the American managed care programme, HCA) is collaborating with London cancer service providers to develop a major private cancer network (the London Cancer Group) in the UK that would link to the NHS (Sikora and Bosanquet 2003). Despite recently recommending that 'within two years, 30 per cent of diagnostics, radiotherapy and chemotherapy should be outsourced to the independent sector' (Sikora *et al.*, 2005: 5), private sector provision is yet to make a significant impact on managed cancer networks. However, it is evident that there is a move towards greater collaboration with the private sector. Again, the impact of this private sector drive remains to be seen.

4.1.4 Conclusion

Cancer was the first managed network model to be established in the UK and was to be used as a prototype for the organisation of services in other clinical areas. This section has detailed the growth of managed cancer networks for cancer alongside other initiatives of the modernisation agenda, and most recently moves towards private sector cancer networks. Both managed cancer networks and the Service Improvement Programme in cancer were developed with the intention to streamline and standardise patient care, and provide a forum for the expansion of multi-disciplinary and interorganisational research and training.

An extensive range of national targets and treatment guidelines was established for the care of cancer patients. There was a national expectation that those targets, particularly with regard to the elapsed times between referral, diagnosis, and treatment, would be met, and that new organisational arrangements would contribute to significant improvements not only in waiting times, but also to clinical outcomes and the experience of care. Guidelines on treatment involved the establishment of cancer centres, where most surgery would be conducted, and cancer units, which were to become mainly diagnostic and referral centres, some of which could still provide some treatments. These changes were evidently policy-driven, and to a large degree imposed on the service, rather than originating with front line clinical or managerial staff, who nevertheless had to implement the required changes in a manner appropriate to local circumstances, and to monitor and report on the outcomes in line with performance targets.

4.2 Context: introduction to the cancer cases

The purpose of this section is to provide an analytic comparison of the three cancer case study sites. Table 5 presents an overview of each trust.

Table 5 Factual data on cancer sites

	Cancer 1	Cancer 2	Cancer 3
Established	1985	1999	1994
Population	203 000	500 000	250 000
Ethnic diversity	37.8%	48.0%	4.9%
Deprivation	Social deprivation	Social deprivation	Diverse
Urban/rural	Urban	Urban	Mixed
Star rating	3	1	2
Finance	£273 million	£321 million	£75 million
Number of staff	1905	4000	1800
Number of PCTs serving	1	2	2
Number of hospitals (providing cancer services)	1	3	1

This section will explore the impact of context on the roles and relationships within each trust and their influence on organisational change, and conclude by exploring how innovative organisational change has been hampered by consistent barriers across two of these organisations in particular. Firstly, the following section will provide a brief analytic commentary on each of the aforementioned individual

case studies, to be followed by the comparative analysis. Appendix 2 provides a list of all the interviewees from each trust and the roles they perform within their organisation.

4.2.1 Cancer 1 (NHS trust)

Cancer 1 is a single site, three star rated trust in an urban location. It is based within a highly deprived area, where the local population suffer poor health and the number of adult and infant deaths is significantly above the national average. The trust has recently been awarded foundation trust status, as part of the government's policy to raise standards across the NHS and to provide a service that is responsive to patient needs, fast, convenient and of a high quality. This acute trust forms part of the managed cancer network as a cancer unit, and along with two other trusts as the joint cancer centre. Within this trust hospital, cancer services are not considered to be one of the primary financial concerns, with the foundation process and the European working time directive consuming considerable attention.

Cancer (combined with palliative care) services fall under the directorate of surgery, anaesthesia and critical care, and are thus officially co-ordinated by the clinical director for this directorate. Along with cancer and palliative care, the other services co-ordinated by this directorate include:

- surgical wards
- intensive treatment unit and critical care services
- anaesthetics
- back pain service
- chronic pain and acute pain services
- general surgery
- ear, nose and throat services
- maxillofacial surgery
- plastic surgery
- podiatry
- trauma and orthopaedics
- urology
- operating theatres
- day surgery unit
- endoscopy services
- sterile supplies services.

As evidenced by this list of services, it would be easy for cancer services to be 'lost' within this broad and demanding directorate. This concern was indeed apparent from the data collected, where the relevant clinical director was consumed with the more administrative (rather than strategic) aspects of the directorate and where other executives were absorbed with the foundation trust bid. On a broader level, the trust was concentrated on large-scale organisational change while appearing to overlook the need for service improvement in specific internal departments, namely cancer services. The operational management of cancer services was instead co-ordinated by the combined team of the general manager for the directorate and the lead clinician for cancer.

The clinical director was unsure whether he wished to commit, longer term to following a managerial identity. Without any managerial responsibilities he feared that he would have no organisational influence. The clinical director joked that he had 'gone native' or 'crossed to the other side' – inferring that the clinical and managerial responsibilities are quite opposed. He believed that others perceived him as somebody to be suspicious of, however none of the other interviewees explicitly suggested this to be their perception. Rather, they rarely spoke of the clinical director having any direct relevance to the delivery of cancer services.

As represented in Table 2, there were six respondents from the Cancer 1 site (including the clinical director) who filled hybrid roles. Overall, these respondents were committed to continuing their careers as clinicians in the trust, however there was variability regarding their impressions of their managerial tasks and roles. Those in pure executive positions (for example director of nursing, chief executive) were more committed to following a managerial career, compared to those in hybrid positions who were more uncertain of their managerial future plans. The clinical lead for urology tended to shun any managerial responsibility and stated: 'I don't have any managerial accolades to say that I am a very good lead or anything.' As he was the more senior of two urological consultants at Cancer 1, he defaulted to the position of lead urologist. However, he was adamant that he was a 'mere component' of the urological service – an equal team player with a title of lead, but no formalised additional responsibility.

The lead clinician for cancer was more accepting of his managerial responsibilities, and considered his lead role to be to co-ordinate and control, and to ensure that the service was run according to the guidelines. However, he had no line management responsibilities and therefore could not 'tell anyone to do anything'. He considered this a barrier in being able to fulfil his control and co-ordination role effectively. In extreme situations, his way of working around this barrier was to approach the medical director and 'he would pick up the phone and things would happen'. Generally, if there were problems he would ask others – the medical director or cancer manager – to deal with the issue.

However, there was only limited attention given to strategic organisational change within cancer services, and even less so within urological cancer. This view was supported by those at the managed cancer network – there were no representatives from within the trust who could be described as active change leaders in cancer services, especially urological cancer services. The trust had been without a service improvement lead for a considerable time, and as such had not extended its focus beyond the common tumour areas that were part of the initial Cancer Services Collaborative programme. Since data collection concluded for this study at the trust, a service improvement

lead has been appointed and it remains to be seen how this will impact on organisational change in urological cancer services.

The urological consultants were typically reluctant to accept any unnecessary managerial or administrative responsibilities, with this reluctance extending to strategic organisational change more specifically. As mentioned, the lead clinician for cancer was more accepting of his managerial responsibilities, however this did not spread to an interest in change management. Interestingly, the lead cancer nurse at the trust mentioned that he had generated a number of service improvement ideas on the basis of his academic knowledge. In the interview, he spoke in great length about a number of these ideas. However, he also mentioned that 'it is not actually under my control' and this was further evidenced in the cancer services development group meetings whereby he did not feel that he had a receptive forum for articulating any of these ideas. These meetings instead concentrated on operational management and adherence to government performance targets. Along with an absence of active change leaders within cancer services, there was also no forum for communicating organisational change ideas. Where there were breaches in meeting performance targets, discussion centred on defensively justifying these breaches rather than on considered processual changes that may ensure that performance targets were met in the future.

As a young organisation, the trust appears to have been particularly successful in enacting large-scale change, such as the foundation trust bid and the European working time directive. However, cancer services – in particular urological cancer – had not received the same degree of attention.

Particularly in regard to urological cancer, this appears to be due to two factors. Firstly, this was partly due to the fact that cancer was 'hidden' within the surgical directorate and often ignored at an executive level. Secondly, it was also partly due to a lack of change leadership within the service. While cancer services were not receiving substantive attention from the trust, there was also nobody within the service that was attempting to rectify this situation and no forum for increasing communication in the area of change management.

There was very little professional commitment to change within urological cancer services. There was a preoccupation with clinical and operational activities, with very little emphasis on strategic service improvement. As mentioned previously, the lead nurse for cancer was the only interviewee who spoke in detail of service improvement ideas. However, at the cancer services development group meetings there was no forum for him to articulate any of these ideas.

As the managed cancer network was beginning to focus on the structural reconfiguration of urological cancer services in accordance with the NICE guidelines (2002), the trust will be required to devote more attention to this issue. At the time of data collection there was

no clear understanding of where urological cancer services would be centralised. The message from the managed cancer network was that urologists at this trust had not been particularly proactive regarding organisational change. If this pattern continues during the reconfiguration process, the trust is likely to miss an opportunity to lead in a meaningful way on urological cancer for the managed cancer network.

4.2.2 Cancer 2 (NHS trust)

This trust incorporates three hospitals in a large urban setting. Two hospitals are on the same physical site and one is remote at a distance of several miles away. The trust has recently been judged as a two star rated trust, after previously being downgraded to one star, partly because of poor cancer waiting times – only 65 per cent of urgent referrals were being seen within two weeks, as opposed to the target of 100 per cent. More funding was then allocated to improving cancer services at the trust.

Most of the interviewees were based at the central site, rather than the remote satellite hospital. Many of those interviewed – especially hybrid or managerial representatives – discussed the poor relationship between the trust hospitals. While two of the hospitals are on the same site one of these has its own management team, and is thus not directly involved in the administrative relationship between the remaining two. However these two hospitals are physically distanced from each other. Since the merger of the two hospitals in 1999, relationships between individuals at the two sites have reportedly improved considerably, however senior level personnel are generally based at the central site and do not have as much day-to-day contact with representatives from the satellite hospital. Many executive and managerial interviewees had office space at this satellite hospital, however did not utilise this very much. Although relationships have improved, many felt that there was still a long way to go and many individuals' 'hearts aren't in it'.

In 1999, the trust opened an ambulatory care and diagnostic centre on the satellite hospital site. The next phase is the development of emergency, inpatient and outpatient services as part of a major emergency care and diagnostic development – a major private finance initiative to provide a network of care. This will include accident and emergency (A&E), critical care, major elective, emergency inpatient, intermediate, and outpatient services. This initiative represents a major change for the region both in terms of structure and process and is taking up considerable time and energy for the trust, the two associated PCTs and the SHA.

Cancer 2 is part of the cancer network as a cancer unit, with another trust as the cancer centre and seven other cancer units extending across the region. Our research site, Cancer 2 was collaborating with another local hospital to become a centre for the provision of

urological cancer services for the network. The decision had recently been made for the network to incorporate three urological cancer centres. Our research site trust with its collaborator would form the 'hub' for the outer region of the managed cancer network.

Cancer services at Cancer 2 also fell under the surgical directorate, with the clinical director of the directorate describing her role as the 'interface between professional managers and my clinical colleagues'. She had been determined to maintain a clinical caseload in her position as a vascular surgeon. The clinical director tended to focus on general surgical issues, and took an overview of cancer services, without becoming directly involved. While the clinical director focused more on general surgical issues, the general manager for cancer appeared to concentrate more specifically on cancer-related issues. The lead urological consultant described his role as purely clinical. The clinical director was aware of the current relationship problems in urological cancer at Cancer 2, but considered herself to be a last resort in dealing with matters directly. Very few interviewees referred to the clinical director as significant in relation to cancer services, however those that did discuss the role more generally repeated the sentiment of the clinical director – that the position is operational, rather than focused on service improvement or organisational change.

At the time of the merger between the two hospitals, the more experienced urologists resigned from the trust. Executive level interviewees suggested that the urology consultants at Cancer 2 at the time of the fieldwork were 'younger', had not formed cohesively as a team and lacked clinical leadership. Executives at the trust had therefore developed links with another local hospital, which they hoped would provide some of the clinical leadership that was lacking in urological services at Cancer 2. As a result of this collaboration it had been agreed that jointly, these two trusts would become a cancer centre for urological services.

The urology consultants at Cancer 2 were described by other representatives as not fully engaged in service improvement, the network or in the management of the urology service. It was felt that the urology consultants did not communicate, and there was no commitment to improving their service. One interviewee felt that if there was a choice between Cancer 2 and another trust in the network becoming a cancer centre for urology, Cancer 2 would be the site to retreat because the 'consultants can't hack it'. No urology consultants attended any of the trust or managed cancer network meetings that were observed. Instead the lead urologist from the local collaborator hospital led the service reconfiguration change process.

The clinical director did not intend to continue her managerial role into the future, but was committed to resuming her clinical career as a vascular surgeon. Similar to the Cancer 1 case study, those in executive positions were more committed to a managerial identity

while those in hybrid or clinical positions at Cancer 2 were less aligned to managerial agendas.

Although mentioning that her role was difficult to 'pin down to anything in particular', the clinical director went on to describe her role as the 'interface between professional managers and my clinical colleagues'. Before coming into the role, the clinical director was wary that her clinical colleagues would be distrustful of her in her new managerial capacity – reflecting the sentiment of the clinical director at the Cancer 1 site. However, in practice this has not shown to be the case. The clinical director addressed her role as representing her clinical colleagues to management and found this approach to be successful in maintaining trust.

In a practical sense, the role was not considered by the clinical director to be strategic or change-oriented, but she focused more on appraisal, troubleshooting and discipline –HR issues rather than strategic direction or change management. As mentioned previously, others also largely saw the clinical director role as operational. The lead clinician for urology considered the clinical manager position to be more managerial than clinical, and to take the side of management over their clinical colleagues.

Overall, there were six individuals at Cancer 2 who filled hybrid positions, incorporating clinical and managerial responsibilities. Other than the clinical director, two of these were based at the acute trust (the other three being based at the PCT and the managed cancer network). The medical director was another interviewee who could be described as fulfilling a hybrid role, however he no longer had clinical responsibilities. The medical director considered his role to be extremely broad, and to be related to quality of care, clinical governance, appraisal, strategic service improvement and education. The medical director chaired the cancer management meeting and therefore concluded that, by default, 'I guess I am officially the lead cancer clinician then'.

The other role that could be described as a hybrid was the urology nurse practitioner. She had no direct managerial responsibilities, with nobody within the organisation accountable to her. However, she was the most senior urology nurse at Cancer 2 and her role was quite varied between clinical work, patient education and staff training. The urology nurse practitioner increasingly focused on managerial responsibilities. Prior to taking on the role of nurse practitioner, she was a senior nurse and not 'too worried about management and trying to remember "oh, I have got to go to this meeting", or trying to meet up, or do the networking with all these... as we say 'management people''. The urology nurse practitioner considered the greatest change to her role to be that she had to find free time to attend particular meetings.

Despite a lack of clinical leadership in the development of the proposal, Cancer 2 had been successful in becoming part of a cancer

centre for the provision of specialist urological cancer services for the managed cancer network. Cancer 2 staff had not been particularly proactive in enacting large-scale change in cancer services. This can be partly attributed again to limited clinical leadership, and limited investment from senior or executive level representatives. This may further be because cancer services are 'hidden' within the surgical directorate.

Due to the lack of commitment and leadership of urology clinicians, there had been limited service improvement changes in urological cancer at this trust. For instance, the Service Improvement Programme was attempting to develop a patient information leaflet regarding transrectal ultrasound guided biopsy. At the time of data collection, those leading on the development of the leaflet had been waiting for the necessary information from the urology clinicians for nine months. Waiting times for these biopsies is a problem at one hospital in particular and reflects the lack of initiative on behalf of the urology clinicians. For example, at this particular hospital, there was a 12-week wait, while the satellite hospital had greater capacity. The trust decided that, on alternative weeks, all patients from the central hospital site would attend the satellite hospital site for their biopsies. This was working well and the waiting time at the central site was reduced to six weeks and was continuing to decrease. The radiologist at the satellite hospital site then left the position and had not been replaced. Therefore the arrangement ceased and waiting times for the biopsies at the central site increased again to 16 weeks. The lead urology consultant has been asked by the medical director to produce an action plan for tackling poor waiting times, however he either did not attend the cancer management meetings to present any information, or had not produced an action plan when asked to. Further, it was suggested that the radiologist left the satellite hospital site partly because of poor treatment by clinicians from the central site.

The resistance and what could be described as poor 'attitude', of urology clinicians obstructed some service improvement changes at Cancer 2. In particular in relation to transrectal ultrasound guided biopsies, the negative behaviour of clinicians had been partly attributed to the abandonment of attempts to implement change. Trust executives were aware of these interpersonal issues but appeared, however, to be reluctant to address them in light of the higher-level organisational and structural changes that were occurring, such as the ambulatory care development.

4.2.3 Cancer 3 (NHS trust)

Cancer 3 is an acute district general hospital on the fringe of a medium-sized city, providing a full range of elective and emergency services, with around 440 beds, around 1800 (whole time equivalent) staff, and an annual budget of around £75 million. Staff costs represent around 70 per cent of annual expenditure.

The area covered by the hospital includes a mix of urban and rural communities and a population of around 250 000. Compared with the national average, the health authority area had a lower level of chronic illness, and the standardised mortality rate was lower than the average for England. The population in the area served by the trust drew mainly from the white ethnic group, and the largest non-white ethnic group were Asian (1.9 per cent of the local population).

Cancer 3 is an interesting example of an organisation which has undergone a 'turnaround' process. Following a serious crisis, a new chief executive officer (CEO) was appointed in 1999, and with a new management team sought to develop a more open, supportive, listening and dynamic culture of change and innovation. The first task of the new management team, in the words of the new CEO, was thus 'to wake up the organisation'.

From 1999 to 2002, the main aim of the new CEO was 'to put the trust at the leading edge of innovation', particularly with regard to staff and patient involvement. A series of initiatives began. These included putting computer terminals into every ward and department to speed up internal communications; facilitating bed booking and management and also streamlining patient discharge procedures; and winning funding for Action On projects in orthopaedics, dermatology, audiology and cataracts. The trust won investment for new projects and also developed in 2002 a new £1.2 million dialysis unit and a new £2.9 million 'state of the art' day surgery unit.

In 2003, the hospital established an improvement partnership for health initiative, to develop a 'no wait hospital' jointly with the local PCT. This project ran into difficulties in 2004 and was abandoned. However, this initiative had two roots that continued to have significance for the changes in cancer services reported here. The first concerned a study of patient flow through the A&E service which revealed that problems were not, as first thought, due to lack of capacity, but to systems and procedures, and in particular to the way in which elective cases were handled, and to modes of collaboration with PCTs and social services. Second, this initiative reflected a shift in national policy, away from numbers on waiting lists (which are of limited interest to patients), to waiting times for appointments, diagnosis, and treatment, which are of considerably more concern.

However, in late 2002, the CEO left to run another, larger trust. Since then, through a series of coincidences, the trust had had five CEO appointments over one year, and a number of critical issues (such as the appointment of a new director of HR) were put on hold during this period. Despite these changes, the issues which had given the trust a 'two star' standing had been addressed, and the hospital was given a 'three star' rating in 2003 and commenced proceedings to apply for foundation status. However, the rating was reduced to two stars in 2004, putting the foundation bid on hold.

Since 1999, Cancer 3 had been part of the cancer network, covering the local urban and rural areas in the region. From the point of joining the network, the senior management in this trust decided that this was an organisation which could help them to achieve their aims. The CEO promoted the network and took an active role in it himself. He also encouraged other key staff to participate. As a consequence, both the CEO and the lead cancer nurse from Cancer 3 were members of the network board.

Within the trust, hybrid managers were more likely to have low clarity roles, while general managers or clinical managers generally reported greater role clarity. Interestingly, where some general managers reported low clarity, they perceived this as advantageous, as it gave them scope and autonomy to define their role on their own terms. However, hybrid managers with low role clarity were more concerned that others did not understand their role and lack of role clarity equated to low power and influence within the trust.

The clinical director at Cancer 3 reported low control over his future managerial aspirations. He stated that it was not his ambition to pursue a managerial role, and that he was enticed into the role by local managers. He felt that he could easily be replaced in the role if his strategic vision was at odds with that of the trust. So he was concentrating on developing the clinical aspect of his role. The other four clinical hybrid interviewees from Cancer 3 were apathetic about their future managerial or clinical aspirations, although interestingly many respondents reported that they were definitely not interested in the CEO role.

Service improvement changes in urological cancer were policy-driven, based on national directives, including the *Cancer Plan*, the *NHS Plan* and the NICE guidance on improving outcomes for urological cancer (2002). Management and clinical staff had limited choice with regard to implementing these changes, although there was scope for local variation with regard to implementation timing, and to the detailed arrangements that would be put in place to achieve the desired end results. However, while the central objective may have concerned achieving the two-week wait, a package of related and interdependent changes was developed which involved substantial revisions to organisation structures and processes, and to medical practice. While each of the individual components of this package of changes was relatively straightforward, together they accumulated to produce what may be described as systemic or 'deep change', reflecting entirely new ways of reconfiguring and providing the service, rather than simply the 'fine tuning' of, or 'tinkering' with, some existing routines and working practices. This package was a deep change both in organisational terms, and also with regard to the experience of patients presenting with prostate cancer symptoms.

The ultimate goal of achieving the two-week wait was identified by many as 'the big change', as the substance of what was implemented.

Dramatic reductions in the time elapsing between referral, diagnosis, and treatment for patients relied on redesigned patient management protocols and processes. Standardisation of those protocols and care pathways across the primary and secondary care network was one of the overall objectives of 'improving outcomes'.

There was general agreement that four particular roles were critical in implementing and sustaining improvements in prostate cancer services. These were:

- consultant urologist/lead cancer clinician
- prostate project manager for the CSC programme
- lead cancer nurse
- urology cancer nurse specialist.

The clinical cancer lead was key to service improvement changes at Cancer 3. His role will be explored in more depth in the following comparative section.

By 2003, so many improvements had been made in urological cancer that one service improvement lead commented, 'in terms of prostate on this site, over this network, they have done it at XXXX, they have done it to death there'. One clinician observed that, 'sometimes people say we have done enough for prostate'.

4.3 Comparative analysis

4.3.1 Contexts for change

While Cancer 2 is a large trust based across three hospitals (commissioned by two PCTs), Cancer 1 is a single site trust with an apparent closer connection to its local community and Cancer 3 provides all acute services on a single site, with only intermediate care situated on a different site. Cancer 2 thus represents a more complex organisational context than the other two trusts, because of the number of hospitals and the merger. All three trusts in their current form are quite young (Cancer 1: 1985, Cancer 2: 1999 and Cancer 3: 1994). Both Cancer 2 and 3 have experienced a more turbulent development in this time. At Cancer 2, as a result of an initial merger of the three hospitals and turnover of clinical staff, and at Cancer 3 as the result of high turnover of senior and executive staff members.

Cancer 3 experienced high staff turnover, particularly at CEO level over the period of the study, resulting in a potentially unstable organisational structure and 'jerky' progress in service improvement. Previous management teams had been described as 'insular and self-serving', and as a result many basic systems and procedures were either absent or undeveloped. The style of the previous regime had also isolated the trust within the sector. The workforce was 'disengaged' and not involved in hospital management. Many doctors had 'switched off', content to focus on their private work without

challenge from, and without themselves challenging, the management team. Following an external audit, in 1999, a new CEO was appointed to develop a more open and dynamic culture of change and innovation. From a highly corrupt organisational culture in the 1990s, a creative and dynamic culture emerged. The hospital atmosphere became less formal and more relaxed, with more frequent use of first names and a more approachable senior management team.

Likewise, the merger at Cancer 2 had also resulted in a high level of senior staff turnover over several previous years, primarily on a clinical level. However, this had not had the same ultimate positive impact as at Cancer 3. Cancer 2 had been forced to recruit a number of new clinical staff who, as a result, were not embedded within the trust or able to generate a strong team culture. This appears to have impacted significantly on motivation, expertise and interest in leading organisational change (which will be explored in more depth shortly).

These staff turnover issues were not apparent to the same extent at Cancer 1. This trust, perhaps unusually, had been able to maintain a stable senior level workforce over the past several years, with staff progressively developing through the organisation rather than employing new recruits. Further, Cancer 1 is a three star rated trust with a reputation for being a young and innovative organisation – having been awarded beacon status and becoming a pilot foundation trust. Cancer 2, alternatively, is a two star rated trust that has experienced difficulties in meeting its performance targets. Cancer 3 also missed out on an opportunity to apply for foundation status because of losing a star. At Cancer 2, this meant that funding was allocated to cancer services as a means of improving performance in relation to the government targets, however it was unclear exactly where this money had been allocated and what changes had been put in place. Cancer services had consistently remained a high priority at Cancer 3, and in particular urological cancer where there were a number of major upcoming initiatives. At the time of the fieldwork all three trusts were consistently meeting their waiting time targets in relation to cancer.

On a trust level, Cancer 2 and 3 also expressed greater financial concerns than Cancer 1. Both trusts had been carrying a deficit, with severe constraints on new appointments.

Cancer services were located within the surgical directorate in all three trusts. While this was explicitly considered to be a problem at Cancer 1 (with respondents feeling that cancer services were 'lost' within the broader directorate), there was no such overt sentiment expressed at Cancer 2 and 3. While cancer services at Cancer 1 and 2 did appear to have been somewhat neglected within the broader remit of general surgery, there was no such evidence at Cancer 3 where it was given greater priority and reportedly 'done to death'.

4.3.2 Relationship with the cancer networks

All three trusts form an important part of the 'outer hub' of their respective cancer networks. None of the trusts form part of the core cancer centre, and they are all geographically based on the periphery of their network regions. As such, their links with the inner parts of their networks and their network management teams were relatively limited, especially at Cancer 1 and 2. Management from neither of these trusts considered the activities of the network to be particularly important to the local organisation. At Cancer 1, staff were concentrated on broader level service reconfigurations (for example the foundation trust bid) while those at Cancer 2 did not have much faith in the network model. To a large extent, both these trusts concentrated on co-ordinating local services while remaining largely disengaged from network activities. Cancer 2 had been successful in becoming half of one of the cancer centres for urological cancers for the managed cancer network. Cancer 1 had previously held a similar viewpoint and some stakeholders (particularly clinicians) were disenchanted and not engaged with the network. Consequently, from 2003 new (and complex) structures were introduced throughout the network. However, there was no indication that this restructure had generated enhanced engagement with the network. However, this example does indicate that there was a greater awareness of engaging all stakeholders within the cancer network. Cancer 3 and its surrounding structures were far more attentive and responsive to disengagement and problems within the system. Both the CEO and the lead cancer nurse took an active interest and held posts on the cancer board, with the CEO taking the role of chair of the board to indicate senior management involvement. Within the trust, this active interest could be as a result of a new executive team which was more responsive to organisational change and service improvement. Within the broader network, this may have been a result of a less complex organisational structure than is usual in large urban conurbations, where a multiplicity of powerful teaching trusts dominate decision-making, partially negating (or deflecting) such a need for cancer unit or network management team involvement.

The organisational context – and the relationship with the broader cancer network – evidently permeates the entire change story and comparative analysis for these trusts. Therefore the following sections will now explore and compare the roles and relationships within each trust and the resulting impact on organisational change – with a continual reference to the impact of organisational context and the cancer network.

4.3.3 Roles

Interestingly, of all those interviewed across the three trusts only four individuals identified themselves as purely clinical – all urological

consultants. All of the other stakeholders described their roles as purely or partially managerial.

At Cancer 1 and 2, of those fulfilling hybrid roles (see Appendix 2), there were none who considered their responsibilities to be strategic in nature, rather they largely concentrated on operational management within their clinical area. Those in executive level positions (for example the CEO or foundation director) did discuss broad level, strategic decision-making. However, hybrid roles within particular clinical areas (such as surgery, cancer or urology) did not consider strategic development to be part of their role. As such, change management tended to be co-ordinated on an organisational-wide level, with limited appreciation for service improvement activities within particular clinical areas.

Cancer 3 provided a rather different (and more positive) story of strategic management. There were more respondents at this trust who considered change management to be part of their role. Cancer 3 had a service improvement lead in post within the trust and a service improvement facilitator and modernisation projects manager had been appointed to the network. Each of these stakeholders led on developing the modernisation agenda. Two of these posts – most significantly the trust-based service improvement lead – were absent at the two comparator trusts.

It is evident that this trust-based service improvement post was critical to enacting local change activities within urological and other cancers. Service Improvement Programmes are evidently vulnerable to turnover of these lead positions. At Cancer 2, the quality cancer facilitator appointee was previously the CSC project officer for the trust, and had retained an informal responsibility for service improvement within cancer services. Alternatively, Cancer 1 previously had a CSC project officer in post who concentrated on colorectal and gynaecological cancers, however the organisation has been without a project officer for a considerable period of time. This delay ensured that the trust has not been progressing with local service improvement changes in cancer. This issue will be discussed further in the organisational change section to follow.

The clinical director

The clinical directors from each of the trusts fulfilled similar duties. Each of the representatives considered their roles to be largely operational, with an emphasis on HR issues and limited concentration on strategic development, with the exception of one clinical director in Cancer 3. Within the context of cancer in particular, the clinical director at Cancer 1 was considerably less engaged with service provision – preferring to concentrate on the broader surgical area. He also continued to practice as an anaesthetist and was thus more focused on the surgical, rather than chronic care aspect of the directorate. The clinical director at Cancer 2 also was not as ‘hands on’

with cancer services, however she explicitly stated that this was because it is a clinical area that does not 'need much input from an outside body... it is a service that almost runs itself'. The clinical director at Cancer 1 described his role as 'administrative' and focused on the difficulties he was experiencing with the HR aspects of the position. As mentioned previously however, the relative position at Cancer 2 described her role as 'the interface between professional managers and my clinical colleagues', and seemed to have reflected more considerably on the function of the managerial aspect of her role. The clinical director at Cancer 2 also focused on HR difficulties, particularly regarding having to take bad news to clinicians (at the time of the interview she was preparing to discuss job cuts with her clinical colleagues and she was concerned about whether this would damage her relationship with them).

Although the clinical director at Cancer 2 was initially concerned that her clinical colleagues would be distrustful of her new role, she found that this had not been the case. The clinical director at Cancer 1 alternatively considered that clinicians were suspicious that he had 'gone native'. Conversations with other stakeholders at this trust, however, did not substantiate this view. Rather, their relationship with the clinical director was not raised. Interestingly, the clinical director at Cancer 2 was not confident that she would retain her managerial responsibilities in the longer term, while she was adamant that she would continue to practice as a clinician. The Cancer 1 clinical director, however, felt that he could not return to a pure clinical role as he felt that he would have no influence.

Within Cancer 3, the main clinical director (for surgery) was focused on day to day management also. However, an associated clinical director was a very proactive promoter of improvements and frequently attempted to influence clinical colleagues. The clinical directors overall had more generally expressed concern about lack of support and other resources, lack of involvement in budgetary decisions affecting them, and lack of clarity surrounding their roles. To increase their involvement in management decisions, two were invited to become involved in the annual service and financial framework (funding) negotiations, while a further two were involved in the rebuilding projects for maternity and the day case unit. In addition, a lead clinical director was invited to join the weekly operational management meeting. According to one senior manager, this amounted to 'throwing scraps', however it again represents attempts to respond to organisational issues at this trust – which was not prevalent at the other two trusts.

Overall, the three clinical director roles were predominantly similarly perceived – focused on operational activities, such as HR and other administrative responsibilities. However, none of the clinical directors were particularly focused on cancer services as a high priority within their role, as for each organisation this functional area was based within the broader surgical directorate. As such, other respondents

from all three organisations rarely referred to the clinical director as a key relationship, and instead referred to other hybrid roles that were more directly linked with the provision of cancer services.

Other hybrid roles

As illustrated in Appendix 2, there were six interviewees from Cancer 1 and 2 and five from Cancer 3 who could be described as fulfilling hybrid roles. However, of these hybrid roles a number were PCT or cancer network staff. Particularly given that there were overall more interviews undertaken at the Cancer 3 site, it appeared that there were proportionately more hybrid roles at Cancer 1 and 3.

There were more clinician-only roles represented at the Cancer 3 site, while those at Cancer 1 and 2 tended to have some managerial responsibilities. There were also more urologists overall at Cancer 3. Unlike the other two sites, the clinical lead for urology at Cancer 2 did not consider his role to have any managerial responsibilities. As such, responsibility for delivery of cancer services resided with the cancer manager on an operational level (which will be discussed in the next section), and the medical director on a strategic level. The clinical leads for cancer at Cancer 1 and 3 did consider their roles to have a managerial aspect. (At Cancer 3 the lead clinician had not been formally categorised as a hybrid. However on the basis of the interview transcript and for the purposes of this comparison, he will be considered to be a hybrid.)

The medical director at Cancer 2 considered his role to be extremely broad, and related to quality of care, clinical governance, appraisal, strategic service improvement and education. The medical director chaired the local cancer management meeting and therefore concluded that, by default 'I guess I am officially the lead cancer clinician then'. As such, this site was without a lead clinician for urology to take on any managerial responsibilities, and the medical director assumed the role of clinical lead for cancer, however in practice this responsibility did not appear to extend beyond chairing the cancer management meeting. He had instead delegated many of his responsibilities to the cancer manager, including – quite often – chairing the cancer management meeting.

Of the four described hybrid roles that were based at Cancer 1, it was only the clinical manager and lead nurse who appeared to consider their managerial responsibilities to be a fundamental aspect of their role. Both the lead clinicians for cancer and urology considered managerial tasks to be an add-on or even a burden, on top of their clinical responsibilities.

At Cancer 3, the lead clinician for urology was also the lead cancer clinician and the Chair of the network urology tumour group and the chair of the cancer strategy board for the trust. He had a much more strategic vision than the lead cancer clinicians from Cancer 1 and 2, and aspired to become the lead clinician or service improvement lead

for the network in the future. He considered his managerial role to be far less operational, but to work with the CEO to generate service improvement and reduce waiting lists.

The other hybrid role that is worthy of note is that of the principle nursing representative interviewed from each trust. At Cancer 1, the key hybrid nursing role was responsible for cancer and palliative care, while that at Cancer 2 was urology-specific. However, both nursing roles assumed managerial responsibilities as an important aspect of their position, although that at Cancer 1 was more formalised with the lead nurse for cancer and palliative care line managing four other members of staff. However, the urology nurse practitioner at Cancer 2 understood the managerial aspects of her role to be simply the non-clinical aspects – attending meetings and education of other nursing staff, rather than any clearly defined managerial responsibilities as such.

Overall, the hybrid roles at Cancer 1 and Cancer 3 sites were more formalised than those at Cancer 2. Managerial responsibilities were more explicitly understood at these sites, while there did not appear to be the same explicit role definition at Cancer 2, with no hybrid role taking responsibility for the delivery of cancer services. Instead, operational duties were delegated to the cancer manager. At Cancer 3 in particular, service improvement was built into these roles and more explicitly understood and actively and competently pursued. The nursing management hybrid was selected specifically to drive forward changes and was particularly committed and energetic. At the other two sites, managerial responsibilities were considered operational rather than strategic. This difference will be explored later in more depth in the context of relationships within each of the organisations.

General managers

Those in pure managerial roles had greater clarity regarding the nature of their role – exceptions were those in acting positions, or those who were job-sharing. Many individuals in managerial roles reported that they were given additional responsibilities as the role evolved, particularly in response to a broadening national cancer agenda. In relation to cancer specifically, managerial representatives predominantly considered their roles to encompass monitoring the trust's performance against national targets. Cancer service managers across the three trusts also reported a strategic component to their role, in particular compiling business cases and strategic plans in response to managed cancer network initiatives. This required considerable collaboration within the trusts, as well as interaction with other acute trusts, PCTs and SHAs.

Those in general management roles (both within a trust, and within associated organisations such as the PCT and the managed cancer network) were typically the initial representatives responsible for deciphering and implementing the initiatives handed down as part of

the *Cancer Plan*. These general managers then reported on the initiatives to trust or network management forums. Typically, the general managers then led on the subsequent business case or strategic plan development. Across the three trusts, the cancer service managers reported that their most significant relationships were with the lead cancer clinicians. Any strategic planning was typically developed initially by this 'duo'.

General management respondents reported difficulties with engaging clinicians in a strategic change process, in particular managers had problems influencing clinician behaviour (for example collecting data or attending meetings). The cancer service manager from the Cancer 2 site in particular reported difficulties interacting with clinicians at the trust, and reported variable success in these interactions. She reported that these relationships are reliant on 'good will' and she thus finds that the best way of influencing clinicians is through open communication, being diplomatic and factual (rather than emotional).

The cancer service manager at Cancer 2 focused on the importance of individual personalities and mentioned that the personality of lead clinicians for particular tumour types dictated how she related to them and influenced them – for example some wanted their ego massaged, others wanted all the work handed to them on a platter. She strongly believed in keeping communication channels open. To illustrate, at an observed cancer management meeting, a consultant mentioned that they were receiving inappropriate referrals from GPs. The cancer service manager responded that unless she is aware of this, there is nothing that she can do – the cancer service manager was keen to ensure that there was an open forum where others could communicate where there were problems.

Relationships

The clinical managers from the three organisations tended to describe their key relationships as with other managerial and executive representatives, with minimal mention of clinical colleagues when asked about their key relationships. However, the clinical cancer lead at Cancer 3 also considered his secretary and the clinical nurse specialists to be his most significant relationships. He mentioned the network management as a key relationship – an important distinction from the responses from the other two trusts who did not discuss network relationships. While the clinical director at Cancer 2 mentioned that she had a good relationship with her clinical colleagues and was regarded as one of the 'better' clinical directors at the trust, the clinical director at Cancer 1 believed that his clinical colleagues felt that he was no longer trustworthy and was a 'spy' for management. No such sentiment was expressed at Cancer 3.

Clinical representatives also did not mention the clinical directors within their key relationships, and instead focused on relationships with clinical colleagues – medical and nursing. Only one representative

from across the three organisations (a urology consultant) mentioned patients as being one of his key relationships, however the clinical cancer lead at Cancer 3 did consider patient information to be one of his greatest priorities.

As the Cancer 1 and 3 cases are each predominantly based on a single site, these organisations did not experience the complexity of interorganisational relationships that Cancer 2 did. Most of the interviewees from Cancer 2 were based at the central site, rather than the satellite hospital. Many of those interviewed – especially hybrid or managerial representatives – discussed the poor relationship between the hospitals that comprise the trust. Since the merger of the two hospitals in 1999, relationships between individuals at the two sites have improved considerably, however senior level personnel are generally based at the central site and do not have as much day-to-day contact with staff across sites.

Operational management – ‘duos’ versus managers

To reiterate, cancer services at Cancer 1 were managed by the combined duo of the cancer manager and the clinical lead for cancer, who were active in operational activities, however their roles did not extend to strategic development. Alternatively, the cancer manager alone took responsibility for co-ordinating cancer services at Cancer 2, with some support from the previous cancer manager who had progressed to become the clinical governance lead for the trust. However, there was limited or no clinical involvement in managing cancer services at Cancer 2. Within Cancer 3, the management of the cancer service was split between the clinical director for surgery and urology and the clinical director for radiology and pathology with strong and growing support from the lead cancer clinician. This trio constituted an active team.

At Cancer 1, the lead clinician for cancer was accepting of his managerial responsibilities, and considered the ‘lead’ aspect of his role to be to co-ordinate and control, and to ensure that the service was run according to the guidelines. However, he had no line management responsibilities and therefore could not ‘tell anyone to do anything’. He considered this to be a barrier in being able to fulfil his co-ordination role effectively. In extreme situations, his way of working around this barrier was to approach the medical director and ‘he would pick up the phone and things would happen’. Generally, if there were problems he would ask others – the medical director or cancer manager – to deal with the issue. The lead clinician and cancer manager worked closely together in the management of cancer services. The cancer manager did not tend to have close relationships with the clinical leads for particular tumour types or the clinical director. Most of the communication with tumour specific clinical leads was co-ordinated via telephone, however he had many face-to-face interactions with the clinical lead for cancer.

Alternatively, at Cancer 2, the medical director was the default clinical lead for cancer but did not adopt an operational role in the service. Instead, it was the responsibility of the cancer manager to handle the operational responsibilities of the service. The relationship between the cancer manager and 'clinical cancer lead' (the medical director) at Cancer 2 was not as formal, strong or effective as that at Cancer 1. However, the cancer manager appeared then to focus more strongly on developing relationships with the clinical leads for particular tumour types – although this was still in relation to the operational management of the service. As mentioned previously, the medical director at Cancer 2 delegated some of his responsibilities to the cancer manager. The cancer manager mentioned that when she was in her previous role as cancer services administrator, there were occasions when the CEO was expected to attend the managed cancer network Board meetings but delegated this responsibility to the medical director, who delegated to the then cancer manager, who then delegated the responsibility to her. She was very daunted by attending this meeting and was instructed by the then cancer services manager 'not to make any decisions'. The CEOs of other trusts attend the meeting and she felt very overwhelmed. The cancer manager told her to just attend and not to say anything. Therefore, she questioned the purpose of going and subsequently stopped attending. The frustration of senior level representatives at Cancer 2 delegating their responsibilities was also expressed by those at the managed cancer network. This situation further reflected the low priority that cancer services had within the trust, and the lack of senior level – or clinical – interest in developing the service or linking with the cancer network.

The lead cancer clinician at Cancer 3 had initially been reluctant to assume the managerial aspect of his role, but was subsequently considered by others to be very 'service improvement led' and 'very proactive about change'. He felt quite confident in working with executives at the trust in service improvement, however felt less supported in his role with the network. For instance, his secretary at the trust assisted with duties relating to the trust but would not assist with network responsibilities. In this part of his role, he forged a closer relationship with network management. There was no indication from the other two trusts that they relied on network management at all or considered them a valuable support.

Related to role clarity, the cancer manager at Cancer 1 had undergone extensive management training while the cancer manager at Cancer 2 had advanced into the role from a clerical position when the previous cancer manager took on the clinical governance position. The acting general manager at Cancer 3 was planning to undertake an MA in management. There was a much more formal structure and remit to the cancer manager role at Cancer 1 than there was at Cancer 2. Moving from the clerical position into the cancer management role was a significant development, and the interviewee was not sure that she has made the correct decision or if the role would be right for her. She

mentioned that she felt daunted by the responsibility and almost undeserving. Her biggest fear was the responsibilities that the medical director delegated to her. In short, the cancer manager at Cancer 2 did not feel fully supported in her role and had limited clinical links. The cancer manager at Cancer 1 however had a strong relationship with the clinical lead for cancer and the combined duo felt more confident in their role of managing the operational development of cancer services. However, it is unclear how these differing relationships impacted on organisational change within the two trusts – as both roles were largely operational. Apart from the lack of support, role clarity and clear performance management arrangements that the cancer manager (and other representatives) at Cancer 2 emphasised, there did not appear to be considerable differences between the two organisations in the way that the service functioned.

The following section will examine management training and education across the three trusts, particularly among those fulfilling hybrid positions.

4.3.4 Training and education

Table 6 Management training in cancer sites

	Managerial	Hybrid	Clinical	Total
Cancer 1	5	2	0	7
Cancer 2	4	2	1	7
Cancer 3	7	1	1	9
Total	16	5	2	23

Table 6 demonstrates that managerial training was variable and limited across the three cancer sites, especially for individuals fulfilling hybrid positions (such as clinical director).

The clinical director at Cancer 1 undertook several short courses in management when first coming into role. He did not find their content worthwhile and considered them too 'academic' and not relevant to his day-to-day work, but he appreciated the opportunity to meet with others performing similar roles. The clinical director believed in learning from experience, and mentioned that the most significant difficulties he has with his role are HR-related. Other than the lead cancer nurse, no other hybrid or clinical representatives had participated in any formal managerial training. One clinical and two hybrid interviewees said they found no value in managerial training, and believed that they could learn these skills through experience. The clinical director felt other management training courses relevant for the private sector could not seamlessly translate to a public sector context.

At the Cancer 2 site, those interviewees who had participated in management training or education had typically undertaken short, focused courses on particular topics – such as teaching and appraisal – however there was minimal dedicated management training. All the interviewees performing hybrid roles emphasised the importance of learning through experience. The medical director discussed various short managerial workshops that he had attended, relating to negotiating skills, communication and financial management. However, he stated that he had gained much more experience on the job. He described the acquisition of managerial skills as like an ‘apprenticeship’.

When coming into the role, the clinical director at Cancer 2 undertook a three-day residential training programme. She found this useful to identify what she ‘needed to know in terms of how to be a manager’. The clinical director mentioned that external speakers attend the clinical directors’ meetings. The value of these external speakers was variable, and the clinical manager appeared resentful of external (for example Department of Health) speakers, who seem to have little understanding of the local organisational reality. On the whole, the clinical director was comfortable with the level of managerial training. She stated that HR issues, particularly matters of discipline, are the most difficult for her to handle.

Overall, the courses undertaken consisted of short courses and workshops rather than Masters degrees or other formal, long-term commitments. The hybrid managers valued being able to pick and choose short courses rather than committing to a more formal qualification.

Of the five hybrid respondents from Cancer 3, three had no formal management qualifications, the clinical director had a Masters of Business Administration (MBA) and the urology nurse specialist had a Masters in advanced practice. Other respondents mentioned that they had participated in other training and development experiences, including internal programs and courses co-ordinated by the Department of Health.

An absence of formal management qualifications was not considered to imply a lack of knowledge and understanding of managerial topics. However the clinical director at Cancer 3 expressed frustration concerning his inability to effectively engage with and influence the decisions of his management colleagues.

The clinical director at Cancer 3 had participated in some management training in complaints handling, appraisal and the role of clinical director. The clinical director also mentioned that he attended a workshop run by the British Association of Medical Management on leadership. Although not expressing a desire to undertake more managerial training, the clinical director felt that further education in this area was inhibited by overwhelming clinical commitments. Similarly, a consultant urologist at Cancer 3 commenced a certificate

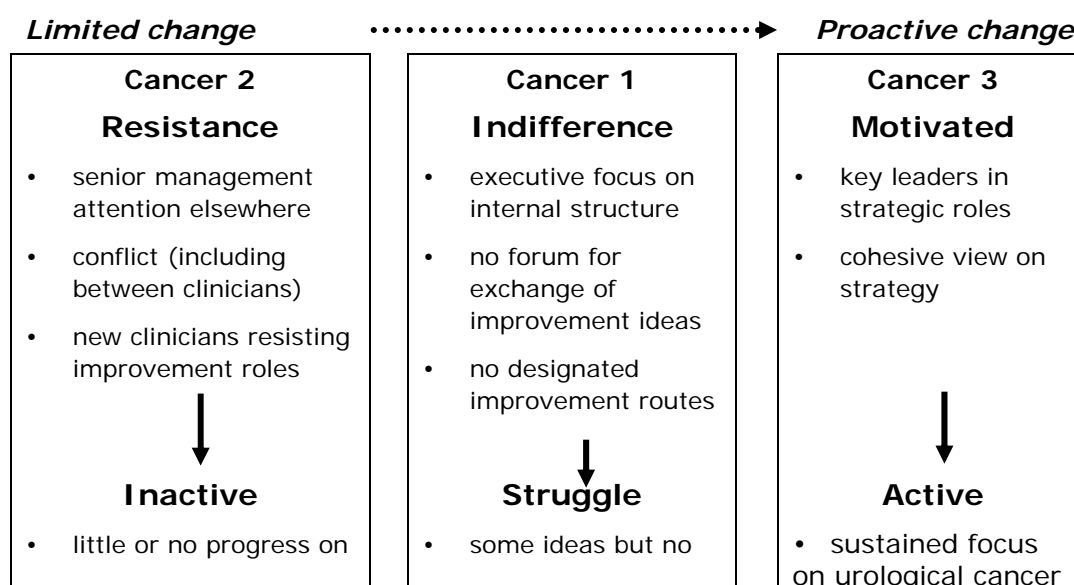
in health service management, but had no time to complete the course.

4.3.5 Progress on change and service improvement: indifference, resistance and motivation

Thus far in our presentation and analysis of the cancer cases, we have raised a number of themes and issues which highlight the impact of aspects of the organisational context, within the wider institutional environment on the progress and development of clinical service improvements in prostate cancer. Here, we attempt to link our analysis of the organisational context to the actual development of improvements within the clinical service. This begins the first stage of our presentation and exploration of the nature and rate of progress in service improvements in these three sites. Figure 1 presents our first attempt at considering these interconnections. Subsequently, we continued to develop this analysis and in Section 7, we explain in greater detail, the conceptual thinking, which has underpinned the gradual development of these ideas.

The organisational context for service improvement in cancer services at Cancer 1 could be characterised as *indifferent* or preoccupied – with considerable attention being focused on broader strategic change, such as the foundation trust bid. The Cancer 2 context, however, could be regarded as more overtly *resistant* to change. Poor relationships among clinical representatives in particular ensured that service improvement initiatives were difficult to implement. On a positive note, the service improvement context at Cancer 3 could be considered as *motivated* – despite only achieving small organisational changes in urological cancer. Figure 1 places each of the trusts in a typology to show how they have comparatively progressed on service improvement in cancer services.

Figure 1 Typology of service improvement capacity across cancer sites



urological cancer	executive focus <ul style="list-style-type: none">• little or no progress on urological cancer	(despite turnover of key staff)
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Cancer 2 and Cancer 1 are both experiencing a high degree of broad strategic change, with Cancer 1 concentrating on their foundation application and ensuing implementation, and Cancer 2 focused on the ambulatory centre development at the satellite hospital. Senior level executives at Cancer 2 were also concurrently focused on reacting to the structural reconfigurations that arose out of the merger of the two main hospitals in 1999, and the subsequent high turnover of clinical staff. As such, Cancer 2 was finding it difficult to progress strategically, while also continuing to manage much of the political fallout that resulted from the merger six years ago. Within cancer services, Cancer 2 was slightly more responsive to service improvement initiatives (such as for transrectal ultrasound guided biopsy waiting times). However to re-emphasise, this again has been *responsive* to challenges within the organisational context, rather than *proactive*. Cancer 3 did not have this degree of structural turbulence, though it was still recovering from a high level of executive turnover. The appointment of a new CEO and senior management team had, however, motivated service providers and there are now key leaders in strategic roles and a more cohesive view on strategy. Those in senior management positions were also demonstrating a greater commitment to service improvement in urological cancer services.

As mentioned previously, Cancer 2 lost a star in the trust rating exercise – largely because of problems in meeting the waiting time targets for cancer. Cancer 3 had also lost a star in the rating exercise, however this was not attributable to difficulties in the delivery of cancer services at the trust. Not meeting the targets at Cancer 2 was not necessarily as a result of poor clinical performance, but appears to have reflected problems in collecting and reporting data and a lack of understanding of the performance measures by the cancer administrators at the trust. In particular, the current cancer manager (who was then the cancer services administrator) mentioned that she was never informed of the importance of collecting and reporting on the waiting time data, until it was too late. At the time, Cancer 2 was not collecting uniform data and were ‘breaching all over the place’.

Some funding was then allocated to improving cancer services at Cancer 2. A centralised booking system was developed which allowed the cancer administrators greater control and knowledge of the service. Previously, this responsibility was divided out to the particular tumour areas, however results were mixed (some were actively working on this issue while others were not). Following the change, the cancer manager was able to co-ordinate the process and ensure that all services were on track. Cancer 2 has since progressed from being a one star to a two star trust. The impression of the current and previous cancer managers is that the money that was allocated to cancer following the loss of the star rating was never actually seen by

the service. Further, it was felt more generally that cancer services represent a low priority for the Cancer 2 trust, in the aforementioned conflicting organisational environment.

Service improvement in cancer services – particularly urological cancer – was also regarded as a low priority at Cancer 1, because executives were preoccupied with the foundation bid and cancer services were ‘lost’ within the broader surgical directorate. The clinical director did not appear to play a part in the foundation application and implementation process, however he was much more concerned with the European working hours directive and meeting waiting time targets.

In dramatic contrast, Cancer 3 was more proactive in service improvement in urological cancer – with the impression that service improvement in prostate cancer had been almost ‘done to death’. Cancer 3 demonstrated an organisational context that was more receptive to service improvement initiatives than that at the other two sites. However, the service changes that had been undertaken in urological cancer at Cancer 3 largely reflected a response to the national policy directive. These service improvements applied to changes in the delivery of all cancers (not just urological), such as two-week-wait targets, guidelines for urgent referrals by fax, the creation of multi-disciplinary teams, booked admissions and patient information.

Cancer 3 was more motivated in its service improvement approach and capacity for change, as it was more innovative in its service level appointments and had greater senior management support than the other two case study sites. However, Cancer 3 was no more innovative in the actual service improvements undertaken. The implemented service improvements were based on the Department of Health directive from the *Cancer Plan* and the *Manual of Cancer Services Standards* (NHS Executive, 2000). Nevertheless, considered as a whole, the service changes undertaken at Cancer 3 (and the nature of the roles involved) did represent a major change in the delivery of cancer services that had not been realised to nearly the same extent at Cancer 1 or Cancer 2.

Cancer 2 was slightly more successful than Cancer 1 in attempting to enact service improvement in urological cancer services, predominantly due to the CSC project officer (who had recently moved to another role, but retained an involvement in service change in cancer services). However, these initiatives had been hampered by resistance from urologists. For instance, waiting times for transrectal ultrasound guided biopsies had been poor at one central hospital, in particular and reflected the lack of initiative on behalf of the urology clinicians. Attempts to collaborate with the satellite hospital site to reduce waiting times were thwarted when the radiologist at the site resigned – reportedly due to a poor relationship with the urologists at the central site.

As previously mentioned, Cancer 2 and another local hospital had collaborated to become a centre for urological cancer services. The network management team, cancer managers from Cancer 2 and cancer managers and the consultants from the local collaborating hospital had been key to developing the proposal (note – *not* the urologists from Cancer 2). Stakeholders from Cancer 2 and its collaborator met with Department of Health representatives to discuss the proposal and one interviewee mentioned that the consultants from Cancer 2 did not speak at all. The urology consultant from the collaborating hospital instead led the change process.

The resistant behaviour of urology clinicians at Cancer 2 obstructed some service improvement changes at the trust, in particular in relation to transrectal ultrasound guided biopsies, where the negative behaviour of clinicians had been partly attributed to the abandonment of attempts to implement change. This active resistance was not so clearly evident at Cancer 3 or Cancer 1. Cancer 3 were largely motivated and engaged in service improvement. And at the Cancer 1 site, the atmosphere of indifference to service change in urological cancer services and preoccupation with the foundation trust application took precedence. Although the lack of successful service improvement initiatives in two of our trusts can be conceptualised in different ways – resistance versus indifference – both organisations could also be considered to lack clinical and strategic leadership.

Clinical leadership

Although both Cancer 1 and 2 were undergoing innovative strategic developments – through the foundation bid and the ambulatory centre developments – neither were able to develop or sustain any successful service improvement initiatives within cancer services, specifically urological cancer. This was partly due to the preoccupation with organisation-wide initiatives and partly due (in the case of Cancer 2) to clinical resistance. However, this lack of success could also be attributed to a lack of clinical leadership within the service area and a lack of appreciation for service improvement.

Particularly at Cancer 2, the lead urological consultant described his role as purely clinical and was actively resistant to accepting any non-clinical responsibilities. Further, there was no designated clinical lead for cancer more generally. The medical director assumed it was his role, but did not take any practical steps to accept this responsibility other than, occasionally, chairing the cancer management meeting. As such, there were literally no representatives in cancer services who could undertake a clinical leadership role. Furthermore, there were no apparent interventions in cancer services by senior management, who were preoccupied with central structural changes.

Within Cancer 1 however, there was a clinical lead for urology and a clinical lead for cancer who both assumed some managerial responsibilities. Neither could be described as a change leader, instead

focusing on the operational management of the service. The combined duo of the cancer manager and the clinical lead for cancer were active in operational activities, however did not extend their role to strategic development. Likewise, the clinical lead for urology was concentrated on clinical and operational responsibilities, with no consideration for the strategic development of urological services.

This presents a different picture to that at Cancer 3, where the lead cancer clinician considered service improvement to be a key part of his role and interacted more closely with the network management to achieve sustained organisational change within the trust and across the network. Perhaps because of this closer relationship with the network management, Cancer 3 was more proactive in meeting the policy objectives.

Neither Cancer 1 nor Cancer 2 had a CSC project officer (nor more recently a service improvement lead) at the time of data collection. In the absence of any other clinical leadership, this delay further ensured that Cancer 1 and Cancer 2 had not been progressing with local service improvement changes in cancer. In two trusts, service improvement proved to be highly vulnerable to staff turnover in these service improvement posts. Despite some turnover of service improvement representation, Cancer 3 was able to achieve a more motivated and sustained service improvement focus through the consistent prominence of the lead cancer nurse and the nurse practitioner alongside the clinical lead for cancer, whose interest in service improvement grew.

In contrast, the lead cancer nurse at Cancer 1 was the only clinical service representative who was enthusiastic about service improvement in the provision of cancer services. He mentioned that he had generated a number of service improvement ideas on the basis of his work and reflection during a Master's degree (in the interview speaking in great length about a number of these ideas). However, he also mentioned that 'it is not actually under my control', and this was further evidenced in the cancer services development group meetings whereby he had no forum for articulating any of these ideas. As such, there was only one representative from within Cancer 1 and 2 who mentioned innovative service improvement in cancer services and had generated several ideas. However, in practice this representative was not able to (or was not equipped to) articulate his ideas in the appropriate forum. There were no successful clinical leaders identified in the delivery of cancer services at either of the trusts. This has impacted considerably on a lack of service improvement initiatives in cancer services at the two trusts. In contrast, the clinical lead for cancer in Cancer 3 was in the more privileged position of having a close relationship with trust executives and network management, which he used as leverage for enacting service improvement within that trust.

4.4 Conclusions

In summary, the descriptive narrative of each of these organisations and the subsequent comparative analysis, illustrate disappointing findings from two of the trusts and a more positive picture of the third. Although all three trusts examined were consistently meeting their waiting time targets, neither Cancer 1 nor Cancer 2 had undergone sustained or successful service improvements in urological cancer services. Although both organisations had different contextual environments (particularly in relation to complexity and performance), some comparative conclusions can be drawn – with three factors in particular appearing to contribute significantly to the discouraging results from these two trusts.

Firstly, both organisations were **distracted by structural developments** that were consuming considerable resources and attention on an executive level. As such, those in strategic decision-making roles were unable to dedicate the necessary consideration to cancer services (and potentially other clinical areas) that was needed. In contrast Cancer 3 was not subject to such strategic change on an executive level – having forgone on their intention to apply for foundation status. Senior management at Cancer 3 were dedicating attention to the delivery of urological cancer services.

Secondly, cancer services in all three organisations were based within the broader surgical directorate. As a result, **cancer services were 'lost' within a broader surgical remit**. The clinical directors of the Cancer 1 and Cancer 2 surgical directorates did not consider cancer services to be one of their key priorities. However, at Cancer 3 urology was a key part of the title of the directorate. Further, cancer forms a significant part of urological services at Cancer 3 and was therefore granted greater prominence at the trust.

Thirdly, neither at Cancer 1 nor at Cancer 2 was there evidence of strong cancer service level leadership. Clinical hybrid roles at Cancer 1 were concentrated on operational management and were too preoccupied to consider a strategic element to their role, while those at Cancer 2 were actively resistant to undertaking managerial or strategic responsibilities. Further, at the time of data collection neither organisation had a service improvement lead project officer to guide service improvement. Service improvement at Cancer 3, however, had advanced further due to the impact of the clinical cancer lead and his motivation to enact organisational change in urological services at the trust. Alongside the service improvement lead at Cancer 3, the clinical cancer lead was successful in carrying the service improvement message through to the executive level. The findings from these three case studies highlight the importance of local level clinical leadership in generating a capacity for organisational change. This was a positive finding at Cancer 3, that was also absent at the Cancer 1 and Cancer 2 sites. Service improvement leads also had a crucial role in enacting change, with the lead at Cancer 3 playing a pivotal role in the change

agenda. Problems with retention and recruitment of such roles at the Cancer 1 and Cancer 2 sites further represents a contrasting finding that emphasises the limited capacity for change when dedicated service improvement roles are absent.

In conjunction with these three identified common barriers to change in Cancer 1 and Cancer 2, there was an additional factor at Cancer 2 that impacted negatively on opportunities for organisational change in cancer services. As a result of the merger of the two hospitals in 1999, the ensuing turnover of clinical staff, and the recruitment of less senior urologists, the previous six years had seen considerable **resistance and political battling between service providers** and executives across the two sites. This complex political environment had diverted attention from service improvement and further ensured that those remaining staff were exceedingly unmotivated, resulting in further retention problems (as in the case of the radiologist who resigned). Executives from Cancer 2 considered these problems to be a result of lack of team cohesion, as the urology clinicians were all relatively new to the organisation. However, these more recently recruited urology clinicians were operating within an existing dysfunctional organisational culture where they had quickly disengaged from, and resisted innovative organisational change. Senior executives at this trust did not provide evidence that they had recognised the issues demonstrated here.

Overall, these three case studies highlighted the significant barriers to enacting service improvement in cancer services in the first two trusts, and the factors at Cancer 3 that led to sustained and somewhat meaningful service improvement. The clinical cancer lead at Cancer 3 was service improvement oriented, while the clinical managers from the two remaining trusts were clearly not strategists, but very HR management-oriented. This left the entire surgical directorate within each of these trusts without any genuine strategic leadership. There is no single factor that explains why these two organisations had not been able to develop or sustain significant change management in cancer services. Instead it was the combined configuration of lack of clinical leadership and preoccupation with high-level strategic development that represented key obstacles to implementation and should be recognised by the trusts. The Cancer 3 site demonstrated a more receptive organisational change context, characterised by dispersed leadership on a local level. At the other two sites, these local change roles were absent, while clinical directors instead concentrated on operational activities.

This may suggest that a more dispersed leadership arrangement, where an 'associate' clinical director is responsible for operational duties while the clinical director concentrates on strategic management, may be more effective in developing the capacity for service improvement in urological cancer services.

Section 5 Comparative analysis of maternity case study sites

5.1 National policy context: maternity

The field of maternity care and maternity services poses another set of challenges to health care providers. This area of clinical service was selected for study because of its unique characteristics. It is a service which affects and engages a large population of patients/clients and the families - for example, on a typical day in the NHS 2000 babies are born and 22 000 midwives are in its employ (Department of Health, 2000). Maternity services also cross the boundaries between the acute, community and primary care sectors, and require co-operative effort for an effective service. Within maternity services, there are relatively active advocacy groups. Finally, maternity services are faced with a differing array of challenges when compared with cancer or diabetes services.

Quality standards and service configuration in maternity services have been fundamentally altered over the last decade by clinical developments; official reports and government policy. In particular, the targets set by the policy document *Changing Childbirth* (Department of Health 1993) provide an especially interesting example of policy-led change. This document was produced after a process of consultation, which included representatives of the clinical groups involved and it also contained some relatively precise targets (when compared with other policy documents). It led to several novel models of care being developed which aimed to improve continuity of care, or shift the care of low risk mothers into the community, or use the clinical resources better, usually through a caseload model (Green *et al.*, 1998; 2000).

Further impetus for change was generated by the Audit Commission reports (1997 and 1998) which illustrated the views of the clients and reinforced the need for change and movement towards the targets proposed in *Changing Childbirth* if the NHS was to deliver a patient centred maternity service. Other policy initiatives have been developed that directly and indirectly influence maternity care. For example, efforts to reduce inequalities in health outcomes (Department of Health, 1999b) have redirected the efforts of the maternity services to target care to women traditionally excluded from routine service provision. Many midwives are now working in multi-agency Sure Start programmes and teenage pregnancy programmes (Social Exclusion Unit, 1999).

While *Changing Childbirth* set the agenda for maternity services for the 1990s and beyond, it is useful at this point to review progress

some ten years after its publication. There was a comprehensive review of progress between 1993 and 1998, (Department of Health, 1998). This progress review provided information on a range of development projects undertaken between 1994 and 1998 under the initiative and demonstrated, in part, the extent to which a woman-centred service has been achieved. It presented summary accounts of the aims, work, and outcomes of the projects. Among the areas explored by the projects were midwife/GP collaboration; continuity of care across health service boundaries, and user representation. However, other research demonstrates the patchy and variable rates of progress in achieving the *Changing Childbirth* targets in differing locations (Fitzgerald *et al.*, 1999; Ferlie *et al.*, 2000). Other projects also examined consumer choice and childbirth education (Green *et al.*, 1998; Green *et al.*, 2000; Wyke *et al.*, 2001).

Much current effort is directed towards addressing the skills shortages among clinical staff, while maintaining a safe service. *Making a Difference* (Department of Health, 1999b) was launched by the Prime Minister and outlined the government's intentions in recognising the value of nurses, midwives and health visitors. It aimed to encourage and support new roles and new ways of working. It proposed a broader role for midwives within women's health and public health with specific proposals related to extending their involvement in postnatal care. The document saw its approach as underpinning broader policy and strategic developments in the NHS. This was reinforced with the publication of the *NHS Plan* and the midwifery action plan (Department of Health, 2001c) which included proposals for changes for nurses, midwives, therapists and other NHS staff. In relation to maternity services, the thrust of the plan was to break down the barriers between staff, brushing aside older, hierarchical ways of working and creating more flexible team working between different clinical professionals. Midwives were specifically mentioned; and it was suggested that their role be developed to one which included public health and family well-being, working with local doctors and nurses in developing maternity and child health services and Sure Start projects. To support this, there was investment of an extra £140 million to support a major programme of training and development of all staff.

Further developments led by the Royal College of Obstetrics and Gynaecology and the Royal College of Midwives (1999; 2000) aimed to improve care for women with complications and emergency care and to alter the roles and responsibilities of the health professionals involved in providing care.

More recently, the Department of Health (2004c) set out the government's response to the Health Select Committee's fourth, eighth and ninth reports concerning the provision, inequality of access and choice in maternity services. This paper identified government action in the following areas:

- The establishment and development of the *NSF for Children, Young People and Maternity Services* (referred to as the *Children's NSF* in the rest of this section). This was identified as setting out a ten year strategy for improving services for children and is considered in detail below.
- The establishment of NICE guidelines to improve the safety and well-being of mother and baby. This includes the development of guidelines on the use of caesarian section and intra-partum and post-natal care.
- Ensuring informed discussion before caesarian sections and heralding the launch of NICE's clinical caesarean section guide on 29 April 2004.
- The establishment of effective ante-natal screening programmes in order to modernise this area.
- Taking action to address inequalities in access to maternity services through the document *Improvement, Expansion and Reform: The next three years' priorities and planning framework 2002-2003* (Department of Health, 2002b).
- Choice in maternity services through consultation resulting in the government strategy paper *Building on the Best: Choice, responsiveness and equity in the NHS* (Department of Health, 2003) which addresses the difficulties in attracting and retaining midwives; investment and resources in maternity services and cross-government action in the form of , for example, Sure Start local programmes and children's centres, a teenage pregnancy strategy and the Connexions Service.

This report presages the publication of the *Children's NSF* (Department of Health, 2004a). The NSFs were part of the original *NHS Plan*, and the *Children's NSF* is a ten-year strategy programme intended to stimulate long-term and sustained improvement in children's health. This is the government's main area of activity in improving and developing maternity services. The *Children's NSF* aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood. A specific set of standards in the NSF addresses the requirements of women and their babies during pregnancy, birth and after birth. However, this standard does not stand alone, and should be considered in conjunction with other standards in the framework document.

The *Children's NSF* explains its threefold vision as:

- 1 flexible individualised services through pregnancy and motherhood
- 2 support and encouragement for women to have as normal a pregnancy and birth as possible with medical intervention only if of benefit to the mother and baby

- 3 midwifery and obstetric care based on good clinical and psychological outcomes for the woman and baby putting equal emphasis on helping parents prepare for motherhood.

The overarching emphases are on the involvement of women in the planning of their care, normal childbirth, the notion of 'managed care networks' providing services for women, the promotion of breastfeeding, and involvement of users in planning and review. The vision and emphases support the rationale that pregnancy and childbirth are normal life events and that women ought to experience them as times of choice and control.

Two aspects of the *Children's NSF* are particularly notable from the perspective of this research. Firstly, it represents continuity of policy from the targets set out in *Changing Childbirth* and indeed reinforces and extends those targets. It recognises, overtly, the close relationships between maternity care; experiences of childbirth and child care, including breastfeeding and later health in childhood. Secondly, in order to operationalise the integration, it introduces the notion of managed care networks. This extends still further the development of network forms of organisation as a means of achieving collaboration in health care.

The 'care pathways approach' is described as being the basis of the *Children's NSF*. Care pathways are used to illustrate the woman's progress through the variety of services available, and have emerged in the last decade as an important technique for quality improvement in healthcare. They formalise evidence-based protocols and guidelines into direct woman-focused care. The report argues that the use of these pathways should result in the same high standard of care being provided for all women. In introducing the notion of managed maternity and neonatal care networks, the argument is made in the NSF that these will facilitate the delivery of the care pathway approach. These networks are envisaged as linked groups of health professionals and organisations from primary, secondary and tertiary care, and social services and other services, working together in a co-ordinated manner, to ensure equitable provision of high quality care. This recognises that pregnant women require care from variety of sources or professionals, provided through such networks, as well as support from peers and local support groups.

A number of parts of the NSF outline the notion of 'woman-focused care', and explain that good maternity services place the mother and baby at the centre of this care. This includes the effective use of maternity services liaison committees and other local groups. The emphasis is clearly on timely advice and appropriate time to make choices. The document also discusses the need for ongoing training and development of staff to work within the full range of their competences, and the potential development of new roles. It suggests that additional necessary support can be provided by a 'maternity worker service'.

Finally, the document talks of the planning and commissioning of maternity services, and says that all NHS trusts, together with their neighbouring NHS trusts and social service departments and, if necessary, SHAs, should plan and commission maternity services as part of a locally agreed and managed network of maternity and neonatal care appropriate and accessible for all women. Of particular relevance in the light of the case study sites which follow, it identifies that any *reconfiguration* of maternity services ought to provide services which are more women-focused and family-centred, expand community-based provision, and enhance the network of care for women requiring specialist, particularly tertiary care.

It is important to note that during the majority of the period of the fieldwork, the *Children's NSF* had not been published, or had only recently become public and had still not had time to impact. In the context of this study, it is perhaps more relevant to acknowledge that the *Changing Childbirth* targets had been in existence for ten years and that the *Children's NSF* and its prior consultation period did not suggest a major shift of policy in maternity services.

5.2 Context: introduction to the maternity cases

The purpose of this section is to provide a comparative analysis of the three maternity case studies included in this project, which for the purpose of this project and to protect anonymity will be labelled Maternity 1, Maternity 2 and Maternity 3. This part of the report is set out in three main sections, the first section provides a description of each of the maternity sites in this study; the second section will compare data across the sites, focusing on the contexts of the aforementioned trusts, the roles and relationships within the trusts and the influences of these on organisational change within maternity services at these trusts. In the third and final section conclusions are drawn. To start with a brief overview, Table 7 (overleaf) provides some initial facts and figures.

It was argued that maternity care has traditionally been at the back of the queue when it comes to investment and change, with services such as surgery and medicine taking priority, due to the targets attached to them. At all three research sites, there was agreement among clinical and general management that maternity services were not a current priority at trust level. All respondents agreed that it is important to have an efficient and effective maternity service, but argued that maternity only becomes an issue if something goes wrong. Interviewees at both Maternity 2 and Maternity 1 pointed to other care groups being a current priority at trust level; at Maternity 2, cancer, surgery and A&E, were quoted as key priorities, while at Maternity 3 no particular service was mentioned, however respondents argued that meeting government targets was the main priority. At Maternity 2 and Maternity 3, they also had other overarching strategic

priorities which were seen to be taking precedence at trust level, over other changes. At Maternity 3, this was the private finance initiative (PFI) project and at Maternity 2, it was the bid for foundation trust status and the impending merger. At Maternity 3, the PFI project included the building of a new maternity hospital, so to some extent, maternity services formed a part of the priorities.

Table 7 Factual data on maternity sites

	Maternity 1	Maternity 2	Maternity 3
Established	2000	2000	1993 (established 1854)
Population	641 000	1 000 000	352 000
Ethnic diversity	0.8%	7.2%	35%
Deprivation	Prosperous	Diverse	Social deprivation
Urban/rural	Rural	Mixed	Urban
Star rating	2	3	3
Finance	£285 million	£460 million	£248 million
Number of staff	7183	11 000	3500
Number of PCTs serving	3	6	3
Number of hospitals (providing maternity services)	3	3	1
Midwifery-led units	1	2	0
Number of births	3000	9,000	4,200

5.2.1 Maternity 1 (NHS trust)

Maternity 1 serves a population of 641 000 residents and is based in a rural county with relatively poor transport links.

In overall terms, each of these trusts have staffing levels comparable with their size, however as can be seen in Table 7, Maternity 1 serves more than twice the population of Maternity 3, but this is not reflected in their overall financial budget.

Perhaps reflecting the rural location, Maternity 1 residents include only 0.8% of people from ethnic minorities, which is well below the national average. Most of the geographic area served by Maternity 1 could be said to be prosperous, with only a few interviewees pointing to the fact that there were geographic pockets with social problems, such as drugs. In order to serve the rural community, Maternity 1 is a trust which incorporates nine hospitals in total, which are geographically dispersed. The majority of clinical work is undertaken at the four main hospitals. Maternity services are split across three sites, two of which are main hospitals and provide an obstetric service and one smaller

'community' hospital, which includes a midwifery managed unit. All of these hospitals are distanced from each other by at least 15 miles.

In its current form, Maternity 1 is a relatively new trust, created by a merger of two former hospital trusts in 2000 and has experienced a number of complications due to this. Maternity 1 has had a high turnover of staff at directorate and strategic management level. At the time of interview, the majority of trust directors had been in post for less than two years, and some key appointments had still not been made. The trust headquarters was based at the first of the four main hospital sites, while many clinical staff perceived that the second was the 'lead' hospital. This fragmentation, alongside the problems of placing senior managers on different sites had created difficulties of communication and cohesion. The medical director commented that 'trying to gel together, as well as keeping a high profile within the trust is quite difficult in such a wide and dispersed trust'. These issues were further exacerbated with the introduction of a new organisational structure in 2004; which resulted in each of the four main hospitals served by this trust having a separate hospital director, clinical director and director of nursing. In addition, 11 clinical management teams were appointed which were either pan-trust or hospital-based, with the intention of engaging more clinical staff in management processes. But at the time of data collection, these changes were causing huge disruption.

Structurally, maternity care at Maternity 1 was based within the women's and children's directorate. This directorate covered maternity care, gynaecology care, neonatal care and paediatrics. It is important to note that maternity care and paediatric care were within the same directorate. Managerial responsibility for maternity care was divided between those with responsibility across the whole of the directorate, and those with responsibilities solely for maternity care. At Maternity 1, the directorate was headed by an associate director for women's and children's services which was a new post created in the restructuring of the trust. The associate director was responsible for the performance and delivery of women's and children's services across the trust. The role of the clinical director had changed in the restructuring of the trust. Previously, the clinical director would have been a budget holder, whereas in the new structure their position had taken on a more advisory role to the directorate head. The clinical director role was part time and supported by a general manager. These two managers also had clinical management support from a director of midwifery (acting); also heads of midwifery (one for each main hospital site) and labour ward sisters with management responsibilities.

Of these staff, the associate director and the director of midwifery defined themselves as occupying wholly management roles, while the remaining clinical managers perceived that they were hybrids and carried both clinical and managerial responsibilities. Interestingly, the

medical director at this site also retained a measure of clinical practice and identified himself as a hybrid manager.

The role priorities listed by members of the clinical management team focused on their management roles. The associate director couched this in terms of taking forward the modernisation agenda within the NHS. Despite giving priority to government targets, she also displayed clear evidence of competent strategic approach to implementing changes, stating for example: 'We would probably get a report identifying the need for a change in the way that we do something. And the first thing that we normally do is to try to benchmark ourselves against standards to find out where we are.'

Similarly, the clinical director saw his role in terms of meeting targets and encouraging colleagues to do the same, in part because the financial implications of failing to meet targets. The clinical director said the majority of his daily tasks were clinically-based. He saw his role as 80 to 90 per cent clinical. He said it was difficult to separate the managerial responsibilities within his clinical role, unlike his management responsibilities in relation to the trust: 'I have to physically set out time for management when it comes to trust but the rest of the time it comes essentially as one with my day-to-day duties.'

For the heads of midwifery, dealing with management issues was a prime part of their role, though both struggled to maintain a clinical workload, although they believed it was essential to their role as managers. Both argued that to maintain credibility with staff, they needed to ensure continuing fitness to practise. It was also recognised that due to the structural gap in management levels, between the directorate general manager and the sites, the two heads of midwifery at Maternity 1 both held mainly strategic roles and were heavily involved in service organisation and improvement at their individual sites, while still trying to maintain a clinical workload. However in order to progress any improvements, agreement still had to be sought through the directorate, which led to slow progress and frustration.

All the midwives interviewed had management responsibilities, as well as clinical responsibilities, although one claimed to be an unofficial manager. Management duties tended to be defined in terms of staffing such as line management and professional development. Two midwives described involvement in auditing, in particular benchmarking against national guidelines and reporting statistics to the clinical negligence scheme for trusts. Two had service development responsibilities such as producing information leaflets. One midwife had budget responsibilities. One was based at the midwifery led unit and described her role differently to the other midwives who tended to state how many beds they were responsible for: 'But because we're a midwife managed unit we do deliver low risk women here in this unit if they fit specific criteria... We also have quite

a large number of home confinements, probably one of the highest in the country.'

At service level, the priorities of interviewees revealed both clinical and management issues. Five of the eight interviewees stressed the need to provide a safe service for the women using maternity care.

5.2.2 Maternity 2 (NHS trust)

Maternity 2 serves a mixed urban and a rural population and is part of a large teaching hospital. Overall, the trust is based on three main sites, all sited in a large, urban conurbation, with one smaller unit some 15 miles away. It serves a population of somewhere in the region of one million people. Traditionally and historically, the three main sites were separate hospitals and have competed with each other for prime position in the city.

Both Maternity 3 and Maternity 2 serve ethnically diverse communities. While the exact breakdown of populations served by Maternity 2 are not known, it is known that it serves an urban community with a longstanding and rich, ethnic, religious and cultural background. Ethnic diversity brings with it a number of issues to consider, including language barriers, cultural differences and different prevalence of diseases. Maternity 2 covers areas with high deprivation levels, which bring with it significant health problems such as tuberculosis, heart disease and diabetes.

Maternity services are largely provided from two sites, within the urban conurbation with a distance of about five miles between them. In addition, mothers also have access to a midwifery managed unit, which is around 15 miles from either of the central sites, in a small rural area. In its current form, Maternity 2, like Maternity 1 is a relatively new trust, created in 2000. However, Maternity 2 had not experienced the turnover of staff to the same extent as Maternity 1. Nevertheless, as a result of the merger, a number of new posts were created, both at trust level and at directorate level, which the incumbents needed time to adapt to. For example, the medical director had previously been medical director at one hospital and had now undertaken responsibilities spanning all three hospitals. These changes had been made slightly easier by a majority of appointments being made internally (as in the case of the medical director).

At Maternity 2, the main strategic development was a large PFI Scheme, a £761 million five-year plan to extensively redevelop and reconfigure the three hospitals within this trust. It is one of the largest hospital developments in England and the most ambitious in the country to date. The PFI project was intended to enhance the patient journey and allow staff to deliver the highest levels of care in a purpose built, modern environment. It aimed to address many of the building maintenance issues and provide a landmark children's hospital, a new single site maternity service, which would be the

largest in western Europe and finally, a dedicated planned care and rehabilitation hospital.

Structurally, at Maternity 2, maternity care was part of the directorate of women's, perinatal and sexual health services, and this directorate provided a broader range of care, focusing on women's health, including all maternity care, gynaecology care, neonatal care, sexual health and clinical genetics. It is important to note that in this trust, paediatrics fell under a separate directorate.

The directorate was headed by a clinical director, supported by a general manager. At Maternity 2, it can be argued that the clinical director jointly led the department with the general manager. At this site, there was additional support at general management level from service managers and at clinical management level, there were heads of service located at each of the two main sites. Additionally, there was a head of midwifery for all maternity services and two ward managers, again one at each site, together with a manager for the midwifery led unit.

Those staff at the top of the hierarchy who had responsibilities which were either trust-wide, such as the medical director, directorate-wide, such as the clinical director and head of nursing and midwifery, perceived their roles as management. Top level clinical managers interpreted their roles as mainly strategic; their main aims being to ensure the directorate met their objectives and to make sure the views of their profession were heard. They were much more likely to be aware of the trust's financial position and therefore the constraints they needed to work under and were directly accountable to the trust board.

Hybrid managers, such as the heads of service and ward managers did also have a strategic role with the responsibilities of running a maternity/obstetric unit, demonstrating that services were being delivered to a level that met the expectations of the trust and implementing strategy from the top management. Hybrids at this service level also had a large clinical workload which to some extent overrode their management responsibilities. Hybrid clinical managers, on the whole, described their roles as professional and providing expert advice to the management team. One clinical manager described her role as: 'Professional stuff, a professional role for nursing and midwifery, giving advice to the management team... and taking the nursing lead within the directorate for the different components of clinical governance'.

Most hybrids at Maternity 2 stated that their management responsibilities were a minor part of their role, between 10 to 50 per cent. However the clinical director stated he performed two 100 per cent roles.

The directorate general manager had a strategic management responsibility for the whole of the directorate and the service

manager's role was to support the general manager. In contrast to clinical managers, general managers described their roles as mainly strategic; they also described themselves as 'lead manager', 'lead in change', 'link with directorate'. Only one general manager in maternity services, at this site had a specifically change management or change lead role.

5.2.3 Maternity 3 (NHS trust)

Maternity 3 serves a population of just 352 000 and is part of a teaching hospital trust. In addition to being a service provider, it has a large research and development agenda and has a high profile in clinical research, innovation and development, comparable with Maternity 2. This trust is based on a previously a long-established hospital, first established in 1854 and gaining trust status in 1993. The majority of services are co-located and provided from a single site, centrally placed in a large city, but the current trust also includes a smaller hospital and a specialist hospital.

Maternity 3 has both an ethnically diverse and mobile population, with more than 35 per cent of inhabitants coming from minority ethnic backgrounds. One of the districts served by Maternity 3 is the second most ethnically diverse of all English and Welsh local authority districts. In addition to this, more than 30 per cent of asylum seekers live within the geographic catchment area of Maternity 3, contributing to a total of 200 languages in use.

The configuration of maternity services at Maternity 3 differed from the other two trusts in the study, as all maternity services were provided from one site. While all maternity care was provided on one site, there were some facilities within the site for low risk, midwifery-led deliveries. Also, there had been no major changes to organisational structure, leadership or management within the recent past. The current CEO had been in post since 1999, providing continuity in strategic leadership.

At a strategic level, Maternity 3 (like Maternity 2) had a huge strategic change agenda underway, at the time of carrying out this research. At Maternity 3, this included a modernisation project which planned to integrate this trust with another trust in the area, alongside the medical faculty of the university it is affiliated with. The newly-merged unit would, it was planned, be located on the current main site of Maternity 3. The extended site was to comprise newly built and refurbished buildings and state of the art facilities. This project was active during the course of the research and influenced events and the planned development of maternity services. In addition to this development, Maternity 3 entered a programme to upgrade existing facilities, with a capital investment of upwards of eight million pounds in 2003. It is notable that the refurbishment made no mention of maternity services. A specialist unit, which is part of this trust, also

underwent a sustained programme of investment, to improve the building, furniture and equipment.

Alongside these major strategic developments, Maternity 3 had recently been invited to apply for foundation trust status, so a large amount of senior management time was being spent in preparation for this.

Structurally, maternity care in Maternity 3 was based within the women's and children's directorate. This directorate covered maternity care, gynaecology care, neonatal care and paediatrics. The directorate was headed by the general manager for women's and children's services, which was currently held as a job-share post; one post-holder had a clinical and one a managerial background. They each took the lead on their respective areas. One of the role sharers simultaneously held the head of midwifery post for maternity services, the highest post in the maternity hierarchy, but not in the directorate hierarchy. Thus she was her own boss within the directorate, though accountable to the director of nursing (a pan-directorate post). The clinical director for maternity was the next senior post to her. The clinical director was supported by the service director, lead clinician, service lead and consultants, in declining hierarchical order. Within maternity, the lead clinician for maternity was a hybrid post taking responsibility for operational issues on a day-to-day basis. Thus the key management roles were defined and split in a different pattern to the other two study sites.

Of the 17 individuals interviewed, ten had purely managerial roles, two had purely clinical roles and five defined their roles as hybrid roles. Of the hybrids, the consultant midwife perceived her role as a 'leadership' rather than management, but was engaged in strategic and other management activities. At this site, there were a large number of managerial roles held by individuals with a clinical background. Of the ten respondents with purely managerial roles, five had clinical backgrounds. There was evidence that the benefit of having a clinical background, presented as facilitating communication and mutual respect, was recognised.

There was an evident spectrum with regard to the range of role definitions provided by clinicians, hybrid managers and general managers. Most narrowly defined were clinical roles, focusing on service provision, operational management and leadership. Hybrid managerial roles were broader, with clinical, operational, supervisory, advocacy and liaison roles most predominant. There was little evidence of self-defined strategic responsibility among clinical managers at this site. Emerging from this an important consideration is whether hybrid managers have the capacity and/or willingness to take on strategic roles, and why this was not occurring at that time. However the broadest range of role definitions applied to general managers, spanning both operational and strategic management.

Given that clinical hybrids had both clinical and significant managerial responsibilities, it was unsurprising that they identified a broader range of roles than clinicians. These encompassed clinical practice, professional supervision, professional development, ensuring patient safety, service monitoring, providing service cover for staff training, financial management, advocacy for fellow staff and patients, representing their clinical area, liaison with higher management and clinical leadership in service improvements. The director of nursing suggested that the lack of hybrid involvement at a strategic level was indicative of a trust level policy for hybrids to work at primarily operational level.

The general manager post for the women's and children's directorate was shared among two individuals – one with a clinical, the other with a management background. They each led on their area of respective expertise, and this appeared to work well, with complementary experience leading to effective outcomes. This was acknowledged by other staff working in the directorate. This effectiveness was mediated by a good working relationship between the two.

The clinical director for maternity considered herself to be an advocate for other clinicians (consultants, house doctors and nurses) in connection with their conditions of work and training needs. In contrast, the lead clinician for maternity positioned himself as a patient advocate, focusing on service quality and the provision of appropriate services. Another key role identified was liaison between peer and subordinate clinical staff with higher levels of management. The lead clinician for maternity also emphasised clinical leadership, in terms of proposing and driving improvements in clinical practice, as a key part of the role. Finally, the service director for maternity indicated that he accepted less responsibility for some aspects of his role than others. In particular he was dismissive of his budgetary responsibility, citing it as something outside of his control.

The general managers at this site described their roles in wide-ranging terms, embracing both strategic and operational tasks, partly depending on position in the hierarchy. Change management roles were overtly mentioned. As already stated, many general manager at Maternity 3 had clinical backgrounds. Perhaps, unsurprisingly, there was some evidence of individuals finding it hard to juggle multiple roles, which were not always congruent.

One interesting point to note is the high number of managers who held multiple roles (or portfolio roles). Overall, portfolios of roles appeared least likely at board level, and most likely among hybrids. However the extent and remit of individual roles was an important consideration. For example although one consultant and service lead at this site identified 11 external roles, these were all quite limited in scope.

5.3 Comparative analysis

5.3.1 Contexts for change

It is clear that in these three cases, the configuration of services is dramatically different. In terms of the current systems of service delivery, none of these sites could be said to be meeting all the targets set out in *Changing Childbirth*, though for different reasons.

In all of the sites, there was some concern that maternity services were not a strategic priority at senior executive levels in the trusts. At Maternity 1, it seems that services were a result of historical and political factors which were still being felt within the trust and that service level managers, in particular, were keen to renegotiate current service levels and provision. At Maternity 2 and 3, there was clear evidence that the major developments in these sites were a core focus for senior executives, though maternity re-development or re-provision formed a part of each plan.

Structurally, there were two trusts with split sites and one with a single site for the delivery of maternity services. The structural organisation of roles was undoubtedly affected by these split sites. But it was also affected by the historical prior configuration of services before mergers *and* precipitating events. Thus historical events at Maternity 1, following a case of abuse in nursing had impacted on the delivery of services, because of difficulties in staff recruitment and a lack of trust in the midwives/nurses.

Each of the three maternity sites in this study was fortunate to have a level of stability in senior personnel in the sites. However, in Maternity 1 the clinical director had changed according to a rotation system agreed at this trust, while the retiring clinical director at Maternity 2 had deliberately been replaced with a new individual, within a changed structure and with a new remit. This set of changes resulted from the widely-acknowledged view that the retiring clinical director had lost the confidence of the doctors. In Maternity 3 stability existed at both trust board level and clinical directorate levels.

The current required standards for the staffing by obstetricians of labour wards, combined with the standards which need to be met to provide care for tiny/premature babies mean that the obstetric and paediatric specialities are inextricably intertwined. This has major repercussions for the planning of any change to maternity services. In Maternity 1 and 3, these specialities were within the same directorate while in Maternity 2, they were not.

Another factor affecting the receptivity of the context to change was the nature and quality of the relationships between the professional groups, delivering maternity care, namely the obstetricians and the midwives. These issues will be discussed in greater detail in Section 5.3.3(under 'relationships'). However, in all three sites, there were some historical issues with midwifery management and leadership. In

Maternity 1, this emanated in part from a crisis, while at Maternity 2 it was due more to turnover of senior midwifery personnel and the higher status and greater dominance of doctors in a teaching hospital. At Maternity 3, also a teaching hospital, the parties had worked to improve maternity leadership and had now achieved this with the current head of midwifery held in respect.

5.3.2 Roles

This section analyses and compares the roles across the sites. A full list of all interviewees, by site and professional role category is given at Appendix 2

For the purpose of this stage of analysis, interviewees are analysed according to the roles they undertake and the interviewees have been split into three categories;

- 1 general managers
 - those who have solely a management responsibility, though they may come from a clinical background
- 2 hybrids
 - those managers who have both clinical and significant managerial roles
- 3 clinicians
 - those who perform clinical roles and have no significant management responsibility.

General managers

At board level, interviewees rarely mentioned patient care as a priority, with the exception of the CEO at Maternity 3 and the medical director at Maternity 2. While it is not unusual for the medical director to be aware of his responsibilities towards patient care, it could be seen as relatively unusual for the CEO to see this as a priority.

When looking at the medical directors at Maternity 1 and Maternity 2, it is evident that there were some differences between the roles. The medical director at Maternity 1 still carried out clinical duties, while the medical director at Maternity 2 held a full-time management role. It is the norm for medical directors to abandon clinical duties when taking over the role of medical director, due to the extensive nature and senior level of the role. It is interesting when analysing these two roles to note that the medical director at Maternity 1, while being classed as a clinical manager talked more about his corporate, strategic responsibilities than the medical director at Maternity 2, who seemed much more aware of clinical priorities. One might anticipate that as a practising clinician, the medical director at Maternity 1 would have had greater credibility among his clinical colleagues and would be seen as more approachable. However, the medical director at Maternity 1 saw his joint roles as causing him problems, he argued that his clinical colleagues saw him as being co-opted by management, and if he

wanted to arrange a meeting with them they automatically became wary. On the other hand, the medical director at Maternity 2 did not experience these problems. This was due to the fact that he had substantial experience as a medical director, being one of the first to be appointed, and had also undergone management training and development.

In terms of the senior management of the directorates, there were some notable differences in the structures and roles at the apex of these directorates. At Maternity 1, the ADWCS, a general manager, headed the directorate; at Maternity 2, it was the clinical director, holding a full-time management role, and at Maternity 3, it was the joint general managers; all these posts were budget holders. It is notable that the clinical director at Maternity 2 had no clinical duties, possibly due the scale of maternity services at this trust, since the merger. Or it may be due to the fact that this clinical director was handpicked for the job, in order to generate service improvements in maternity services. There are thus some significant differences in the way the role holders interpret their roles. The associate director discussed the role in terms of investment, targets and developments. The clinical director at Maternity 2 believed he was responsible for everything within the directorate, by saying that 'the buck stops here'. However, the joint general managers at Maternity 2 saw their role in terms of both professional leadership and oversight and service developments.

Key roles in Maternity 1 were also held by the general managers, working within the directorate. The general manager had a strategic management responsibility for the whole of the directorate, while the service manager's role was to support the general manager. In contrast to clinical managers, general managers described their roles as mainly strategic; they described themselves as 'lead manager', 'lead in change', 'link with directorate'.

Across the sites, there were substantial numbers of general manager with clinical backgrounds. And it is notable that those general managers from a clinical background, as well as being aware of government targets, frequently referred to their responsibilities to their profession, such as professional development of staff, quality and safety of clinical care. They also saw themselves as providing professional advice to the directorate.

Across the sites, there was only one manager with the specific and sole remit to manage or facilitate change and this was in Maternity 2. Unlike the situation in cancer care, where service improvement facilitators existed in the networks and sometimes within trusts, similar resources were rarely available in maternity care.

Clinical or hybrid managers

The medical director at Maternity 1 was the only clinical manager interviewed who held a board level position and although he discussed clinical leadership, he adopted a strategic view.

At clinical management team level, the majority of interviewees described their roles as mainly strategic, and all perceived themselves to have a role in service improvement, as well as operational management, including staff management and service provision. In terms of the management aspects of the roles, clinical managers at clinical management team level were all aware of targets and guidelines set by the government and their role in meeting these. They also perceived themselves as both advocates of their profession and conduits of information between their colleagues and management.

Attention has been drawn to the differences in the senior management of the directorates. Another significant comparison between the three sites was the differing roles of the clinical directors. The clinical director role frequently represented a key hybrid role in the service and one which could exert influence over the development of the service. While the clinical director at Maternity 2 headed the directorate, at the other two sites, the clinical directors reported to directorate managers. At Maternity 1, the clinical director reported to the associate director of women and children's services and through the medical director, and emphasised that he saw his role as advising the general manager. At Maternity 3, clinical and general management functions were combined in the joint general manager role. At this latter site, the clinical director for maternity services also reported to the joint general managers.

The clinical directors at Maternity 1 and at Maternity 3 saw themselves as either representing their colleagues or being a conduit of information between their colleagues and management. While the clinical director at Maternity 2 (at a more senior level) did not, he saw himself as managing the directorate, and the heads of service were the conduits of information between their colleagues and management.

At Maternity 1 and 3, the clinical directors discussed the difficulties they had in carrying out what they saw as two separate roles. The clinical director at Maternity 3, worried that he was not performing either of his roles to the best of his ability as the overall job was too large. The clinical director at Maternity 1 argued that there was a blurring of boundaries between the two roles and it was sometimes difficult to distinguish between the two.

Within the service, the majority of hybrids across all three trusts were from a midwifery background and viewed their role as operational management with a small number arguing that they had a strategic role in activities such as setting guidelines and developing services.

However, it is significant that the majority argued that their clinical role had significantly decreased since taking on management responsibilities.

Clinicians

The majority of clinicians interviewed were doctors or consultants. Clinicians by definition have a clinical role with no classical management responsibilities. However in the study, clinicians higher up the hierarchy, such as consultants, did state that one of their key priorities was teaching and training junior staff. Clinicians described their roles in terms of patient care and looking after the patients within their speciality and all that this entailed, whether in ante-natal clinics, post-natal clinics or labour wards. Two of the midwives at Maternity 2 had no management responsibilities and described their roles as purely clinical. Their main responsibilities were carrying out the care of mother and babies to the best of their abilities.

5.3.3 Key themes

When analysing the roles of individuals across the three maternity sites a number of themes emerged:

- interrelationship of structure and roles
- models of directorate leadership
- joint or complementary roles as effective means of directorate management
- difference in roles and predominance of midwifery services across sites.

Interrelationship of structure and roles

It is recognised that roles and job titles varied between the three sites (see Appendix 2), and it is believed that one of the main reasons for this was the complexity of the individual structures of the sites involved.

Maternity 2 had implemented an extra tier of management, both in clinical and general management terms, to assist in managing the directorate. This was deemed necessary due to the scale of maternity services and the split site. They introduced a number of service managers (general managers), to manage each individual service as well as a number of Heads of Service (hybrids). This included a service manager for maternity across the two sites and two heads of service, one located at each site. This has meant that both the clinical director and general manager could concentrate on strategic matters, while delegating the majority of the operational management to the tier of management below. The clinical director had delegated matters of staff management to the heads of service and they met regularly with him to keep him informed and acted as conduits of information between the management and their colleagues (see 'relationships'

below). This was seen as necessary in such a large trust with maternity services being split across two sites, and seemed to stop clinicians at either trust feeling isolated from the decision-making process. It also overcame the possible problems associated with the clinical director having no clinical work and meant he had not experienced the blurring of boundaries experienced by many clinical directors.

It was believed by many of the interviewees that the joint management of the service by the general manager and clinical director, had led to effective outcomes and this had only been possible by inserting an extra tier of management. This division of responsibility between the clinical director and the general manager at this hospital was a key issue, emphasising that joint working between someone from a management background and someone from a clinical background can be an effective means of management.

This structural model worked well at Maternity 2, but was not adopted at Maternity 1 though consultant-led maternity services at Maternity 1 were also spread across two sites, vastly distant in terms of geography. The general manager at Maternity 1 appeared to be running the directorate single-handedly, having full responsibility for the budget and strategic developments. The clinical director at this trust played a similar role as the heads of service at Maternity 2, with little strategic responsibility, due to his clinical workload. This has had a number of implications for service improvement at Maternity 1 hospitals. Due to one general manager running a directorate across three sites, all of which were geographically dispersed, two of the three sites felt isolated from the decision-making process. It was also hard to see how the clinical director could represent all his colleagues with no dedicated general management support. He also argued that there was a blurring of boundaries between his two roles that left him frustrated, but his clinical work came first. Many interviewees complained that they rarely saw the directorate management. The fact that the general manager is solely responsible for strategic developments meant that the implementation of change was slow. Moreover, crucially, this model of organisation and management did not engage the medical staff well.

At Maternity 3, maternity services were based on one site, so some of the difficulties in roles experienced at the other two sites were minimised. The directorate was run smoothly by the joint general managers. The clinical director on the other hand, had limited input into the running of maternity services, due to his heavy clinical role, and to the fact that he was a paediatrician by profession. This may work well in such a small trust, however, it would produce difficulties in either of the other larger trusts.

Models of directorate leadership

In discussing the differences between sites, attention was drawn to roles at the apex of the directorates and the differences in directorate leadership. Questions arise as to what implications these differences have and whether there is evidence of which is the best model? Some points can be drawn out.

Firstly, there is much more clarity in the role of clinical director at Maternity 2, due to his role being purely management. The strategy for delineating the role was clear, with the medical director arguing that the clinical director was hand picked for this role, was mentored by him and had a remit to improve maternity services.

Alternatively the question arises, was the clinical director at Maternity 2 too distanced from his colleagues to represent their views at board and directorate level? This was suggested by one of the consultants who argued that he now had no contact with the clinical director, whereas he used to see the previous clinical director on a regular basis. However this viewpoint can be countered by the argument that an additional tier of clinical management was available at Maternity 2 in the heads of service. Similarly, staff at Maternity 1 argued that the associate director could not represent the views of clinical colleagues and that the clinical director was too geographically distanced from the hospital that he was not based at, and anyway only spent 10% of his time on clinical management duties. There was some compensation in that the outgoing clinical director was based at the second main hospital and was willing to offer advice. However, clinicians did argue that they felt distanced, and that in terms of service improvement their hospital was being left behind.

Other problems are represented in the model adopted at Maternity 3. Here the clinical director was supported by service managers, who saw it as their role to manage the day-to-day running of their services. The main problem here lies with the clinical director's clinical responsibilities, as he was a paediatric consultant and due to his speciality was single-handed, so had no-one to delegate his clinical responsibilities to. This raised a number of concerns, firstly, what selection criteria were adopted for the selection of clinical director? Secondly, how far were the views of obstetrics represented at directorate level in a directorate where paediatrics traditionally dominated?

Lastly, questions arise as to the credibility of the clinical director at Maternity 2. It is argued in order for clinical directors to maintain credibility among their colleagues, they still need to be practising clinicians.

Joint or complementary roles as effective means of directorate management

The data suggest that directorates may be most effectively managed, when there are duos or trios running them. This is evidenced through an analysis of roles and structures, as can be seen above, but also when analysing organisational change. It would seem that pairs of managers with complementary skills can lead to the smooth running of the directorate. This is especially true when there are close working relationships between the lead managers and the team immediately below them (see 'relationships' below).

At Maternity 3, the general manager post for the women's and children's directorate is shared between two individuals – one with a clinical, the other with a management background. They each lead on their area of respective expertise, and in combination offer a broad range of skills. Other interviewees argue that the effective running of the directorate is down to this effective partnership.

At Maternity 2, again the smooth running of the directorate would seem to be down to the joint running of the directorate by the general manager and the clinical director. Once more these individuals would seem to complement each other, as one has a clinical background and one management; they work well together in initiating change. However, this is complemented by the clinical director working closely with the heads of service and the general manager working closely with the service managers.

At Maternity 1, progress in implementing changes has been slow and this maybe due to the fact that the directorate is headed by one general manager, (which has led to her being overworked) and also to the lack of involvement of key clinical staff.

Difference in roles and predominance of midwifery services across sites.

When analysing the roles of midwives across the three sites, it became evident that there were some significant differences in the roles and predominance of midwifery in decision-making across the three sites.

At Maternity 3, one of the joint general managers was also head of midwifery, so there was a major role for midwifery in the decision-making process. This was supported by the roles of the two senior midwives/heads of midwifery at Maternity 3, who did not undertake clinical duties. The head of midwifery (acute services) held a strategic role and was heavily involved in service organisation and improvement, as well as staff management, although this would seem to be at a strategic level, with operational management of staff being delegated to senior midwives at ward manager level or equivalent. The senior midwife (primary care) undertook more of an operational management role in activities such as organising case loads, and had less of a role in service improvement. When analysing organisational

change, it is obvious that the joint general manager/head of midwifery took the lead in the majority of service improvement and the head of midwifery (acute care) was also heavily involved in a supportive role.

At Maternity 1, the director of midwifery was involved at a strategic level within the directorate, however delegated a lot of the role of the running of midwifery-led services to her two heads of midwifery, one located at each site. One significant aspect of this can be seen when analysing organisational change. The two heads of midwifery at Maternity 1 played vital roles in the management of change. They also described their roles in terms of both strategic planning for their units and operational management. It is noted that all of the midwives interviewed at Maternity 1 undertook a management role. The heads of midwifery also meet on a regular basis with the general manager and clinical director to feed back the opinions of midwives and to inform the midwives of changes at directorate level.

There are significant differences at Maternity 2, where the head of midwifery classed her role as offering expert advice, but could be seen in a strategic management role in producing guidelines and auditing. She did not see herself as having a role in service improvement. It is significant to mention that she also did not see herself as part of the clinical management team, and was not regarded by others as part of the decision-making core (see 'relationships' below). This view is supported by other interviewees who argued that historically, midwifery care had been impeded by poor management. All other midwives interviewed at this site classed themselves as operational management, so it suggests that at Maternity 2, there was less of a joint, interprofessional approach to planning services and midwives were left out of the decision-making process.

Midwives at all levels across Maternity 2 and Maternity 1 argued that it was very difficult to get midwives' voices heard at trust level, which meant it was very difficult to make significant service improvements. At Maternity 2, it was notable that this was due to an historical lack of strong leadership at midwifery level, however even with leadership at Maternity 1, they were still experiencing problems, because it was recognised that the director for midwifery was only in an acting capacity and would shortly be leaving. This problem was not mentioned at Maternity 3 and may be due to the strong leadership qualities of the joint general managers and having a midwife in this position.

Relationships

In considering the data on relationships within the maternity sites in the project, this section builds cumulatively on points which have been made in the previous section, where the discussion on roles has already highlighted structural issues and paired relationships. When analysing relationships across the three sites a number of key themes emerged.

The quality of overall, collective relationships between the doctors, obstetricians and midwives varied between the three sites. None of these sites experienced poor or conflicted relationships between the medical and midwifery professions, but there were tensions. At Maternity 1, tensions were apparent as a result of a number of historical events, which had affected the configuration of maternity services in the trust. In the 1990s, a case of clinical abuse had led, it was believed, to the redundancy of local paediatricians and thereafter the reconfiguration of maternity services, since paediatric cover could no longer be supplied to one site. From then on, further staff shortages in paediatrics had led to greater stress and further centralisation of maternity services. Moreover, in a geographically dispersed location, the medical profession did not always express confidence in midwives' ability to provide safe, but independent care. So this exacerbated the tension between the professions of obstetrics, paediatrics and midwifery. To counter this, there was a need for strong, strategic leadership in midwifery, but the current head of midwifery was 'acting' and potentially not permanent. At Maternity 2, there was clear evidence of good working relationships between the doctors – the clinical director, heads of service and consultants all demonstrating good, informal relations. But the view was expressed that midwives had greater difficulties in influencing decision-making and getting their voice heard. The head of midwifery was relatively new into this role and so was still in the process of building and embedding her position, though there appeared to be the intention to promote sound interprofessional relationships. At Maternity 3, there was stronger evidence to support the view that at this site, the relationships between the obstetricians and midwives were good and both professions were soundly led. Thus a foundation of trusting relationships had already been built.

When analysing the data, it was evident that the majority of the sets of relationships and networks described by interviewees were predominantly managerial or clinical professional, however there were bridging roles mainly provided by hybrids.

In interviews, the majority of clinicians argued that the only people they had a significant relationship with were their colleagues, nurses, midwives, and registrars, but again they all argued that the relationships were good and they worked well together as a team. The majority did not mention their relationships with senior managers as being significant. Clinicians' relationships were mainly with other clinicians within their tight network and they rarely strayed from this, if they wanted to influence they would usually take it up the hierarchy. Clinicians at one of the hospitals within Maternity 1 did however argue that they had a good relationship with the clinical director, this may have been due to the fact that he was based there and still undertook a large clinical workload, so worked closely with them. However, this differed at the other hospital site within the trust where clinicians

noted that they had little involvement with the clinical director and regarded this as detrimental.

Among general management, relationships varied considerably depending on where interviewees were in the hierarchy. At all three trusts, the majority of relationships at board level were managerially-orientated, with extensive relationships among these groups both internally and externally. The case of Maternity 2 differed from this template as both the medical director and the clinical director were classed as general managers, and had an excellent working relationship; however they did have significant relationships with clinical managers. Further down the hierarchy at clinical management team level, general managers appeared to have relationships across boundaries and levels, in all three trusts. However, general managers at Maternity 1 and 2, on the whole, had working relationships with people in a management role whether from a clinical or general management background, rarely pointing to clinicians as being important. This was different at Maternity 3 where a number of general managers pointed to clinicians as being 'significant others'. And it might be argued that this is due to a number of the managers coming from clinical backgrounds.

On aggregate, the hybrids were characterised by relationships with both managerial and clinical groups. It is important to emphasise that these relationships took the form of discrete sets of relationships, with the hybrid bridging rather than integrating the groups, in the majority of cases. The higher up the hierarchy, the more contact hybrids had with those from general management. At Maternity 2, service-level clinical managers argued that they had no contact with general managers higher up the hierarchy however the Heads of Service provide this bridging role in this case. This was slightly different at the other two trusts, where at Maternity 1 all of the clinical managers interviewed mentioned the Head of the clinical management team as a significant relationship, and similarly at Maternity 3, all interviewees mentioned the Joint general managers and senior midwives. It appeared that hybrids moved between clinical and managerial worlds and when working effectively could bridge the gaps between these two groups, providing communication between all personnel involved in maternity services.

Among clinicians and hybrids, the majority of relationships were internal, with the exception of the heads of midwifery at Maternity 1, who had external relationships at PCT level, and the consultant midwife at Maternity 3 who bridged the gap between primary care and acute care. The majority of general managers, especially at senior level, did have extensive relationships outside of their organisations. These were usually with other people from similar backgrounds in other acute trusts, PCTs, local authorities, SHAs, the Department of Health and voluntary organisations.

When looking at how interviewees influenced decision-making, it was obvious that at all three levels and across all three categories of role, the preferred method of influence was informal. Respondents described the use of evidence-based knowledge to persuade, negotiate and discuss, with people relying on respect, credibility and long-standing relationships to gain a hearing. Occasionally respondents described using formal mechanisms when trying to influence those higher up the hierarchy, for example, giving a paper to the board.

At Maternity 2, the relationships within the clinical management team would be regarded as good; they all had good working relationships and all mentioned each other as 'significant others'. They all relied on each other to achieve effective decision-making. The clinical director, general manager and the two heads of service for maternity had weekly meeting to plan services and to discuss any matters arising. The relationship between the clinical director and the general manager seemed to be particularly good, both mentioning each other as the most significant person they had a working relationship with. They both seemed to appreciate and understand the significance of each other's role and provide support. The general manager commented:

...without a strong clinical director you have more difficulties with the medical staff and whatever anybody says, the consultant is still a very powerful body.

It would seem that these two, with input from the two heads of service made the majority of strategic decisions, with operational matters largely being left to the heads of service. This worked particularly well as both of the heads of service could feed back to their colleagues about changes being made and take back concerns. This led to clinicians feeling less isolated from the decision-making process, however, it was strongly believed by the majority of interviewees that one of the hospitals sees itself as the lead provider. It is necessary to mention that no-one from midwifery was involved in the clinical management team, or any of the discussions, so there was clearly a gap here. Midwives were often involved in decisions at a later stage, on project groups, and did see themselves as implementers of change, but were not involved in actual decision-making.

At Maternity 3, the key relationships were between the joint general managers and the two heads of midwifery. They had close working relationships and were seen as the key links to all other groups. They had visible involvement in strategic change planning and consultation processes. The effective implementation of changes and the outcomes were often attributed to them by others. The missing link here would seem to be medical involvement, however the key individuals did recognise the need to involve the medical profession and did consult them when organising change.

It is harder to determine what the key sets of relationships were at Maternity 1 as they were less discernible. The associate director for women's and children's services and the clinical director both

mentioned each other as significant others, and although both were involved in strategic planning for the directorate, they did not meet often. The clinical director had a heavy clinical workload and was finding it hard to keep on top of his management role. However he did act as a bridging role between his colleagues and the general manager, so some clinicians' views were being heard. Another important relationship was between the clinical director and the two heads of midwifery, who met to discuss and plan changes, however changes were often implemented by the heads of midwifery.

In summary, at Maternity 1 the key relationships between the associate director, the clinical director and the two heads of midwifery provided input from a mixture of people from different backgrounds with varying views, all having some measure of influence on change. Although all professional groups would seem to be involved in decision-making processes, the relationships were not as clear cut as they were in the other two trusts. A lot of decisions seemed to be made in duos/trios. This may explain why this trust was further behind the other two with regard to development of maternity services.

Training and education

The majority of interviewees had undertaken some level of management training, although some had no formal management qualifications. Formal qualifications refer to accredited qualifications in health service management or related areas. Informal management training refers to one to three day courses undertaken in-house or within other NHS organisations. The number of people from each category with accredited qualifications can be seen in the table below:

Table 8 Management training in maternity sites

<i>Trust</i>	<i>Managerial</i>	<i>Hybrid</i>	<i>Clinical</i>	<i>Total</i>
Maternity 1	3	3	0	6
Maternity 2	2	3	2	7
Maternity 3	8	1	0	9
Total	13	7	2	22

It is noted that in all trusts, general manager were much more likely to have had formal management training than clinical managers. Although it is noted that it was more likely for clinical managers from a nursing background rather than medical to have some form of management qualification. All the heads of midwifery had attended formal management courses.

On the whole, senior midwives did have official management qualifications - either a certificate or diploma in health and social services, or qualifications through the Institute of Management. Most consultants had no official management qualifications but had attended one or two-day management courses and admitted they

found them useful. However the majority said that they were influenced mainly by experiential learning. They were particularly sceptical about the need for formal management training, believing that medical training of doctors would be wasted if they took on formal management responsibilities. It is noted that some of the clinical managers from medical backgrounds were undergoing courses at the time of the fieldwork, or were thinking about it in the future, as they saw potential benefits for their careers.

Progress on change and service improvement: responsive and supportive responses

This section examines in more detail how clinical service improvements in maternity services are implemented in these three sites. It is important to note that within all trusts people at board level, though recognising the importance of having quality maternity services, did not see improvements in this service as a priority.

The medical director at Maternity 2 had gone some way in trying to improve maternity services with a review and had been instrumental in appointing the new clinical director. Interviewees at all sites alluded to the fact that it was difficult for maternity services to have a voice at trust level and felt that this impeded change in this area. It was also believed that this was a hindrance in competing for resources. All three trusts agreed that another difficulty was the recruitment and retention of staff within maternity services.

Midwifery can be seen as an ageing occupation, and this was a particular concern at Maternity 1. Questions were raised everywhere concerning future levels of staffing and the need for both obstetric cover in labour wards and available paediatric support. Maternity 2 had gone some way to alleviating this problem at strategic level with the introduction of a project aimed at improving recruitment and retention in maternity services. This campaign arose out of the need to recruit more staff to work in maternity and neonatal services across the directorate and emerged from a review of services. National advertising, attendance at job fairs, overseas recruitment and role reviews meant that the directorate had been able to attract staff to a number of new posts.

A number of government documents over the last decade have begun to bring maternity care more to the forefront, such as *Changing Childbirth* and the *Children's NSF*. However, investment is often still slow. These policies do seem to be having an impact on maternity services. A resurgence of interest at strategic levels can be linked to the advent of the *Children's NSF*. This was published on 15 September 2004, as fieldwork was being completed.

Another interesting finding is that across all three sites, there was no coherent set of service improvements underway, though numerous changes were noted. Common changes did occur across all sites and

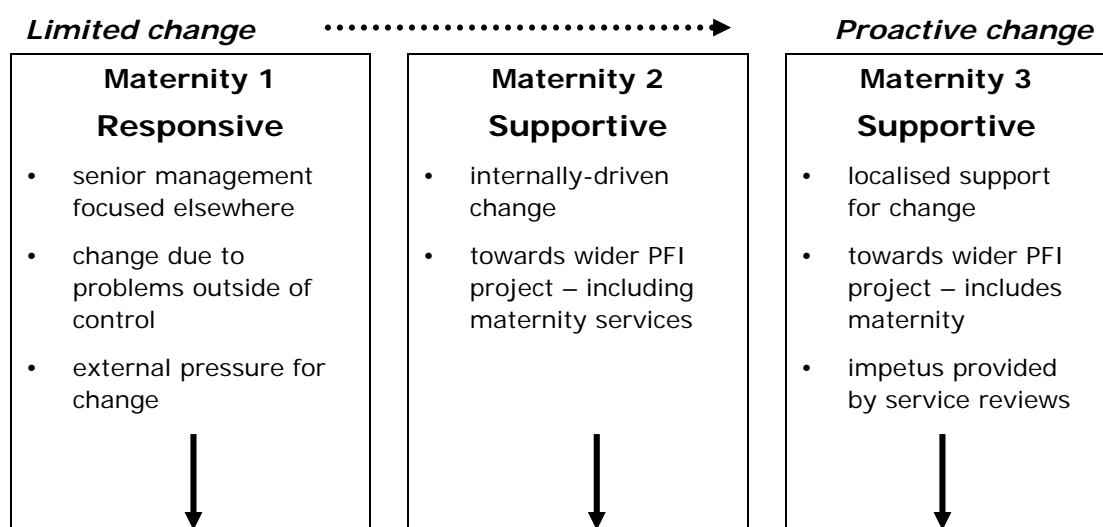
were frequently mentioned by numerous interviewees. For the purpose of this analysis, we focused on the following:

- at Maternity 1, the creation of the midwifery managed unit and the move towards midwifery-led wards at two of the hospitals
- at Maternity 2, the creation of a midwifery-led unit and the move towards specialisation of clinics
- at Maternity 3, the refurbishment of the labour ward, which included the development of a low risk, midwifery-led care unit in 'low tech' facilities, and the development of community midwife 'caseload' teams.

A common theme is that all three sites were working towards changing the model of care away from a consultant-dominated towards midwifery-led care for low risk women, which increases choice in line with the *Changing Childbirth* recommendations. However, this policy document was published in 1994 and the move towards implementing its recommendations had been slow at all three trusts. It is noted that other trusts had made significant progress towards implementing these recommendations. It has also been noted at the start of this section of the report that the *Children's NSF*, rather than moving away from these recommendations, reiterates their importance, so it is therefore disappointing to note the slow rate of progress towards the targets.

Figure 2 provides a typology of the trusts, representing the way that change capacity within each trust impacted on the progress towards improvement in maternity services.

Figure 2 Typology of service improvement capacity across maternity sites



Reactive	Active	Active
<ul style="list-style-type: none"> • general manager leads; limited clinical change champions • compromised on best course of action 	<ul style="list-style-type: none"> • key project leads / key players in place • all team focused on the same outcome 	<ul style="list-style-type: none"> • authority delegated to dynamic leadership duo/trio at unit level

The top labels within the typology, namely 'responsive' in Maternity 1 and 'supportive' in Maternity 2 and 3 are symbolic labels aimed at succinctly labelling the nature of the context in relation to change activity. We seek here to provide the reader with a short label of the site context. Behind this label lies a far more detailed substance of data to support the label. Thus in Maternity 1, we see maternity services at this site are subject to a range of external pressures which are sustained over time. Many of these pressures are created by problems and negative publicity and so maternity services are 'driven' by these pressures. There is limited interest and support from senior management and there are additional problems with the distributed site and the management structures. Hence in this site, the approach to service improvements in maternity services is characterised as 'reactive'. There is limited evidence that clinical service leaders are able to gain control and be proactive and there is limited local change capacity.

So the drivers for clinical service improvement at Maternity Site 1 can be characterised as responses, in many cases to external pressure from a variety of sources, public, government, other health care organisations, and other departments within the trust, as well as the media.

Historically, the major change at this site was due to the fallout of criminal activities, as well as the withdrawal of paediatric services. In the early 1990s, a case of abuse and the conviction of a clinical professional led subsequently to the two consultant paediatricians employed by the unit being made redundant. As a direct result of this, discussions took place with another hospital over 15 miles away, which led to consultants from this hospital attending the trust on a daily basis, so care could continue. However, following the retirement of a key consultant paediatrician who had developed this model, services were withdrawn. The withdrawal of paediatric services caused the closure of obstetrics at this hospital site, because without paediatric support the obstetric service was unsustainable.

Although the current changes towards the development of the midwifery managed unit were in line with national policy, none of the interviewees here attributed them to national level policy. Other changes, such as the reorganisation of services at one of the other hospital sites and the inclusion of midwifery-led wards at two further hospitals would also seem to result from this fallout, as well as pressure from the public for equal choice for women across all of the three hospitals.

On a more positive note, service improvements at Maternity 2 can be seen as supported by senior management and in line with *Changing Childbirth* targets. However organisational change in maternity services is being largely driven by broader strategic changes, most notably the PFI project. The building of a state of the art women's hospital is a major part of this project, so improvements in maternity services are included within this agenda. However, there are severe tensions in the planning of new service configurations at this site, between the wishes of the paediatric services and those of the maternity services.

Although senior management at Maternity 3 can be seen as supportive, the majority of current change would seem to be internally driven by key change initiators/leaders within the directorate in response to specific service reviews. Again, as in Maternity 2, major developments and reconfiguration of maternity services at Maternity 3 are integrated in the large PFI which was underway.

When drawing together themes concerning the impact of context on improvements to maternity services, it is evident that a number of key points arise.

- 1 There have been key factors in all the organisational contexts which have influenced progress on service improvement in maternity services. The case of criminal activity at Maternity 1 made it necessary to alter clinical service provision, however due to the publicity and external agencies involved, progress towards change was slow. At Maternity 2, all service improvements in maternity services can be seen as being driven by the wider agenda of the new women's hospital.
- 2 However, it is evident that where change is internally-driven and dynamic leadership is in place with the authority to make change happen, such as in Maternity 3, progress towards change is fast.
- 3 As highlighted earlier, maternity care was not seen as a trust-level priority in any of the three cases, although it was recognised that maternity services were important. The majority of respondents were in agreement that unless problems occurred, maternity services were left to their own devices. It could be argued that at all three sites maternity services were seen as being very insular and run like a small business that was separate from the hospital at a strategic level.
- 4 There are a number of reasons why this maybe the case. Firstly, there were no government targets for maternity that could influence trust performance outcomes such as star ratings or reviews by the Commission for Healthcare Improvement. Secondly, paediatrics often dominate the directorates of women and children services, and this can be seen most clearly in Maternity 1, where the withdrawal of paediatrics had such a profound affect on the provision of maternity services that they had to withdraw obstetric services at one of the hospitals.

- 5 It is also noted that at Maternity 2, paediatrics had heavily influenced decision-making around the new women's hospital, by refusing to be a part of it and insisting that paediatric services stayed at their original site close to A&E. Both the medical director and the clinical director at this site point to the fact that paediatrics is a lot more politically powerful than maternity services. At Maternity 3, the clinical director is a paediatrician, who has little involvement in the service improvement within maternity services and it is difficult to observe whether paediatrics dominated in this directorate. In some respects, at Maternity 3, paediatrics are counterbalanced by the combined power of the role of joint general manager/director of midwifery.

Impact of high change contexts

At the time of interviews Maternity 2 and Maternity 3 were experiencing high levels of strategic change, with major PFI projects underway. Everyone interviewed at Maternity 2 gave significance to the PFI project, whether from a strategic perspective or from a service level perspective. People with management roles concentrated on the strategy behind the PFI project talking about the significance of change for the trust as a whole, and emphasising facts about issues such as the bidding process and timescales. The medical director commented: -

'Oh the huge team appointed to run the PFI and the size of it is like having a separate industry in the trust really because there is a huge amount of resources going into it.'

At Maternity 2, hybrids and clinicians were much more likely to look at it from a maternity point of view, emphasising what it meant for the future of maternity services, and talking about their role in planning and reconfiguring services. They were all in agreement that the changes currently being implemented were in preparation for the new build to ensure as smooth a transition as possible. In this way maternity services could be seen as a priority as part of this wider project for the future, but for the time being most of the clinical service improvements taking place would seem to be driven from within the directorate, while priorities at trust level were on contracts and building work.

Although managers and hybrids from within maternity services have been consulted in the planning for the new 'women's hospital', they still felt that decisions were being made at a strategic level, with poor consultation. As a result of this, some of them argued that they had been left with a new service that was less than ideal, and they put this down to politics within the trust and the fact that paediatrics had refused to collaborate and form a Women's and Children's hospital. The staff within maternity services were clear that this would have been the ideal, but felt that they had been steamrollered into accepting an alternative. Again, this is an example of the interlinkage between paediatrics and maternity, and the need for political leverage.

At the time of interviews, Maternity 3 was operating in a similar complex, high change context. At trust level, they were in the process of negotiating high level strategic changes in the guise of the merger, a PFI development and the foundation trust bid. On top of this, there were a number of ongoing system-wide and more limited changes driven by or emerging from both the internal and external contexts. The numerous changes which had already occurred at strategic and operational levels indicate that this trust was broadly supportive of, and receptive to, change. However, within the trust, maternity services were not seen as a priority, which meant they had to fight harder for recognition and resources. This led to the service developing an insular culture. As a result it was described as its 'own little business', with a tight team which was removed from the executive level. At that stage, maternity service improvements within the site had largely been internally-driven within the directorate, with some external influences, such as rising birth rates, the government agenda, and the need for external funding.

At strategic level, maternity services at Maternity 1 were seen as 'low priority', with little mention of them in the trust's priorities. Concentration at strategic level seemed to be on structural reconfigurations, both in response to the merger, and a more recent reconfiguration of management teams. There was also talk of concentrating on establishing relationships and getting together as an executive, due to the high level of new appointments. Due to this, service improvement changes were low down the agenda, although there was a recognition that they had to concentrate on government targets, which had not, thus far, included maternity services.

At Maternity 1, improvements within maternity services were few and far between, with the majority being small-scale changes, to help the service run smoothly. Changes could be seen as reactive to challenges within the organisation and to external pressure. The only change within maternity services that was recognised by everyone, at all levels, was the opening of the midwifery managed unit, mainly due to the fact that it was preceded by a criminal investigation, which led to the withdrawal of paediatrics and the closure of obstetric services at one of the hospitals. The decision to open this unit was a mixture of pressure from the public, SHA, politicians and the media to provide some sort of maternity service at this outlying hospital, as the next closest hospital was about 40 minutes drive away. The unit can be seen as a compromise, as without paediatrics it was impossible to sustain a full obstetric unit. However the trust was still experiencing criticisms about this from staff, the public and the media, all still wanting obstetric care to be provided, and raising the risks of distance to the nearest obstetric unit for mothers and babies. The public also argued that 'low risk' care should be an option open to all women. These pressures led to a review into the provision of midwifery-led care at two hospitals, however due to its low priority at trust level,

changes to service provision would have to be provided from existing resources.

Duos and trios as change initiators/drivers

When analysing the data on service improvements in maternity services, it is evident that change is implemented more effectively when there are pairs or trios of change drivers. This is particularly evident when looking at Maternity 3. Within this hospital, change was led by the joint general manager, consisting of two staff - the head of midwifery and a general manager - along with the support of the senior midwife for hospital services. Within primary care, the latter was substituted by the senior midwife for primary care and assisted by a GP. Thus, there is evidence of change generation and implementation centring on management trios, with others providing support as and where appropriate.

For example, the director of midwifery/joint general manager acted as a consistent defender of changes. The refurbishment of the labour ward was primarily overseen by her and she adopted a supervisory and oversight role throughout the process. She was also broadly recognised as leading the development of community midwife teams, and acted in a strategic and supervisory capacity as well as having direct involvement with the change process. While the labour ward manager acted as a patron and implementer, her role in refurbishing the labour ward focused more on maintaining service provision than on the change itself. The consultant midwife acted as a defender and adopter - an expert advocate for the changes - and was described as a 'strong catalyst', and a clinical champion. Here medical hybrids and/or clinicians were not key drivers or generators of change, but only acted in an advisory capacity or as implementers.

The key characteristics of change roles within this hospital were the powerful, combined trio; the dominance of the head of midwifery/joint general manager, and the fact that many individuals involved in change processes adopted more than one role in the generation, implementation and adoption of change. The roles adopted were typically related to the stage of the change.

In Maternity 2, the decision-making core were the general manager, the clinical director and the two heads of service, with this group being the main drivers of service improvement. Service improvements were discussed at the senior management team meetings which are attended by these key individuals. It would seem that the role of key implementer was given to the project lead of the change being implemented, in each case this was a different person. Analysing the specific implementation processes of the specialist clinics and the birthing centre (the two key changes focused on in this site), in each case, a senior level midwife, was given authority by the senior management team to oversee the project. In planning the specialisation of clinics, a midwifery team leader was seconded to be

the change manager. Her role was to arrange consultation with all individuals to be affected by the change, to oversee this process, and to ensure the smooth implementation of the changes. A number of study days and open days were set up for staff and patients. They were asked what they thought the problems were and how they thought things could be improved.

A key point in the analysis of this change is that project teams or implementation groups were set up, comprising of people from management, hybrid and clinical roles. It was unclear how these people were chosen, but their role was to advise and to prepare guidelines. For the planning and setting up of the birthing centre, it is again evident that this change was overseen by a senior midwife. Her role was to organise a project management structure and to oversee the implementation of the change. Many staff were involved in the implementation of the birthing centre, including all senior midwives, the service manager, consultants and PCT representatives. It is apparent that, in this case, although there were key drivers for change, there were dispersed change implementers covering a cross-section of all those who had involvement in maternity services.

In Maternity 1, change was led by the general manager, who had the key oversight role for all of the changes, and could be argued to be the key defender of change. When analysing the creation of the midwifery managed unit, which was put in place due to the closure of the obstetric unit as explained earlier, the general manager played a significant role in developing and implementing the change. Yet in this site, there was confusion over who was managing the change process. No one person was visible and identified by interviewees as being responsible for the planning and development of an alternative service model. However, a taskforce was established. Again, the role of the taskforce was unclear. Some saw its role as assessing all options, while others stated it had been created to manage the process of establishing a MMU. The taskforce had strong external membership and comprised representatives from the local community health council, regional health authority, local MPs, obstetricians, and nursing staff. In addition, the National Childbirth Trust and Royal College of Midwives were also included. The taskforce was chaired by the director of nursing. There was some suggestion that initially nurses and not midwives were involved in discussions.

In implementing the move towards midwifery-led wards, the heads of midwifery were identified as the key change agents. Their roles were to consult with staff and to do the groundwork on the project. One interview stated that staff consultation was essential groundwork. Meetings were held with midwives about what they wanted and how things could be taken forward.

So, though the key driver for change at Maternity 1 was the general manager, others were called on when needed, for example the head of midwifery and a consultant led on producing the guidelines for the midwifery managed unit.

At this trust, many people interviewed at all levels argued that they were change leaders, and to some extent the evidence supports this, as small scale changes, such as initiatives to improve breastfeeding rates and to keep mothers and babies together, could be seen to be led by hybrids, usually from a midwifery background. The multitude of people involved in supporting and initiating change at this trust did not produce such efficient outcomes as in Maternity 3, possibly because the senior leadership was not as strong or inclusive

5.4 Conclusions

When looking at all of the data across these three maternity sites, a number of conclusions can be drawn:

- 1 **A slow rate of change** - it is evident that in all three cases, service improvements in maternity services were seen as low priority. As such all three cases had failed to achieve even some of the most basic recommendations in *Changing Childbirth* though ten years had elapsed since its publication. The pace of the changes that had been implemented had been very slow. Across all three sites, the changes currently targeted concerned moving towards midwifery led care and other changes in line with *Changing Childbirth* targets.
- 2 At all three trusts senior management were distracted by other key developments. At Maternity 2 and 3, these were major strategic developments that were taking place at the time, and Maternity 1 was undergoing massive structural change as a result of the merger. All of which were consuming considerable attention and resources at executive level. Thus **contextual pressures were distracting senior management from service improvements in maternity services**. Maternity services, it was argued, only get attention when something goes wrong, as in Maternity Case 1.
- 3 There is **limited evidence that mothers have a major influence in determining current maternity service improvements**. *Changing Childbirth* clearly argues that mothers should be involved in decisions around service provision. In all three cases, there is little evidence that this is taking place. Maternity 1 is the only case where interviewees mentioned the involvement of mothers at all, they argued that mothers had been one of the key drivers behind the two service improvements being analysed. They also argued that in the move towards implementing midwifery-led wards, mothers had been consulted during the process. It is important to note that at the other two sites, service improvements were more clinically-driven.
- 4 When comparing the analysis of the three sites, it is evident that change was most effectively implemented at Maternity 3. It would seem then that change occurs most successfully when there are a trio of people working together, in this case the joint general

manager/head of midwifery, joint general manager and the senior midwife (acute care). So **service improvement is more effective when duos/trios are appointed as change leaders**. All of the interviewees who described these changes evaluated them as a success and as having achieved the objectives set.

Secondary themes

The evidence suggests that none of these cases have particularly strong and complementary, collaborative relationships between midwives and obstetricians. There is **limited evidence at the three sites that these two professional groups are working together to bring about change**. It would seem that, at all three sites, one or other of these two key groups is missing or has limited access to the decision making process. It is recognised that service improvement may be more effective, if these professionals were to work more closely together.

It is also evident that **resources are severely restricted** in terms of financial and manpower at both Maternity 1 and 3, and to some extent at Maternity 2. This can also be seen as restricting change initiatives.

Section 6 Comparative analysis of diabetes case study sites

6.1 National policy context: diabetes

This section will look at NHS policy around diabetes care, in particular the development of the NSF for diabetes care (referred to here as the *Diabetes NSF*), which recommends the creation of a network of stakeholders involved in the provision of diabetes care. The cases focus on the implementation of this NSF in five PCTs.

6.1.1 Diabetes

Diabetes mellitus is a chronic and often progressive disorder, which results in the amount of glucose (sugar) in the blood being too high because the body is unable to use it properly. Normally a person's pancreas produces a hormone called insulin, which controls the levels of glucose in the blood. Diabetes occurs when the body does not produce enough insulin, or secreted insulin cannot be utilised by the body.

There are two types of diabetes: type 1 (also called insulin-dependent diabetes) occurs when there is a severe lack of insulin in the body because most or all the cells in the pancreas that produce it cease to function. This type of diabetes usually appears in people under the age of 40, often in childhood, and is treated by insulin (replacement) injections and dietary control. Type 2 (also called non-insulin-dependent diabetes) develops where the body can still make some insulin, but not enough for its needs, or when the insulin that is produced does not work properly (known as insulin resistance). This type of diabetes usually appears in people over the age of 40 years, although it can appear in younger people. Lifestyle is known to affect the risk of developing diabetes in later life. Controlling blood pressure, managing weight and taking regular physical exercise can reduce the risk of developing type 2 diabetes. Diabetes is more common among certain ethnic minority groups (for example South Asians) probably because of a complex interaction between environmental and genetic factors resulting in a higher incidence of insulin resistance.

The number of people developing diabetes is increasing around the world. In the UK alone, it is estimated that 1.8 million people have been diagnosed with diabetes and a further one million are undiagnosed (Department of Health and Diabetes UK, 2005). Although research and treatment of diabetes has improved over the last century, it can still have a devastating impact on individuals and their families, leading in some cases to impaired vision including blindness, renal failure, heart attacks and strokes if not managed properly.

6.1.2 Diabetes care service improvements in the UK: the development of a National Service Framework for diabetes

Over the last 15 years, various government organisations alongside Diabetes UK (formerly the British Diabetic Association), have been carrying out research and producing documentation to improve the lives of those living with diabetes. There is also a real determination across the NHS, in primary care, acute hospitals and community services, to reduce the burden on healthcare services of diabetes.

In 1996, the British Diabetic Association produced a report called *Training and Development in Diabetes Care*, in response to the St Vincent Declaration (WHO Regional Committee for Europe, 1990), which recognised that, in Europe, diabetes is a debilitating and costly disease, both to the patient and to society; and recommended actions on prevention and control of diabetes. The BDA report produced a number of key recommendations:

- Training in diabetes care should be provided locally and be accessible to all professional disciplines.
- The changing structures brought about by the NHS reforms should be employed to enhance professional training in diabetes care.
- An investment of time and other resources is required in order to implement the strategies outlined in this report.

Further to this report, the British Diabetic Association continued to exert pressure on the government to upgrade standards in diabetes care. They produced a report (1999) looking into the structure of specialist diabetes care services, which made recommendations for the following:

Organisation of local diabetes services: Local diabetes services advisory groups should be established in each locality to monitor and advise on the services which should be commissioned and provided in order to improve the health of local people with diabetes. These groups should include professional and managerial representatives from the acute, primary care and community sectors. The association also recommended that, because diabetes registers are essential for monitoring progress towards diabetes targets, they should be established in all localities and that local guidelines should be prepared for the management of people with diabetes.

Diabetes specialist staffing and associated service requirements: Although they recognised that staffing requirements and resources would vary from locality to locality, they made a number of suggestions, including consultant physicians with specialist training in and responsibility for diabetes; and diabetes specialist nurses with specialist training.

Diabetes centres and other facilities: By 2001, the government, recognising that alongside real progress in diabetes care there still remained significant variations in the quality of services, produced the *Diabetes NSF*. This was developed with the help of an external reference group, as well as being informed by views and experiences of people with diabetes, and the report of the Audit Commission. It also builds upon the St Vincent Declaration and reports from the British Diabetics Association.

The *Diabetes NSF* its associated standards were published in 2001 (Department of Health, 2001b). Thus they were in place at the period when this research was being conducted. The NSF aims to make best practice the norm; to provide better support for people so they can more effectively adjust their insulin; provide dedicated nurses on hospital wards to reduce the length of stay in hospital; decrease complications; and provide community-based diabetes clinics to bring together at one location specialist expertise. The NSF was established to improve services by setting national standards to drive up service quality and to tackle variations in care in different parts of the country. Its primary goal is to enable people with diabetes, or at risk of developing diabetes, to manage their own lifestyle and diabetes by providing them with support and structured education as well as drugs and insulin replacement treatment. It exemplifies the approach to patient-focused care set out in the *NHS Plan*.

The *Diabetes NSF* includes standards, a rationale, key interventions and an analysis of the implications for planning services. There are 12 standards in total, which are briefly outlined below:

- Standard 1: Prevention of type 2 diabetes
- Standard 2: Identification of people with diabetes
- Standard 3: Monitoring strategies to identify people who do not know they have diabetes.
- Standard 4: Clinical care of adults with diabetes
- Standards 5 and 6: Clinical care of children and young people with diabetes
- Standard 7: Management of diabetic emergencies
- Standard 8: Care of people with diabetes during admission to hospital
- Standard 9: Diabetes and pregnancy
- Standards 10 and 11: Detection and management of long-term complications
- Standard 12: Diabetes and multi-agency support.

As can be seen from this list, the standards are intended to cover the full range of care, including prevention, and to recognise that diabetes patients will move across the boundaries of health care between primary and secondary care. However, many of the standards are laid out in aspirational terms.

Following the publication of this policy document, an implementation group was set up to steer the development of the delivery strategy (Department of Health, 2002a). As a result of this, the Department of Health produced a delivery strategy (Department of Health, 2002) which lays the foundation for the implementation of the vision set out in the standards documentation. The key elements proposed in the delivery strategy are:

- The establishment of a local diabetes network, or similarly robust mechanism, which involves identifying local leaders and appointing and resourcing network managers, clinical champions and a person(s) with diabetes to champion the views of local people.
- A review of the local baseline assessment, to establish and promulgate local implementation arrangements with a trajectory to reach the standards.
- The participation of all stakeholders, for example GPs and podiatrists, in comparative local and national audits.
- The development of a local workforce skills profile of staff involved in the care of people with diabetes and the development of education and training programmes with the local workforce development confederation.

While the delivery strategy lays out some core ideas, it was for PCTs to decide the best approach to delivering the diabetes standards, drawing on the approach outlined in this delivery strategy, while reflecting local circumstances and the communities they serve. However, the delivery strategy recommended that, in developing an integrated service, PCTs should consider putting robust mechanisms in place to reach the standards and deliver the targets.

The document also recommended that the delivery strategy should engage all stakeholders, work across traditional service boundaries, have clear lines of accountability and demonstrate excellent leadership and management. It suggested that clinically-led managed diabetes networks, involving people with diabetes, provide one means of embedding these principles in practice. It recommended that these networks involve all stakeholders and cover the population served by specialist diabetes services based within the NHS trust. Clearly this is a further government policy which advocates the creation and use of managed networks as a means of delivering improvements in clinical services.

The strategy also focuses on the training and development of frontline staff. It suggests that one way that PCTs can add their support to staff working in the front line is by undertaking a workforce skills profile of staff involved in the care of people with diabetes and developing education and training programmes with the workforce development confederation.

The *Diabetes NSF* also links to broader strategy and recognises two specific national diabetes targets, for eye screening and registers, in the priorities set for the NHS over the period 2003 to 2006 (Department of Health, 2002). These are:

- By 2006, a minimum of 80 per cent of people with diabetes should be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end 2007.
- In primary care, practice-based registers should be updated so that patients with chronic heart disease and diabetes continue to receive appropriate advice and treatment in line with NSF standards. By March 2006, practice-based registers and systematic treatment regimes (including appropriate advice on diet, physical activity and smoking) should cover the majority of patients at high risk of chronic heart disease, particularly those with hypertension, diabetes and a body mass index greater than 30.

Between them the documents set out a systematic programme to deliver a service built around the needs of the people with diabetes. They herald a ten-year programme for change, and it is intended that all standards should be reached by 2013.

The role of patients' and patient advocacy groups is in evidence in this area of care. In addition to the work of the BDA, the patient education working group was set up in May 2004, with the aim of supporting the development of structured education for people with diabetes. It delivered its report in 2005 (Department of Health, 2005c).

This report argues that patient-centred care is one of the central pillars of the *Diabetes NSF*, and in order to meet this it is necessary to empower patients. The report outlines the current education programmes that are available, and provides up to date advice on key areas such as health professional training and quality assurance, as well as highlighting gaps in education provision.

The report argues that currently there are two structured education programmes for adults with diabetes:

- 1 DAPHNE: a skills-based education programme in which adults with type 1 diabetes learn how to adjust insulin to suit their free choice of food, rather than having to work their life around their insulin doses (for further information see www.daphne.uk.com).
- 2 DESMOND: a new structured group education programme for adults with type 2 diabetes which supports people in identifying their own health risks and responding to them by setting their own specific behavioural goals (This was piloted in 2004 - for further information see www.desmond-project.org.uk).

This report argues that learning needs assessments should be carried out in a formal, comprehensive and standardised way, with training of

staff, in order to work interprofessionally with patients, ensure quality and validity of any training programmes and that training should be accredited. The working group also identified a number of gaps in education which need to be addressed.

Nominally, then, in this area of care there should be evidence of all PCTs and their local acute trusts working towards the improvement of services for diabetes, which is clearly an area of increasing demand and a condition which is creating major problems for sufferers as well as incurring high costs in providing health care.

Diabetes is a chronic and progressive disease which is affecting increasing numbers of people, particularly older people and those from ethnic minority and socially disadvantaged groups. Over the last 15 years, the NHS has made considerable attempts to improve diabetes care. This culminated, in 2001, in the introduction of the diabetes NSF, which recommends, among other things, that PCTs develop professionally-led networks of organisations and individuals involved in providing diabetes care.

6.2 Context: introduction to the diabetes cases

This section of the report discusses the roles and relationships surrounding the introduction of improvements to care and the *Diabetes NSF* in five PCTs labelled Diabetes 1, 2, 3, 4 and 5. As stated in the previous section, the *Diabetes NSF* sets out standards which the PCTs must comply with in the delivery of care for people with diabetes. Changes associated with the *Diabetes NSF* are therefore examples of cases of the management of change in professionalised organisations and provide valuable insights into how to bring about effective change in health care and whether or not this might be achieved.

The remainder of this section provides an overview of five primary care organisations which the research team studied. Section 6.3 provides a comparative analysis of the cases and discusses the roles played by individuals within all five cases, particularly managers, clinicians and clinical manager hybrids, and their impact on change in diabetes care. In this section, the report also looks at relationships; the internal relationships between groups and individuals within the PCTs, external relationships between the PCTs and organisations they work with in the delivery of primary care, particularly local acute trusts, and their impact on the *Diabetes NSF*; and briefly discusses managerial training received by those within the PCTs. The penultimate part of Section 6.3 of the report looks more specifically at the changes associated with improvements in diabetes care, including drivers and inhibitors. Section 6.4 draws conclusions about the five cases overall, highlighting similarities and differences between them, how they implemented the *Diabetes NSF*, implications for future

changes in professionalised healthcare organisations and then draws some final conclusions.

The report now provides a brief overview of the five case study organisations; the PCTs are labelled Diabetes 1, 2, 3, 4 and 5.

Table 9 Factual data on diabetes sites

	Diabetes 1	Diabetes 2	Diabetes 3	Diabetes 4	Diabetes 5
Established (year)	2002	2001	2002	2002	2001
Star rating (02-03/03-04)	1/2	2/2	1/2	1/1	1/2
Annual income (£m – 2003/04)	203	274	225	320	152
Number of staff	1300	1200	1200	560	1000
Number of GP practices covered	37	55	30	74	29
Population served	241	320	250	300	148
% ethnic minority population	Low	14%	Low	38%	12%
Deprived population	No	No	No	Yes	Yes
Urban/rural	Rural and suburban	Urban	Urban and rural	Urban	Urban

6.2.1 Diabetes 1 (PCT)

Diabetes 1 is PCT based in the Midlands. It serves a rural and suburban population of almost 250 000 people, incorporating 37 GP practices (equating to 137 GPs) and three community hospitals, and directly employees 1300 staff. The PCT had an annual budget of £185 million in 2002/3 and £203 million in 2003/4. The Healthcare Commission gave Diabetes 1 a one star rating in 2003 and two stars in 2004. The results of the most recent staff attitude survey were below average for other similar PCTs. The results of patient surveys were positive.

Diabetes 1 was formed through the deliberately transparent merger of three primary care groups in 2002. Many roles in the new PCT were assumed by former employees of the primary care group; however a new CEO came to the PCT from a different geographical area. The new PCT chair was formerly a non-executive director of the local health authority.

The PCT was structured in line with government regulations. It had a trust board which was responsible for PCT performance, supervision of the PCT as a whole, accountability to the public, strategic requirements and objectives. The board consisted of a chairman, five

non-executive directors, a CEO, a director of finance, a director of quality and professional practice, a director of public health, a director of strategy and development, a GP representative, and the Professional Executive Committee (PEC) chair who ensured clinical focus and had operational responsibility for clinical matters.

The PEC committee contained a majority of clinicians, which advised the board and ensured that the PCT had an appropriate clinical focus. The board thus contained working managers and clinicians. In addition it included five co-opted members who attended meetings but did not hold a formal position. The PCT, like other PCTs, was led by a 'strategic triumvirate', made up of the CEO, PCT chair and PEC chair.

Diabetes 1 was split into five directorates; quality and professional practice; strategy and professional development; public health; finance; and healthcare services. The PCT had five strategic objectives; to improve the overall health of the population; to tackle health inequalities; to provide high quality, fast, responsive service; working partnerships with other agencies; and to devolve responsibility to clinical and other professional staff. In 2003/4 it had five priority areas of clinical care, which did *not* include diabetes, although this might fall under the remit of services for older people.

Diabetes 1, like other PCTs, is required to meet national, non-negotiable targets. It planned to invest in services following themes for local development, which *did* include diabetes care and to lay out some targets for this: a local implementation group and action plan to improve services; investment in exercise schemes; and increased involvement in nutritional initiatives.

Fieldwork at Diabetes 1, including interviews with 16 people, took place between July 2003 and January 2004 (see Appendix 2 for details). This was during a period of major change for the PCT, including a shift in the provision of diabetic care from the acute to primary care.

6.2.2 Diabetes 2 (PCT)

Diabetes 2 is a PCT which serves a population of 320 000 in an urban location serving a relatively affluent borough. In 2004, the PCT directly employed over 1200 people. The PCT had at the time of field research been in existence for three years, formed through the merger of three primary care groups. In 2003-4, the PCT spent £274 million. In 2004/5 it was due to receive over £318 million from the Department of Health and was expected to overspend by £5 million. The PCT was given a two star rating by the Commission for Healthcare Improvement in 2003 and 2004. In 2004, a staff survey found that Diabetes 2 was in the lowest 20 per cent for staff satisfaction however, which was seen to result from fragmented relationships at the top of the organisation.

Diabetes 2 had six key objectives: to reduce gaps in health status; to achieve public health goals as set out in NSFs, including the *Diabetes NSF*; to achieve financial balance without compromising quality, innovation and modernisation of care; to enable modernisation, improvement, innovation and integration of services; to use a local improvement finance trust to progress the modernisation of primary and community estates and the integration of these services; and to strengthen patient and public involvement and communication.

Notably the provision of diabetes care was not one of the PCT's main priorities during field research. Diabetes care had been relatively high on the PCT's agenda for a while but, due to funding constraints, this has not been translated into action. However diabetes care was to be one of Diabetes 2's key areas for research, development and action in 2004-05.

Diabetes 2's board comprised 14 members, which had overall responsibility for the PCT's strategic development, service provision, performance against objectives and accountability. Members included a non-executive chairman, seven non-executive directors and two executive directors, two of which were on the PEC, ensuring both clinical and managerial representation. The Board met bi-monthly.

The structure of the PCT was unusual with a matrix form and a 'cabinet group', comprising 12 directors (more than in the typical PCT) with strategic and operational roles, surrounding and accountable to the CEO. The main trust business occurred at a fortnightly senior management team meeting. This was attended by 11 service directors, three with geographic responsibility and eight with responsibility for different areas of service delivery, and the CEO. The meetings were managerially-focused, with little clinical input.

The PEC, which played only an advisory role considering clinical matters but making no decisions, contained 14 GP and nursing representatives, including a GP chairman, the CEO of the board and the director of finance. It provided a link between managerial and medical agendas and decision-making processes.

Another important committee was the clinical governance committee which dealt with issues relating to quality, including diabetes, where there were concerns about risk due to high workload.

Within the PCT's strategic triumvirate, the CEO had worked managing the PCT and its predecessor organisations for some considerable time. The PEC chair was a GP with 30 years' experience in the local area and the board chair was a retired consultant physician and academic researcher. The relationships within the triumvirate in Diabetes 2 were difficult. In particular, there was confusion over the role of the PEC and its relationship to the board, culminating with the resignation of the PEC chair because the PEC was not seen to be central to decision-making in the PCT. This is discussed in-depth later.

In Diabetes 2, research data was gathered in June 2004, including interviews with 17 people (see Appendix 2 for details)

6.2.3 Diabetes 3 (PCT)

Diabetes 3 was formed as a PCT in 2002, serving an urban and rural population of 250 000 in the North West, and employing over 1200 people. Its services include 30 GP surgeries, an acute hospital and a specialist mental health trust. The PCT's budget in 2003/04 was £225 million and it anticipated being in surplus. Diabetes 3 received a one star rating from the Healthcare Commission in 2002/3 and two stars in 2003/4. It scored in the top 20 per cent of similar organisations in its staff satisfaction survey.

Diabetes 3 was focused upon but struggling to respond to the organisational changes, changing goals and performance targets imposed upon it by central government, particularly given its lack of resources and dated technologies. Diabetes care was therefore a relatively low priority for the PCT throughout the early period of field research.

Diabetes 3 had a complex management structure and this complexity caused concern within the PCT. The structure comprised:

- a PCT main board, made up of executive and non-executive directors, which had oversight of the strategic agenda of the PCT, ensured public accountability and compliance with government framework and also discussed operational issues
- a PEC which was a forum for clinicians to agree and prioritise the PCT's work and was accountable to the main Board. It was made up of GPs, allied health professionals and senior PCT managers (including the CEO and director of finance)
- a senior management team is made up of six directors running directorates, who are accountable to the CEO and provide specialist knowledge and skills to inform strategic decision-making.

The PCT board, the PEC and the senior management team all met monthly.

The PCT was led by a cohesive and experienced triumvirate made up of the CEO who was an experienced NHS manager, the chairman, who was a professor at a local university, and a PEC chair, an experienced senior GP. The triumvirate was a cohesive group, respected within Diabetes 3 for leadership and engaging with colleagues on equal terms.

The PCT placed particular emphasis on communication and staff involvement; paying attention to the 'people dimension'. Diabetes 3's organisational culture emphasised devolved decision-making, staff influence, patient and public influence, high trust, low bureaucracy, risk-management to assess benefits rather than risk avoidance and balanced perspectives across the organisation. The PCT promoted the

principles of 'REACH': right service at the right time and place; effective resource use; achieving national and local targets; creating and organisation people want to work with and for; and health improvement. The atmosphere within Diabetes 3 was highly professionalised and collegiate. Diabetes 3 also scored favourably in its staff survey. It appeared to be a motivated and hard-working organisation. Yet there was evidence of fatigue and work overload resulting from constant and rapid organisational change and pressure to meet shifting national and regional goals and performance targets.

The implementation of the *Diabetes NSF* provides a good example of the tension and ambiguity generated by implementing change within structural limits. There was an apparent tension between the autonomy of Diabetes 3 and the imposition of national targets; between central political goals and the needs of patients at a local level. This produced emotional debates within the PCT. The imposition of a blanket national policy of research ethics approval, for example, was seen as inconvenient and unnecessary bureaucracy. Similar tensions existed about provision of information for the SHA, also seen as bureaucratic, time-consuming and duplicating existing performance monitoring systems. Field observation at meetings suggested that the PCT 'turned against' those they perceived to be outsiders, such as a representative of the SHA, explaining the necessity of SHA monitoring. PCT management was challenged by dealing with such complexity and diversity.

Research in Diabetes 3 took place during the first half of 2004, including interviews with 20 people (see Appendix 2 for details).

6.2.4 Diabetes 4 (PCT)

Diabetes 4, established in 2002, is located in a large urban community and is a 'teaching PCT'. The purpose of a teaching PCT is to attract high quality staff into disadvantaged areas; Diabetes 4 serves a disadvantaged population of approximately 300 000, with a high proportion of Black and Asian people who have a greater risk and prevalence of diabetes. The PCT has a staff of 560. Its income was £286 million in 2002/3, achieving an underspend of £2 million, and its income was £320 million in 2003/04. Diabetes 4 most recently received a one star rating from the Healthcare Commission. Diabetes 4 received mixed results from patient satisfaction surveys and in 2003/04 received 253 written complaints. The results of Diabetes 4's staff satisfaction survey were average for PCTs.

The values underpinning Diabetes 4 are: putting the patient first; being a good employer; being a trusted partner; being innovative; being accessible and being outcome focused. The PCT's vision is to improve health and well-being and reduce inequalities; to develop an integrated health service to meet the needs of local people; and to commission high quality secondary care from other NHS trusts, including acute hospital services

At the time of the fieldwork the PCT was structured into a number of directorates: commissioning and modernisation; finance, information communication technology and purchasing; nursing, quality and clinical governance; primary care services; human resources; joint working directives; learning disability services; overall joint working directorate structure; press and communications; primary care services; public health; public user and community involvement and the senior management team.

The three main decision-making forums were the board, the PEC and priority action groups. The board was co-ordinated and 'friendly'. The strategic triumvirate leading the PCT consisted of the CEO, who, as a former public health consultant, had a medical background, a chair (a magistrate) who did not have a clinical background but argued that his expertise came from life experience, and the PEC chair, a female GP. The PEC was described as the clinical 'engine force', feeding clinical issues into the management agenda, and working closely with the executive management team and board.

Hierarchically below the PEC were various priority action groups, including one for diabetes. The diabetes group was made up of a range of health professionals involved in the provision of diabetes care and had a significant role in decision-making about diabetes care. It aimed to promote the health and well-being of people with diabetes through a programme of primary prevention; education and empowerment; early detection and management of complications and prompt appropriate advice and treatment for acute hospital-based problems. The diabetes priority action group's vision was for a team of professionals to provide a seamless service to diabetes patients, spanning acute and primary care. At the time of the fieldwork, the group discussed clinical decisions rather than matters relating to finance. Initiatives developed by the group had been rejected by the PEC, therefore it appeared to have advisory influence in the area of diabetes rather than decision-making power.

£275 000 had been tentatively allocated to diabetes care in Diabetes 4 in the year 2005/06, suggesting that diabetes was likely to become more important than it was during field research, involving interviews with 12 people (see Appendix 2).

6.2.5 Diabetes 5 (PCT)

Diabetes 5 was established as a PCT in 2001. It serves a deprived urban population of 148 000 in the Midlands, containing a high proportion of ethnic minorities, who suffer many of the health problems associated with poverty and social exclusion, including a higher than average prevalence of diabetes. The PCT hosts a number of services and incorporates 29 GP practices. In 2003/04 the PCT spent £152 million. In 2002/02 Diabetes 5 was one star rated and in 2003/04 it received two stars from the Healthcare Commission. The results of the staff attitude survey were mixed.

At the time of the fieldwork this PCT, like the others, was structured around a triumvirate arrangement of the PCT chair, a PCT CEO and a PEC chair. Much of the day-to-day decision-making and strategy development took place in the PEC however, which was described as the 'engine room' of the PCT, and drove the implementation of NSFs, including that for diabetes. The senior management team was operationally focused and consisted of nine directors, led by the CEO. The relationship between the senior management team and PEC was close.

Due to levels of deprivation in the locality, one of the PCT's main priorities was health promotion and there was a strong emphasis on tackling health inequalities and wider factors affecting health and public health. The PCT worked in collaboration with a number of organisations on projects to address these issues.

The PCT established a multi-disciplinary implementation group for the *Diabetes NSF*, which worked to support GP staff around local priorities. The group's strategy focused on prevention and addressed the link between diabetes and deprivation.

Field research in Diabetes 5 was conducted in late 2004 to early 2005 and included interviews with 15 people (see Appendix 2).

6.3 Comparative analysis

6.3.1 Contexts for change

All five PCTs were established at the roughly same time (2001 or 2002) and are structured in a broadly similar way. Diabetes 2 and 4 have the highest income and serve the largest population. Diabetes 1 and 3 serve slightly smaller populations with slightly less income. Diabetes 5 serves significantly fewer people than the other PCTs and accordingly has a smaller income. Diabetes 1, 2, 3 have the largest number of employees, Diabetes 5 is slightly smaller, but this is relatively high given that it serves half as many people and has half the income of the other PCTs. Diabetes 4, despite serving a relatively large population and having a relatively large income, has only about half as many staff as the other PCTs.

Urban-based PCTs tend to serve more GP practices; Diabetes 2 and 4 serve a larger number of GP practices (55 and 74 respectively) than the more rural Diabetes 1 and 3; Diabetes 5, despite serving approximately half the populations of Diabetes 1 and 3, serves almost as many GP practices.

Three of the PCTs, Diabetes 2, 4 and 5 serve populations with a higher proportion of ethnic minorities, and in the cases of Diabetes 4 and 5 deprived populations too, among whom diabetes is more likely to be prevalent. Therefore one might expect diabetes and the implementation of the *Diabetes NSF* to have been a higher priority in

these PCTs, providing a more receptive context for change, and the expectation of more progress in the development of diabetes care in these cases.

Diabetes 2 is distinctive for its unusual matrix form and for having more directors. It is also distinctive for its more 'managerial' culture and poorer clinical-managerial relations than the other PCTs. In Diabetes 3, 4 and 5, and to a lesser extent Diabetes 1, clinical-managerial relations within the PCT and the strategic triumvirate were good. One might therefore expect Diabetes 2 to provide a less receptive context for change.

Diabetes 1 PCT had a 'difficult' relationship with its local acute hospital, which was perceived to not take the PCT seriously.

Relations between Diabetes 2 and local acute trust were also tense because the PCT was attempting to be the lead organisation but the acute trust did not respect the validity of this change. Only one informant was from the acute sector but this person was rather defensive about the location of the diabetic services and was against the PCT's 'takeover' of diabetes and moving it into a community setting. She voiced her concerns quite forcefully at an observed meeting. The acute trust reported directly to the SHA, which also undermined the position of the PCT. Diabetes 2's CEO also believed that the acute trust CEO had blocked the development of direct relations with clinicians in the acute trust. There were clear differences between secondary and primary care in terms of clinicians' perspectives of each others' ability. The data suggested there were cultural differences between the acute trust and Diabetes 2 and that the organisational changes in primary care had re-energised this sector and the acute side had been more introspective in their outlook. But acute staff had been less involved and knowledgeable about changes and how to improve services for the local population.

6.3.2 Roles

This section looks at roles within each organisation. In all five PCTs, roles broadly fell into one of three categories; general managers who were non-clinical middle and senior managers; clinical/managerial hybrids, who held both managerial and clinical roles, including GPs, nurses and allied health professionals such as dietitians and podiatrists; and clinicians who largely or wholly did clinical work. The distinction between clinical manager hybrids and non-managerial clinicians, however, was often a tenuous one. First, however, we examine general attitudes towards roles.

In Diabetes 1 it seemed that 'management' was a word which people, particularly those with clinical workloads, avoided using. Instead they talked about the 'strategic', 'educational' or 'influencing' aspects of their roles. Nonetheless management did appear to play a major part of many roles in the PCT. Perhaps it was necessary to use neutral language in order to provide a bridge between clinical and managerial

groups and communicate the importance of these activities to clinicians.

In Diabetes 2, in contrast to Diabetes 1 and the other PCTs, management was more overtly acknowledged and respondents were clear about their roles, which were often set out in documentation. Managers and clinical managers in Diabetes 2 were more likely to acknowledge their managerial roles than in other PCTs. Members of the PEC, however, were less likely to do so, remaining firmly wedded to their clinical identities. It may be because management was more overt and forceful in Diabetes 2 that relationships with GPs involved more conflict. This will be further discussed later in the section on relationships. Clinical manager hybrids in Diabetes 2 also acknowledged their managerial roles, considering what they did to be both clinical and managerial. However they argued that they would not like to lose their clinical workload because a clinical background provided essential understanding of issues and credibility to authoritatively communicate with other clinicians.

In Diabetes 3, as in Diabetes 1, roles were less overtly managerial, particularly among managers and clinical managers involved in leading and managing change. The PCT appears to be highly professionalised, emphasising clinical and professional values over management. The boundaries between clinical professionals without managerial responsibility and those with managerial responsibility were blurred in Diabetes 3, perhaps more so than in Diabetes 1. In Diabetes 3, roles could be interpreted flexibly and redefined by individuals, as long as they could demonstrate benefits to patients.

Diabetes 3 paid particular emphasis on the 'people dimension' to running an organisation, yet there appeared to be signs of 'initiative fatigue' from constant government pressure to change, even among some managers who were the most enthusiastic and committed to leading change. One such middle manager seemed to be overwhelmed by the breadth of her responsibilities and the constant changes imposed on PCTs. It therefore seems that even the most committed, energetic and enthusiastic managers do not have an infinite capacity to manage change; change should therefore be targeted where it is really needed if it is to be effective.

Diabetes 4 also appeared to be dominated by clinical and professional roles. Like Diabetes 1 and 3, management in Diabetes 4 seemed to be phrased in clinical language; management was absorbed within established clinical ways of doing things, rather than challenging them. Hence there was some confusion about managerial roles. What is also apparent in Diabetes 4 is the importance of bridging between different groups; clinicians and management, diverse clinical professions, and primary and secondary care.

In Diabetes 5, too, management was seen much more in terms of influencing through communication, education and training; talking with people rather than telling them what to do. Clinical managers

argued that it was important to have a clinical background both to understand services and relate with clinical colleagues.

The report next looks at specific roles, beginning with general management roles.

General management roles

In Diabetes 1, the role of PCT chair could be defined as a general management role. However the chairman was adamant that his role was 'strategic' rather than managerial, in line with the wider culture of the organisation. Other senior managers in Diabetes 1 had clear and cohesive views of their roles too and all consistently advocated an open and transformational style of management within the PCT. They placed much importance upon 'getting out and about' and spent 'a lot of time' meeting and talking to people.

At lower levels in Diabetes 1, however, middle managers were less clear about their roles, and found this stressful, because the PCT was in a nascent stage and roles were changing over time. Middle managers saw their role as making sure the government agenda was carried out; dealing with performance issues and ensuring that GPs, in particular, as independent contractors, were practising in line with standards of clinical governance. Middle managers were focused on meeting government targets - for access, waiting times and immunisations - which affected the PCT's star ratings.

Similarly in Diabetes 3, general managers fell within two sub-clusters: strategic leaders/change drivers and those in more supportive roles. Strategic leaders and change drivers provided vision and leadership at strategic and operational levels within the PCT, initiating and implementing changes in collaboration with a network of external and internal stakeholders. For example the chair of Diabetes 3 saw her role as keeping the PCT focused on demonstrating health improvements year on year. Another strategic leader in Diabetes 3 was the CEO, who was experienced in the role having been CEO in another trust prior to his appointment. He argued, however, that 'the whole modernisation agenda has dramatically changed what a CEO does because it is no longer about actually trying to get the best out of an established system, it's now about changing the way the system works'. Hence his role was believed to be about leading change.

The Diabetes 3 director of service development argued that flexible management structures were necessary for effective functioning. She commented that the PCT started off with clear structures around roles and responsibilities for service areas but that they had not been practical due to changing priorities. Her role was to translate the national change agenda into specific change projects and implement these; guiding, supporting and managing her team in order to do so and liaising and communicating with various stakeholders about progress and achievement of these various projects. Her role therefore varied with changes to the national agenda.

The second cluster of managers in Diabetes 3 was involved in facilitating, monitoring and supporting, similar to middle managers in Diabetes 1. This group had a greater sense of clarity about their role. These roles, for example, included delivering training, monitoring trust performance in relation to clinical governance and acting as a change agent to bring about improvements in clinical governance systems, and financial roles; monitoring financial performance against targets and reporting these externally.

Managerial roles were both strategic and operational in Diabetes 5. The chair of the PCT board believed that his role was clear; he was a manager and did not cross into clinical matters which the PEC chair was responsible for. The CEO saw his role as leading the organisation, overseeing the PCT's operations and meeting government objectives. He did so by meeting regularly with staff, working closely with the senior management team, and keeping the organisation 'as clear and simple as possible'. As elsewhere the triumvirate leadership of board chair, CEO and PEC chair were perceived to be vitally important and in Diabetes 5 this relationship worked well by staying within boundaries of expertise. At a lower level, managers' roles revolved more around implementing changes, comparable to similar managers in Diabetes 1 and 3.

As noted earlier, management in Diabetes 2 was more visible than in other PCTs and both clinical and general managers were accountable to non-clinical service directors. Diabetes 2 had a higher than average number of directors than in other PCTs and only two of these directors were clinicians, who considered themselves managers who just happened to have a clinical background. Thus in Diabetes 2, general management roles were clearer and more powerful than elsewhere.

By contrast, Diabetes 4 was dominated by clinicians; three of its four senior managers 'fortunately' had clinical backgrounds, which they considered essential to running the organisation, although they no longer had any clinical responsibilities. The Diabetes 4 chair was the only senior manager without a clinical background; he argued that his managerial credentials came from 'I guess living a long time'. He too agreed that his role was clear but found balancing strategic and operational roles more difficult. The three other managers in Diabetes 4 were clear about their roles in managing the PCT too, although this was influenced by earlier clinical experience.

Hybrid roles

Next we look at hybrid roles across the PCTs. Hybrids in Diabetes 1, like their non-clinical manager colleagues, often described their roles as 'educational'. They fell somewhere between clinicians and managers, aiming to provide the best service to patients within the constraints of the health system. A number of hybrid respondents also perceived their role as involving change management; using evidence to influence colleagues to change the way they practised.

In Diabetes 2, there was a difference between hybrids with formal managerial roles and those with less formal managerial responsibilities, such as clinicians on the PEC. Informants from the PEC defined themselves as clinicians first and PEC members second, because the clinical work provided more income, in the case of GPs, and stability. For this reason the two GP members of the Diabetes 2 PEC could be classified as clinicians rather than clinical managers, even though both GPs, like and allied health professionals on the PEC, have various (sometimes majority) managerial responsibilities. Clinicians with less formal managerial roles put their clinical work before management. Indeed time, rather than financial resources, was often the biggest constraint on managerial roles. Hybrids often found it difficult to find the time for the managerial side of things, such as supporting staff and service development.

In the acute sector relating to Diabetes 2, clinical managers were clinical directors and therefore often more senior than their clinical-manager colleagues in the PCT who were accountable to service directors (often general managers). Hence in the acute sector, clinical input seemed to be more significant.

The PEC chair in Diabetes 3, similar to hybrids in Diabetes 1, saw his role as strategic; co-ordinating, organising and liaising across the PCT. He was keen that clinicians were at the heart of policy and decision-making, although he was also conscious of the conflict between his role as a GP and manager. The PEC chair's role was heavily political; dealing with national and regional politics while mitigating conflict between the PCT and local acute trust. The PEC chair did not see himself as a manager ('I have deliberately shied away from that') although many of his non-GP roles had a managerial dimension. As in other PCTs, the PEC's identity was firmly clinical rather than managerial.

Another hybrid in Diabetes 3, a public health consultant, saw his role as fluid and not managerial; more as getting everyone working together towards a common vision driven by a professional ethos. Hence it appears that hybrids in Diabetes 3 were still very much professionals. Yet they were also strategic and operational managers and change agents, searching for adaptation and reform but also developing and implementing their own changes.

In Diabetes 4, like in Diabetes 1, there was a degree of confusion as to who was in hybrid roles, as many clinical roles involved a degree of management. Three people interviewed were clinicians with 'formal' management positions in the PCT. A public health consultant, for example, had a clinical background but no clinical responsibility other than thinking about the public health of the population and 'understanding data and being able to convert that into the sort of knowledge to be able to communicate both with managers and with clinicians and then hopefully bridge the gap between them'. It seemed important that hybrids and managers were able to bridge

management and clinicians, translating the national change initiatives into terms which clinicians could understand.

Most hybrid GPs on the Diabetes 4 PEC or the priority action group, like many hybrids in the other PCTs, considered themselves primarily clinicians and representatives of the clinical group, although they had responsibility for designated service areas. Some had to take time out from their clinical workload in order to attend PEC meetings. GP PEC representatives' managerial responsibilities were sometimes in an advisory capacity. A GP - the PCT lead for clinical governance - reflecting the wider culture of the organisation, 'educated' stakeholders about clinical governance and quality. Here again we see those in hybrid roles avoiding overtly managerial terms, instead using language more commonly used by clinicians.

Hybrids in Diabetes 4 appeared clear with regard to the clinical aspect of their jobs but the managerial aspects were often 'not terribly well-defined', particularly those in the PEC and the priority action group. A major difficulty mentioned by hybrids was the extent to which lead roles should be regarded as directly managerial and had managerial authority. The chair of the Diabetes 4 diabetes priority action group, for example, spent four days per week as a GP and one on diabetes. He had been 'looking to do something else a little bit outside purely clinical work so sort of volunteered myself and found myself appointed within 24 hours'. The introduction of the *Diabetes NSF* had formalised the role of the priority action group and its chair and had provided a sense of direction for the group. He mentioned that the other professional groups, especially nurses, involved in diabetes care would be uncomfortable with him managing their roles because 'I'm a doctor and I don't understand how nurses work'.

It appeared, therefore, that although clinicians may accept a clinician from another background as lead for a change project involving multiple disciplines, they are unprepared to be managed by someone from outside their profession who might not understand it fully. Therefore it may be important for hybrids to bridge between professional clinical groups through negotiation, as well as manager and clinicians more generally.

A diabetes specialist nurse in Diabetes 4 on the diabetes priority action group divided her role between the PCT and the acute trust. She considered her role to be to bridge between the primary and acute care sectors and to reduce some of the repetition of service, although she is having difficulties in doing so. She reported that her primary care colleagues did not understand why she needed to maintain a role in secondary care yet she considered this to be essential to avoiding a division between the two 'because otherwise it's us and them'. She felt that she was being pulled into more managerial and administrative responsibilities (the strategic development of diabetes services) and was fighting this development because it was important to maintain her clinical role.

It might be that for the specialist nurse, as with other hybrid roles, it was important to maintain a clinical workload to retain credibility with clinical colleagues. Yet at a more senior level in Diabetes 4 PCT, three of four senior managers had clinical backgrounds but no longer did clinical work. Therefore simply having a clinical background without continuing clinical work may provide sufficient credibility.

All of the Diabetes 4 ex-clinical managers that were interviewed considered their clinical background to be a benefit. Some struggled to understand their role as either a clinician or a manager while others were clear that their role was that of a manager. These hybrids believed that their clinical understanding (nursing, podiatry or nutrition) assisted in their managerial development and interactions with other clinical and managerial colleagues. They felt that they gained respect and credibility in their interactions – particularly with clinical staff – as they had reputable clinical knowledge.

In Diabetes 5, most hybrids interviewed were on the PEC and, again like most of those in other PCTs, considered themselves primarily clinicians and secondarily managers. Few GPs had significant input into decision-making processes in the PCT, one commented that he was but 'a tiny cog in the system' and therefore could only make marginal difference. The only clinician to hold a senior managerial role was the PEC chair, who argued strongly that, although the role as PEC chair was a continuation of his role as a GP, he did not see himself and his role as being representative of GPs. He wanted to modernise services, abandon what was not working and deliver care in a more holistic way. However hybrids believed that they did have some strategic input into the direction Diabetes 5 was taking.

The majority of hybrids in Diabetes 5 had significant clinical workloads on top of their managerial responsibilities. Three hybrids had roles in the local acute trust. A nurse manager believed that her role was both strategic and operational. A consultant hybrid described his role in clinical terms despite a significant managerial element to it. Hybrids prioritised clinical and service improvement matters, but also mentioned government targets and strategies. Interviewees were divided as to whether they had clear job descriptions; some did but others had no job description or said that it was 'enormous and vague'. Most respondents reported however that they were personally clear about the boundaries between their clinical and managerial work. Hybrids tended to influence their colleagues through communication, including listening, building trust and education and training rather than overt management.

Clinical roles

Finally, we look at clinician roles without managerial responsibility.

Diabetes 1's clinicians, in contrast with their hybrid colleagues, seemed solely interested in providing good patient care, were less involved in managerial duties and less interested in meeting targets.

In Diabetes 2, GP input was critical to change mainly because, as independent contractors, relations between managers and GPs were difficult to manage. Data suggests that the PEC was not particularly influential and that the main decisions were taken by the senior management team. Two senior management team directors had clinical backgrounds, which they argued were essential to the job, but they considered themselves primarily managers who happened to have a clinical background.

In Diabetes 3, clinical professionals were important change agents; absorbing best practice and diffusing them among colleagues through networking and considerable debate, argument and negotiation about how such changes could be integrated within professions. Clinical practitioners can therefore be seen as professional experts, change agents and managers (of resources and a small number of staff). The introduction of the *Diabetes NSF* is an example of how such external changes affect professionals in Diabetes 3. There was a tension between the NSF and how clinicians used their professional values and autonomy to interpret and internalise it. Performance assessments appeared to relate more to conformance with professional norms, which enforced the importance of being a clinician.

Allied health professionals saw their role in Diabetes 3 more in terms of 'leadership' than management, and the management style within the PCT was democratic or 'humanistic' rather than autocratic, which might clash with the professional ethos. As previously noted in Diabetes 1, clinical managers in Diabetes 3 appeared to avoid using autocratic managerial styles or language which might not bridge to clinical groups. Clinical managers displayed a degree of role fluidity; they did not have a direct line relationship with specific subordinates and managed more through leadership and expertise than managerial authority. Performance was measured more in professional than managerial terms too.

All clinicians in Diabetes 4 had some managerial responsibility therefore are commented upon in the earlier section on hybrids.

In Diabetes 5, there appeared to be clarity and cohesion with regard to roles among clinicians. Clinical roles appeared to be powerful and focused upon providing clinical care, with managerial members of the triumvirate respecting clinical authority on clinical matters too. However there seemed to be confusion among non-managerial clinicians about where responsibility for diabetes lay.

Conclusions on roles overall

Comparing all roles within the five cases overall, we see that in four of the five cases, with the exception of Diabetes 2, there appeared to be deference to clinical roles. Management was often described as 'educational', 'strategic' and 'influencing', perhaps in order that it was acceptable to clinical groups. Accordingly, although many clinicians did not appear to place much importance upon government targets, they

were prepared to help, or at least not hinder, PCT management in achieving them, even though it was ultimately the board which was responsible for doing so.

Managers often required a clinical background to have credibility within the PCTs or, where they did not have one, relied heavily on a hybrid, such as the PEC chair, to bridge between managerial goals and clinical groups. Bridging seemed to involve negotiation and communication with different stakeholders, and respect for their language and clinical ethos.

Individuals capable of interpreting bridging roles were often clinical manager hybrids. Those with formal managerial responsibilities appeared to believe that they were both clinicians and managers, but hybrids in less formal roles, such as members of the PEC, remained very much clinicians despite doing some management. In Diabetes 1, and 5 the PEC chair had a managerial role and personally and individually provided a bridge between the management team and clinicians. Clinical leadership was more dispersed in Diabetes 3 and 4, with clinicians more generally influencing the PCTs.

There was also evidence of individual clinicians (nurses, GPs and allied health professionals) playing bridging roles between primary and secondary care and different clinical groups. This role relied upon good personal relationships, negotiation and communication, rather than telling people what to do.

We see the example of the breakdown of a bridging role in the case of the PEC chair in Diabetes 2, where historical differences between dominant GPs and PCT management and difficult personal relationships within the triumvirate, meant that the PEC chair resigned. In this case, the PCT management, although it acknowledged and attempted to engage with GPs, seemed to run the organisation more overtly and forcefully. In so challenging GP dominance, managerial/clinical relations were distant if not confrontational.

There was a mixed picture with regard to role clarity; senior managers and clinicians were commonly clear about their roles whereas middle managers and clinicians in informal management roles were less sure of managerial rather than clinical responsibilities; middle managers were sometimes confused by doing things in clinical terms and clinicians in informal managerial roles were sometimes confused by the blurring of the management-clinical boundary.

Relationships

Moving on from roles, this section looks at relationships within the PCT and between them and organisations they work with to provide diabetes care.

Relationships in Diabetes 1 were good in general. This included the most important relationship for effective functioning of the PCT, those

within the triumvirate, which worked well despite being somewhat fragile and indeterminate. At the periphery of the PCT people were less positive about relationships. In particular, the organisation was seen to be 'detached' from GPs and GP practices, although clinical managers involved with the PCT were more sympathetic to the PCT's efforts to engage with GPs. GPs believed that less significance was given to their relationships with the PCT. Managers' contact with GPs was mainly channelled through the lead GP and PEC chair. The manager responsible for diabetes, for example, was only in regular contact with the PEC chair. Often managers' most significant relationships were with other managers, within and outside the PCT, and key managers responsible for diabetes were unaware of some local developments within the PCT.

Hybrids in Diabetes 1 working closely with the PCT management, such as the PEC chair, described their relationships with clinicians as close and they appeared to play a critical if fragile role in bridging and managing the relationship between clinical and managerial networks. Certain roles, such as specialist diabetes nurses, had a roaming remit which enabled them to span boundaries.

In Diabetes 2, as in other PCTs, the most important relationships were within the triumvirate. Although the CEO and board chair got on well, their relationship with the PEC chair was more troubled. Indeed the PEC chair resigned during field research due to frustration with a slow pace of change, risk aversion and a lack of perceived clinical influence within the PCT. The breakdown of the relationship within the triumvirate was both unusual and significant and provides an interesting deviant case which is discussed at length in this section.

Despite being fragmented, Diabetes 2 GPs were perceived by managers themselves and other clinicians (including allied health professionals and pharmacists) to be the largest and dominant group within the PCT.

The poor relationship between the PEC and PCT management in Diabetes 2 was partly due to historical issues which led to reluctance among GPs to get involved with the PCT structures, particularly committees such as the PEC. And rapid and constant change appeared to have undermined goodwill among GPs. This did not create a receptive context for change. Relations with GPs had improved however and those GPs closely involved with Diabetes 2 acknowledged that the PCT had tried to re-engage with them. 'Respectful' relations meant that GPs were prepared to support the PCT on certain issues. Although some GPs considered the need to meet government targets to be not 'terribly important', they were prepared to help the PCT to avoid 'getting into trouble' and saw no need to be 'bloody-minded' about targets. However other 'rank and file' GPs believed that the PCT still did not actively encourage their involvement in decision-making; their ideas and suggestions for new projects were often received

negatively by PCT management and GPs felt that they were 'untapped resources'.

Senior managers in Diabetes 2 argued that GPs were a heterogeneous group, with lots of different and conflicting ideas about what was best in their own practices. GPs were consequently difficult to deal with and the PCT acknowledged that it should develop better ways of communicating with them. Thus for historical reasons, and despite PCT management's attempts to remedy the situation, the relationship between the PCT and 'rank and file' GPs was distant and there was no clear link between the two.

The importance of clinical input (and by 'clinical' this usually means input either by a GP or a hospital consultant) was mentioned by most informants in Diabetes 2. The CEO of the PCT stated that he never made decisions without clinicians at the table because if they did not agree with a decision they would block it. The CEO went on to express the latent power of GPs in relation to the management of change and why their co-operation was essential in any change initiative. When wanting to make changes within primary care, it is the GPs who are in the dominant position and the group that needs to be influenced. This is how the CEO describes the GPs' position in terms of managing change:

You don't need to make a big song and dance to resist a change, you just need to do nothing really and you can sit that out and it's very evident that is what happens in the NHS. And it's no use people ranting and raving, people are where they are and they will do what they will do and they won't do what they won't do and when you're dealing, as we do in the PCT, with independent contractors, it's all through relationships and influence. You cannot constrain them.

(CEO, Diabetes 2)

Despite the CEO's insistence that GPs were central to the decision-making process, the PEC chair resigned from the triumvirate during the period of research. This was due to frustration about risk aversion, slow pace of change (including about the *Diabetes NSF*) and because he believed that the PEC lacked influence in the PCT's decision-making processes. The PCT's matrix structure facilitated a high level of co-working, but was seen to frustrate service development. The PEC chair argued that the PEC was originally set up as the 'engine' of the PCT, but that its role and function had become 'muddled' between the Board, senior management team and clinical governance committee. And although the PEC's role was supposed to be about service redesign and the development of care, the processes by which these could be implemented were made complex and difficult by a 'very bureaucratic environment'.

The PEC chair in Diabetes 2 felt that the PEC structure was not being properly used, demonstrated by the fact that it had been unable to instigate a single care pathway in the three years the committee had met. It was not focused on important decisions, often asked to consider things like the colour of paint in toilets and to look at the

PCT's accounts after they had been submitted. GPs on the PEC also believed that the committee was too mixed and met too infrequently. Another problem for the PEC chair was that his role was complex and he found it difficult to figure out when to be using his different 'hats' – corporate, GP and PEC – and how to separate them. The issue of role conflict was problematic for other GP PEC members too, who felt that their GP and PEC roles were in direct conflict.

There was a view among the Diabetes 2 GP informants that PCT general managers have a very different attitude to decision-making. These differences had also contributed to the resignation of the PEC chair who felt that decisions were being taken in an unnecessarily cumbersome way. He argued that GPs made decisions quickly, often in under an hour, because they were used to making decisions and living with their uncertain consequences. Managers by contrast had a different mindset and made decisions by writing lots of papers and having lots of meetings, thus taking months to often reach the decision that certain action was not possible. The PEC Chair commented that the PEC had become frustrated by managerial decision-making processes and that clinicians' and managers' views needed to be married up and better balanced.

The data does not point to any underlying tension in Diabetes 2 between clinicians and PCT managers, in fact the relationships between managers and clinicians seems to be good and they both seem to understand the importance of one another. However, the data does suggest that GPs in particular have quite a different management style to general managers in this location. Other GPs confirmed that they had different approaches to management from managers: 'We are used to seeing a problem, identifying the problem and doing something about it. We don't fiddle-fuddle around; we just get on with it'. A GP PEC member described the management style of GPs as 'flexible ducking and diving' which contrasted with the more rigid approach of managers.

Thus we see in the case of Diabetes 2 a marked divide between clinicians, particularly GPs, and PCT management which the PEC chair was unable to bridge, leading to a distant relationship between them. This demonstrates the importance of key individuals in bridging roles but also that the effectiveness of such hybrids will be dependent upon a receptive context often established historically.

In Diabetes 2 relationships can be seen to be about conflict, partly due to historical reasons and a failure of individuals to bridge between different parties in the conflict. There appeared to be fewer attempts to couch management in clinical terms than elsewhere. The CEO argued that the discipline of management provided a solid body of knowledge which was able to stand up to clinical knowledge. Indeed conflict in the PCT may have been because PCT management was attempting to wrestle power away from dominant GPs. And the relationship between the PCT and local acute trust were awkward due

to different ways of seeing things, interests and relations between the two CEOs.

In Diabetes 3, as elsewhere, the strategic triumvirate relationship is key; they must represent strategic leadership and work closely together. Staff in Diabetes 3 felt frustrated by the SHA which they believed did not trust the PCT and therefore imposed performance management on it, which clashed with the PCT's democratic internal management style. The key characteristic of Diabetes 3 is high people-oriented management; it was cohesive internally, dominated by clinical professional values and hostile towards external organisations such as the SHA, which attempted to performance manage the PCT. Indeed it may be that Diabetes 3 was too cohesive and therefore its boundaries with organisations it works with too impermeable.

Clinical professionals operated in a tight-knit world of like minded and committed individuals where professional pride and credibility unite them into a cohesive and supportive body. This was demonstrated in Diabetes 3 in the area of diabetes care where one clinician described his clinical colleagues as the 'diabetes mafia' who were not 'afraid to push when push is needed.' The capacity to interact and relate to others appears to depend on a shared ethos of care and vocation. A podiatrist argued that what drove clinical care was that clinicians were all interested in what they did.

Influencing in Diabetes 3 is based heavily on formal and informal meetings to raise and debate issues, problems and concerns with fellow professionals. For example, a practice nurse cited how an immunisation issues involving non-English speaking mothers was a cause for concern. This prompted her to call a meeting with other professionals (GPs, midwives, health visitors). Prior to the meeting, a draft paper was circulated for discussion and professionals who had some linkage to the issues were then expected to attend and give their view about the issue before an agreed solution was arrived at. Individuals also rely on one-to-one informal conversations on a professional to professional basis. A district nurse cited her influencing strategy as getting to know people and staying in regular contact with them.

These examples were typical of what many in Diabetes 3 suggested was their preferred approach when interacting and seeking to influence others. There is a constant emphasis on the collective ideal that they all adhere to - patient care and how to improve that care and the systems that support it. Argument and persuasion were the main approaches – presenting the facts and requiring the other person to agree or present counter arguments that are then given serious consideration. In other words, there is a heavy reliance on being strong-minded and believing in what you are doing is the right thing to do. The expectation is that fellow professionals will always respect

your point of view and trust the motives that lie behind your arguments:

Whatever you do to influence, you've got to have done your homework and its got to be sound. It's got to be evidence-based and credible. And as with anything if you were selling vacuum cleaners you know that, if it's a good one and it's better than all the rest, you don't really have much of a problem selling it. We're sales people. We have to be visionary and have charisma you know. Communication that the key thing. And involvement; not just go out there and tell them but to go out there and ask them what their experiences are and then suggest, well I wonder if you've heard of this or that or we've been discussing something.

(Specialist diabetes nurse, Diabetes 3).

There were other means of influencing evident in Diabetes 3. For instance being credible as a role model or clinical expert were identified as effective in certain situations. For example, one of the diabetes specialist nurses cited a GP who appeared to be resisting a new initiative in diabetes care in connection with insulin management. After investigation it was found he did not understand certain specialist requirements and therefore re-education was required which solved the problem.

Interestingly, among all of the Diabetes 3 clinical professionals none of them pointed explicitly to any overt form of political, status-linked or coercive form of influence – even when prompted ('How would you influence those who do not agree or resist your motives'). However, a number recognised that there would be different interests to accommodate. The best approach was to talk to them and to find out where they were coming from and then see how you could meet their requirements through force of argument leading to an acceptable and pragmatic compromise.

Clinical managers' in Diabetes 3 were very much involved in negotiation, mediation and conflict resolution, building and improving relationships. There were concerns about members of the PEC being intimidated by the status of senior managers, but the PEC chair attempted to run the committee on the basis of being equals. He was also conscious that fellow GPs may be suspicious of him 'selling out' in the managerial role as PEC Chair, and likened himself to 'a puppy that's taken away from the litter for a bit and when you come back you smell funny'. However he continued to firmly believe that it was important that clinicians were central to decision-making in the PCT.

General managers in Diabetes 3 had complex and diverse relationships with a range of internal and external stakeholders, involving historical arguments and difficulties a cross the various clinicians. Of particular importance was developing relations between primary and secondary care.

As in all PCTs the relationship within the triumvirate was perceived to be important to the effective functioning of Diabetes 3. The Diabetes 3 CEO argued that he achieved change through creating 'the vision,

hopefully a patient-centred vision of what we are actually trying to create', rather than hierarchy, and 'enabling people to go ahead and do that'. Influence was again through debate discussion and negotiation. Another manager echoed this style of management; he suggested that management was not about telling people what to do but facilitating them in redesigning their own service. When asked to illustrate what he meant, he cited an example of conflict between GP appointment waiting times that were below those required by NHS performance targets. He met with groups of GP representatives to debate the resource issues associated with this. He convinced them why resources had to be put into this area but also made them more aware of the wider political issues and realities that surrounded this and how the PCT could benefit by meeting government targets. The result was that within a month the target of 100% was achieved.

Relationships between Diabetes 3 and those 'accountable' stakeholders such as the SHA and other NHS and government agencies were much more wary and guarded. Here the emphasis was on 'keeping them happy and off our backs'. However, at times the relationships became fraught as the PCT's strong desire to organise and manage itself in an autonomous and locally accountable way clashed with a philosophy that it viewed as centralising and controlling – having to meet national performance targets that were seen to be based as much on political as health care imperatives.

Diabetes 3 can be seen as highly democratic, where there was little conflict which was not resolved through communication and negotiation. This led to effective working relationships within the PCT, although those with external organisations were more difficult.

As stated earlier, in Diabetes 4 there was a diabetes priority action group, which was responsible for the developing diabetes care in the PCT, reporting to the PEC. Research in Diabetes 4 centred upon this group. Relationships within the group were considered very important for driving service improvement for diabetes forward. The key relationship as far as diabetes was concerned, according to members of the group and individuals involved, was between the group chair and the service development manager for diabetes. The group chair was a local GP and his local knowledge as a GP was crucial to making changes. He was also considered to be the link between the GPs and the PCT and relations between managers and clinicians appeared to be strong.

Communication in Diabetes 4 around diabetes also appeared to be good, although some were less clear about how diabetes fitted within the wider strategy of the PCT. The diabetes priority action group chair emailed the minutes of meetings about diabetes to GPs in order to 'fulfil my obligation' but believed that few would read them. It was also seen to be important that the service development manager for diabetes and the group chair met with 'rank and file' GPs on a one-to-

one, face-to-face basis, although given the sheer number of GPs this possibility was limited.

Most respondents in Diabetes 4 argued that due to intra-organisational politics, influencing people to introduce service improvements must be done 'softly' rather than through command and control and performance was accordingly monitored on an *ad hoc* and informal basis within. However some interviewees commented that the service development manager could take quite a 'forceful' approach to managing change some times.

Relations in Diabetes 5 appeared to work in most respects. Influence appeared to be informal, through persuasion and discussion, founded upon a good working atmosphere within the PCT. One manager commented, however, that although they usually used the 'enthusiasm of the group to push things forward' she was prepared to 'bang heads together and hassle people' when necessary.

In Diabetes 5, the key relationship was again between the three members of the strategic triumvirate, which worked effectively, based upon trust and understanding and forged through good personal relationships. The senior management team, general managers and hybrids appeared to get on too. The PEC chair, a GP, was the main link between the PCT and GPs. Other hybrids, for example a practice nurse advisor and a dietician, also successfully played bridging roles between management and clinicians groups.

The relationship between Diabetes 5 and the acute trust also appeared to work well. Despite historical conflict over the situation of diabetes care, during the time of field research there was agreement that diabetes should be situated in the community. The relationship between primary and secondary care may have stemmed from cordial, personal relations between the CEO of the PCT and CEOs of local organisations it worked with, including that of the acute trust.

Looking at all five PCTs overall, two kinds of relationships seem to be important in the management of change; those between senior managers and hybrids within the organisations providing care, for example between CEOs of different organisations and within the triumvirate; and relationships between different groups within and between organisations, which have their own languages, values and interests.

The key relationship was within the triumvirate, which needed to provide cohesive leadership. In four PCTs, this was cohesive and friendly. In Diabetes 2 the triumvirate relationship broke down, due to personal and historical difference between the managerial and clinical way of doing things. This contributed to low morale within the organisation and slow change in diabetes care. In Diabetes 2 the relationship between the CEO of the PCT and the CEO of the local acute trust was also difficult, meaning that the development of intra-organisational diabetes care provision was slowed. By contrast the

relationship between the CEO of Diabetes 5 and the CEO of his acute care provider was strong and diabetes care seemed to progress more smoothly.

Relationships between management and clinicians in the PCTs were good in general, but variable and somewhat distant in Diabetes 1, channelled through the PEC chair. In Diabetes 2, the PEC chair appeared unable to manage their different ways of doing things. In Diabetes 3, and to a lesser extent in Diabetes 4 and 5, a democratic organisational culture, built upon inclusion, communication, and negotiation, appeared to create a receptive context, one necessary ingredient, for effective intra-group relationships and the development of diabetes care.

Training and education

This section discusses managerial training. Across all five PCTs a similar pattern emerged in relation to training and managerial qualifications: general managers were likely to be qualified in management, often to postgraduate level in the case of senior managers.

Most clinicians and clinical managers had no formal management qualifications. Some clinical managers had fallen in to a managerial role by default, for example: 'The head of [department] was off sick so it didn't really leave anyone else, so I was in an acting role.' Clinicians and hybrids clinical managers often mentioned management training courses that they had attended, and which many had found useful; leadership training provided by the Kings Fund was praised in two PCTs. But most clinicians stated that their working experience gave them the necessary skills to function effectively in managerial roles. Often clinical managers argued that their clinical background, rather than managerial qualifications, was essential in providing credibility to manage professional colleagues.

Table 10 Management training in diabetes sites

	Managerial	Hybrid	Clinical	Total
Diabetes 1	5/5	0/6*	0/5*	5
Diabetes 2	8/8	0/9	N/A (0/0)	8
Diabetes 3	8/9	0/4*	0/7*	8
Diabetes 4	4/4	0/8*	N/A (0/0)	4
Diabetes 5	5/6	0/7*	0/2*	5
Total	30/32	0/34*	0/14*	30

**Note: Although they had no formal management qualifications some had attended short management courses which they found useful.*

All managers were subject to appraisal but argued that, although they had to meet targets, their day-to-day activities were not monitored.

Nurses and nurse managers too were appraised by managers, but GPs were appraised only by fellow GPs. Very few professionals (including hybrids) had their performance evaluated against formal performance measures, rather it was evaluated in more informal professional terms. Hence performance management and appraisal appeared to be more ad hoc and flexible than one might have expected.

The CEO of Diabetes 2 was interested in management and believed that it provided a body of knowledge that could 'stand up' to clinical professionals in terms of its clinical background. However it should be noted that there was significantly more managerial- clinical conflict in this PCT than elsewhere.

Progress on change and service improvement

This section looks specifically at the changes associated with service improvements in diabetes and the introduction of the *Diabetes NSF* and the effect of the organisational context they were set in. A key point to make is that although all the PCTs were obliged to introduce the *Diabetes NSF*, it was one of many priorities, which all competed for time, resources and attention. Interviewees frequently commented that it did not have financial rewards attached to it. Consequently it was a relatively low priority and little change had occurred to diabetes care. There is not a receptive context for change in diabetes care.

The key focus for improvements in diabetes in this case was setting up registers for monitoring and early diagnosis of diabetes, including practice nurse-led clinics; the appointment of diabetes specialist nurses to work in the community and with outpatients in hospital; changes in drugs used (for example rapid start insulin and once a day insulin); outpatient retinal photography; near-patient testing (use of a HBA1C machine in general practice to measure glucose in the body; and an outpatient referral pilot).

The *Diabetes NSF* was not however high among Diabetes 1's priorities, particularly among managers. Diabetes 1 was overstretched attempting to meet government targets and its agenda for change, including many other NSFs. Clinical staff argued that diabetes should be higher on the PCT's agenda but there was no overarching strategy and extra resources (both financial and in terms of manpower) for diabetes and consequently changes in this area were small and fragmented.

There seemed to be little evidence of explicit project management in the implementation of change in Diabetes 1. Change around diabetes seemed to be more emergent; individual GPs practices had begun implementing the *Diabetes NSF* without the PCT's involvement. The drive and resources to implement changes was provided in Diabetes 1 more through self-motivated individuals, often nurses, 'doing it out of the kindness of their heart' rather than via an organised and strategically managed process. It was therefore difficult to push these individuals to make changes more quickly.

Change in Diabetes 1 involved diabetes specialist nurses opting to work out in the community. At the time of the fieldwork, this arrangement meant that one diabetes specialist nurse was working between two units and played a useful bridging role. She was providing support to a diabetes outpatient clinic at a satellite hospital and she was also providing support to the PCT. However even though this nurse had been closely involved in the implementation of the changes, she did not consider that she understood the background of the changes. She spoke of a lack of clarity about change roles and responsibilities, finding the role 'quite strange' because a manager told her that staff were waiting to be 'told what to do' whereas she was involved more in project management and gaining agreement with clinical groups about what changes needed to be made and how to do them.

Diabetes 1 GPs were clearer about how they wanted diabetes care to develop but were frustrated by gaps between the PCT and GP practices and only fragmented developments around diabetes care. At the time of fieldwork in late 2003, there did not seem to be any strategic leadership of the *Diabetes NSF* and it was individual clinicians who appeared to be change agents, where there was change at all. A strategy board for diabetes was only just being established and was barely mentioned by respondents.

The key focus for improvements in diabetes in Diabetes 2 was moving diabetes care into primary care. In Diabetes 2, diabetes was seen as somewhat of a 'Cinderella' service that is in much need of improvement and development. Although diabetes had been on the PCT agenda for sometime there had been very limited service improvements in the past five years.

Diabetes was a subject that everyone in Diabetes 2 was well versed in and it was widely held that the service was under-resourced; and that PCT staff were overstretched and inadequately supported by the acute hospital. The *Diabetes NSF* had moved diabetes up the PCT agenda, driven forward by its director of public health who also chaired the diabetes committee, but because no new money was attached to it had been slow in developing. To make changes it is necessary to 'pump prime money' into an area, rather than 'just the same old money being repackaged in a different way'. A nurse specialist felt that she was 'just trying to keep the service going very much on a day to day basis' she was therefore unable to 'step back' and train other staff to run and organise the service the way she wanted.

Change in Diabetes 2 was retarded by conflict between acute and primary care about where diabetes services should be located. The PCT believed that it should be located in the community, yet resources were held in the hospital which was unprepared to give away or pool them. Hence they 'spent a year just going round and round in circles'.

The Diabetes 2 PEC chair, who as noted earlier resigned from the triumvirate, believed that diabetes had 'got bogged down in

committees' and if it 'had been managed properly, you would certainly have got the money to develop a service like diabetes'. Frustration with bureaucracy and the lack of progress in the development of diabetes care, for which the PEC chair believed he had been given responsibility, led to his resignation.

The local diabetes working group for implementing change in Diabetes 2 was not particularly effective as it was formed from a loose connection of interested clinicians, clinical managers and general managers from primary and secondary care. Observation of this local diabetes working group suggested that it was rather unfocused and diffuse in nature. A GP member argued that roles were not well-defined, individuals each had their own ideas about how to change diabetes care, and therefore the group needed a firm structure and local co-ordination. It was believed that the local diabetes working group lacked financial and authoritative resources and was too diverse to push through change in diabetes care. The importance of having a senior manager co-ordinating diabetic services as a whole was mentioned by most the clinicians and clinical managers that were directly involved in developing the service.

Change in Diabetes 2 related to the *Diabetes NSF* was limited. It was retarded by conflict and a different way of working between clinicians and managers, according to the PEC chair. It was also hampered by conflict with the acute trust, and because diabetes was not seen to be sufficiently important, compared with other issues, to warrant financial resources or project leadership as a senior level.

The key focus for improvements in diabetes care in Diabetes 3 was implementing the *Diabetes NSF* and complying with its 12 defined standards (see Section 6.1). Yet in Diabetes 3, general senior managers were vague about the status of the *Diabetes NSF*. This may have been because it had been dormant for so long or due to reluctance to discuss an area which might be embarrassing given the lack of leadership or organisational time devoted to it.

The management of diabetes in Diabetes 3 has been achieved through a local diabetes services advisory group, which drew upon local knowledge and expertise. The group had a local implementation team: a multi-functional group of specialists who were responsible for planning and delivering diabetes care.

To begin with, the implementation of the *Diabetes NSF*, as in other PCTs, was a relatively low priority in Diabetes 3: 'diabetes... is seen as... a poor relation to some of the other bigger areas that have been going longer like cardiac care and cancer care.' There was also conflict and confusion about the role of the local advisory group, which was driven by the acute trust and lacked primary care focus, resulting in the group's leader withdrawing from the role. Hence progress was particularly slow as there was a lack of project management expertise to drive it forward.

A new project leader was appointed in 2003 but due to the pressure of other ongoing projects and for the PCT to change in other areas, progress remained slow. In mid-2004 the implementation of the *Diabetes NSF* became a higher priority. The local implementation team for diabetes began to report directly to the PCT Board. In July 2004 the *Diabetes NSF* was seen to be on a sound organisational and management footing and moving forward with a clear sense of direction and purpose. Hence although diabetes change was initially slow, when diabetes care became a higher priority for the Diabetes 3 at a senior level, change came about more quickly than in other PCTs, in part due to amicable relations with the organisations, including between clinicians and managers.

The *Diabetes NSF* was seen by Diabetes 3 clinicians as a useful framework, although many clinicians were already actively involved in 'continuous improvement' of diabetes care, and hence they played an active part in its implementation.

In summary for Diabetes 3, the implementation of the *Diabetes NSF* got off to a slow start. This was mainly due, as in Diabetes 1, to other more pressing and immediate PCT priorities compounded by a lack of available management expertise and commitment to lead a project of this scale. Other factors that contributed to this inertia included a lack of clarity about responsibilities across the primary and acute sectors for diabetes care, a possible unwillingness by individuals to absorb the changes required by the NSF, and paradoxically, a lack of impetus by senior PCT management.

The Diabetes 3 new project leader was not able to get to grips with the implementation until mid-2004 but having turned her attention to the *Diabetes NSF*, there was clear evidence that the implementation was gathering momentum and making clear progress towards implementation of the new standards.

One of the most interesting points to note was how important it was to have the right person appointed into the role of project leader/change agent in Diabetes 3. Previous efforts to get the project off the ground had come to little with question marks over the suitability of the person appointed. It was only when an experienced and effective change agent was appointed that the project began to take shape.

It was noticeable that among all of the respondents in Diabetes 3 this individual service development/project manager was the one who displayed real change expertise. Significantly, her expertise extended beyond core management and organisational skills to include sound interpersonal and political skills coupled to a reputation and credibility as an effective change agent. For instance, her restructuring of the local implementation team and the creation of sub-groups of clinical professionals was widely supported as a way of involving those professionals and giving them a voice.

She was conscious of the need to manage the tensions between the acute and primary sectors in Diabetes 3. For instance during the local implementation team meetings, she made sure that the chair of the meeting was a clinical professional from the acute trust but that she sat alongside him as project leader and effectively controlled the meeting. She also made sure that the local implementation team would report directly to the PEC.

The key focus for improvements in diabetes in Diabetes 4 was the development of a 'one stop shop' for diabetes treatment in a local health centre, supposed to redesign diabetes care away from secondary to primary care, and which provides an example of progress in change relating to the *Diabetes NSF*. Diabetes 4 should have seen diabetes as an important priority, due to the high incidence of the disease in the local population, as in Diabetes 2 and Diabetes 5. But diabetes did not appear to be a key focus for the PCT overall, relative to other priorities like meeting the targets for which the PCT was rewarded financially.

Most interviewees in Diabetes 4 were enthusiastic about the redesign of diabetes services. Most also believed that it was the diabetes priority action group chair and the service development management who had pushed it forward. The action group chair commented that getting the different stakeholders on board with the project, getting GPs to attend meetings and to refer patients to it had been extraordinarily time-consuming and personally 'a nightmare'.

The project had partly been so difficult because the service development manager originally responsible for one stop shop had moved roles. As the Diabetes 4 action group chair pointed out, such projects require 'somebody at the top to really own it', echoing the findings in Diabetes 3. Nonetheless respondents appeared to be optimistic about the future of the one-stop shop, although GPs removed from the PCT were more cynical about the diabetes priority action group.

The development of the one-stop shop diabetes care appears to have been slow because diabetes was also a relatively low priority for Diabetes 4. Its progress was hindered, as in Diabetes 3, by the resignation of the project manager and seems to have moved forward because of the efforts of the action group chair. However, he seems to have found the project difficult and, as comments suggests, involved lots of time and communication with the various stakeholders involved.

In Diabetes 5, the key focus for improvements in diabetes was, as elsewhere, in the implementation of the *Diabetes NSF*. The research focused on two areas which provided an example of the way in which the PCT implemented changes relating to the *Diabetes NSF*; the development of local guidelines for diabetes care and an initiative to establish a health and social care centre.

A steering group was set up to specifically look at the *Diabetes NSF* and to interpret national policy into local initiatives which would best meet the needs of the local population. The diabetes guidelines took a relatively long time to develop (one year) and involved people from both primary and acute trusts. Indeed the steering group was led by a consultant diabetologist working along side the PCT.

The guidelines were sometimes controversial, with individual differences about what should be included in them, but such problems were commonly resolved in meetings. The consultant diabetologist had to spend a whole afternoon going through the guidelines with the various stakeholders involved and answering key points relating to them. However the effort appeared to be worthwhile. These guidelines were ratified by the Diabetes 5 board and then circulated to GP practices. The process appeared to be successful, although time-consuming, compared to other PCTs because diabetes care was, from the start, a priority for the PCT's senior management (in contrast with Diabetes 3 for example). It seems, on the basis of limited evidence, that the implementation of guidelines have been successful perhaps because of the involvement of all stakeholders. This in turn may reflect the wider context in which such changes occurred within the organisation's culture.

The second example of changes in diabetes care in Diabetes 5 was the establishment of a health and social care centre which enabled diabetes care to be provided in the community rather than in hospital. As with the implementation of diabetes guidelines, the project was led by a small team consisting of the consultant diabetologist, a nurse diabetes consultant, a nurse diabetes specialist and the director of strategy for the PCT. Although at the end of the period of research the centre had not yet been set up, an agreement between primary and acute care to develop the centre indicated good working relations between them, despite the potential for acute care to be concerned about the loss of diabetes care into the primary sector.

Looking at change in the five PCTs overall, the first point to make is that, during the period of field research, the *Diabetes NSF* appears to have been a low priority for all five PCTs in comparison with other more pressing issues, usually driven by the central government agenda. Thus, although many of the PCTs had groups dedicated to the *Diabetes NSF* and senior managers were conscious of the need to improve diabetes care, change in the area was limited. What change did occur was fragmented and largely driven bottom-up by dedicated individual hybrids or clinicians with some managerial responsibilities, often nurses in bridging roles.

The case studies demonstrate that change requires dedicated time, resources and project management. In two of the cases (Diabetes 3 and 4), the implementation of the *Diabetes NSF* was retarded by losing the project leader and elsewhere by lack of project leadership at all. The process of change appeared complex, slow and involved

political skills and negotiation with the range of stakeholders, which one project leader described as 'a nightmare'. It also requires attention from senior-level individuals within organisations (for example, like the replacement project leads in Diabetes 3 and 4). This suggests that progress with the *Diabetes NSF* may be quicker as diabetes moves higher up government and PCT agendas.

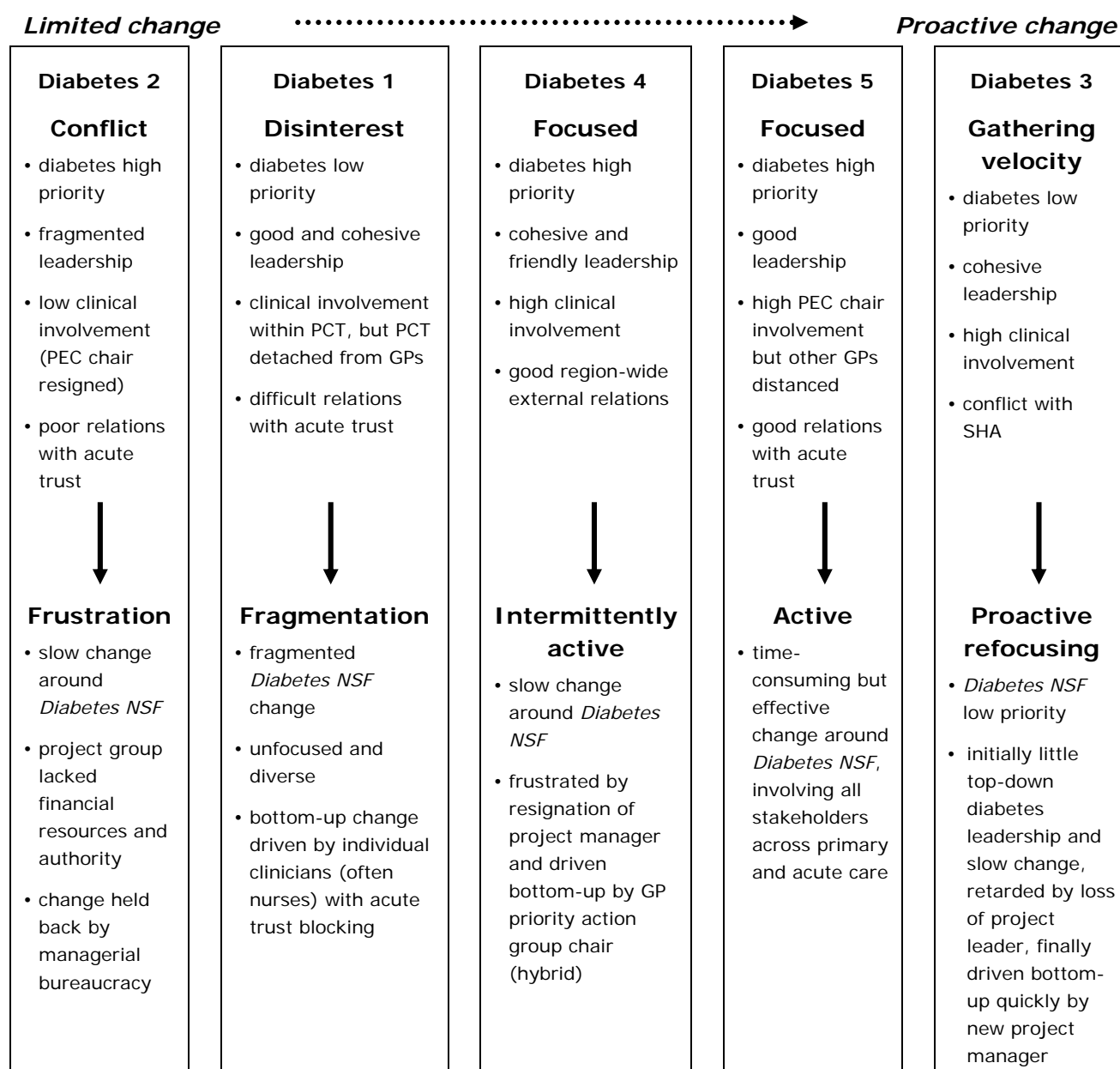
It is interesting that the needs of local populations appeared to have relatively little bearing upon the speed at which changes occurred; even where senior managers recognised that the *Diabetes NSF* was important, because the prevalence of diabetes was high within the local population, it was not a high priority for implementation due to other competing demands for time and resources created by government targets.

6.4 Conclusions

All five PCTs are structured in a broadly similar way and provide similar services. Clearly all five have to meet the same targets (all achieved either a one or two star rating from the Healthcare Commission) and must conform to the same protocols, including the *Diabetes NSF*. Diabetes 2 was notable for its fragmented leadership and low morale. In contrast, Diabetes 3 was notable for its cohesive triumvirate, democratic, professionalised culture and high employee morale but hostility towards its SHA. Diabetes 5 was the exception for its good relationship with its local acute provider.

Figure 3 overleaf attempts to make sense of the PCTs overall, comparing and contrasting the five cases of the implementation of the NSF and the contexts they are set in. The top label in the columns describes the organisational context surrounding diabetes care, and below this there are descriptions of key factors associated with this context. The second label describes the progress in organisational changes that took place around diabetes care; this is also followed by a brief description of changes.

Figure 3. Typology of service improvement capacity across diabetes sites



It should be noted that the horizontal axes (labelled 'limited change' to 'proactive change') indicate the PCTs' *capacity* for change rather than how much change necessarily occurred during the period of field research. Therefore, for example, although Diabetes 3 was slow to make changes around diabetes care initially, when it did attempt to do so, towards the end of field research, change occurred more quickly than elsewhere. By contrast for Diabetes 2, although diabetes was a higher priority, making changes to diabetes care was more problematic.

There are certain patterns which are replicated between different cases. Diabetes 1 and 2 both had low staff morale; in Diabetes 1 this was because it was struggling to develop as a new organisation

and to adapt to a heavy national change agenda; and in Diabetes 2 it was due to fragmented leadership and historical differences between management and GPs. Good relationships with partner organisations in the provision of diabetes care appeared to be important for the implementation of change. In both Diabetes 1 and 2, the PCTs' relationships with their acute trust and GP practices were difficult and detached.

Diabetes care was a relatively low priority in Diabetes 1. In Diabetes 2, it was a higher local priority but the organisation's leadership was divided and hence, although senior managers were conscious of the need to develop diabetes services, had done little about it. In both PCTs the organisational context was unreceptive to changes required by the *Diabetes NSF*, resulting in slow and fragmented improvements to diabetes care, led bottom-up by motivated individual clinicians where there was change at all.

Relationships in Diabetes 3 and 4, both within the PCTs and with partner organisations in the provision of diabetes care such as acute trusts, were more harmonious. Both organisations, particularly Diabetes 3, were democratic, clinically-dominated, and led by strong and cohesive triumvirates. In Diabetes 3, however, the *Diabetes NSF* was a low priority and in both PCTs it was hampered by the loss project leaders. It only made real progress when it received dedicated project management and the attention of senior management. Consequently, change to diabetes care in Diabetes 3 and 4 was mostly fragmented and driven by individual clinicians rather than senior management. Therefore, even in a receptive context, change seems to need to be specifically managed by a dedicated project managers and required support at a senior level within the organisation.

In Diabetes 5 progress with the *Diabetes NSF* was slow but steady. The PCT involved, negotiated and communicated with all relevant stakeholders in changes. This process was helped by good internal and external relationships, cohesive leadership and because diabetes was a high priority locally.

In all cases we see the importance of getting both management *and* clinicians, in primary *and* acute care, to buy into change. Without the support of management at a senior enough level and a project manager, change is unlikely to develop sufficient impetus. Without the support of clinicians (achieved through education and evidence-based formal and informal influencing rather than top-down management) change is unlikely to be implemented. And it is often a senior clinical manager hybrid that can play this bridging change agent role.

Overall, however, there was relatively **little evidence of change** surrounding the implementation of the *Diabetes NSF* in any of the organisations, in large part because it was a relatively **low priority for the PCTs** given the other pressures they were under. However a number of lessons can be drawn from the study about the management of change in professionalised healthcare organisations.

It is evident that diabetes care presents a robust example of an area of care which needs a cross boundary strategy, integrating care between the acute and primary care sectors. The data suggested that core stakeholders, both general managers and clinical managers acknowledged this. However, there was more limited evidence of agreement about who should lead improvements. **The ability of PCT managers, both general managers and clinical managers, to drive such cross boundary change was low.**

As the previous sections illustrate, the primary care sector continues to work through a process of transition, which is not yet complete. **The major strategic changes** to the functions of the sector in establishing PCTs as novel organisations and in extending the roles of primary care clinical staff **take time.**

Hybrids with clinical and managerial responsibilities, or in some cases senior managers with a clinical background but only managerial responsibilities, are in an **important role** in relation to change. **Change requires political skills and personal credibility;** it is **achieved through negotiation and communication** with the stakeholders involved rather than through being imposed. It seems important that senior management *and* clinicians support changes (where change was successful it commonly involved clinicians) and hybrids can bridge between the two because they understand the language, ethos and interests of both.

Traditionally, medical professionals have dominated healthcare organisations. In primary care, GPs might be expected to fill hybrid roles. However in these cases, hybrid clinical change agents were often nurses and allied health professionals, although they were sometimes GPs and consultants. PEC chairs were always GPs. Indeed it seems important to have hybrids from different clinical disciplines involved in the change process to mediate between the different groups. Although nurses and allied health professionals may be happy for a project lead to be a GP, they are less happy to be managed by someone outside their field.

Similarly it is **important to bridge between primary and secondary care**, as both are involved in the provision of diabetes care. Hybrids, often nurses, working in both primary and acute organisations appear to play a useful bridging role in this respect. In the absence of *Diabetes NSF* leadership at a senior level in the PCTs, it is often motivated individual hybrids who were leading change bottom-up.

The **key relationship** is **within the triumvirate** leading the PCTs and between the CEOs of different organisations partnering in the provision of care. Where this breaks down, the organisation became a less receptive context for change. Yet the quality of relationships also appears to be a consequence of the historical context.

The **relations between different groups also affect the context for change**. Where relationships between management and clinical groups, between different clinical groups, and between primary and secondary care are good, change appeared more likely. And hybrids are often able to facilitate these relationships. Good relations seem more likely in organisations which pay more attention to the people dimension and clinical values. Yet even here **change is fragmented without dedicated project management and support from senior management**; even in organisations with motivating cultures need change leadership.

There was little evidence of management training. Outside senior management, who were often educated to post-graduate level, very **few clinicians or clinical manager hybrids had management qualifications**. Many had attended management training courses, which they had mixed views about, but most clinicians argued that experience and a clinical background enabled them to function effectively. And performance management and appraisal were accordingly *ad hoc* and clinically-oriented.

The process of change relating to the *Diabetes NSF* was slow and complex. The **needs of local patients seemed to have surprisingly little impact** on the PCTs. There was little evidence that changes in diabetes care were prioritised where diabetes was more prevalent within the local population. What seemed to determine change more was a combination of factors:

- leadership and support, including resources, at a high level in the organisation
- clinical manager hybrids able to bridge between the different groups and organisations involved, using their personal credibility and political skills
- a receptive context of good relationships between the senior people and different groups involved.

Section 7 Concluding themes

In this concluding section of the report, we begin to draw together the themes emerging from all our data, in the light of prior research. These themes are an initial, but comprehensive analysis of the findings, emerging from the ongoing and iterative processes of comparison which we have undertaken. A number of these themes offer an opportunity for greater theoretical elaboration and we shall to continue to develop our analysis in greater detail and depth. In Section 7, we allude to a number of additional areas for further investigation and directions for future research which have been identified.

For clarity, this section of the report is set out under a number of themed sub-headings, however, these should not be viewed as separate or atomised issues, since most themes interrelate.

7.1 The primary care sector and the acute sector: receptive contexts for change?

In taking a broad overview of the eleven cases, the impact of some of the characteristic differences between the primary care sector and the acute care sector are apparent. In reviewing these differences, we are primarily interested here in the impact which such factors may have on the capability of an individual trust, whether it be an acute or PCT, to deliver clinical service improvements.

Firstly, the data provide substantial evidence that the primary care sector continues to be in a state of transition. The major changes to structures and purpose in the establishment of the PCTs are as yet not fully embedded. There are many new tasks to be learnt; many new relationships to develop and build; and many novel systems to put into place. This is a process, not an event and it requires a considerable amount of time and effort. All our PCTs showed evidence that this major strategic change was still continuing. Unlike parts of the acute sector, there was limited evidence that staff could build on the credibility already established through earlier contacts; or cut corners because all the players were so familiar with systems and processes and the part played by their various roles that activities slid effortlessly into place.

Secondly, the structures which now exist within PCTs make the delineation of responsibility and accountability for leading and managing change difficult. In particular, our respondents drew attention to the lack of clarity at strategic level where it is sometimes unclear whether the key decisions are taken by the PCT Board; the senior management team or the PEC. On occasion, even the members of these bodies were unsure of the extent or focus of their role. Within

this framework, the majority of our interviewees were well aware of the need to ensure an active and substantial role for clinical professionals, but not always so sure about how this might be effectively achieved. The data suggest that GPs are always involved, to a greater or lesser extent, in decision-making but it is less apparent that other clinical professionals have a similar level of influence before decisions are taken. And yet in examining the individual drivers of clinical service improvements in diabetes care, it was clear that nurses and allied health professionals had an absolutely crucial role to play.

Thirdly, the resources which are available to PCTs particularly in terms of staff are constrained. All our PCTs showed clear evidence of management and clinical staff stretched thinly, sometimes to breaking point. This may in part be a feature of the transition state already alluded to. But it also appears to be partially an issue of scale. These data raise the question of whether PCTs can legitimately, within their budgets, expect to employ high quality support staff. The employment of good quality HR staff within a PCT would be a prime example. PCTs are in competition with acute sector trusts and the private sector and it is unlikely that an organisation of this scale can afford to attract a high class, experienced HR manager. So the question is raised — what alternatives are open to PCTs? The idea of common service organisations or, alternatively, the outsourcing of specialist functions comes to mind as a proposal.

Fourthly, as a result of all the factors already addressed, cumulatively, the leadership of clinical service improvements in primary care appears fragile and based on the willingness, motivation and dedication of a few people. This is true of both general management and clinical management staff, but the latter are especially vulnerable. They do not *need* to commit to involvement in clinical service improvements and if they choose to withdraw, it is very difficult to offer incentives, as PCT management have limited leverage.

7.2 Influence of context on the progression of improvement strategies

While not setting out to focus specifically on context, our data display overwhelmingly and universally, the crucial importance of context for understanding why and under what conditions clinical service improvements may or may not progress. Here we offer a typology (Appendix 5) which has been constructed to develop our findings conceptually and theoretically.

The theoretical underpinnings of our thinking in constructing this typology lie within the literature which was discussed in Section 2 (particularly Section 2.2.2).

As stated, our analysis of the themes emerging from the data was carried out in a number of ways:

- by case
- by care group
- across cases
- comparatively across care groups.

In *all* the cases, the analysis highlighted a similar finding. This finding was rated as a 'strong' influence on clinical service improvements in all cases. We therefore explore and delineate the theme here.

In all the cases, it was apparent that *clusters of features* of the context had a strong negative or positive impact on the progress of clinical service improvements in the nominated care groups.

Previous research work on organisational change in both the private and the public sectors has highlighted the significant impact which organisational context can have on the effective implementation of strategic change (Child and Smith, 1987; Pettigrew and Whipp, 1991; Pettigrew *et al.*, 1992; Child, 1997; Dawson, 2003). However, previous work has not, thus far, enabled managers and others to identify accurately the characteristics of the context which may/will influence effective change implementation. In part, this is because we may find that the same factors are not relevant in all organisations, for example, in both public sector and 'for profit', commercial organisations. So the nature and form of the organisations must be taken into account. In health care, previous studies by Pettigrew *et al.* (1992) characterised some of the features of 'receptive' contexts for change. These dimensions included consistency of strategy; continuity of leadership; involvement of professionals in the process and HR capacity. Later work on innovation draws additional conclusions from an extensive data base of 47 cases in health care (Dopson and Fitzgerald, 2005). This research demonstrates that a foundation of sound or good interprofessional relationships is an essential foundation for effective service changes to be implemented.

Building cumulatively on this base, our current study illustrates that specific *configurations of characteristics* are detectable across the cases and these configurations by their presence or absence impact positively or negatively on progress in service improvements in the clinical areas. This finding represents a theoretical development in two ways. Firstly, we argue that conceptually, managers and researchers should move from a consideration of single or linear cause and effect relationships. It is not probable in a dynamic, complex organisation that even several unchanging characteristics a) will lead to an effective outcome or that b) managers intuitively know this! These data reconfirm and strengthen the previously expressed view that one needs to conceptualise the influence of context in terms of configurations of factors/variables (Dopson and Fitzgerald, 2005). The significance of combinations of factors or conditions - what has been described as 'conjunctural causation' (Goldstone, 2003) - appears to be supported strongly by the experience of these trusts. So to aid

understanding and guide action, researchers need to prioritise from a large range of variables and direct attention to a sub-set. And then identify the 'probable' configurations within this sub-set of variables. Our data suggest that we can progress beyond a general finding to specify, with greater precision, the conjunctures of combinations, which can lead to positive or negative progress in clinical service improvements.

Our second contribution is that we seek to overtly link the characteristics of the broader organisational context, including dimensions of the strategic apex of the organisational units, to events and progress in improvements at the 'workface' of health care.

In this typology, presented in Appendix 5, we have sought to develop these ideas. The typology identifies (and labels using a 'symbolic' label) groups of characteristics in the organisational context which are demonstrated to be significant to the change capacity of the organisation. Furthermore, these characteristics of the context's change capacity are then linked to the progress (or otherwise) in clinical service improvements.

From our data we highlight the specific elements which, if present, in combination, can lead to progress. The data suggest the core factors are:

- executive team focus on that particular service, for whatever reason
- absence of other pressing agendas to divert senior management attention in other directions
- dispersed leadership for change; organisations with the capacity for change leadership at both senior, executive *and* clinical service management levels
- a positive history of prior changes which has generated trust and a long term effect on the culture for co-operation and proactive improvement
- the presence of strong external pressures and relevant leverage
- a sound foundation of interprofessional relationships as an essential foundation
- key service improvement roles populated, and rapidly filled when they fall vacant.

The secondary factors are:

- continuity of leadership
- minimal resources.

In order to exemplify these points in greater detail, we present a typology (at Appendix 5), which has been developed for all 11 sites. This typology seeks to exemplify the links between the positive or negative factors and characteristics of the context and the extent of progress within the specific care group under study. The typology is a

crucial element in our analysis. So in the following paragraphs, we explain it in greater detail.

In this typology, we provide for each site in the study a box which links together the characteristics of the capacity of the context with progress in service improvement. At the top of each box, each site is given a symbolic title to 'label' the nature of the context simply. Then each of these context labels is supported by a brief explanation of the title to show the facts which support the symbolic title. Then towards the bottom of each box, we provide a title to 'label' the nature of the progress which has been made in improving the specific area of care under study in this trust. We would stress that this lower label only refers to progress in the particular area of care studied and does not suggest that good, sound or appropriate progress has not been made also in other areas of care. Then in a similar manner to the context label, we provide the evidence which supports our view of current progress in improvements in the clinical area studied. All of the eleven sites are laid out along a continuum, which ranges from limited change to proactive and continuing change.

The typology illustrates a range of progress which includes positive and negative extremes and many points in between. To demonstrate some of the points, the cases at the extremes will be used here to exemplify. At the negative end, the Cancer 2 case is given the context label '*resistance*'. This is because this case is characterised by a number of factors which, in combination, produce a negative context for improvements in cancer services for people with prostate cancers. Firstly, senior management's attention is focused elsewhere. They have a major development in train, and this requires much management effort and they are therefore 'distracted' from paying direct attention to cancer care despite government targets for cancer. Secondly, and significantly, due to an earlier merger of two hospitals, many of the established consultants in urological cancers resigned and new clinicians were appointed. This has had two effects. The conflicts, which existed historically, including between clinicians have been re-absorbed and continue, despite changed personnel. And the new clinicians are resisting the extension of their roles and are unwilling to adopt improvement roles. The overall consequences of this context are that no one at the senior management level wishes to prioritise the poor relationships between the consultants even though there was evidence within the period of study that this caused a breakdown in improvement projects.

So no attempt is made to embark on a process of reconciliation or seek the means to break out of this negative frame. (It is notable that despite the fact that this is a major trust hospital, there was no evidence at all that the HR function was actively supporting clinical management development).

So what are the effects of this context? Within the area of cancer care, there is very limited evidence of any improvements in care for

urological cancers. So progress towards improvements in this site has been labelled '*inactive*'. It is clear that one key reason for this is that there is no clinical opinion leader or champion who is prepared and able to lead change within this site. So the only progress which has been achieved has been the result of activity and leadership from the urological consultant at a neighbouring, collaborative trust. The clinical staff at our site have been virtually 'hangers on'. From the management's perspective, it is evident that many managers (not clinically trained) do not feel competent to intervene (or interfere?) in disagreements between medical colleagues. Perhaps also, many managers may suspect that, if they were to become involved in repairing such relationship tangles, their interventions may be ineffective, and could perhaps make matters worse, particularly if they were perceived to be 'taking sides' in any respect. Clearly, the role of the medical director is highlighted within such a situation, as is the professionalism of the HR function, already mentioned.

At the positive end of our spectrum, we have the case of Diabetes 3. Here the context has been given the symbolic label '*gathering velocity*'. This is based on a number of facts and characteristics in this site. Firstly, there is a senior management team in this PCT who have a very cohesive view on strategy and who operate within close and amenable relationships. While at the commencement of the period of study, progress on diabetes care had been relatively slow, the senior management team were aware of this (as was the case at a number of our diabetes sites). But here, at Diabetes 3, this was then translated into action, leading to the label for progress on diabetes development of '*proactive refocusing*'. Firstly, the senior management did an analysis of the issues facing the PCT, with regard to diabetes care. And then it acted on this analysis, which highlighted the need for the PCT to adopt a more proactive approach and indeed to try to develop and improve their relationships with the local acute hospital. As a result, the analysis translated into a post and a highly effective and experienced manager was appointed. This individual was able to support other staff, but also to generate new ideas and to drive change forward. From this point onwards a degree of steady, if not spectacular progress was achieved. A key part of this was an ongoing attempt to work more closely and co-operatively with the local acute trust. This was the only case in our study, where the PCT gained agreement that they had the 'lead' responsibility for improving diabetes care.

This exemplification from our typology attempts to explain the important influence of context on progress, but more than this, it is hoped that these examples provide some evidence of the relationships between context and action. It underlines that the presence and activities of actors at several levels in the hierarchy is required to move improvements forward. This concept of dispersed leadership for change will be returned to in a later section. This analysis does not suggest that exactly the same combination of factors accounts for

progress in all positive cases, but rather that there are variable combinations. Nor can we claim that the identified factors are an exhaustive list of all the potential connections, since our current findings will need replication and further testing in other health care settings.

Finally, there is a temporal dimension. Is this a static representation? We would tentatively postulate that the change capacity of a context will endure and have a medium to longer term impact on clinical service improvements. However, this proposal is subject to one reservation – change capacity may be impacted by personnel changes and thus be fragile.

From a further perspective, it is interesting to examine this typology and question whether the complexity of the context for change within each site has affected progress on improvements within the area of care under study? Reviewing the data on each site, it is evident which of the sites are making the most limited progress. These are listed here in descending order:

- Cancer 2
- Cancer 1
- Diabetes 2
- Maternity 1
- Diabetes 1.

Cancer 2 was developing an ambulatory centre which was a major development, but one which might be expected within a large acute trust; Cancer 1 was applying for foundation trust status; Diabetes 2 and Maternity 1 did not have any major strategic developments underway and Diabetes 1 was undertaking a range of developments rather than one or two major projects.

At the positive end of the end of the spectrum, our three cases with the most positive progress are:

- Diabetes 3
- Maternity 3
- Cancer 3.

Of these cases, both Diabetes 3 and Cancer 3 were coping simultaneously with a large range of developments and improvements and Maternity 3 was in the throes of a massive process of re-development. However, these other developments and improvements did not impede clinical service change in each of the areas of care under study.

7.3 The 'distraction' effect and its impact on clinical service improvement

One specific aspect of the characteristics of the change capacity of a context relates to the activities of senior management. In a number of our sites, senior management's attention was concentrated on an externally-imposed target or structural change which effectively 'distracted' their attention from clinical service improvement. Thus the research findings draw attention to fact that externally-imposed changes can hamper the development of clinical services.

7.4 Frameworks and standards for services do not guarantee change

Our typology and the discussion of the data which justify and explain it highlights the importance of change capacity. Each of the areas under study either had a set of service standards in a published NSF or in the case of maternity services, this was emerging as we completed fieldwork. But our data display a slow rate of change in all care groups across the eleven sites. The approach of issuing in a 'top down' manner, a service framework does not of itself guarantee that service configurations will change or that services will improve.

7.5 The nature of clinical manager roles

Through the analysis of our data on the roles held by respondents, it is apparent that many general managers and clinical managers hold complex roles. The number and range of clinical staff performing hybrid management roles appears to be on the increase. 'Hybrid' roles are here defined as roles in which the incumbent performs some significant management duties, while also practising as a clinician. Thus both the individual and those with whom they interact have to cope with and manage the split in duties. On occasion, this is achieved relatively easily, with clinical managers being able to clearly divide their time by splitting the time/week, and nominating days for different activities. But much more frequently, this division of labour presents problems and issues. In appointing staff to these roles, far more attention needs to be paid to these issues by senior management and by HR specialists. Initially, attention needs to be paid to whether the targets are achievable and the workload in the role manageable. Put simply, all such roles need to undergo a focused review at six months and one year. Beyond this, role holders and others need to negotiate around the processes which may work best in a specific setting and be prepared to adapt the role.

In terms of role enactment then, we found a narrow focus within the roles as enacted by the clinical managerial hybrids tracked. The focus was on operational, rather than strategic management, with little attention paid to service improvement or change management. In

some cases, the day-to-day pressures from the service seemed to be close to overwhelming the construction of any coherent role at all. This conclusion is more pessimistic than much of the earlier literature which had assumed relatively broad role definition.

When comparing these data to earlier research on clinical director and other hybrid roles such as medical directors, (Fitzgerald, 1994; Marnoch, 1996; Fitzgerald and Dufour, 1996; Thorne, 2000), it becomes apparent that there is very limited evidence that the clinical director roles are progressing into full-time management roles. Similarly, many of the issues identified in this earlier research remain. In particular; there is limited data to suggest that the training and development of clinical managers has improved substantially. Indeed, one might argue on the basis of these data that those clinical managers who are working in primary care are less well supported than their acute sector counterparts (see Section 7.11, training and development support). Additionally, while the respondents at only one site described the relationships between general managers and clinical staff collectively as poor; a proportion of the clinical managers interviewed were experiencing difficulties in their relationships with clinical colleagues as noted in prior research.

So what about the possible professionalisation of the medical management role? Using Montgomery's (1990) theoretical framework of collegueship and legitimacy, we again found evidence of only a very limited professionalisation process. Structurally, there have been some modest developments in the proliferation of clinical and medical director roles and the establishment of the British Association of Medical Managers as a professional association (although with weak impact on our sample of role holders). Yet more fundamentally, the hybrid group does not yet have a coherent work identity or credentialised knowledge base – instead clinical managers undertake some operational managerial duties, but primarily concentrate on clinical responsibilities within their *clinical* specialty area. Externally, there is no recognition of clinical management as a specialty, with limited educational opportunities or credentials – and an unwillingness to undertake major training. Other medical professionals do not consider clinical management to represent a medical specialty – rather clinical managers uncomfortably span the managerial/clinical divide and are not full or influential members of either occupational group.

In terms of their longer term career orientation, a proportion of clinical managers argue that their tenure as clinical director is not perceived by them as a permanent move into management. Our initial findings on this topic are that a substantial percentage of clinical managers do not wish to remain in management. This is an area where further research is required. Further analysis, with a larger sample of hybrids is needed to examine in greater detail, the motivations and rationale of those hybrids who may wish to continue in a management role.

7.6 The roles of those leading, facilitating and driving change

Within this research project, we are interested in who leads or facilitates clinical service change (and why). Perhaps coincidentally, our first general observation is that there were some identifiable differences between the acute and primary care sectors. Comparison across the acute and primary care sector sites revealed that many (the majority?) of the service changes in acute care are led by clinical managers, while in primary care, they are led by general managers. At this stage, we are unsure if there is any logic to this. It may be partly a function of the care groups under study. Or it may be that, as the majority of GPs tend to be 'distanced' from PCT structures, the leadership or facilitation of PCT-wide change falls naturally to PCT general managers. In which case, structure is the main determinant. A further issue here may concern the use of the terms 'lead' and 'leadership'. Clinical managers who are involved in service improvement in acute settings do not invariably view or define themselves as 'leaders' or even as 'change agents' - terms which some would vociferously challenge if applied to them. So it may be helpful to unpack the meanings in the phrase 'lead change' and focus attention and further analysis on the activities in which people are engaged and the tasks they perform. For many clinicians (and even management project leads), 'leading' change actually means 'just doing it' and expecting other people to fall into line and colleagues to copy. However, while further analysis may help to reveal the nuances and offer other explanations, it is pertinent to observe that where clinical service changes are led solely by general managers, they would appear to encounter greater difficulties. The cases of Cancer 2; Maternity 1; Diabetes 1 and Diabetes 2 are all, in different ways, good examples of this. It is also interesting to note that none of the maternity cases had service improvements which were exclusively led by general managers.

Comparison across the cases further reveals that those actively involved in leading and facilitating change are to be found in all our role categories; that is, there are general managers; hybrid clinical managers and clinicians engaged in change. We make further detailed comments about how these roles are enacted, tasks, relationships and processes, under other themes in this section. Here there are two general observations to be made. Firstly, the majority of major or strategic changes to services are led by the hybrid clinical managers or general managers. While clinicians of all backgrounds are engaged in leading and facilitating changes at local levels, these changes tend to be smaller in scale and because they are localised, but not part of a wider strategy, such change can be fragmented. This, unfortunately, limits the impact, even when it has been successfully implemented. Secondly, many attempts to introduce service improvements are fragile and depend to too great an extent on the motivation and energy of one or a few individuals. This issue seems to be especially

prominent within primary care. Here, the GPs, nurses and allied health professionals who engaged in improvement activities in diabetes care often did so out of enthusiasm or personal motivation, and they were a small minority of those delivering such care.

Some important, specific aspects of roles in the leadership of change are also alluded to under the themes of 'effective networks for facilitating change' (Section 7.10) and 'dispersed leadership' (Section 7.9).

7.7 The nature of 'portfolio' roles

The data reveal that 'portfolio' roles are also much in evidence. We are using the term to refer to an individual who describes their current role in terms of a number of discrete parts (on average three to seven) with differing targets and where they engage with different sets of people. These types of roles are most commonly held by senior executives and also by managers working within or between networks and trust organisations. It would therefore seem logical to conclude that if networks increase in health care, such portfolio roles are likely to also increase. Such roles present greater problems of role clarity, than hybrid roles and the key aspects of the role need communicating to other, interacting staff. With a degree of clarity, such roles may work effectively in an ambiguous or complex context. In stressing the need for clarity, we would underline that this is not to suggest rigidity. As one respondent observed, in the current organisational context, which is itself unstable for many reasons, one would expect roles to be fluid and at times ambiguous. Many managers welcomed this ambiguity as it gave them scope to create profiles of activity and responsibility that suited their interests and preferences. Thus one can identify and demonstrate the motivating power of role flexibility. Some of the managers who complained of a lack of role clarity actually wanted better information and more power!

7.8 The impact of the quality of relationships

This research reinforces again the notion that in order to progress the implementation of change in a multi-professional service organisation, such as health care, you need to establish and maintain a foundation of good intra and interprofessional relationships (Pettigrew *et al.*, 1992; McNulty and Ferlie, 2002; Locock, 2001; Illes and Sutherland, 2001). Without this foundation being in place, even small scale changes are difficult.

On a positive note, the quality of relationships within our sites between clinicians and general managers was perceived by most respondents as sound, but slightly distanced. However, this was not universally the case and Diabetes 2 was one exception. The distant nature of these relationships was more apparent within primary care, and was more heavily criticised in PCTs. There was evidence in some

sites of very limited contacts between PCT managers and the 'average' GP or primary care nurse.

However, the quality of the relationships within the sites between clinicians and other clinicians was more variable. Sometimes, this was also a case of distance and limited contact, but where the relationships were poor, this proved *very* disruptive to providing good care. In these instances, the causes of the current poor relationships were frequently historical and might, as in the case of Cancer 2, be the result of an event such as a merger. It did seem strange that in these circumstances, working on improving relationships did not readily rise up the institutional agenda. Why did management not intervene? There may be a number of plausible explanations. First, many managers (not clinically trained) do not feel competent to intervene (what they may class as 'interfering') in disagreements between medical colleagues. Second, many managers may suspect that, if they were to become involved in repairing such relationship tangles, their interventions may be ineffective, and could perhaps make matters worse, particularly if they were perceived to be 'taking sides' in any respect. Third, most middle and senior managers in health care have other pressing current agendas (star ratings, foundation trust bids). So it may be simplistic to suggest that management accept these situations, although that may be the result. Such issues are typically left to the medical director to handle, so the status and relationships of the individual in that position may be critical.

One key and important finding of this research is that the networks of relationships which exist are predominantly either managerial *or* clinical. When asked to describe their key relationships and interactions, general managers listed a range of other managers while clinicians asked the same question listed largely other clinical staff. Only some of the hybrid, clinical managers in the research listed a mixed group of individuals in their network of relationships. This does represent a critical finding. It means that in reality the influences on decisions may be one-sided and that projects and processes for improvement are not routinely and mundanely drawing ideas from a wide range of sources. Furthermore, lack of regular contact at both individual and collective levels does nothing to aid understanding between clinicians and managers. Finally, the situation makes the 'bridging' roles which do exist critical. These roles are, largely, but not exclusively, hybrid roles, which by their nature cause people to move between the differing worlds. Other staff who play useful 'bridging' roles may be those who hold a position with oversight across a PCT, such as a pharmacy advisor; or those who hold a management or facilitative role in a network. But this situation also makes the service overly dependent on these few people.

7.9 Effective, powerful dispersed leadership for change

As in previous research, (Denis *et al.*, 1996; Denis *et al.*, 2001; Denis *et al.*, 2002) the utility and effectiveness of small core groupings of collective leadership have been identified in this research. Here our findings confirm and extend prior work. It is evident that in some of our most positive sites, there were small groups (duos and trios) of senior managers who worked effectively together, who collaborated and consulted each other and who had respect for each others viewpoints. It was also notable, in these sites that the impact of the effective working of these teams was acknowledged by many other staff in the organisation. In acute sites, these collective leadership teams frequently included the CEO and medical director or at the level of the care group, the clinical director and general manager. In primary care sites, the key strategic group was the chair; CEO and the chair of the PEC, with fewer systematically identifiable groupings at lower levels. In primary care, the sound working of these groups was even more crucial, because they are smaller organisations with fewer resources.

Some illustrations of how these teams support change were given in the discussion of the typology in Section 7.2..

However, our research results illustrate a further development of the idea of collective leadership. Within our cases, those sites which were the most effective in achieving clinical service improvements demonstrated a *dispersed leadership* of change. Dispersed leadership for change involves the active engagement of staff both at different levels in the organisation and from a range of professional and managerial backgrounds. So dispersed leadership for change has a number of characteristics:

- There is a supportive and active senior management team which is willing to become involved in facilitating change.
- Clinical managers and senior clinicians work within the organisation and sometimes across organisational boundaries providing leadership and advice to colleagues, negotiating for resources and constantly pushing the changes forward.
- Individual clinicians (of all professions and backgrounds) are willing to undertake specific tasks and are keen and energetic.

This new finding extends and develops previous ideas beyond the effectiveness of collective leadership at senior executive levels in health care. The effectiveness of dispersed leadership for change also has implications for models of change agency (and particularly what now appear to be dated or commercially-biased role taxonomies). This finding has further implications for practice, as these widely-dispersed contributions to change may not always be recognised, supported or rewarded.

Tentatively, at this point, we would also suggest that the data demonstrate that if there are 'gaps' in this dispersed leadership system, then the progress of change initiatives may be slowed or impeded. A gap might refer to a level of the organisation where there is no support for the espoused changes, say at senior management level or at clinical director level. Or alternatively, a gap might refer to the fact that in one key professional grouping involved in the changes, there is no one willing or able to act as a facilitator or opinion leader.

7.10 Effective networks for facilitating change?

Our research data offers many examples of the growth of networks as an organisational form in health care. Within the current study, we observe the operation of mandated networks in cancer which are heavily performance managed and of more organic networks in diabetes care which though 'recommended' do not have such a specific mandate. Additionally, we have noted that current policy recommends the establishment of networks for care in maternity care also. In reviewing the operation of networks, it is interesting to question whether they could be described as a mechanism within which change is planned and implemented, across organisational boundaries.

Broadly speaking, the cancer networks created a wide spectrum of reactions among clinical staff, from 'waste of space, go away', to 'source of valuable additional staff resource and funds'. Within the diabetes cases, it was notable that many staff accepted that an integrated strategy for diabetes care required collaboration between the acute and primary care sectors. However, the setting up of networks between the acute and primary care sectors was still at a very early stage of development. Even where they had been set up, many staff involved in diabetes care were unaware of their existence or functions.

Drawing especially on the cancer cases, it can be observed that the operation and effectiveness of the networks are dependent to a considerable extent on network-wide appointments. Where these appointments were vacant or unfilled for a period, as at Cancer 1, the impetus for change was slowed. On the other hand, where these posts were filled, the occupants were frequently 'change drivers' who provided the energy to move initiatives forward. Many of the incumbents of these posts also responded to the challenge of working in a fluid and novel organisation and were active in 'bridging' between organisations and professional groups.

One especially interesting element of the networks is the role and function of the strategy board. One observes firstly, that in both cancer care and diabetes care, trusts had established strategy boards though these were only mandated in cancer care. There were a

number of issues surrounding their operation. The strategy boards tend to have large and fluid memberships (different people turn up at each meeting, so there is lack of continuity), and deal with wide-ranging but fragmented agendas, rather than with strategic organisational change issues. Two aspects were repeatedly mentioned by respondents. One was the difficulty of dealing effectively with non-attendance by key individuals. The second aspect was the extent to which the strategy board was a decision-making body or not. Even if it was agreed by all stakeholders that decisions should be taken at the board — who then was accountable for implementation?

These issues raise questions concerning the role and functions of strategy boards in the processes of strategy formulation and implementation. It is apparent that the boards may be useful vehicles for mapping areas of consensus across different organisations and sectors; for identifying priorities and for developing options for action. Their role in decision-making and in delivery and implementation of changes is more debatable. Finally, they may have a useful role to play in monitoring progress, if they were embedded within an adequate reporting structure.

The questions raised by comparison between the mandated networks and the more organic networks are one topic for further analysis which we have already identified. This topic highlights queries concerning the engagement of clinical staff in change initiatives; the locus of decision-making in networks and the leverage and accountability for driving change. We aim to compare cancer and diabetes networks as examples of mandated and organic networks and compare and contrast their strengths.

7.11 Training and development support

Another absolutely key finding from this research is that the management training and development of clinical, hybrid managers and clinicians is very underdeveloped. The evidence suggests that little progress has been made in tackling this issue since it was identified some ten years ago (Fitzgerald, 1994; Marnoch, 1996; Fitzgerald and Dufour, 1996).

Generally, throughout all the cases there were poor levels of training and executive development. The levels of training for key posts within primary care were especially poor, but there was barely any evidence that these issues were being addressed. Development opportunities were unsystematic and variable. Many staff throughout the health service were unclear about provision.

A neat exemplification of this occurred at our session at the NHS Confederation Annual Conference. One group of approximately ten to 12 general managers and clinical managers, while reporting back on their discussions, stated that no one at their table knew what a workforce confederation was or did! This situation appears to

completely contradict what might be expected from stated policy (Department of Health, 2000; Stevens, 2004).

7.12 The role of HR : developing multi-professional leadership for change

Beyond the specific aspect of management training and development, the role of specialist HR functions within health care is also raised by these data. Individual HR specialists were rarely seen playing an active part in facilitating change within their organisations, with one or two exceptions. There was limited evidence of systematic processes of development inside trusts, even large ones. Clearly, there is the issue of economies of scale for PCTs. There are a number of specialist service functions, of which HR is one, where it simply cannot be economic to engage the full range of specialists within a relatively small organisation. Thus PCTs must surely need to consider other means of developing these resources, such as through shared services or contract outsourcing.

In discussing the current reform processes in health care, Stevens (2004), makes the point that the reform strategies have moved from one dimensional approaches to three dimensional approaches in an effort to cope with the complexity of system-wide changes. This means that current reforms place greater emphasis on the development of staff; on shifting professional boundaries and on engendering flexibility. Stevens describes this as a search for 'constructive discomfort'. However, this cannot be achieved without a much more sophisticated HR strategy and investment in the appropriate development of staff.

7.13 Change substance and the timescales of change

There are a number of interesting dimensions to this theme, which will be briefly discussed here.

While many of the targets in the *NHS Plan* were relatively straightforward (for example a two week waiting time), the substance of the changes required to achieve those targets was complex. Implementing 'rapid access' for prostate cancer patients is a typical illustration of how the change agenda 'proliferated' (Van de Ven *et al.*, 1999) in pursuit of that performance target. So we can observe a situation of *simple targets, but complex substance*. In other words, one is frequently not talking of 'a change' here, but of a systemic package of interrelated changes.

Despite the disarming simplicity of the ultimate target, therefore, these changes took a long time to implement. The logistics of putting all of those components into place, and making them work together, took time. Trusts had to find adequate free resources (money, people,

time, management attention) to devote to both implementing and operating those changes. The complexity of the changes meant that many more people had to be persuaded to contribute, involving more interpersonal 'face-to-face time' on the part of change agents, and subsequently more familiarisation and training time. As a consequence, it is inevitable that addressing complex issues of substance requires an extended timescale.

To the extent that this is a broadly accurate portrayal of the substance of the 'tracer' changes we have been considering in diabetes, maternity, and cancer care, one major policy implication concerns expectations. Expectations with regard to the time it would take to achieve many of the targets set out in the *NHS Plan* have been unrealistic.

Section 8 Implications for policy and management

8.1 Impact of multiple, changing policy directives and targets

Previous research has highlighted the disruptive and potentially dysfunctional impact of constant strategic change on the functioning of health care services (Pettigrew *et al.*, 1992; Ferlie *et al.*, 1996). For example, the gap between strategic intent and operational reality has been underlined (Pettigrew *et al.*, 1992). However, these data display a new dimension to the impact of policy changes. While strategic changes rightly claim the attention of senior management, limiting their capacity, this process also distracts from the monitoring of ongoing, clinical service change. And this is where improvements to health care systems are actually delivered.

The policy implications of this are:

- Serious reflection and risk assessment is required before increasing and adding to required policy changes, based on new or revised policies.
- Policy which assumes that organisational effectiveness in healthcare can be manipulated through a relatively small number of variables, and in particular funding, performance targets, structures, and leadership, ignores the evidence. The results of new policies, and the outcomes of change, depend on combinations of factors, their interaction, timing, and on a complex set of organisational conditions. As those combinations of factors can be both complex and fragile (but are not necessarily uncommon), a policy environment that continues to inject fresh imperatives and priorities, and (as we have seen recently) structural changes can easily disturb the properties of the local context that are conducive to more rapid, effective, and sustainable change.
- In the past, the timescales set for implementation have been inadequate and sometimes naïve; more realistic timescales need to be set.
- Far more policy attention needs to be paid to the processes by which targets will be achieved. For example, the necessary stages might include - publish target; invite local action plan (to a deadline) and then approve and monitor milestones.
- A need to ensure that performance targets (however described) have a sound clinical basis and consequently enjoy broad clinical support.

8.2 Policy approaches and options: the impact of training in techniques versus building change capacity

Our project data illustrate the relatively slow, even disappointing pace of clinical service change despite these being priority areas of care. This raises critical questions concerning the current policy approaches to change implementation and the spread of changes across the health care system. The previous approaches adopted by the Modernisation Agency have focused considerable attention and resources on identifying standard change techniques, which are held to be effective. One key strand of activity has been to train many members of staff across the service in specific techniques. However our data suggest that there needs to be a shift of focus and greater weight needs to be placed on building longer term change capacity in the organisation. This infers training those in clinical management posts better; and in supplying support through specialist change roles, embedded within the service. The question is whether this is too expensive?

8.3 Visibility of policy impacts and policy developments

Throughout the main empirical sections of this report (Sections 4, 5 and 6), we have portrayed the impacts of policy, as they were perceived by those working within the services in these case study sites. In some fields of provision, such as cancer care, the impact of past policy initiatives, such as the NSF for cancer, were much in evidence and regularly discussed by respondents. To a lesser extent, this was also true of the cancer networks and their functioning. However, as our typology indicates, this level of awareness did not automatically translate into the implementation of the NSF targets in practice.

It is also apparent that in other areas of care, namely maternity care and diabetes care, there were lower levels of widespread awareness of the current policy objectives. In the case of maternity care, it was argued by many respondents that improvements in maternity care had been shunted down the agenda and were perceived as lower priority. Thus it can be argued that the production of 'new' policy objectives also has the effect of hampering the 'still-not-completely-achieved' old ones. Another and possibly complementary explanation for the lack of awareness of improvement targets in maternity care may lie in the fact that the impact of the *Changing Childbirth* document had faded with time and the new *Children's NSF* was not published until 2004 (Department of Health, 2004a). This was towards the end of our period of fieldwork and so the impacts of this document will not be evident within our data. So there may now be a resurgence of interest in achieving the targets laid out in this document.

The lower levels of awareness within diabetes care are, we would argue, accounted for by different explanations. Our data suggest that the primary care sector, as a whole, is still in a period of transition. Within this state, individual PCTs are at slightly differing stages of development. So the capacity of PCTs to respond to policy requirements is more variable. Again there is the issue, as within the acute sector, of many competing policy priorities with which trusts must contend. In addition, the primary care sector is more fragmented, and it remains more difficult to communicate with all the health care professionals working in the sector. Some general practices are distanced from their PCTs and not all practitioners attend to the call to achieve policy targets. As a result, although the incidence of both types of diabetes is rising and there is clearly and evidentially a need to prioritise improvements in diabetes care, the implementation of the standards in the *Diabetes NSF* remains patchy. Many respondents argued that there had not been 'money attached to diabetes' when this NSF was published.

It may also be observed that some aspects of policy and the impact of policy were virtually 'invisible'. It may seem surprising that very few of our respondents mentioned or discussed the impacts of policies such as the EU directives on working hours and junior doctor hours. In only one area of our study, in the maternity sites, was this mentioned as an issue. Here the concern expressed focused on the changing pattern of rotas for the senior staff and the consultants in order to staff the labour wards appropriately. This was frequently perceived as an issue of resourcing and staff retention, as well as carrying financial implications for the cost of services. However, we have not offered any focused debate on the impact of these policies as this did not form a significant part of our data.

We now comment briefly on currently emerging policy developments, such as the expansion of networks as a form of organisation and the encouragement to adopt a network form of organisation for women and children's services (Department of Health 2004e; 2005b). The evidence which we have offered in this project report, especially from the cancer sites, suggests that the benefits of a network form of organisation will only be realised if there is investment in the key service improvement roles. To complement this, senior management at the constituent trusts need to delegate oversight of the network's operation and the trust's role in the network to a committed manager. A hybrid manager might be particularly helpful in this role.

In considering the emerging 'choice' agenda in referrals from primary care (Department of Health, 2004d), our data generate concerns about the ability of the primary care sector to cope with the extensive changes which this policy implies. This observation has to be set alongside the knowledge that the planned restructuring of SHAs and the PCTs will produce an added burden of disruption to the present arrangements (Department of Health, 2005c).

8.4 The critical importance of hybrids to facilitating and bridging between professions

There are multiple policy implications from this single finding. A selection of the policy implications are detailed here.

The Department of Health and professional bodies need to work immediately and in a focused manner to delineate these types of roles. This will not happen naturally, as the instinct and interests of the professional bodies are to maintain roles within current boundaries.

The Department of Health should apply serious attention to the fragility of the current structures within the primary care sector. To underpin the relationships between PCTs and general practices requires the presence of more numerous hybrid, bridging roles than currently exist. While the hybrids in nursing and allied health professional roles in primary care are perceived to have great potential, on the basis of these findings, they are generally not well embedded in the PCT structures. This could be rectified.

Finally, hybrid support and development is receiving little or no apparent recognition as an issue of importance to the health care system. There are no national support systems and no national training or development opportunities. Current provision by the workforce development confederation is very fragmented and patchy. There needs to be multi-professional development opportunities which are readily available.

8.5 Role definition

The research data display a basic flaw in the processes of selection and appointment. Many individuals when appointed to their roles as hybrids or 'leads' or to portfolio roles are given no initial role definition and rarely undertake a process of review of the role and its boundaries. This is a basic task which should be automatically accomplished. It is clear that roles will need to develop and flex, especially novel roles. It is essential that role holders and their colleagues have a measure of understanding of the current priorities of a role.

8.6 A patient or consumer-oriented health care system?

Our evidence suggests that there is still a long way to go to achieve a consumer-oriented NHS. In these cases, there is evidence of high level influence by advocacy groups such as Diabetes UK and advocacy groups in maternity care. There is much more limited evidence that advocacy groups have had equal influence in cancer care. The level of

consumer influence into national policy is clearly important. It is a high policy priority to improve patient-centred care.

But at the level of the SHAs and trusts where the policies are implemented, there is far less evidence of consumer influence or even consultation processes. So consumers fail to shape local services. It is therefore vital that the health service builds on knowledge of what is and can be effective (Baggott *et al.*, 2005) and supports and increases the levels of consumer engagement at local levels and within trusts. Potential mechanisms for this might include:

- Work with local patient and public involvement forums – they may work with SHAs/trusts to undertake research on patient needs within particular condition areas.
- SHAs should attempt to identify good practice for patient and public involvement in different condition areas; this can be through national health consumer groups that are working at local level or from existing networks within NHS.
- Contact and links with local branches of national health consumer groups and local advocacy groups – often the national groups will provide resources and support (for example guidelines) for local groups and representatives for working with NHS.

8.7 The huge HR management agenda

8.7.1 Developing local capacity

There is ample evidence that locally, many general managers and hybrids are ill-equipped to perform their roles. There are many examples of general managers at senior and clinical service management levels who are doing superb jobs and making a difference. There are equally positive examples of effective hybrids at all levels and across the professional groups of medical, nursing and the allied health professionals.

But there are also frequent examples of staff struggling. There is evidence of low levels of capacity; limited development occurring and few development opportunities. The policy and investment implications of these facts are clear.

8.7.2 Interventions by HR specialists and the role of the HR function

The HR function within many trusts is far too distanced from the clinical workface and workforce. It does not play a facilitative and advisory role to service general managers and clinical directors. It appears to play a more limited 'maintenance' role to sustain the system, as is. Thus the interprofessional and intra-professional relationship issues which are frequently well known are not addressed and no interventions are made.

These data clearly raise issues about the intended role for the HR function in health care. Ulrich (1998) offers four models for the interactions and relationships of HR to the organisation – business partner; change agent; administrative expert and employee champion. Recent research demonstrates the increasing utility of the business partnering model to today's organisations (Chartered Institute of Personnel and Development, 2004). Does this suggest a new and different role for the HR function, which would be more conducive to improvement?

8.7.3 Development of Interprofessional Forums

Following on from items 6.1.1 and 6.1.2 above, HR should explicitly be charged with the task of working collaboratively with the clinical professionals to review and improve existing interprofessional forums to ensure that are genuine forums for interprofessional sharing. Thus, starting with existing forums such as audit and governance groups/meetings, one might facilitate the improvement of relationships and the sharing of knowledge towards evidence-based health care.

8.8 Recommendations

8.8.1 Recommendations for policymakers

- 1 Reflecting on multiple changes and directives:
Serious reflection and a process of risk assessment of the benefits and impact of frequent new policy initiatives are now needed.
- 2 Realistic timescales for change:
A major and crucial part of this assessment has to be the appropriate timescales for the changes which are required. Setting unrealistic timescales, especially when managers know these will be monitored, is almost self-destructive. It creates pressures, and does not achieve quality outcomes. Indeed, on occasion, it may cause dysfunctional outcomes, both directly in the form of mistakes and indirectly, through producing outcomes like staff turnover.
- 3 Attention to capacity building:
Policymakers have adopted a combination of top-down policy directives and monitoring of performance as the main mechanisms through which improvements in public sector organisations are to be achieved. Questions have been raised by public policy researchers and commentators as to the effectiveness of these measures. Here we can observe that they have not produced rapid improvements to clinical services at the 'workface' in these 11 trusts, despite investment in some areas. The processes of implementing policies need greater attention and even possibly greater prescription.

- 4 General and hybrid management function to intervene on intra- and interprofessional relationship issues:
It is clear that conflicts and poor intra- and interprofessional relationships will hamper any attempt to improve our health services. While these problems will have to be addressed with sensitivity, they require the intervention of senior general and hybrid managers. Clearly the roles of medical director and director of nursing are integral to these processes.
- 5 The huge HR management agenda – addressing the role of the HR function and HR capacity:
Many of the more detailed issues of development and training are mentioned in Section 8.8.2, but the research evidence suggests that the HR management agenda is a strategic one and not merely an operational one. The HR function barely makes its presence felt at the front line of clinical service delivery. SHAs need to review and re-direct the HR function and question how the change facilitation and development activities which are demonstrably necessary are currently being delivered. Clearly the workforce confederations have a role to play.
- 6 Greater incentive to work with consumers?
Incentives might encourage SHAs, trusts and managers to reach out and work collaboratively with local advocacy groups. Starting with these groups would widen the range of voices and overcome some of the difficulties of selecting and supporting ‘representatives’ of consumers and the public.

8.8.2 Recommendations to managers

- 1 Senior management attention and dedicated project management:
Without support and attention from senior management on the fundamental clinical service improvement agenda and dedicated project management, changes in clinical services will be limited and overlooked due to competing and more pressing priorities.
- 2 Develop dispersed leadership and clinical involvement in the change process:
Effective dispersed leadership requires attention to the strategic apex or triumvirate, and to supporting and developing clinical managers and opinion leaders at all levels in the organisations. A context of good relations between clinical and managerial groups facilitates the change process.
- 3 Develop hybrid roles to span boundaries between clinical and managerial groups, and primary and secondary care:
Hybrids appeared to play an important role in personally spanning between the groups involved in organisational change; a clinical background, personal credibility and the ability to communicate and negotiate with different stakeholders made these individuals more effective in this role.

Hybrids, but especially clinical directors need support and development opportunities.

- 4 Role definition and review:
A simple but effective improvement would be to ensure that new appointees to hybrid roles such as clinical directors have an adequate understanding of their role at the commencement of their tenure, have an opportunity to question priorities and have a clearly agreed point of review, say after three or six months.
- 5 Review and re-direct the HR function:
Trusts should re-consider how the whole of the HR agenda can be effectively delivered. There are clear opportunities for basic and repetitive HR functions to be delivered through shared services and/or outsourcing. More importantly, trust boards should consider how the change facilitation and development activities which are demonstrably necessary are currently being delivered and how they support fundamental clinical service improvement activity.

8.8.3 Recommendations to research commissioners

- 1 Pursue with vigour (and funding) the 'development' aspects of R&D:
By aiding and facilitating the dissemination and development aspects which result from relevant research on organisational change in health care, research commissioners would be directly helping and supporting the organisational change capacity building at local levels that we have called for. Commissioners can act as filters to focus managerial attention on key research results from studies on clinical service improvement processes and offer them in an easily accessible form.
- 2 Consider the ideas for future research set out in Section 9.

Section 9 Further dissemination, debate and future research directions

9.1 Planned dissemination

As indicated in Section 3, the research team has already accomplished an extensive process of verification and debate with practitioners, both clinical and managerial and with representatives from advocacy groups. We plan to extend this process further and have already embarked on the early stages of a dissemination strategy, which in the next stages will target academic audiences to complement the practitioner audiences. This strategy of dual streams of practitioner directed and academic directed dissemination will continue.

Table 11 below sets out the current, only partially-accomplished stages of our dissemination strategy, in order to provide substance. We also outline the content of the academic papers in preparation to give readers information on the nature of the academic outputs already being prepared on the basis of this final project report. Beyond these planned activities, we have a medium to longer term publications plan which involves papers being prepared by a range of team members, with lead authors agreed who will guide this work forward.

Table 11 Planned dissemination

<i>Conferences : abstracts/papers submitted</i>	
Organisation Behaviour in Health Care	Aberdeen, April 2006 (accepted)
European Group for Organisation Studies (EGOS)	Bergen, June 2006 (accepted)
Academy of Management, USA	Atlanta, August 2006 (submitted)
<i>Articles in preparation</i>	
1 Paper 'Nobody in charge' prepared for the British Academy of Management Conference, revised for submission to the journal <i>Human Relations</i> . It develops an argument about the need for dispersed leadership in clinical service improvement.	
2 Paper on hybrids and middle managers prepared for the Organisation Behaviour in Health Care conference to go to a leading management journal. It develops an argument about the need to consider multiple levels in complex change processes.	
3 Paper on issues of governance in primary care.	
4 Paper based on the typology prepared for the US Academy of Management conference to go to Academy of Management journal. It explores the interrelationships between aspects of context and organisational capacity to implement change.	

9.2 Briefing papers for dissemination

Discussions have already taken place, prior to reviewers' comments being received on this final report, to consider the wider dissemination of these findings into the health service. It has been agreed that briefing papers will be prepared, targeted at specific audiences, such as those with responsibility for cancer care containing a synopsis of the key findings, recommendations and ideas for action and future improvement. The SDO Programme team have agreed to offer support in the writing and preparation of the papers and in their distribution and dissemination.

9.3 Future research directions

Throughout this report we have hinted at or mentioned a number of areas where further research would be advantageous. Here we propose a selection of these which would seem to us, on the basis of our data to be the most fruitful or the most necessary lines of enquiry.

- 1 Testing the water in primary care:** a study of the current views on the capacity or fragility of the primary care sector to undertake further changes, given the concerns about the sector which emerged in this study. The focus of this research would be to test out on a larger sample a number of critical issues, some factual and some attitudinal. These might include the rate of turnover of senior staff and PEC members of PCTs; training of executive team members and the views on the current rates of progress on targets.
- 2 Why clinical directors wish to stay in management or to return to full-time clinical careers.** This could explore the careers, identities and self conceptions of clinical directors, and their experience of being managers.
- 3 The nature of portfolio roles:** who holds them; how widespread they are across the health care sector; strengths and weaknesses of defining roles in this way and relationships to organisation structures.
- 4 The types and effectiveness of networks in health care:** this topic has already been commissioned by the SDO Programme.
- 5 Models for an effective service from the HR function:** to explore differing models of HR as they currently exist and their impact on clinical service improvement activity.
- 6 Interdisciplinary forums:** a study to trial the impact of HR facilitation in improving and developing interprofessional and interdisciplinary forums (between general managers and clinical staff), to work collaboratively on 'real' projects and their impact on clinical service improvement activity.
- 7 Clinical management as a profession:** why has this been so slow to develop? By using theory derived from the sociology of

the professions and also international comparisons of the development of the profession of clinical management, this would seek to illuminate and explain the current position in the UK.

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Appendices

Appendix 1 Interview questions

Background

- 1 What positions do you currently hold in the trust (full job titles)?
- 2 What external positions (outside the trust) do you currently hold?
- 3 How clearly defined are these roles?
- 4 In what three main ways have your roles and responsibilities changed since 1999?
- 5 How is your performance in these roles monitored and assessed?
- 6 What management training/development/qualifications have you had which are relevant to your current posts?
- 7 Where do you expect to be in five years' time?

Role Interpretation

- 8 Across those various roles, what are your key priorities? If necessary prompt:
 - Can you give me examples of the kinds of tasks involved?
 - Which do you see as management roles/responsibilities?
- 9 Who are the most significant others you have a relationship with, through work?
- 10 How do you influence these key individuals?
- 11 What if anything is distinctive about the way in which you work compared with colleagues in similar positions, here and/or in other trusts?
- 12 If you could make three changes that would allow you to perform your role or roles more effectively, what would those be?

Tracer issue

- 13 What have been the most significant service improvement changes in this area since 1999?
- 14 Can you explain these changes under the following headings?
 - What changes have been put in place?
 - Who have been involved in implementation roles?
 - What external links have been significant?
 - What internal links have been significant?
 - What are the overall objectives of this change?What changes in emphasis or shifts in direction have taken place?
 - What project management structures have been used?

- Your overall assessment of the change process to date?

- 15 The hindsight question: If you could go back and do it all again, what would you do differently?

Appendix 2 Complete list of interviewees

Main title	Gender	Role type
<i>Cancer 1</i>		
Acting director of nursing	M	M
Cancer data services manager	M	M
Chief executive	F	M
Clinical director: surgical directorate	M	H
Clinical lead: cancer and palliative care	M	H
Clinical lead: urology services	M	H
Consultant urologist	F	C
Foundation director	F	M
Lead nurse for cancer and palliative care	M	H
Manager: surgical directorate	M	M
Network clinical director	M	H
Network information lead	F	M
Network lead manager	M	M
Network nurse director	F	M
Network service improvement facilitator	F	M
PCT cancer lead	M	H
<i>Cancer 2</i>		
Associate director for performance governance and service improvement	M	M
Cancer manager	F	M
Chief executive	M	M
Clinical director	F	H
Clinical governance lead	F	M
Lead clinician: urology	M	C
Lead clinician: urology (neighbouring trust)	M	H
Medical director	M	H
Network clinical director	F	H
Network lead manager	F	M
PCT cancer lead	M	H
Quality cancer facilitator	F	M
Urology nurse practitioner	F	H

Cancer 3

Acting head of clinical information	F	M
Assistant general manager surgery	F	M
Chair of trust board	M	M
Clinical director: pathology and radiology	M	H
Clinical director: surgery and urology	M	H
Consultant surgeon: urology	M	C
Consultant urologist	M	C
Deputy director human resources	F	M
Deputy director of nursing	F	M
Director of communications	M	M
Director of finance	M	M
General manager surgery	F	M
Medical director	M	H
Modernisation projects manager	F	M
Network lead clinician	M	H
Service improvement facilitator	F	M
Service improvement lead	F	M
Urology nurse specialist	F	H

Diabetes 1

Chair of PCT	M	M
Chief executive	M	M
Clinical governance lead PCT	F	M
Community sister	F	H
Diabetes specialist nurse	F	C
Dietician	F	C
Director of health care services	M	M
District nurse	F	H
GP	M	H
GP PEC lead for chronic heart disease	M	H
GP PEC member	M	H
Podiatrist	F	C
Practice development nurse	F	H
Prescribing manager	F	M
Service and development manager	F	M
Staff nurse	F	C

Diabetes 2

Chair of PCT	M	M
Chief executive	F	M
Chronic disease manager (podiatrist)	F	M
Diabetes nurse / senior nurse	F	H
Dietetics manager	F	H
Dietetics service manager (acute sector)	F	H
Director of clinical governance	F	M
Director of modernisation	F	M
Director of public health	F	M
Director of service development and strategy	M	M
GP	F	H
GP (diabetics lead)	M	H
GP (LMC chair and member of PEC)	M	H
PEC chair (GP)	M	H
PEC clinical governance lead	F	H
Pharmacist	M	H
Service director (adult services)	F	M

Diabetes 3

Assistant director of finance	F	M
Assistant director of learning and development	F	M
Chair of PCT	F	M
Chair of PEC	M	H
Chief executive	M	M
Clinical governance lead (GP)	M	H
Clinical governance manager	F	M
Deputy head of medicines management	F	H
Diabetes specialist nurse	F	C
Diabetes specialist nurse	M	C
Director of corporate development	F	M
Director of service development	F	M
District nursing sister	F	C
Optometrist	M	C
Podiatrist	M	C
Podiatrist	F	C
Practice nurse	F	C
Public health consultant	M	H
Service development and re-design manager	F	M

Managing change and role enactment in the professionalised organisation

Strategic development manager, primary care	F	M
<i>Diabetes 4</i>		
Chair of PCT	F	M
Clinical governance lead	F	H
Diabetes specialist nurse	F	H
Diabetologist	M	H
Dietetics manager	F	H
GP (priority action group chair)	M	H
GP PEC link	M	H
GP PEC link	F	H
Head of podiatry	F	M
PCT clinical governance lead and director of nursing	F	M
Public health consultant	F	H
Strategy and development manager	F	M
<i>Diabetes 5</i>		
Assistant director of primary care	F	M
Chair of PCT	M	M
Chief executive	M	M
Community nurse	F	C
Consultant diabetologist	M	H
Diabetes nurse consultant	F	H
Diabetes programme board manager	F	M
Diabetes specialist nurse	F	H
Director of nursing research and development	F	M
Director of strategic development	F	M
GP	M	H
Lead dietician	F	H
PEC chair	M	H
Practice development nurse	F	H
Primary care dietician	F	C
<i>Maternity 1</i>		
Acting director of midwifery	F	M
Associate director of women's and children's services	F	M
Chief executive	M	M
Clinical director	M	H
Consultant obstetrician	M	C
Consultant obstetrician	M	C
Consultant obstetrician	M	C

Managing change and role enactment in the professionalised organisation

Head of midwifery	F	H
Head of midwifery	F	H
Lead midwife ante natal clinic	F	H
Medical director	M	H
Professional development midwife	F	M
Sister labour ward	F	H
Sister MMU	F	H
Ward sister post natal	F	H

Maternity 2

Chief executive	M	M
Clinical director	M	M
Consultant neonatologist	F	C
Consultant neonatologist	M	C
Consultant obstetrician	M	C
General manager	F	M
Head of midwifery	F	M
Head of service	M	H
Head of service	M	H
Manager of midwifery-led unit	F	H
Medical director	M	M
Midwife	F	C
Midwife	F	C
Service manager	F	M
Ward manager	F	H
Ward manager	F	H

Maternity 3

Chief executive	M	M
Clinical director: maternity services	F	H
Clinical governance manager for women's and children's services	M	M
Consultant midwife	F	H
Director of human resources	F	M
Director of nursing	F	M
Finance director	M	M
GP	M	C
Joint general manager for women's and children's services	F	M
Joint general manager for women's and children's services and the head of midwifery	F	M

Managing change and role enactment in the professionalised organisation

Labour ward manager	F	H
Lead clinician: maternity services		H
Maternity services manager	F	M
Neonatal consultant and lead clinician	F	H
Senior midwife for acute maternity services	F	M
Senior midwife for primary care	F	M
Specialist registrar	F	C

Note: M = manager; C = clinician; H = hybrid.

Appendix 3 Examples of questions posed at workshops

- 1 Could we adapt the structures of cancer networks/PCT diabetes boards in order to make them work more effectively?
- 2 Do you have examples of any innovative roles in change management? Please describe and explain effectiveness.
- 3 How can network boards motivate all trusts (whether units or centre trusts) to participate in network activities?
- 4 How can network management assist clinical managers to understand the broader, improvement oriented aspects of their roles?
- 5 How can the service encourage joint working both within sectors, and between the acute and primary care sectors?
- 6 How can trusts assist clinical managers to understand the broader, improvement oriented aspects of their roles?
- 7 How could we adapt the structures of cancer and diabetes network boards in order to make them aid more effective service improvement?
- 8 What actions can be taken if key people do not attend decision making fora?
- 9 What are the most effective means for network management to encourage the development of clinical change management expertise?
- 10 What are the most effective means for senior managers to influence clinicians' priorities?
- 11 What are the policy and managerial implications of these findings for HR management in the NHS?
- 12 What are the policy and managerial implications of these findings for the workforce development confederation?
- 13 What are the policy and managerial implications of these findings for the Department of Health?
- 14 What are the policy and managerial implications of these findings for the network boards?
- 15 What are the policy and managerial implications of these findings for the HR department within a trust?
- 16 What are the policy and managerial implications of these findings for trust executives?
- 17 What do you consider are the most effective means for clinicians to influence senior managers' priorities?

- 18 What education and training activities could be developed to give clinical managers more confidence in the change management aspect of their role?
- 19 Where should decisions about priority service improvements be made and who should be accountable for delivery?
- 20 Who should be responsible for driving change through a network?
- 21 Who should drive change in cancer networks and/or joint strategy making between primary care and acute care? Why?
- 22 Would joint training and development activities in change management for clinicians and general managers together encourage more 'paired working' on service improvement?

Appendix 4 Examples of actions suggested by workshop participants

There is a broad need for clinical leadership courses, and to make sure service improvement is embedded in this. However, although not intended this has developed into a uni-professional forum. It needs to be broader, but has a lot of potential to develop the confidence of clinical managers.

There is a need for Department of Health and others to provide more funding for such training programmes (in organisational change) and also to give managers more time for strategic work and training. The characteristics of effective managers were identified as capacity, knowledge, willingness, culture and motivation. These need to be supported. In addition, there is a need to support individuals in owning the process of change.

Capacity, knowledge, willingness, culture and motivation, are key characteristics of [the] change manager. There is a need to support individuals in owning the process of change. The development of clinical panels between trusts and PCTs is helpful. If you have both networks and trusts you need two-way communication between them. Make sure you train and support staff and give them ownership of change, and articulate the benefits of change to them.

It was asserted that the primary care sector generally thinks that change means more work without support, as this has been historically the case. As a result there is a need to frame change and the benefits to clinicians. There is evidence of change fatigue among doctors, who think that change will happen regardless of their opinions. Framing is important. Evidence based change is not sufficient. Need to focus on usefulness and incentives, particularly in primary care.

Changes which could help make diabetes boards more effective were identified as, resourcing GPs to facilitate their participation. In order to encourage GP involvement and to get their views, full use should be made of events that are already there, i.e. protective learning time (PLT) events. There is a need for infrastructure to shift support into primary care, the programme board needs to be representative of the whole diabetic world. We need to look at ways of translating decisions made at the programme board into practice. There needs to be a clearer understanding of the role, accountability and power base of the board.

The structural differences between primary and secondary care are also important. It was asserted that the specialised and team-based nature of acute care is more conducive to ownership of change in a care area, while GP's were presented as independent business people, not part of the NHS. It was asserted that this helped to explain the difficulties in creating ownership among GPs.

Accountability should be located where the care is delivered. The best place for the patient to receive their care needs to be determined and the pathway should then be designed around them – rather than round the existing organisational structures. However in an example given it was easy to map where clinical changes should occur but progress was slowed by conflict over money.

More local autonomy is necessary – the central approach (at SHA or Department of Health level) limits change. Knowing local needs, and then designing change initiatives around those is important. This emphasises the need to understand local as well as national priorities.

Cancer and diabetes networks

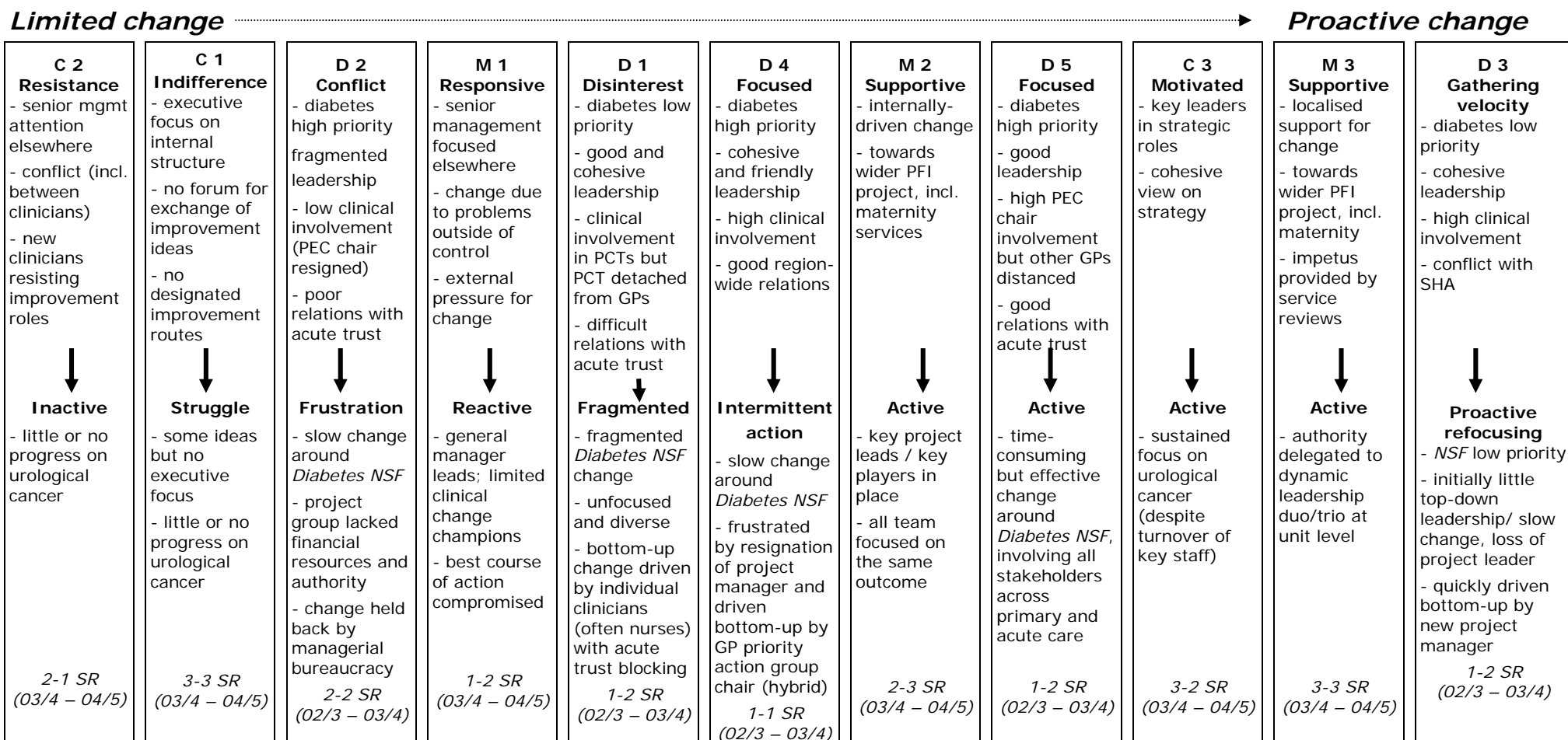
There is a:

- need to look at the type of people drawn on to take charge within networks:
 - creative appointments
 - 'tag teams'
- need to look at ways in which to improve clinical director training
- need for a clinical champion to drive change upwards as departments run themselves:
 - this needs a cohesive view, with a group/department working with the champion – all sharing a goal.

Cancer networks are very organisationally unit focused rather than patient focused. They are shifting towards performance management entities, which is not a good development. Accountability should be where most of the care is coming from. To this end care pathways should be designed and accountability should be placed where most of the care is. This may entail straddling organisational and sectoral boundaries.

In terms of responsibility for driving change in a network, there needs to be more local autonomy to deliver change. The current centralised approach is hindering change.

Appendix 5 Typology of service improvement capacity



Abbreviations: C = Cancer; M = Maternity; D = Diabetes; SR = star rating.

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