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Implementing service-improvement change in Irish hospitals: Exploring facilitating and hindering factors

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A dissertation submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy in Business Studies

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DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy in Business Studies, is entirely my own work and has not been taken from the work of others save to the extent that such work has been cited and acknowledged within the text of my work. I further certify that this material has not been submitted previously as an exercise for a degree at this or any other university and agree that the library may lend or copy the thesis upon request.

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The Methods Used and the Major Findings

The principal objectives of this thesis are (1) to identify who holds change-related roles, how are they enacted in and affected by role-related constraints and what works effectively; (2) To identify the contextual factors beyond role level that facilitate or hinder the implementation of service-improvement change; and (3) To explore whether there are there systematic differences between voluntary, public and private hospitals in the dimensions considered above. Fundamentally the research is concerned with the initiation and implementation of service-improvement initiatives through people, who act within constraints.

To accomplish these objectives three case-studies were undertaken with a processual orientation, conducted in a partial-methodological replication of a three year study in the NHS (Fitzgerald et al., 2006b). Due to the complexity of the Irish hospital sector, which has public, voluntary and private hospitals, a case study corresponding to each hospital type was completed. Undertaken in cardiology in the wake of the National Cardiovascular Strategy, the cases examine both policy and senior-management driven (top-down) and emergent front-line driven (bottom-up) service-improvement initiatives by considering the roles and relationships of respondents in day-to-day service delivery and service-improvement. In addition, data collection and analysis traced the initiation and implementation of specific service-improvements with respondents. Interview, observation and secondary data was collected and analysed. Interviews were conducted with fifty-one respondents across organisational levels and from key actors in the policy and health-administration domains. In addition, observation and secondary data was collected and analysed. Analysis used a pre-determined coding scheme, but also took account of emergent themes through an iterative process. Factors emphasised in the literature that were absent from or significantly differed from the data were also sought.

The first research question asked *'Who holds change-related roles, how they are enacted within the role structures in place and what works effectively?'* Change-related roles were predominantly held by consultants and clinical managers, with the exception of the private hospital, where consultants were by-passed in bottom-up service improvements. Crucially, the enactment of change-related roles tended to be adopted as an extra-discretionary responsibility, as job-roles, with the exception of those in the private hospital, tended to be focused on service delivery, rather than service improvement. A significant number of changes were led by highly committed individuals. The second major finding at the role level was the capacity of the role structures in place to constrain or enable individuals in their change-related roles. Specifically, role structures and the role adopted by the consultant affected the efficacy of moving initiatives from initiation to implementation and the level of multi-disciplinary participation and control in service improvement. The third role-related finding identified the pivotal but underused role of clinical managers in service improvement. The exploration of the clinical-management role identified three sub-groups, across whom the enactment of the role varied. Outside of consultants, there was a predominantly operational focus. Issues encountered in the enactment of the role pertained to a lack of authority, budgetary control and different perceptions of fairness between clinicians and managers. Finally, the role of networks in facilitating service improvement was an unanticipated finding. At regional level networks provided a forum to identify regional priorities, to agree to the distribution of resources and to monitor service-improvement implementation. At the organisation and role levels networks provided individual change-agents legitimacy to proceed with service development, peer mentoring, support, ideas, advice and generated informal communities of practice.

The second research question asked *'What additional factors beyond role level influence the effectiveness of service improvement?'* The three major findings to emerge concerned the configuration of factors which affect the (1) *capacity* and (2) *climate* for service-improvement across the cases, and (3) the relationship between the capacity and climate for service

improvement. The capacity for service improvement was defined as the prevailing set of conditions that affect the ability of the organisation to initiate and implement both top-down and bottom-up service-improvement initiatives. The capacity for service improvement has been linked to the nature of and configurational interaction between governance, accounting and service-planning. The second major finding pertained to the climate for service improvement. The climate for service improvement was defined as the extent to which there was a willingness to exercise the available capacity for service improvement. This finding took account of role and organisational level factors, explaining the climate for service-improvement with reference to the level of strategic distraction, senior-management support and the role structures in place. The third major finding presented was the absence of a direct or strong relationship between the capacity and climate for service improvement. Further findings beyond role level pertain to the constraints imposed upon service improvement by the service-planning and accounting systems in the public and voluntary hospitals. In addition, the lack of understanding of the role of the HR function, the most effective mechanisms for HR service delivery and the failure of the HR function to support the critical actors in service improvement were identified as significant deficits.

The findings of this thesis, and particularly those regarding constellations of facilitating and hindering factors, add to the existing literature. systems In particular, the finding regarding the capacity for service-improvement is a theoretical development of the literature, which has previously only focused on the climate for change. While previous research has emphasised the need to consider the impact of configurations of characteristics from the context (Dopson & Fitzgerald, 2005b; Fitzgerald et al., 2006a), moving towards what Goldstone (2003) terms 'conjunctural causation', this thesis begins to delineate the *specific* combinations of factors that affect processes of change. Although providing a complex interpretive framework, the identification of the factors influencing the capacity and climate for service improvement reflect the multifaceted and interactive reality of organizational life. These relationships also emphasize the uncertainty associated with change management, which is enacted in and through constellations of contextual and other factors. While these factors begin to account for differences in the level and sources of change, the nature of their interactions remains somewhat ambiguous. Nonetheless the findings do have practical implications at a number of levels. These are presented throughout the thesis.

Overall, in developing prior theoretical work regarding the factors affecting the climate for service-improvement to address the factors affecting the capacity for service-improvement the primary contribution of the thesis is a theoretical one. Crucially, the theoretical findings presented, which explain the patterns observed in the data, are counter-intuitive, with the capacity and climate for service-improvement not directly correlated.

DEDICATION

This thesis is dedicated to my two grandmothers; my late grandmother, Christina McDermott and Anne Fagan.

It is also dedicated to those, without whom it would never have been undertaken or completed; my parents, Kevin and Mary, my supervisor, Mary Keating and Louise Fitzgerald; all unfailing in their support and encouragement.

Thank you all.

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ACCRONYMS

ADON	Assistant Director of Nursing
CC	Consultant Cardiologist
CCT	Chief Cardiac Technician
CNM2 CCU	CNM2 for the CCU
CRC	Cardiac Rehabilitation Co-ordinator
CSM	Cardiac Services management
DOF	Director of Finance
DOHC	Department of Health and Children
DON	Director of Nursing
GM	General Manager
HRM	HR Manager
HSE	Health Services Executive
MD	Medical Director
RTO	Resuscitation Training Officer

Introduction

With the exponential increase in Irish healthcare expenditure, 326% in public healthcare expenditure and 254% in private healthcare expenditure from 1995 – 2004 (Department of Health and Children, 2005), the debate on the quality of health care delivery and the need for change in the Irish healthcare system has increased among stakeholders. Concomitant with the funding increases, service users are demanding higher standards of care and service (McAuliffe, 2002). However, specific attempts to implement service improvement, including the national healthcare strategy and specific incentives such as the national cardiovascular and cancer strategies, have suffered from implementation problems (National Health Strategy Consultative Forum, 2001). To compound these issues, Ireland has a historical deficit of research related to service-delivery and organization in healthcare. The Health Research Board, the Irish funding body for health-related research, funds both clinical and service-delivery research, with the latter maligned as a result. Hence, Ireland has lacked a systematic or evidence-based knowledge base from which to address issues relating to the implementation of service-improvement. This thesis begins to address that deficit.

Similarly to Ireland, a lack of awareness regarding who is responsible for initiating, driving, leading and implementing change in hospitals was identified in the UK (Iles and Sutherland, 2001). This problem has since been addressed via a three year research project funded by the National Health Service (NHS) Service Delivery and Organisation (SDO) Research and Development Programme (Fitzgerald et al, 2006). However the direct application of learning from the UK to Ireland is precluded by different policy, regulatory, structural and historical developments, which mediate both the degree of receptiveness for change (Pettigrew, 1992a) and appropriate role and relationship configurations. Therefore this study undertook a partial methodological replication and expansion of that used in the above-mentioned SDO project. Replication has been identified as desirable to ensure the reliability and validity of research, and for rigorous theory development (Singh, Ang, & Leong, 2003). Although the seminal methodology has been predominantly maintained, some modifications have been made to the research design to address the research questions in the Irish context. One difference explicitly addressed in the research design is whether the status of the hospital as a public, voluntary (non-profit) or private hospital affects role definition and enactment[1] or the factors facilitating or hindering service-improvement processes.

[1] Role 'enactment' is defined as the activities, tasks and decisions which are actually undertaken by the role holder in the organisational context (Fitzgerald et al, 2005)

In the wake of the Irish national cardiovascular strategy (Department of Health and Children, 2001) this study explores who holds change related roles, how they are enacted in and affected by role-related constraints and what works effectively. Furthermore, recognising that roles are enacted in organisational and environmental contexts, the thesis considers additional factors that facilitate or hinder the implementation of service–improvement change. Adopting a qualitative research methodology from the processual approach (Pettigrew, 1992b, 1997), the thesis presents findings from three exploratory and analytical case studies, conducted in the cardiology services of a public, voluntary (non-profit) and private hospital, to represent the three hospital types in operation in Ireland.

Fortuitously, through the cardiovascular strategy, an opportunity was provided to explore the implementation of both top-down and bottom-up service-improvement change. For the purpose of this research, top-down service-improvement refers to policy driven, or senior management driven initiatives, while bottom-up service-improvement refers to initiatives brought about by front-line service-providers within the organisation. In addition, the cardiovascular focus of the strategy facilitated the inclusion of the private hospital sector, as cardiology is one of limited clinical areas in which the private hospitals provide services. In a second serendipitous occurrence, policy developments preceding data collection served to make sectoral differences and dynamics particularly salient. These included the restructuring of the Irish health service, which led to the homogenisation of relationships between public and voluntary hospitals and the establishment of a new administrative body, to oversee the management of the health-service. In addition, the introduction of tax incentives to encourage the development of private hospitals led to increased competition in that sector. These opportune developments facilitated discussion of sectoral differences with respondents. Next, an overview of the objectives and structure of the thesis are provided. The specific objectives of the thesis were;

1. To identify who holds change related roles, how are they enacted in, and affected by, role-related constraints and what works effectively;

2. To identify the contextual factors, beyond role level, that facilitate or hinder the implementation of service –improvement change and;

3. To explore whether there are systematic differences between voluntary, public and private hospitals in the dimensions considered above.

In addressing these contextually entrenched objectives, grounded in the relationships between multiple professions and embedded in organisation processes, the thesis necessarily draws upon literature from several disciplines. This demands attention from the reader, to avoid missing key links. Without such links, a sense of fragmentation within and between the literature review sections is inevitable. While the literature review could be criticised on this basis, the structure of both the thesis and literature review reflect the context-embedded, configurational and messy reality of organisational life, rather than the arbitrarily imposed constraints of a discipline.

> *'Because our education is from the start conducted in terms of the division into distinct subjects, it is not easy to remember that the divisions are man-made and arbitrary.'* (Checkland, 1981: 27)

The composition of the literature review is strongly defensible in the light of the findings which are presented. These findings justify both the adoption of the processual approach, and the multi-faceted and context-oriented literature review. An overview of the content of the thesis is provided below.

To begin, chapter 1 provides an overview of the change literature. This active yet fragmented literature provides the primary context in which the research is embedded. In addition to the significant undertaking of organising the change-literature, the pivotal function of this chapter is to identify an appropriate framework for the research. Premised on the objectives of the research, the processual approach is identified as an apposite approach. Prior to discussing this in Chapter 3, Chapter 2 provides an overview of the more specific service-improvement change literature, as the specific form of change with which the research is concerned. Chapter 3 then presents a conceptual review and preliminary critique of the approach, with the latter reconsidered in the final chapter. The review of the processual approach further delineates the framework for the thesis, emphasising the need to take account of the content, context and process of change. This is undertaken in the remainder of the literature review. Specifically, chapter 4 is dedicated to reviewing the historical and current internal and external context of Irish hospitals, including the content of the service-improvement changes recommended under the cardiovascular strategy. This chapter draws attention to the significant differences in the external and internal context of Irish and UK hospitals, supporting the adoption of a partial-replication strategy. To conclude the literature review, chapter 5 reviews literature on the roles and relationships in healthcare, through which service-improvement processes are enacted. As there has been no prior Irish research in this area Chapter 5 draws upon UK, US and Canadian literature. The paucity of Irish literature in this domain reinforces the necessity of Irish research. Chapter 6 then discusses the research

design adopted for the study, delineating the choice of a qualitative approach, discussing the informing paradigm and defending the choice of the case-study method. In addition, the chapter discusses the benefits of replication, the approach to data collection, data analysis, theory building, ethical issues and the quality of the research.

Data analysis and key findings are presented from chapter 7 onwards. Chapter 7 provides an overview and analysis of the internal context of each case, providing a contextual background to key findings, orientating the reader and making the consequent presentation and discussion of the key findings, presented in chapters 8 and 8, more meaningful. Chapter 8 describes, analyses and explains the research findings pertaining to the first research question;

> *'Who holds change related roles, how are they enacted in, and affected by, role-related constraints and what works effectively?'*

In so-doing, it also begins to address the third research question, the existence of systematic differences across the cases. The chapter is comprised of four sections. Findings in each section are initially presented on a case-by-case basis, followed by an overarching analysis and comparison across the cases. To conclude each section findings are compared with the UK, which, although a different context, does provide a benchmark of experience. The findings are also compared with the themes raised in the broader literature review. The first section delineates the actors involved in the initiation and implementation of bottom-up and top-down service-improvement. Consultants and clinical managers emerge as key actors in initiating and implementing bottom-up service-improvements in the public and voluntary hospitals. In a significant contrast, consultants are by-passed in the private hospital, managed separately to the remainder of the staff. As a result, clinical managers and heads of departments emerge as critical actors. In top-down initiatives, significant differences emerge in initiating initiatives, and the degree of formality and multidisciplinary involvement in implementation. The second section considers the role-related constraints which respondents encountered in their change-related roles. Across all of the cases, the role structures in place, in conjunction with the role adopted by the consultant, served to either constrain or facilitate service-improvement processes. Specifically, they affected the efficacy of progressing initiatives from initiation to implementation and the level of multidisciplinary participation and control in service-improvement. Thirdly, the pivotal but under-utilised and constrained role of clinical managers in service-improvement is explored. Clinical management roles, and the constraints faced by individuals holding such roles, are evaluated in the wake of their identification as 'key players' in the implementation of service-improvement. To conclude, the

final section presents an unanticipated finding regarding the benefits of network groups within and across organisations in the generation and implementation of service-improvement.

Chapter 9 addresses the second research question, which aims to identify additional contextual factors, beyond role level, that facilitate or hinder the implementation of service–improvement change;

> *'What additional contextual factors, beyond role level, facilitate or hinder the implementation of service –improvement change?'*

Similarly to chapter 8, it also addresses the third research question, which asks whether there are systematic differences between the voluntary, public and private hospital, in the research findings. The findings presented are predominantly focused at the organisation level, although some organisational-level constraints are ultimately determined by environmental factors. As in chapter 8, the findings are presented in four separate sections, three of which build on each other. The first subject pertains to the *desired* and *actual* role of the HR function, as well as the delivery mechanisms for HR services, in Irish hospitals. This role is considered in the wake of the HR function's marked absence from the responses of respondents across all sites, in spite of the identification of change-management facilitation as a primary role for HR (CIPD HR Survey Report, in Francis et al, 2006). The second topic considers two inter-related constraints on service-improvement processes. The desired and actual role of the service-planning and accounting systems in the public and voluntary hospital are delineated and discussed and contrasted with the private-sector approach to finance, service-planning and accounting systems in the private hospital. The third section makes a significant contribution to the thesis, developing prior theory regarding the climate for change in healthcare organisations. This section describes and analyses the interaction between governance, accounting and service-planning systems and explains their effect on the *capacity* for change at organisation level. Capacity for service-improvement refers to how the prevailing set of conditions affects the ability of the organisation to initiate and implement service-improvement. To conclude, the fourth section of chapter 8 presents the configuration of factors affecting the *climate* for change in Irish hospitals. The climate for change refers to the motivation for exercising the available capacity for service-improvement in an organisation. The climate for change is discussed with reference to the capacity for change, although the two are not directly correlated. The climate for change across the cases is affected by levels of strategic distraction, senior management support and the role structures in place. Hence, this section brings together role, organisation and environmental level findings, regarding the factors facilitating and hindering service-improvement.

The findings regarding the capacity and climate for service-improvement develop prior theory regarding the climate or receptivity for service-improvement and add to the literature pertaining to context. This has moved from considering cause-and-effect relationships towards what Goldstone (2003) terms 'conjunctural causation', where combinations, rather than individual factors, are significant sources of influence (Dopson & Fitzgerald, 2005; Fitzgerald et al., 2006). This study profiles the specific constellations of factors which affect the capacity and climate for service-improvement change. This profiling is a significant finding in the broader process of considering the initiation and implementation of service-improvement through people, who act within role-related and other constraints. Next, chapter 1 presents an overview of the primary literature in which the research is embedded, classifying approaches to change, to identify an appropriate framework for the research.

Chapter 1: Approaches to Change

Introduction

The range of approaches to change, and the confusion over their strengths, weaknesses and suitability, is such that the field of organizational change resembles more an overgrown weed patch than a well-tended garden

- *Bernard Burnes, 2004a*

The primary purpose of this chapter is to identify an appropriate research framework. To this end, the chapter provides a systematic overview of the change literature, which is the primary context in which the research is embedded. In addition, recognising that change is ultimately implemented through people, acting as change-agents, this chapter considers discourses on change-agency. On the basis of this overview and the criticism of the field which emerges, the processual approach is identified as apposite for this research.

The literature on change is significant, fragmented and complex, encompassing perspectives, approaches, theories, and models. The scale of the literature is illustrated in a search of the ABI/INFORM database for the period 01.01.05–31.12.05, which led to the identification of 6,176 articles on the subject of 'change and management'. However the issue is not solely one of volume. Theories and approaches to change are fraught with tension, and scholars are often unable to agree on the meaning of the term, or how to study it (Van de Ven & Poole, 2005). Similarly, there is contestation over the most appropriate way to implement change processes. There have been some attempts to explain inconsistencies in the literature (By, 2005; Higgs & Rowland, 2005). However Somerville (2006: 4) noted that *'the overarching reason for the contradictions and confusion is the subject's complexity'.*

Attempts to manage this complexity have led to the classification of the literature according to multiple criteria. These criteria include historical development, purpose, focus, motivation, scale, and whether the change is planned or emergent (Beer & Nohria, 2000). Further bases for classification include the rate of occurrence and how the change comes about (By, 2005; Senior, 2002; Senior & Fleming, 2006). This has led to various divisions in the literature, including a differential focus on theory and practice, radical and incremental change, strategic and operational change, and change implemented in a soft or hard manner, among other dimensions.

However in spite of the vast literature in this arena and the prominent position of organizational change in the field of organizational theory (Greenwood & Hinings, 2006), there remains some uncertainty over why some organizations are able to achieve radical change, although others flounder in the face of similar external pressures (Greenwood & Hinings, 1996). Additional questions address differential performance; levels of absolute performance in change management initiatives remain poor. A failure rate of approximately 70% has been identified amongst change programmes initiated (Balogun & Hope Hailey, 2004; By, 2005; Higgs et al., 2005). Somerville (2006) cites research to indicate that this is the case in both archetypal change (Reger, Mullane, Gustafson, & Demaire, 1994) and incremental change (Hirschhorn, 2002). These levels of failure have been attributed to a lack of empirical evidence underpinning the various theories and approaches (By, 2005; Guimaraes & Armstrong, 1998). By (2005) suggested that this poor rate of success is indicative of the lack of a valid framework for the implementation and management of change. He followed Burnes above in describing the current literature available to academics and practitioners *as 'a wide range of contradictory and confusing theories and approaches'* (By, 2005: 370). In addition to the literature on organisation change, similar questions and issues have been faced in the context of strategic change (Pettigrew & Whipp, 1991), operational change (Ferlie, Fitzgerald, Wood, & Hawkins, 2005; Fitzgerald et al., 2005), and in specific contexts such as healthcare (Pettigrew, Ferlie, & McKee, 1992).

One of the key divisions in the literature is that between the practitioner and academic literature, resulting from a lack of meaningful engagement between the two (Pettigrew, Woodman, & Cameron, 2001). As a result this review of change begins with a pragmatic orientation, outlining the historical development of the predominant approaches to change adopted in practice before the 1980s. These were often rooted in addressing specific and practical problems faced by organisations. Increasing environmental complexity and related academic and practitioner interest led to the proliferation of perspectives on and approaches to change from that time forward (Senior et al., 2006). Aligned to this increase in perspectives was a shift in emphasis. The historical overview of change provided in the next section outlines the move from traditional mechanistic perspectives on change to modern dynamics. These are contrasted by McMillan (2004). She asserted that traditional, classical, mechanistic views of change are perceived as linear, disruptive, cause and effect, incremental, controllable, and abnormal. In contrast, new modern dynamic views of change include the perception of change as normal, full of opportunities, revolutionary and incremental, continuous, turbulent, uncontrollable, creative, and non-linear.

To facilitate an overview of the approaches which have emerged since the 1980s, the chapter makes a transition into a theoretical and explanatory mode. The overview of approaches to change is a precursor to positioning this research within one specific approach to change which addresses prevalent criticisms of the change-literature—the processual approach. A conceptual overview of this approach and its characteristics is provided in chapter 3. Prior to this chapter 2 considers service-improvement change, the particular form of change of interest in this context. This tends not to be radical in nature. Next, a historical overview of organisational change is provided.

Section 1.1: Historical Overview of Perspectives on Organisational Change

The development of thinking on organisation change has been closely linked to issues faced by organisations at specific times, leading to a historical focus on change as a discrete and planned event. Planned change tends to be driven from the pinnacle of the organisation according to a predetermined plan (Burnes, 2004). The Scientific-Management and Human-Relations schools are early examples of planned change, with contingency approaches coming later and hailing from within the same school. However, more recent approaches have emphasised emergent, rather than planned change. Emergent change is more unpredictable, being a continuous process emerging from the bottom of the organisation (Burnes, 2004). Reflecting these positions, By (2005) argues that change occurs in four different manners; being planned, contingent, based on choice, or emergent (By, 2005). The historic development of these approaches to change is outlined below, with discussion of the nature and shortcomings of each approach.

In providing a chronological overview, this section links these forms of change to historical developments and key perspectives. Until the 1960s change was perceived as a mechanistic and planned affair. Since that time a significant proliferation in thinking and approaches has occurred. The diversity of these approaches led to the conclusion of the chronological description in the 1980s when the focus of the review shifts to providing a theoretical overview. The move from a chronological to a theoretical and thematic analysis reflects the exponential proliferation and evolution of change-related knowledge from the 1960s onwards. It also reflects the fact that although some approaches to change are pragmatic and operational, others have evolved from clear theoretical foundations.

1.1.1 Early Planned Approaches to Change

Scientific Management is a rationally oriented perspective on management and was one of the strongest influences on thinking about change from the late 19th century until the 1930s (Stickland, 1998). Frederick Taylor was the most influential proponent of this approach (Burnes, 2000). Organisationally based, Scientific Management presents human activity and organisation systems as rational, with behaviour responsive to financial reward. Emerging from this approach was a conception of change as a rational and managed process, applied in the search for an optimal solution to organisational processes. Critiques include its neglect of external context and the intangible components of organisations, such as culture (Stickland, 1998). Within the Scientific Management approach, change was perceived in the following manner:

> *Essentially, then, the notion of change was seen as associated with: internal, operational issues only; hard measurement and quantification; rational, maximising behaviour; subjugating individual interests to achieve standardisation and unity of purpose; scientific, reductionist analysis and methods. Hence change was largely an internal planned affair, driven by a unitary world view and focused on the rational, mechanical nature of work at the operational level. (Stickland, 1998: 31)*

Scientific Management was critiqued and usurped by the Human-Relations school after the 1930s. The Human Relations school was critical of the over-emphasis on individuals within Scientific Management, as well as its one-dimensional perception of human nature (Burnes in Caldwell, 2006). As a result, the Human-Relations perspective adopted an informal and social conception of organisations, which emphasised the emotional and psychological needs of the worker, in addition to the rational components. This led to an emphasis on soft variables such as motivation and satisfaction in contexts of change. In this approach the focus remained on the individual and group within the organisation. Stickland (1998: 31) noted that arguably the pendulum swung too far the other way in moving the organisation from the rational towards the social. Four common themes across the Scientific-Management and Human-Relations approaches are (a) the planned nature of organisational change; (b) the implementation of change without awareness of the impact or dynamics of the environment; (c) the fact that change is a one-dimensional phenomena that occurs in a sequential manner and (d) the presence of a perceived best way (Stickland, 1998). The move from Human Relations to Organisation Development (OD), discussed below, entailed an up-scaling in the scope of change, from the individual and group to organisation-wide change.

1.1.2 Organizational Development as a More Complex, Planned Approach

From the 1960s, multiple perspectives on change emerged from management and organisation theory. One of the most influential of these from the 1960s to the 1980's was OD (Cummings & Worley, 2001), though it had been gaining in momentum and support for a significant prior period. OD emerged from Lewin's three-step model of planned change, developed in the 1940s. For Beckhard (1969) OD is *'An effort (1) planned, (2) organisation-wide (3) managed from the top to (4) increase organisation effectiveness and health through (5) planned interventions in the organisation's processes using behavioural science knowledge'*. It emerged from a sense of inadequacy of the bureaucratic model of organisation (Coghlan & McAuliffe, 2003) and the belief in the benefit of a move from a mechanistic to an organistic conception of the organisation (Argyris, 1960; Burns & Stalker, 1961). OD is a facilitative model of helping based upon the presumption that a desire to change exists or can be created. Thus its diagnoses and interventions are psychologically rather than socio-politically based (Reason, 1991). The OD approach focuses upon how change is implemented, as well as what is being changed. It has been identified as a mechanism for organisational change and cultural alignment in mature organisations such as hospitals (Schein, 1992; 1999). Similarly, Stace and Dunphy (1988) have stated that the incrementalist[2] OD tradition is suited to stable and growth environments such as healthcare. However OD has been criticised on the basis that it presumes a stable-environmental context (Schein, 1999) and emphasises small-scale and incremental, rather than radical, change. This makes it inappropriate where transformation is required (Senior et al., 2006). In addition it has faced censure for being inappropriate in political and power-oriented contexts such as healthcare (Reason, 1984, 1991).

An increasingly competitive business environment in the 1980s was accompanied by an increased emphasis on radical rather than incremental change in many organisations (Stace & Dunphy, 1991). For Burnes (2000) the consensus-based and incrementally oriented nature of the OD approach, with its strong underlying value-orientation towards participation, did not meet the needs of the market, and a plethora of alternative approaches began to emerge. These approaches are difficult to classify, not least due to the broad range of disciplines drawn upon during their development. Although OD was underpinned by psychology, Burnes (as cited in Caldwell, 2006: xiii) indicated that *'the newer approaches drew on an eclectic mix of sociology, anthropology, economics, psychotherapy and the natural sciences, not to*

[2] Incrementalist strategies apply when the organisation basically fits with its current and predicted future environmental conditions, but where some adjustments are needed in mission, strategy, structure and/or internal processes. Alternatively they are suitable when there is sufficient time to recreate fit without jeopardising organisational viability (Stace & Dunphy, 1988, p. 321).

mention post-modernism'. Burnes gave them the broad categorisation of 'anti-OD', asserting that;

> *These newer approaches to change were less wary than OD in embracing issues of power and politics in organizations; they did not necessarily see organizational change as clean, linear and finite. Instead they saw change as messy, contentious, context-dependent and open-ended. (Burnes, as cited in Caldwell, 2006: xiii)*

Burnes included within the 'new' grouping the contingent, emergent, processual, complexity, chaos, political, institutional, and cultural approaches. In addition, Poole and Van de Ven (2004a) drew attention to coevolutionary theory and dialectical theory as further emerging theoretical approaches. These perspectives add to both the pragmatic and theoretical literature on change. The institutional, complexity, and chaos approaches mentioned by Burnes all stem from organisational theory and began as approaches to understanding and explaining change. Many of these approaches have provided insights into change dynamics that have been addressed in practice. These theoretically based approaches are discussed in the next section of the chapter. However the remainder of this section maintains focus on approaches emerging from changes in practice, namely the contingency, choice, and emergent approaches. Prior to this, open-systems ideas and the conceptual understanding which they offered to organisations are outlined.

1.1.3 Open Systems Approaches

OD, in conjunction with contingency approaches, has led to the broad acceptance of open-systems influences on change (Cummings et al., 2001). An open system is one that is connected to, and interacts with, its environment (Open Systems Group., 1981). The open systems perspective emphasises that organisations *'are not hermeneutically sealed entities, but collectivities that depend on or are influenced by environmental agents and resources'* (Jaffee, 2001: 4). Specifically, they emphasise that environments can *'shape, support and infiltrate organizations. Connections with "external" elements can be more critical than those among "internal" components; indeed, for many functions the distinction between organization and environment is revealed to be shifting, ambiguous and arbitrary'* (Scott, 2003: 29). Open-systems ideas emphasise the complexity and variability of individual organisational parts, as well as the looseness of the connections between them (Scott, 2003). This conceptual understanding of organizations and their functioning has been very influential. These ideas have underpinned many prescriptive proposals for the analysis of organizations and much academic research such as the Quality-of-Life experiments. The contingency and choice approaches, both examples of open-systems approaches, are discussed in Section 1.1.4.

1.1.4 Contingency and Choice Approaches

Since the 1960s there has been a radical shift away from the 'one best way' approach to change, leading to the emergence of the contingency and choice approaches. The contingency movement was premised on work undertaken by Lawrence and Lorsch (1967) who found that variations in the internal structures of firms were linked to their external environment. Building upon seminal work by Burns and Stalker (1961) they provided the insight that organisations and their subsystems are adaptive to their environment (Jaffee, 2001). This insight led to the advent of the contingency approach, whereby the appropriate change strategy is perceived to be influenced by a variety of organisation-specific factors. Crucially the contingency approach also links planned change to open-systems concepts. Thus not alone does it link change processes to organisational variables such as size, strategy (Miles & Snow, 1978), and technology, but it also introduced the notion of the environment and external variables as influences upon change. The notion of 'fit' between these internal and external variables and the organisation's change strategy has been developed by several authors within the approach (Hendry & Pettigrew, 1990; Stace et al., 1991). However the approach has also been criticized in this regards. For Pascale (1986) attempts to gain and sustain 'fit' can leave organisations vulnerable to shocks from a variety of sources. Organisations can move from a position of complete fit to one of total lack of fit in a very short period of time.

Although the influence of the environment is recognised in the contingency approach, the dynamic nature of the environment is not. As a result, Stickland (1998) noted that the approach remains underpinned by planned change and rationality. This led Stickland to assert that the approach has an *'underlying scientific determinism'*. Similarly Burnes (1996) criticized contingency theory regarding its assumption that managers and organisations have little influence over situational variables and structures. In contrast, Burnes suggested that organisations can choose to influence situational variables to promote a particular managerial or change style.

> *The point is that rather than having little choice, rather than being forced to change their internal practices to fit with external variables, organizations can exercise some choice over these issues* (Burnes, 1996: 16)

By (2005) termed this the 'choice' approach to change. The effectiveness of this latter approach in practice remains mediated by environmental complexity. Recognition of the complexity and dynamism of the environment led to the development of the emergent approach to change.

1.1.5 Emergent Change

By (2005) emphasised a significant difference between earlier and later approaches and theories of change. This difference underpins the emergent approach. Early approaches to change presented it as a necessarily discrete process, grounded in routine behaviours and driven from above. The most predominant types of change were discontinuous and incremental (By, 2005). In contrast more recent approaches—and specifically emergent change—have advocated the need for continuous change, emerging from the bottom of the organisation (Burnes, 2000, 2004). The utility of the emergent approach is premised on organisations operating in dynamic environments and therefore requiring devolved decision making to respond to developments in a timely manner.

Although marking a shift in change-thinking, the emergent approach does have resonances with other approaches. Specifically, both the emergent and processual approach emphasise power and politics as central to understanding processes of organisational change. Both also emphasise that incremental changes can, over time, lead to radical change. Small planned changes can lead to unintended, emergent, radical change through amplifying actions and contextual conditions (Ashmos Plowman et al., 2007). However change is not necessarily a bottom-up process in the processual approach (Burnes, 2000). Although Dawson (2003) accepted that some characteristics of the emergent approach correspond with element of the processual approach, others do not. The characteristics of the processual approach are further discussed in the next chapter.

Although discontinuous and discrete change is still evident in practice, By (2005) identified consensus amongst contemporary authors that the benefits from this type of change do not last. Discontinuous change is marked by a rapid change in strategy, structure, or culture. As a continuous bottom-up process, emergent change is influenced by myriad variables and emphasises readiness for change (Burnes, 1996). By (2005) noted that, in comparison to planned approaches to change, emergent change lacks coherence and diversity in its set of techniques.

This section has indicated that early approaches to change were often rooted in addressing specific practical problems faced by organisations, and based on attempts to learn, through research and practice, what works effectively. Because the number of approaches and perspectives on change has since proliferated greatly, in reaction to a changing business environment, Section 1.2 makes a transition into a theoretical and explanatory mode to facilitate the provision of a holistic overview of recent developments.

The practice-based approaches to change outlined in this section are incorporated into Figure 1.3 toward the end of the chapter. In providing an overview of the change literature, the Figure also incorporates the theoretical approaches, discussed in Section 1.2.

Section 1.2: Theoretical approaches to change

It is impossible to conceive of an approach which is suitable for all types of change, all types of situations and all types of organization. Some may be too narrow in applicability whilst others may be too general. Some may be complementary to each other whilst others are clearly incompatible.

-Bernard Burnes, 2004a

Underpinning the pragmatic change literature and approaches that developed in response to specific organisational issues are organisational theories pertaining to change. Narayanan and Nath (1993) differentiated among change theories on the basis of two dimensions—the source and type of change. The source of change can be internal or external to the organisation. The pragmatic change literature initially focused on addressing changes emerging from within the organisation and later took account of external influences. The second dimension on which change theories can be differentiated is whether they are natural or adaptive systems theories. Natural systems theorists explore predictable patterns in organizational change, which occur regardless of whether they are planned. Adaptive theorists describe the organisation as managing and shaping their responses to different pressures. The two are primarily differentiated by the extent to which they see managerial discretion as important. In this section, the various theories regarding change are classified as internally or externally motivated and discussed within the natural and adaptive systems groupings

1.2.1 Natural Systems Approaches

Natural systems approaches include the life-cycle model (internally motivated), population-ecology theory (externally motivated) and chaos theory (internally motivated). Powell and Friedkin (1987) related life-cycle change to internal organisational conditions and processes. In particular, they refer to growth, decline, and crisis (Chandler, 1977; Greiner, 1972). In this view, change is related to the dynamic qualities of organisations and their subsystems. There is also an argument that operational goals tend to supplant purposive goals (Blau, 1963). Population ecology (Hannan & Freeman, 1977) emerged from theories of natural selection in the biological sciences. It proffers why certain organisations survive. Within the approach,

survival is linked to a match between the organisation's structure and the capacity to acquire resources from its environment (Jaffee, 2001). It is deterministic, underpinned by the assumptions that (a) organisations have limited capability to adapt to environmental change and (b) that processes of change are ultimately controlled by the environment (Narayanan et al., 1993). It is based on a three-stage model of variation, selection, and retention. Variation

	Source of Change: Internal	Source of Change: External
Type of Change: Natural	Internal dynamics of organizations create life-cycles (Life-cycle model, chaos theory)	Environments induce changes outside managerial control (Population ecology theory)
Type of Change: Adaptive	Managerial action brings about changes (Planned change and innovation)	Environments and managerial responses to them create change (Resource dependence model and institutional theory of imitation, complexity theory)

Figure 1.1: Theoretical approaches to change.

between organisations occurs due to managerial style, organisational structure, and other factors. Some organisations are more successful than others on the basis of these characteristics, with the implication that selection is linked to variation. Selection is based on environmental constraints in resources or competition for information. Organisations which best meet these constraints survive, although others change or fail. This leads to the retention of appropriate organisational forms, which can become dominant in the environment. *'In summary, variation, selection and retention constitute the three stages of organizational change. Variation among organizations initiates the process, selection by environmental criteria weeds out certain organizations and retention mechanisms preserve the selected organizations.'* (Narayanan et al, 1993: 141) Environmental determinism, inherent in the approach, provides the basis for Jaffee's (2001) criticism, and limits its utility to practitioners.

Chaos theory is a relatively new natural systems approach. Both it and complexity theory emerged from the natural sciences. At the core of both are systems dynamics, the principle of nonlinearity, and a lack of central control. Nevertheless, the nature of the systems and the forms of nonlinearity differ between the two, making them appropriate for different contexts. Reitsma (2003, in Gatrell, 2003) associated chaos theory with simple, deterministic, nonlinear, dynamic closed systems. In contrast, he asserted that complexity deals with nonlinear open systems—making it an adaptive systems approach. Chaos was the forerunner of the two and is often presented as a subset of complexity science as it provided the foundation for exploring the dynamics of complex systems, which is at the heart of complexity. Their close linkages often lead to conflation and cross referencing, but Marion (1999: 5) asserted that although complexity exhibits characteristics of chaos, they are discrete and appropriate to describe different phenomena. Marion (1999) put forth that chaos theory is too mechanical to be applied to social systems and complexity remains more strongly equipped to deal with issues such as adaptation and deliberate or intelligent behaviour. Next, Section 1.2.2 considers adaptive systems approaches.

1.2.2 Adaptive Systems Approaches

Adaptive systems approaches include institutional theory (externally motivated), resource-dependency theory (externally motivated), planned change (internally and externally motivated) and complexity theory (externally motivated). Contrary to population ecology, institutional theory (DiMaggio & Powell, 1983) has an external adaptive orientation. Institutionalism, although encompassing a significant number of perspectives and ideas (Jennings & Greenwood, 2003), is broadly concerned with explaining the similarity and stability of organisations, within a given field (DiMaggio et al., 1983). However, institutionalism has been applied through a variety of disciplines and has therefore taken on a variety of meanings. As a result, this analysis focuses on institutional theory as analysed by sociologists and within the business literature.

The sociological conception of institutions takes account of the influence of emotion and tradition on organisational functioning. These are presented as constraints on change, facilitating persistence, endurance, and stability (Jaffee, 2001). In addition, Greenwood and Hinings (1996) used institutional theory to elucidate the dynamics of radical change. They asserted that resistance to change is linked to the *'normative embeddedness of an organization within its institutional context.'* (Greenwood & Hinings, 1996: 1023) The core tenet of institutional theory is therefore the processes of imitation by which organisations change. Imitation is initiated as all firms face uncertainty. Managers copy successful firms

because they have useful strategies for reducing uncertainty. In addition, managers copy practices perceived as widespread or successful to achieve legitimacy.

For Gondo (2006) although institutional theory has been used to understand change in terms of the link between organisation and society, and particularly how organizational practices are spread and reproduced, there is less understanding of why some organisations conform to pressure for institutional change, while others do not. Related to this, institutional theory has been critiqued for its relative inattention to the role of the human factor as an active agent and influence on change (Jaffee, 2001). However, neo-institutionalism, where *"'actors" behaviour is supposed to be strongly influenced by institutions: formal and informal rules, structures, values and perceptions, which over the course of time have acquired stability'* (Van Gesterl & Teelken, 2006: 100), goes someway towards addressing this criticism. In neo-institutionalism, human agency leads to the conception and legitimisation of new ideas, logics and routines (Berger & Luckman, 1966; Watson, 2007). However, as with institutional theory, there are multiple bodies of thought in neo-institutionalism. These are historical, rational, and sociological institutionalism, which emphasise the normative, regular, and cognitive aspects of institutional life (Van Gestel & Teelken, 2006). In this context, sociological neo-institutionalism, where actors operate in institutionally generated shared-values and frameworks of meaning, conflates particularly well with the critical realist and interpretivist research orientations adopted, as outlined in Chapter 5.

Resource-dependency theory also has an external orientation. It emphasises the tendency of organisations to alter their structures and goals to survive (Pfeffer & Salancik, 1978) by acquiring resources from their environment. From the perspective of this approach, change is initiated in an attempt to reduce or eliminate resource vulnerability. The key idea is that organisations should, and will, respond to the demands of those groups that control critical resources. Organisations then become dependent on the elements that provide the most needed forms of support. The managerial task becomes to respond to environmental demands and constraints, and mitigate the influence of funders.

The change-practice and planned change literature is premised on adaptive change. The historic overview in the previous section illustrated that it initially focused on internally initiated change but now both internally and externally initiated changes are evident. In further developing planned approaches to change, large numbers of theorists have attempted to draw out the implications of the new sciences for change. These include Ralph Stacey

(2000), Margaret Wheatley (1994), Ikujiro Nonaka (1988) and Francis Stickland (1998). They personify the dawning realisation that chaos and complexity have *'major implications for our notions of change, how it occurs, the types and degrees of change and thus for strategic planning and associated activities'* (McMillan, 2004: 2).

Chaos and complexity challenge notions of predictability via nonlinearity, cause and effect rationalisation, and the importance of small events or minor differences. The idea of the butterfly effect, or sensitive dependence on initial conditions, limits the use of general principles and recommendations within organisations and may account for high rates of failure in prescriptive and often linear change processes. Medd (2002) asserted that as predictability is problematised, the capacity for long-term planning is undermined with particular implications for strategy. Strategic planning necessarily becomes more emergent, or at the very least reflexive, and planning and implementation are increasingly aligned. The primary implication is that bottom-up people-driven approaches, rather than top-down strategic planning processes, are the key to understanding change, particularly when it is second order in nature (McMillan, 2004).

Applied in a metaphorical manner, complexity is similar to Morgan's approach (McMillan, 2004); based on the assumption that life is complex, ambiguous, and full of paradox. An important difference between complexity, chaos, and other organisational theories is the relative emphasis placed on, as well as the desirability of, stability versus change. For McMillan (2004: 95) *'In designing organizations and organization systems, complexity suggests that we need to learn how to balance them on the edge of chaos.'* McMillan described a desirable state whereby the system balances at the point between structure and disintegration, so that flexible responses to the environment can be achieved. This is reminiscent of emergent change discussed at the outset of the chapter. However McMillan (2004) asserted that the two concepts of emergence differ. They share the sense that something unplanned and unintended arises, but complexity indicates that something greater than the sum of the parts arises. In contrast, many organisational theories focus on stability as the norm, with change perceived as a means to restoring equilibrium. Burke (2002) highlighted the likelihood of innovation and creativity at 'the edge of chaos', however an important question is whether the culture of the organisation facilitates innovation rather than a 'deer in the headlights' reaction. Organisations with particularly stable, hierarchical, or non-participative cultures could face such issues.

Principles derived from complexity have been used to generate management models (Pascale, Millemann, & Gioja, 2000) and theories of organisation (Stacey, 1996), which have

in turn been used to understand and change the structure and dynamics of organisations. Although some of these models assert that complexity principles should solely be used as sense-making tools (Stewart et al., 2000), others claim that complexity concepts can be directly applied (Stacey, 1996) and used as the basis of organisational interventions (Stewart et al, 2000).

The above section described the myriad approaches to understanding and theorising change. Several attempts have been made to provide an integrated overview of the components of change. One useful and widely adopted framework for bridging historically embedded and theoretical approaches to change with pragmatic models was provided by Poole and Van de Ven (2004b). This is discussed in the next section.

Section 1.3: An Integrated Approach to the Literature on Change

The basic concept of organisation change involves three ideas: (a) difference, (b) at different temporal moments, (c) between states of an organisational unit of system (Poole et al., 2004a). Models and theories of change were amalgamated in four ideal-type theories of change by Poole and Van de Ven (2004b). Poole (2004) differentiated between process and variance theories of change. Process theories of change follow Lewin (1951) in explaining change as a sequence of events leading to an outcome, although variance theories explain change in terms of the relationship between independent and dependent variables. Poole and Van de Ven's (2004b) four ideal-type theories of change are process based, with each underpinned by a different motor of change. The types are variously described as teleological, dialectical, evolutionary, and life-cycle types. Poole et al (2000) note several advantages of process theory:

1. Process theory provides insight into how change occurs by describing the generative mechanism that drives the process;
2. Process theory can account for path dependence and the role of critical events in change;
3. Process theory can incorporate the role of human agency in change without reducing it to causal terms.

As a result, a process theory of change is appropriate for this research, which is concerned with how change occurs and the role of human agency in facilitating this change.

For Fitzgerald et al. (2006) defining these four models of change focuses attention on the variations between them regarding their units of analysis (i.e., a field or sector), and whether developments are prescribed or constructed. They also note differences in the extent to which human agency can guide or control the process of change. For Fitzgerald et al. (2006) this is a useful starting point for a discussion of organisational change in healthcare, as it provides a basis for positioning the research orientation within a broader theoretical framework. However Fitzgerald et al. (2006) do note that many applied theories of change are built around a combination of two or more theories operating together, at different levels or at different times. This point is also noted by Van de Ven (1992) who wrote, *'In practice, of course, scholars across disciplines often combine elements of these ideal types of theories. ... However, in so doing the conceptual basis of applied theories can easily become confounded and incoherent'* (Van de Ven, 1992: 177). He reasoned that although the conceptual basis of each ideal type is logical and internally consistent, borrowing elements from a number of arenas can result in a mélange of logics.

The four ideal types are premised on four generative mechanisms for change. Each generative mechanism has a different underlying logic that leads to change unfolding in different ways. Van de Ven and Poole (1995) are concerned with (a) understanding the impetus or generative mechanism for change, and (b) how this affects the process of change in terms of whether the final state is predefined, the path of development is predetermined, and the concept of time adopted. The typology is illustrated in Figure 1.2, and the characteristics associated with the four families of process theories are outlined in Table 1.1. Each of the ideal types are also discussed below.

1.3.1 Life Cycle Process Theory.

Life cycle process theory is described by Poole and Van de Ven (2004b) as 'regulated change'. They identify three variations of life-cycle theory, depending on whether the generative mechanism is regulated by natural, logical, or institutional requirements. Change processes driven by natural or logical requirements are more deterministic than those underpinned by institutional influences. Regardless of type, the underlying logic in the entity moves the process of change from a given point towards a prefigured end. The trajectory leading to the final state is predetermined and requires a specific sequence of events that need to occur in order. Greiner's (1972) article on the evolution of organisations is a classic example of this. According to Van de Ven (1992), life-cycle process theory is the second most used theory of development and change, after teleology. Poole and Van de Ven (2004b) note that institutionally driven life-cycle models can be resisted.

1.3.2 Teleology Process Theory

Teleology process theory is described as 'intentional change' by Poole and Van de Ven (2004b). From this perspective change is a cycle of goal formation, implementation, evaluation, and modification on the basis of reflection. Inherent in this approach is the proactive construction of a desired end state, and the selection of a path to reach it. Although

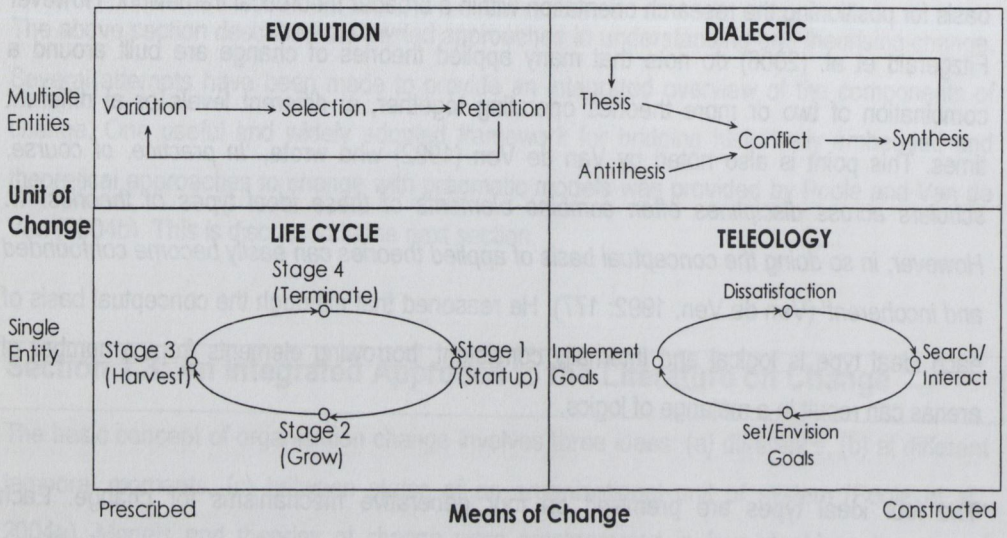


Figure 1.2: Typology of process theories of change and innovation. (Poole & Van de Ven 2004b: 376)

the approach does not have an implied or necessary sequence of events, unlike life-cycle theory, progression towards the desired end state can be used to measure change. The most popular of the change theories, teleology is based on the assumption that the entity is purposeful and adaptive, both in its own right and in interaction with others. Van de Ven (1992) notes that teleological models incorporate the systems theory assumption of equifinality in having several equally effective ways to achieve a given goal. Poole and Van de Ven (2004b) identified adaptive learning and most models of strategic planning as examples of this approach. It also has strong resonance with Action Research. From a practical perspective, Poole and Van de Ven (2004b) note that common problems in teleological change processes are individual cognitive bias (Kahneman, Slovic, & Tversky, 1982), errors in critical thinking and decision making (Nutt, 2002), escalating commitments to failing courses of action (Ross & Staw, 1986), and groupthink (Janis, 1989).

1.3.3 Dialectic Process Theory

Dialectic process theory is described as conflictual change by Poole and Van de Ven (2004b). This theory asserts that change emerges from conflict, contradictions, or tensions that may

occur internally or externally. Internally this may manifest as conflicting goals, although externally the desired path of development may clash with other organisations. Thus it is based on the assumption that the entity in question is embedded in a pluralistic world, where competing factions vie for control. Van de Ven and Poole (2004b) cite Sztompka's (1993) theory of social change as one example of this. Sztompka (1991) was also invoked by Pettigrew (1992) in his attempt to explain the ontological assumptions of the processual

Table 1.1: Families of Theories on Development and Change Processes (Poole et al., 2004b; Van de Ven, 1992)

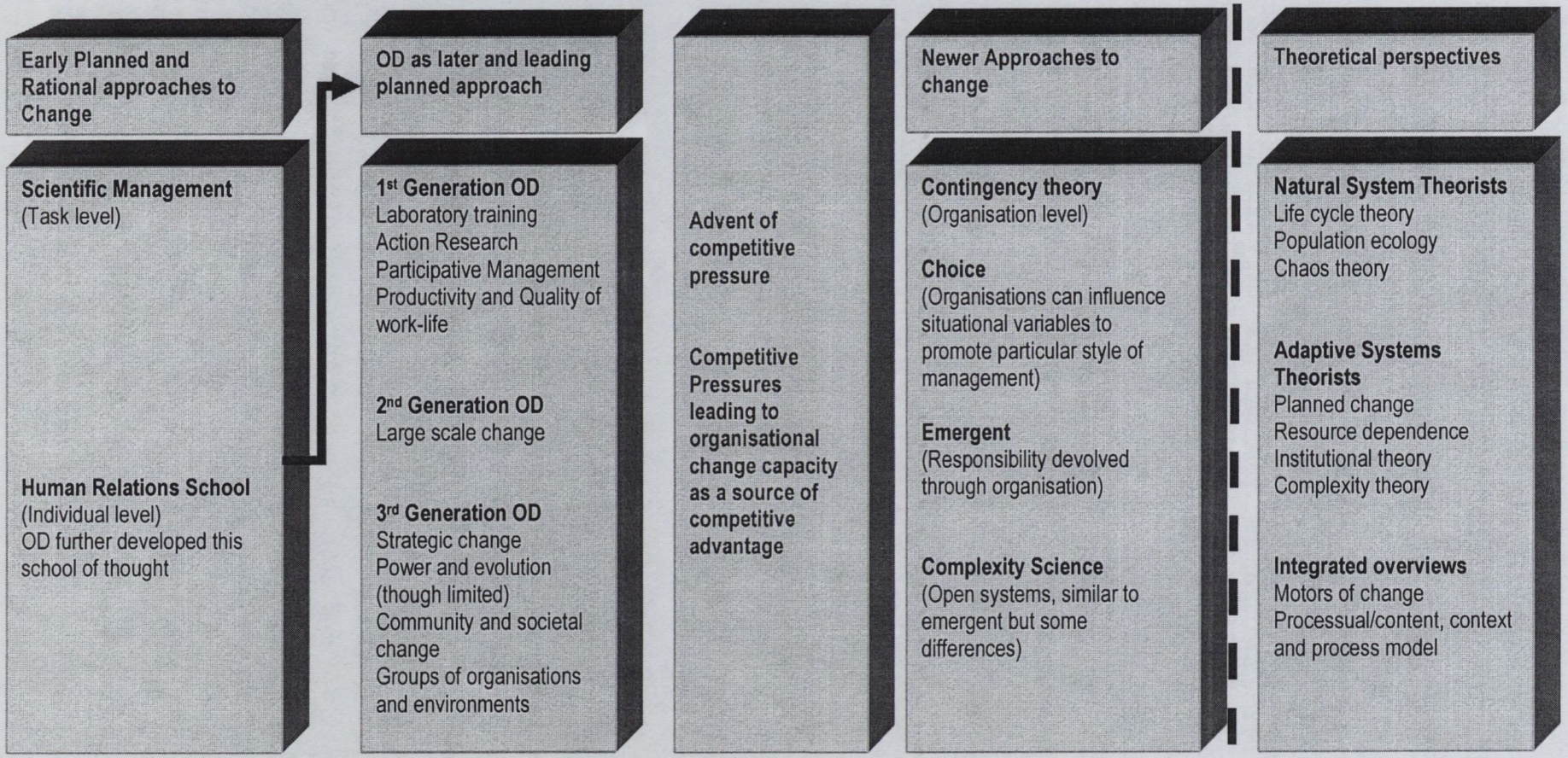
Family	**Life cycle (Regulated Change)**	**Teleological (Intentional Change)**	**Dialectic (Conflictual Change)**	**Evolution (Competitive Change)**
Generative Mechanism	Regulated	Planned	Conflict	Competition
Process of change	Set sequence of stages; full sequence has initiation, growth, decline and termination stages	Unit perceives problem or opportunity, sets goals, acts to achieve goals, and monitors outcomes.	Unit changes through coping with or due to effects of conflicts, tensions or contradictions	Unit changes through random or planned variation, which are then selected by environmental pressures; effective variations are retained in the unit
End state defined at the outset?	Yes; final point in sequence	No	No	No
Path of development predetermined	Yes	No	No	No
Change process	Convergent	Divergent	Divergent	Convergent
Concept of time	Cyclical	Event	Event	Cyclical
Members	Developmentalism Biogenesis Ontogenesis Stage theories	Functionalism Religions/utopias Goal/planning models Enactment theories Rational choice	Conflict Deconstruction Pluralism Bifurcation theories Polyphonic themes	Darwinian evolution Punctuated equilibrium Saltationism Gradualism Lamarckian evolution
Pioneers	Nisbet, Piaget	Weber, Parsons.	Marx, Freud	Darwin, Gould, & Campbell
Logic	Imminence, prefigured program continuity	Envisioned end state, social construction, equifinality	Contradictory forces thesis, antithesis, synthesis	Natural selection of organisms and species

approach. Van de Ven (1992) noted that the levels of stability and change are explained in this perspective via the balance of power between opposing forces. When power is balanced, stability results, however changes in power levels can lead to oscillation or chaos. The shift between these reflects Lewin's (1951) model of the change process as unfreezing, moving, and refreezing, premised on the balance of power between forces striving for change and those attempting to maintain the status quo. Dialectical processes of change most commonly fail due to dysfunctional models of conflict resolution and negotiation (Bazerman, 1985 in Poole and Van de Ven 2004b). A classic example of a dialectical model is Marx's theory of economic development (Poole et al., 2004b).

1.3.4 Evolution Process Theory

Evolution process theory is described as competitive change (Poole et al., 2004b). Evolution, in the context of evolution process theory, refers to *'cumulative changes in structural forms of populations of organizational entities'* (Van de Ven, 1992: 180). A cycle of variation, selection, and retention (VSR) is caused by competition for scarce resources among entities in a population. The VSR cycle describes the microlevel process of organisation evolution, where selection leads to the survival of organisations best suited to an environment. Normally used at the level of organisational populations, Van de Ven (1992) noted that it has been applied to processes of strategy making by Burgelman (1991) and Singh (1990), and to the social processes of organising by Weick (1979) and Gersick (1991). Van de Ven (1992) identified the pace of change, the form of change and the unit of change as the basis for identifying forms of social evolution. However Poole and Van de Ven (2004b) noted that as competitive pressures change over time, the trajectory of VSR cannot be predicted. Thus they characterise this theory as weakly predetermined. Although one or more VSR cycles will occur, the number of cycles and the specific paths through them are not specified. In addition they note that selection and retention processes may be influenced by actor's choices. Poole and Van de Ven (Poole et al., 2004a) further noted that processes of VSR only work where there is resource scarcity. Emerging from biology, Poole and Van de Ven (2004b) provided examples of this using Darwinian and Lamarckian organisational evolutionists. Darwinians claim that organisational traits are imprinted at founding and do not change over time due to organisational inertia. In contrast, Lamarckian theorists argue that traits can change and be acquired over time, via learning and imitation. The Lamarckian view is more predominant in organisational theory.

Figure 1.3: Overview of theoretical perspectives and approaches to change.



For Van de Ven (1992) both lifecycle theory and teleological theory are predictive, with a prescribed end point either inherent (life cycle) or constructed (teleological). In contrast Van de Ven (1992) described dialectical and evolutionary theories as descriptive, focusing on the means of action.

Crucially for Caldwell (2006), Van de Ven and Poole (1995) failed to include agency in the form of intentional action as a categoryin their typology. For Caldwell, it is impossible to have an adequate theory of organisational change, without including a theory of agency. This issue undermines the usefulness of Van de Ven and Poole's typology, which remains a descriptive and explanatory device, rather than a typology from which direction can be derived. Although Van de Ven and Poole provide a useful and integrated overview of the field of organisation change, the theory–practice divide alluded to at the outset of this chapter necessitates a consideration of the literature on the management of change. This particular research project necessitates consideration of both general themes and healthcare specific research. As a result, practice-based literature pertaining to the implementation of change in healthcare contexts is discussed in Section 4.6.4. In addition, contextual factors affecting the implementation of change in the Irish hospital sector are discussed in Chapter 5. Finally, a general overview of the theoretical literature pertaining to change agency provided in Section 1.4 below. Agency is emphasised in the light of the research's focus on the initiation and implementation of service-improvement, which occurs through people, who act within constraints.

Section 1.4: Agency and Change

In addition to the theoretical and conceptual literature regarding change and the development of change-related thinking, there is also a large practitioner-focused literature pertaining to the implementation of change. Fitzgerald et al. (2006) characterised this division as being between 'best practice' and 'theory development'. Best-practice advice often takes the form of key success factors, or steps to be followed to ensure successful change (Cummings et al. 2001; Kotter, 1996, 1997). Buchanan (2003) criticised practitioner-oriented work as aprocessual, undertheorised, and offering static portrayals. Of particular note across the domains of theory and practice and identified above in the critique of Van de Ven and Poole's typology, is the broad issue of the role of agency in change. The concept of 'agency' underpins both the theory and practice of change, as change is ultimately implemented by individuals, acting as change-agents. Hence agency in change is considered in Section 1.4.1.

1.4.1 Agency in Change

Caldwell (2006) asserted that the concept of 'agency' in organisational change has changed greatly over the past 50 years. As a result he identified two types of agency. For him, the more traditional notion of agency is captured within centred agency. This is defined as *'intentional forms of rational and autonomous action'*. Traditional agency is premised on planned rationality, grounded in rational action and expert knowledge. In contrast, a newer form is captured in decentred agency, which refers to *"'emergent" and "embodied" forms of action which emerge through practice'*. (Caldwell, 2006). Thus decentred agency is more complex and plural, and at its extreme may entail action which is not primarily informed by intentional choice. Thus, although Anthony Giddens (1984) identified agency with choice, Caldwell (2006) noted that instances where agency is not primarily informed by intentional choice are neglected in the literature, as is the question of whether agency is possible without a perception of intention. For Caldwell, agency is actually a synthesis of both forms, lying between the intentional model of rationalism, and the more embodied models in constructionist discourse.

Caldwell (2006) outlined four competing disciplinary discourses[3] on agency and change in organisations, which he classified as rationalist, contextualist, dispersalist, and constructionist discourses. He noted that these exclude collectivist models of change agency associated with formal institutions and social and political movements. He also emphasises that although these discourses provide a way to navigate the meta-theoretical arena of agency and change, they do not offer scope for a new paradigm or theoretical integration. Each discourse is discussed below:

1.4.2.1 Rationalist Discourse

Rationalist discourse is the traditional view of agency. It gives priority to intentional action and agency, and emphasises rationality, expertise, and to a lesser degree, autonomy and reflexivity. It is linked to the idea that organisations are ordered systems that can be subject to planned change, and that resistance to change can be managed. This is closely associated with Lewin's (1951) concept of the change agent as an expert facilitator of planned incremental change as well as with concepts of planned change and possibilities of strategic action.

1.4.2.2 Contextualist Discourse

[3] Caldwell (2006, p. 9) defined disciplinary discourses as 'forms of language, meaning and interpretation representing and shaping relatively coherent social, cultural or disciplinary fields of academic knowledge creation and practice that embody contextual rules about what can be said, by whom, where, how and why.'

The contextualist discourse presents agency as embedded in processes of 'emergent' change. Emergent change is not predetermined by internal or external environmental factors, but rather is *'the outcomes of non-linear, multi-level and incremental transition processes open to choice by human agents, who operate within contexts of "bounded choice" defined by competing group interests, organisational politics and power'* (Caldwell, 2006: 6).

For Caldwell (2006), this was exemplified by Simon's (1947) critique of decision-making processes in complex organisations. Caldwell identified this appraisal as the foundation of processual and contextual critiques on the rationalism of strategic planning (Mintzberg, 1994) and other arenas of organisational life (Pettigrew, 1997). This conception of agency underpins the processual approach adopted in this study.

1.4.2.3 Dispersalist Discourse

Dispersalist discourses focus on non-linear complex systems of self-organisation and learning processes in organisations. There are many variants of dispersalist discourses all of which are characterised by the distribution of change agency throughout vertical and hierarchical levels in the organisation. In practice, this means a shift of change agency to decentred groups and teams. For Caldwell (2006), this discourse is evident in the concept of the learning organisation and communities of practice. Dispersalist discourses of change agency are associated with a conception of organisations as loosely coupled systems, networks or processes of learning, and collective knowledge creation, rather than rational top-down systems of control. For Caldwell (2006), the reduction in hierarchical control in many organisations has increased emphasis on ways of coordinating across organisational divisions, units, and work processes. These are particularly important dynamics in the healthcare context. There has been some evidence of decentred agency and dispersed leadership in healthcare organisations (Denis, Langley & Cazale, 1996; Denis, Lamother & Langley, 2001). This is not incompatible with the contextualist model of 'bounded choice' outlined above, due to the fact that healthcare organisations are not simple, rational, top-down systems of control.

The role for dispersalist discourse has increased over the past 20 years with the emergence of new modes of organising (Caldwell, 2006). These include models of organisational flexibility and the increasing role of Information Technology, which has undermined traditional bureaucracy and forms of control. Instead, for Caldwell, managers in this vein now have to encourage 'commitment' and 'empowerment' and receptivity to cultural change. Caldwell described this as the 'dispersal' or 'distribution' of change agency, and asserted that self-managed teams, quality circles, and task groups are all characteristic of this dispersalist form

of agency. For Caldwell, these allow new forms of 'sense-making' agency, 'distributed leadership', and 'communities of practice' to emerge, and are characteristic of the learning organisation. In this discourse, leadership encompasses participation from across the organisation. Caldwell noted that concepts of the dispersal and decentering of agency are synonymous with chaos and complexity theory.

1.4.2.4 Constructionist Discourses

Constructionist discourses decentre human agency within discourses or 'discursive practices' over which human actors appear to have little rational or intentional control.

> *Constructionist discourses abandon subject–object distinctions and the corresponding agency–structure dichotomies; there are no objective scientific observers or autonomous actors; only socially constructed worlds of fragmented cultural discourses, practices, and fields of knowledge in which the possibilities for 'embodied agency' and organizational change are fundamentally problematic.* (Caldwell, 2006: 7).

Caldwell noted the difficulty of disentangling multiple strands of constructionism. However he noted that there are four strands common across all types: anti-rationalism, anti-scientism, anti-essentialism and anti-realism. Anti-rationalism refers to the belief that rationalism is only one discourse of many. Anti-scientism suggests that science is just an interpretation within a discourse, rather than an overarching truth. Anti-essentialism refers to the position that there are no inherent structures, either within objects or people. Caldwell illustrated this assertion by saying that within this stance, humans do not have predetermined characteristics such as human nature or personality, and that these things only exist within particular social discourses. Finally, anti-realism asserts that there is no fixed reality that can be discovered by research.

1.4.2.5 Overlapping Discourses

For Caldwell, these four discourses are ideal types, and in reality some aspects of each may overlap with competing discourses. He provided the example of the shift in rationalist OD towards the learning organisation, leading to some overlap with dispersalist discourses. Similarly, he noted the potential for the contextualist processual perspective to blend into constructionist ideas. This has occurred from the outset in this context, with the adoption of an interpretivist research orientation. In addition, while a rationalist discourse of planned change is expected among some respondents, the research is focusing upon exploring the role-related and other constraints encountered by change agents. This is aligned with a contextualist discourse of 'bounded choice'.

The final section of this chapter provides a critique of the change literature and introduces the specific approach to change adopted in this research.

Section 1.5: Critique and Conclusion

Returning to the theme of the introduction, Fitzgerald et al. (2006) asserted that in spite of the research to date and the significant theoretical literature addressing organisational change, there remain many enduring problems in the implementation of change in practice. They link this to issues in change-related research and the fact that *'generic guides are offered with limited attention being paid to either the impact of context or of culture'* (Fitzgerald et al., 2006: 31). For them, following Fiol (1996), there is a need for research to distinguish between (a) the varied content of change; (b) the stages in the change process at which events are occurring; and (c) the differing participants. These issues are addressed in the research design for this project, discussed in Chapter 6. The issue of the content of change is also addressed in chapter 2, which considers the nature and form of service-improvement change in healthcare. Fitzgerald et al. also cited Pacale, Millemann, and Gioja (1997), who asserted that the change literature tends to be either too conceptual and impractical, or too company-specific.

Further issues on the state of change-management research were identified in Pettigrew, Woodman, and Cameron (2001). They noted the fragmentation of approaches and some of the difficulties in capturing the dynamism that change involves. They called for a new pluralism in the study of organisational change and presented six specific challenges: (a) Examining multiple contexts and levels of analysis; (b) Including time, history, process, and action; (c) Linking between change processes and performance outcomes; (d) Investigating international and cross-cultural comparison in research on organizational change and development; (e) Studying receptivity, customization, and sequencing; and (f) Creating partnerships between scholars and practitioners. Pettigrew et al. (2001) indicated that the field has only a limited understanding of these areas. In particular, static states and cross-sectional analyses are privileged in research, rather than studying the dynamics of change across time and space. However although the six key issues identified here are highlighted by the authors as outstanding areas of concern, some attempts have been made to address them and to create theories of change in management that face the double requirements of scholarly quality and practical relevance (Pettigrew, 1997). Two approaches which address the link between change processes and outcomes; which include time, process and action; which examine multiple contexts and levels of analysis and; which focus on creating partnerships between scholars and practitioners are action research (Cooke & Wolfram-Cox,

2005) and the processual approach (Pettigrew, 1997). However, as a university-based researcher, rather than a hospital employee, action research was not a feasible approach for this research.

The ongoing issues in the implementation and theorisation of change provide the context in which this research is embedded and have influenced the research design. To address Pettigrew's (1985) critique of the treatment of change as acontextual, ahistorical and aprocessual, and the additional critiques identified by Pettigrew et al (2001) above, the processual approach has been adopted for the research. The processual approach explicitly includes both internal and external context at a number of levels, takes account of time, history, and process, and links to organisational outcomes. It has potential to be used to investigate cross-nationally, and it has been used to study receptivity (Pettigrew et al., 1992). Although it has advocated partnership between scholars and practitioners through participant observation, this is declining (Dawson, 2003). The processual approach has been adopted for this project as it addresses several of the key issues in the research of change. Furthermore the complexity of the Irish hospital context, outlined in chapter 4, necessitates explicit consideration of the role and impact of context on change, as advocated within this approach. This chapter has also identified it as less wary than many approaches in dealing with power and politics, pivotal issues in healthcare organisations (Fogel, 1989). The processual approach is further explored in the next chapter and its application in this research is outlined in Section 6.3.1.

This chapter has provided a systematic overview of the change literature, drawing attention to the fragmentation therein. In addition, the chapter has drawn attention to the under-emphasis on change-agency in the literature, in spite of the fact that change is ultimately implemented through people. Pivotally, through a further critique of the change literature presented, the chapter has identified an appropriate research framework for this study. The processual approach addresses significant criticisms of prior research into organisation change. In addition, it provides scope to take account of the complexity of hospital sector is which the research is embedded and to explore change agency.

Chapter 2: Service improvement change in healthcare

Introduction

Chapter 3 will draw attention to the fact that while the focus of this thesis is on service-improvement change, much of the seminal work undertaken in healthcare using the processual approach was concerned with understanding strategic change (Pettigrew et al., 1992, Ferlie et al., 1996). As a result the focus of this chapter three-fold. Firstly, it will define service-improvement within a healthcare context. Secondly, it will detail the range of ideas and initiatives evident within the service-improvement literature. Thirdly, it will conclude by establishing analytic links between service-improvement and change management. Chapter 3 will then discuss the processual approach as a method to explore service-improvement change within this research.

Section 2.1: Service-improvement in a healthcare context

Having been defined in many different ways, approaches to measuring and improving the quality of health care have become confusing, leading to misunderstandings and hindering efforts to improve care.
Buetow & Roland, 1999: 184

Service-improvement change refers to first order, or incremental change (Bartunek, 1987) and in healthcare tends to refer to incremental changes to the nature or form of service delivery. Interestingly, while service-improvement change is a term used by academics adopting a managerial perspective (Gollop et al., 2004, Fitzgerald et al., 2007), the term 'quality improvement' is more prevalent among clinicians (Macfarlane et al., 2004, Shield et al., 2003, Watts et al., 2007). Both remain poorly defined, but generally refer to the fact that 'what is good can be better' (Buetow and Roland, 1999: 187). The existence of the two terms reflects the fact that traditionally, service-improvement has referred to the organisational and managerial aspects of service-delivery, while quality-improvement has referred to the clinical aspects. However this division is becoming increasingly blurred. This reflects the growth of approaches such as clinical governance, which bridge managerial and clinical approaches to service-improvement. In addition, it is increasingly recognised that quality is a systems property (Berwick, 2003) and addressing issues such as clinical safety requires attention to organisational issues such as the design of equipment, jobs, support systems and organisations (Berwick, 2004). As a result, in this context, service-improvement is taken to refer in generic terms to any incremental development to the organisational, managerial or clinical aspects of care. It is also recognised that incremental development in one aspect of

care may have implications for others. While the above definition of service-improvement creates significant overlap between the service improvement and the quality improvement literature, an important caveat is that not all quality improvement changes are first order in nature. As a result, the quality improvement literature is selectively drawn upon for the remainder of the chapter.

Reflecting the organisational, managerial and clinical aspects of care (Buetow & Roland, 1999), the incremental changes encompassed under these terms can include changes in the nature or form of service-delivery, increased levels of staffing, infrastructural development through the provision of additional space or equipment and service expansion or establishment. Such changes aim to support the provision of quality care. In describing quality care, Berwick (2004) cites a 2001 report by the Institute of Medicine in the US entitled 'Crossing the Quality Chasm'. On the basis of meta-analysis of health services research, this report identified six 'aims for improvement' in healthcare organisations. These issues are supported by the service-improvement initiatives described above, with the exception of number 6, which requires a more large-scale and co-ordinated effort. The six aims for improvement are summarised below;

1. Safety: reducing medical injuries to patients;
2. Effectiveness: increasing the reliability of evidence based care;
3. Patient centredness: giving patients are carers more voice, control and competence in self-management;
4. Timeliness: reducing waits and delays throughout the system;
5. Efficiency: reducing the total cost of care and;
6. Equity: closing racial and socio-economic gaps in health status

Historically, there has been a paucity of published work premised on service-delivery and medical service-improvement methods. 'This lack of published reports has arguably deprived the healthcare system of rigorous scholarly evidence on improvement work and, hence, has slowed improvement of the improvement process' (Davidoff & Batalden, 2005: 322). Although a recent surge in quality management is ameliorating this deficit, the fact that most improvement work is undertaken by front-line healthcare professionals, with service delivery responsibilities remains an impediment (Davidoff and Batalden, 2005). In describing where responsibility for service-improvement lies, the NHS Institute for Innovation and Improvement note that 'every single person is enabled, encouraged and capable to work with others to improve their part of the service' (Penny, 2003).

Five main approaches to measuring and improving the quality of care have been identified (Buetow and Roland, 1999), with an overview of the approaches provided in Table 2.1. Each is underpinned by the first approach, quality assessment, which is premised on measuring the quality of care. It identifies opportunities to improve quality but doesn't impose solutions. Several issues arise with quality assessment. Specifically, there can be temptation to focus on what is easily measurable, and there is no requirement that issues identified are addressed. A second approach, quality assurance, aims to identify outlying patient results, which may be indicative of inappropriate patient care. The independent scrutiny of services, either by managers or through professional inspection, is a key factor within this. In the US quality assurance has tended to be a proactive activity, while it remains reactive and professionally led in Europe (Buetow & Roland, 1999).

A third approach, clinical audit, focuses on raising performance in one specific area through peer review against best-practice. It remains a professionally controlled process. On the basis of the evaluation outcome, the clinical team considers if and why individual standards have not been met, and adjusts practice as required. This approach is often implemented in a cyclical manner, as messages from audit can be acted upon selectively and re-audit is necessary to ensure that all requisite actions are undertaken (Snooks et al., 2004). In addition, further issues do arise with this approach. In particular, professionals may lack the resources required for improvement and there may be a lack of consensus regarding involving patients in the process (Buetow and Roland, 1999). A fourth approach is quality improvement. This is premised on addressing issues identified in quality assessment. This approach has tended to be managerially led, and has often adopted formal techniques and approaches such as continuous quality improvement (CQI) (Heard et al., 2001), which entails the empowerment of individuals to improve quality. Total quality management (TQM) has also been adopted. This entails a management devised strategy for quality improvement, with decentralised implementation. Both CQI and TQM are premised on incremental improvements to services. In contrast, business process reengineering entails a top-down evaluation and amendment of organisational processes to improve efficiency, and moves beyond first-order change.

The last approach to service-improvement identified by Buetow et al. (1999) is clinical governance. This is presented as an attempt to 'bridge the gap' between managerial (quality assurance and quality improvement) and clinical approaches (quality assessment and clinical audit) to the quality of care and service-improvement. Within the clinical governance approach clinicians lead the quality improvement strategy for those aspects of the

organizations which affect the delivery of care. They identify clear standards of care, and take accountability for these. It is underpinned by a constant dynamic of improvement.

Table 2.1 Approaches to measuring and improving quality of care (Adapted from Buetow & Roland, 1999)

	Quality assessment	Quality assurance	Clinical audit	Quality improvement	Clinical governance
Aim	Identify discrepancies between desired and actual performance	Research and maintain an acceptable standard of care	Raise performance in one area to meet local needs	Continue to improve the whole system as part of normal daily activity	A systematic process of service improvement combining clinical judgement & clear national standards
Philosophy	Through daily activity, professionals can identify and remedy gaps in performance	Outliers can be identified, to indicate potentially inappropriate care, and corrected when necessary	Self evaluation and professional improvement can achieve best practice	What is good can be made better through continuous process improvement	An expectation of and statutory duty for increased professional accountability for care provided
Method	Performance measurement against standards and investment in selection and training of professionals	Detection of outliers through external or internal inspection, and their correction, when necessary, through systematic activity.	Peer review by professionals	Prevention of problems and control of unintended variation in process through total quality management	Strategy to be developed by each organisation including quality improvement methods. Requires borrowing from managerial approaches
Principal responsibility of:	Professionals at an individual implicit level	Payers (US) or managers responsible for purchasing health care (UK)	Clinical teams involved in care delivery	Clinical services managers	Named individual appointed with responsibility. Also clinical leadership albeit with external accountability.

This section has defined service and quality improvement and explored the relationship between them. In addition, it has identified four prevalent and one emerging approach to improving service quality in healthcare. Overarching the approaches to service and quality improvement defined above, there are a number of ongoing developments and emergent ideas in the service improvement literature. These are discussed in Section 2.2.

Section 2.2: Ideas and initiatives within the service-improvement literature

There are a number of emerging initiatives and ideas evident within the service-improvement literature. Chief among these are the emergence of evidence based medicine, the incorporation of quality and service-improvement as elements of reflective practice and the involvement of service-users in service-improvement initiatives. In addition, there is an increasing range of tools and strategies to support service-improvement, beyond the CQI and TQM methods outlined in the previous section. These are discussed below, beginning with the moves towards evidence based medical practice and reflective practice.

2.2.1 Evidence based medicine and reflective practice

'The very definition of quality in healthcare has now come to incorporate the use of scientific evidence in practice; that is what the Institute of Medicine mean in its call for improvement of 'effectiveness' as a key aim for improving care' (Berwick, 2005: 315)

Evidence based medicine is premised on the scientific evaluation of clinical practice, to avoid individual bias and identify hidden and uncontrolled influences (Berwick, 2005). The benefits of this have been very significant for clinical service-improvement. However, the grounding of evidence based medicine in particular methodologies is serving to filter the spread of improvements premised in practice. Concern regarding this issue is increasingly being articulated, with the publication of practice-based systematic learning advocated (Berwick, 2005, Davidoff and Batalden, 2005). This advocacy is a broader reflection of a rising theme within the service-improvement literature, whereby service-improvement is increasingly recognised as a component of reflective practice (Berwick, 2005). Service improvement is now a core dimension of the NHS Knowledge and Skills framework and likely to become a component of pre-registration education for many healthcare professionals and support staff (Janes and Mullan, 2007). For Berwick (2005) reflective practice can be a pragmatic science and a systematic learning method. However he notes that learning derived from such efforts tends to be harder to publish. In providing guidelines for service-improvement as a reflective learning method, Penny (2003) identified four inter-related components of service improvement, which she described as the basis of all improvement activities and tempts to

improve care for clients. These are (1) involving users, carers, staff and the public; (2) process and systems thinking; (3) personal and organisational development and (4) initiating, sustaining and spreading improvement. In addition, there is an increasingly broad range of tools and strategies which are drawn upon to support the implementation of service-improvement. These are discussed below.

2.2.2 Tools and strategies to support the implementation of service improvement

There is a wide array of tools and strategies to support the implementation of service-improvement. These include include the plan, do, study, act cycle (PDSA), which has risen in popularity with the move towards reflective practice detailed in 2.2.1, lean thinking (IHI Innovation Series white paper, 2005), associated with the aim of efficiency, clinical systems improvement, (Janes and Mullan, 2007), associated with moves to increase effectiveness, accreditation (Scrivens, 1997, Buetow and Wellingham, 2003), associated with a variety of objectives and specific instruments such as the Malcolm Baldridge framework (Foster et al., 2007) and the Royal College of General Practitioners Quality Team Development programme (Macfarlane et al., 2004). Of these, hospital accreditation is the most formal initiative. It entails a self-assessment and an external peer assessment process which are used to accurately assess an organisation's level of performance in relation to established standards. While traditionally process focused, there have been recent attempts to incorporate outcome measures (Buetow and Wellingham, 2003). Accreditation can be used for quality control, regulation, information giving, marketing and quality improvement purposes. When utilised for the latter, it has tended to be associated with CQI (continuous quality improvement) where systematic methods and statistical tools are used to create process improvements. In addition, a further emerging trend in service-improvement initiatives is the adoption of computer and internet supported initiatives. These include computer simulation to assess issues such as patient flows and pathways (Elkhuizen et al., 2007) and web-based incident reporting systems (Nakajima et al., 2005). Finally, there is an increasing move toward the adoption of evidence-based quality or performance indicators as a motivator of service-improvement (Shield et al., 2003), with a recent shift towards health outcome indicators (Davies and Lampel, 1998). However, this move has not been uncontested, with warnings that performance indicators and health outcomes are meaningless and debate over how useful they can be. In addition, concern has been articulated that there have been few attempts to evaluate reactions to performance indicators (Wilkinson et al., 2000). On the basis of Wilkinson et al's (2000) evaluation, it was found that common concerns among clinicians regarding performance indicators include an increase in

workload, reductions in professional autonomy and trust, financial penalties based on performance issues beyond the scope of professional control and short term expectations of improved quality of care. Perceived advantages included the capacity to monitor important areas of care, improving efficiency and facilitating up to date clinical practice (Wilkinson et al., 2000). Davies and Lampel (1998: 159) argue that 'attempts to force improvements through publishing health outcomes can be counterproductive', although performance indicators have been strongly associated with the rise of managed competition in the NHS. Davies and Lampel identify three main problems with performance indicators. First is the fact that performance indicators are premised upon error detection at the end of a patient care process, rather than during it. In fact, errors may not be detected until years later. Secondly, there are methodological problems with the observational nature of the data and ambiguity over causation, which prevent strong punishment or error. Thirdly, and perhaps most importantly, they suggest that performance measurement may create an adversarial and defensive culture that mitigates against quality. They outline an alternative approach which involves fostering greater trust in professionalism as a basis for quality enhancements.

Although all of the tools mentioned above are used for service-improvement the PDSA cycle, which is highly similar to action research, is ideally suited to incremental service-improvements, as it allows them to be reviewed repeatedly. It is also unique in not requiring financial investment or significant preparation, and therefore aligns particularly well with the concept of the reflective practitioner. It is also amenable to clinical, organisational and managerially premised service-improvements, with Berwick (2003) advocating the model as one that provides a framework for the workforce to be involved in service-improvement. For him, this builds on earlier work by Thomas W. Nolan, who developed a model premised on three questions; (1) what are we trying to accomplish?; (2) how will we know that a change is an improvement ? and; (3) what changes can we make that will result in an improvement? For Berwick, once a team has answered these questions it will be in a position to evaluate what works, and what doesn't. Underpinning these three questions are issues of trust, and the capacity to be open and honest about 'failed' undertakings, which can be most valuable for learning. Relational issues in service-improvement are further discussed in Section 2.3 and in Chapter 5. Prior to this, Section 2.2.3 considers the movement towards involving service users in service-improvement initiatives. This movement is part of a broader shift towards patient-centred care.

2.2.3 Involving service users

Patient centred care refers to 'constellations of qualities of care that can give patients and carers power, knowledge, dignity, self-efficacy skills, respect for their diversity and freedom of

action.' (Berwick, 2004: 408). Berwick notes that not alone is this a political agenda, but rather that empowered, informed patients tend to have much better outcomes and use resources more effectively. The issue of patient-centred care is rising internationally and is evident in both the UK and Ireland. In Ireland, patient-centred care is one of the four aims of the National Health Strategy (Department of Health and Children, 2001). In service-improvement terms, patient-centred care is evident in a variety of initiatives. Examples include the co-design of services and service-improvement with patients (Bate and Robert, 2006), through listening and responding to what they say. Bate and Robert note the emergence of the 'design sciences' and 'experience based design' 'in which the traditional view of the user as a passive recipient of a product or service has begun to give way to the new view of users as integral to the improvement and innovation process' (Bate & Robert, 2006: 307). In fact, they suggest placing the experience goals of patients as equal in importance to the process and clinical goals. Hence, there is increasing advocacy of the patient involvement process moving away from user groups feeding back, towards co-design in service-improvement. This is important as staff and patients can emphasise different aspects of service-quality as important. For example, in one study on mental health services, (Brooker and Dinshaw, 1998) it was found that patients were more positive about the physical environment and professional care than staff, but less so about issues of privacy, social interaction and empowerment. The two sets of interviews therefore led to different service-improvements.

To conclude, Section 2.3 draws analytical links between the service improvement literature reviewed above and the broader literature on change reviewed in Chapter 1.

Section 2.3: Analytic links between service-improvement and change management

> Despite the evidence of defects and the tantalising promise that some among us excel and could be teachers to us all, changing healthcare systems to make them better has proven disappointingly challenging, cumbersome and time consuming.
>
> – Berwick, 2003: 2

There are a number of significant analytical links between service-improvement and change management. Firstly, the introduction to this chapter emphasised that service-improvement change refers to first-order change, tending to be micro. Secondly, similarly to the more general situation outlined in Chapter 1, service-improvement change encounters ongoing difficulties in implementation, spread and sustainability (Buchanan et al., 2007). While the source of quality problems in clinical care has been distilled into three categories, namely the overuse of procedures that do not help people get better, under-use of procedures that can

help and errors (Berwick, 2003), addressing these and other issues is plagued by broader challenges in the service-improvement process. In a review of seven studies of the adoption of clinical service-improvements Dopson et al (2002) identified issues which affect service improvement. These are as follows; (1) robust evidence is not sufficient to facilitate diffusion; (2) the interpretation of evidence is socially constructed; (3) evidence is differentially available for difference professions; (4) hierarchies of evidence exist and a variety of sources, including tacit and experiential knowledge are important; (5) professional networks shape behaviour and professional boundaries are significant barriers to the spread of change and; (7) context is an influence on diffusion.

In particular, social and cognitive boundaries between professions have been identified as key barriers to the spread of change (Ferlie et al., 2005). In contrast, devolved and dispersed responsibility for change have been presented as facilitating factors (Denis et al., 2001) and are increasingly advocated within healthcare (Berwick, 2003). As a result, these are discussed in Chapter 5, which outlines the key roles and relationships in service-delivery and service-improvement change in healthcare. Roles and relationships provide the lense through which service-improvement processes are explored in this study. In particular, Section 5.3.2 discusses the emerging healthcare-specific literature concerned with change roles and leadership while Sections 4.4.1, 4.4.2 and 4.4.3 consider the issues which arise in inter-professional relationships. Crucially, Dopson et al's (2002) research cited above indicates that while service-improvement is a form of change, the healthcare context makes the change process more intractable, due to the multiple professions and complex context. The context for service improvement in which this study is embedded is discussed in Chapter 4.

Conclusion

This chapter has defined and differentiated between service improvement and quality improvement, emphasising that service-improvement is fundamentally concerned with first order or micro level change initiatives. While service improvement is generally focused on improving quality, in terms of the safety, effectiveness, appropriateness, patient-centredness, equity, access or efficiency of care, it is differentiated from quality improvement in terms of scale as not all quality improvement is first order in nature. Hence, although the quality improvement literature has been drawn from in this chapter, this has been done selectively, and with the above caveat emphasised. It has also been noted that, for the purposes of this thesis, service-improvement is taken to refer in generic terms to any incremental development to the organisation, managerial or clinical aspects of care. Having defined the scope of service improvement, the chapter identified four prevalent approaches to it, from

managerial and clinical perspectives. In addition, it emphasised the emergence of clinical governance, which attempts to bridge the managerial and clinical perspectives.

Having identified approaches to service-improvement, the chapter then emphasised the range of initiatives and ideas emerging within the literature. These include the emergence of evidence based medicine and management, reflective practice as a source of service improvement, the shift towards involving service users in service improvement and the array of tools and strategies adopted in support of service improvement endeavours. Finally, the chapter concluded by establishing the links between service-improvement and change management, emphasising analytical linkages between the two and the common challenges faced. The analytical framework for exploring these challenges, the processual approach, will now be explored in Chapter 3.

Chapter 3: The Processual Approach

Introduction

The irreducible purpose of a processual analysis remains to account for and explain the what, why and how of the links between context, process and outcomes.

-Pettigrew, 1997: 340

The purpose of this chapter is to provide a conceptual overview and critique of the processual approach to understanding change, which underpins this research. The processual approach has informed both the research design and structure of the thesis, with the literature review presented according to its core dimensions. These are the context, content, and process of change. This chapter illustrates that the processual approach and its associated methodology go a significant way towards addressing three of the key concerns in change-related research (Pettigrew, Woodman, & Cameron, 2001). These are (1) the examination of multiple contexts and levels of analysis; (2) the inclusion of time, history, process and action and (3) the link between change processes and organisational performance outcomes in studying organisational change. Hence, this chapter describes the characteristics, merits, and critiques of the processual research frame adopted in this study, which contrasts with traditional *'ahistorical, aprocessual and acontextual'* (Pettigrew, Ferlie, & McKee, 1992: 6) approaches to change.

Definitions of process in the literature on change should refer to sequences of individual and collective events, actions, and activities unfolding over time to expose processes and mechanisms of change (Pettigrew et al., 2001). Pettigrew et al. noted that any adequate theory of change should also account for continuity. Pragmatically they asserted that there are three options in integrating time, process, and history into research. These are (1) historical investigation; (2) the Minnesota Innovation Research Program (MIRP) model for real time analysis of change and (3) the Warwick tradition of processual research on retrospective and real-time analysis. It is this last approach that is adopted in this context. The reasons underpinning this choice are several. Firstly the MIRP approach has a quantitative form, based in variance theory, that undermines the strong internal validity and holistic portrayal of phenomena, which Dopson and Fitzgerald (2005a) identified as the distinctive strength of processual research. Furthermore, the processual approach is the only one of the three to have an explicit focus on context and on linking processes with outcomes. The complexity of the Irish hospital sector and the focus on establishing and understanding the link between role and relationship configurations and service-improvement make these

particularly valuable traits for this research, as well as desirable aims from a general research perspective (Pettigrew et al., 2001). Finally the processual framework is becoming increasingly prevalent in health and other change management studies (Iles & Sutherland, 2001).

The chapter begins by outlining the history and underpinnings of the approach. Emerging from this it provides a definition of the approach embedded in a discussion of the meaning of *'process'*. It provides an overview of the variants on the approach and identifies the specific form adopted in this research. Emerging from this discussion, and in the wake of the discussion of the meaning of 'process', the role and meaning of the two remaining central tenets of the approach are discussed: the content and context of change. In addition, time is discussed as an under-represented but central influencing factor upon the approach. To conclude, the benefit and critiques of the approach are explored.

Section 3.1: History and Underpinnings of the Processual Approach

There is a relatively small but increasing number of academics in Europe, and to a lesser extent Northern America, Australia, and New Zealand, who are recognising the benefits of processual research for understanding organisations (Dawson, 1997). Dawson (2003) noted that early interest in processual dynamics were evident in Burns and Stalker (1961), Woodward (1958, 1980) and Elger (1975). These works, in conjunction with the development of open-systems approaches, drew attention to the variety of contextual factors affecting processes and outcomes in organisations. Specifically, the open-systems approach moved towards a relational conception of organisation, away from the substantialist definitions associated with rational and natural-systems approaches (Scott, 2003). In addition, open-systems approaches emphasise the influence of context and environment on organisations, and the *'multiple loyalties and identities'* (Scott, 2003: 29) of organisational actors. The definition of organisations from the open-system perspective, which emphasises process rather than structure, mirrors the development of themes in work conducted at the Centre for Corporate Strategy and Change at the University of Warwick. *'Organizations are congeries of interdependent flows and activities linking shifting coalitions of participants embedded in wider material-resource and institutional environments'* (Scott, 2003: 29). A mirroring of these themes is specifically evident in Pettigrew's (1985) articulation of the founding premise of the processual approach.

> *As long as we continue to conduct research on change which is ahistorical, acontextual and aprocessual, which continues to treat the change programme as the unit of analysis and regard change as an episode divorced from the immediate and*

> *more distant context in which it is embedded, then we will continue to develop inadequate and descriptive theories of change which are ill-composed guides for action. Indeed as I have implied already there is still a dearth of studies which can make statements about the how and why of change, about the processual dynamics of change, in short, which go beyond the analysis of change and begin to theorise about changing.* (Pettigrew, 1985: 15)

Early examples of the processual approach include Pettigrew (1973, 1985), who explicitly articulated the principles of the approach in the late 1980s (Pettigrew, 1987). Further key writing in this area includes Pettigrew (1987, 1988, 1990; Pettigrew et al., 2001), Pettigrew and Whipp (2001) and Dawson (1994, 2003). There is also a specific processual literature in healthcare, in which key works include those by Pettigrew, Ferlie, and McKee (1992), McNulty and Ferlie (2002), Ashburner, Ferlie, and Fitzgerald (1996), Ferlie, Fitzgerald, and Ashburner (1996), Ferlie, Ashburner, Fitzgerald and Pettigrew (1996) and Fitzgerald et al. (2006). Research findings have included the identification of common patterns regarding the key features of managing strategic and operational change (Pettigrew & Whipp, 1991b). Providing a specific example, Figure 3.1 outlines the five interrelated factors for which Pettigrew and Whipp (1991b) observed differences. They identified the primary and secondary influencing factors on effectively managing change within the interrelated areas of environmental assessment, leading change, linking strategic and operational change, human resources, and coherence. Similarly Pettigrew, Ferlie, and McKee (1992) identified eight interrelated factors that produce receptivity for change in healthcare organizations. These formed *'a pattern of association rather than a simple line of causation.'* (Pettigrew et al., 1992: 275) Their theory of the factors affecting the climate or receptivity for service-improvement will be developed in chapter 9. In addition, emphasis has also been placed on power and politics (Buchanan & Badham, 1999). The next section provides a clear definition of the processual approach

Section 3.2: Defining the Processual Approach

In the case of organisational change, the process of transition is generally studied over time and within an historical and organisational context.

-Dawson, 1997: 389

The processual approach, as discussed by Andrew Pettigrew (1987, 1997), is an emerging theoretical framework for understanding change. However, Patrick Dawson (2003) presented it as a framework for researching, analysing, and explaining change processes in a way that takes account of the people in organisations (Dawson, 2003) as well as the contexts in which

Figure 3.1: Managing Change for Competitive Success: characteristics of the five central factors (Pettigrew et al., 1991b)

	Environmental Assessment	Leading Change	Linking strategic & operational change	HR as assets & liabilities	Coherence
Primary conditioning features	1. Availability of key people 2. Internal character of organisation 3. Environmental pressures 4. Environmental assessment as a multi-function activity	1. Building a receptive context for change; legitimation 2. creating capability for change 3. Constructing the content and direction of change	1. Justifying the need for change 2. Building capacity for appropriate action 3. Supplying necessary visions, values and business direction	1. Raising HRM consciousness 2. Use of highly situational additive features to create positive force for HRM change 3. Demonstrating the need for business and people change	1. Consistency 2. Consonance 3. Advantage 4. Feasibility
Secondary Mechanisms	5. Role of planning, marketing 6. Construction of purposive networks with main stakeholders 7. Use of specialist task forces	4. Operationalising the change agenda 5. Creating the critical mass for change within senior management 6. Communicating need for change and detailed requirement of the change agenda 7. Achieving and reinforcing success 8. Balance continuity and change 9. Sustaining Coherence	4. Breaking emergent strategy into actionable pieces 5. Appointment of change managers, relevant structures and exciting targets. 6. Re-thinking communications 7. Using the reward system 8. Setting up local negotiation climate for targets 9. Modifying original visions in light of local context 10. Monitoring and adjustment	4. Ad hoc, cumulative, supportive activities at various levels 5. Linking HRM action to business need with HRM as a means not an end 6. Mobilizing external influences 7. Devolution to line 8. Construction of HRM actions and institutions which reinforce one another	5. Leadership 6. Senior management team integrity 7. Uniting intent and implementation 8. Developing apposite knowledge bases 9. Inter-organizational coherence 10. Managing a series of interrelated changes over time

they are embedded. Thus, as a developing framework, it is characterised by some differences in interpretation amongst its advocates. In this research, Pettigrew's perspective that the processual approach is an emerging theoretical framework is adopted.

According to the processual approach, change is a result of the interplay between the (1) content or *'what'* of change in terms of its objectives, purpose and goals; (2) the process or *'how'* of change implementation and (3) the organisational context for change in terms of the internal and external environment (National Co-ordinating Centre for NHS Service Delivery and Organisation R & D, 2001). The core tenet of the approach is that *'actions drive processes but processes cannot be explained just by reference to individual collective agency. Actions are embedded in contexts which limit their information, insight and influence.'* (Pettigrew, 1997: 338). At the heart of the approach is a concern with process and the factors that influence it. As with any research approach, having a clear understanding of the unit of analysis is crucial. As a result, the first part of this section considers what is meant by a concern with *'process'* and the analytical differences among proponents of the processual approach. The second component of the section outlines the characteristics of the variant of the processual approach adopted.

3.2.1 Understanding Process and Variants on the Processual Approach

Van de Ven (1992) identified three definitions of process that are evident in the literature. In the first instance *'process'* refers to the logic of a causal relationship in a variance[4] theory. In the second instance the term *'process'* describes a category of concepts that refer to the actions of individuals or organisations. In the third usage, *'process'* refers to a sequence of events that describe how change unfolds over time. Van de Ven (1992) asserted that these different views of process influence the type of questions asked and the research methodology employed in change-related research. Van de Ven advocated the third understanding on the premise that while change can be observed directly, the process of change refers to conceptual inferences about the relationship among observed changes over time (Van de Ven, 1987). This understanding was also adopted by Pettigrew (1992, 1997) and others (Dawson, 2003) in their discussions of processual research.

[4] Poole and Van de Ven (2004b) followed Mohr (1982) in distinguishing process from variance theories of change. While process theories focus on explaining how change unfolds over time via the path of events they follow, variance theories focus on explaining causal relationships between variables.

In his discussion of strategy process research, Pettigrew (1992) noted that it, like the broader processual approach, lacks a coherent and universally accepted analytical structure and set of conceptual tools. In addition he noted a lack of ontological and theoretical discourse regarding the founding assumptions of processual thinking. At that time Pettigrew called for more debate and discourse on the analytical and conceptual assumptions underpinning process research. Whilst there has been little evidence of this in the interim, Pettigrew (1992) did note that Sztompka's (1991) sociological principles and ontological assumptions regarding social reality have resonance for processual scholars. Both focus on agency while also recognising the structural frameworks and contexts within which action occurs. Building on this assertion and following Sztompka (1991) the ontological assumptions underlying the processual approach are as follows:

1. Social reality is not a steady state, but, rather a dynamic process that occurs rather than exists;
2. The social process is constructed and created by human agents—individual or collective—through their actions;
3. Social life is a process of structural emergence via actions, and the tension between actions and structures is the ultimate moving force of the process;
4. Action occurs in the context of encountered structures, which it shapes in turn, resulting in the dual quality of structures (as both shaping and shaped) and actors (as both producers and products);
5. The interchange of action and structure occurs in time and is cumulative such that the legacy of the past is always shaping the emerging future. What happens, how it happens, why it happens, and what results it brings about are dependent on when it occurs, the location in the processual sequence, and the place in the rhythm of events characteristic for a given process.

One benefit of having this ontology underlying the processual approach is that it avoids the *'variable paradigm'* which Abbott (cited in Pettigrew, 1992) criticised for having led to the neglect of real actors.

Whilst there is a shared understanding of process among the proponents of the processual approach, there are some analytical differences that have methodological implications. The tension underlying these differences was outlined by Ropo, Eriksson, and Hunt (1997):

> *One might ask, whether we wish to develop process research practices toward generic, standardized patterns, or whether we would rather leave more space for personal orientations, individual voices and self-reflections that is inherent in social theory development?* (Ropo et al., 1997: 332).

For Dawson the key choice in this regard is whether the researcher adopts a generic model and applies standardised procedures, rather than developing their tacit skills as a creative analyst (Dawson, 2003). He identified three positions in this regard. The first advocates standardization and codification in processual analysis (Hinings, 1997). The second position advocates comparative case studies, which can be executed in large multidisciplinary research groups (Pettigrew, 1990), and the third advocates the in-depth longitudinal case study (Dawson, 2003). The key characteristics of Pettigrew's approach, which adopts the second position above, are outlined in the next subsection. This approach has been adopted in this thesis.

3.2.2 The Characteristics and Aims of Pettigrew's Processual Analysis

Pettigrew adopted a working definition of process as *'a sequence of individual and collective events, actions and activities unfolding over time in context.'* (Pettigrew, 1997: 344) The explicit inclusion of context in his definition of process emphasises that processes do not occur in a vacuum but rather are subject to multiple influences. To ensure that these influences are taken into account, Pettigrew (1992) outlines further requirements to classify as a processual analysis. These are *'internally consistent insights and assumptions to guide thinking and empirical inquiry about the analysis of process issues'* (Pettigrew, 1997). The five characteristics of processual analysis identified by Pettigrew (1997) are listed below and illustrated in Figure 3.2.

1. Embeddedness, which refers to studying processes across a number of levels of analysis;
2. Temporal interconnectedness, which refers to studying processes in past, present, and future time;
3. Having a role in explanation for context and action;
4. Searching for holistic rather than linear explanations of process;
5. Using process analysis to find and explain outcomes

Pettigrew's (1997) first characteristic of a processual analysis, the concept of embeddedness, refers to studying processes across a number of levels of analysis. This requirement is premised on the fact that social processes are embedded in contexts that both shape and are shaped by them. This leads to the explicit consideration of the role of the context, while simultaneously

recognising that processes occur at different levels of analysis and that there may be multiple processes at the same level of analysis. For Pettigrew (1997) the asymmetries between levels of contexts can be a source of change.

The second required characteristic, that of temporal interconnectedness, refers to studying processes in past, present, and future time. Pettigrew (1997: 10) described this as *'the search to catch reality in flight.'* He indicated that understanding the sequence and flow of events over time is crucial for process scholars. In particular, the carrying forward of history in the human consciousness is noted and explored via consideration of repeating patterns.

The third characteristic outlined is having a role in explanation for both context and action, which are interrelated. *'Organisational processes are both constrained by features of context ... and also shape contexts'* (Pettigrew, 1997: 341). Thus context and action are presented as inseparable and intertwined, reflecting Giddens' (1979) notion of a duality between the two. Structure and context are conceptualised by Pettigrew (1997) as involved in the production of action, shaping its character. Importantly, Pettigrew (1985, 1997) noted that some aspects of the context can be mobilised by key actors in their pursuit of particular goals. Dawson (1994) also emphasised this interrelationship between context and action as a particularly valuable characteristic. He asserted that while there are many academic and practitioner models that explain aspects of the process of organisational change, most models on the management of change remain rooted in Lewin's (1951) seminal notion of unfreezing—change—refreezing. For Dawson, while this model is useful in relatively stable conditions, the inability of this model of change to deal with dynamic change has led to the need for an alternative framework. Specifically, he advocated,

> *An approach which is less prescriptive and more analytical would further our understanding of the processes involved, and enable practitioners to adopt a broader perspective on the problems and practice of managing change. To this end, a processual framework is developed for explaining the process of transition.* (Dawson, 1994: 3)

The fourth characteristic of processual analysis is a search for holistic rather than linear explanations of process. For Pettigrew (1997) this is a natural concomitant of the first three principles, with a focus on causal processes in context, which tend to be neither linear nor singular. Pettigrew (1997) cited Ragin as explaining this as *'the search for multiple intersecting conditions which link features of context and process to certain outcomes.'* One example of this is

explicated in Pettigrew et al. (1992), which outlines eight key characteristics for successful change in healthcare organisations.

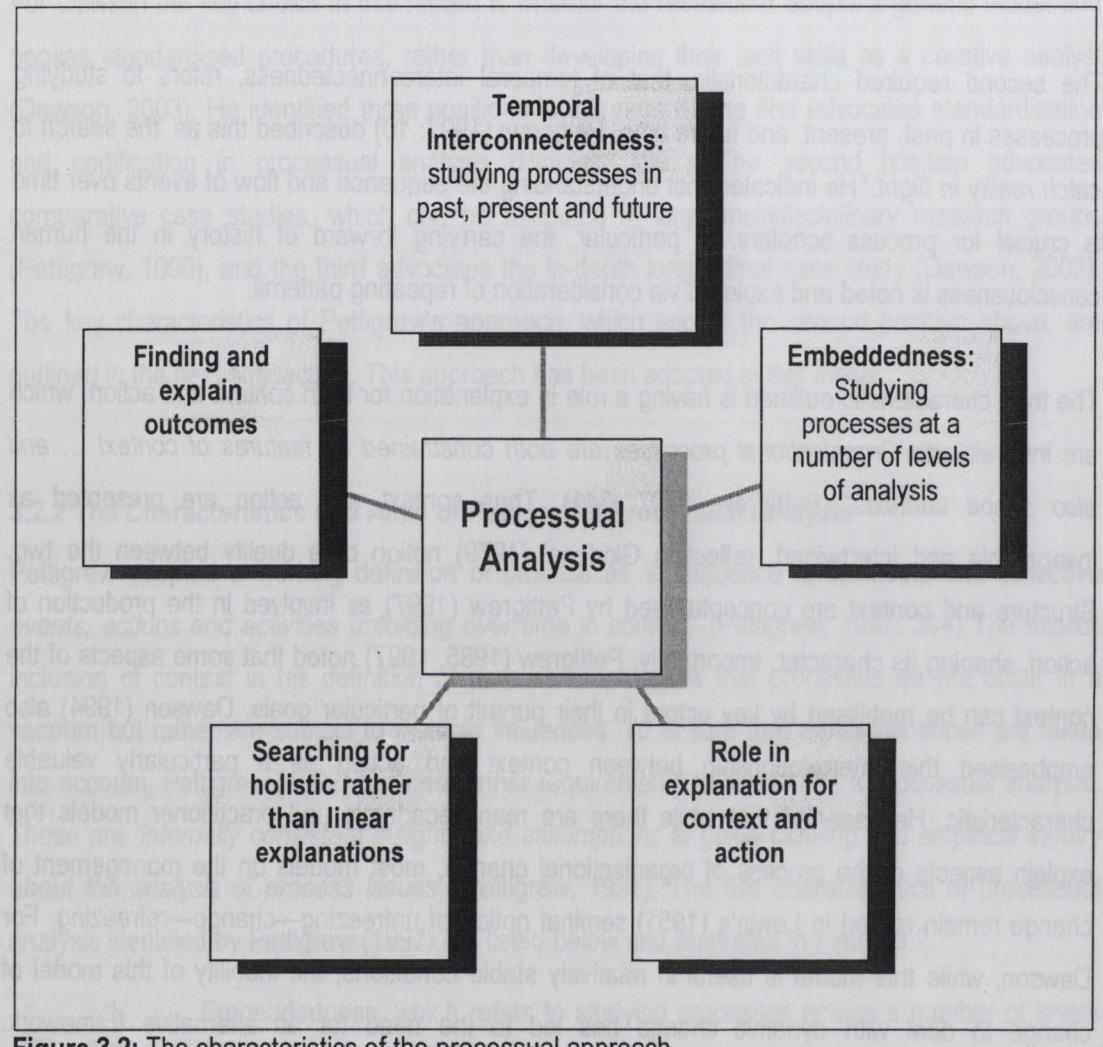


Figure 3.2: The characteristics of the processual approach.

The fifth and final characteristic of Pettigrew's perspective is the use of process analysis to explain outcomes. Achieved by determining a clear outcome to explain in the research, this characteristic is both an aim in itself and a method of reducing complexity through research design. Providing a focal point for the investigation facilitates the exploration of *how and why* variations in the context and process affect the outcome in question: *'Process research is capable of generating sound knowledge not only of processes and outcomes but also of why and how outcomes are differentially shaped by processes'* (Pettigrew, 1997: 342). In Pettigrew and Whipp (1991b) the outcome variable that was identified and explained was the differential performance of the eight firms in the study. Pettigrew (1997) recommended exploring the outcome variable in between six and ten cases.

Pettigrew's processual approach has two key goals (Caldwell, 2006). The first is to create theoretically sound and practically useful research on change, which is based on explorations of the context, content, and process of change over time. Pettigrew (1987) indicated that the '*what*' of change corresponds to what is formally termed the content section, while the '*why*' is based on an analysis of inner and outer context. Finally the '*how*' of change is understood via an analysis of processes of change. This broad framework is illustrated in Figure 3.3 (Pettigrew, 1987).The second aim is to emphasise the contextual influence of micropolitics and conflicts over the direction, rationality and outcomes of change (following Pettigrew & Whipp, 1991a). This latter aim was more explicitly emphasised by Dawson (1994). He asserted that the processual frame should explicitly take account of the politics of change because competing perspectives can shape the change process. Political activity can entail consultation, negotiation, conflict, and resistance at various levels, internally and externally, during the process of management of change. Dawson (1994) added a third goal to Pettigrew's two aims. For him a key question was how the characteristics of the changes introduced affect the management options available during the introduction of change. The next section outlines the role and meaning of the content of change in processual analysis.

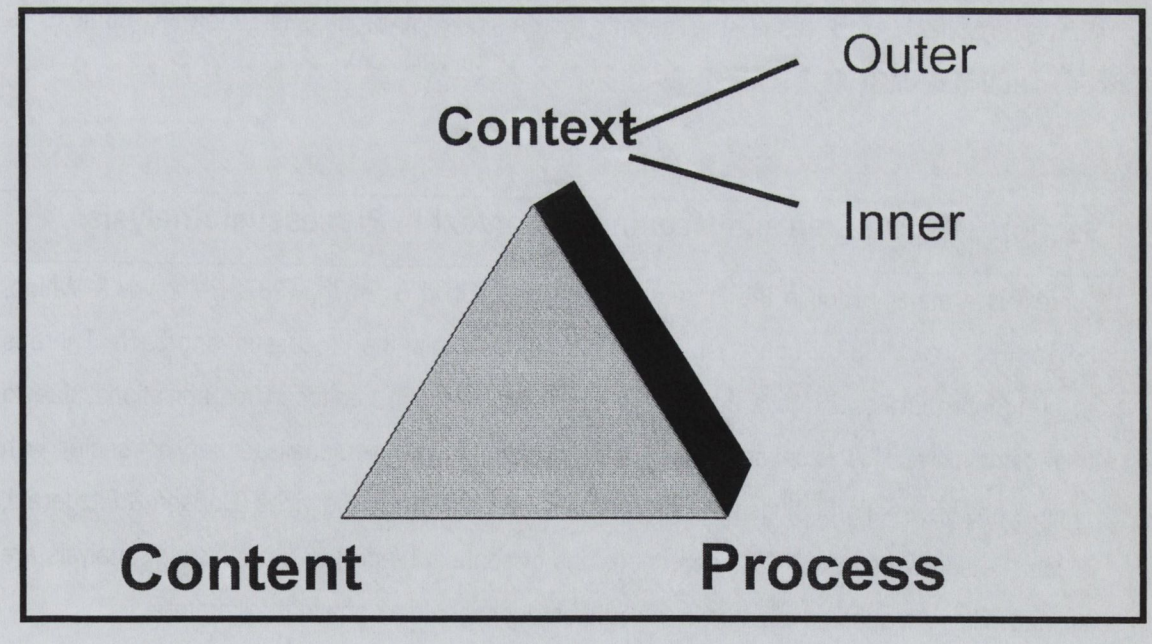


Figure 3.3: Pettigrew's processual framework of change.

Section 3.3: The Content of Change

The content of a change can vary in substance, scale, pace, and form. Authors have used a variety of terms to identify the substance of a change, including Christensen and LæGreid (2003), who differentiate between sustaining and disruptive innovations and Greenwood and Hinings (1996), who distinguish between convergent and radical change. For Buchanan and Fitzgerald (2007), these differentiations can be broadly summarised as the difference between *'improving what we have'* and *'creating something new'*. Buchanan and Fitzgerald asserted that the process of creating something new is riskier and harder to manage, because there are no established routines for handling the new events. Greenwood and Hinings (1996) further differentiated between revolutionary and evolutionary change, in referring to the scale and pace of the adjustment. Changes can be made to technology, ideas, products, tools, services, business models, and organisational practices (Buchanan & Fitzgerald, 2007). Drawing upon Rogers (1995), Buchanan and Fitzgerald asserted that a change is more likely to be adopted when the content is perceived as (1) advantageous compared to existing practice; (2) compatible with existing practice; (3) easy to understand; (4) observable in demonstration sites; (5) testable; and (6) adaptable to fit local needs. However, in addition to the substance of the change, Buchanan and Fitzgerald (2007: 48) noted that *'individual and contextual factors are as important as the innovation itself.'* As a result, the second cornerstone of processual analysis, context, is considered in Section 3.4.

Section 3.4: The Role and Meaning of Context in Processual Analysis

Context is a major factor in the literature on change (Child & Smith, 1987; Pettigrew & Whipp, 1991a; Pettigrew, 1987; Pugh et al., 1969), as well as within the processual approach. There is an argument that context is a particularly significant factor in healthcare organisations, due to their complexity. This is influenced by their position in the personalised service sector with multiple professional groupings providing complex and skill-based services (Dopson & Fitzgerald, 2005b; Pettigrew et al., 1992). The dimensions of context integral to a processual analysis are outlined. These are then evaluated in the light of recent contributions to the literature.

3.4.1 The Components of Context in Processual Analysis

Dawson (1994, 1996, 2003) and Pettigrew (1987, 1997) identified the dimensions of context that should be considered in a processual analysis. For both, the context of change had a temporal

element, incorporating current and past internal organisational context, as well as external contextual factors related to the environment in which the organisation operates. Dawson (1994) defined external contextual factors as changes in competitors' strategies, the level of international competition, government legislation, changing social expectations, technological innovations, and changes in the level of business activity. For him, the five key internal contextual factors comprise human resources, administrative structures, technology, product or service, and history and culture.

Dawson (1994) defined human resources as the individuals and groups of people who comprise an organisation, which often leads to a focus on teamwork and intergroup development. He defined administrative structures as the allocation of tasks and the design of jobs and work structures. Technology refers to both plant, machinery, and tools *and* the associated philosophy and system of work organisation used to produce goods and services. Dawson (1994) emphasised that whilst changes in technology often focus on equipment, they tend to have associated changes in work tasks, job content, and supervision. Finally, Dawson drew attention to the fact that it is important to view how these factors have developed and become legitimised over time. He refered to this as the history and culture of an organisation. More specifically Dawson (1994: 43) defined history and culture as

> *the contextual evolution of shared beliefs and assumptions within organizations. The concept is intended to incorporate both a historical perspective which can take account of multiple histories of the context in which change is taking place and an understanding of organizational culture.*

Similarly, Pettigrew (1985, 1987, 1988) referred to both internal and external context, in past and current events. Pettigrew (Pettigrew et al., 2001; Pettigrew, 1987) asserted that inner context refers to the structure, corporate culture, and political context within the firm, through which ideas for change have to proceed. For him, the outer context refers to the social, economic, political, and competitive environment in which the firm operates, including questions about the links between firm-level behaviour, the changing boundaries and compositions of sectors, and the effects of altering macroeconomic conditions.

Both authors recognised that the context of behaviour for change processes includes events and history inside and outside of organisations. Both also articulate concern with broadly similar areas, although Dawson articulated an additional concern with technology in both the inner and

outer context. The understandings of context held by Dawson and Pettigrew overlap and are summarised in Table 3.1 overleaf.

For Caldwell (2006) exploring context is an affirmation of bounded choice. However as a function of being a holistic concept, Caldwell (2006) noted that it has multiple meanings some of which overlap with the idea of process, and that ultimately make both context and process complex and confusing. Also related to the holistic nature of the context, Caldwell asserted that *'Pettigrew has no adequate concepts that theorize the environmental boundaries of organizations or the possible efficacy of organizational structures as system entities with emergent properties'.* (Caldwell, 2006: 65) For Caldwell, context occupies an explanatory role rather than being an analysis of patterns of causality. Similarly, Chia (1999) was critical of Pettigrew for examining aspects of the broader context as relatively static features.

Table 3.1: The Context of Change (adopted from Pettigrew, 1987, 1997, 2001 and Dawson, 1994, 2003)

Author	Inner Context	*Outer Context*
Dawson	▯ Human resources ▯ Administrative structures ▯ Technology ▯ Product or service ▯ History and culture.	▯ *Changes in competitors' strategies* ▯ *The level of international competition* ▯ *Government legislation* ▯ *Changing social expectations* ▯ *Changes in the level of business activity.* ▯ *Technological innovations*
Pettigrew	▯ *Structure* ▯ *Corporate culture* ▯ *Political context*	▯ *Competitive environment* ▯ *Political* ▯ *Social* ▯ *Economic*

For Caldwell (2006), in spite of developments in the literature, the definitions of inner and outer context in the processual approach have not substantially developed since Pettigrew's early work (Pettigrew, 1985), and are theoretically limited. Similarly Fitzgerald et al. (2002) noted that context

has been operationalised in a primitive way in processual research, with a need for more specification. For Caldwell, this led to the presentation of context as a realm of *'strategic choice, rather than a powerful area of constraint and determinism'.* The next section identifies recent developments in the conceptualisation of context, which further critique the conceptualisation of context in the processual approach.

3.4.2 Developments in the Conceptualisation of Context

Recent and critical additions to the literature on context include the fact that change is differentially impacted by configurations of characteristics from the context (Dopson & Fitzgerald, 2005b; Fitzgerald et al., 2006). For Fitzgerald et al. this made a theoretical contribution to the literature in moving away from considering cause and effect relationships and towards what Goldstone (2003) termed *'conjunctural causation'*, whereby combinations rather than individual factors are significant. A second contribution argues that context is an interactive process rather than a backdrop to change (Dopson & Fitzgerald, 2005a; Read et al., 1999), whilst a third asserts that there can be interplay between outer and inner context (Fitzgerald et al., 2002). In addition, various assertions on the nature of context, including the fact that *'learning and change capacity may vary sharply by local setting; that these competencies build up over a long time'* (Fitzgerald et al., 2002: 1447), drew attention to the temporal nature of context. Such assertions emphasise the need to consider both an organisations' current context, and the historical contextual events which have influenced this. Finally, there has been a move towards examining the interrelationship between actors and context (Dopson et al., 2005a; Salaman & Storey, 2002).

> *Ultimately, the behaviour of the stakeholders and the features of context are interlocked. The combination of multilayered, two-way influences, multiple stakeholders with interpretative schemes, innovation-seeking behaviour by individuals and groups, and differing absorptive capacity in organisations produces a situation in which context is an actor.* (Fitzgerald et al., 2002: 1447)

Whilst the processual approach focuses on generating holistic and configurational explanations of outcomes, this approach has not been explicitly applied to consideration of context. However the processual approach does, in theory, recognise the interplay between inner and outer context. Specifically, Pettigrew drew on Giddens' (1984) structuration theory to emphasise the bidirectional interrelationship between agents and contexts;

> *Actions drive processes but processes cannot be explained just by reference to individual or collective agency. Actions are embedded in contexts which limit their*

> *information, insight and influence. But the dual quality of agents and contexts must always be recognised. Contexts are shaping and shaped.* (Pettigrew, 1997: 338)

The integration of this bidirectional view of context was identified as important by Dopson & Fitzgerald (2005a). For them, a unidirectional view of context created three difficulties. The first is in portraying organisations and individuals as passive recipients of contextual influences. The second is the fact that context is not treated in a configurational manner and the third is that context is perceived as static rather than as evolving and changing over time. Thus whilst the processual approach has made note of the bidirectional influence, the impact of this influence needs to be made more explicit within the approach. Caldwell (2006) noted the lack of a systematic concept of the potential or actual interrelationships between the internal and external environment. For him it is unclear from Pettigrew's work, *'where outer and inner context, process and context, begin and end. Processes are embedded in contexts, which produce processes and are reproduced by processes, which are in turn context dependent'.* (Caldwell, 2006: 75) For Caldwell, Pettigrew's definition of inner context presented it as an open-ended definitional construct, while also asserting the need to explore how structural constraints constrain action. Whilst he recognised that its purpose is to decrease the potential for determinism and reaffirm choice, Caldwell noted the difficulty in reconciling structure as a fluid concept, and structure as a constraint. This is particularly evident in the Irish health service, where identifying the location of the organisational boundary and defining the limits of context is difficult. This is particularly the case in voluntary hospitals, which are privately owned but government funded. In addition to government funding, political influence, national policy initiatives, the restructuring of the health system, oversight by the Health Service Executive make organisational boundaries unclear. Internally, in the hospital sector, the professionalized workforce, dual administrative and medical hierarchy, and an articulate but fragmented and less-knowledgeable consumer stakeholder group provide a very specific and sensitive context. On this basis Watson (2004: 8) asserted that *'one cannot understand change processes without considering context at the forefront, and not as a backdrop to change'.*

Whilst the above section has critiqued the conceptualisation of context in processual research, Dawson and Pettigrew's processual models of context did emphasise the influence of context upon change, and the need for longitudinal consideration of events: both significant contributions. In the former instance, context serves to build a bridge across macro and micro levels of analysis, facilitating what Weber & Glynn (2006) termed *'mechanisms based theorising.'* They described

mechanisms as *'small pieces of theory that specify how a specific input will reliably create a specific output.'* (Hedstrom & Swedberg cited in Weber & Glynn, 2006:1640) In healthcare, Pettigrew et al. (1992) identified the features of receptive contexts for change, and there are increasing attempts to identify the impact of different contexts on the success of change (Fitzgerald et al., 2002; Fitzgerald et al., 2006) While Fitzgerald et al. (2006) have recently identified the characteristics of context that impact change implementation in healthcare, Ashburner et al. (1996) noted that different factors may affect organisations across sectors. As a result, further research is required for the Irish context, with its public, voluntary and private hospitals. This section has raised the importance of considering context over time. The following section further explores the role of time and history in processual analysis.

Section 3.5: Role of Time and History in the Processual Approach

In conjunction with the content and context of the change process, time is the third founding stone of processual analysis. But what exactly does time mean in processual analysis? Two perceptions are explored here. The first perception is that of time as a timeframe of interest. The second perception of time refers to the temporal orientations of researchers and respondents.

> *Time itself sets a frame of reference for what changes are seen and how those changes are explained. ... The longer we stay with an emergent process and the further back we go to disentangle its origins, the more we can identify continuities.* (Pettigrew, 1987: 649)

Of the three approaches to integrating time and history into the study of processes outlined at the beginning of the chapter (historical investigation, MIRP and the processual approach) Pettigrew and Whipp (2001) noted that processual is the only one to integrate both real-time and historical components. With regards to real-time analysis Dawson (1994) emphasised that change should be studied as it happens, so that the processes and activities involved can reveal themselves over time and in context. To facilitate this, Dawson (1994) identified the three phases associated with organisational transitions: (1) the conception of a need to change; (2) the process of organisational transition and; (3) the operation of new work practices and procedures. These phases are illustrated in Figure 3.4 which emphasises the interrelated nature of the components of the processual approach. However, Dawson emphasised that the phases should not be treated as sequential stages. Rather he emphasised that change is comprised of complex and nonlinear events, which make it difficult to identify the beginning and end of change processes, as well as

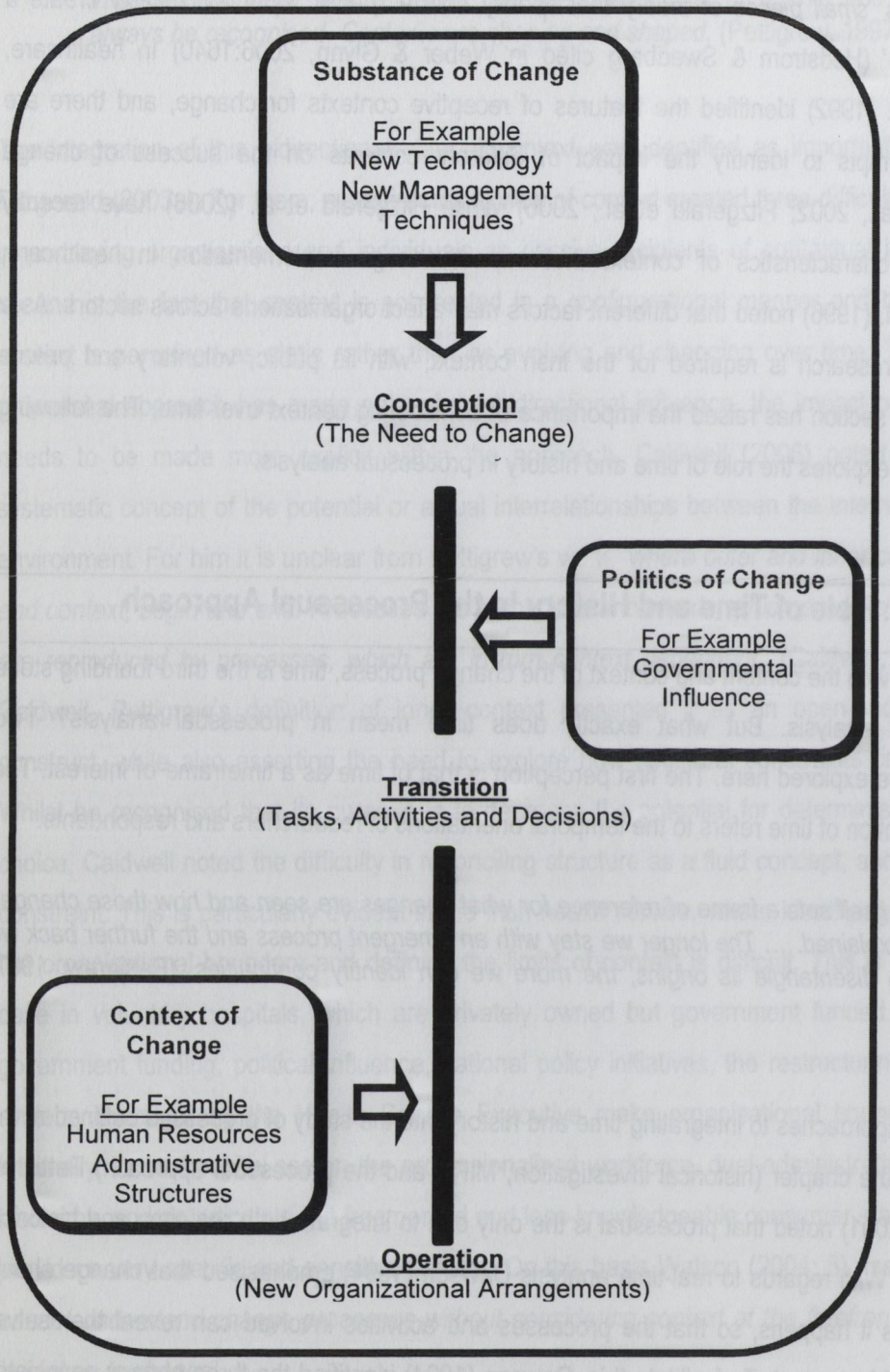


Figure 3.4: Dawson's processual framework (Dawson, 1994)

the intervening stages. As a result, he emphasised the need to understand how change processes are developed at critical junctures and the major determinants of change. *'Although in reality it is often unrealistic to talk of an "endpoint" of change (as the process continues ad*

infinitum) it does make sense to talk of the "effects" of a particular type of change' (Dawson, 1994: 40).

In an earlier development of these caveats Lovelady (1984a, 1984b) strongly criticised any emphasis on stages in change. *'The neat image of a project with a beginning, middle and end, designed in that way, has little basis in reality'* (Lovelady, 1984a: 10). Her work indicated that change processes are often premised upon interspersed bursts of activity (Lovelady, 1984b). Her empirical evidence suggested that many change projects do not end, and that the stages encountered in the change processes are less uniform than is traditionally presented in the literature. In critiquing models such as Dawson's she noted that *'a model, whilst it may be intended as a simplified version of reality, must be a close representation of the process to be helpful'* (Lovelady, 1984a: 3) In contrast she noted that the phases of a change process overlap, are untidy and do not follow a pattern of stages and uniform order. She used the analogy of the links in a chain to illustrate this. This emphasised the circuitous nature of change processes, the constant need for reappraisal and review, and the fact that the process of change, unlike time, is not linear or uniform in stages. As a result, for Lovelady (1984a) it was more appropriate to speak of *'creating'* or *'evolving'*, rather than *'planned'* or *'managed'* change.

Next, the possible temporal orientations of researchers and respondents and their implications are considered. Tuttle (1997) asserted that differences in temporal orientations among researchers and organisational informants should be considered because time concerns are central to management and organisational processes.

> *Because processes are comprised of a series of activities spanning a period of time, differences in what that period of time means to researchers and organisational informants may pose a threat to the validity of research methods and findings.* (Cook & Campbell cited in Tuttle, 1997).

A core part of processual research is representing a period of time in terms of change management or other activities (1997). For Tuttle there is potential to improve the quality of processual research by ensuring that the temporal aspect of research design is correct so that elements of the process under consideration are not misunderstood or missed (Tuttle, 1997). Tuttle (1997) identified four broad categories which can be used to consider an individual's orientation to temporal issues. These are (1) physiological time, (2) objective time, (3) psychological time and (4) socially constructed relative time. The third category, psychologically relative time is of particular concern in processual research. This refers to the flow

of time as experienced by the individual and suggests that individuals possess unique orientations to the past, present, and future. At role level this may manifest in terms of whether the individual focuses on short, medium, or long-term goals. In addition, as change tends to be one of competing priorities, different amounts of time and attention may be afforded to a project by different respondents.

Ensuring an understanding of both the respondent's and researcher's orientation may impact on the outcomes of analysis. Tuttle provided an example of how this could transpire in practice if a researcher with a strong orientation to the present and future explored a strategic planning process without acknowledging the CEO's strong orientation to the past. The degree to which processual research is affected by differences in temporal orientation among the researcher and organisational respondent will be a function of several factors including the degree of incongruence and the level of tension or conflict arising from it.

Thus far the chapter has provided a conceptual overview of the processual approach, which has been considered as an emerging theoretical framework for understanding change. The chapter has illustrated that the approach goes a significant way towards addressing three of the key concerns (Pettigrew et al, 2001) in change-related research, through the examination of multiple contexts and levels of analysis; the inclusion of time, history, process and action; and linking change processes to outcomes. Having outlined the three variants on the approach, the chapter has focused on that proffered by Pettigrew (1987, 1990) and discussed the role and meaning of its three cornerstones – the process, content and context of change, as well as the role of time and history. Whilst the focus of the chapter to date has been predominantly discursive, the next section focuses on critiques of the processual approach.

Section 3.6: Critiques of the Processual Approach

Whilst the limitations of the conceptualization and analysis of context in the processual approach have been outlined in Section 3.4, with regard to recent developments in the literature on context, further critiques of the processual approach are addressed in this section. The processual approach has been criticised for being overly complex, making it difficult to extract practical recommendations. More recently, it has been criticised for moving away from theory generation, towards a concern with more applied problems, in what Ferlie & McNulty (1997) termed a *'theoretical routinisation'* process. In a similar vein, though utilising a different thread of argument,

the approach has been criticised for lacking a critical edge. Finally, the approach has been reproved from inverse perspectives, firstly for sidelining people, and secondly for having an over-focus on micro-dynamics. The latter criticism asserts that the approach has therefore failed to account for macro-dynamics and particularly the relationship between organisation structure and change.

> *While most writers of a critical bent would tend to accept that Pettigrew offers a useful and valid framework for the analysis of change and its management, some have observed an imbalance in Pettigrew's work. It has been observed, for example, that whereas Pettigrew quite correctly observes that matters of theory and practice are inseperable and indivisible, the theoretical, conceptual and methodological elegance of Pettigrew's work seems to have been purchased at the expense of practical advice and practitioner relevance. (Read cited in Dawson, 2003:19)*

Dawson (1994) noted that while the approach provides rich data on the basis of its multilevel analysis, this can also lead to difficulties in interpretation for non-academic practitioners who want simple and practical tools on which to act. Buchanan and Boddy (1992) and Caldwell (2006) were similarly skeptical of Pettigrew's approach for its ineffectiveness as a source of pragmatic advice for managers. However, while Buchanan and Boddy (1992) remained critical of Pettigrew's work on this basis, Dawson (2003) asserted that it was not Pettigrew's intention to offer managerial advice, and that the approach has been used successfully in executive teaching and consultancy. In addition Dawson (2003) asserted that it is both possible and valuable to use this approach to identify practical recommendation on how to manage change. Dawson (1994) felt that his variation on the processual approach addressed some of these concerns, being focused on both gaining a clearer understanding of the process of transition, and also on developing a set of practical guidelines for the management of change. In addition the criticism regarding the lack of practical recommendations for managers emerging from the approach seemed exaggerated in light of key studies such as Pettigrew and Whipp (1991b), Pettigrew, Ferlie, and McKee (1992) and Fitzgerald et al. (2006), where there was little translation required to make the research findings of benefit to managers.

Finally, critiques regarding practical application may decline with the change in emphasis towards pragmatic output identified by Ferlie and McNulty (1997), due to the emergence of a market for practitioner-oriented research findings in the UK. However, they argued that theoretical routinisation has emerged as a by-product of this shift. Theoretical routinisation refers to a move away from the generation of new theory and towards a concern with more applied problems. This development has some inherent trade-offs, and is unwelcome in some quarters (Dawson, 2003).

In an assertion which further undermined criticism regarding the practical application of processual research, Ferlie and McNulty (1997) suggested that the outcomes of processual research have particular appeal to certain management groups, meaning that it may have been *particularly* affected by theoretical routinisation.

> *Small scale personal scholarship may be giving way to specialist teams of contract research. Traditional forms of provider led and curiosity driven research appear to have declined, with an increasing emphasis on purchaser led criteria of output, "deliverables", and target realisation. There is pressure for greater researcher involvement in the policy process, and for shorter term, more action oriented research governed through contract.'*(Ferlie & McNulty, 1997, p. 367)

Funder deadlines and a pragmatic orientation to research have eroded time available to consider broader theoretical debates surrounding research. While Dawson (2003) was voiciferously critical of this development, the process has led to larger scale, more methodologically rigorous studies. As a result Ferlie and McNulty called for a measured return to theory. The differences between individual and market-oriented processual studies are outlined in Table 3.2.

Table 3.2: Changes in the Organisation of Process Research (Ferlie & McNulty, 1997: 370)

	Individual processual studies	**Market oriented processual studies**
1. Macro mode of organisation	Professional college	Marketisation plus managerialisation
2. Labour Supply	Tenured core	Contracted periphery
3. Financial flows	Grant	Contract
4. Orientation of researcher to partners	Inwards facing	Outwards facing
5. Micro mode of organisation	Individual scholar	Multidisciplinary ad hoc team
6. Alternative providers	*Few*	Many

Ferlie and McNulty assert that the tendency for funders to shape the nature of the output has increased. In addition, monitoring and reporting requirements have tightened, with researchers

expected to produce output on time and to specification. Table 3.3 below outlines changes in the character of process knowledge due to the change in funding experienced. This particularly illustrates the increased focus on provider user-friendly and pragmatic rather than theoretical output.

Aligned to the issue of theoretical routinisation is a critique of processual research as lacking a critical component. Specifically, Knights and Murray (1994) were critical of Pettigrew's tendency to accept management strategy as unproblematic and failing to criticise the political process of social construction. Similarly Dawson (2003) cited Alvesson and Willmott (1996) who were critical of Pettigrew's support for the status quo and failing to engage in critical scrutiny of change, by assuming established priorities and values to be legitimate. However, Pettigrew's emphasis on studying processes at a number of levels facilitates the emergence and exploration of divergent perspectives.

Table 3.3: The Shift from Individual to Market Oriented Process Research: Changes to the Character of Process Knowledge Generated During the Research Cycle (Ferlie & McNulty, 1997: 377)

Indicator	Individual	Market oriented
1. Problem definition	Lower lay involvement	Higher lay involvement
2. Theoretical base	Higher level	Substantive Theory
3. Quality of specification of research design	Lower concern	Higher concern
4. Methods	Standard	Standard
5. Access to sites	More problematic	Less problematic
6. Empirical database	Smaller scale	Larger scale
7. Control over publications	Lower lay involvement	Higher lay involvement
8. Concern for knowledge diffusion	Lower	Higher
9. Concern for implementation	Lower	Higher

In combining some elements of Pettigrew's perspective in terms of an emphasis on context and processs, with a more critical conceptualisation of politics, Knights and Murray (1994) developed what they term *'a critical processual perspective'*. Knights and Murray(1994) asserted that while Pettigrew's processual process does recognise sociopolitical processes, *'it tends to view conflict and resistance as potentially disruptive to the smooth and rational management of an organization.'* (Dawson, 2003). Similarly Dawson (2003) differentiated his approach on the basis of exploring the experience of change for a variety of different employees, rather than focusing on the role of senior managers. Dawson commented that while Pettigrew would argue that he doesn't view politics as pathology, he focuses on higher levels of management where major decisions are made. In addition, Dawson (2003), Buchanan and Boddy (1992) and Burnes (2000) were critical of the approach for marginalising the role of the individual change driver and agent. However, for Watson (2004) bringing context to the forefront of considering change leads to recognition of the role of actors in change, serving to alleviate this critique. Nonetheless, the focus on multiple cases and generalisable findings have led to a decline in the focus on individuals in Pettigrew's work. This is an unfortunate opportunity cost that can be rectified through careful methodological design, if desired. Similarly, the justified critique regarding the focus on senior management can be rectified through research design.

In a reverse critique Caldwell (2006) criticised *'processual analysis'* for its failure to sufficiently explore the reciprocal relationship between organizational structure and change. For Caldwell, Pettigrew separated the process of organisational change from any system reference points to organisational structure, meaning that structure and organising are presented as processes of microbehaviour. Caldwell noted that this leads to the presentation of organisational change as *'incrementalism with transitional breaks'*. For Caldwell this undermines understandings of order and continuity in change processes, as well as discontinuity and transformational change.

Similarly, Caldwell (2006) asserted that the focus on organizational politics and micropower relations leads to the neglect of organisations as broader entities involved in larger patterns of resource allocation, normative regulation, and mediation of professional expertise. In a related vein, Trade Unions and other formal institutional perspectives, are underrepresented in Pettigrew's work, as the data is predominantly collected from inside organisations.

Having outlined and addressed some of the critiques of the approach, the chapter concludes with an overview of its associated benefits.

Section 3.7: Benefits and Conclusions

The processual approach is of benefit from practical and analytical and standpoints. From a practitioner standpoint, the NCCSDO (National Co-ordinating Centre for NHS Service Delivery and Organisation R & D, 2001) asserted that the approach is a reminder that change is influenced by historical, cultural, economic, and political factors. In addition, by linking findings to outcomes, it has been used to provide pragmatic guidelines to managers (National Co-ordinating Centre for NHS Service Delivery and Organisation R & D, 2001).

From an analytical perspective, Pettigrew (1992) asserted that the distinctiveness and benefit of process research derive from its link to outcomes and its focus on describing, analysing, and explaining patterns in management. Providing an analytical framework that emphasises pattern identification and holistic explanations, it also has the capacity to illuminate why, when, and how policy and other change outcomes are shaped by processes and contexts. As a result processual analysis goes beyond presenting case histories to producing case studies (Pettigrew, 1997). In addition, for Dawson, (1994) the analytical benefits of the processual approach include understanding how processes and activities evolve in context, and gaining insight into how critical events in the process of change can hasten, impede, or redirect the route of change. The approach also has the capacity to accommodate a number of competing histories on the process of change (which may be further refined, replaced, or developed over time). The latter is particularly important as the official characterisation of change may represent the political position of certain key individuals, rather than the organisational reality. Aligned to this, Dawson noted that the approach can identify when internal and external determinants of change don't have equal explanatory significance at all stages of the change process.

Chapter 1 has provided a systematic overview and critique of the change literature, which is the primary context in which the research is embedded. As the processual approach goes a significant way towards addressing several of the critiques of change-related research raised, it has been identified as an appropriate framework for this research and discussed in this chapter. The conceptual priorities in this study are closely aligned to those in the processual approach – the research is concerned with how processes of service-improvement are enacted through individuals, who act within role-related and contextual constraints. As a result, the study explicitly attempts to address the critiques of the processual approach pertaining to context. Specifically, in

analysis, the study has attempted to consider context in patterns of causality, rather than in a background explanatory role. In so-doing, the study has also taken account of the developments in the conceptualization of context, outlined in Section 3.4, considering combinations rather than individual factors and the interplay between inner and outer context. The findings presented from chapter 7 onwards support the value of this endeavour, which is a methodological contribution of the study.

At the outset of this chapter, processual research was defined in contrast to what were termed '*traditional ahistorical, acontextual, aprocessual*' approaches to change. In writing about methodology, George C. Homans (cited in Pettigrew, 1973) remarked that *'it is a matter of strategy, not morals'*. Whilst, like most, the processual approach is subject to criticism, it does address several of the major concerns in change-related research. Crucially, it also emphasises the key dimensions of concern in this research—the history, context, and process of change. Thus, in conjunction, chapters 1 and 3 have led to the creation of a framework for this study. This framework has informed data collection and analysis, discussed in chapter 6, and the structure of the thesis. The remainder of the literature review explicitly addresses the context, content and process of service-improvement in hospitals in Ireland. Specifically, the next chapter outlines the history and context of the Irish hospital sector. Later, chapter 5 returns to a concern with process—exploring the roles and relationships through which change processes are enacted in hospitals. Both chapters provides further insight into the difficulty of change in healthcare organisations, the complexity of the Irish hospital context and the value of the processual approach in addressing these issues.

Chapter 4: Context

Introduction

The purpose of this chapter is to provide an overview of the historical and contemporary context of the Irish acute[5] hospital sector, in accordance with the processual orientation adopted in the research. To this end, the chapter draws upon the definitions of context provided by Dawson (2003) and Pettigrew (1987, 1997), outlined in chapter 3. Context includes *historical* and *current* events, inside and outside of organisations (Pettigrew, 1987, 1997). As a result, the chapter begins with an overview of the historical development of Irish hospitals, charting the emergence of these organisations as non-profit (voluntary)[6] and public hospitals, and the later addition of private-sector hospitals. This history leads into a critical discussion of a contemporary debate in the Irish hospital sector, regarding the increasingly blurred nature of the boundaries between private, public and voluntary organisations. As well as being embedded in the historical context, this blurring has been further precipitated by the recent advocacy of 'New Public Management'.

Adopting a contemporary focus, the second section of the chapter outlines the current *external* context of the acute hospital sector. As there is significant overlap between the definitions of context provided by Pettigrew (1987, 1997) and Dawson (2003), a combination of factors, derived from both, are considered. Extensive consultation with the literature and experts in the area identified seven key external contextual factors, pertinent to the research. These are (1) changing social expectations; (2) the new public-management movement, and how it has been adopted in Ireland; (3) health-service reform in Ireland; (4) the availability of resources; (5) the expansion of the private hospital sector, leading to increased competition for staff; (6) the general context for service-improvement in Irish hospitals and; (7) the cardiovascular strategy, which is the immediate external context of the research. These issues have pan-hospital relevance.

Finally, as per the processual definition of context, the third section of this chapter addresses current *internal* contextual factors. As the specific internal context of each case is discussed in chapter 7, this section provides a broad overview of macro dynamics in the internal context, with particular attention to the literature on the full variety of administrative structures, which emerged

[5][5] Acute hospitals are those intended for short-term medical and/or surgical treatment and care.

[6] Voluntary hospitals are privately owned and governed organisations that have become largely government funded in a progressive development since the 1960s.

as important during data analysis. The section specifically examines (1) governance systems; (2) strategic management; (3) administrative and operational management; (4) the role of the HR function; (5) accounting and service-planning systems and; (6) the provision of private healthcare in public and voluntary hospitals. Reflecting the paucity of the health service management knowledge-base in Ireland, outlined in the introduction, there is little specific Irish literature pertaining to the first five of these themes.

Of particular relevance to the content of this chapter are the recent additions to the literature on context, outlined in Section 3.4. These note that organisations, and their change processes, are affected by *configurations* of contextual factors (Dopson & Fitzgerald, 2005; Fitzgerald et al., 2006a), thus moving away from considering cause-and-effect relationships and towards considering combined rather than individual factors as significant sources of influence. Although, for the purpose of clarity, factors are discussed in isolation in this chapter, attention turns to considering combinations of factors in the analysis section. Immediate attention now turns to the historical context of the acute hospital sector in Ireland.

Section 4.1: The historical context of acute care in Ireland

In 2004, there were 22 voluntary and 38 public acute hospitals in operation in Ireland (Department of Health and Children, 2005). In 2006, there were sixteen private hospitals, up from twelve in 1998 (IIMD, 2006). The first additional private hospital in more than twenty years was built in 2004, with ten more private hospitals planned in mid 2005 (Shanahan, 2005).

Public hospitals are administered by the Health Services Executive (HSE), and financed by state funds. Voluntary hospitals have widely variable management and ownership structures. Some are owned and operated by religious orders, while others are incorporated by charter or statute, and work under lay boards of governors. Voluntary hospitals are financed to a large extent by state funds (Department of Health and Children, 2003b, 2005). Finally, private hospitals receive no direct state funding and are independently owned and governed.

The composition of the Irish hospital sector has changed over time, with state involvement increasing significantly since the 1960s. The most recent development in the acute hospital sector is governmental advocacy of private hospitals, with associated tax-breaks encouraging development (Wall, 2005). As a result, in accordance with the numbers presented above, the

proportion of private hospitals is increasing. Until 2000, most private hospitals operated on a non-profit basis, however this situation is now changing (Nolan & Wiley, 2000), as a result of the above developments. This section begins with a historical overview of acute hospital services in Ireland. It becomes evident that voluntary hospitals, and voluntary activity in public hospitals, have historically been the bedrock of hospital care in Ireland. However, the fact that voluntary hospitals are now mostly state-funded raises several issues. These include the function of voluntary organisations in Irish society today; levels of autonomy in mostly state-funded voluntary hospitals; and related debates regarding the blurring boundaries between private, public and non-profit organisations.

4.1.1 Historical overview

Adopting a historical focus, Irish hospital activity can be divided into voluntary and state-led provision. Within the voluntary component, Donoghue (1998) identified two strands of provision, divided along religious traditions and corresponding to time periods before and after the Catholic Emancipation Act of 1829. The Emancipation Act facilitated Catholic religious involvement in Irish society, which had been illegal previously. As a result, voluntary provision prior to the Act is associated with Protestant's and Quaker's, who provided charitable assistance to the poor and needy. By 1753 Protestant and Quaker-led movements had established five voluntary hospitals that provided for the medical needs of the poorer population, as well as providing an arena for medical training. These were primarily lay endeavours (Donoghue, 1998).

The second strand of voluntary health provision was driven by Catholic religious orders, and emerged in the wake of the Catholic Emancipation Act. Voluntary hospitals opened during this wave of development were predominantly placed in highly populated areas. They have since developed to become some of the major acute general hospitals in operation in Ireland today (Simons et al., 1998). The main religious orders that were active were the Irish Sisters of Charity, the Sisters of Mercy and the Brothers of the Hospital Order of St. John (Simons et al., 1998).

Hospital care in rural areas was, and continues to be, predominantly provided through state-founded and run Health Board Hospitals. The earliest roots of the Health Board hospitals can be traced to the 1765 County Infirmaries Act (Simons et al., 1998). This Act was the first parliamentary government attempt to provide healthcare and led to the establishment of hospitals in each county. These hospitals were known as County Infirmaries and were open to the public. In addition, The Poor Relief (Ireland) Act of 1838 led to the building of workhouses, which often

developed into hospitals due to the poor health of their populations. Although established by the state, these institutions were primarily staffed and run by religious orders. By 1900, eighty-four workhouse hospitals were being run by nuns (Luddy, 1995 in Donoghue, 1998). Religious assistance in the operation of state-founded hospitals endured until the 1960's.

After the establishment of the Irish state in 1922, in 1923 the Local Government (Temporary Provision) Act, changed the classifications of workhouse and county hospitals, re-establishing them as county and district hospitals. These classifications endure to this day. The Act also made the local authority hospitals the responsibility of regional Health Boards (Simons et al., 1998). The establishment of the Irish state led to an enhancement of the role of the Catholic Church in health, as well as in education and social services (Donoghue, 1998). The increased role of the Catholic church was linked to the Catholic principal of subsidiarity (Mulvihill, 1993 in Donoghue, 1998), whereby the family had primary responsibility for providing for the needs of its members, with residual needs met by the community. In practice, Catholic religious bodies acted as a proxy for the community, and met shortfalls in health and social welfare. The strength of the Catholic Church in Ireland, and their influence on social policy-making, was made particularly salient by one initiative which challenged the subsidiarity principle (Barrington, 1987). The 'Mother and Child' debate was centred on the provision of free prenatal and postnatal care and the provision of free medical care to children under 16, without a means test. The debate occurred between 1945 and 1951, and was a central issue in the fall of the inter-party government of that time (Browne, 1986).

The ideological shift away from subsidiarity in the second Vatican Council (Vatican II) in 1963, facilitated the endorsement of state adoption, of previously voluntary, roles and responsibilities (Donoghue, 1998). Vatican II proved a crucial turning point in the development of the hospital sector, leading to a shift from a Church to a state-led service, and precipitating the inter-linkage between the public and voluntary elements of hospital management. Since Vatican II the Irish state has become the primary funder of hospitals and healthcare. Reflecting this shift, the role of the state in the provision of healthcare was increasingly codified into statute during the 1960s and 1970s. The 1970 Health Act, which made regional health authorities responsible for providing and coordinating health services, was particularly central (Donoghue, 1998). The advocacy of partnership between voluntary hospitals and the state is more recently evident in the 1997 Green

Paper[7] (Department of Community Rural and Gaeltacht Affairs, 1997), entitled *Supporting Voluntary Activity,* which states that the activities of the voluntary sector complement those of statutory agencies, and that relationships between the two should be supported and augmented. In response, in 2000, a white[8] paper provided for a range of funding measures to support the community and voluntary sectors (Department of Community Rural and Gaeltacht Affairs, 2000).

The key point of this section is that both the voluntary and health-board hospitals have their early foundations embedded in the voluntary non-profit tradition. Many of today's health-board hospitals were once run by voluntary religious orders as county hospitals, while many voluntary hospitals were both established and run on a voluntary basis. In spite of this, the ideological shift inherent in Vatican II has led to the current situation whereby the public sector aspect of hospital management is dominant. Nonetheless, there remains a classificatory division between voluntary and health-board hospitals: although the staffing and operations of both are state-funded, voluntary hospitals remain privately owned and in possession of independent boards. The decreasing autonomy of voluntary hospitals and their strained relationship with the state since the 1940s is discussed in the next subsection.

4.1.2 Declining autonomy in voluntary hospitals

Two threats to voluntary hospital autonomy have been identified. The first is increasing dependence on non-voluntary funds while the second concerns decreasing control over staff appointments.

The most significant perceived threat to voluntary-hospital autonomy was financial. The deficits in voluntary hospitals increased greatly from the 1940s, which Meenan (1995) attributed to (1) the increased demand for hospital services; (2) rapid developments in medicine and technology leading to the requirement for expensive equipment; (3) an increase in the number of medical and ancilliary services during the 1930s and 1940s; (4) a decline in funds from charitable sources. By the end of the 1960s Meenan notes that the state paid for most of the voluntary hospitals' deficit of £5,000,000 per annum. For Meenan the advent of the 1953 Health Act, which led to the extension of hospital services to most of the population at nominal charge, exacerbated the dependence of voluntary hospitals on state funding.

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[7] A green paper is a tentative government report without any commitment to action; the first step in changing the law. A green paper may result in the production of a white paper.

[8] "White paper" is an informal name for a parliamentary paper enunciating government policy

> *Over the next forty years conflict periodically erupted, as more and more of the population were given free medical services, whether the facilities were available or not. The increased costs meant that the voluntary hospitals had to be subsidised by the State to provide the services. This resulted inevitably in the erosion of the hospitals' independence – a process that is still continuing.* (Meenan, 1995: 151)

The second challenge to the autonomy of the voluntary hospitals concerns staffing. Comhairle na nOspideal was established under the 1970 Health Act to advise on the number and type of consultant appointments in all voluntary and health-board hospitals. Since that time, all hospitals have had to obtain its consent before appointing specialists. A further challenge to the authority of the hospitals to appoint their own staff emerged from medical schools, under pressure from the American Medical Association, which wanted a similar structure to their own before recognising graduate training. Thus the universities gained power to appoint professors, lecturers and tutors in 1957.

In addition to encroachments on autonomy, Meenan (1995) noted that beginning in the 1970s a decline in vocations led to increased dependence on lay workers in voluntary hospitals. He also noted the increasing public sentiment that, as voluntary hospitals are now almost entirely subsidised by the state, the religious orders shouldn't be able to impress their ethos on the hospitals they own and manage. This follows Donnelly-Cox and O'Regan's (1999) assertion that long-established, state-funded voluntary organisations *'will effectively appear as an agent of or for the State. Many in the general community may be unaware of its independent and voluntary status. Majority finance will be government supplied'.*

Overall, the development of the Irish hospital sector is indicative of the general trend towards increased interdependence between the state and non-profit organisations (Salamon, 1995; Skelcher, 2005). This is described at the policy level as 'partnership' (Department of Community Rural and Gaeltacht Affairs, 1997). It has been illustrated that this shift towards partnership and interdependence has occurred since the late 1960s, precipitated by a change in ideology of the Catholic Church and an associated increase in state-funding. Thus, although interdependence theory (Anheier, 1999) suggests that non-profit organisations precede government due to initially decreasing transaction costs, and develop relations with the public sector because of 'voluntary failures', the shift in this case was caused by a change in ideological stance. Donoghue (1998) classified the shift in the provision of healthcare as a move away from a liberal model with a strong element of corporatism, towards a more social-democratic model with a state-sponsored, if

not wholly delivered, social welfare and health system. This occurred in tandem with statutory recognition and codification of the state's role in service provision. Thus, historically, health is a field in which voluntary organisations have undertaken significant activity although their role in service funding and provision has been eroded since the 1960s. Outstanding differences between public and voluntary hospitals are predominantly evident at the board level, with voluntary hospitals possessing independent boards, and public hospitals governed through regional HSE structures. However autonomy is increasingly subject to challenge (O'Ferrall, 2000).

The Irish health sector provides a historical example of what Salamon and Anheier (1999) termed the search for a 'middle-way' between relying solely on the state or the market. However, the balance of emphasis is increasingly shifting towards state provision. This can be explained using Welfare State Theory. This theory's premise is that as the welfare state expands, non-profit organisations are crowded out by the provision of public goods. In support of this thesis, healthcare funding has increased by 225% from 1997 to 2002[9], in line with improvements in Ireland's economy.

The issues raised in this historical overview are multiple. Firstly, the function of voluntary hospital organisations in Irish society is raised, particularly given increased state responsibility for healthcare, post Vatican II. Secondly, the issue of whether the boundaries between sectors have been blurred is raised. As a precursor to considering blurring of boundaries between sectors, the function and definition of voluntary hospitals as non-profit organisations is outlined below.

Section 4.2: Positioning Irish voluntary hospitals in the non-profit sector: Function and definition

This section outlines the array of functions and definitions of non-profit organisations, and considers how Irish voluntary hospitals can be positioned with regard to both.

4.2.1 Functions and definitions of non-profit organisations

There are five dominant structural patterns evident across international non-profit sectors (Salamon et al., 1999). These are (1) education, (2) health, (3) social services, (4) culture and recreation and (5) balanced models. The education-dominant model is attributable to the

[9] Derived from Department of Health and Children report (2003b: 258)

prominent presence of religious involvement in education, and is particularly evident in Latin America and Ireland. However Donoghue (1998) identified debate in the Irish context as to whether national schools are part of the public sector, particularly as teachers are paid directly by the state. A similar case can be made about voluntary hospitals, which are predominantly funded by the state. The contribution of these public-sector type organisations to the voluntary sector is substantial. The entire Irish non-profit sector generates income of €4.12 billion per annum, which accounted for 8.2% of GNP in 1998, and 9.3% of GDP (Donoghue, 1998). Total employment in the sector is 125,600, with 33,700 volunteers. Excluding schools and hospitals this income drops to €1.5 billion, and employment to 32,000. Thus, Ireland's non-profit sector is dominated by the public sector. This is further reflected in the fact the three quarters of non profit revenue is generated from public sources in Ireland, while the European average is 55% (Donoghue, 1998)

The five patterns of sector development can be related to heterogeneous demand, ideology, information asymmetry and the nature of the welfare regime (Anheier, 1999)[10], as well as the different roles fulfilled by the sector (Donnelly-Cox, 1998). Of the five roles of the sector identified (O'Regan, 1998), Donnelly-Cox (1998) asserted that (1) *'the delivery of services, often in conjunction with the state'*, as well as (2) *'the identification and addressing of new societal needs'*, are functional roles, requiring organisational and managerial level action. In contrast, (3) *'maintaining and changing the value system in society'* and (4) *'mediating between the individual and the state'* are not related to specific activities carried out by particular organisations. Finally, the fifth role is (5) *'providing a forum for the social construction of individual meaning'*, and is presented as a precursor to the previous four roles. The delivery of services in partnership with the state is the role that the Irish healthcare sector primarily fulfils. The next subsection considers definitional criteria for non-profit organisations, both internationally and nationally. These criteria provide a basis for considering whether Irish hospitals can still be considered voluntary organisations in spite of their governmental funding, and whether the boundaries between the public and non-profit sectors are blurring.

The breadth of the non-profit sector is reflected in the multiplicity of terms used to describe organisations that work outside of the public and private context. These include 'third-sector', 'community', 'voluntary', 'charity' and 'non-profit'. In Ireland, non-profit organisations are most commonly called community and voluntary organisations (Donnelly-Cox & Jaffro, 1999;

[10] These explanations are derived from Anheier's (1999) discussion of heterogeneity theory, supply-side theory, trust theory, interdependence theory and social origins theory as bases for explaining the existence of non-profit organisations.

Donoghue, 1998), although this does not reflect the full range of organisations in operation. The diversity in nomenclature is reflective of the variety of ways in which non-profit organisations are defined. The two most commonly adopted definitional criteria are 'purpose-based' and 'structure and operations based', with many countries adopting some combination of the two. The Irish state used a purpose-based definition to define the sector.

A prevalent entrée into the international non-profit sector is the Johns Hopkins definition of non-profit organisations (Salamon et al., 1999). This focuses on the structure and operations of organisations, and was developed to enable comparative treatment of sectors (Donoghue, 1998). It presents non-profit organisations as formal, private, non-profit distributing, self-governing and having meaningful voluntary activity, if only at the board level. Thus non-profits must be institutionalised rather than ad hoc groupings. They must also be separate from the state and internally controlled.

In the Irish context, the current nonstatutory definition of a charity is primarily concerned with the purpose rather than the structure of the organisation, and is premised on case-law and common-law interpretations. These are used to determine whether an organisation is entitled to tax exemption under the 1997 Taxes Consolidation Act. However, the recent publication of the Charities Bill (Department of Community Rural and Gaeltacht Affairs, 2007), which has yet to be ratified into law, will provide a statutory definition. The bill aims to enhance accountability and transparency, and will provide a definition of 'charitable purpose' in legislation. The definition of charitable purpose is to be based on an organisation having an exclusive charitable purpose and aiding the public, rather than having any particular legal form. Charitable purposes are to include,

- The prevention or relief of poverty or economic hardship;
- The advancement of education;
- The advancement of religion;
- Any other purpose that is of benefit to the community, which includes the promotion of health, including the prevention or relief of sickness, disease or human suffering.

The Bill reflects and extends existing nonstatutory requirements because there is an explicit desire to maintain congruence between any new statutory definition and organisations with existing charitable status.

4.2.2 Classifying hospitals as non-profit organisations

Under Irish criteria, voluntary hospitals can be defined as non-profit organisations. However, as the second Johns Hopkins criteria, that of being private, requires hospitals to be institutionally separate from government and maintain autonomy (Donoghue, 1998), defining voluntary hospitals as non-profit under these criteria is less straightforward. In particular, the historical outline provided above indicates that hospitals are now operating on the boundaries of the public sector, receiving the vast majority of their funding through government. This may be problematic: Donoghue (1998) noted that the receipt of significant state funding can undermine autonomy. Voluntary hospitals are also somewhat constrained in levels of recruitment and the allocation of funds, required to be in-line with service-plans submitted, further obscuring consideration of their autonomy. This issue is exacerbated by the lack of clarity regarding *sufficient* levels of autonomy. An additional Johns Hopkins' criteria, that of meaningful voluntary activity, is limited to the board level in hospitals.

This section has provided a brief overview of the defining criteria of non-profit organisations in an international and Irish context. From an Irish perspective, and from the standpoint of purpose-based definitions, Irish voluntary hospitals can be classified in the non-profit sector. However, there has been no research exploring whether Irish voluntary hospitals retain what Salamon and Anheier (1999) described as the requisite autonomy to be classified as voluntary organisations, and significant evidence of factors that could undermine such autonomy. Thus a definitional issue remains with regards to structural-operational criteria. Having explored the functions and definitions associated with Irish voluntary hospitals, Section 4.3 explores debate about the blurring of boundaries between private, public and non-profit organisations, a theme which has been raised in this section about public and voluntary organisations.

Section 4.3: Blurring boundaries in the hospital sector?

The line between "private" and "public" has now become so blurred that it is difficult to tell where government leaves off and private business begins.'

-Nigro and Nigro, 1973 in Greenwood and Wilson, 1993, 7-8)

There is much contention regarding the blurring of boundaries between private, public and non-profit healthcare organisations. Whilst debate regarding blurring has been particularly sustained in the U.S. (Marmor, Schlesinger, & Smithey, 1987; Schlesinger & Gray, 2006), there is broad international debate concerning the *'fading distinctions among the non-profit, government and for-*

profit sectors' (Ferris & Graddy, 1989) in healthcare (Sloan, 1998) and more broadly (Davies, 2005; Palmer, 1996). Broad debates are outlined in Appendix 1. These debates are particularly prevalent in the U.S., which is faced with structural change in the hospital sector (Ferris & Graddy, 1999), and in Canada (Birdsell, 2001)[11]. In the U.S., this topic is controversial (Marmor et al., 1987; Schlesinger et al., 2006), with some expressing convergence as the dominant theme, and others emphasising divergence. This reflects broader conflict in the debate regarding the blurring of the sectors, which has been attributed to different foci across disciplines, overgeneralisations caused by strong disciplinary orientations, vague definitions and poor choice of samples (Rainey & Young, 2005). Similarly, in finding that most assessments of hospital ownership assert that it is largely irrelevant, Schlesinger and Gray (2006) counter with the assertion that,

> *These assessments are misleading, reflecting a literature that is fragmented along disciplinary lines and in which empirical models are sometimes specified in ways that obscure rather than illuminate ownership-related differences.* (Schlesinger & Gray, 2006: 398–9)

Two consistent findings emerged from Schlesinger and Gray's systematic (2006) review. The first found non-profit hospitals to be more efficient than for-profit hospitals, with the difference in efficiency increasing with the size of the hospital. Secondly, less fraudulent behaviour was evident in the for-profit context. A key issue raised by Schlesinger & Gray (2006) is the need for clear criteria about what constitutes a meaningfully large difference in levels of performance. This is important in a context where the behaviour of hospitals across sectors has become more similar due to increasing similarity in their funding sources (Ferris et al., 1999). Underpinning debate regarding what Coston (1998) termed the 'complex mingling' between sectors, is an increasing acceptance of partnership between the public and non-profit sector, though within this relationship there may be a power asymmetry in favour of government.

In this research, an important consideration was whether to differentiate between hospitals on the basis of sector. The decision to differentiate was premised on a lack of clarity regarding convergence, and was influenced by theoretical debates and research output at the organisational and sector level. Specifically, debates concern the autonomy of voluntary

[11] Both the U.S. and Canada share the public/private/non-profit mix in healthcare provision with Ireland (Sloan, 1998; Klatt, 2000) Canada is similar to Ireland in having predominately publicly funded healthcare (70%) provided through mostly non-profit and state hospitals, with the remaining 30% paid for by the individual or via private health insurance (Klatt, 2000). Similarly 60% of short-term general hospitals in the U.S. in 1994 were non-profit, 12% were private and the remaining public. In Ireland 54% are public hospitals, non-profits are 35% and private are 11% (Sloan, 1998).

hospitals, and whether management practices are converging or diverging across hospital types. For Marmor et al. (1987) while factors other than the legal form of organisation – whether non-profit, for-profit or governmental – have dominated discussion of the medical landscape, *'there do appear to be systematic, ownership-related differences in the practices of health institutions. It thus seems reasonable to consider such differences as the basis for some public policies in the health industry'* (Marmor et al., 1987: 234). A caveat to drawing upon this finding is the fact that non-profit hospitals in Ireland receive approximately a 30% greater proportion of their funding from government than those in the U.S. (Vanderwoerd, 2004). The specific case for differentiating between sectors in Ireland is outlined below.

In Ireland, in the policy realm, The National Health Strategy Consultative Forum on the voluntary/statutory interface (National Health Strategy Consultative Forum, 2001b) noted that the role and position of the voluntary hospitals in the Irish health sector may need some clarification. This provides a foray into what is a conceptual and definitional question regarding voluntary hospitals, identified by O'Ferrall (2000). For him, as outlined above, it was unclear whether being 'voluntary' entails independence and autonomy in governance and management. Although the Health (Eastern Regional Health Authority) Act of 1999, asserts that voluntary hospitals have the right to *'manage their own affairs in accordance with their independent ethos and traditions'*, O'Ferrall's (2000) case study on the establishment of the public-voluntary AMNCH Tallaght via the amalgamation of three pre-existing voluntary hospitals encountered *'attempts to reorient the governance and management of the Hospital towards a mould shaped by the Department of Health and Children'* (O'Ferrall, 1998: 223). While O'Ferrall primarily focuses on board-level activity in an unusual whole-system change process, this research is concerned with the extent of autonomy, as evidenced at a variety of organisational levels (board, management and service) and in day-to-day management. Considering this multitude of levels is important given what Rashford and Coghlan (1994) and Coghlan (2000) termed 'inter-level dynamics'.

Secondly, although, given different development trajectories, variations in role definitions and configurations would seem likely across hospital types, O'Sullivan (1999–2000) draws attention to changes that have had a bearing on healthcare delivery. He asserted that Ireland has been characterised by *'an increased blurring between state and non-state provision of welfare services'*, to the point whereby education and health have *'much in common with statist mechanisms for welfare delivery, and are probably best described as a 'shadow state'* (O'Sullivan, 1999–2000: 61). This assertion is based on the perspective that the histories and

identities of hospitals are shaped by changes in their financing (Ferris et al., 1989; Marmor et al., 1987). Thus a key question is the extent to which Irish non-profit hospitals now differ from their state and private sector counterparts, given their almost complete reliance on state funds. Ideologically, difference is most likely to manifest itself at the board level – given that the board is charged with upholding the mission of the organisation. Although difference may be expected to transfer from board to management level, the extent of ideological difference expected at the professional level is questionable, given external socialisation from professions. To date, consideration of convergence has focused on private and voluntary hospitals via consideration of output and descriptive characteristics (Ferris et al., 1989; Hollingsworth, 1986; Schlesinger et al., 2006). In contrast, this study introduces the issue of public hospital management, and also focuses on management processes. This is justified given Doyle et al.'s (2000) survey-based finding that the experiences of change, including implementation and relationships, varied between the public and private sectors, and also between management levels. In addition, the issue of management in private hospitals is one of rising importance in the Irish context, albeit one ignored in the literature to date. In Ireland, plans for the private sector to build facilities for fee-paying patients on the grounds of public and public-voluntary hospitals have been recently announced (Wall, 2005), and are being supported with tax breaks and incentives.

Thirdly, the public sector focus on generating and implementing policy may contribute to the blurring of boundaries through its implementation via a mix of statutory agencies, state-founded and funded organisations, quasi-autonomous nongovernmental organisations or funding of service provision via the non-profit or private sector. Quasi-government[12] can extend to public ownership, as in the case of nationalised industries and organisations such as schools and hospitals. However it is normally only used to refer to industrial and business ventures. In terms of situating hospitals within this variety of public-sector organisational types, Greenwood and Wilson (1993) provided a useful continuum ranging from the polar extremes of government to private companies. At the public-sector extreme is government (G), such as central departments. Further down the continuum are quasi-government organisations (QG) such as nationalised industries. Gravitating further towards autonomy are quasi-nongovernmental organisations (QNG), with the most extreme form being nongovernmental organisations such as private companies, nongovernmental (NG). The further the organisation is from the "G" side of the continuum, the less government control and hence accountability. A key consideration is why there is such a

[12] 'The term 'quasi-government' refers to both the government-created and semi-private organizations which are both distinct from, but usually relate to, either central government departments or local authorities' (Greenwood & Wilson, 1993: 209).

range of organisational types in the public sector. Pliatzky (1980: 2–3, in Greenwood and Wilson, 1993) asserted that these can be explained by four central reasons. Firstly, that work does not require ministers to be involved in day-to-day management; secondly, work is more effectively carried out by a single-purpose organisation rather than by a government department with a wide range of functions; thirdly, it involves people from outside government in the direction of the organisation; and fourthly, it puts the performance of particular functions outside political-party control. All of the above apply in the Irish hospital context, where voluntary hospitals currently operate as QNGs.

Whilst there are multiple facilitating factors for the blurring of boundaries across sectors, there is little agreement. This research will contribute to this debate through its analysis of management processes and differential levels of autonomy across organisations. However, one of the most accepted influences on the adoption of private-sector techniques in the public sector is the 'New Public Management', discussed in Section 4.4.2. Having explored the historical context of Irish hospitals, and the contemporary debate associated with and embedded in this history, focus in the ensuing sections remains with healthcare organisations, but explores their current context. Specifically, it explores the dynamics of the external and internal context faced by Irish hospitals, in line with the dimensions of the processual approach outlined in the introduction. Section 4.4 examines the dimensions of the current external context identified as important on the basis of the processual approach, as outlined in chapter 3, in conjunction with a review of the literature and consultation with experts in the health-service domain, both in academia and through contextual interviews.

Section 4.4: Current external context

Five components of the external context of Irish hospitals are considered in this section. These are (1) changing social expectations; (2) the international movement towards new public management; (3) how new public management has been implemented in Ireland; (4) health-service reform in Ireland; (5) resources in the general-hospitals programme; (6) competition for staff; (7) the cardiovascular strategy, which is the immediate external context of the research and; (8) the general context for service improvement in Irish hospitals.

4.4.1 Changing social expectations

The annual report of one hospital in this study refers to *'The adverse media coverage about the health services and the terrible state it is in'.* Social expectations regarding standards of care in health service have been augmented by the significant funding increases that have occurred over the past decade (Downey-Ennis & Harrington, 2002; McAuliffe, 2002). For example, healthcare funding increased by 225% from 1997 to 2002 (2003b). However, specific attempts to implement service improvement, such as the 'Shaping a Healthier Future' (Children, 1994), 'Quality and Fairness' (Department of Health and Children, 2001b) and the national cardiovascular and cancer strategies (Cardiovascular Health Strategy Group, 1999; Department of Health, 1996) have suffered from implementation problems (National Health Strategy Consultative Forum, 2001). In an attempt to circumvent issues of capacity and service-quality, which have been difficult to directly address, the government has provided incentives for expanded private-sector service provision. Movements towards New Public Management (NPM) and the 'Health Sector Reform Programme' have also been introduced to address these issues. A general overview of the international and UK movement to NPM is provided below, as a precursor to outlining the Irish experience. The Irish move towards NPM has been precipitated by the UK shift. This is a common tendency in Irish public policy, a trend influenced by a shared language and geographical proximity.

4.4.2 The international movement towards new public management

Governments prefer to reform healthcare structures and processes continually and blindly, reluctant to learn from their continual social experiments and refusing to accept that their success is dependent on the evidence base about practice and policy.

- Maynard, 2005: 290

Analysis of international healthcare markets is characterised by common, well-researched and durable manifestations of inefficiency, regardless of the nature of the public–private mix (Maynard, 2005). One common and enduring attempt to manage such inefficiencies is New Public Management. NPM is widely referred to as an ideological shift in how public-sector organisations should be managed, and is a concept based on economic language and management rhetoric from the private sector. While Ferlie et al. (1996: 10) indicated that there is no agreement about what NPM actually is, what it is becoming, or what it should be, *'many would agree that the new public management should now be seen as a major break point in public*

sector management (Dunleavy and Hood, 1994) 'of much greater significance than the usual fad or fashion' (Ferlie et al., 1996: 9). It has assumed a dominant and global role in public-sector reform throughout the 1980s and 1990s (Robbins, 2004) and entails importing market-based ideology and aligned private-sector management techniques to the public sector. Ferlie and Fitzgerald (2002) referred to these characteristics as the dual processes of 'managerialization' and 'marketization'. As a result, NPM can be conceptualised as the application of private-sector management approaches in public-sector contexts. This is reflected in a rhetoric and reality of privatisation, the introduction of quasi-markets, an increased focus on efficiency, explicit standards and performance, an emphasis on professional management, and a change in emphasis from process to results-based accountability (Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996; Greenwood et al., 1993; Robbins, 2004).

The extent to which this has occurred in an Irish context will be explored later in the chapter. However, taking the UK as an ideal-type example, it appears that complete alignment between management in the public and private-sector contexts remains unlikely, in spite of attempts. This is because it is difficult to identify and measure the outputs of many public-sector organisations, particularly those such as healthcare organisations, where the concept of the market is limited. In such contexts *'imported notions of profitability or other financial ratios will only ever be surrogate, artificial measures'* (Greenwood and Wilson, 1993: 11). In addition, the necessary implications of following through on market principles such as efficiency in allocating contracts in public-sector organisations such as hospitals would lead to service closure or reduction in some contexts. The potential for political fallout is surely one key reason there has been a language shift evident in UK policy from the rhetoric of the market to that of the quasi-market, and finally to the much weaker 'managed market'. Thus, NPM can not be presented as a pure colonisation of the public with the private. Ferlie et al. (1996) asserted that it can also be perceived as a management hybrid, with continuing emphasis on core public-service values, expressed in a new manner. Illustrating the spectrum of NPM approaches, they outlined a typology of four models of NPM, each with distinctive characteristics. Each model is based on different diagnoses of problems (Flynn, 2002). Ferlie et al. (1996) derived these models from the UK experience. The four models are (1) the drive for efficiency; (2) downsizing and decentralisation; (3) the search for excellence; and (4) public-service orientation. Flynn (2002) asserted that the diagnosis of the problem to be solved is a response to the interpretation of long- and short-term problems, and is mediated by the political process. Thus diagnosis is influenced by context, as are perceived possible solutions. Ferlie and Geraghty (2005) differentiate between the models on the basis of their 'hard' and 'soft'

orientations, with models (1) and (2) having a hard orientation, and models (3) and (4) having a soft orientation. Hard NPM is associated with radical managerialisation, an accounting orientation, audit, performance measurement, performance management and performance-related finance. Soft NPM is associated indirect managerialisation through a human relations orientation and an emphasis on quality improvement, development and learning. Soft NPM is increasing in popularity, although it has been criticized on a similar basis to OD (Cummings & Worley, 2001; Harrison & Pitt, 1984; Stace & Dunphy, 1991) Further scenarios for reform in hospitals, and broader public service include professional managerial hybridisation, as discussed in chapter 4, and a move towards a governance and networks-based model (Ferlie et al., 2005). Ferlie and Geraghty emphasised the greater professional involvement in soft NPM and the 'governance model'. The application of NPM in the Irish context is explored in the ensuing section, as the governance model has yet to be adopted. Crucially, however, while this section has emphasised the different models of NPM that can be applied, Kirkpatrick et al. (2007) delineated different responses of professionals to reform, cross-nationally. They emphasised that the application of NPM is not uncontested, and varies in form, process and outcome across contexts, on the basis of history, institutional structure, how reforms are influenced and the perceived role of the professions in this regard.

4.4.3 Exploring NPM in the Irish Context

Although managerialism and the adoption of private-sector management practices have been explicitly encouraged in the NHS in the UK since the 1993 Griffiths Report, the Irish health sector has lagged in this process. In exploring NPM in the Irish context, Ferlie and Geraghty's (2005) differentiation between hard and soft models of NPM is reinterpreted by Robbins (2004). She describes the orientations as either a 'let the managers manage' approach or a 'make the managers manage' approach. The 'let the managers manage' approach presumes that managers possess the characteristics required for effectiveness, but are hampered by bureaucratic systems, structures and processes. For Robbins (2004) the Irish experience has occurred in this vein, with a lengthy, unsuccessful struggle to implement change followed by enshrining best practices and the principles of NPM in statute in the Public Service Management Act (1997). This act aimed to change governance from centralised financial resources to decentralised authority, based on new accounting frameworks. On this basis, the Irish experience is most closely aligned with Ferlie et al.'s 'downsizing and decentralisation' model. Robbins (2004) indicated that reform is ongoing. The Delivering Better Government report provided by the Implementation Group on

the Strategic Management Initiative (2001) is described by Robbins (2004) as the Irish government's NPM document, focusing strongly on improving public-sector financial management. In addition, the 2003–2005 'sustaining progress national social-partnership agreement' contained a chapter entitled 'Delivering Quality Public Services', which provides a framework for the continued modernisation of health, among other topics. More specifically related to health, the Health Amendment Act of 1996 extended some elements of NPM to the health sector. This aimed to improve financial accountability and expenditure control in health boards. It provided a legal framework for service planning. In addition to financial restructuring and control, Robbins (2004) asserted that further elements of NPM such as reform, evaluation, modernisation and performance are contained in the Quality and Fairness (Department of Health and Children, 2001b) health strategy. Nonetheless the 2003 Brennan report identified the lack of relating budgets to outputs as a core weakness in the hospital system (Department of Health and Children, 2003a), with weak evidence of NPM techniques such as performance indicators, financial-management information systems, financial targets and delegated budgets. The attempt to integrate NPM principles into the Irish health service is part of a broader and explicit health-service reform process, explored further below.

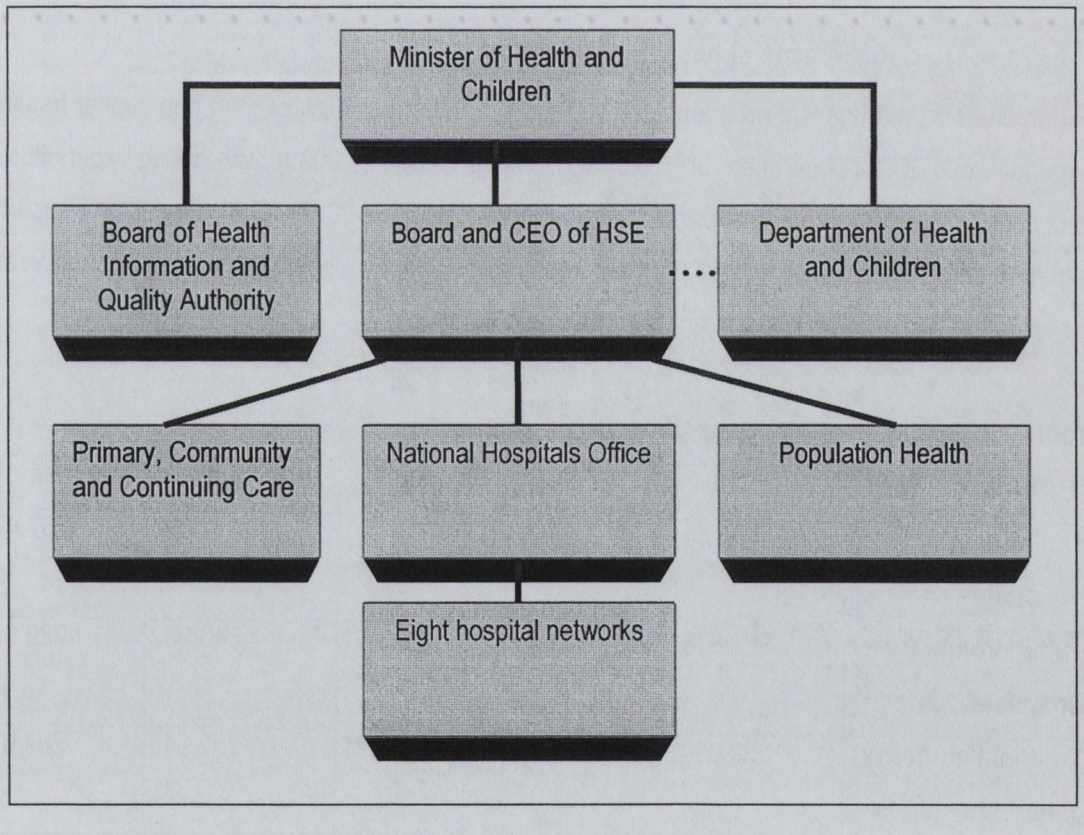
4.4.4 Health Service Reform in Ireland

The restructuring of the Irish health services, via the Health Service Reform Programme announced in June 2003, is part of a broader international trend towards attempts to improve the functioning and outcomes of government (Barzelay, 1992). The reforms are designed to modernise health service, to provide high-quality care, better value for money and improved management. The reform programme is underpinned by the values of equity, efficiency and responsiveness and appropriate care (Department of Health and Children, 2001b) and entails both structural and program reform. Structural reform is premised on an independent audit of the structures and functions in the health system (Prospectus, 2003). This report identified fragmented, complex, outdated and cumbersome management and financial systems. A further examination of financial systems, practices and procedures in the health services (Department of Health and Children, 2003a) highlighted inadequate planning and costing structures as well as accounting deficiencies. Finally, the National Taskforce on Medical Staffing (Department of Health and Children, 2003b) provided a template for acute hospital provision in Ireland at four levels: (1) national services and facilities; (2) regional hospitals providing emergency and specialist care; (3) local hospitals, providing diagnostic, elective and day-patient, out-patient and continuing care

services; and (4) intermediate general hospitals providing some emergency and specialist care, where appropriate. The medical-staffing report also outlined an implementation plan for reducing the working hours of non-consultant hospital doctors, in line with the requirements of the European working-time directive. While issues have arisen in the implementation of this last report, this is not unexpected. Robbins (2004) cited Maddock and Morgan (1998) who argued that those attempting to develop new forms of public-sector management may have an uphill struggle in professional contexts.

A key component of the structural reform that emerged from the Prospectus report (2003) is the separation of the policy-making and management functions. Policy remains the remit of the Department of Health and Children, with management of the health service, as a single national entity, devolved to the newly established HSE.

Figure 4.1: Structure of HSE



**Note that the dashed line refers to liaison, rather than accountability.

The establishment of the HSE aims to reduce fragmentation. The HSE is comprised of three constituent parts: population health, primary community and continuing care and the National Hospitals Office. The National Hospitals Office manages acute services in 51 public and voluntary acute hospitals. It also provides pre-hospital emergency-care services. Hospitals are divided into eight network groups, each with their own manager. Delivery of regional and local health services is undertaken by four regional health offices. A Health Information and Quality Authority has also been established to promote quality care. The reform programme also aims to devolve budgets to those in charge of service delivery, and to modernize supporting processes such as service-planning and management reporting. In aggregate, the programme aims to improve the planning and delivery of health services through a uniform management structure. The reform entails clarification of reporting systems and accountability, which have heretofore been unclear. These reforms have occurred in a context of rising expenditure on healthcare. This is detailed in the next section.

4.4.5 Resources in the general-hospital programme

Expenditure on the hospital programme in Ireland accounted for 48% of total non-capital health expenditure in 2002 (Department of Health and Children, 2002a, 2003b), with health expenditure accounting for 23% of total government expenditure (Robbins, 2004). Government non-capital expenditure on the general-hospital programme is listed in Table 4.1 below, for every second year between 1998 and 2004 (Department of Health, 2003b, 2005).

Table 4.1: Spending on the General Hospital Programme

HOSPITAL TYPE	1998 €000	2000 €000	2002 €000	2004 €000	Increase
Regional Hospitals	549,144	739,033	1,191,401	1,413,827	257.4
Public Voluntary Hospitals	825,876	1,070,374	1,557,951	1,840,932	222.9
Regional authority general hospitals	362,324	474, 548	643,336	752,546	207.6
District/ community Hospitals	61,208	73,334	105,131	122,518	200.1
Regional authority	141,059	182,489	254,789	295,768	209.67

long stay Hospitals					
Ambulance Service	48,851	64,711	79,529	93,220	190.8
Programme Total	1,988,461	2,604,489	3,832,187	4,518,811	227.25

Although, on aggregate, non-capital expenditure increased by 227.5% between 1998 and 2004, the extent of the increase varies between hospital types. The biggest variation is evident among regional hospitals, which received an increase of 257.4% over this six-year period, and the district and community hospitals, which received a 200.1% increase over this period.

Of total non-capital expenditures, in 2001, 86.51% was sourced via the exchequer, 10.74% came from health contributions and 2.75% came from receipts under EU regulations. As a percentage of GNP, health expenditure increased from 5.96 to 7.39 during the time outlined above. However, what is not evident from this table is the increasing role of private hospitals in the hospital sector. One related implication is the increasing competition for staff, discussed below.

4.4.6 Increasing competition for staff: The expansion of the private hospital sector

In the summer of 2005, the government announced plans to expand private sector involvement in hospital care, with incentives provided through tax-breaks (Wall, 2005). Tax allowances were made available to those building standalone private hospitals. These allowances also facilitate the establishment of private hospitals on the grounds of existing public and voluntary organisations (co-location). A key incentive underlying the scheme is the provision of 3,000 new beds by 2011, which was a component of the National Health Strategy (Department of Health and Children, 2001b). These plans have been opposed by the Irish Congress of Trade Unions (Donnellan, 2005), on the basis that private hospitals tend not to offer complex acute-care services, but rather focus on elective surgery in less complex and more profitable areas. As a result, they fear that such beds will not free up beds in acute hospitals on a one-for-one basis. The plan was also criticised by a consultant cardiac surgeon in a contextual interview for this study, on the basis that the government is considering concentrating care provision in regional centres of excellence, while simultaneously facilitating the opening of 100-bedded private hospitals not conducive to volumes of procedures associated with optimal clinical outcomes. Nonetheless the development of private for-profit hospitals is proceeding, creating competition for consultant and other staff among public, voluntary and private hospitals.

Section 4.4 has provided a broad overview of the external context of the Irish hospital sector. This is characterised by rising social expectations, the move towards NPM, the health service reform programme, an increase in resources available for the general hospital programme and policy support for private hospitals, which has led to increased competition for staff. The ensuing section outlines the general context for service improvement in Irish hospitals.

4.4.7 General context for service improvement

It is important to recognise that the apparently sizable increase in health funding outlined in section 4.5.5 was provided to a system that has carried significant deficits since the late 1970s. These were particularly exacerbated by the expansion of free public-hospital care to the entire population in 1979, in conjunction with significant cut-backs in hospital funding and bed numbers since 1987 (Wren, 2003). Contextually, prior to 1979, *'we were a long way behind in the number of people that we had, to deliver the service that was needed by our people.'* (Consultant cardiologist, Voluntary hospital). Wren (2003) asserted that between 1986 and 1989 public spending on health fell to 6.7% of national income, from almost 8% in 1986. She noted that comparatively, the EU states were spending on average twice as much per capita on health. Between 1987 and 1989, 3,244 hospital beds were closed, a 19% reduction. Wren noted that an additional 13% were closed from then through 1993. During this period 19 hospitals 'changed roles', which Wren (2003) alluded to as an alternative form of closure. Placing the scale of these closures in context, there were sixty hospitals operating in the state in 1999 (Department of Health and Children, 1999b). In addition, an embargo on recruitment took effect in 1987. By 1988 there had been a fall of 10,000 in the workforce from the 1981 numbers of 66,000 (Wren, 2003).

The legacy of these deficits is only now being ameliorated and addressed. In being questioned regarding why approximately 40% of the Cardiovascular Strategy had not been implemented in the allocated time frame (Fitzgerald, 2005), the same consultant who had been involved in the strategy from the outset attributed this to the *'extraordinary deficiency in the acute services'*. This is illustrated by the fact that one organisation participating in the study had two consultants working in cardiovascular disease in 1998. By 1999, with the assistance of the funding provided under the cardiovascular strategy, this had increased five-fold. On a national level, at the outset of the cardiovascular strategy there were sixteen cardiologists and eight general physicians with a special interest in cardiology practicing in Ireland (Department of Health and Children, 1999). This led to the lowest per capita numbers of cardiologists in Europe – with 5 per million population,

compared to a mean of 49 per million in other European countries (Department of Health and Children, 1999). These numbers had risen to 29 by 2002 (Heart Health Task Force, 2003), and had increased by 200% in April 2004, to fifty one cardiologists (Comhairle na nOspideal, 2006). Comhairle asserts that at that time a further thirty consultant cardiologist posts were awaiting approval. However it is important to remember that the deficits were not limited to staffing alone, but also affected management and infrastructure.

This brief section has attempted to illustrate the fact that although health services funding has increased greatly since 1997, this does not represent an enhancement of existing excellence, but rather a delayed investment into a previously significantly underfunded service. This background had implications for the nature of the changes which were undertaken by the research participants and the context in which changes occurred. Next, attention turns to the aims, implementation structures and challenges encountered in the implementation of the national cardiovascular strategy, which provides the immediate context for this research.

4.4.8 The national cardiovascular strategy

In Ireland, in 2003, cardiovascular mortality accounted for 39% of all deaths, compared to 51% in 1980 (Irish Heart Foundation, 2004). While there has been a decline in mortality at younger ages from cardiovascular diseases in all countries, the number of chronically ill patients may be increasing due to an ageing population (Department of Health and Children, 1999). For example, there are 10,000 new cases of heart failure in Ireland each year, and the Irish Heart Foundation projects that by 2010, 300,000 Irish people will be directly affected by this illness, or by impending heart failure (Irish Heart Foundation Council on Heart Failure, 2002). Levels of mortality have also been found to be unequal in different social groups (Department of Health and Children, 2001a). Given the increasingly defined causes of cardiovascular diseases, a National Strategy to address the issue was commissioned in 1998 by the then Minister for Health, Brian Cowen (Department of Health and Children, 1999). Published in 1999 it outlines a strategic approach to the prevention and treatment of illness caused by cardiovascular disease. Its remit was to consider initiatives to improve cardiovascular health, the further development of cardiac care and rehabilitation at primary, secondary and tertiary care levels, and the coordination of services for patients. It was also asked to consider additional measures to assess the impact of the overall strategy and its main constituent elements. Key findings pertained to a lack of baseline data, fragmentation between service providers, a lack of personal responsibility for health, an undervaluing of the role of rehabilitation and criticism of evaluation processes for change.

Following from the preexisting national health strategy, the cardiovascular strategy emphasises the principles of (1) health and social gain; (2) equity of access; (3) quality; (4) effectiveness and efficiency; and (5) accountability and audit (Department of Health and Children, 2001b, 1999). Following the Report of the Commission on Health Funding (Funding., 1989) both the publicly and privately funded healthcare systems were included in the strategy. There was a five-year time frame for the implementation of the strategy, meaning that recommendations should have been implemented by December 2004 (Department of Health and Children, 2002b). Recommendations were made for health promotion structures and public health strategies, primary care, pre-hospital services, hospital services, cardiac rehabilitation and information systems, audit and research. This research is concerned with recommendations pertaining to acute services only. These recommendations are outlined in Appendix 2.

By May 2004, €57m had been allocated to implement the strategy (Department of Health and Children, 16th May 2004), a figure that rose to €60m by 2005. The government allocated €52.3m in the first two years (2000-2001). Of this, €34.3m was directly allocated to implement the strategy, with the remainder funding nicotine-replacement therapy under the General Medical Service, among other health-promoting initiatives. €14.20m was allocated to develop cardiac surgery (Department of Health and Children, 22 November 2001). In addition, the National Development Plan provided additional funding for capital projects undertaken by the health-boards, as part of the implementation of the strategy (Department of Health and Children, 2002b). Each health board was guided in planning expenditure, with staff and equipment put in place in the first year. By 2004, almost 800 additional staff had been appointed to implement the strategy. This included 19 additional consultant cardiology posts and 109 cardiac-rehabilitation staff. The latter facilitated the development of structured cardiac-rehabilitation services in all acute hospitals. 139 health-promotion officers were also appointed. The Minister for Health (Department of Health and Children, 16th May 2004) outlined that arising from the strategy's implementation and the monitoring system adopted to track its progress, *'immediate benefits are evident from the wide range of new and higher quality services already available from this investment'*. He asserted that these included

- reduction in emergency call-to-treatment times;
- regional self-sufficiency for noninvasive diagnostic procedures;
- new services, such as the Heartwatch programme, for coronary heart disease;
- the development of chest-pain clinics and cardiac rehabilitation;

- an almost 200% increase in certain cardiology procedures and a 24% reduction in the waiting list for cardiology procedures, and;
- the increase in the numbers being detected and treated with chronic heart failure.

However, the 2004 annual report of the Irish Heart foundation noted that the total amount allocated falls well short of the initial €220million projected.

In November 2001 the first progress report on the strategy was published (Heart Health Task Force, 2001). Much had been achieved, but also there was a significant amount outstanding. The Irish Heart Foundation (2004) estimated that 60% of the strategy had been implemented by 2004. This figure was supported by a principal officer in the Department of Health, with whom a contextual interview was conducted. The strategy adopted innovative implementation structures, outlined below.

Structures for implementing the Cardiovascular Health Strategy.

As the strategy implied working with agencies in the voluntary, statutory and public sector, national, regional and local-level structures were put in place to facilitate the implementation of the strategy. These reflected the need to ensure a high level of engagement from a number of stakeholders over a significant period of time. The structures included the six following components (Department of Health and Children, 2001a; Department of Health and Children, 2002b):

- Heart-health task force
- Advisory forum on cardiovascular health
- Joint working group to review consultant cardiology-staffing requirements
- National cardiovascular information-systems steering committee
- Interdivisional working group on cardiovascular health in the Department of Health and Children
- Regional cardiovascular steering/implementation committees at the health-board level.

In addition, during the first phase of implementation, the strategy was supported by a Ministerial Group, chaired by the Minister for Health and Children and the Joint Oireachtas Committee on Health and Children.

The key overarching structures were the Heart Health Task force and the Advisory Forum on Cardiovascular Health. The task force was charged with reviewing the implementation of the strategy by government departments and statutory agencies in the short, medium and longer term. It was also given responsibility for implementing the intersectoral recommendations in the strategy. The advisory forum was charged with an advisory role to the Heart Task Force regarding prioritisation of recommendations and best practice in cardiovascular disease. This had four working subgroups: health promotion, primary care and pre-hospital care, hospital services and cardiac rehabilitation. The regional responsibility for implementation fell to the now restructured health boards. These established regional structures for implementation. In addition, a unit of general civil-service posts and health professionals within the Department of Health and Children were provided to support the implementation structures, as well as incorporate policy responsiblities: an Assistant Principal, Executive Officer and Clerical Officer. From a more clinical perspective, a Heart Health Advisor was contracted, as well as health-promotion officers, a nutrionist, a nurse and research officers. In spite of these structures, challenges were encountered in implementing the strategy. These are outlined below.

Challenges identified in implementing the Cardiovascular Health Strategy

The second report on implementation noted that some of the recommendations in the original report were not implemented (Heart Health Task Force, 2003). Particular reference was made to the development and implementation of practice guidelines, the implementation of cardiovascular health systems, support for clinical audit and for research to enhance the quality of service (Department of Health and Children, 2002b). The review attributed problems to deficits in infrastructure and the shortage of trained staff in a number of disciplines (Department of Health and Children, 2002b). The report emphasised that most impact was evident where there was nationally coordinated staff-training and guidance in relation to work practices, for example in cardiac rehabilitation, resuscitation training and pre-hospital care. As a result, the report recommended that an increased proportion of funding should be spent on national coordination initiatives. Reflecting this emphasis, networks are considered as an organising form in healthcare, discussed in chapter 5.

In the ensuing section, Section 4.5, the macro dynamics of internal context are explored. As delineated in the introduction, the specific internal context of each individual case is discussed in chapter 6; this section provides a broad overview of macro dynamics in the internal context, with

particular attention to the literature on the full variety of administrative structures that emerged as important during data analysis.

Section 4.5: Current internal context

Common themes pertaining to the internal context of acute hospital organisations are discussed in this section. The internal complexity of hospital organisations will also be further outlined in chapter 5 through exploration of roles and relationships between professions and managers in the provision of multifaceted services. This section outlines the impact of governance structures on organisational priorities and functioning. The challenges of strategic and operational management in enacting such priorities are also discussed, as are the role and limitations of three supporting functions: HR, accounting and service-planning. With the exception of service-planning, all are discussed in general terms due to a dearth of research in the Irish context. Finally, the section outlines a contextual anomaly in the Irish hospital service: the provision of private healthcare in public and voluntary hospitals.

4.5.1 Governance systems

The concept of governance is applied in multiple contexts, at international, state and institutional levels (Chambers, 2006) with many different meanings (Kjaer, 2004). In the field of public administration and policy it refers to both the principles and practice of how public organisations are managed (Kjaer, 2004). Section 4.5.2 has outlined a change in this regard, in the move towards NPM. For Chambers (2006), this shift has been influenced by high-profile organisation failures around the world, leading to an emphasis on control in governance debates. However, the focus in this subsection is on organisational governance. While markets, hierarchies and networks have been identified as the main forms of governance in the NHS (Davies et al., 2005), a more limited range is evident in Ireland and delineated later in this section.

In organisations, the principal role of governance structures is to help them adapt to new circumstances (Denis, 2004, in Pomey et al., 2007). For Chambers (2006), governance is underpinned by a need for direction, the importance of control, an underpinning set of values and the need to demonstrate accountability. The causal chain between governance structures, associated incentives and outcomes is complex and influenced by multiple variables (Davies et al., 2005), making it difficult to identify how the relationships will unfold. Nonetheless, Greenwood et al. (2007) in their study of professional service firms found that private forms of governance

outperformed public forms. They attributed their finding to greater monitoring in private-sector firms, in addition to increased motivation among staff premised on economic incentives. Thus governance structures are mediated by incentives, which can include economic, moral, professional or social inducements to affect behaviour in organisations. Reflecting perceived differences in levels of board performance across sectors, a key aspect of public-sector reform in the NHS has been the statutory introduction of the private-sector board model (Ferlie et al., 1996). While Ferlie et al. emphasised that this model has failed to adequately address accountability, it has attempted to move away from an 'endorsement' model of governance, by introducing non-executive directors. This has attempted to improve efficiency, but has decreased opportunities for staff involvement. While there are multiple potential board structures and compositions, Cornforth (2003) asserted that there is no ideal board model. Rather, he emphasised the need for boards to maintain reflexivity in their operations. One further outstanding issue concerns whether boards should be involved in strategy formulation or evaluation. Chambers (2006) drew upon Garratt's (1997) differentiation in conformance, which emphasises accountability and the supervision of management, and performance, which emphasises policy formation and strategic thinking in the role of the board.

EXTERNAL FOCUS

CONFORMANCE	**PERFORMANCE**
Board focus: Accountability (explaining) Requires exploratory OD activities and generic and specific induction and skills development programmes (e.g. training on patient and public involvement). Acceptant, catalytic and prescriptive consulting styles.	Board focus: Policy formation, establishing core values (what) Requires exploratory and transformational OD activities (e.g. awaydays, visioning) and 'new board' work. Reflective, acceptant and confrontational consulting styles.
SHORT TERM	**LONG TERM**
Board focus: Monitoring of progress and behaviours (monitoring) Requires generic and specific induction and skills-development programmes (e.g. briefings, seminars, board director induction programmes, clinical governance training). Catalytic and prescriptive consulting styles	Board focus: Strategic thinking and key principles (how) Requires exploratory and transformational OD activities (e.g. awaydays, workshops, teambuilding) and 'new board' work. Reflective and catalytic consulting styles

INTERNAL FOCUS

Figure 4.2: Framework for board development in healthcare (Chambers, 2006: 280)

She noted that there is a need for all these aspects to be addressed by a competent board. She provided a framework for NHS board development, shown above in Figure 4.2. Reflecting the possible combinations of these above roles in practice, Pomey et al. (2007) identified three models of governance, each providing a specific interpretation of governance functions and roles, with differences in their foci and incentives. These are outlined in Table 4.2.

Table 4.2: Three models of governance (Pomey et al., 2007)

Comparative Dimension	Agency Model	Stakeholder Model	Stewardship Model
Core preoccupations	Efficiency, control of opportunistic behaviours	Integration of stakeholder interests	Continuous improvement, vitality of democratic institutions, social betterment
Accountability principles	Technocratic, pre-defined, exogenous	Attentive to legitimate stakeholders	Endegenous, autogeneous, organic and dialogic
Motivation	Self-interest	Instrumental and moral	Self-actualization, collective interests
Power	Concentrated, hierarchical authority	Pluralist	Distributed, shared responsibility
Trust	Effectiveness of control mechanisms	Comprehensiveness and balance	Integrity, loyalty, shared values
Coordinating Mechanisms	Contracts, financial incentives/information	Interaction, negotiation	Ideology, transparent information and feedback processes
Leadership	Individualistic, authoritarian	Politically skilled	Collective
Time perspective	Short-term	Mid-term	Long-term

As ownership of an organisation is *'a governance design parameter as well as an important input to stakeholder power'* (Huse, 2007: 114), governance structures vary across public, voluntary and private hospitals. Public hospitals are governed through regional health-service executive structures. Some voluntary hospitals are owned and managed by religious orders, represented on their independent boards, with still others incorporated by charter or statute and working under lay boards of governors. Private hospitals are variously owned by religious orders and business groupings, and are independently governed. A key theme emerging in comparative analysis, and outlined in chapter 9, is the impact of differences in governance structures, on the motivation to

change at the organisational level, and associated behaviours. Attention in the next section turns to strategic management in hospitals.

4.5.2 Strategic Management

> *'Some NHS managers are extraordinarily skilled, but even they tend to focus on tactics (e.g. surviving the demands of government access and financial targets) rather than strategy. Most NHS managers do not have the skills and time to concentrate on evidence-based, data-driven decision making.'* (Maynard, 2005: 307)

According to McMillan (2004), unconnected strategy tends to be found in organisations such as universities or hospitals, where individual units have sufficient autonomy to pursue their own strategic change activities without reference to any central vision or plan. In addition, strategic management in healthcare is complicated by the inefficient allocation of resources, due to inappropriate incentives, often linked to politicisation in health services (Maynard, 2005). This undermines management systems, by creating a focus on satisfying political or short-term demands at the expense of evidenced-based decision making or longer-term strategy making. Strategic management can therefore be undermined by political and other distractions. Although the restructuring of the Irish health service has separated the macro policy and management functions, political factors remain in perceived agendas of the regional and national HSE functions.

Furthermore, as services differ from products, strategy making for service-organisations such as hospitals should take account of their distinctive characteristics (Segal-Horn, 2005). However, most strategic frameworks have been generated in manufacturing contexts. For Segal-Horn, strategies in service-firms are most dependent on the implementation of the strategy by front-line staff, rather than the generation of the strategy through analysis. Implementing strategy is therefore highly correlated with the management of the key roles and relationships outlined in chapter 4. As a result, operational and administrative management, respectively, have roles in facilitating and supporting the implementation of strategy. Further challenges faced by operational and administrative management are outlined in the next section.

4.5.3 Administrative/operational management

In addition to the management of diverse professionals and key relationships, a key issue for operational management pertaining to change is the fact that while change-targets in healthcare

may appear straightforward, the complexity of the system in which they are enacted can make them complex. In practice, a 'change' can refer to a number of interrelated changes necessary to achieve a target (Fitzgerald et al., 2006b). An important implication is allowing sufficient time for the implementation of a change.

Operational management also has a significant role in facilitating bottom-up change. The key role of management, in healthcare and other contexts, is to create a 'can-do' atmosphere at all levels in the organisation (Robinson, 2006). For Robinson, this entails harnessing resolutions to issues from front-line staff, and eliminating those that are unsuitable. However, difficulties have been identified in facilitating bottom-up service improvement, where service-improvement ideas are brought forward by nurses or allied health professionals (Robinson, 2006). In such instances, Robinson (2006) emphasised the need to gain the sponsorship or support of a consultant. Managing consultant power is a key issue in hospital management, both on a day-to-day basis and in contexts of change:

> *'It can be quite difficult for the management to achieve things because there is a powerbase of consultants in the organisation that has the capacity, the ability, to block change – and even to remove the Chief Executive if it comes to that.'* (CEO, in Robinson, 2006)

In a case outlined by Robinson, management capacity was limited by the felt inability to directly challenge consultants and the perceived illegitimacy in addressing clinical issues. This led Robinson to a very insightful and pivotal question, with relevance to all hospitals: 'Who manages the consultants?' On aggregate, he characterised a situation where no one, in practice, is in charge of consultants, and, in the instance outlined, the CEO felt constrained in attempting to manage them. For Robinson, the issues evident in the relationship were culturally embedded. His interpretation mirrors the pluralistic one outlined by Bate (2000) and discussed in chapter 5. The next section explores the role of the Human Resources (HR) function, identified as an under-utilised resource in the findings.

4.5.4 The role of the HR function

Throughout this subsection, the term 'HR' refers to the human resource function, while the term 'HRM' refers to the management of people within an organisation. The core focus of the HR function is to ensure that service-related issues are effectively addressed by management (Walker, 1992). Since the 1970s the themes in the HRM literature have moved from a focus on

the lack of power afforded to personnel management and issues of legitimacy and credibility (Legge, 1978), towards a focus on retaining the core HR components and outsourcing non-central staffing requirements (Atkinson, 1984; Paauwe, 1995). More recently, a focus on e-HR (Ulrich & Brockbank, 2005), the management of 'Human Capital'(Chieh Hsu, Yeh-Yun Lin, Lawler, & Wu, 2007; Merritt, 2007), and linking HR to the needs and values of internal and external stakeholders (Ulrich et al., 2005), have emerged. The idea of HR as a 'business partner', propounded from the late 1990s (Ulrich, 1997), emphasises adding value in economic terms. However, Francis and Keegan (2006), articulated concern with the 'business partner' model increasingly being adopted because it maligns conceptions of HR premised on employee well-being and advocacy.

The complexity of acute healthcare means that a 'one best way' approach to management and HRM is unlikely to be effective (Hyde et al., 2006b; Marchington & Wilkinson, 2005) Similarly, organisational complexity makes the resource-based view difficult to apply in practice (Hyde et al., 2006a). As a result, the contingency model has been advocated (Hyde et al., 2006a; Stace et al., 1991), with the implication that different healthcare organisations should have different HR practices. Such an approach may help to ameliorate some of the difficulties reported by organisations in implementing national policies in local contexts (Hyde et al., 2006a; National Health Strategy Consultative Forum, 2001). In support of this recommendation, West et al. (2006) found that, after controlling for confounding factors, greater use of a complementary set of HRM practices has a statistically and practically significant relationship with patient mortality. Similarly, in Australia, Bartram et al. (2007) found some support for the relationship between strategic HRM and improved organisational outcomes, in hospitals and community health centres. Crucially, Bartram et al. also found differences in the perception of strategic HRM and HR priorities between CEO's, HR managers and other senior managers in large organisations. As a result, managing perceptions and goals is necessary to benefit from the link between HR and improved organisational outcomes. In choosing appropriate HRM practices, Hyde et al. (2006b) emphasised the need for caution in adopting practices from other sectors, given the specificities of healthcare.

Potential roles for HR managers include (1) handmaidens, providing tactical advice; (2) regulators, enforcing the implementation of procedures and rules; (3) advisers, regarding the human dimension of strategic decisions and (4) change-makers, assisting the development of corporate and HR strategy (Storey, 1992). Ulrich (1997), in a prescriptive rather than empirical

piece, identified four main roles for HR professionals, along two axes; strategy versus operations, and process versus people. The four roles are (1) strategic partners, who support the implementation of business strategy; (2) administrative experts, who add to organisational efficiency by reengineering the HR function and work processes; (3) employee champions, who support employee commitment; and (4) change agents, who deliver both transformational and organisational change. More recently, Ulrich and Brockbank (2005) identified employee advocacy, human-capital development, HR functional expertise, strategic partnership (business expert, change agent, knowledge manager and consultant), and HR leadership as key roles for the HR function. For Caldwell (2003), the role of the personnel professional has become more multifaceted and complex between the delineation of these potential roles, and overlap between them is evident in practice, often leading to multiple roles and role conflict. In a survey conducted by Caldwell, key themes included the rise of the advisory role of HR as a method of internal consultancy, an increased emphasis on remodelling the HR structure to improve effectiveness, and a rise in the change-agency role. An additional survey of 1,200 HR managers found that one third perceived their primary role as being a 'strategic partner', a quarter perceived themselves as change agents, less than 5% perceived themselves as administrative experts in the longer term, and few individuals perceived themselves as employee champions (CIPD HR Survey Report 2003, in Francis et al., 2006).

However in healthcare, Barnett et al. (1996) asserted that the choice regarding the role of the function is illusory, particularly in hospitals. They emphasised the particular difficulty of the HR function contributing to change in hospitals, due to the scepticism historically associated with management. In the NHS, individual HR specialists rarely played an active role in facilitating change, and there was limited evidence of systematic development processes, in spite of increasing demands on staff (Fitzgerald et al., 2006b). Fitzgerald et al. (2006b) identified the potential for an increased role for HR in the NHS in three domains: training and development; providing a facilitative and advisory role to general and clinical managers; and developing inter-professional forums. The increasing complexity of healthcare organisations has blurred the boundary between HRM and general management (Hyde et al., 2006a), and there is a need to revisit the desired role of HR, and how this might be obtained. For Barnett et al. (1996) the evolution of the HR function is affected by local contextual factors that need to be addressed in a context-specific manner, and the contested ownership of the HRM agenda between professional groups.

There is little research on the role of the HR function in Irish hospitals, however there is some awareness that it is underdeveloped (National Health Strategy Consultative Forum, 2001). One potential reason for this is the ongoing embargo on public-sector recruitment, which has led to the introduction of staffing ceilings in hospitals. By default, this creates issues around workforce management and industrial-relations issues, which distract HR from a broader role. Similarly, in the NHS, Fitzgerald et al. (2006b) and Hyde et al. (2006a) found that the HR function is underdeveloped and lacks capacity, with uncertain potential for a strategic approach towards HRM in healthcare due to the limited credibility of the HR function, a focus on a narrow operational contribution and a peripheral position in the organisation (Bach, 1994 in Barnett et al., 1996). Such issues have faced HR across several industries (Kamoche, 1994) and have led, in the NHS, to a lack of evidence of a relationship between the existence of a specialist HRM department, and the perceived effectiveness of staff (Guest & Peccei, 1994; Legge, 2005).

In evaluating the operational contribution of HR, in the NHS a poor reflection of the function emerges. In spite of the identification of the need for management training for clinicians and managers in healthcare over a decade ago (Fitzsimmons & White, 1997; Rioridan & Simpson, 1994), Fitzgerald et al. (2006) found that management training and development among clinical and clinical-management staff remained significantly underdeveloped, and they did not identify any evidence that this issue was being addressed. They emphasised the need for investment in appropriate staff development. Beyond training and development, Fitzgerald et al. (2006) considered the broader role of the HR function in facilitating change. Specifically they noted that individual HR specialists rarely played an active role in facilitating change. They also emphasised the need for more sophisticated HR strategies. Following from Stevens (Fitzgerald, 1994; Marnoch, 1996), Fitzgerald et al, noted an increasing need for the development of staff and flexibility to cope with the increasing complex change. This section has emphasised significant scope for augmenting the role of the HR function, both in general, and in supporting change. The next section explores the role of two further administrative and management systems: accounting and service-planning.

4.5.5 Limitations in accounting and service-planning systems

Budgets can be considered an outline of the annual service-plan in financial terms, meaning that service-planning and accounting systems are closely linked (Byrne, 2006). Inadequate planning and costing structures, as well as accounting deficiencies, have been formally identified in the Irish Health Service (Department of Health and Children, 2003a). Specific criticisms include the

failure to relate budgets to outputs, and variations in accounting practices in and between regions (Robbins, 2004). These issues have led to problems in comparison and the equitable allocation of resources, supposed inherent benefits of adopting an accounting and service-planning structure (Prowle & Jones, 1997). The annual budgeting cycle is also problematic (Byrne, 2006), leading to the inflation of funding requirements (Hyndman, Jones, & Pendlebury, 2003 in Byrne, 2006) and wasteful year-end spending, which may not provide optimum service-improvement (Cassell, 2003 in Byrne, 2006; Hyndman et al., 2003). Basing resource allocation on historical criteria (Robbins, 2004) has led to the incremental allocation of budgets. This fails to reward efficient use of resources or facilitate long-term service-planning, and the rigid system can impede innovation (Byrne, 2006). These system flaws can prevent the development of services aligned with social needs. Finally, adopting budgets and service-plans without linking them to performance indicators can be de-motivating (Hope & Fraser, 2001 in Byrne, 2006). These challenges, which derive from macro systems, are further exacerbated by constraints on discretion, caused by the nature of the service.

While the hospital administrator and executive committee have responsibility for meeting budgets under the Health Amendment Act of 1996, they actually have limited discretion. Salary costs account for approximately 70% of hospitals' budgetary allocation. In addition, because 80% to 94% of service activity is based on emergency admissions, it is hard to control activity (Robbins, 2004). Despite these difficulties, Robbins (2004) asserts that there have been attempts to engage in accounting and service-planning processes in efforts to reduce costs and augment efficiency. However, these aims have been undermined by the lack of discretion outlined above, in addition to macro system issues. Citing bureaucracy, limited discretion and a focus on accountability, Robbins (2004) asserted that the 'let the managers manage' New Public Management movement has not taken root fully in Ireland, in spite of attempts.

To ameliorate the problems in the Irish accounting system, Byrne (2006) advocated the use of multi-annual, real-time and bottom-up, activity-based budgets, with individual departments or services allocated resources based on evidenced-based assessment, and expenditure linked to recognised and meaningful performance indicators. Having explored the strategic, management and support systems in hospitals, the following section outlines an anomaly unique to Irish hospitals; the provision of private and insurance-funded healthcare in public and voluntary hospitals.

4.5.6 Providing private healthcare in public and voluntary hospitals

The characteristics of healthcare as a complex, professional service are outlined in chapter 5. However, one additional and unique component of the Irish health service is the fact that care is provided to 'private patients' in public and voluntary hospitals. 'Private patients' refer to those who opt to receive private consulting services and accommodation rather than those who avail of the public consulting services and accommodation available to all. In practice, the same consultants provide treatment across public and private patients however private patients tend to receive speedier elective admission, and a higher standard of accommodation. Nolan and Wiley (2000: 3) emphasised that the *'scope to treat their private patients within the public hospital system is an integral part of the contract many consultants work under, and is seen by them as of central importance'.* The right to maintain private practice is currently being contested in negotiations regarding consultants' contracts.

Nolan and Wiley (2000) asserted that covering the cost of private care in public, voluntary and private hospitals, has been the main role for health insurance in Ireland. Currently 40% of the population has private health insurance (Nolan et al., 2000). For Nolan et al., this high level of private-insurance coverage is problematic, as the system was designed for approximately 15% of the population. This initial calculation was premised on the percentage of the population with limited entitlement to public healthcare on the basis of income. However public-hospital entitlement was extended to all citizens regardless of income in the mid 1990s. Nolan and Wiley (2000) asserted that since then, attempts have been made to restrict private patients to designated private beds in public and voluntary hospitals. Private beds account for 20% of total in-patients beds, and 32% of all day-beds in these organisations. Attempts have also been made to extend government control over the numbers of public and private beds available in public and voluntary hospitals. Nolan and Wiley (2000) asserted that one in five patients receive private hospital care, but that as the care received by them is more costly on a per-night basis, they account for one-quarter of the direct cost of providing care in public hospitals. From an operational-management perspective, bed-management as a means to maximise revenue is a typical occurrence in Irish hospitals, and one raised by respondents in each of the three cases undertaken for this research.

Section 4.6: Overview and conclusion

The purpose of this chapter was to provide an overview of the historical and contemporary context of the Irish hospital sector, in accordance with the processual orientation adopted in the research. From chapter 7 onwards, context is identified as a significant influencing factor on service-improvement, with factors in the internal and external context acting in configuration to affect the capacity and climate for service-improvement. While this chapter has provided a somewhat fragmented overview of contextual factors, consideration of these multiple factors in relative isolation was necessary for purposes of clarity. Crucially however, in later chapters, analysis uncovers the interrelationships between contextual factors.

The first section of this chapter explored the impact of history on current organisational functioning, raising key themes. These include the role of voluntary hospitals in Irish society; the increasing similarity of management styles and the blurring of boundaries between private, public and non-profit hospitals; and whether, on the basis of the preceding developments, voluntary hospitals have become subsumed into the public sector.

The second section of the chapter identified and discussed key themes in the external contemporary hospital environment. These included changing social expectations; the New Public Management movement; health-service reform; an increase in resources in the acute-hospital sector; the expansion of private hospitals; increasing competition for staff; and, more locally, the national cardiovascular strategy.

The third section of the chapter identified key internal contextual factors. These included the impact of governance structures on operational functioning and the difficulties associated with strategic and operational management. In addition, concern with specific support systems was raised, namely HR, accounting and service-planning systems. Finally, the section outlined an anomaly in the Irish hospital sector; the provision of private healthcare in public and voluntary hospitals. Further consideration of the internal dynamics of hospitals is provided in chapter 5, which provides an overview of roles and relationships in healthcare organisations. In addition, chapter 7 details the internal and external contexts of the specific organisations that participated in this research.

Although, for purposes of clarity, historical and contextual factors have been considered individually, they interact and influence each other. In considering such interaction, outer context

has been presented as a 'predisposing' influence, internal context acting as an 'enabling' influence, and politics a 'precipitating' influence (Abelson, 2001, in Fitzgerald et al., 2002). Furthermore, there is increasing recognition that clusters of contextual factors impact service improvement. For example, Fitzgerald et al. (2006) have made preliminary attempts to identify core and secondary factors affecting service improvement. Hence, in moving towards analysis, a key issue to consider is configurations, rather than individual factors, influencing change, and whether findings differ across sectors. In so-doing, this chapter provides a frame of reference. The research findings pertaining to context are presented in chapter 9. Next, chapter 5 provides further insight into the complex internal context of healthcare organisations. It provides an overview of roles and relationships in healthcare and hospital organisations, both in day-to-day service provision and in contexts of change.

Chapter 5: Roles and relationships in hospital contexts

Introduction

The purpose of this chapter is to provide a review of the literature, and insight into, the roles and relationships through which hospital services and service-improvement change are delivered. Understanding change processes in organisations requires a focus on the *'daily processes and practices of organizational life in order to get to grips with what is actually done and by whom'* (Gondo, 2006: 3). Thus, this chapter provides an overview of research pertaining to the roles and relationships of clinicians, clinical managers and managers in healthcare. Roles and relationships provide the lense through which service-improvement change is explored in this study. They influence both the change-related activities undertaken by individuals (roles), and the social processes and context in which roles are enacted (relationships). Recent research undertaken in the UK has indicated that change is often implemented by individuals, who undertake change-related activities as extra-discretionary roles, outside of their basic job description (Fitzgerald et al, 2006b). In addition, it has been shown in UK-based research that change can have implications for roles, causing role change, role expansion and affecting power-relationships between role-holders (Fitzgerald et al., 2006a). As a result, it is important to consider the nature and manageability of basic job roles, whether change is explicitly considered a component of a job role and ongoing or change-related developments pertaining to job roles. Considering relationships is particularly important in healthcare, where social and cognitive barriers between groups have been demonstrated to affect the implementation (Ferlie et al, 2005a) and spread of change (Buchanan, Fitzgerald, & Ketley, 2007). Because there is a significant paucity of research in this area in Ireland[13], the chapter draws on literature from outside of the Irish context, predominantly the UK, U.S. and Canada.

The first section of the chapter discusses role theory as a valuable theoretical framework for exploring roles and relationships. The second section provides an overview of key roles with involvement in service-delivery: the board, managers, doctors, nurses and clinical managers. Developments in these roles, and the contextual influences upon them, are considered in both the Irish and UK context. The third section considers literature regarding roles in contexts of

[13] The Health Research Board is the body responsible for Health Research Funding in Ireland (www.hrb.ie). However, the vast majority of research funded by it has a clinical rather than service-management, focus. Although attempts have been made to broaden its focus, there remains a historical dearth of service-management research in Ireland. See the 2007 Annual Health Research Board report at http://www.hrb.ie/display_content.php?page_id=245&stream=1&div_id=5&publication_id=303

service-improvement and change. In so-doing, healthcare specific and broader change literature are drawn upon. The fourth section considers inter-professional relationships. Patterns in, barriers to, and strategies for improving inter-professional relationships are explored. To close the chapter, the fifth section examines specific key relationships in service-delivery and change.

It is hoped that this research will contribute to the emerging literature concerned with roles in service-improvement change in healthcare. As a result, this chapter provides a frame of reference for the research findings pertaining to roles presented in chapter 8. Key findings include the central role of consultants and clinical managers in initiating and implementing service-improvement, the importance of the relationship between the consultant and other professions for the progression of service-improvement, role-related constraints encountered by respondents and the importance of uni- and multi-professional networks for facilitating service-improvement. The following section details role theory, which provides a theoretical frame for the issues addressed in the study.

Section 5.1: Role Theory

Roles are a central feature of every organisation structure and are specified in the organisation hierarchy. All organisation structuring occurs through the specification of the roles that employees are expected to play.

-Huczynski and Buchanan, 2001: 470

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 health services. Huczynski and Buchanan (2001) emphasise the centrality of roles to organisational functioning. They assert that roles are associated with positions in the organisation, and should be underpinned by mutual and complementary expectations among organisational actors. Similarly, role theory is constructed on the basis of social interactions, suggesting that roles are shaped by social *expectations* and particularly the expectations of those who interact with the individual in the context of their role. Role theory has been popular among social scientists for over three decades. However it is only recently that it is being considered in autonomous and power-devolved organisational structures such as hospitals (Willcocks, 1994).

In a sociological review, Biddle (1986) identified five approaches to role theory. Of these, two have particular resonance with this study. Firstly, organisational role theory is focused on social systems which are pre-planned, task oriented and hierarchical.

> *Roles in such organizations are assumed to be associated with identified social positions and to be generated by normative expectations, but norms may vary among individuals and may reflect both the official demands of the organizations and the pressures of informal groups.* (Biddle, 1986: 73)

Organisational role theory is made pertinent by its focus on multiple sources of norms and role conflicts. Secondly, symbolic interactionism asserts that the role of the individual evolves through social interaction, and is influenced by the cognitive constructs through which social actors interpret their own and others conduct (Biddle, 1986).

> *Actual roles then, are thought to reflect norms, attitudes, contextual demands, negotiation and the evolving definition of the situation, as understood by the actors.* (Biddle, 1986: 71)

Symbolic interactionism is made relevant by its focus on the evolution of roles through a combination of social interaction, contextual demands, norms and attitudes. Its contextually embedded focus on role enactment provides an explicit link to one of the key research themes in this study, namely the identification of the factors, at role level and beyond, which facilitate and hinder the enactment of change-related roles.

Applying a role-theory perspective in healthcare, 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. Extrapolating from Ashburner et al. (1996), those which appear most likely in healthcare contexts are role ambiguity, incompatibility and overload. These are discussed below.

Role ambiguity refers to a lack of clarity regarding a particular role. Research (Bedeian & Armenakis, 1981; Breaugh & Colihan, 1994; Jackson & Schuler, 1985; Singh, 1996) has led to consensus on the four dimensions of role ambiguity: 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, Wolfe, Quinn, Snoek, & Rosenthal, 1964; Miles, 1974) and is also negatively correlated with variables such as

job satisfaction and job performance (Rizzo, House, & Lirtzmand, 1970; Singh, 1998). However, in healthcare, Willcocks (1994) indicated the contingent nature of appropriate role ambiguity. For some, this can act as an 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 of the role holder (Willcocks, 1994). This is a particular concern in hospitals and healthcare settings, where diverse professional groups with different cultures interact to achieve goals. 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) questioned whether there is a need for managers to be more selective in what they hope to achieve via doctor involvement in management, particularly as role incompatibility is one of the several causes of role overload.

Role overload is caused by an overabundance of roles, or differences in expectations, which can lead to a highly demanding workload. In healthcare, role overload has been associated with decreased job satisfaction in acute and primary care (Pearson, Reilly, & Robinson, 2004) particularly among clinical directors (Willcocks, 1994). Clinical directors 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 et al., 1994). This indicates that role incompatibility is an affliction likely to affect the broader community of clinical managers. It is more likely to arise 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.

The individual role incumbent's perception of their own role, and whether they perceive this as manageable, is at the heart of all of the major concepts in role theory. In UK-based healthcare research, Willcock's (1994) case study of the clinical director role made role-size and role-change salient concerns in healthcare contexts. More broadly, Fitzgerald et al.'s (2006b) finding that portfolio roles are increasing raises further concerns regarding role size, clarity, and manageability. Portfolio roles refer to *'an individual who describes their current role in terms of a number (on average 3–7) of discrete parts with differing targets, and where they engage with different sets of people'* (Fitzgerald et al, 2006b: 206). The components of a portfolio role may

include managerial and clinical tasks inside and outside of the hospital. Such roles can present greater problems of clarity than clinical-management roles (Fitzgerald et al., 2006b). Fitzgerald et al. (2006a) found that portfolio roles are predominantly held by senior management executives and by managers, working within or between networks and trusts in the NHS. As a result they suggest that a rise in networks in healthcare will be accompanied by an increase in portfolio roles. In addition, given the emergence of clinical managers, a rise in the number of individuals holding a portfolio of roles is to be expected. Currently, with the exception of Fitzgerald et al. (2006a), there is little research into the nature or prevalence of such roles. With the exception of clinical managers, discussed in the ensuing section, no attention has been paid to the residual training needs of such individuals nor to the degree to which such roles are manageable, empowering or motivating. These issues are of crucial importance for workforce planning, service-delivery and change; as for Willcocks (1994), role effectiveness is determined by the extent to which the role incumbent can mange, modify or live with conflicting or significant role expectations. This outlook is mirrored in the symbolic interactionist perspective. However, in addition to individuals, symbolic interactionism emphasises the impact of contextual demands, and the contextually embedded nature of roles. As a result, the following section will consider the background influences that have shaped role developments in the NHS and Irish context prior to and throughout this study.

5.1.1 The importance of context in role theory

Role theory is a useful heuristic for conceptualising roles and for exploring the key issues that arise in role definition and execution. It particularly focuses attention on the interpersonal aspects of role evolution. However, with the exception of the symbolic-interactionist perspective, it simplifies role emergence into a dyadic process between the role incumbent and role set. In reality, internal and external context also influence the evolution of roles. Internally, Gondo (2006) noted that behaviours are mediated by institutions. Similarly, Barley and Tolbert (1997) asserted that institutions influence the behaviour of individuals in many ways. In particular, they influence how people communicate, how power is enacted and the behaviours which are sanctioned and rewarded.

While the UK and Irish healthcare contexts differ substantially, there is no research on the influence of context on roles in Ireland. As a result, UK research has been considered here. Crucially however, Davies and Harrison (2003a) emphasised that the changes evident in the UK are part of an international phenomenon rooted in a perceived crisis in healthcare funding and attempts to improve efficiency. This has been accompanied by 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 et al., 2003a). In the NHS, historical role relations have been challenged by the advent of NPM, with its associated developments of "managerialism" and "marketisation" (Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996). These have had implications for service delivery, organisational structures and work practices, which have, in turn, influenced the configuration of roles and responsibilities in healthcare (Ashburner et al., 1996). Specific effects are evident in an increased managerial mandate (Lesley & Griffiths, 2000), a rising emphasis on inter-professional working (Braithwaite & Westbrook, 2005), shifting role boundaries (Humphris & Hean, 2004) and tensions in the clinician – manager interface (Levitt et al, 1999). Managerialism has had particularly significant implications for roles and relationships in the acute hospital context, through the introduction of clinical-management roles and clinical-directorate structures[14]. In contrast, marketisation has had particularly marked effects on the roles and relationships of primary and acute care (Ashburner et al., 1996) and for the balance of power and relationships between managers and healthcare professionals in the NHS (Griffiths & Hughes, 2000). However, there appears to be disagreement regarding whether clinical-directorate structures have increased inter-professional working (Braithwaite & Westbrook, 2005) and the extent to which there has been success in getting clinical directors or other clinical-managers to buy into managerial values (Hoque, Davis, & Humphreys, 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, which has impacted role responsibilities and relationships (Humphris et al., 2004).

In Ireland, managerialism has manifested in emphasis on the criteria of 'efficiency' and 'effectiveness' in government health policy (Department of Health and Children, 2001b). The integration of these criteria into public policy was outlined in Section 4.4.3. In tandem, these criteria have led to the restructuring of the health-service administrative structures; a process outlined in Section 4.4.4. While marketisation has not occurred in the same form or with the same speed as in the UK, there has been an increasing emphasis on competition in the health service. Thus it is important to consider any impact upon roles or relationships that may have occurred or be occurring.

[14] A clinical directorate is generally presented as a management cost centre, which covers one or more clinical specialities (Kitchener, M. (2000). The 'bureaucratization' of professional roles: The case of clinical directors in UK hospitals. Organization, 7(1): 129–154..

In line with chapter 3, the above section emphasises the impact of context on roles. This research attempts to explore processes of service -improvement, in context, at the level of the individual, through the medium of roles. As healthcare roles are enacted in contexts with strong socially and cognitively based groups (Ferlie et al., 2005) aligned to professions, the ensuing sections examine both the roles and relationships of key service providers in healthcare, who both implement and are affected by change. Section 5.2 explores key roles in contexts of service-delivery while Section 5.3 explores roles in service-improvement and change.

Section 5.2: Roles in service-delivery

Based on research conducted in the UK and U.S., boards of trustees, managers, doctors and nurses have been identified as the four most powerful role groups in healthcare organisations (Boss, 1989; Johnson, 1979; Mintzberg, 1997). However, in both the U.S. and UK, clinical managers are increasingly emerging as influential (Schneller, 2001; Montgomery, 2000; 2007; Fitzgerald et al, 2006). As a result, board, managerial, medical, nursing and clinical-management roles are outlined and reviewed. In addition, the interaction of these key roles in the context of change is delineated.

5.2.1 The role of the board

Organisations tend to be governed by boards of governors and managed by boards of directors. In this section, concern is focused on boards of governors. In most private and voluntary hospitals in Ireland, representatives from the board of directors sit on the board of governors. Interestingly, public hospitals in Ireland do not have boards of governors, but are centrally administered by the HSE through a network manager. Chapter 9 emphasises the negative impact which this structure has for the autonomy of senior management in the public hospital studied. In Ireland, the only research on hospital boards was undertaken by O'Ferrall (2000), who raised the issue of government attempts to influence the governance of a voluntary hospital, in the context of the amalgamation of three organisations onto one site. His research raised the issue of whether voluntary boards can maintain independence while in receipt of significant government funding. In voluntary hospitals there are three board forms evident. Firstly, voluntary hospitals are predominantly independently owned and governed by boards of governors. Secondly, a move towards adopting limited company status, with an associated change to a 'board of trustees' has been driven by a fall in vocations. Thirdly, some voluntary hospitals are Corporate Bodies Act Hospitals, incorporated under charter or by statute, and governed by lay boards of governors

(Department of Health and Children, 2005). Such hospitals tend to have senior executives from the Department of Health and Children on their Boards.

Due to the paucity of literature about Ireland, a broader literature is drawn upon to consider the range of possible roles undertaken by boards. These include stewardship (Conger, Lawler, & Finegold, 1998); preventing and managing crises (Conger et al., 1998); policy formation and strategy development (Brown & Iverson, 2004; Mankins, 2007; Waitzer & Enrione, 2005) assisting in obtaining resources (Callen, Klein, & Tinkelman, 2003; Oster, 1995); CEO succession and executive team selection (Conger et al., 1998; Lorsch & Khurana, 1999); managing the board–CEO relationship (Czinege., 2005; Leduc & Block, 1985); ensuring legitimacy (Conger et al., 1998); boundary spanning (Harris, 1996) and evaluating organisational performance (Jansen & Kilpatrick, 2004). While each board will have different functional priorities that may change over time (Wood, 1992), what is universally important is that the board agrees on its mission (Oster, 1995).

Writing about the private sector, Murphy (2004) asserted that boards can be characterised by four orientations to how they carry out their roles. These are (1) defenders, who operate within stable environments and are concerned with maintaining the status quo; (2) Reactors, who give little consideration to the environment and drift without paying attention to strategy formulation; (3) Prospectors, who work in environments characterised by high uncertainty and risk, and thrive on growth and new opportunities; and (4) Analysers, who stress the maintenance of the status quo with innovation in a moderate environment. However, Oster (1995) highlighted that, in both structure and function, the nonprofit board differs from their for-profit counterpart in size, composition, degree of dissension and level of involvement in the operating function. Nonprofit boards are larger and tend to be more diverse than for-profit boards. They also tend to be entirely composed of non-employees. In terms of function, Oster (1995) asserted that nonprofit boards tend to have more dissension and more involvement in operating functions than for-profit boards. Nonprofit organisations work within a non-distribution constraint and instead of acting on behalf of shareholders they act on behalf of customers and donors. Thus the nonprofit board has fewer natural constraints on its behaviour than the for-profit organisation. Section 4.2.2 returns attention to healthcare-specific managerial roles.

5.2.2 Managerial roles in acute care

There is no literature regarding managerial roles in hospitals in Ireland. In the UK, key developments in managerial roles in acute care include the expansion of strategic involvement among middle managers, a general expansion of roles and a specific increase in change-related activities (Ashburner, Ferlie, & Fitzgerald, 1996; Fitzgerald et al., 2006b). In the acute sector, middle management has expanded from a traditional focus on operational concerns, to incorporate strategic involvement and more change-related activities (Ashmos, Huonker, & McDaniel, 1998). Such activities include the multifaceted quality-improvement role (Bradley, Holmboc, Mettera, & Rouomnis, 2003). Ashmos et al. (1998) related this to the introduction of contracting for services. Similarly to developments regarding pure managerial roles, there has been a general trend towards expanding doctors' involvement in management in the NHS (Davies et al., 2003a) and U.S. (Montgomery & Oliver, 2007).

5.2.3 Nursing roles

The structure of nursing education in Ireland has been subject to significant change since the 1998 Commission on Nursing Report (Government of Ireland, 1998). The Commission on Nursing Report led to a move away from an apprenticeship model to the integration of nursing into third-level education. It also provided for the development of centres of nurse education, the initiation of a 'clinical career pathway' and the establishment of a National Council for the Professional Development of Nursing and Midwifery. In addition to changes generated by this report, there have been additional significant changes to nursing roles, with more planned for the future. 'The Scope of Nursing and Midwifery Practice Framework' (An Board Altranais, 2000) was developed by the Irish Nursing board (An Board Altranais) to support nurses in the expansion of their scope of practice (An Board Altranais; National Council for the Professional Development of Nursing and Midwifery, 2005. Such expansion is evident in the ratification of the introduction of nurse prescribing (An Board Altranais et al., 2005) by the Minister for Health and Children in 2007. In an earlier aligned development, the training of healthcare assistants has been adopted as a strategy to maximise the professional skills of nurses (Department of Health and Children, 2001a). Thus, role expansion is evident in the nursing profession in Ireland. As clinical nurse specialist and advanced nurse practitioners roles are not developed across all clinical areas, An Board Altranais has identified this and nurse-led clinics as areas for future development.

In addition to role expansion, role ambiguity is also evident in nursing roles, with the exception of recently formalised Clinical Nurse Specialists and Advanced Nurse Practitioner Roles (An Board Altranais et al., 2005) While nurse specialists have been operating in Ireland for a significant

period of time, they historically lacked a framework for development, have had a diversity of role titles and been at a variety of grades, from staff nurse through to Clinical Nurse Manager Grade 2. While their role definition is now clear, role ambiguity remains for general nursing staff (An Board Altranais et al., 2005). Finally, nurse managers have been identified as key roles within service improvement, with investment in their professional development a priority (An Board Altranais et al., 2005).

5.2.4 Doctors' roles

In Ireland, key developments pertaining to doctors' roles are the European working-time directive, which has restricted working hours and led to renegotiations of the consultant contract. The proposed consultant contract, provided by the HSE, has been opposed by the Irish Hospitals Consultants Association on the basis that it will compromise clinical independence, introduce new working patterns, including nights and weekends, lower existing rates of pay, and compromise a preexisting right to engage in private practice (Irish Hospital Consultants Association, 2007). As there has been no Irish research to date regarding broader role developments among Irish doctors and consultants, attention now reverts to UK research.

A key role development in the NHS is the evolution of clinical-management roles among doctors, increasing and formalising their involvement in management. Clinical-management roles tend to be adopted by consultants (Fitzgerald et al., 2006b) and, due to their significance, are discussed in detail below. Their development can potentially be related to fragmentation of roles among doctors. Freidson's restructuring thesis 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 (Montgomery, 2000; Montgomery et al., 2007). These are classed as the producers, the knowledge elite and the administrative elite respectively. Thus key developments among doctors' roles include the expansion of involvement in management and a potential fragmentation of roles in the profession itself. Increasing doctors' involvement in management has been advocated in Ireland, through the clinicians-in-management scheme, introduced in 1998. However this has been variably implemented in limited numbers of pilot sites. Nonetheless, clinical management roles are presented as pivotal in service-improvement in chapter 8. As a result, the following section considers developments in clinical-management roles in the UK and U.S. as potential benchmarks.

5.2.5 Clinical-management roles

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

– Bate, 2000: 493

The use of clinical managers has 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 main assumptions (Hoff, 1999a): clinical managers make different and valuable offerings when compared with clinicians and managers, and the core skills required to be a manager and to be a clinical-manager are similar. For Hoff (1999a), the first assertion justifies the emergence of a medical-management speciality, while the second facilitates a claim towards a body of professional knowledge. However Hoff's core concern is that striving for management credibility will undermine the clinical credibility that underscores their unique offering. Drawing upon research from the UK and U.S., this section considers the role of clinical managers and issues that have arisen in those contexts. Crucially, there is sparse evidence regarding the organisational or professional outcomes associated with clinical managers (Schneller, 2001). In spite of anecdotal claims that clinical managers are of benefit, Montgomery (2000) asserted 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.

In the NHS, the number and range of clinical staff performing clinical-management roles appears to be increasing (Fitzgerald et al., 2006b). However, although the roles adopted by clinical managers have been described as large and complex, with significant change management as well as operational functions (Ferlie et al., 1996), recent research has identified a focus on operational management, with little involvement in service improvement or change management (Fitzgerald et al., 2006b). Fitzgerald et al. attributed this focus on operations to day-to-day pressures. They noted that their finding is more pessimistic than earlier literature, which had presented a broad role definition. Prior research into the construction and enactment of clinical-management roles in the UK (Bouffard, 1993; Buchanan, Jordan, Preston, & Smith, 1997a; Fitzgerald, 1994; Fitzgerald & Dufour, 1997; Fitzgerald & Ferlie, 2000; Marnoch, 1996) has also raised questions regarding the nature of power and legitimate authority and autonomy. Willcocks (1994) found that some clinical directors did not have sufficient authority to execute their responsibilities, although they were accountable for results. He also found evidence of

misunderstanding between managers and clinical directors[15] regarding the extent of devolution of authority and responsibility. This was attributable to initial uncertainty regarding the nature of the role and its responsibilities (Willcocks, 1994). Further concerns raised include problematic relationships between clinical managers and colleagues who are peers (Fitzgerald, 1994; Montgomery, 1990) and debate regarding the commitment of clinical managers to management (Dopson, 1993; Gatrell & White, 1996; Fitzgerald, 1994). Another recurring theme in the literature is a lack of management training among clinical managers (Ferlie et al., 1996; Hoque et al., 2004; Jacobs, 2005; Kirkpatrick, Maltby, Dent, Neogy, & Mascie-Taylor, 2007). In particular, a lack of financial expertise has been identified as problematic (Llewellyn, 2001), although there has been some interest identified among clinicians in acquiring management skills (Jacobs, 2005). Given this training deficit, Hoque et al. (2004) questioned the wisdom of providing further autonomy to clinical managers. Attempts to provide systematic training have been led by the British Association of Medical Managers 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 clinical-management posts are being adopted for limited periods of time, have yet to be explored in the UK. Due to their recent introduction in Ireland, an evaluation of this nature has not occurred. The underlying motivations of clinical managers in entering posts could also provide insight into aspirations towards professional managerial roles. Finally, a crucial issue is the finding that a significant number of clinical managers in the UK do not wish to remain involved in management (Fitzgerald et al., 2006b; Hoque et al., 2004).

In contrast, U.S.-based research has identified the development of clinical-management responsibilities from internal and operational to more external and strategic roles, including strategic planning and capital decision making (Bodenheimer & Casalino, 1999; Scherer, 1999). This shift has occurred in the form of role expansion among clinical managers, without reduction in preexisting responsibilities (Schellner, 1997). Specifically, Betson & Pedroa, 1989 (in Montgomery, 2000) found that in addition to practicing medicine, clinical management roles encompassed three broad categories of tasks, all classified as 'boundary-spanning' activities: quality assurance, communication and conflict mediation. In addition, Montgomery (2000) cited

[15] In the NHS the clinical director role was introduced as a part-time management post, which was to be held by a practicing clinician. In practice, this role is predominately held by consultants. The clinical director is usually supported by a business manager and a nurse manager Kitchener, M. (2000). The 'bureaucratization' of professional roles: The case of clinical directors in UK hospitals. Organization, 7(1): 129–154. In contrast the medical director role is full time in nature, necessitating the abandonment of clinical commitments Bruce, A., & Hill, S. 1994. Relationships between Doctors and Managers: The Scottish Experience. Journal of Management in Medicine, 8(5): 49-57. This latter role attempts to bring doctors and managers together in the development of strategic objectives.

Schneller et al. (1997) and Dunham et al. (1994), who highlighted the rise of the negotiator role among clinical managers. However these responsibilities remain residual to the more prevalent boundary-spanning activities outlined above.

In both the U.S. and UK, a recurring theme among clinical managers is the desirability of maintaining clinical practice (Fitzgerald et al., 1997; Schellner, 1997). Although clinical-management roles appear, by definition, to be held by individuals with clinical responsibility, Hoff's (1999a, 2001a) U.S.-based survey found that over half of the respondents did not currently practice medicine, and of those who did, approximately 85% practiced for only one or two days per week. Hoff's (1999a) parting assertion about medical management was that the legitimization of medical management does not have to progress in an either/or capacity; physician managers don't have to abandon their clinical roles. Although this limits the time available for management activities, this will only become an issue where clinical managers see themselves as *traditional* rather than *medical* managers. The onus is on the professional group to persuade stakeholders that maintaining practice is of benefit. In addition, the organisation has the responsibility to provide the space and resources to fulfil both roles.

An important issue is that while broad reference is made to 'clinical managers', research tends to address this group as a whole, without considering the extent to which nurses and AHPs are involved in clinical-management posts. If this is the case, stratification in the experiences and responsibilities of clinical managers should be expected, due to the pluralistic and hierarchical nature of healthcare organisations (Bate, 2000). As a result, building upon this overview of key roles, which draws on literature from the U.S. and UK, inter-professional relationships and particularly the relationships between key service providers are considered in Section 5.5. Prior to this, Section 5.3 considers the interaction of key roles in change.

Section 5.3: Roles in service-improvement and change

While there is significant literature on change roles and implementation, a majority has been completed in and oriented towards commercial contexts (Beckhard & Pritchard, 1992; Burke, 2002; Pettigrew, 1985). Although there are a number of common issues in change management, the unique characteristics of the professionally dominated organisation have been identified both in healthcare (Fogel, 1989) and elsewhere (Brock, Powell, & Hinings, 1999). On this basis a more specific literature has developed, concentrating on change in healthcare. This includes an OD

literature (Boss, 1989; Coghlan & Mc Auliffe, 2003; Margulies, 1982). However OD is an organisation-wide approach to change, unlike the more limited service-improvement change of interest in this context. In addition there is a specific healthcare literature using the processual perspective, premised on UK-based research (Pettigrew, Ferlie, & McKee, 1992; Ferlie et al., (1996). While there is research on managing healthcare in Ireland (Leahy & Wiley, 1998; McAuliffe & Joyce, 1998; O'Sullivan, 2002), there is no work that particularly addresses change roles in hospitals. The closest research concerns OD and change agents on health boards (Coghlan, McAuliffe, & Pathe, 2002-03; McAuliffe, 2002), and called for further research into the role of internal change agents, both in that context and in healthcare more broadly. The present research addresses that call. The broader literature pertaining to change roles and the literature specific to healthcare are considered below.

5.3.1 Change roles

The broader practice literature pertaining to change roles and agency emphasises role taxonomies and competencies, and is further subdivided between internal and external change agents (Buchanan, 2003). Buchanan noted that greater emphasis is placed on external agents in the literature, though the focus in this context is on internal change agents.

Three broad categories of change-agent roles have been identified by Ottaway (1983). These are (1) change generators; (2) change implementers and (3) change adopters. Change generators comprise key agents, demonstrators, patrons and defenders. Change implementers can be internal or external to the organization and change adopters comprise early adopters, change maintainers and users. Buchanan (2003) cited Beatty and Gordon (1991), who distinguished between senior management patriarchs as the source of ideas and evangelists who implement them. A broader and more political array of change-agency roles are outlined by Buchanan and Storey (1997b). They identify change initiators, sponsors, drivers and subversives. Buchanan (2003) asserted that change drivers undertake the day-to-day work of change implementation. Importantly Buchanan and Storey (1997b) asserted that individuals can both adopt and switch between these roles. In fact, they identify the capacity to switch as a key skill in change management.

Buchanan (2003) was critical of these taxonomies, asserting that they fail to accurately reflect the fluidity of change roles, and particularly those involved in implementation. He asserted that categorical approaches to change agency may only be of limited value, specifically as descriptive

or explanatory devices. In general, these taxonomies focus on senior and middle management (Buchanan, Claydon, & Doyle, 1999b). However, recent research in the healthcare domain indicates that change-management roles have become more widely dispersed, involving staff across all organizational levels (Fitzgerald et al., 2006a). This is particularly the case in bottom-up and emergent change, although it is also evident in strategic change (Buchanan et al., 1999b). In addition, leadership has been identified as a key factor in both initiating change, and generating follower acceptance (Grint, 2005; Kavanagh & Ashkanasy, 2006). *'Leadership is the art of mobilizing others to want to struggle for shared aspirations'* (Kouzes & Pozner, 1981 in Kavanagh & Ashkanasy, 2006).

While there is little consensus on the definition of leadership, it has been defined in relation to the person, result, position and process, with some overlap (Grint, 2005). Leadership as a person-based trait emphasises the relationship component, which implies increased difficulty in effective leadership in multi-professional or contested contexts. For Grint (2005), leadership is inherently bound with notions of change. *'Management is concerned with executing routine and maintaining organizational stability – it is essentially concerned with control; leadership is concerned with direction setting, with novelty and is essentially linked to change, movement and persuasion'* (Grint, 2005: 15). Similarly, Kavanagh & Ashkanasy (2006: 82) described leadership as *'the process of motivating people to change'.* Their study, exploring mergers, found that the success of the change process depended on the manner in which it was both managed and led. For them, there has been insufficient analysis of the role of leadership in change management. An alternative approach to generating change are individuals meeting DiMaggio's (1988) notion of an 'institutional entrepreneur'. These individuals are particularly critical to whether organisations can implement radical change. DiMaggio described an 'institutional entrepreneur' as an individual able to change perceptions of the appropriate way to respond to particular stimuli. For him, they change behaviours and then use rhetoric to legitimise the new action in the context of the broader change. Gondo (2006) asserted that some contexts are more amenable than others to institutional entrepreneurship. She based this argument on Barley and Tolbert's (1997) assertion that that unconscious action is unlikely to produce radical change. As a result, high-change contexts have fewer routines, and require more conscious thought than the activities of actors in stable environments. Similarly, Gondo (2006) asserted that highly political contexts lead to more conscious action than less political ones, as actors actively campaign to maintain their interests. As politicking is a component of some change-related roles, and as the political environment in

organisations affects the enactment of roles, politics in change and its effect on roles are considered below.

> *It may be assumed that, in most organizations, the prevalence of political behaviour is the norm rather than a variant.* (Buchanan & Badham, 1999: 610).

Buchanan and Badham (1999a) emphasised the centrality of politics as a component of individual roles in change processes. While power refers to the *capacity* to exert will over another, politics refers to the *application* of power, which requires action by an individual role holder. Buchanan outlined definitions of politics that all portray political behaviour in negative terms (Mintzberg, 1983, Mayes & Allen, 1977; Drory & Romm, 1990). However, others argue that organisational politics are central to both the theory and practice of change. Buchanan and Badham (1999) cited Burns (1966); Mangham (1979), Kakabadse and Parker (1984) and Frost and Egri (1991) in this regard. They noted that, to date, theory has avoided political behaviour, presenting it as a field of 'dirty tricks'. Consideration of politics is limited to generalised theoretical overviews and lists of 'power tactics.' In contrast, Buchanan and Badham suggested that political behaviour is, in practice, an accepted rather than objectionable element of the change-agent role. However, they asserted that little is known about the motives, conduct, manoeuvering, tactics, power plays, perceptions and self justification of change agents. Overall, Buchanan and Badham (1999) indicated that the change-management literature neglects politics in theory construction and prescription.

The change literature remains fragmented in how it deals with political behaviour. Several approaches to change either repress or superficially consider politics. For example, OD has historically attempted to distance itself from political behaviour, aiming to produce agreement and consensus that may be difficult in large organizations. Similarly, in recipe-type approaches to change, politics tends to be superficially addressed via identifying power brokers (Buchanan & Badham, 1999). While the processual approach recognises the significance of political factors in implementing strategic organisational change, for Buchanan and Badham, (1999) those working in this perspective have failed to offer guidance on the nature and consequences of political interventions, focusing on the theoretical rather than the practical. However, by drawing attention to nonlinear dynamics, the political arenas where decisions are made and the enabling and constraining characteristics of the substance and context of change, Buchanan and Badham asserted that processual change can provide a useful platform for researching political agendas.

Attention now turns to the literature on change roles in healthcare, where collective leadership has been adopted as a mechanism for managing multiple and competing agendas in change.

5.3.2 Change roles in healthcare

A healthcare-specific literature concerned with change roles and leadership suggests that clinical leaders can act as both supporters and obstructers of change (Pettigrew et al., 1992). In addition, research in both Canada and the UK has emphasized the need to examine leadership as a collective as well as an individual trait. Based on research conducted into strategic change in Canada, Denis et al. (1996: 690) asserted that there is a need *'to involve all the main structural poles of leadership in the organization'.* While they identify these as the board, medical staff and administration, Mintzberg (1997) also incorporated nursing into his classification. Crucially, Denis et al. (1996: 690) noted, *'we are not suggesting that within a functional leadership constellation, all roles necessarily carry equal weight.'* Underlying collective leadership is the premise that, given the multiplicity of stakeholders in healthcare, there is an increased likelihood of success in change where a collective leadership approach is adopted (Mintzberg, 1997).

Denis et al. (2001) drew upon Hodgson et al.'s (1965) assertion that leadership constellations can be more or less effective depending on the levels of specialization, differentiation and complementarity achieved between members of the management team. These respectively refer to the adoption of specialised areas of expertise; the division of roles so that there is little overlap; and the fit between roles. Denis et als noted that, in healthcare, collective strategic leadership is often explicitly formalized in the organizational structure. Nonetheless, even where formally established, collective leadership is fragile due to diffuse power and multiple objectives. It can disintegrate due to internal conflict or discrediting associated with unpopular change tactics. The issues of diffuse power and multiple objectives lead to a climate suitable for politicking and the adoption of politicking by change agents.

In UK-based research exploring the implementation of service-improvement rather than strategic change, Fitzgerald et al. (2006a) confirmed and extended prior findings regarding collective leadership. In their most successful cases, duos and trios of senior managers worked together to implement change, their success often acknowledged by other staff in the organisation. Fitzgerald et al. identified the CEO, general managers and senior clinical managers as potential members of the leadership teams. In addition, they noted that the most successful sites had dispersed leadership of change. They defined dispersed leaders as involving *'the active engagement of*

staff, both at different levels in the organisation, and from a range of professional and managerial backgrounds' (Fitzgerald et al., 2006: 209). Fitzgerald et al. identified the specific characteristics associated with dispersed leadership: (1) a supportive and active senior-management team willing to become involved in facilitating changes; (2) clinical managers and senior clinicians providing leadership, advice to colleagues, negotiating for resources and constantly pushing the change forward and; (3) individual clinicians (of all professions and backgrounds) willing to undertake specific tasks. Fitzgerald et al. (2006) asserted that this new finding regarding dispersed leadership enhances previous findings regarding collective leadership. They also tentatively suggested that change initiatives may be impeded where gaps in dispersed leadership are present. Such gaps may take the form of a level in the organisation that lacks support for espoused changes, or the lack of a facilitator or opinion leader in a key professional grouping.

Fitzgerald et al. (2006) found that general managers, clinical managers and clinicians acted as change leaders and facilitators. However, most service-improvement changes were led by clinical managers in acute care. Specifically, larger and more strategic changes tended to be led by clinical or general managers, with smaller, localised and more fragmented change led by clinicians. Where clinical-service changes were solely led by general managers, they encountered greater difficulties. Interestingly they found that many of the clinical managers in acute care did not define themselves as leaders or change agents. Fitzgerald et al. noted that many attempts to introduce service-improvement change are fragile, and overly dependent on a small number of individuals. One short-coming of the literature on change roles is its failure to address the fact that most managers now combine change responsibilities with their regular duties, rather than being specialist project managers and change consultants. (Fitzgerald et al, 2006)

This section has shown that individuals dispersed throughout organisational levels, and from multiple professions, interact in the implementation of change. In particular, through collective leadership, collaboration between consultants, nurses and managers is encouraged. As a result, Section 5.4 considers patterns in and barriers to inter-professional relationships, as well as how these might be addressed.

Section 5.4: Inter-professional Relationships

Multidisciplinarity seems perennially easier to talk about that to realise

-Masterson, 2002 in Braithwaite & Westbrook, 2005: 11

Inter-professional relationships occur in the context of socially constructed entry (membership) and domain (task) boundaries that delimit different professions and social entities (Montgomery et al., 2007). Relationships and professional relations affect both day-to-day organisational functioning and the implementation of change (Fitzgerald et al., 2006a; McNulty & Ferlie, 2002; Pettigrew et al., 1992). For Fitzgerald et al., the absence of good working relationships makes even small-scale changes difficult. Thus considering inter-professional relationships is an integral component of researching the implementation of service-improvement change.

Healthcare organisations are multi-professional milieus, where the expertise and values of several groups are required for effective organisational functioning (Anderson & McDaniel, 2000). As a result, they have been described as 'negotiated orders' (Weick, 1979), 'multi-voiced' and 'pluralistic' (Bate, 2000). In inter-professional interactions, medical power has been extensively researched by political and social theorists. It has been found to have an enduring legacy (Bond et al., 1987, McIntosh & Dingwall, 1978). Specifically, the connections between power, knowledge and discourse have ensured that medicine has been able to determine who has a voice in clinical settings (Degeling & Maxwell, 2004). This raises questions regarding whether and how the key role groups in the healthcare arena can work effectively together, both in day-to-day service provision, and in contexts of change. These questions are considered in this section. Specifically, this section discusses patterns and barriers in inter-professional relationships and how inter-group relationships might be improved. Building on this general overview, section 5.5 then explores the specific key relationships emphasised in the literature. These are the relationships between doctors and nurses, doctors and managers, and the relationship groupings of clinical managers.

5.4.1 Patterns in inter-professional relationships in healthcare

Reeves and Lewin (2004) described inter-professional relationships in healthcare service provision as fragmented, of short duration and recurrently shifting between individuals and organisations. With collaboration premised on short, unstructured and opportunistic interactions, they asserted that clinical professionals form loose and transient groups around a purpose, rather than adopting continued and purposive collaboration, leading to sustained relationships. Similarly, Engestrom et al. (1999) described inter-professional relationships as 'knotworking', based on establishing and reestablishing links via brief interactions. Although most interaction occurs within professional groups, Reeves and Lewin (2004) described collaboration between nurses and AHP's as being more friendly and of longer duration than other inter-professional relationships. A

key issue is whether this goal-focused transient and superficial relationship structure is also evident in the context of change. Findings by Fitzgerald et al. (2006a) suggested this might be the case. They found that networks of sustained relationships tended to be predominantly managerial or clinical. Exceptions to this critical finding were predominantly evident among clinical managers. For Fitzgerald et al. (2006: 173) the implications of this finding are threefold: not all parties are involved in decisions for change, which decreases the pool of available experts; lack of regular contact and liaison fails to strengthen relationships or increase understanding between professions, clinicians and managers (Bruce et al., 1994; Davies, Hodges, & Rundall, 2003b; McCutcheon, 1998; Nash, 2003); and roles that span professional groups are crucial. In accord, Reeves and Lewin's (2004) found that doctors tend to view collaboration as something involving their medical colleagues, while other professionals perceive it as a more inter-professional activity. In the clinical realm, Reeves and Lewin (2004) highlighted the use of care coordinators and nurses as boundary spanners between professionals, passing information between those who couldn't interact in person. In the managerial realm, clinical-management roles span clinical and managerial groups (Fitzgerald et al., 2006b). The spanning of the two worlds also leads to the recurring theme of the desirability of clinical managers to maintain clinical practice (Fitzgerald & Dufour, 1997; Schellner, 1997), although this is less likely in senior management positions (Hoff, 1999a).

In considering the quality, as well as the locus of relationships, Fitzgerald et al. (2006a) noted that relationships between clinicians and general managers were generally perceived as functional, if distant. However, the relationships between clinical groupings were more varied (Fitzgerald et al., 2006b). Problems in these relationships had significant impact on the provision of care. Barriers to inter-professional relationships are discussed below.

5.4.2 Barriers to inter-professional relationships

Inter-professional relationships are hindered by social and cognitive boundaries between groups (Ferlie, Fitzgerald, Wood, & Hawkins, 2005) and are complicated by the fact that healthcare relationships can span organisational boundaries. While social boundaries are *'created by well developed professional roles, identities and traditional work practices'* (Ferlie et al., 2005: 128), cognitive boundaries are underpinned by different research traditions and knowledge bases. Despite the fact that professional 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 multidisciplinary team membership. Significantly,

doctors tend to have a determining role in interactions (Connor, 1998). In describing the effect of these social and cognitive boundaries, Bate (2000) asserted that tribalism is an active manifestation of these paradigmatic differences. He described such tribalism as an innate element of hospital culture, which remains paternalistic and authoritarian, with ramifications for inter-professional relationships. For him, what differentiates effective from ineffective professional organisations is the extent to which such tribalism is contained. As a result, Section 5.4.3 looks at how inter-professional relationships can be improved.

5.4.3 Improving inter-professional relationships

Given the differences between professions, the issue of how to generate productive inter-professional relationships is vital. Coghlan and Mc Auliffe (2003) asserted that dialogue is central to the basic functioning of inter-professional relationships. They define dialogue as listening to one another and exploring meanings and assumptions to reach common understanding. They also asserted that successful inter-professional relationships are characterised by role clarity and differentiation and that for a team to be successful it must have *specific* goals to ensure that everyone is working in the same direction and understands the teams' priorities. Thus, goals must also be accepted by all professions. A similar orientation is adopted by Bate (2000), who asserted that, as professional allegiances are too strong to facilitate an overarching hospital or healthcare 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.

One emerging approach to organising in healthcare, with implications for inter-professional working, is the adoption of network structures. Although networks of individuals with shared interests can emerge organically (Addicott, McGivern, & Ferlie, 2006), the focus in this section is on more formalised networks, increasingly being used to streamline complex patient pathways (Addicott, McGivern, & Ferlie, 2007). Networks can operate both within and across organisations. For Bazzoli et al. (1999: 1687) health networks are *'strategic alliances or contractual affiliations of hospitals and other health organizations (e.g. nursing homes, home health agencies), that provide an array of health services.'* More broadly, Addicott et al. (2007) noted that while there is no single definition of a network, the terms tends to refer to strong *formal* and *informal* communications between individuals in related organisations. Ferlie and Pettigrew (1996) identified specific network forms in the NHS, which included internally oriented network-based styles of working, clinical networks and multidisciplinary working. Externally, inter-organisational networking and inter-agency alliances were evident, including alliances with social care, voluntary

organisations, educational institutions, local employers and the EU. Of these network forms, they noted that *'clinical networks exercise an important role in interorganizational communication as well as managerial networks, and remain outside direct managerial control'* (Ferlie & Pettigrew, 1996: 93). The importance of inter-organisational clinical networks in facilitating relationships and service-improvement is discussed in chapter 8.

Networks have been adopted in healthcare on the basis that they can respond more flexibly to changing conditions than hierarchies (Ferlie, Hawkins, & Kewell, 2002). In addition, networks have been advocated on the basis of being effective forums for sharing best practice, and developing education forums across organisational and professional boundaries (Addicott et al., 2007). To stimulate the transfer of knowledge between professional groups, *'a sustained platform of joint activity and local learning'* (Addicott et al., 2006: 88), is highly useful. This facilitates the generation of shared cognition through socialisation, interaction, knowledge sharing and experience (Addicott et al., 2006).

Addicott, McGivern and Ferlie (2006) explored whether the theoretical benefits of managed, rather than organic professional networks, encouraged the transfer of 'best-practice', and accelerated organisational learning, knowledge management and the formation of communities of practice. However, in four of the five cases studied, knowledge sharing was undermined by competition for resources, and there was limited exchange of best practice across organisations and professions. This finding was classified as a distortion of the network agenda regarding knowledge exchange and education with the managerial focus undermining some of the preexisting networks between clinicians (Addicott et al., 2007). For them, this finding undermines early indications of an emphasis on education in networks by Kewell et al. (2002). An explanation is provided by Addicott et al. (2007), who identified a fundamental incompatability between the goal of knowledge sharing and the competitive nature of performance management in the NHS. Another network-management issue identified by Ferlie & Pettigrew (1996) concerns how to sustain interest and commitment to a network over time, particularly in a context where the participants' time is in demand. Thus, while networks have been advocated, issues have emerged in practice. This explains Addicott et al.'s (2006) assertion that there is evidence of a shift away from networks and back towards quasi-markets, in organising in the NHS. The form and impact of networks in service-improvement, in this study, is discussed in Section 8.3.

A third method for improving inter-group relationships is to encourage and support boundary spanners as a method of integration. In healthcare, Richter et al. (2006) suggested that boundary spanners have a beneficial impact on inter-group relations where they have high levels of identification with their organisation and high levels of inter-group contact. Richter et al. (2006) described this as a 'dual identity effect'. Creating a common super-ordinate group (organisational identification), without challenging the boundaries of the existing subgroup, acts a buffer to the negative effects of group identification on inter-group working. In practice, Richter et al. asserted that organisational identification can be increased through measures such as communication of organisational success, values and goals. Similarly they asserted that rotating boundary spanners and promoting employees who have both strong group and organisational ties may be of benefit. Having explored patterns and barriers in inter-professional relationships and how they might be improved, section 5.5 explores specific key relationships in greater depth.

Section 5.5: Key Relationships in service-delivery and change

This chapter is concerned with providing an overview of the roles and relationships through which healthcare services and service-improvement change are delivered. To this end, having considered the broad dynamics of inter-professional relationships, this section focuses on the key relationships through which service-delivery and change are enacted. These are the relationships between doctors, nurses and clinical managers (Kitchener, 2000, Fitzgerald et al., 2006b).

5.5.1 Doctor–nurse relationships

Historical tensions in the doctor–nurse relationship are related to gender (Ferlie & Geraghty, 2005), status and role (Smith & Preston, 1996). As the doctor–nurse relationship is characterised by close proximity, increasingly similar work and an overlap of tasks (Smith et al., 1996), doctors and nurses can clash over who is accountable and what is best for the patient (LeTourneau, 2004) In the U.S., the emergence of nursing as an independent profession has provided nurses with increased decision making and care-provision responsibilities (LeTourneau, 2004). Such developments challenge the traditional distinction between doctors as the directors of care, and nurses (and other AHP-care professionals) as the managers of the care process. Interestingly, in the UK, Smith and Preston (1996) found that junior doctors felt caught between senor medical staff and the nursing staff. This implies a different relationship between nurses and doctors, on the basis of the doctor's seniority. In Ireland, the integration of nursing training into third-level education and the expansion of the nursing role have potential to affect doctor–nurse

relationships, and to create tensions such as those found by LeTourneau (2004) in the U.S.. Attention now turns to doctor–manager relationships, where tension has historically been evident.

5.5.2 Doctor–manager relationships

While there is consensus that clinical autonomy should be limited to the individual patient–doctor relationship, and that managers should have some capacity to challenge the medical profession in their areas of expertise (Bruce et al., 1994), management capacity to challenge clinicians is undermined by (1) the underdeveloped nature of medical-performance management, with monitoring still embryonic; and (2) the question of legitimate authority in the clinical realm. Clinicians mediate between managerial decisions and clinical outcomes, which constrains management's capacity to control professionals (Griffiths et al., 2000). As a result, by not accepting the legitimacy of management, consultants can undermine managerial power (Bate, 2000). Thus, in reality the doctor–manager relationship is not one of equal or balanced power. The embedded nature of medical power is evident in the fact that in the UK successive reorganisations of the NHS have failed to shift power away from doctors (Pettigrew et al., 1992). As a result, NHS management continues to be characterised as 'diplomacy', with the perception that NHS managers possess little independent power or influence (Hoque et al., 2004). In contrast, Griffiths and Hughes' (2000) presented alternative findings, based on research in the UK. They found that neither clinicians nor managers tend to encroach on each other's areas of expertise, but that each group attempted to define problems in ways that placed them in their specific area of concern. Such a strategy makes it more difficult for managers to challenge clinicians, and vice versa. Regardless of which dynamic is most accurate, in the UK both clinical managers and mangers have articulated frustration with the divide caused by professional boundaries (Hoque et al., 2004). In practice, this divide has led to stereotyping (Hoque et al., 2004) and alienation (Davies et al., 2003a). Both groups are alienated by the sense that the core power is held outside of their remit (Davies et al., 2003a). There is some hope that clinical managers may help to integrate clinicians and management, addressing some of these tensions. However, there remains a lack of knowledge regarding the impact of clinical-management structures and roles on power relationships and the quality of relationships between doctors and managers; *'Even if the overall balance of power remains broadly unchanged, the nature of working relationships and roles in allocating resources may still be affected'* (Griffiths & Hughes, 2000: 211). In both service provision (Griffiths & Hughes, 2000) and service-improvement (Fitzgerald et al., 2006b) research has emphasised the importance of clinical-management boundary spanners. Recent work on clinical managers is explored in the next section. Overall, in

exploring the relationship between clinicians and managers, Griffiths and Hughes (2000) found an internally differentiated but powerful group of clinicians, subject to managerial encroachment in some areas but limiting the extent of real change via cultural authority. These findings suggest that management may have more power and influence in the context of non-clinical changes, and vice versa.

5.5.3 Relationships amongst clinical managers

Inherent in recent international policy changes, in the UK, U.S. and Australia, has been the notion that doctors should become more integral to healthcare management (Braithwaite et al., 2005; Hoff, 2001b; Montgomery et al., 2007; Rioridan & Simpson, 1994). However, with the exception of problematic relationships between clinical managers and their clinical colleagues (Fitzgerald, 1994; Montgomery, 1990; Rioridan et al., 1994), there is little understanding of how clinical managers interact with other clinicians and managers, and whether the relationships and management styles of clinical managers differ from those of general managers (Hoff, 1999a). The problematic relations between clinical managers and their clinical colleagues can be related to the difficulty of simultaneously establishing trust between clinicians and managers, which is a critical characteristic of success for clinical managers (Guthrie, 1999 in Montgomery, 2000; Hoff, 1999b). Clinicians may be predisposed not to trust clinical managers, which can be attributed to a perception of them 'working with the enemy' (Riordan & Simpson, 1994) and a dislike for contentious decisions (Riordan & Simpson, 1994). Thus the latter asserted that there is the risk of professional isolation, a concern also articulated in U.S.-based research by Schneller (2001) and Montgomery (1990). Importantly, in the U.S., Hoff (1999a) indicated that negative experiences are more prevalent among clinical managers who have ceased to practice medicine. At the polar end of the spectrum he asserted that clinical managers who maintain their clinical practice are accorded enhanced credibility by their clinical colleagues. However, the relationships between clinical managers, clinicians and managers should also be influenced by the medical-management culture in the hospital.

Montgomery (2000) identified fairness as a source of tension within medical-managerial relationships, with associated implications for relationships between clinical managers and clinicians. For clinicians, fairness is defined at a micro level, while for managers definitions of fairness pertain to populations of patients. For Montgomery, it is in this context that the clinical-management boundary-spanning roles of negotiation, communication and conflict mediation are most valuable. Finally, there is a need to consider whether clinical managers have relationships

that merely *span* or actually *integrate* disparate professional groupings. Next, Section 5.6 reviews and concludes the chapter.

Section 5.6: Conclusion

The purpose of this chapter has been to review the literature pertaining to roles and relationships in hospitals, through which service-improvement change is delivered. Due to a paucity of Irish research pertaining to service management and change in healthcare, this chapter has drawn upon UK, U.S. and Canadian research to provide an overview of the literature pertaining to roles and relationships in service delivery and change in healthcare. While the healthcare sectors in these contexts differ from Ireland in terms of their structure, policy context and other pressures, some common themes are evident. These may be linked to the professional nature of healthcare organisations. Research from these countries provides a comparative frame to the Irish research findings presented in chapter 8 of this thesis.

Roles and relationships provide the lenses through which service-improvement change is explored in this study. The chapter considered the roles of the key players in service delivery and service improvement and the relationships between them. In so doing, both the literature referenced and the theoretical framework provided for considering roles and relationships, role theory in particular, has raised the constraining influence of context. They indicate that roles and change-related roles have formal and informal components, with role definition and enactment influenced by internal and external context, as well as the role incumbent and those with whom they work. The constraining influence of context on change-related roles is a theme that emerges strongly in the research findings, and that is explicitly considered in chapters 9 and 10.

This research addresses the significant gap in the Irish literature on the initiation and implementation of service-improvement change, relationship groups, and the extra-discretionary nature of change-related roles. In so doing, chapter 8 draws attention to the different actors involved in the initiation and implementation of policy-driven (top-down) and emergent change (bottom-up) and identifies the constrained nature of Irish clinical-management roles in service improvement. Chapter 8 also draws attention to the benefit of networks of individuals in similar roles or undertaking similar forms of service improvement. In addition, the research draws attention to additional contextual factors, which facilitate and hinder their endeavours. These are explored in chapter 9, with the policy and managerial implications of all findings discussed in

chapter 10. Prior to exploring these findings, chapter 6 provides an overview of the research design adopted in this study. Chapter 6 delineates the processes of data collection and analysis that led to the research findings.

Chapter 6: Research Design

Introduction

People who write about methodology often forget that it is a matter of strategy not of morals. There are neither good nor bad methods but only methods that are more or less effective under particular circumstances in reaching objectives on the way to a distant goal.

– George C. Homans, 1949: 330, in Pettigrew, 1973

In this quote Homans emphasises that appropriate research methodologies are context-specific. In also adopting this stance, Adam and Healy (2000: 152) noted that *'a clear and unambiguous statement of the research objective is therefore necessary to enable the selection of an appropriate research methodology and data collection techniques'.* Thus, research objectives and questions influence research design choices. The objectives and research questions underpinning this study are outlined in the following section, as a precursor to outlining and explaining the research design adopted. Research design includes both methodology, which refers to a general approach to undertaking research and emerges from a particular paradigm, and methods, which are particular techniques for undertaking research (Fulop, Allen, Clarke, & Black, 2001). The qualitative methodology adopted has been influenced and informed by critical realism and social constructivism, undertaken through a case-study method, with a processual orientation. Each of these components of the research design are discussed in the ensuing sections, as are practical issues associated with research design, site selection, data collection, data analysis, theory building, research evaluation and ethics. The chapter concludes with a chronology of the research process.

Section 6.1 Research background, objectives, questions and application

This section outlines the background to the research and describes the objectives underpinning the work. The research questions are delineated, and the potential application of the research is demarcated.

6.1.1 Research background

With an exponential increase in Irish healthcare expenditure, 326% in public healthcare expenditure and 254% in private healthcare expenditure from 1995 – 2004 (Department of Health

and Children, 2005), the debate on the quality of healthcare delivery and the perception of the need for change in the Irish healthcare system has increased among stakeholders. Concomitant with the funding increases, service users are demanding higher standards of care and service (McAuliffe, 2002). However, specific attempts to implement service improvement, including the national healthcare strategy (Department of Health and Children, 2001b) and specific service-improvement incentives such as the national cardiovascular and cancer strategies, have suffered from implementation problems (National Health Strategy Consultative Forum, 2001). Such problems are common, both in healthcare (Iles & Sutherland, 2001), and more broadly, as outlined in Chapter 1.

While issues have been encountered in the implementation of both strategic and service-improvement change in Ireland (National Health Strategy Consultative Forum, 2001), the focus in this research is on service-improvement. In spite of the significant policy interest in service-improvement, the significant increase in healthcare funding, and in public dissatisfaction, no prior research has been conducted about the implementation of service-improvement in Irish hospitals.

In the wake of the Irish national cardiovascular strategy (Department of Health and Children, 2001) this research explores the role and relationship structures and contextual factors that affect service-improvement initiatives in cardiology, in three acute hospitals. Adopting a qualitative research methodology using a processual approach (Pettigrew, 1992, 1997), this research conducts three analytical case studies that explore the factors facilitating and hindering service-improvement delivery. In identifying the effect of specific forms of role and relationship structures, and the contextual factors influencing service-improvement, and profiling how these can be used to cultivate a climate for change, the research makes a contribution to both theory and practice.

In the UK, Iles and Sutherland (2001) highlighted a lack of awareness regarding who is responsible for initiating, driving, leading and implementing change in hospitals. In the UK context, this problem has since been addressed via a three year research project funded by the NHS Service Delivery and Organisation (SDO) R&D Programme (Fitzgerald et al., 2006b). However, while the need for similar research in Ireland is reflected in the dearth of successful change-management initiatives, the direct application of learning from the UK is precluded by different policy, regulatory, structural and historical developments, which mediate both the degree of receptiveness for change (Pettigrew et al., 1992) and appropriate role and relationship configurations. Thus, in an environment that faces problems in the implementation of service-

improvement, a dearth of research and difficulty in the transfer of previous research into the Irish context, this study has undertaken a partial methodological replication of the above-mentioned project (Fitzgerald et al., 2006b). The nature of this partial replication is outlined in section 6.3.4. The specific objectives of the research are outlined below.

6.1.2 Research objectives and questions

Underpinning the thesis, this exploratory research has four objectives. The first objective is to identify who accepts responsibility for initiating and implementing service-improvement change in Irish hospitals. Having identified those involved in implementing service-improvement, the second objective, also encompassed in the first research question, is to explore how change-roles are defined and enacted by the role-holders who work within role structures, and what works effectively. In addition, as service-improvement is enacted in organisational, and broader environmental contexts, the third objective is to identify further factors which differentiate successful from unsuccessful service-improvement endeavours. The fourth objective is to consider whether there are systematic differences across the public, voluntary and private hospitals studied. Thus, in accordance with the literature review presented in chapters 4 and 5, the research is focused on the roles and behaviour of service-improvement agents and additional contextual influences on service improvement. The research questions are as follows:

1. Who holds change-related roles, how is change enacted within the role structures in place and what works effectively?
2. What factors beyond role level influence the effectiveness of service-improvement?
3. Are there systematic differences between voluntary, public and private hospitals in the dimensions considered in questions (1) and (2)?

These questions mirror and expand those undertaken by Fitzgerald et al. (2006b), who explored the following research questions;

1. How do clinical directors and service managers from non-clinical backgrounds interpret and enact their roles and use them to implement service change?

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

As indicated in the previous section, cardiology was chosen as the care area in which to conduct the research. This was chosen as a high service-improvement change context in the wake of the National Cardiovascular Strategy (Department of Health and Children, 1999), and its consequent progress reports (Heart Health Task Force, 2001, 2003). Specific information regarding the National Cardiovascular Strategy has been provided in Appendix 2. This high-profile strategy initiative provided an incentive for change in the cardiovascular arena, with an average of six out of ten recommendations implemented (Fitzgerald, 2005). Forty six of the two hundred and eleven recommendations pertained to the acute hospital context. Thus, researching the implementation of the strategy provided scope to explore differences in role and relationship configurations, and other success-related factors, in successful and unsuccessful attempts at change. Scope was also provided to explore whether differences were evident between change initiatives that emerge in a top-down or bottom up manner. As exploratory research, there is potential for both descriptive and explanatory findings (Yin, 2003). Therefore, Section 6.3.1 explores the potential applications for the research.

6.1.3 Research application

As the first study into the implementation of service-improvement change in Ireland, the research will provide baseline information. It will make a pragmatic contribution, by informing the future introduction of specific changes in roles, organisation and service-improvement processes to improve the delivery of health care. In addition, it will provide an agenda for future research in a newly emerging field of interest in Ireland. Since 1999 the Health Research Service Delivery Organisation Board of the NHS has provided significant funding to consolidate and develop the evidence base on the organisation, management and delivery of health services, and to promote the uptake and application of that evidence in policy and practice. In contrast, the Health Research Board in Ireland, which has responsibility for clinical and service-related research, has only recently begun to fund service and management-related research. Such funding remains residual, compared to the clinical research programme.

Close linkages with and feedback to the organisations encompassed in this study have been incorporated to facilitate the application of the research in those organisations. Broader

dissemination will include liaison with those responsible for reviewing the cardiovascular strategy in the HSE, and senior officials in the Department of Health. Consultation with this array of individuals across the health system, from the outset of the project, and feedback to these individuals throughout the project, is aimed to facilitate the application of the research in practice. This approach recognises that joint creation of the findings and the practitioner-design of actions based on the findings is desirable (Van de Ven, 2007). Thus, as Yin (2003) described, this exploratory research will make a significant contribution through its descriptive and explanatory focus. Attention now turns to the research approach and the informing paradigms.

Section 6.2 Research approach and informing paradigm

Although differences in epistemological stances remain and will continue in the future, there has been a shift away from researchers having a consistent, personal set of assumptions regarding how the world operates, towards a concern with using the appropriate methodology and tools for a specific research problem (Dawson, 2003). The choice of paradigm for this research has been influenced by the appropriateness of a qualitative approach, which is outlined in section 6.2.1. In addition, the decision has been determined by the subjectivity inherent in the enactment of roles, and the desire to explore the influence of contextual factors on the process of service-improvement.

Section 6.2.2 outlines how the social constructivist and post-positivist paradigms, specifically the interpretivist and critical realist approaches have *informed* the research. It is noted that, as ideal types, both are less than perfect matches to the ontological and epistemological stance underpinning the research. Section 6.3.3 provides a more detailed overview of critical realism as the overarching paradigm in which an interpretive orientation to data analysis is adopted. First, however, the adoption of a qualitative approach is considered.

6.2.1 Adoption of a qualitative approach

As a as a descriptive and exploratory study, designed to facilitate explanation and theory generation (Eisenhardt,1989)[16], a qualitative approach is appropriate (Yin, 2003). In addition, the research aims to account for the influence of context on service improvement. Qualitative

[16] Eisenhardt noted the potential for qualitative research, and specifically case studies to be used to provide description, test theory and generate theory.

research adopts methods that are more flexible and sensitive to context than quantitative methodologies (Denzin & Lincoln, 2005; Phillips & Pugh, 2000). Finally, adopting a partial replication strategy will facilitate later comparison between the Irish and UK contexts. Such comparison is, however, outside of the scope of this thesis. Section 6.2.2 considers the influence of the social-constructivist and critical-realist approaches.

6.2.2 Identifying an appropriate paradigm

Although paradigms are clear ideal-types at a philosophical level, their application is more problematic in reality. In this study, an interpretive approach, which falls within the social constructivist paradigm, was initially identified as appropriate. This approach stems from the perspective that reality is socially constructed and given meaning by people, requiring the investigation of the subjective experience of respondents (Easterby-Smith, Thorpe, & Lowe, 2001). However, as organisational and other factors place constraints on individuals, an alternative paradigm, taking account of both individual subjectivity and constraining factors was sought. Critical realism, a post-positivist approach, was found to resonate.

Table 6.1 provides an overview of five paradigmatic positions (Guba & Lincoln, 2005), their basic beliefs and associated methodologies. It can be considered a tool in choosing paradigm. On the basis of the methodologies associated with the approaches, the table indicates that neither positivism nor the participatory paradigm are suitable approaches for this research. Positivism adopts a quantitative orientation. In addition, it assumes that social reality can be studied without taking account of individual sense-making or action (Weick, 1979a), and is therefore not amenable to the interpretive focus on role enactment, nor to the qualitative methodology adopted. In the case of the participatory paradigm, the table indicates that its methodology entails political participation in collaborative action in inquiry, which is not a feature of this research design. Turning to critical theory, the table indicates that in spite of the ontology of historical realism which is amenable with the processual approach, its epistemology is highly normative, which is not amenable with the case-study method in this work. Critical theorists endeavour to challenge the inequities evident in the research context.

Attention now turns to the remaining two paradigms – interpretivism and post-positivism. The hermeneutic methodology associated with interpretivism is amenable with the focus on role interpretation and enactment in this research. Hermeneutics entails exploring the individual negotiation of subjective meanings and experiences. However, interpretivism neglects the

constraints of social structures on individual subjectivity (Kincheloe & McLaren, 2005). This is an issue addressed by the post-positivist ontology of critical realism. As a result, the research has been *influenced* by the post-positivist ontology of critical realism, which retains an orientation towards interpretivism, while recognizing that there is a world that exists independent of our knowledge of it (Sayer, 2000). In addition, the research remains *informed* by interpretivism, which emphasizes the socially and historically negotiated nature of human experience (Cresswell, 2007). The influence of both critical realism and interpretivism on the case studies is congruent with the position that institutions place constraints on individual actions, either through 'cognitive constraints', whereby institutions narrow the perceptive field of the individual (Barley & Tolbert, 1997), or through the social policing of action, based on institutionalised expectations, explicated through social cues and feedback (Weber et al., 2006).

A second reason for the influence of both paradigms is the combination of inductive and deductive approaches to data analysis adopted in the research. This is consistent with the desire to identify emergent themes in the Irish context, but recognises the existence of prior study to inform the research. Critical realism, as a post-positivist approach, tends to begin with theory, while the focus in interpretivism is upon inductive analysis. Thus both interpretivism and post-positivism, and specifically the post-positivist critical-realist approach, imperfectly inform this study. However, certain aspects of critical realism have additional resonance with the processual approach adopted, discussed below.

6.2.3 Critical realism as the primary influencing paradigm

Central to critical realism's project is the abstract identification of the structures and mechanisms which, although not directly observable, underlie and govern the events of experience, and hence explain ***why*** *regularities occur.*

– Johnson & Duberley, 2000: 155

Critical realism is a post-positivist approach that aims to transcend the opposition between positivism and interpretivism (Benton, 1981, in Blaikie, 1993). In moving away from positivism towards appreciating the role of human subjectivity, it adopts an objective ontology and a subjective epistemology (Johnson et al., 2000). Crucially, the subjective epistemology associated with critical realism facilitates its adoption with the processual approach, which rejects the focus on objective epistemology associated with positivism (Dawson, 2003).

Critical realism differs in application from both interpretivism and positivism, in that both qualitative and quantitative techniques can be utilised in data collection and analysis. As a result, it is particularly appropriate to use the case-study methodology adopted in this research. It shares positivism's desire to produce causal explanations with interpretivism's perspective that society is interpreted, produced and reproduced by its members (Blaikie, 1993). Thus, it takes account of the interpretive element identified as important in the previous section. Data analysis, at the role level, is particularly informed by interpretivism. Interpretivism is concerned with how individuals and groups shape social processes and shared meanings (Easterby-Smith et al., 2001) through the negotiation and construction of social reality (Burrell & Morgan, 1992). The adoption of an interpretive orientation to data analysis reflects the significance of the interpretation of change roles, context and history in processes of change, rather than more objective measures such as formal job descriptions. This interpretivist approach to role-level data is also congruent with the symbolic interactionist approach to role theory, outlined in chapter 4. The application of an interpretivist approach to data-analysis affects the quality criteria used to evaluate the research. These are discussed in Section 6.7.

Table 6.1: Basic beliefs of alternative inquiry paradigms (Modified from Guba et al., 2005: 195-196)

Issue	Positivism	Post-positivism	Critical Theory et al.	Constructivism (Interpretive)	Participatory
Ontology	Naïve realism	Critical realism; imperfectly apprehendible reality	Historical realism	Relativism	Participative reality
Epistemology	Dualist/objectivist Findings true	Modified objectivist; findings probably true	Transactional/ subjectivist; value-mediated findings	Transactional/ subjectivist; co-created findings	Critical subjectivity; co-created findings
Methodology	Experimental/ Manipulative; quantitative	Modified experimental/ manipulative; may include qualitative methods	Dialogic/ dialectical	Hermeneutical/ dialectal	Political participation in collaborative action inquiry
Nature of knowledge	Verified hypotheses as facts or laws	Non-falsified hypotheses as probable facts or laws	Structural/historical insights	Individual and collective reconstructions	Practical knowing
Knowledge accumulation	Generalisations & cause-effect linkages	As in positivism	Historical revisionism; generalization by similarity	Reconstructions and vicarious experience	In communities of inquiry embedded in communities of practice

Critical realism focuses on the identification of underlying generative mechanisms of cause and effect, to explain patterns in events (Blaikie, 1993; Johnson et al., 2000). The emphasis on underlying mechanisms emerges from the perception of social laws as tendencies rather than certainties (Outhwaite, 1987, in Blaikie, 1993), and findings as 'probable truth' (Guba & Lincoln, 1994). This research has been informed by the focus on identifying underlying generative mechanisms in critical realism (Johnson et al., 2000), an objective mirrored in the processual approach. The research has specifically aimed to identify the underlying mechanisms affecting the effective implementation of service-improvement change at role, organisational and environmental levels.

The relationship and tension between critical realism and social constructivism, grappled with in Section 6.2, has been subject to a recent call for papers from Organization Studies, reflecting increasing interest and awareness. Having outlined the influence of critical realism and interpretivism on the research, Section 6.3 outlines the methods adopted.

Section 6.3 Methods

This research is a partial operational replication, which can also be described as a partial methodological replication. The nature and significant benefit of this replication is outlined in Section 6.3.1. This is followed by a discussion of the three key design choices made. These are (1) to undertake case studies; (2) to adopt a processual orientation within the case studies and; (3) for the case study analysis to be comparative in form. These choices, in addition to the selection and structure of the cases, are explored in this section. In addition, this section outlines the criteria for choosing the cardiology care area.

6.3.1 Partial operational (methodological) replication

An overemphasis on creativity for evaluating research has led to a serious devaluation of replication studies.

– Hunter, 2001: 149

Although 'reproducible results are the bedrock on which the scientific edifice stands' (Planalp, Rutherford, & Honeycut, 1988), replication studies have long been maligned, with a long-standing, and undeserved publication bias against replication studies (Eden & Aviv, 2002; Kelly, Chase, & Tucker, 1979). The term 'replication' refers to the reproduction of an original. However,

replication studies tend not to be exact copies, with potential for difference in methods, procedures and outcomes (Kelly et al., 1979). Eden and Aviv (2002: 842) note that *'there is a tendency among scholars to count only exact replications, but very few replications are exact'*, with many studies adopting a partial-replication strategy (Kelly et al., 1979). Replication has been identified as desirable to ensure the reliability and validity of research, and for rigorous theory development (Singh, Ang, & Leong, 2003). Eden and Aviv noted (2002) the numerous calls for replication research, particularly as a vital ingredient in meta-analysis[17].

Kelly, Chase and Tucker (1979) differentiated between literal, operational, instrumental and constructive replication, outlined in Table 6.2 These categories reflect increasing levels of departure from the original study, and the increasing generalisability of research findings.

Table 6.2: A Taxonomy of Replication Designs (Kelly et al., 1979: 339)

Category	Manipulations	Measures
Literal	Replicated	Replicated
Operational	Replicated	Varied
Instrumental	Varied	Replicated
Constructive	Varied	Varied

Based on this taxonomy, this research can be classified as a part-operational replication of Fitzgerald et al. (2006b). Although the seminal methodology has been predominantly maintained, some modifications have been made to the research design to facilitate addressing the research questions in the Irish context. Operational replication may also be accurately termed 'methodological' replication. The modifications made to the research design are outlined below.

The methods adopted in the seminal project have been predominantly retained (Fitzgerald et al., 2006). Chief among these are the use of the same basic interview schedule, case study template and interviewee list (see Appendices 3, 4 and 5 respectively). Modifications to fit the Irish context include the addition of four questions to the original interview schedule, highlighted in Appendix 3. These questions cross-translated the interview schedule, for the Irish context, and were piloted with three respondents. There are four further differences between this and the original project.

[17] Meta-analysis is a method for reviewing and evaluating a field of literature, and determining the extent to which a finding has been replicated, that is, enriched through high-quality replication studies that can provide a credible basis for generalizations (Eden & Aviv, 2002) Eden, D., & Aviv, T. 2002. From the editors: Replication, meta-analysis, scientific progress and AMJ's publication policy. Academy of Management Journal, 45(5): 841-846.

The first two differences relate to scale and sector. The original project dealt with six acute sites and five primary-care sites. In contrast, this study focuses exclusively on acute care, where three, rather than six, cases have been conducted. The third difference is the basis for site selection. While the advent of the NHS in 1945 led to a more homogenous hospital sector in the UK, the Irish sector has continued to develop with a more fragmented underpinning, as outlined in chapter 5. As a result, case selection has occurred on the basis of hospital type –public, voluntary or private – rather than the complexity of the environment in which the hospital is operating, as determined by levels of deprivation and scale. While levels of deprivation are taken into account in the case-study account, in Ireland, the notion of 'scale', which referred to the number of sites within a given healthcare trust, is much less meaningful. The majority of Irish hospitals operate in a stand-alone capacity rather than as part of an overarching, multi-site healthcare group. Case selection is more explicitly detailed in section 6.3.7.

Crucially, as an early replication study, this study significantly increases the data available as a potential contribution from later studies (Rosenthal, 1990: in Eden & Aviv, 2002). As a result, the research will increase the reliability and validity of shared findings with the seminal project, thus contributing to more rigorous theory development and meta-analyses. In addition there is potential for a 'spill-over effect' through cross-country comparison, with lessons from the Irish context being of benefit elsewhere. Next, section 6.3.2 considers the processual orientation adopted.

6.3.2 A processual orientation

The irreducible purpose of a processual analysis remains to account for and explain the what, why and how of the links between context, process and outcomes

– Pettigrew, 1997: 340

A processual orientation to the research has been adopted due to the behavioural focus of the first research question, an awareness of the role of history and context, and the desire to incorporate multiple accounts of change processes. These factors are all assets in a research environment where, following chapters 4 and 5, context and multiple stakeholders are presented as central. In addition the approach offers *'the prospect that both theory and practice can be "bridged", and that engaged academic scholarship can* ***make a difference'*** (Pettigrew, 2001: 66, 2002: 55, in Caldwell, 2006).

However, following Section 3.2.1, there are three potential analytic positions for researchers in the processual approach. For Dawson the key choice in this regards is whether the researcher adopts a generic model and applies standardised procedures, rather than developing their tacit skills as a creative analyst (Dawson, 2003). The first position identified by Dawson (2003) advocates standardization and codification in processual analysis (Hinings, 1997). The second position advocates comparative case studies that can be executed in large multidisciplinary research groups (Pettigrew, 1990); and the third advocates the in-depth longitudinal case study (Dawson, 2003). In this research the complexity of the context has led to a multiplicity of organisational forms in Irish hospitals. As a result a single in-depth case-study would not have facilitated an answer to the research question, which encompassed the three hospital types operating in the environment. For this reason Pettigrew's model, associated with comparative case-studies is adopted. However, as the adoption of a case-study method allows the integration of Dawson's focus on individual voices and self-reflections which Ropo et al. (1997) identified as inherent in social theory, the research does attempt to integrate Dawson's focus on in-depth and person-centred narratives with Pettigrew's emphasis on comparative case studies. As a result it is important to consider the differences between the two approaches. In addition to his focus on single rather than multiple cases, Dawson (2003) further methodologically and conceptually differentiated his processual approach on the following bases;

1. The use of competing narratives is a central concept. He notes that no attempt should be made to reconcile outliers or different interpretations of change. This gives critical understanding of the change by taking account of multiple perspectives. Dawson emphasises the power of narratives for resisting as well as encouraging change;
2. The concept of multiple histories is important in understanding the political process of change. History can be used to fit the interests of different groups;
3. A broader concept of the substance of change is used to capture the content, scale and timeframe of change. It is also used to capture the interpretation of the change and its centrality among organisational actors;
4. Dawson's approach assumes that practical lessons can be derived, with implications for managing, resisting, steering and making sense of change. Pettigrew's approach has been criticised in this regards.

A focus on identifying the underlying mechanisms mediating context, processes and outcomes is a common feature of both critical realism and the processual approach, and a central tenet of this research. This study incorporates the five characteristics of the processual approach identified by Pettigrew (1997), namely studying processes across a number of levels, temporal interconnectedness, having a role in explanation for context and action, searching for holistic explanations and using process analysis to find and explain outcomes. In addition, this research has adopted Dawson's orientation towards exploring different perspectives across levels and occupational groups (Dawson, 1994, , 1997). This has been achieved by conducting interviews with respondents from across organisation levels, and is congruent with the interpretive orientation to data analysis outlined in Section 6.2.2.

Processual research attempts to examine organisational change over time and requires a framework to do this. As a result, it has become associated with longitudinal research. However, Dawson (1997, 2003) noted that 'longitudinal research' can refer to studies operationalised in a variety of ways and adopting diverse methodologies. For example, over time, Pettigrew's work has moved to encompass more documentary material and semi-structured tape-recorded interviews, rather than observation (Pettigrew et al., 1991b). Five variations on longitudinal research design are outlined in Table 6.3. Importantly, Dawson (2003) asserted that the 'static snapshot' of social life, characteristic of the first and second approaches, does not fit with the processual concern of exploring interconnected and dynamic processes. In this study, the longitudinal design is closest to number three, in considering changes retrospectively, with limited exploration of how routine operation is progressing. As the study fails to fully meet the depth of analysis that Dawson (2003) associated with longitudinal research, the research design can be described as case-studies with a processual orientation, rather than a processual analysis undertaken through case-studies. Having outlined the reasons for adopting a processual orientation, the case study method is outlined in Section 6.3.3

TABLE 6.3: Longitudinal research designs (Dawson, 2003)

1. **Quantitative studies** seek to identify the temporal relationship between two causally related variables.
2. **Cohort studies** can be carried out over a number of years, to take time spaced sequential snapshots. These can be used to derive more general trends and explanations.

3. **Retrospective analysis** of the process of change, combines with real-time study of the ongoing effects of the change under routine operation.
4. **Examination of the process of change as it develops over time** entails interviewing staff before and after a change, and collecting data during the process of change.
5. **Collection of data in organisations at different stages of change, focuses on** conceptual, implementing or operating.
6. **Phased data collection uses different techniques.**

6.3.3 The case study method

A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.

– Yin, 2003: 13

The relevant situations for different research strategies are influenced by (a) the type of research question; (b) the extent to which the researcher can control behavioural events and; (c) whether the focus is on contemporary or historical events (Yin, 2003; Yin, 1994). The descriptive, exploratory and explanatory research questions in this research, in conjunction with the limited control over the behavioural events of interest and the focus on current phenomena in their real-life context, made a case-study approach appropriate for this study (Yin, 2003). Case studies can also be used to generate theory, an aspiration of this context (Eisenhardt, 1989; Eisenhardt & Greaebner, 2007). More specifically, four analytical aims of case studies have been outlined by Pettigrew (1997). All four aims have been aspirations of this context, although Pettigrew (1997) recognizes that the linking of processes to outcomes is not always an analytical objective. The four aims are,

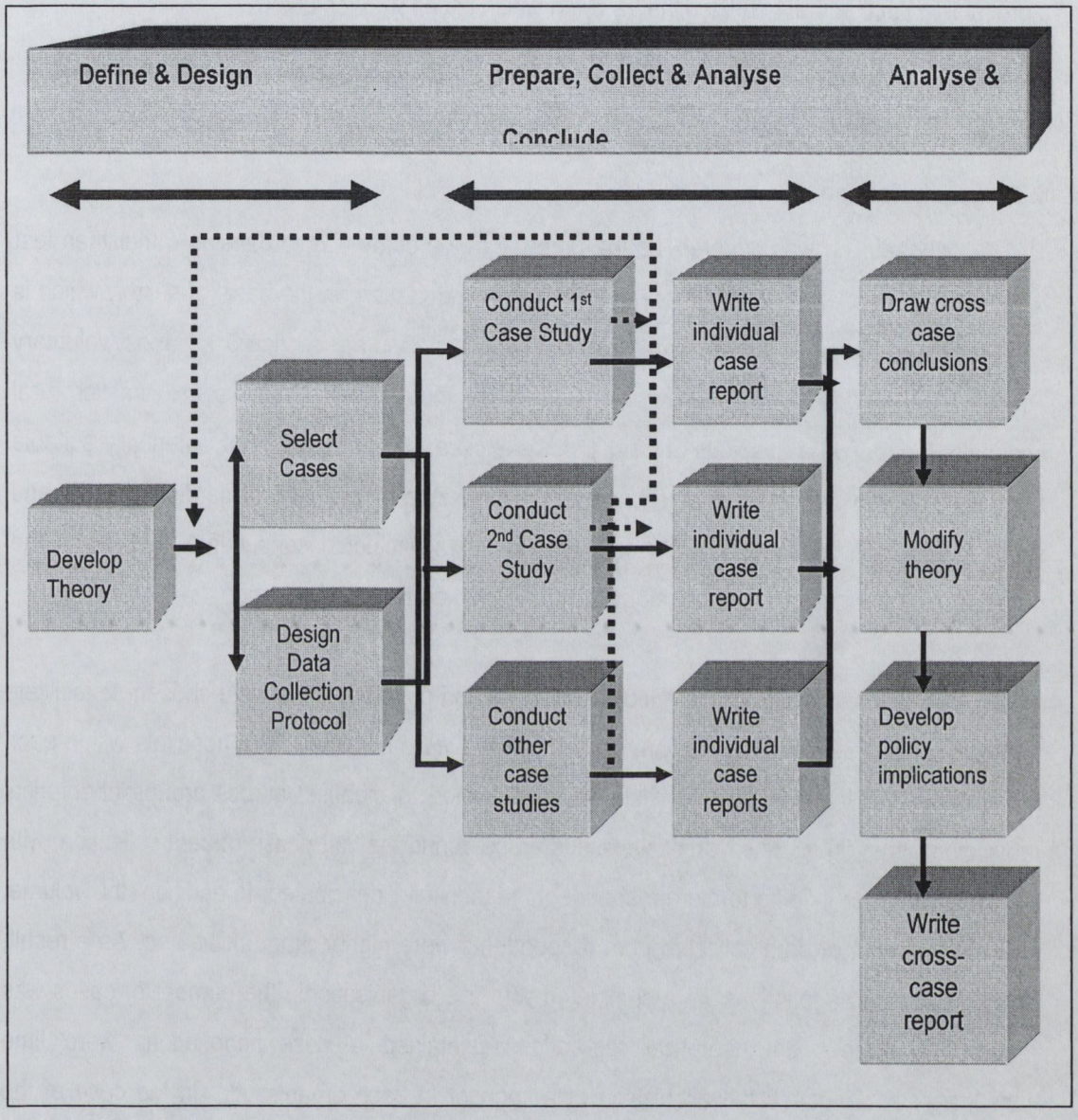
1. The search for patterns in the processes within and between cases;
2. The attempt to identify the underlying mechanisms that shape patterns of observed processes. They can be observable, part of the immediate context, the distant context or even outside of the sensibility of the actors. Identifying and explaining these mechanisms can be difficult to achieve and justify;
3. Inductive pattern recognition and deductive analysis should be complementary and;
4. Processes should be linked to outcomes.

Although, in addressing these aims, case studies can incorporate qualitative and quantitative evidence, the exploratory nature of the research made rich qualitative data appropriate (Yin, 1981b). Multiple cases were undertaken in an attempt to derive some general conclusions (Gummesson, 2000). Case studies are appropriate for and associated with the processual framework (Pettigrew, 1998) due to the desire to incorporate context into the research (Yin, 2003). As well as being consistent with the critical realist and interpretive orientations, case studies are also a prevalent and accepted methodology in this research field. In their review of change management in healthcare, Iles and Sutherland (2001: 13) asserted that *'many of the most useful studies are well-conducted qualitative studies'*. They identified twenty seven useful empirical research studies on the effectiveness of change models in healthcare organisations, of which fourteen employed a case-study methodology. The logic of the case-study design is outlined in Figure 6.1. This follows a six-stage process of (1) theory development, which in this case was informed by the prior seminal study and the context outlined in chapter 4; (2) case selection, which is described in Section 6.3.7; (3) the definition of specific measures, which in this research were self-definitions of role, context and the success or challenge of a change-process; (4) the conduct of the case study, which is outlined in Appendices 4, 5 and 6[18]; (5) report writing, which occurred through the individual case accounts, cross-case analysis and the feedback of briefing papers to sites and; (6) feeding back into theory development, which is presented in chapters 8 and 9 of this thesis.

Emerging from stages five and six of this process, there are four potential levels of output from the written case study (Pettigrew, 1990), which are also cited by Dawson (2003). The first, the analytical chronology clarifies sequences of events through analysis of the inner and outer context over time. The second, the diagnostic case, is an analytical chronology, with some strategic recommendations, which can be presented to and discussed with managers. The third, the interpretive theoretical case, links emerging conceptual and theoretical ideas from the case to stronger themes in the case and literature. Finally, cross-case analytic comparison aims to identify generalisable themes, leading to meta-level output. Each level of output was aspired to, and attained through iterative cycles of data analysis. For Dawson (2003), the equation of cross-case comparison with higher level output is a negative occurrence, contrary to his conception of the richness of data as the basis of the contribution from processual research, as discussed in chapter 3. To address this issue, Dawson (2003) presented four types of cases, where the

[18] Appendices 3, 4 and 5 outline the case-study template, the desired list of interviewees issued to each site and the actual interviews undertaken at each site.

Figure 6.1: Case Study Method (Yin, 2003: 50)



structure and content is influenced by the audience in question; the company case write up, the teaching case file, the academic book chapter and refereed journal article. These are differentiated on the basis of their structure, the role of the researcher and their audience. While Dawson's classification is useful for considering dissemination, Pettigrew's classification provides greater insight into the type of outcome emerging from analysis.

In addition to output, case-study design is concerned with practicalities, including the definition of the issues to be studied; developing a case-study design; developing a case-study protocol; preparing for data collection and undertaking data collection. Section 6.4 discusses data

collection, which was influenced by the fact that the study was a partial operational replication. As a precursor, Section 6.3.4 outlines the basis on which cases were selected.

6.3.4 Case selection

Theoretical sampling was adopted, as the purpose of the study was to develop rather than test theory (Eisenhardt et al., 2007). Case selection was undertaken on the basis of sector, which is correlated with higher and lower organizational complexity; as per section 5.1.1, most voluntary hospitals are large, urban teaching hospitals while most public hospitals are smaller rural hospitals. Most private hospitals are small scale – circa 100 beds. A list of potentially suitable organisations was drawn up on the basis of the presence or absence of cardiology units and sectoral position. Consultation with major stakeholders, including consultants involved in the generation of the cardiovascular strategy, further narrowed the case selection.

Initially two cases from each of the public, voluntary and private sectors were chosen, to facilitate both literal and theoretical replication; similar findings were expected from hospitals within each group (literal replication), with any differences expected to manifest across groups (theoretical replication; Yin, 2003). However, scale issues arose during the first phase of data-collection, with snowball sampling leading to more respondents than initially anticipated. In addition, the volume, quality and depth of data collected from respondents were higher than anticipated. As a result, although access negotiations were completed with five organisations, the number of cases was reduced to three, with theoretical replication maintained. Access negotiations were time consuming, and required the acquisition of a sponsor in each organisation. In the case of the public hospital, a link was made through a serendipitous meeting with a consultant at a conference. In the case of the private hospital, a formal presentation was made to the CEO in writing, with the sponsorship of a consultant. On this basis, responsibility for overseeing the project was delegated to the cardiac-services manager. Finally, in the voluntary hospital, a prior academic link with the university was used to gain access to the CEO. A case for the research was presented and later accepted.

Across all of the cases, access negotiations were made considerably easier by the sponsorship of a highly renowned consultant, who had been involved in the generation of the cardiovascular strategy. His support provided legitimacy to the project, and hastened the research considerably. The ensuing section explores data collection.

Section 6.4 Data collection

Case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion

– Yin, 2003: 13-14

Data collection primarily took the form of interviews, which were supplemented by document analysis and informal direct observation (Yin 2003). Each form of evidence is discussed in this section. Yin's three principles of data collection were followed: (1) using multiple sources of evidence; (2) using a case study database, comprised of an assembly of evidence distinct from the final case-study report; and (3) maintaining a chain of evidence with an explicit link between the questions asked, the data collected and the conclusions drawn. For Yin (2003) these principles are valid regardless of the source of evidence used, and assist in addressing the design challenges of construct validity and reliability of the case studies. These issues are discussed in Sections 6.6.2 and 6.6.3 respectively.

6.4.1 Preparing for data collection

A case study protocol was generated prior to data collection, as advocated by Yin (2003). The case protocol outlined the background and relevance of the study, key objectives of the research and findings from the preliminary literature review, and seminal study. In conjunction, these provided insight into additional questions required in the interview schedule.

A case study database was compiled for each case. This helped to address Yin's (2003) concern of separating the data from the report of the investigator. In this context, the database for each case was comprised of basic information, provided through transcripts, observation notes and documentation. In addition, semi-analysed material was incorporated. This included notes generated after each interview and notes pertaining to data analysis and potential themes to be considered. This database helped to maintain a chain of evidence, increasing reliability by making the path of evidence explicit from the initial research questions to the conclusions of the case study. In the ensuing chapters it will become evident that the findings presented in chapters 7, 8 and 9 draw upon and further develop the case-study database.

The ensuing sections consider preparations undertaken for data collection, and the methods used. A key issue identified in the preparation stage was the need for congruence between the

envisaged levels of analysis and the levels at which data was collected. This is discussed in Section 6.4.2 below.

6.4.2 Levels of data collection, analysis and adopting tracer issues

The appropriate level of analysis, and hence the delineation of the case, is determined by the research question (Yin, 2003). In this study there are a mixture of levels of analysis evident in the research questions, outlined in Section 6.1.2. Research question 1 focused on role enactment at the individual level; question 2 takes account of individual or organizational level factors; and question three was aimed at the organizational level. As a result, the embedded multiple case-study design was adopted, with multiple units of analysis: the hospital as the overarching unit, with board, management and service-level sub-units[19]. Across the three cases, seventeen managers at senior and middle level, 17 clinical managers and 5 clinicians were interviewed. In addition, one individual with exclusive responsibility at the board level was interviewed. Four of the senior managers also participated at the board level.

This multiple embedded unit of analysis design is advocated by Yin (2003). However he noted that a common problem is the failure to return to the larger unit of analysis, particularly where the data collection sources are individual, while the unit of analysis is at the organisational level. This issue arose particularly in the theme addressing the factors influencing motivation to change at the organization level, discussed in Section 9.3. To manage this issue, Yin (2003) provided an overview of the data that can be collected for different units of analysis, outlined in Table 6.4 overleaf. Reflecting the mix of levels in this research, all types of data were collected.

To ensure that data was gathered from the individual respondents across both the individual and organizational levels, the interview schedule and case-study template had role and relationship sections pertaining to the individual, context sections pertaining to the organization, and change sections that integrated the two and allowed exploration of organizational and other factors influencing change. This interaction was explored through the identification of 'tracer' issues explored with respondents. Following Fitzgerald et al. (2006), 'tracer' issues were identified as significant service improvements enacted within the clinical area, identified by the individual respondent. Although this approach led to differences in the changes studied across the sites, the aggregate data from each site was also analysed by theme. The approach allowed questions to

[19] An alternative considered was to divide by clinical, management and hybrid groups, however the above was deemed more appropriate due to the expectation of difference at the board level.

be directed at concrete situations, which, as Alvesson (2003) suggested, encouraged respondents to report their own personal observations and experiences. In addition to the interviews, data was collected through document and archival analysis and observation. Each form of data collection is discussed in the ensuing sections.

Table 6.4: Design versus data collection: Different units of analysis (Yin, 2003: 76)

	Data collection from an individual	**Data collection from an organization**	**Study Conclusions**
Design about an individual	Individual behaviour – role enactment and relationships Individual perceptions – would they do anything differently, effect of organisation and sector on behaviour	Archival records Other reported behaviour, attitudes and perceptions, through secondary data and reports	If case study is an individual
Design about an organisation	How organization works – effectiveness or otherwise of change processes Why organization works – things facilitating and hindering change	Personnel policies Organization outcomes from HSE audits, organisation documentation and media	If case study is an organization

6.4.3 Interviews

One of the most important sources of case study information is the interview

– Yin, 2003: 89

The link individual in each organization – variously a CEO, cardiologist and the cardiology services manager, were issued with an ideal-type list of potential respondents, modified through a process of consultation upon entry to the organization. Most of the fifty interviews undertaken across the three sites, including important contextual informants, were between forty minutes and an hour in length, with the longest interview lasting two and a half hours Respondents by site are outlined in Appendix 6, with Appendix 5 detailing the generic list of interviewees issued to and modified by each site on the basis of their particular cardiology department. For example, the public hospital did not have a cardiac catherisation laboratory. Those interviewed (see Appendix 6) came from different hierarchical levels and professions, providing diverse perspectives on the change processes, a form of reducing bias (Eisenhardt et al., 2007).

The interviews, which were cross-translated for the Irish context, detailed in Section 6.3.4, were comprised of nineteen questions with some associated prompts where required (see Appendix 3).

The interview questions were divided into four sections, focusing on the hospital background, the personal background of the respondent, their interpretation of their role, and discussion of their involvement in two specific changes (tracer issues). The focus on the hospital background explored the respondents' awareness and perceived impact of the hospitals sector. The questions pertaining to the respondents' background concerned their current position, the clarity of their role, how their role had changed over the previous three years, performance-management systems in place, management training undertaken and ambitions for the future. The questions pertaining to role interpretation explored the respondents' key priorities, key relationships, whether they worked differently to others in similar roles, and how their roles could be made more effective. Finally, the tracer-issue section explored the respondents' involvement in specific changes, and the factors that facilitated and hindered these. The questions pertaining to tracer issues were repeated a minimum of two times with each respondent, allowing them to discuss distinct changes.

In conducting the interviews there was, following Yin (2003) a need to strike a balance between satisfying my own lines of inquiry and asking 'non-threatening' questions (Yin, 2003). Yin (2003) emphasised this by citing Becker (1998), who highlights the difference between asking a 'why' question of a respondent, which leads to defensiveness, in contrast to a 'how' question, which is a better way of addressing the same concern in an actual conversation. As a result, prompt questions used in interviews particularly emphasized 'how' questions. Yin (2003) also differentiates between 'respondents' and 'informants. For him, respondents become informants when they provide their own insights into occurrences, which can act as propositions for further inquiry. This was particularly facilitated by the adoption of the tracer-issue approach.

Issues encountered during the interview process included the difficulty of scheduling meetings with clinicians and managers. This was exacerbated by the fact that interviews were undertaken from July to September 2006, clashing with the peak holiday period. Once scheduled, interviews progressed smoothly with managers; meeting with clinicians often entailed significant waiting time. However, this provided many opportunities for informal observation. Scheduling progressed more speedily after the completion of the first interview at each site, as the respondents' facilitated further links and introductions. The second challenge encountered was to create a rapport with respondents in a short period of time, to facilitate meaningful data collection. In this regard, the conduct of the interviews was greatly facilitated by having memorized the interview schedule, which facilitated the direction of the interview in a conversational manner. Finally, two

respondents became particularly emotional during interviews, a situation discussed in the ethical section. Section 6.4.4 outlines the observation undertaken.

6.4.4 Observation

Permission to observe meetings in the care area was requested upon entry to the organizations. However, as such meetings entailed discussion of identifiable patients this would have significantly delayed the entry process, due to ethical issues. Ethical approval is further discussed in Section 6.7. Nonetheless, informal non-participant observation was undertaken in each organization, a situation hampered by often long delays, particularly in meeting clinical staff. Although necessarily selective, as premised on opportunity, observation did provide insight into the context of each organization. In the public hospital, a total of nine full days were spent in the organization, with one further visit to conduct an interview. Areas observed included the coronary-care unit, reception area, general ward where cardiology patients were located, and a medical-team meeting. In the voluntary hospital, individual interviews were scheduled over a five week period, providing opportunities for shorter periods of observation over a longer timescale. Opportunism led to a half-day of observation on the cardiology ward, observation in the echocardiography area and in the public areas of the hospital. In the private hospital, opportunities arose for observation in the cardiology ward, the cardiac-catherisation laboratory, the cardiac technicians' area and the public area of the hospital. As a result, observation notes were drawn on in analysis. Section 6.4.5 outlines the role of document analysis.

6.4.5 Document analysis

Internal and external documentary information was identified and analysed for each case. Only limited access to internal documentation was provided at two sites; the private hospital and the voluntary hospital. However, the information provided was augmented through that available in the companies' records offices, in annual reports and in the public domain. Following Yin (2003), analysis of this material took critical account of the intended audience of documentation; patients, colleagues, management and the broader public. A key benefit of documentary and archival evidence is its stability and broad coverage. However, such sources of evidence can be subject to low levels of retrievability, biased selectivity, reporting bias and access issues (Hill, 1993). The combination of the three sources of data was valuable. This value is discussed in section 6.4.6.

6.4.6 Value of multiple sources of evidence

The use of multiple sources of evidence, a form of data triangulation, led to what Yin (2003) termed 'converging lines of inquiry' in analysis. This reinforced findings, which were underpinned by multiple sources of evidence. Such data triangulation, as opposed to the investigator, theory or methodological triangulation identified by Patton (1987), led to improved construct validity in providing multiple measures of the same phenomena, factors affecting the implementation of service-improvement change. Common to all of the forms of data was the role of the researcher as a 'key instrument' in the collection of data (Creswell, 2007). This has been referenced with regards to establishing a rapport with respondents and is further discussed in the next section.

6.4.7 Role of the researcher in data collection and analysis

In qualitative research, the researcher is a 'key instrument' who uses their own experience and resources to collect data through the examination of documents, observation and interviews. (Cresswell, 2007; McCracken, 1988) While documentary and observation analysis are skills that can be, to an extent, codified, the tacit skill involved in establishing and maintaining a rapport in interviewing is more challenging. However, my capacity to conduct interviews with a greater sense of personal and respondent ease increased throughout the research.

While investigators should theoretically be unbiased by preconceived notions, even those derived from theory, this is particularly difficult for case-study researchers. In this context, this issue was particularly exacerbated by a six-month period spent as a research assistant in the seminal project. To counter-balance pre-conceived ideas, particular attention was paid to contradictory evidence during analysis, following Miles & Huberman (1994). In addition, emerging findings were presented at the European Group of Organisation Studies in July 2007 and proofread by two 'critical colleagues' to check for contradictory explanations. Data were also fed back to respondents for comment as a form of 'member-check' (Miles & Huberman, 1994). The data analysis process that led to the findings is outlined in Section 6.5. At the end of Section 6.6, which outlines the theory-building process, a timeline of the collection and analysis of the data is provided.

Section 6.5 Data Analysis

The central challenge in analysing process data is
moving from a shapeless data spaghetti toward some kind of theoretical understanding that does not betray the richness, dynamism and complexity of the data, but that is understandable and potentially useful to others.

– Langley, 1999: 693

Analytically, a similar approach to that in the seminal study was adopted. As suggested by Langley (1999), who outlined strategies for theorising from process data, narratives of the changes undertaken within each case were constructed. These were used to focus on the meaning, interpretations and enactment of roles among individuals, as well as constraining and enabling factors. The narrative strategy is aligned with the emphasized aspects of the influencing research paradigms, discussed in Section 6.2. In keeping with Langley (1999), a temporal bracketing strategy was also used to identify differentiating factors at the initiation, leading and implementing phases of service-improvement change processes. In addition, the data were thematically analysed with the aid of NVivo. This was undertaken as both an inductive and deductive process.

Inductive themes were explored through a process of coding. In coding, transcripts are broken down into fragments that are combined with other fragments to develop categories, both pre-defined and emergent (Dawson, 2003). Data was effectively deconstructed, labelled and reconstructed to explain and facilitate understanding. *'In other words, processual analysis centres on decoupling, classifying and recombining data to develop, redefine and create concepts that enable the presentation of new accounts'* (Dawson, 2003: 114) , which took the form of narratives and thematic overviews. The coding scheme is outlined in Appendix 7. In addition, after inductive analysis, deductive themes, derived from the literature review and seminal project (Fitzgerald et al, 2006b) were explored (see Appendix 9 for the deductive themes explored). Finally, some surprising and interesting themes emerged in the account of the single cases, as well as in cross-case comparison, and these are also detailed in Section 6.5.1, which outlines the role of NVivo as a software data-analysis tool. This discussion is followed by deeper consideration of the data-analysis strategy.

6.5.1 Software as a data analysis tool

'Many people apparently continue to believe that QDA software intends to do the data analysis.'

– Weitzman, 2000 in Cisneros-Puebla, 2004

Qualitative computer programs have been available since the late 1980s, and can assist qualitative data analysis in five ways. These are outlined in Table 6.5. For Cresswell (2007) the benefits of computer programmes include the provision of an organized filing system, making large databases manageable, ease of searching, the capacity to draw a visual map of concepts and ease of retrieval of memos associated with codes, themes or documents. In addition, from an analytical perspective they can help to conceptualise different levels of abstraction. Disadvantages include the learning time required and the perception of distance between the researcher and data. Richards and Richards (1999 in Cisneros-Puebla, 2004) note their concern with the rise of pattern analysis as a consequence of using computers to analyse data. Pattern analysis refers to identifying, describing and reporting the occurrence of patterns in the data, rather than attempting to create new categories, or link the data in new theoretical ways. Cisneros-Puebla (2004) articulated a related concern, that the 'charisma' associated with qualitative analysis is lost in the systematisation and routinisation inherent in computer analysis.

In keeping with Cresswell (2007), the data-analysis programme used in this study, NVivo, was found to be easy to use, secure and an aid to data management and analysis. The distance between the researcher and data did not emerge as an issue, a finding supported by Bryman (2002) Although it can support all of the functions outlined in Table 6.5, it was primarily used to code and retrieve data throughout iterative cycles. As an exploratory study, the data analysis attempted to both create new categories across the codes and link the data theoretically in new ways, addressing the concern raised by Cisneros-Puebla (2004). While useful, the significant time required in verbatim transcription as well as the learning time required would lead to caution in a unilateral recommendation of computer-aided analysis, particularly for single cases. With almost 60 hours of recorded data transcribed at a ratio of between 4 and 6 hours of typing per hour of data, the trade off between time spent on transcribing and that on analysis could be considerable. Attention now returns to the data-analysis strategy adopted, supported by NVivo.

Table 6.5: Types of computer-assisted qualitative data analysis (Weitzman & Miles, 1995)

Type of function	How it is supported
Text Retrievers	Search facility for words or phrases
Textbase Managers	Sorting and organizing facility
Code and Retrieve	Coding and reporting by code

Code-based Theory Building	Coding, with the ability to build conceptual structures
Conceptual Network Building	Diagrams, concept mapping and charts

6.5.2 Data analysis strategy

Under the processual approach, there is a continuous interplay between academic preconceptualization...and detailed empirical descriptions of emerging themes and topics, out of which new concepts are refined and interpretations developed.

– Dawson, 2003: 84

There is little written on the actual practice of data collection and analysis in process research (Dawson, 2003, Eisenhardt, 1989), and although Glaser and Strauss (1967) and Straus and Corbin (1998) do provide some guidelines, their approach is exclusively inductive. Dawson (2003) noted that many researchers derive knowledge of how to do research from 'diving in at the deep end', allocating sufficient time for analysis. Deductive themes were derived from the literature review and seminal project, with inductive themes derived from interviews, iterative analysis and respondent and organization feedback. Deductive themes were explored with a pre-determined coding scheme (Appendix 7), with further analysis as emergent themes arose (see Appendix 9). In each instance, a search for both confirming and disconfirming data was undertaken.

Data analysis was undertaken on a case-by-case basis, through three iterative cycles. After the description of a case history that provided the context for data-analysis, the following phases were undertaken: (1) an initial cycle of data analysis by case, based on the coding scheme, which generated themes closely aligned to the interview protocol; (2) revisiting each case to explore themes raised in the other cases, and to search for disconfirming data; (3) a cross-case comparison. Comparative analysis entailed both a descriptive phase and an emergent conceptual phase, drawing upon patterns in cases and attempting to explain them through the data provided. Dawson described this process:

> *'In essence, a processual analysis involves breaking down data into the various constituent components, then locating data under one or a number of different categories and sub-categories, before building connections across the research material as a whole'* (Dawson, 2003: 114)

In step one, in keeping with Dawson (2003), the data-analysis strategy described above drew upon observation notes and documents to provide contextual information. Secondly, the

interviews for each respondent were read, with annotated notes added, both in NVivo and in a computer document used to keep track of emergent themes. As new themes arose during the coding process, the transcripts were revised after the first cycle of coding. The coded data and contextual information were gathered into case-studies. Each case took a total of approximately 8 intensive weeks to complete, with one week allocated to writing the case history, and the remainder allocated to analysis. A case-study template was used to ensure that the cases provided the required information and were similar in structure. As well as being an organising device, the writing of these cases led to insights in individual contexts. For Eisenhardt (1989: 540) allowing *'the unique patterns of each case to emerge before investigators push to generalize patterns across cases'* is important in both gaining familiarity with individual cases, and accelerating cross-case comparison.

In step 2, case-studies were revised to explore the emergent themes from the other cases. Following Dawson's (2003) recommendation, ambiguities and conflicting data were not hidden. The five characteristics of processual research outlined by Pettigrew (1990) were addressed, helping to create an 'analytical chronology' (Dawson, 2003). Thus in the first and second stages of within-case analysis, organized data was both descriptive and analytical.

In step 3, cross-case comparison led to the search for patterns across cases. For Eisenhardt (1989) the key to effective cross-case comparison is to explore the data from different perspectives. She identified three strategies to achieve this. The first is to explore within case similarities and between case differences. This strategy was adopted, with dimensions or themes derived from the interview questions, the prior SDO study and emerging from the data itself. Cross-case comparison led to thematic writing at a meta level, with the aim of *'linking the theoretical and empirical findings across the case to wider bodies of literature'* (Pettigrew, 1997 in Dawson 2003: 118). Although advocated by Pettigrew, (1997), Dawson (2003) is unsure whether Pettigrew's aim of moving towards higher levels of theory is appropriate for processual data. For Dawson, Pettigrew's comparative abstractions mean the loss of the contextual nature of processual data, and can lead to the neglect of more specific insights. For him, there is a danger in playing down individual experiences and inter-group differences, in attempts to create broader patterns from which to generalise. For Dawson such an approach does *'not get the multiple voices, the different interpretations and views of change, and as such the orientation of these studies contrasts significantly with the type of processual case study being advocated here'* (Dawson, 2003: 119). To mediate this concern, explicit attention was paid to conflicts in

interpretations and views between and within groups of respondents in analysis. A key aim of data analysis was the generation of theories to explain the findings.

For Eisenhardt (1989) within and cross-case comparison are useful for description and explanation. However, for her, two further stages are required in theory-building: 'shaping hypotheses' and 'enfolding literature'. However, this is but one approach to theory-building, which is contested terrain. The adopted approach to theory building is discussed in Section 6.6

6.6 Theory building from the cases

There is no 'sure-to-please' standard template for writing emergent theory in theory-building research.

– Eisenhardt et al., 2007: 29

In keeping with Eisenhardt et al. (2007) theory building from the cases was primarily inductive, and premised on the recognition of patterns of relationships and their underlying explanations. As suggested by them, the theory emerging from cross-case comparison was more parsimonious than that from individual cases, as only those relationships replicated across most or all of the cases were retained (Eisenhardt et al., 2007).

Strategies for theory building differ. For example, Glaser and Strauss (1967) and Eisenhardt (1989) differ fundamentally on the extent to which theory building should be inductive. While Glaser and Strauss adopted an extreme position regarding interpretivism, Eisenhardt adopted a positivist orientation, concentrating on developing testable hypotheses and theories that are generalisable (Eisenhardt, 1989). This reflects her much lower focus on the role of context in comparison to Pettigrew (1992, 1997). However, common to all approaches to theory-building is a process of abduction, deduction and induction (Van de Ven, 2007). Abduction initiates theory by considering a surprising observation. This is followed by deduction, to identify the consequences of the surprising observation so that it can be observed. The theorized consequences can then be tested using induction (Van de Ven, 2007). My approach to theory building is detailed in Section 6.6.1.

6.6.1 Approach to theory building

In this research, detailed case-histories have been used to provide insight into context in an attempt to retain the detail characteristic of single cases. In addition, while the analytical strategy

in this context follows Eisenhardt (1989) in not relying solely on inductive data, it has not adopted her focus on hypothesis testing, which undermines the contextual and processual focus. Dyer and Wilkins (1991) pointed out that those using Eisenhardt's method tend to make *modest* advances in theory, while paradigm-challenging and changing insights can emerge from traditional case-study research that doesn't begin with a clear focus and allows the analytical concern to emerge over time. Although desirable, the latter approach was precluded in this context by the fact that it is a partial replication and expansion of an existing study, and the codes used to analyse the data were derived in the interview schedule.

In this context, theory building occurred through an iterative process of moving between the case data, emerging theory, and extant literature, as suggested by Eisenhardt et al. (2007). The generation of emergent themes began in single cases, and continued throughout cross-case comparison (Eisenhardt, 1989), leading to *'tentative themes, conceptions and possibly even relationships between variables'*. The process of the generation, support, revision or disconfirmation of the emergent themes was based on comparison between the emergent theory and the data, to ensure that the theory accurately reflected the data. This process used narrative and temporal bracketing strategies, as mentioned in the introduction to this section. A close fit between theory and data is an indicator of empirical validity (Eisenhardt, 1989). Once a close fit was generated, the emergent themes were compared to the existing literature, considering similarities, differences and underlying explanations. As is evident from the emergent themes listed in Appendix 9, not all themes were maintained. Central to the process of theory building is the individual researcher, as emphasised by Langley (1999).

> *'Theory development is a synthetic process. Whatever strategy is used, there will always be an uncodifiable step that relies on the insight and imagination of the researcher'* (Langley, 1999, following Weick, 1989).

Alternatively, Langley asserted that another way to think of analysis involves induction, deduction and inspiration. This sentiment is echoed by Morse (1997), who described her cognitive processes of analysis as comprehension, synthesising, theorising and re-contextualisation. For Cisneros-Puebla (2004) this is important, as it presents research as a continuous cognitive process, wherein analysis occurs in all phases, from the initial data collection to writing. This concept of theory building as a synthetic and partly uncodifiable process contrasts with the model of research as a validating process, and raises questions regarding how research can be evaluated. Research evaluation is considered in Section 6.7. However, prior to this, Figure 6.2

provides a time-line of the process of theory-building, which started with data collection and ended with the final writing of the thesis. Throughout that time, the analysis was iterative.

Section 6.7 Evaluating the research design and the quality of the research

The case study has long been (and continues to be) stereotyped as a weak sibling among social science methods. Investigators who do case studies are regarded as having downgraded their academic disciplines. Case studies have similarly been denigrated as having insufficient precision (i.e., quantification, objectivity or rigor).

– Yin, 2003: xiii

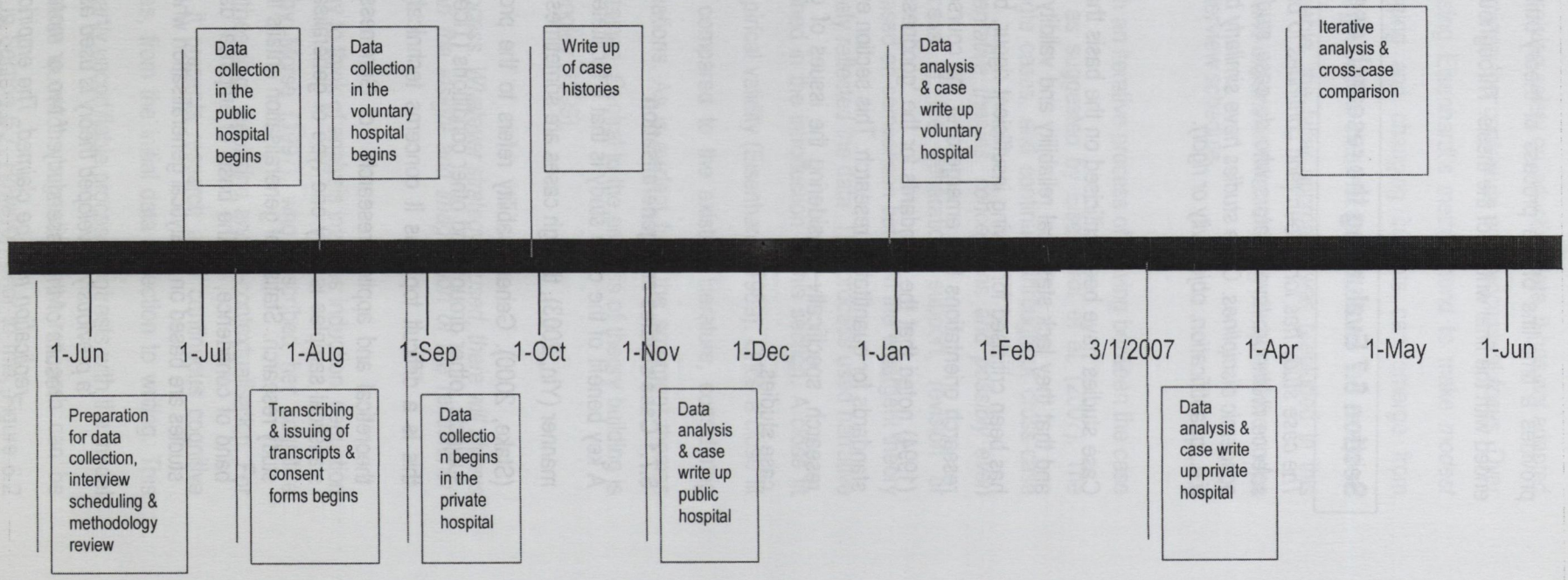
Case studies have been criticised on the basis that generalizations cannot be made from them, and that they lack statistical reliability and validity (Gummesson, 2000). In addition, the method has been criticised for having insufficient rigour, being too time-consuming, and having different research orientations that emerge over the course of the work. However, Miles and Huberman (1994) noted that the standards for the 'goodness' of qualitative research differ from traditional standards for quantitative research. This section evaluates the research design and quality of the research, specifically considering the issues of generalization, validity, reliability and rigour in case studies.

6.7.1 Case studies and generalisation

A key benefit of the case study is that it facilitates consideration of complex events in a holistic manner (Yin, 2003), though cases are sometimes challenged as a weak basis for generalization (Stake, 2000). Generalisability refers to the probability that research findings apply to other subjects, other groups and other conditions (Ticehurst & Veal, 2000). Ticehurst et al. noted that this is a difficult topic as it concerns technical issues and fundamental questions regarding theoretical and applied research. For Gummesson, (2000) and Yin (2003), generalising from statistical samples is only one type of generalisation, albeit one that is not applicable to case-study research. Statistical generalisation entails inference about a population, within a calculated band of confidence, on the basis of empirical data collected about a sample. In contrast, case studies are based on analytical generalisation where

> *'a previously developed theory is used as a template with which to compare the empirical results of the case study. If two or more cases are shown to support the same theory, replication may be claimed. The empirical results can be considered yet more potent if two or more cases support the same theory but do not support an equally plausible, rival theory'* (Yin, 2003: 33).

Data Collection & Analysis Timeline 06/07



On this basis, Yin (2003: 38) asserted that it is problematic to consider generalising from one case to another, and that instead researchers should attempt to generalise to theory. The level at which the theory is developed is also the level at which the generalisation of case-study results will occur. However, following Argris et al. (1985 in Gummesson, 2000) processual analysis seeks *'both generalizability and attention to the individual case.'* Similarly, Gummesson cites Cronbach[20], who asserts that *'when we give proper weight to local conditions, any generalization is a working hypothesis, not a conclusion'.*

While analytical generalization is premised on analytical induction and exploration of deviant cases to facilitate evaluation of the limits of the theoretical claims made, empirical generalization can be claimed on the premise that the cases explored are representative of those in the wider population. It is the latter that is propounded here, although empirical generalization would be facilitated by a literal replication of the study undertaken. Gummesson (2000: 91) asserted that generalisation is closely related to validity, which he defined as *'the extent to which researchers are able to use their method to study what they had sought to study'.*

6.7.2 Validity

Broadly, validity refers to whether a method is actually measuring what it wishes to measure. Gibbs (2002) noted that validity makes most sense for realists. However Gibbs (2002) does note that even idealists want to make realistic claims about multiple views of the world, so that the issue of validity still has to be addressed in some form in qualitative research. For Gibbs, one common strategy to address this is a focus on the possible threats to qualitative data analysis in terms of bias, a focus on positive cases, and the selective deposit or survival of documentary material (Pettigrew, 1973).

A more common approach is to consider internal and external validity (Yin, 2003). Internal validity refers to how the research maps the phenomena in question. For Ticehurst and Veal (2000) a study is said to have low internal validity when it is possible to provide an alternative explanation for the results of the study. For Yin (2003) internal validity is only a concern in causal studies, and where inferences are evident, as in this context. The issues of whether the inference is correct and whether rival explanations are evident also need to be considered. This is difficult to achieve in practice, however Yin (2003) suggested analytic tactics including pattern matching, explanation

[20] Gummesson takes this quote from Patton, M. Q. 1980. Qualitative Evaluation Methods. Beverly Hills: CA: Sage.

building, addressing rival explanations and using logic models. A further suggestion is to develop reflexivity:

> *'Reflection means thinking about the conditions for what one is doing, investigating the way in which the theoretical, cultural and political context of individual and intellectual involvement affects interaction with whatever is being researched, often in ways difficujlt to become conscious of.'* (Alvesson & Skoldberg, 2000, in Brannick & Coghlan, 2004)

Richards (2005) noted that validation, in a more applied sense, can emerge through feedback from respondents. This issue has already been addressed in the chapter.

Secondly, external validity refers to the degree to which findings can be generalised to settings similar to those in which the research occurred. As above, Yin (2003) cautioned that generalisation is not an automatic process, and that it is strengthened by replicating findings in more than one instance where similar outcomes are expected. Gill and Johnson (1991) differentiated between population validity, which refers to the extent to which conclusions can be generalised to other people, and ecological validity, which refers to the extent to which conclusions can be generalised to social contexts other than those in which the data has been collected. Pettigrew (1973) asserted that validity can be increased by the use of multiple methods, data sources, multiple observers and multiple levels of analysis in the analysis of the same empirical events. In this context all of Pettigrew's strategies, with the exception of multiple observers have been adopted.

Thirdly, construct validity is mentioned by Yin (2003) as another sign of quality in case-study design. It refers to having correct operational measures for the concepts being studied. Construct validity can be problematic in case-study research. In this context there is a need to specify the events which constitute 'change'. Yin (2003: 35) asserted that to meet construct validity the researcher has to (1) select the specific types of changes to be studied (service-improvement changes) and relate them to the original objectives of the study, and (2) demonstrate that the selected measures of these changes do indeed reflect the specific types of change that have been selected. As a result, in this context, self-definitions of success were adopted. All forms of validity are closely related to reliability, which is discussed below.

6.7.3 Reliability

Reliability refers to the consistency of the results obtained in research (Gill et al., 1991; Miles et al., 1994). In practice, reliability refers to whether the study would yield the same results upon

repetition at a later date, or with a different sample of subjects (Ticehurst et al., 2000). Reliability is a necessary but not sufficient condition for validity (Cooper & Schindler, 1998). It concerns the extent to which measurement is free from random or unstable error. Cooper and Schindler (1998) asserted that reliability can be increased by the following strategies: minimising external sources of variation, standardising conditions under which measurement occurs and improving investigator consistency. For Miles and Huberman (1994) getting feedback from informants can also be useful in this regards, as can looking at 'unpatterns' such as negative evidence and following up on surprises. In this context, disconfirming evidence was sought for each theme developed. In addition, as outlined earlier, drafts of analysis were provided to 'critical colleagues' for feedback. Briefing papers were also provided to the sites for as a form of 'member check' (Miles et al., 1994)

Although case studies do not have 'statistical' reliability and validity, they do have forms of reliability and validity more suited to their qualitative nature. For Gummesson (2000), reliability can be a substitute for validity when this is difficult to achieve: *'the researcher establishes reliability and assumes validity'* (Gummesson, 2000: 19). Thus, debate regarding reliability and validity is closely linked to the desire to generalise.

6.7.4 Rigour and focus in case-study research

A further common concern with case studies is insufficient rigour. For Yin (2003) the perceived lack of rigour in case study research can be related to the quality of the research conducted and a lack of texts providing guidance on systematic analysis. The systematic structure for analysis adopted in this research has been outlined in Sections 6.5 and 6.6.

Secondly, Yin (2003) asserted that the fact that a different research orientation can emerge over the course of a case study is the biggest source of criticism of the method, as the research design becomes inappropriate for the question being asked. For him, if the research questions do change, there is a need to start again with a new design. In this context the research orientation remained constant throughout the study.

Having outlined the common concerns pertaining to quality in case-study design, the final section outlines the ethical considerations that arose in the project.

Section 6.8 Ethical considerations

Ethical approval for the study was granted from the Faculty of Health Sciences Ethics Committee at Trinity College. The project was fast-tracked for approval on the basis that it was a service-management study, using no identifiable patient records. Nonetheless practical issues remained. These were voluntary participation and protection from harm, which encompassed confidentiality and informed consent (Babbie, 2007). In addressing these issues, following Dawson (2003), the researcher was transparent about their background and the nature and purpose of the study.

6.8.1 Voluntary participation

The principle of voluntary participation was implemented in this study. Although, in one organisation access arrangements led to an email being circulated from the CEO to the desired participants in the organisation, personal contact was made with each individual to emphasise that participation was voluntary and that due to confidentiality arrangements non-participation would not be reported at the organisational level.

6.8.2 Protection from harm

Typically in social research, the question of 'harm' is more likely to arise in the use of data, rather than in the data-collection procedure (Ticehurst et al., 2000), and can generally be addressed through the provision of confidentiality. However, in this study, which asked individuals to reflect on the factors which had helped and hindered their involvement in change, two respondents became disturbed during interviews. The cause of agitation in the first instance was frustration at the lack of progress in change. In the second instance, disturbance was caused by the respondents' reflection upon difficult relationships in their working life. In the first instance the respondent was asked whether they would like to discontinue the interview process. However, they described the interview as cathartic and wished to have their difficulties documented. Follow-up was undertaken via email and written contact. In the second instance, the interview was discontinued, and the respondent spoke about their experience. Significant time was spent with the respondent until they recovered. The respondent was advised that they could withdraw their interview from the study and did not return their consent form. This approach to managing the situation was congruent with Babbie's (2007) concept of informed consent, which he asserted is a method of formalising both voluntary participation and protection from harm. For Babbie (2007:

64) informed consent is when *'subjects base their voluntary participation in research projects on a full understanding of the possible risks involved.'*

The decision not to include the original case-study documents in the thesis was made on the basis that details pertinent to analysis could lead to the identification of the organisations. As a result, these documents have been retained as a primary resource for the researcher. In addition, these documents do not present final-stage analysis. To further protect respondents, a 'stay' has been placed on the thesis document. In practice, this means that the document is not accessible to the public for a period of five years without the consent of the author.

6.8.3 Informed consent

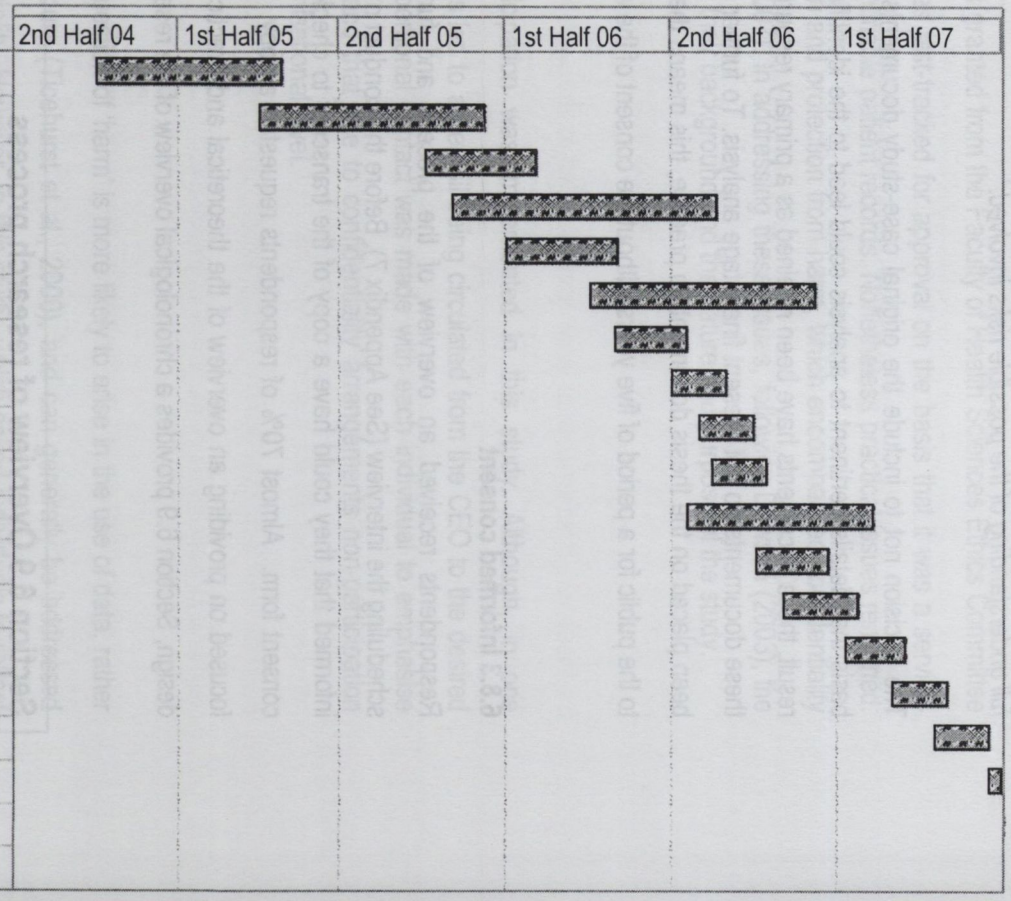
Respondents received an overview of the process and function of the research prior to scheduling the interview (See Appendix 7). Before the conduct of the interview, respondents were informed that they could have a copy of the transcript to check and modify prior to signing the consent form. Almost 70% of respondents requested a copy. While this chapter has, to date, focused on providing an overview of the theoretical and practical choices made in the research design, Section 6.9 provides a chronological overview of the research process.

Section 6.9 Overview of research process

Figure 6.3 provides a chronological overview of the tasks undertaken throughout the research process. The significant overlap between some activities is a function of the difficulty of negotiating access, of scheduling interviews, and of the iterative nature of the data-collection and analysis processes discussed throughout the chapter. In addition, what the table and indeed the chapter fail to make salient are the intensity and immersion which were particularly entailed in the sixteen-month period in which data was collected and analysed. Although previous discussion alluded to choke points in this process, namely access negotiations and the transcription of interviews, the process of data collection and analysis were, at times, both mentally and physically arduous.

Figure 6.3: Overview of the Research Process

ID	Task Name
1	Initial literature review and research design
2	Visiting researcher on seminal project
3	Modification of research design & transfer process
4	Access negotiation
5	Revision of literature review
6	Prep for data collection & scheduling of interviews
7	Write up of methodology chapter
8	Data collection public hospital
9	Data collection voluntary hospital
10	Data collection private hospital
11	Transcription & return of consent forms
12	Case history write up
13	Data analysis & case write up public hospital
14	Data analysis & case write up voluntary hospital
15	Data analysis & case write up private hospital
16	Iterative analysis and cross-case comparisohn
17	Revision of literature review
18	Theory building
19	Integration of thesis



Conclusion

This partial-operational replication study explores issues arising in role definition and enactment in contexts of change, as well as broader issues affecting change processes. The study draws upon the post-positivist and social constructivist paradigms, through critical realism and interpretivism, to generate knowledge that takes account of the role of individual sense-making and interpretation, as well as constraints on action stemming from the social, organisational and environmental context. Data has been collected from a variety of respondents, across hierarchical and professional boundaries, to incorporate a diverse array of perspectives on the change processes studied. The analysed data has been compiled into case-study format on the basis of which cross-case comparison and theory building has been undertaken. The key findings are presented in the ensuing chapters.

Chapter 7 provides a contextual overview of the characteristics of each of the three cases, including an introduction to the perceived role of the organisation's sector, organisational processes and strategic distraction on the hospital's functioning. These factors are further drawn upon in chapters 8 and 9. Chapter 7 provides a context for the reader, making the ensuing presentation of key results more meaningful, and facilitating consideration of whether the findings can be transferred into specific organisations. In chapter 8, the first research question, 'Who holds change-related roles, how are they enacted in the role structures in place and what works effectively?' is explored. This chapter raises four themes, including those involved in the initiation and implementation of change, the impact of role structures on the engagement of particular groups of staff in change, the role and impact of clinical managers, and relationships as facilitators of change. Comparative analysis, at the organisation and environment level is further developed in Chapter 9, which considers the role of the HR function; service-planning and accounting systems; and the configuration of organisational factors that affect the climate for change at the organisation level.

Chapter 7: Contextual Case Overviews: The Impact of Sector and the Role of HR, Accounting and Service-Planning Systems

Introduction

While chapter 4 presented both the external context for the research, and the macro dynamics evident in the internal context, the purpose of this chapter is to present the analysis of the specific internal context of each case. The decision to present the data for the internal context was influenced by the processual orientation, which emphasises the importance of context. However, the objective is not solely to provide a contextual background to key findings, but to orient the reader, and make the consequent presentation and discussion of the research output in chapters 8 and 9 more meaningful. For each case, the data presented has been derived from analysis of secondary data, observation and contextual interviews, with data also drawn from the main body of interviews, where appropriate.

The topics presented in each case overview have been selected and abridged from the case-study template presented in Appendix 4. In addition, additional areas have been selected on the basis of the themes that emerged throughout the research. The process of selection was a function of the iterative nature of the data-analysis process. As detailed in Section 6.5.2, the case histories were initially generated on the basis of the case template. After cross-case comparison and disregarding weaker themes, the pertinence and content of the original case history and contextual information was revised, with greater attention afforded to areas that emerged as important. These included the perceived role and influence of the (1) organisation's sector, (2) HR function, (3) service-planning and accounting systems, (4) governance systems, and (5) levels of strategic distraction, on organisational functioning. These factors emerged strongly from the cases, and their analysis and implications are further discussed in chapters 7 and 8, where they strongly underpin key findings. In particular, the influence of the organisation's sector on its functioning is discussed in Section 9.1, the absence of the HR function in the facilitation of change is discussed in Section 9.2 and the constraints imposed by the current service-planning and accounting systems are discussed in Section 9.3. Pivotally, the configurational impact of strategic distraction, service-planning, accounting, governance systems, and the role structures in each organisation, on the identification, initiation and implementation (harnessing) of change are discussed in Section 9.4.

While extended analytical case contexts and case-studies, were completed[21], these are not presented in the thesis or appendices due to both ethical concerns and relevance. The specific ethical concerns necessitating their exclusion pertain to issues of confidentiality and the need to protect respondents from harm. The organisations and respondents were guaranteed confidentiality in the presentation of results from the study, as outlined in Section 6.8.1. The small size of the Irish hospital sector makes individual organizations relatively simple to identify on the basis of contextual detail. As a result, the presentation of the complete case-study or case-contexts could jeopardize the confidentiality of the organisations. To further protect confidentiality, information drawn from sources such as regional or organisational reports, which could lead to the identification of the cases, has not been referenced in the thesis, although they are referenced in the original case documents. The second reason underpinning the abridged nature of the cases is the volume of underlying data in each case, generated from multiple sources, based on the case template and codes, and revised throughout the iterative cycles of analysis. Any meaningful presentation of cases would therefore be selective. As mentioned, the themes chosen for presentation in this section were limited to the internal context, as defined by Pettigrew and Dawson in chapter 3, with additional themes integrated on the basis of the research findings. To conclude the chapter an assessment of the change outcomes in the three hospital sites is provided. While an overview of the change initiatives undertaken is provided for each case, the closing discussion considers the progress made in relative, rather than absolute terms. After this discussion, the focus in chapters 8 and 9 turns to the process through which these outcomes were achieved, and provides insight into the relative progress made in each case. Specifically, after the contextual case summaries in this chapter, chapter 8 presents the findings from the first research question, concerned with the individuals who take responsibility for initiating and implementing service-improvement, and what works effectively. Thus chapter 8 is focused at the role level. Chapter 9 addresses the second research question, concerned with additional factors that facilitate and hinder the implementation of service-improvement. This chapter is predominantly focused at both the organisation and environment level. Inherent is consideration of whether these factors vary across the public, voluntary and private hospital explored. Data is presented in support of the themes developed throughout chapters 8 and 9. In relating this data to the processual orientation adopted, this chapter presents internal contextual data pertaining to each organisation, which complements the overview of the internal and external context of Irish hospitals presented in chapter 4. This context is important to facilitate consideration of the extent to which empirical generalisation of the findings, detailed in Section 6.7.1, can occur. Chapters 8 and 9 present the findings that have emerged from considering processes of change undertaken in this context, which

[21] Case studies ranged in length from 60 to 110 single-spaced pages

have varied in substance and form. Prior to this, Section 7.1 outlines the characteristics and context of the first case study, the public hospital.

Section 7.1 Case 1 Public Hospital

This case overview of a proactive public hospital with a supportive senior-management team, constrained by its environment, draws upon analysis of interviews with 13 staff, outlined in Table 7.1. It also draws on contextual interviews detailed in Appendix 6, observation notes and documentary analysis. Of the respondents, six held managerial roles, six held clinical-management roles and one was a clinician. A 'clinical manager' role refers to a clinician with significant managerial responsibility, as discussed in Section 4.3.5. The form, impact and constraints upon clinical-management roles in Ireland as well their implications for change processes are discussed in Section 9.2.

Table 7.1: Interviewees in the Public Hospital

Title	Abbrev	Internal Roles	External Roles	Total
Managers				
General Manager	GM	(1) General Manager	Multiple	Multiple
Director of Finance	DOF	(2) Director of Finance Director of Resource Directorate	6	8
Director of Nursing	DON	(2) Director of Nursing Director of Care directorate	4 (+)	6 (+)
HR Manager	HRM	(1) HR Manager	2	3
Assistant Director of Nursing	ADON	(2) ADON Operational site manager, by default	0	2
Clinical Managers				
Medical Director	MD	(2) Medical Director Consultant Pathologist	1	3
Cardiac rehabilitation co-ordinator	CRC	(2) Clinical role Management	0	2
Resuscitation Training Officer	RTO	(2) Clinical role Administration	2	4
Chief Cardiac Technician	CCT	(2) Clinical role Administration	0	2
CNM 2 CCU	CNM2 CCU	(1) Management	1	2
Cardiovascular nurse	CN	(3) Audit Developing/implementing guidelines Training	0	3
Chief Pharmacist	CP	(2) Clinical role Head of Department	0	2
Clinician				

Consultant cardiologist	CC	(2) Clinical role Service development – not perceived as formal component of role but spent considerable time	2	4

7.1.1 Setting, population, services, staffing and culture

The public hospital provides services to a town with a population of 14,000, and to its seven surrounding counties. It has 200 beds of which 132 (66%) are designated as public, 56 (28%) are designated as private or semi-private and 12 (6%) are non-designated beds, as explained in Section 5.5.6. The hospital, which is old-fashioned in design and appearance, has made attempts to redecorate and brighten internal areas, but is suffering from space-constraints.

The hospital provides a range of acute services through twenty-nine consultants of whom eight provide services through a visitation arrangement. The organization has been innovative in service-expansion, providing out-reach clinics in a range of areas. Levels of service provision rose in all areas of the hospital from 1997–2003, the latest date for which data is available. The largest growth was evident in the number of day-cases, which rose by 87% during this time. This increase is related to the opening of an oncology day-ward. The provision of out-patient services also rose significantly, increasing by 24.7%. In addition, casualty attendances increased by 11.8%, the number of live births increased by 5.9% and in-patient admissions increased by 4.8%.

The hospital employs approximately 450 staff, with recruitment a challenge across all disciplines. The hospital is currently exceeding its staffing-ceiling limit set by the HSE. However, the HR manager noted that no sanctions appear forthcoming. The organisation has introduced family-friendly working-time practices over the past three years.

The public hospital has a pronounced warm, friendly and integrated culture, strongly rooted in inter-personal relationships, and linked to the small scale of the organisation.

> *We are a small hospital and everybody knows everybody else.* (Assistant Director of Nursing, Public Hospital)

> *I know everyone…I probably say twenty 'hellos' each time I go up and down the corridor.* (General Manager, Public Hospital)

Six of twelve respondents explicitly emphasized the positive implications of being a small organization. They linked this to the effectiveness of organisational processes and outcomes. They also identified a sense of cohesiveness in the organisation, underpinned by face-to-face communication, and grounded in ongoing personal relationships. (Assistant Director of

Nursing, Chief Pharmacist, Clinical Nurse Manager CCU, Director of Nursing, Medical Director and Resuscitation Training Officer, Public Hospital),

> *It's that small, and I do think that it makes a huge difference when you are trying to plan things and get things done.* (Chief Pharmacist, Public Hospital).

> *Working in a small hospital, it's easier to get things done, because you meet face to face with that person.* (Resuscitation Training Officer, Public Hospital)

In combination, these factors lead to *'a nice atmosphere, a nice ethos'* (CNM2 CCU, Public Hospital). In fact, the assistant director of nursing explicitly acknowledged this cohesiveness;

> *It's friendly, we are very professional when we are working, and we get everything done; people are willing to do it because we are a cohesive group.* (Assistant Director of Nursing, Public Hospital).

Theoretically, these strong and open relationships should facilitate change and multi-professional initiatives, by removing social boundaries. These were identified, in Section 4.4.1 by Ferlie et al. as being one key issue undermining the spread of change in multi-professional contexts (Ferlie et al., 2005a). This appears to be the case, with the scale of the organisation facilitating important impromptu liaisons that can assist change. These can occur in the corridor (Chief Pharmacist, Public Hospital) or the coffee shop (Resuscitation Training Officer, Public Hospital), among other areas.

> *I think because you know [the consultant] well, and you can stop on the corridor, you can do a lot of business on the corridors here (laughing) and things move quicker. Here it is a small enough place for things to happen.*(Chief Pharmacist, Public Hospital)

Several individuals noted the difficulty of achieving a similar culture in a larger organisation. These representations of the culture were upheld by most observations around the hospital. However, the cardiac technician didn't share this optimism, and articulated a strong sense of isolation. This was not shared among the other allied health professionals (AHP's) encountered. Section 7.1.2 considers the hospital's source and level of funding.

7.1.2 Source and level of funding

The hospital receives an annual funding allocation from the HSE, and is integrated into the HSE's regional finance system. This system includes budgets, accounts, payroll, cash management, creditors and annual financial statements. Negotiations regarding the funding allocation of the hospital, and that of all other hospitals in its network, as per Section 5.5.4, are undertaken by the network manager for the region. There was a concern articulated that the largest organisation in the network is consistently prioritised for funding (Chief Pharmacist and General Manager, Public hospital), and that there is a 'pecking order' among the

remaining network members (Resuscitation Training Officer, General Manager, Public hospital). However, upon reflection, the chief pharmacist could see evidence of progress, with new staff posts sanctioned in the recent past. The public hospital was budgeted to receive the following funding in 2002;

	Pay €m	Non-Pay €m	Income €m	Budget Allocation €m
State 1	27	8	5	30

Non-consultant hospital doctors overtime costs were identified as a major challenge to the hospital pay budget. The finance director asserted that the hospital tends to over-run financially, and be granted extra payments to deal with justified deficits. Section 6.1.3 outlines the management structure of the public hospital.

7.1.3 Management structure

The public hospital is governed through regional HSE structures, with significant decisions, made by the general manager, ratified at this level. The hospital operates under a 'clinicians in management' structure, which was described by the regional authority in 2001 as *'a well-developed clinical directorate structure which enables clinicians and managers to make decisions on resource use and allocation, by agreement'.* The structure is comprised of the general manager and three directors – the director of finance, the director of nursing and the medical director. The three directors, in conjunction with the general manager, comprise the senior management team.

The medical director was critical of the design of the clinicians in management structure, noting the lack of attention to detail in areas such as job descriptions and support functions. He asserted that *'the thing was not set up in a forward thinking manner. It sort of evolved and limped along in the interim'.* However, it seems to be favourably viewed by the other organisational members (Medical Director, Director of Nursing, Chief Pharmacist, General Manager, Cardiac rehabilitation co-ordinator). For example, the director of nursing described the management structures as *'very, very good. Clinicians in management works very well.'* This view was also upheld by the chief pharmacist, though it was not mentioned by the other department heads, with the exception of the cardiac rehabilitation co-ordinator.

> *We have a very good reporting structure. Like we have [a medical director] now, but then we have our own allied health group who meet every six weeks...so you can progress certain things for your own department through [the medical director] and then you can progress other things as a group.* (Chief Pharmacist, Public Hospital)

Each individual who enters the organisation is aligned to a particular director. The directors have monthly meetings with the staff in their directorates. There are larger, quarterly meetings between the general manager, three directors and other section managers. Benefits associated with the structure include the fact that that management sit down together for decision making, increasing involvement and awareness, (Director of Nursing) and allowing the general manager to avoid micro-management (General Manager).

Two concerns were raised regarding the clinical-directorate structure. Firstly, the director of HR noted concern regarding the dispersed location of the AHPs within the structure, and how well their needs are met as a result of this positioning. Secondly, the medical director made a qualified statement in support of the structure. He asserted that while *'clinicians in management is a good idea, issues remain in practice.'* In fact, he noted that *'the practice, well that needs a little, well a good bit of work'* (Medical Director, Public Hospital). The specific issues identified pertain to (a) a lack of meaningful authority in his post; (b) a lack of some quid pro quo for involvement in the structure and (c) insufficient administrative and other support. Addressing these issues in the longer term is necessary to ensure that clinicians are attracted to such posts and can engage in meaningful activity once incumbent in their role. Meaningful authority requires capacity to partake in activities with meaningful consequences.

> *If you have a system whereby clinicians are put into relatively powerless positions, or buffer- positions, or positions where they are doing – how can I put this delicately? – where they are doing stuff that is pretty easy to do – I mean, if your function is signing a lot of documents, you are going to turn clinicians off doing that.* (Medical Director, Public Hospital)

Having outlined the management structure of the organisation, Section 7.1.4 considers the ongoing and recent strategic developments in the organisation, which have been managed through this structure.

7.1.4 Strategic developments

The hospital is undergoing a sustained period of capital and service development. An Accident and Emergency expansion was underway in mid 2006, at the time of data collection. In 2002, the hospital opened three new theatre suites, an eight-bedded intensive-care unit, a minor operation room and an endoscopy suite. These developments cost approximately €20m and were government funded. Subsequently, a stroke care and observation ward was developed with the aid of government funding in the area vacated by the old intensive care unit. The Director of Finance noted that there are indicators from the external environment that suggest that further capital development is imminent. Although the Hanley report (Department of Health and Children, 2003b) led to some concern regarding the future of the

hospital as it advocated the development of regional tertiary centres and the closure of regional hospitals, the director of finance asserted that *'Whatever scare we had with the Hanly report – at the moment it seems to have gone.'*

Since the mid 1990s the hospital has cultivated a strategic alliance with a neighbouring hospital, with whom the organization shares three non-cardiology services. A fourth shared service was being developed at the time of data collection. The hospital's development appears to be strategically linked with the neighbouring hospital, with plans for the further development of joint services offered at the regional level. The public hospital appears to be the stronger of the two partners. In spite of these developments, there is not much evidence of strategic distraction at the senior-management level, although there is some focus on ongoing operational initiatives. Section 7.1.5 considers the hospital's external profile through common-quality indicators.

7.1.5 External Profile

The accreditation initiative and the Hospital Hygiene Audit are the two common external quality indicators across Irish Hospitals. In the 2006 bi-annual hygiene audits, the public hospital scored 80 and 82 respectively, rated as 'fair performance'. The scoring system rates 85 and above as good, 76 to 84 as fair and 75 or below as poor. Only four of fifty-two organisations audited scored as low or lower, indicating that this public hospital was at the lower end of the performance spectrum.

The hospital received pre-accreditation status (Advanced) from the Irish hospitals Accreditation board in 2003, for a three-year period. This was in line with the majority of acute general hospitals at that time. The Irish system has five potential levels of accreditation, which are; (1) accreditation; (2) accreditation with report; (3) accreditation with focused visit; (4) pre-accreditation status (Advanced) and; (5) pre-accreditation status. Several staff emphasised the significant time spent on gaining this status (CNM2 CCU, Director of Nursing). Section 6.1.6 considers the role of the HR function in the public hospital.

7.1.6 Role of the HR function

While the HR manager aspired to a strategic role for the HR function, constraints of understanding, influence, budgetary control and a poor-quality relationship with the senior management team precluded this. There was a limited perception of value-added by HR, where discussed. HR was not discussed by front-line clinicians. HR has insufficient status to

be strategic and was described as facilitative and operational by the HR manager. The role of the HR function and its link to service-improvement change is discussed more fully in Section 9.2. The role of a second set of organisational processes, underpinning service-improvement, is outlined below.

7.1.7 Service planning and accounting systems

In the public hospital, as will also become evident in the voluntary hospital, the concerns articulated regarding accounting and service planning systems span organisational and environmental levels. At the organisational level, the desire for devolved budgeting was raised. At the environmental level, concerns included (1) the need to plan for depreciation, (2) the emphasis within the system on money being spent properly rather than effectively, (3) the lack of standardisation in costing systems across hospitals, and (4) the lack of integration between the service plan submitted to the HSE and the actual financial allocation made to the organisation. At an organisational level, the director of finance identified his priority as keeping the books balanced and ensuring that everything is in order for an audit. Thus he adopted a stewardship orientation. The role of service-planning and accounting systems in facilitating a climate for service improvement is discussed more fully in Sections 9.3 and 9.4 In the next sub-section, attention turns to the perceived influence of being a public-sector hospital on organisational functioning and the respondent's experience of work.

7.1.8 Perceived influence of sector on organisation functioning

Respondents were asked whether, in their experience, the status of the hospital as a public-sector organisation affected either their personal daily experience of work or organisational processes. Several themes were raised in this regard, predominantly comparing the public to the voluntary sector, though two comments did draw comparison with the private sector. One consistent theme concerned the perception that historically, voluntary hospitals had more autonomy than public hospitals. However the issue of whether this remains the case, given the new HSE structures, was unresolved. The particular ethos of the voluntary sector, the perception of longer planning horizons, independence in staffing practices and the perception of less bureaucracy in the voluntary rather than the public sector were also discussed. These themes are addressed across the three cases, with reference to the fourth research question, in Section 9.1. Section 7.1.9 considers factors from the external environment that affects the public hospital.

7.1.9 Outer Context

Increasing constraints from the external environment, politicisation of the healthcare context and the dynamics of the network to which the hospital belongs, were identified as external contextual factors affecting the organisation.

Increasing constraints from the external environment were related to the introduction of the HSE by the general manager. They identified a sense of disempowerment and frustration, common amongst their peers in the regional-hospital network, associated with the new structures. Of particular concern was the locus of decision making, which was perceived as being moved away from the hospital managers and towards the regional authority level. These concerns were strongly and clearly articulated.

> *Outside of here you are blocked and you are questioned and at the end of it then you are saying 'God, am I not the person best to know what is what, and what is needed?* (General Manager, Public Hospital)

In practice this meant that external factors could dictate or determine her choices.

> *There are times when I am not comfortable with it myself, even though I know that I am making a decision. It is not what I would really want myself... but I have no choice but to. Cause I have other factors determine or dictate.* (General Manager, Public Hospital).

The change to the HSE structure also led to new reporting structures between the organization and the regional authority. The new structures were not positively received.

> *I find the reporting structures have spread quite a bit and we wonder at times about the integration between the various units that we are reporting to.* (Director of Finance, Public Hospital)

Links with other hospitals and organisations via committees also changed with the new structure (General Manager). Prior to the HSE, committees had a regional brief, whereas now activity is focused by county. This has led to a decline in contact between the general manager and their colleagues in other hospitals in the region. The general manager noted that the evolution was ongoing and not yet settled, but articulated concerns regarding the dynamics of the network and the representation of their interests as a small hospital, outlined in Section 7.1.2.

7.1.10 Context for change

The public hospital is operating in a high-change context – both internally and externally. Structural change in the environment, outlined in Section 5.5.4, has had implications for the

hospital. At the strategic level, consolidation against downgrading in status, the potential for further capital and service development and network dynamics are being careful monitored and managed. It also has a significant A&E development ongoing. Whilst these are potentially strong distractions, the senior management team retain a pro-active focus on day-to-day operations and the management of change. The small-scale of the organisation and cohesive culture, as outlined in Section 7.1.1, further assist the climate for change. Although the organisation as a whole appears broadly receptive to change, it is also important to consider the context for change within the cardiology unit.

Cardiology had declined in priority at the organisational level. While the general manager expressed frustration that there are outstanding areas in need of attention in cardiology, she noted that much of this was beyond her control due to the exhaustion of cardiovascular funding at the national level. Thus, with the decline of funding, attention has moved to other initiatives. These include the expansion of oncology, the A&E development, the imminent development of surgery and the potential for capital development. The medical director of the public hospital noted a concern with strategies in general that there can be an over focus on the means rather than the ends. He did not assert that this has occurred in the case of the cardiovascular strategy, but rather that it is a general concern. The decline in the level of funding and priority attached to cardiology has significant implications for the continuation of change, particularly as the consultant identified the key barriers to implementing the residual changes as infrastructural. These require significant, if one-time, investment to address.

One unanticipated effect of the cardiovascular strategy was that staff moved within the hospital to posts created under the strategy. This left significant gaps in experience. In one small unit, five highly qualified staff moved within the hospital. As a consequence the Coronary Care Unit (CCU) was left with newly qualified staff nurses who were inexperienced in the ward setting. The following sub-section provides an overview of the cardiology department.

7.2.11 Overview of cardiology department

Although the management team were aware that significant development of the cardiology department had occurred, only the general manager made reference to any specific change. The consultant, who is not a cardiologist but a general physician with an interest in cardiology, outlined that the service had developed significantly, over the previous six years, to include (1) an echocardiographic service, (2) a cardiac-rehabilitation service, (3) a resuscitation training department, (4) a coronary-angiographic service, (5) a pharmaceutical

research and clinical-trials research unit, and (6) a pre-hospital emergency-care initiative, which liaises with primary care to develop services for patients. These developments had been largely driven by him, and facilitated by a supportive management team.

Section 7.1.12 presents a concise overview of the public hospital's context, as a reference for the reader.

7.1.12 Overview of context and challenges in the public hospital

Emergent themes in the context of the public hospital can be summarized according to nine sub-themes.

Setting

- Service provision has expanded greatly, particularly in out-patients and day-cases. This has occurred without sufficient infrastructural expansion, creating a need for further capital investment.

Structure and culture

- The 'clinicians in management' scheme is in operation in the hospital. Although there is a positive perception of the structure among staff, issues remain.
- The organization has a cohesive and pro-active culture, facilitated by the small-scale of the organization. This small-scale also has an influence on organization functioning, processes and cross-group relationships.

Strategy

- The hospital's future appears secure, with capital development and service expansion likely.
- The hospital is strengthening its strategic alliance with another regional hospital. Services are being co-developed with some duplicated services moving entirely to the public hospital.
- In spite of these developments, there is not much evidence of strategic distraction at the senior-management level, although there is some focus on ongoing operational initiatives.

HR

- The relationship between HR and the other senior-management functions is poor, with limited perception of value-added by HR, where discussed.

- HR has insufficient status to be strategic and is described as facilitative and operational

Accounting & service-planning systems

- At the organisational level, devolved budgeting was desired by some to improve the efficiency and equity of budgetary allocation.
- At the environmental level, there was a desire for depreciation and the standardisation of costing systems across hospitals. In addition, there was a desire for integration between the service plan submitted to HSE and the financial allocation to the organisation.

Influence of sector on functioning

- In the experience of the respondents, historically voluntary hospitals have had more autonomy, specifically in planning horizons, independence in staffing, less bureaucracy and a faster pace of change. However that situation is in a state of flux, since the restructuring of the HSE, which attempted to standardise the relationship between the HSE and public and voluntary hospitals.

Outer Context

- Increasing constraints on autonomy were imposed by the new HSE structures, although the final outcome of this restructuring is still not entirely evident.
- Politicisation of the environment was emphasised, particularly the concern that hospital network dynamics are potentially not beneficial to small organisations, such as the public hospital.

Context for change

- While there are potentially significant strategic distractions, the senior-management team remain supportive of change initiatives.

Cardiology department

- The department was developed largely by a general physician with an interest in cardiology, from non-existence to providing a range of services. The pro-active consultant led to management facilitating rather than managing the changes. The area ceased to be a priority for them with the decline of funding under the cardiovascular strategy.

Section 7.2 now provides an overview of the key dynamics evident in the second case, the voluntary hospital.

Section 7.2 Case 2 Voluntary Hospital

This case overview of a resource-constrained voluntary hospital, emerging from a significant and distracting capital development, draws on analysis of interviews with 16 staff, and two contextual interviews with the chair and co-ordinator of the regional implementation group for the area in which the hospital operates, observation notes and documentary analysis. Those interviewed included one board member, six managers, seven clinical-managers and two clinicians. Respondents are listed in Table 7.2.

Table 7.2: Interviewees in the voluntary hospital

Title	Abbrev	Internal Roles	External Roles	Total
Managers				
Mission Effectiveness Co-ordinator	MEC	(1) Board member	(4) Administrative role with Religious order Board member on several other boards Responsibility for considering future of sites owned by Religious Order	5
Deputy CEO	DCEO	(4) Operational role in Vol 1 and strategic contribution to other hospitals in the group. Primary role very broad in scope Deputy chair of project team Chair of commissioning and equipping groups	(8) Roles across public sector, academic teaching and hospital groups	12
Director of Finance	DOF	(2) Financial Controller Company Secretary	(2)	4
Director of Nursing	DON	(4) Director of Nursing Executive member of Healthcare group Executive member of Board Education committee	(4) Policy and pan-hospital group membership	8
Director of HR	DOHR	(2) Director of HR Input into group HR strategy	(3+) Policy and pan-hospital committee membership	5 +
General Services Manager	GSM	(4) General Services manager Commissioning committee Hygiene quality improvement committee Health and safety committee	(0) Rare external involvement as links tend to be with senior management through CEO, DCEO or DOF	4

Title	Abbrev	Internal Roles	External Roles	Total
Clinical Managers				
Lead clinician cardiology	LCC	(3) Consultant Chair of consultant group in private hospital Sits on board of private hospital	(1) Involvement in medical societies	4
Consultant cardiologist	CC	(3) Consultant cardiologist Manager of Heart Failure Unit (managing budget €4.5m) Secretary of Medical Board	(0)	3
Clinical Nurse Manager Level 2 CCU	CNM2 CCU	(2) CNM2 and member of accreditation committee. Also sits on other committees as requested.	(1) Senior role in nursing organization	3
CNM2 Cath lab	CNM2 Cath lab	(1) CNM2 Cath lab	(4) Roles in nursing organizations	5
CNM2 Cardiology ward	CNM2 Cardiology ward	(1) CNM2	(1) Active member of nursing organization	2
Chief 1 Cardiac Technician	CCT	(4) Chief 1 Cardiac Tech AHP Committee member Health and safety committee BLS instructor	(1) Active member of nursing organization	5
Resuscitation Training Officer	RTO	(1) RTO	(1) On a medical group	
Clinicians				
Clinical psychologist	CPsych	(2) Clinical psychologist Mission effectiveness committee	(1) Starting group for psychologists in cardiology working in Dublin area	3
Cardiac rehabilitation coordinator	CRC	(1) CRC	(0)	1

7.2.1 Setting, population, services, staffing and culture

The voluntary hospital is a 500-bed urban-based teaching hospital, with a dedicated research centre, engaged in ongoing and significant strategic development. It has an associated private hospital, and links with two other hospitals in the region. Founded by a religious order to provide for the needs of those who could not afford medical care, it has a history of innovative service improvements. The hospital began a funding relationship with the state in

the 1860s. The state grant has increased from approximately 8% of costs in 1884 to become the hospital's main source of financial support following the developments outlined in Section 5.1. However, the hospital remains privately owned and governed, with the religious ethos emphasised in its mission statement and upheld through a mission-effectiveness committee, which provides induction training to new staff.

The hospital's catchment area is a city and its two surrounding counties, where the population is 3% older than the national average. (National Council on Ageing and Older People, 1995). The hospital provides tertiary referral services nationally, has in excess of forty medical specialities, and is one of the 64 members of the Health Promoting Hospital's network. From 1997 – 2003 inpatient admissions declined by 16.1%, although the average length of stay increased by 20%. As a result, the bed occupancy level role by 5.2% to 93%. Day cases rose by 80% and casualty attendance declined by 20%. Cardiology had 31 inpatient beds, with 85.3% of their 11,254 bed days used.

In 2004, the hospital employed over 1900 staff, of whom 190 (10%) were non-consultant hospital doctors, 133 (7%) were consultants, 665 (35%) were nurses, 247 (13%) were clinical support staff, 285 (15%) were administrative staff, and 152 (8%) were general staff. The clinical support-staff grouping includes allied health professionals, laboratory staff and technicians. Of the administrative staff employed, 80% are directly involved in patient support. The 'general staff' grouping includes catering, security, laboratory, patient assistants and maintenance staff. The 2005 annual report noted that the hospital experienced ongoing staff shortages in certain specialized areas. However, successful efforts were made to recruit staff from Ireland and abroad in 2004. Section 7.2.2 considers the source and level of funding available to the hospital.

7.2.2 Source and level of funding

The hospital is emerging from a period of resource constraint, which has affected service development and levels of service provision. In his financial overview for 2004, the CEO described the preceding financial year as 'very difficult'. Due to financial constraints, activity levels were tightly controlled, with priority given to emergency admissions. Staff recruitment was restricted, and other cost-saving exercises were implemented throughout the year. The financial allocation for the voluntary hospital was €145 million in 2004. During the year, additional public funding was secured, based on service pressures and minor capital purchases required. The final budgetary allocation was €160.9m, which, in addition to resource management, led to the attainment of a break-even position. A similar dynamic was

evident in 2005, with an initial financial allocation of €161m, augmented to €175m. As in 2004, medical inflation continued to be higher than the national rate of inflation. The hospital had a minor surplus in 2005. The management structure is outlined in Section 7.2.3.

7.2.3 Management structure

The purpose [of the board] would be that we're there to govern and not to manage and even sub-committees should not interfere with management, they're there to assist in management matters but to let management manage.

– Mission effectiveness coordinator, Voluntary Hospital

The running of the hospital is overseen by a board of governors, consisting of twelve members and a chairman. The senior-management team attend board meetings. The board's remit is to govern and regulate the hospital in accordance with the ethos of the religious order. The board has power to appoint the CEO, administrative officers and other staff as considered necessary, including consultant medical staff and an auditor. The board meets at intervals of not more than two months. Members of the board do not receive any remuneration for their services. However, they may be reimbursed for expenses incurred.

In addition to the board of governors, the executive and medical boards influence the management of the hospital. The executive board comprises the key managerial posts of the organisation, including the CEO, deputy CEO, the director of nursing, the financial controller and four representative members of the consultant staff, including the chairperson and secretary of the Medical Board. This council meets at least every two weeks. The Medical Board is comprised of all of the consultants of the hospital, once they have completed their year of probation. The Medical Board makes recommendations to the Board of Management regarding medical education, policy, staffing, appointments and other matters. It meets at least six times a year. Other committees reporting to the board of directors include the mission committee, finance committee and audit committee.

A new nursing structure was recently introduced, with a director of nursing and ten assistant directors of nursing (ADONs) who each have responsibility for a number of clinical areas. The ADONs are supported by clinical nurse managers, appointed at grade points 3, 2 and 1 in decreasing order of seniority. The director of nursing has a monthly meeting with the ADON's, and information sharing is facilitated by an electronic share-drive.

The CEO focuses on service development and strategic consolidation. He has a strong external orientation, being responsible for the effective management and development of the

organization including the private hospital, and maintaining links with other hospitals. His key functions are corporate management, planning and control, organisation change and development and quality initiatives. The deputy CEO has an operational role in the hospital with a very broad portfolio. There is a dual reporting structure for the other senior managers to both the CEO and deputy CEO. While the hospital does not have a clinical directorate structure, they do adopt a lead clinician model. Lead clinicians are selected by their peers and have a mandate to represent their department. Section 7.2.4 considers current and historical strategic developments in the hospital.

7.2.4 Strategic developments

At the time of data-collection, the hospital was operating in a context of multiple strategic pressures, distracting senior management from day-to-day operations. These distractions included resource constraints with increasing demand for services, the completion of a major capital development and plans to develop a new private hospital in response to incentives for co-located hospitals. Furthermore, in an attempt to consolidate the strategic position of the organisation, in the wake of HSE restructuring, attempts have been made to integrate the management of the voluntary and private hospital. This integration has complicated the development of organisational policies and processes (Director of HR). There is an informal expectation that all managers *'take a lead role in trying to provide a co-ordinating influence, that they're all thinking together'* (HR Director, Voluntary Hospital). This integration, and the emphasis on developing strategic partnerships with other organisations, has placed the CEO under significant pressure (Mission Effectiveness Coordinator, Voluntary Hospital). Further strategic concerns include the need to address changes in the education structures for nurses and paramedics (Director of Nursing). The key strategic issues identified by the CEO, in the 2005 Annual Report were (1) the development of capacity to deal with demands on the service; (2) the modernisation and development of infrastructure; (3) developing pan-hospital structures and networks to integrate with other acute and community services in the HSE; (4) creating partnerships with the HSE and other healthcare providers to ensure quality of care; and (5) pursuing the quality, care and value for money agenda. The director of HR and the mission effectiveness co-ordinator identified the evolution, consolidation and development of the hospital and its links with other organisations as the key strategic concern. The hospital is actively courting alliances with other hospitals and health-related organisations. The hospital is also exploring public and private funding sources for the estimated €40m investment required for an additional 200 beds. A foundation has also been established to raise

philanthropic funds for this venture. Section 7.2.5 outlines the external profile of the organisation.

7.2.5 External Profile

In the bi-annual Hospital Hygiene Audit in 2006, the hospital received 83 in both surveys, rating 'fair' according to the scoring system outlined in Section 7.1.5. Nine of fifty-two other organisations scored an equivalent or lower score on the second audit in that year. Thus the hospital is within the lowest performing 20%.

The hospital has actively participated in the development of an Irish Hospital Accreditation Scheme. In 2004, self assessment and peer review led to the award of pre-accreditation (Advanced) status. This was in line with the majority of acute general hospitals at this time, including the public hospital considered in this study. Section 7.2.6 considers the role of the HR function in the voluntary hospital, which is further evaluated in Section 9.2.

72.6 Role of the HR function

There has been a commitment to using [HR] with a particular focus historically, and now there's certainly a renewed commitment on the part of senior management here to see it play a broader and more prominent role with line managers out there, and in terms of its sphere of influence.

– HR Director, Voluntary Hospital

The HR department was restructured in 2005, after the appointment of a new director in late 2004. The 2005 annual report noted that *'this role is intended to assume a new strategic importance',* with the appointment perceived as an opportunity to move away from a personnel-type model, towards a more strategic orientation (Director of HR, Voluntary Hospital). This orientation contrasts significantly with the marginal operational focus in the public hospital. While acknowledging the *'absolute commitment'* to the new model among senior management, the HR director noted that achieving a strategic orientation was unlikely, due to the nature of the service.

In addition to the desire for a more strategic orientation, there is advocacy for a more devolved model for HR, as opposed to *'what might have been a greater sense of control'* (Director of HR, Voluntary hospital). Section 7.2.7 briefly outlines service planning and accounting systems.

7.2.7 Service planning and accounting systems

Similar themes to those in the public hospital arose regarding service planning and accounting systems. Most organisational level priorities were determined by environmental factors, in particular the accounting, depreciation and service-planning structures outlined by the HSE and Department of Health and Children. One interesting contrast to emerge between the voluntary hospital and the private hospital, discussed in Section 7.3, is the explicit distancing of the organisation from a business model in the voluntary hospital, compared to the explicit focus on this in the private hospital. At role level the devolution of budgetary responsibility was discussed. These factors are further discussed in relation to service-improvement in Section 9.3.

7.2.8 Perceived influence of sector on organisation functioning

As anticipated in Section 5.1.2, the perceived impact of being a voluntary-sector organisation was stronger at the senior-management and board levels, these being the repositories of the mission statement and values of the organisation. However, as the structural change in the environment, detailed in section 5.5.4, have ongoing and incompletely evident implications for the autonomy and operations of voluntary hospitals, the outcomes of this section are not definitive, emerging from a period of transition. The lack of certainty is exacerbated by the active attempts of the voluntary hospital to manage its strategic position. This subject is addressed more completely in Section 9.1. Section 7.2.9 considers factors from the external context that affect the organisation.

7.2.9 Outer context

Key issues in the outer context, as defined in Section 3.3.1, concerned the difficulty of managing the changing external environment, the increased administrative burden associated with augmented performance management and the politicisation of the environment.

The changes in the structure of the HSE and their impact for the organisation were discussed by several individuals (CNM2 Cath lab, Deputy CEO, Director of Finance). Specifically, the director of finance noted that the way in which the HSE operates and foresees the development of health service has changed substantially in recent times, creating a challenge for the hospital in identifying and using the resulting opportunities. In addition, the HSE has increased the emphasis on performance management and achievement of targets, which have amplified the administrative burden and outcome-orientation in the hospital:

> *Therefore we have got to make sure that the way we operate, and the way we capture information and the way we record...well, that we achieve these targets.* (Director of Finance, Voluntary Hospital)

While the director of finance emphasised the need to be aware and take advantage of strategic developments, he noted that performance management *'does distract people from the healthcare.'* In a related vein, he raised the issue of relationship management with the HSE. The organisation desires a closer relationship with the funders regarding service development, as there is *'a gap between us, where we know what's going on, and the funders who we rely on, and so a closer involvement there.'* (Director of Finance, Voluntary Hospital)

Politicisation in the environment is a broadly acknowledged issue, according to the director of nursing and consultant cardiologist. The consultant cardiologist noted that the actions of the Minister for Health and her government colleagues in the health arena are underscored by the desire to perform well in the next election. For him this is the wrong way to manage the system, and what is required is a completely independent authority with responsibility for health. Implicit in this assertion was the perception that the HSE is not fulfilling this role. This perspective was echoed by the director of nursing. She noted that, in spite of the recent attempts to separate policy making and administration, the reporting structure of the HSE to the Minister for Health maintains the political chain. The impact of the above factors on the context for change is discussed in Section 7.2.10.

7.2.10 Context for change

The voluntary hospital is operating in a high-change environmental – both internally and externally. At the strategic level, the consolidation of the hospital's relationships, the development of the private hospital and the relationship with the HSE are of particular concern. In addition, the focus on capital development has provided a further strategic and practical distraction. Attention now turns back to the micro level, outlining the structure of the cardiology department, where the study was undertaken.

7.2.11 Overview of cardiology department

The cardiology service is comprised of a coronary-care unit, a cardiology ward, a cardiac-catherisation laboratory, electrocardiogram and some developing services. Five or six of the cardiologists tend to meet every morning (Clinical psychologist, Voluntary hospital). The department lacks a CNM3, with three of four nursing respondents emphasising this as a deficit (CNM2 Catherisation lab, CNM2 Cardiac Rehabilitation and CNM2 CCU). The CNM2 cardiology ward was unsure of whether the presence of a CNM3 would be of benefit. For her,

the sub-units of cardiology work well together. However, the CNM2 catherisation lab asserted that *'there's no CNM3 in the cardiology department so we have a huge gap then between the divisional nurse manager and the CNM2s in the different areas.'* (CNM2 Cath lab, Voluntary Hospital). For the Cardiac rehabilitation co-ordinator, having a CNM3 would mean having someone with an interest, who has sufficient power to fight for resources etc. The assistant director of nursing and the cardiologist *'have a lot of different areas and interests as well, so they can't give all their time and resources to cardiac rehab, because I'm only one very small area.'* (Cardiac Rehabilitation Coordinator, Voluntary Hospital)

The cardiology unit is no longer a strategic priority in the hospital, after the reduction in funding available to develop the service (Director of Finance, Deputy CEO, Cardiac Rehabilitation Co-ordinator). The cardiac rehabilitation co-ordinator noted that since the initial allocation of resources had been made there has been no increase, in spite of the increase in patient numbers and demands.

At a higher policy level the Deputy CEO noted that national strategies create expectations for *sustainable improvement* but the focus only remains for a limited period.

> *So in a way the cardiovascular strategy has come and gone and it's now all about how do you do with what you have and it's like a deceleration process to bring it to a new level of service provision, because the rate of service growth and development is not sustainable.* (Deputy CEO, Voluntary Hospital)

There is however, one consultant who remains very strongly focused on service-development, with an external orientation for fundraising. A second, similarly oriented consultant has recently retired, potentially creating a leadership vacuum in the department. Section 7.2.12 provides a concise overview of the context of the voluntary hospital.

7.2.12 Overview of context and challenges

Setting

- The voluntary hospital is an urban teaching hospital that has undergone considerable capital investment. However some areas of the hospital, particularly ward areas, require significant upgrading.
- Service provision levels are being managed due to financial constraints.

Structure and culture

- The hospital is linked with a private hospital owned by the same religious order. It has existing and developing links with other hospitals, with clinical areas operating under a lead clinician structure.

History and Strategy

- Senior management have an external orientation, with significant strategic distraction caused by attempts to expand the hospital's links, develop a new education structure, the planned development of a new private hospital and a focus on monitoring and managing the environment.

External profile

- The hospital performed relatively poorly in the hospital hygiene audit, with average accreditation ratings.

Finance

- Finances have been tight, but are actively being managed.

Influence of sector on functioning

- The voluntary sector has been associated with greater scope to be reflexive & innovative. While autonomy has been threatened by HSE restructuring and external funding, the hospital is attempting to strategically manage these dynamics.
- The hospital has a distinctive ethos associated with its voluntary history.

Accounting & service-planning

- The desired changes in accounting and service-planning systems mirrored those identified in the public hospital and were linked to the environment. These included depreciation and longer planning horizons.

HR

- The HR function is moving away from a personnel-management model and towards a strategic orientation. It is increasing in status, but the HR Director recognises that it is difficult for HR to be strategic in health service.

Outer Context

- The organisation is finding it increasingly difficult to manage the environment. This was attributed to the change to the HSE structure, and the greater degree of administration associated with performance management.

Cardiology dept

- The hospital has a large cardiology department with 6 consultants and a comprehensive range of services. Since the decline in available funding, cardiology has ceased to be a strategic priority for management. The prior presence of a strong lead consultant has led to a 'laissez faire' approach to the unit.

Section 7.3 outlines the context and characteristics of the private hospital.

Section 7.3: Case 3 Private Hospital

This case overview, of a pro-active, business-oriented organisation in the process of protecting its competitive position in the market, draws upon analysis of interviews with twelve staff. Of these, six held managerial roles, three held clinical-management roles and three held clinical roles. In addition, the analysis drew upon observation notes and documentary analysis. The respondents are listed in Table 7.3. Section 7.3.1 outlines the setting, population, services, staffing and culture of the private hospital.

Table 7.3: Interviewees in the Private Hospital

Title	Abrev	Internal Roles	External Roles	Total
Managers				
CEO	CEO	(1) CEO	(0)	1
DON	N/A	(2) DON & Deputy CEO as required Very broad scope in role	(2) Lecturing at 3rd level. National-level advisory forum.	4
Head of Finance	HOF	(1)	(0)	1
Quality Manager	QM	(2) Quality Manager Secretary to clinical Governance committee	(1) Representative on national level advisory forum.	3
Cardiac services manager	CSM	(1)	(0)	1
CNM2 Cath lab	N/A	(1)	(0)	1
Clinical Managers				
Radiography manager	RM	(1)	(1) Attends managers-association meetings 4 times per annum	2
Chief Cardiac Technician	CCT	(1)	(0)	1
CNM2 Cath Lab	N/A	(1) Broad in scope	(0)	1

Table 7.3 (Contd): Interviewees in the Private Hospital

Title	Abbrev	Internal Roles	External Roles	Total
Clinical				
Consultant Cardiologist	CC	(1)	(2) Permanent & private practice role in other org	3
Consultant Cardiologist 2	CC2	(1)	(2) Permanent & private practice role in other org	3
Consultant Cardiac surgeon	CCS	(1)	(3) Consultancy elsewhere Director of unit Other role	4

7.3.1 Setting, population, services, staffing and culture

Located in a suburban area, the 120-bed private hospital provides in-patient and out-patient services. It was established during the early 1980s with the objective of addressing the public waiting lists in orthopaedics and cardiology (Consultant Cardiac Surgeon, Private Hospital). The organisation is divided into two components: the clinic, where the individual rooms are owned by the consultants, and the hospital. Crucially, the hospital is a business, which needs to be run like any other (Head of Finance, Private Hospital).

In total, 104 self-employed consultants provide services in twenty-seven clinical areas, from the clinic and hospital, although the hospital is not equipped for emergency care. The predominant areas of service provision are cardiology, with fourteen cardiologists, and orthopaedic surgery with thirteen surgeons. The hospital provides services to over 80,000 out-patients a year and several thousand in-patients per year. In-patient occupancy rates fell slightly in 2005 due to falling lengths of stay and a shift to more day-case activity. The organisation competes on the basis of high technology. The patient populace is specific, being elective rather than acute and either possessing health insurance or being funded under the Nation Treatment Purchase Fund (NTPF).

The organisation is very space constrained (CEO, DON, Head of Finance, CNM2 Cath Lab, Private Hospital), with the physical design leading to several services being provided over two floors. The CNM2 Catherisasion Lab emphasised the lack of beds as an ongoing source of stress.

> *There's no space, we need an extension. So if there was an extension we'd have more space...we're very cramped.* (Head of Finance, Private Hospital)

However, since data-collection, plans for an extension to the organisation have been unveiled. These are outlined in the 'strategy' section. In 2005, there were 555 people working in the hospital, an increase from 526 in 2004. Of these 104 (18.7%) were management and clerical, 140 (25%) offered supplies and services, and 140 were medical and paramedical (25%).

The organisation recently came through a period of acute recruitment difficulty, lessened by the receipt of accreditation to run the nursing-adaptation programme. The staff shortage has led to the organisation recruiting 30% of their staff from overseas. This has generated some difficulties, specifically issues in cultural acclimatisation and delivering a service that satisfies patients (CEO, Private Hospital). This issue appears likely to become exacerbated in the short-term, as there is a big increase in the number of private hospitals without *'a commensurate increase in consultant numbers or staffing numbers'* (CEO, Private Hospital). This will lead to a further increase in competition for staff. The hospital does not recognise unions, which was identified as an advantage from an HR perspective (DON, Private Hospital).

Unlike in the public sector, the CEO noted that there are a variety of organisational customers. These are consultants, patients, insurance companies and GP's, who refer patients to consultants and services. The head of finance expanded these customers to include patients' families. However, for the CEO, the consultants are of most significance.

> *Different people in this hospital have different customers. The Chief Executive's principle customer is the consultant. Because he controls the patient or she controls the patient. Clinical staff, principal customer is the patient, the finance staff's principle customer is the insurance companies and so on. It varies. I dip into all of those but the hospital managers, in private hospitals anyway, keep or lose their jobs on the basis of their relationship with the consultants.* (CEO, Private Hospital)

> *You have a patient coming in here and the patient is the customer, the consultant is a customer, the health insurance company is the customer and the patient's family is the customer. So you have four customers there that have to be satisfied.* (Head of Finance, Private Hospital)

Culturally, there is emphasis upon performance management, valuing staff, flexibility and 'no-blame' within the organisation (QM, CSM, DON, CEO). The quality manager (QM) noted that *'the culture in the hospital is good.'* The cardiac services manager (CSM) noted that attempts are made to incentivise all staff. The culture of trying to value all staff begins with an orientation package upon entry into the hospital. The CEO noted that as a professional organisation,

its' success depends on the people that work within it. It's just a pile of bricks and equipment apart from that ... [the owners] see those people as having created the reputation of the hospital. (CEO, Private Hospital)

The hospital's source and level of funding are discussed in Section 6.3.2

7.3.2 Source and level of funding

I soon found in [a Private Hospital] that [owners] are a mutual corporate organisation, a not-for-profit ... not-for-profit my eye!

– Cardiac Surgeon, Private Hospital

Funding, as detailed above, comes from insurance companies, NTPF patients, and private, fee-paying patients. Pre-tax profits for 2005 were €9.1m, with a net profit of €7.7m. In 2004, pre-tax profits were €8.7m, with a net profit of €7.5m. Turnover increased from €62.3m to €68.9m during this time. However the operating profit margin fell to 13.5% in 2005, from 14.5% in 2004, due to high levels of medical inflation, particularly in salaries.

7.3.3 Management structure and style

The hospital is owned by a consortium of shareholders who exert significant influence on the aims of the CEO. They outline ten annual objectives to him, a combination of financial and quality targets. The senior-management team is comprised of the CEO, head of finance and the DON. They liaise with the heads of clinical and non-clinical departments, and the quality manager and cardiac services manager. Departments have six team meetings a year, with briefings from the board, CEO and departmental head. Should staff raise a query at the team briefing, they are supposed to receive an answer within three days. The organisation has a tradition of having heads of departments who are clinical managers, and expected to be involved in the business side of the organisation. According to the DON, this way of working has become culturally engrained.

Further committee and group structures support the operation of the hospital. These include a monthly medication safety group, a 6-weekly accreditation and quality meeting, an annual patient-survey feedback session, an orientation programme, the medical advisory committee and a quarterly finance-related meeting with the consultants. Both the medication safety group and accreditation forums are multidisciplinary and facilitated by the quality manager, allowing them to build a relationship and rapport with staff. Annually, feedback from the patient survey is provided to a group of 10 staff. Action planning is derived from their suggestions. The quality manager also meets all staff at orientation. She has an informal chat

with them about risk and other quality-oriented topics. The benefits of the finance-oriented meetings with consultants were particularly emphasised by the head of finance;

> *In cardiology there's a particular procedure called stenting. And these are very expensive. The prices can vary quite considerable depending on the stent you use and the volume you use, so by getting buy-in from consultants you can reduce the price to the hospital.* (Head of Finance, Private Hopsital)

The radiography manager and CSM noted that the CEO has a consultative style with staff, which has influenced the management style throughout the organisation.

> *[The CEO] would be very keen on discussing things with the staff, and he would never introduce anything without discussing it with them. So I suppose it comes from the top.* (Radiography Manager, Private Hospital)

Flexibility is emphasised and culturally embedded in the organisation *'It's always been the case here people are flexible'* (Head of Finance, Private Hospital). In addition, the QM noted that *'we do have a no-blame culture but I actually live it.'* She emphasised that she explores processes rather than blaming individuals where issues arise. Similar to the public hospital, the CSM asserted that the smaller scale of the organisation facilitates one-to-one liaisons and personal relationships. For her this helps in getting things done:

> *People know me. So it's easier to get things done.* (CSM, Private Hospital)

> *The big thing is relationships. And like again, how people get on. In the smaller organisation it certainly is much, much easier to do that.* (CSM, Private Hospital)

Next, recent and ongoing strategic developments are outlined in Section 6.3.4.

7.3.4 Strategic developments

The hospital is operating in an environment of high external change. In addition to having to foresee and manage increasing competition, it is entering a phase of significant infrastructural development, which aims to consolidate its strategic position. The changes in the environment, the planned development and competition for consultants occupy much attention at board and strategic levels. In addition, prior to data collection in 2006, the majority of shareholder had sold their stake. This had been distributed among the remaining shareholders and one new entrant. The deal valued the clinic at between €90 and 100m, though some reports had previously valued the majority holding at €200 – 250m. The discrepancy can be attributed to the fact that the value of the deal was calculated on the basis of the hospital and its activities, rather than the value of the site. Although the hospital is

based on a significant site, the sale of the land is problematic, as some consultants working in the clinic own their individual consulting rooms.

The CEO has an exclusive mandate to the board, meaning that the change in board equates to a change in senior leadership. However the CEO did not envisage that this would lead to much change in the day-to-day operation of the business;

> *This place is a successful hospital, that's why they bought it. And they just want it to carry on being successful.* (CEO, Private Hospital)

The greatest source of change for the organisation is the creation of tax breaks for private hospitals, as permitted under the 2002 Finance Act. This has led to dramatic changes in the private healthcare market, with the hospital moving from being one of a very small number of private hospitals to a context of over-supply. This will lead to intensified competition for consultants and clinical staff, who are already in short-supply and subject to an increasingly pressurised work environment, due to changes in the nature of care being provided, which has led to more numerous, shorter stays.

> *We'll be keeping an eye on key staff, making sure they don't leave. We have a lot of fairly key staff. We have a lot of senior staff that we couldn't do without and we haven't even lost that many ratio staff either.* (Head of Finance, Private Hospital)

The CEO noted that the consultants are being actively courted by other private hospitals in the region. The loss of a consultant has significant financial implications for the organisation;

> *So keeping them sweet is important.* (CEO, Private Hospital)

To secure its competitive position, the organisation has planned a significant expansion, which involves a considerable level of capital investment (€45m), to increase accommodation and parking. The head of finance asserted that at the time of data-collection he was attempting to establish clinical areas into which they could profitably expand. In considering their competition, the CEO noted that their biggest challenge would be the establishment of 200–300 bed private hospitals on public hospital sites.

> *If the private hospital is developed on public hospital sites then places like [the Private Hospital] are finished.* (CEO, Private Hospital)

The third potential issue facing the organisation is rooted in ongoing discussions on consultant contracts, which may force consultants to choose between working in the public or

private sector, discussed in Section 7.3.9. Section 7.3.5 outlines the accreditation status of the hospital.

7.3.5 External Profile

The hospital has not applied for accreditation from the Irish Hospitals Accreditation Board. However, the hospital does uphold the JCI Accreditation (Joint Commission International) standard. The JCI is a highly renowned international accreditation standard, with criteria pertaining to patient care, quality and safety. Section 7.3.6 considers the role of the HR function, which is further considered in Section 9.2.

7.3.6 Role of the HR function

There is no dedicated HR department in the organisation. Responsibility for HR is devolved to each individual head of department. However, as the DON has responsibility for the largest sub-group of staff, by default she acts in an advisory capacity to the other Heads of Departments. She is also the link to the Irish Business Employers Confederation (IBEC) and has an administrative assistant to assist her in her role. Service planning and accounting systems in the private hospital are outlined below and evaluated in Section 9.3.

7.3.7 Service planning and accounting systems

The great things about working in the independent sector is decisions are made very quickly. It's very clear; you look at clinical need and business cases and it's not as complicated. There's not as many stakeholders and there's not as much jumping through hoops. (DON, Private Hospital)

Internally the organisation is relatively simply structured with a flexible and facilitative culture, supportive of and receptive to changes that fit within its clear criteria for evaluation. Respondents in the private hospital emphasised the innovation, efficiency, clarity of criteria and lack of bureaucracy associated with the business model and the model of generating business-cases in getting things done (CSM, QM, Consultant Cardiologist 2, DON, Consultant Cardiac Surgeon). The hospital operates outside of the yearly planning cycle of public and voluntary hospitals, and is not influenced by the political or union imperatives they

have to manage (CEO, Private Hospital). Section 7.3.8 further considers the perceived impact on organisational functioning of operating in the private sector.

7.3.8 Perceived influence of the sector on organisation functioning

Interestingly, although all comparisons were made with what the respondents termed the 'public' sector, some of the hospitals mentioned by name were actually voluntary-sector organisations. Themes raised in differentiating the private hospital included the nature of customers, the composition of services and patients and operating outside the sphere of political influence. In addition, discussion emphasised the business orientation of the hospital, outlined above, and its associated implications. These include more efficient process and outcomes, bureaucracy, lack of unions and flexibility. An overview of these issues is provided below.

Nature of customers and position of consultants: The organisation has four potential customers, as outlined in section 7.3.1. The fact that the consultants are organisational customers has implications for managing them, exacerbating the difficulty experienced in most contexts (CSM).

The composition of services and patients: The consultant cardiac surgeon noted that none of the private hospitals offer a comprehensive service, which for him is *'an intrinsic fault-line,'* motivated by money. He noted that the areas of interest to the private hospitals are,

> *quick turnover, quick delivery, money-making specialities, particularly orthopaedic, cardiac surgery and cardiology ... Other things are not as welcome.* (Cardiac Surgeon, Private Hospital)

He noted that this is evident across all of the Irish private hospitals. The focus is also on elective patients, who are very difficult to get into the public sector (Consultant Cardiologist, Private Hospital). In addition, the cardiac surgeon noted the financial incentive of working in the private sector, whereby *'you can get the people on insurance in here for paying.'*

Political influence: The hospital operates outside the sphere of direct political influence. The CEO noted that *'the political agenda in the public health service is huge, and tends to influence most strategic decisions'* (CEO, Private Hospital). The CEO noted that in his experience in the public sector,

> *You had to dance to the government's tune, and the governments tune depended on what politics they followed.* (CEO, Private 1)

Aside from these structurally related differences, major comparisons can be drawn on the basis of the business orientation of the hospital and its implications.

Business orientation and implications: The business orientation in the hospital has led to a revenue rather than cost orientation (CEO, Private Hospital), greater autonomy for senior managers (CEO, Private Hospital), greater efficiency in getting things done and awareness of the financial orientation among staff. Clarity regarding the business-case criteria for service and other developments has raised awareness of the financial impetus underlying service-provision. For example, the CNM2 Catherisation Lab emphasized their awareness of the 'organisation as a business':

> *There is pressure to keep it all afloat. I suppose we don't get involved in the money end of it at all, but we know that it's part of it; keep the business going. So that's important.* (CNM2 Catherisation lab, Private Hospital)

Similarly the Head of Finance noted a willingness amongst the consultant staff to work to optimise costs etc.

> *They understand. They don't necessarily agree with it, but they understand. They are businessmen.* (Head of Finance, Private Hospital)

In combination, the awareness of the financial imperative and the lack of unions create a culture of flexibility.

Lack of unions and flexibility: There are no unions recognised within the organisation (CEO, DON, CSM), which is helpful in the implementation of change. This was a decision taken at the founding of the hospital. It would require a board decision to alter the situation.

> *We don't have any unions here. And I would have to say, that it's a big bonus that you don't.* (CSM, Private Hospital)

This has facilitated changes such as extending the working hours in the Catherisation lab until 9 pm during the completion of the second catherisation lab. It was recognised that such a request may not have been feasible in the public sector, where the culture is less flexible:

> *Whereas this organisation is just, it's so used to it, and so done.* (CSM, Private Hospital)

The outer context, as well as the internal characteristics of the organisation, impact the hospital. The nature of this impact is discussed in Section 6.3.9.

7.3.9 Outer Context

Policy changes from the external environment are monitored closely to assess their impact on the hospital's competitive position and operations. The cardiovascular strategy and consultant contract negotiations are recent and current developments influencing the organisation. The cardiovascular strategy provided an impetus for the re-evaluation and improvement of cardiology services (CEO).

> *Partly because of the government initiative to get to grips with heart disease in this country and partly because it was a commercial opportunity for us, we've made huge changes to our cardiology services.* (CEO, Private Hospital)

Secondly, the organisation is monitoring consultant contract negotiations, which may force consultants to choose between working in the public or private sector. The CEO noted that if these changes are implemented there will be a requirement for the organisation to build up a training infrastructure for non-consultant medical staff. This was presented as desirable from the perspective of the consultant, providing them with an interest and stimulus.

> *If they work in the private sector we're going to have to build up a training infrastructure so that the junior doctors come here and train. Because I think private doctors who don't have that, private consultants who don't have that stimulus, it's not as nice a place to work, basically.* (CEO, Private Hospital)

As junior medical staff require a significant amount of protected academic time that does not generate income or contribute to service-delivery, there are currently few junior staff in the organisation. *'The private hospitals do not enter into teaching undergraduates or even postgraduates, except in a very desultory fashion.'* (Consultant Cardiac Surgeon, Private Hospital). As a result, relationships among the staff are longer-term and don't entail engaging with transient NCHDs. This has implications for the nature and quality of relationships. Section 7.3.10 summarises the general context for change in the private hospital.

7.3.10 Context for change

The private hospital operates in an environment of high external change. In addition to having to foresee and manage increasing competition, it is entering a phase of significant infrastructural development to consolidate its strategic position. The changes in the environment, the planned development and competition for consultants occupy much

attention at board and strategic levels. Internally the organisation is relatively simply structured with a flexible and facilitative culture. It is also a relatively high-change context, with a number of top-down and more bottom-up initiatives evident throughout the hospital. The organisation is supportive of and receptive to changes that fit into its clear criteria for evaluation.

7.3.11 Overview of the cardiology department

There are fourteen cardiologists working in the cardiology department in the private hospital, only one of whom works on a full-time basis. The consultants work as self-employed individuals. The cardiology department is a sub-component of the cardiovascular services unit, where a directorate-type structure is in operation. There has been a high volume of change in the unit over the previous six years. The CEO described this transformation as being from *'a pretty sleepy sort of service and now it's busy and long opening hours.'* (CEO, Private Hospital) This change was precipitated by the cardiovascular strategy and increases in interventional cardiology, due to clinical developments, which in tandem, led to service expansion and higher volumes of work.

The CSM has overall responsibility for the area. The key benefit of this role, introduced four years previously, is having an individual with an overview of the entire cardiovascular service. The cardiology service has several components. Chief among these is a diagnostic service, which includes a cardiac CT scanner and two cardiac catherisation laboratories. The latter are used for diagnostic angiography, angioplasty, coronary stenting, electrophysiology and ablation studies. The catherisation lab is also used for the insertion of pace-makers, ICD and loop recorders. There is an angiography day unit and lab, with two 6-bed day units attached. Finally, there is a 12 bed cardiac ward for post-surgery and cardiac patients. The consultant cardiologist noted that while the range of equipment is not as big as in the public hospital in which he works, *'there is enough of everything we need to get the job done.'*

There is no dedicated resuscitation training officer in the department or hospital, however the nursing staff in the intensive care unit take responsibility for this (CSM, Private Hospital). Also, there is no rehabilitation programme. The introduction of a rehabilitation service was considered two years previously, however it wasn't deemed to be financially viable, particularly as rehabilitation programmes are offered free of charge in the public sector. Staff numbers in the department are increasing (CSM, Private Hospital), due to changes in the nature of cardiology service and the associated workload.

> *Patients who would have been having coronary artery surgery five years ago are now having angioplasty. We can have seven or eight angioplasties a day, so the turnover of patients is huge.* (CSM, Private Hospital)

The increased demand for services and the volume of the workload has allowed the hospital to appoint its first cardiology registrar. Section 7.3.11 provides an overview of the context and challenges faced by the hospital.

7.3.12 Overview of context and challenges

Setting

- The private hospital, with 120 beds and a consulting clinic, is located on a sub-urban site.
- Consultants, insurance companies, NTPF and patients are key customers, with GPs important for referrals.
- The hospital has introduced some innovative roles, specifically process and quality-improvement roles, and the CSM. The hospital also has a long-standing culture of clinical managers.

Structure and culture

- There have been recent changes to ownership, affecting the board composition. The board sets financial and quality objectives for the CEO, which cascade through the organisation.

History and strategy

- The senior-management team face significant strategic distraction, predominantly from attempts to manage the external environment and consolidate their strategic position.

External profile

- The hospital has received JCI accreditation, a standard of international renown.

Finance

- Turnover is increasing, but the profit margin is decreasing due to medical inflation.

Influence of the sector on functioning

- The business orientation associated with the private sector leads to positive implications for efficient processes and outcomes, bureaucracy, lack of unions and flexibility.

Accounting & service-planning

- There are defined criteria for introducing change; a business-case model was adopted

HR

- HR is devolved to departmental heads, with the DON acting as a key link when issues arise. The hospital operates in a non-union environment, with 30% non-Irish staff; this has created issues about experience, skills and language.

Outer context

- Developments in the outer context act as a strategic impetus for change.

Context for change

- There is a supportive environment for change, premised upon business criteria, and identified through strategic monitoring and engaging with front-line staff.

Section 7.4 Assessment of change outcomes in the three hospital sites

Although the focus of this thesis is on those undertaking change-related roles in the process of service-improvement, and the constraints and enablers encountered by them in so-doing, prior to considering these issues this section will undertake an assessment of the change outcomes achieved across the three cases. Change outcomes are evident in four areas; staffing levels, service establishment and expansion, infrastructural development (space or equipment) and in the nature and form of service-delivery. While the change outcomes achieved will initially be considered in absolute terms and presented in isolation for each case, they will then be considered in relative terms. To achieve this, Tables 7.4, 7.5 and 7.6 present the service-improvements initiated and the associated outcomes in the voluntary, public and private hospitals. The outcomes for each case are discussed beneath each table, with an ensuing comparison in which relative progress, taking account of the scale of the organisation and available resources, is considered.

Table 7.4: Service-improvements initiated and associated outcomes in the voluntary hospital

Change initiated	Outcome
Increase in cardiologists sought	Number of cardiologists increased from two to seven
Change in use of three acute cardiology beds in CCU from 24 hour to day-case beds	Allows patients from 3 linking hospitals to be seen quickly
Establishment of new service and associated unit	Now providing services to 3,500 outpatients per annum
New echocardiography equipment and rooms	Rooms and equipment now operating
Increase in staffing levels in CCU and cardiology wards	Number of nurses increased from a total of 17 to 40
Further increase in staffing level in cardiology ward	Staffing level raised
Provision of psychology service for additional service area in cardiology	Limited services now available for patients in new service unit
Restructuring of resuscitation department	Acquisition of additional space
Standardised cardiac-arrest number	Now same as other hospitals in region
Equipment for cardiac unit	Request presented by consultant and equipment obtained
Attempted expansion of service capacity in cardiac rehabilitation	No progress, providing same level of services as smaller public hospital presented
Bottom-up ideas and input into plans for new laboratory	Input ignored; change process encountered major issues. Limited bottom-up components later integrated
Introducing a medical led cardiac-arrest team review	Not supported by consultants

Consideration of table 7.4 indicates that the voluntary hospital had a significant increase in staffing levels through four separate service-improvement initiatives, one of which (the expansion of the cardiologists) was a policy-led change. The greater than three fold increase in cardiologists was accompanied by significant increases in nursing staff in the two cardiology wards and the appointment of a psychologist.

In addition to staffing levels, service establishment and expansion were undertaken. One new service and an associated unit were established. Led by one of the newly appointed consultants, this is now providing services to almost 3,500 outpatients per annum, a very significant achievement. An attempt was made to expand a pre-existing service, cardiac rehabilitation. However this was unsuccessful.

Four further service-improvements pertained to the provision of additional infrastructure, in the form of either additional space or equipment. However, all bar one were small in scope and contained in impact. The most significant infrastructural development, a cardiac catheterisation laboratory, was ultimately successfully completed, but bottom up ideas and input from staff were ignored, delaying a successful outcome. Two final service-improvements pertained to changes in the nature and form of service-delivery. One pertained to the change in the use of three beds from 24 hour to day-case beds, with relatively significant implications for the associated staff. The second pertained to the introduction of a medically led review of cardiac arrests occurring within the hospital, which received limited support.

Overall, while staff levels increased greatly, a significant new service was introduced and the provision of a new cardiac catheterisation laboratory was a noteworthy infrastructural addition, the level of service-improvement evident in the voluntary hospital was disappointing. This 500 bedded urban teaching hospital was very well positioned in negotiations regarding resource allocation under the strategy and under-performed relative to the achievements of the smaller and more poorly resourced public hospital. The progress in that context is outlined below.

Table 7.5: Service-improvements initiated and associated outcomes in the public hospital

Change initiated	Outcome
Appointment of an audit nurse	Appointed
Development of echocardiographic service	Developed from non-existence to a service-provision dept with four full time staff and equipment. Cardiac technician was highly frustrated at plateau of progress and outstanding equipment requirements
Development of cardiac rehabilitation service	Service now provides phases one to four cardiac rehabilitation to approx 180 patients per annum. Some outstanding issues causing frustration. A cardiac rehabilitation coordinator and physiotherapist provide services.
Development of a resuscitation training department	Two resuscitation training officers now provide training to Advanced Cardiac Life Support Level.
Development of an education booklet and leaflets for cardiac rehab	A booklet for patients was produced. This contains information about the medication prescribed to patients, and why they are taking it.
Pharmacy-led education programme for cardiac rehab	Provide group based education about medicine prescribed to cardiac rehabilitation patients.

Provision of resuscitation training on behalf of a local charity.	Basic and advanced life support training and AED[22] training provided to the community. 4 AEDs purchased and installed in the local area
Compilation of clinical guidelines for CCU	Amended guidelines now in use in the unit

Consideration of Table 7.5 indicates that approximately ten new staff, all at non-consultant grades were appointed in the public hospital. In addition, three new services were established, namely an echo-cardiographic service, a cardiac rehabilitation service and a resuscitation training department. Furthermore, improvements to service-delivery were undertaken. Specifically, support material for both patients and doctors were developed by the pharmacist in conjunction with the cardiac rehabilitation department and consultant. A pharmacy-led drug education programme was also developed for cardiac patients. Finally, the resuscitation training department provided training and fund-raised for equipment for a local charity.

Although fewer staff were appointed in the public hospital, the level of progress made was far more significant in relative terms. The hospital established three new services and gradually escalated service provision in each. In fact, at the time of data collection it was providing a level of service provision in cardiac rehabilitation equivalent to that of the 500 bedded voluntary hospital. All of this was achieved with one consultant in a 200 bedded organization which was almost omitted from consideration and funding under the national cardiovascular strategy.

Consideration now turns to the private hospital, the smallest and most resource-rich of the three organisations. Table 7.6 overleaf indicates that the private hospital increased staff levels, through recruitment and the attraction of an additional consultant, gained accreditation to train student nurses, changed the structure of both the job-role and of the working week for non-consultant staff in one department, provided a new cardiac catherisation laboratory and a new working area with additional space and associated equipment for another department. Finally, two further initiatives relating to improved service delivery were undertaken. The first entailed improved management of lab sessions while the second entailed the development of a new medication cardex, the pilot of which was initially unsuccessful. Overall, while the service-improvements achieved were executed efficiently, the level of service-improvement

[22] An AED is an Automated External Defibrillator, used to resuscitate people who suffer from cardiac events

achieved was not significant, focusing mainly on recruitment and infrastructural requirements and minor adjustments to service-delivery.

Table 7.6: Service-improvements initiated and associated outcomes in the private hospital

Change initiated	Outcome
Provision of cardiac catherisation laboratory	Successful
Attraction of additional consultant to the clinic	Successful on development of capacity to provide echocardiographic service
Accreditation to run nursing adaptation programme	Successful
Expansion of radiographers role	Radiographers now take responsibility for areas previous undertaken by consultant. Successful method to keep good staff but problematic process.
Extended working day and weekend work introduced for radiography lab and MRI scanner	Service now provided evenings, weekends and bank holidays
Development of medication cardex for cath lab	Development of pre-preprinted medication cardex for use in cath lab. Pilot ongoing.
New department with increased space for cardiac technicians	Extra space acquired
Additional staff	Allowed provision of additional services and greater volume of services
Improving management of free lab sessions	Free slots offered immediately to consultants on first-come basis

The service-improvements discussed across the cases include improvements to staffing levels, service establishment and expansion, infrastructural developments and changes to the nature and form of service delivery. The most significant increases in staffing were seen in the voluntary hospital, however, the achievements of the public hospital in this regards are perhaps more impressive, given that the hospital was to be bypassed under the cardiovascular strategy and several of the appointments were funded through entrepreneurial type ventures. The most notable service establishments and expansion were in the public hospital, with three new services established. While one very significant service was established in the voluntary hospital, there was negligible improvement across the other services. In absolute terms, the cardiac catherisation laboratories built in both the public and private hospitals were the most significant infrastructural developments. However, the provision of space and equipment for the three new departments in the public hospital had much greater impact within the local community.

The presentation of these outcomes in a comparative light has revealed that the organisations which achieved the most significant amount of change in the areas of staffing, infrastructure and the nature and form of service delivery were not the most successful in relative terms, when scale and available resources are taken into account. In fact, the performance of the voluntary hospital, which achieved the most significant amount of service-improvement in absolute terms, was relatively disappointing, given the scale of the organisation and the available resources. While the private hospital achieved large scale infrastructural development within a small organisation, as a resource rich organisation, this was significant, but not inspiring. However, the public hospital achieved significantly more than would have been anticipated, using the voluntary hospital as a benchmark. Taking relative performance into account, the relative level of change achieved in the voluntary hospital can be classified as moderate, moderate to high in the private hospital and high in the public hospital. Chapters 8 and 9 provide significant insight into the reasons underpinning these differences, developing a two-stage theory to explain the factors which affect the capacity of each organisation to implement service-improvement, and the factors which affect the climate within each organisation to avail of this capacity.

Conclusions

This chapter has presented the internal context of each case, with the objective of orienting the reader, as they progress through the presentation of the data analysis and ensuing critical discussion of the research findings in chapters 8 and 9. This presentation maintains the processual orientation of the case studies and aims to facilitate reader evaluation of the basis for empirical generalisation whereby cases are argued to be representative of those in the wider population. To that end, this chapter has provided an overview of the structure, characteristics and context of each of the three cases underpinning this research. Specifically, following the case template, the cases have provided an overview of the setting, staffing, population, service, culture, funding, management structure and external profile of each organisation. In addition, on the basis of themes that emerged from the research and which are discussed in chapters 8 and 9, an overview of strategic developments, the role of HR, service planning and accounting systems and the influence of sectors on organisational functioning has been provided. Finally, the cardiology department of each organisation, which provides the immediate context for the changes explored in the case studies through tracer issues, have been described.

Chapters 8 and 9 move into the presentation of overarching themes across the cases, moving away from the focus on outcomes in the above section, towards a concern with the process of service-improvement. These chapters implicitly address the third research question, the presence of variation in the factors facilitating and hindering change across the public, voluntary and private sector. Chapter 8 begins by delineating the factors at the role level, which affect the initiation and implementation of change. Chapter 9 then addresses issues arising at the organisation and environment levels. Crucially, these chapters, and particularly chapter 9, bring context into the analysis. This is the basis on which the processual approach has been criticised, as per Section 3.6. In the development of the approach, these chapters treat context in line with the advances in conceptualisation outlined in Section 3.4.2.

Next, chapter 8 considers the first research question, the issue of who takes responsibility for initiating and implementing change, and what works effectively. In discussing those elements that affect effectiveness at role level, the chapter considers role structures, the role of clinical managers, and the facilitation of relationships to facilitate change.

Chapter 8: Who holds change-related roles and what works effectively?

This research aims to answer three research questions. The first research question asks who holds change-related roles, how are such roles enacted in and affected by role-related constraints and what works effectively. The second research question aims to identify additional contextual factors beyond role level that facilitate or hinder the implementation of service–improvement change. Finally, the third research question asks whether there are systematic differences between the voluntary, public and private hospital in the research findings. Thus the research is concerned with how service-improvement change processes are implemented through people, who act within constraints. The specific purpose of this chapter is to describe, analyse and explain the research findings pertaining to the first research question;

> *Who holds change-related roles, how are they enacted in and affected by role-related constraints and what works effectively?*

Hence, the findings presented are focused at the role level. The findings describe, analyse and explain the actions and interactions of individuals, and the factors that constrain and facilitate them in their involvement in service-improvement change. In comparing the findings across cases, the chapter also begins to address the third research question, systematic differences across the three hospitals. The data are primarily drawn from analysis of responses to interview questions. Information regarding change-related roles was primarily derived from questions sixteen through to nineteen on the interview schedule (See Appendix 3). As outlined in chapter 6, this data was used to develop narratives of the changes in which respondents were involved. The application of a temporal bracketing strategy to these narratives, in conjunction with an aggregate consideration of the data by code, led to the identification of actors involved at different stages of service improvement. In addition, also through aggregate data analysis by code, questions fifteen and eighteen were used to explore the constraints on individuals in enacting their roles in both service-delivery and service-improvement change, while questions ten and eleven were used to explore the relationships through which roles were enacted. Further insight into role clarity, ambiguity and expansion, in addition to whether involvement in change is an extra-discretionary role, was derived from questions two, three, four, five, eight, nine and ten. Finally, questions twelve through to fourteen facilitated respondents' reflection upon role-related differences across public, voluntary and private hospitals in Ireland.

The findings are presented in four separate sections, as analysis led to the emergence of four distinct though inter-related role-level findings. In each section, findings are initially presented on a case-by-case basis, followed by an overarching analysis and comparison across cases. To conclude each section, findings are compared with the UK, which although a different context, does provide a benchmark of experience. The findings are also compared with themes raised in the broader literature review, particularly works reviewed in chapter 5.

The chapter addresses four topics. The first topic, addressed in Section 8.1, delineates the actors involved in the initiation and implementation of top-down and bottom-up service-improvement. For the purpose of this research, top-down service-improvement refers to policy-driven or senior-management-driven initiatives, while bottom-up service-improvement refers to initiatives brought about by front-line service providers in the organisation. Each case overview in this section begins by detailing the service improvements undertaken, as the first step in analysis was to establish the existence of service-improvement change. The second topic, presented in Section 8.2, considers the role-related constraints respondents encountered in their change-related roles. The third subject considered, in Section 8.3, is the role of clinical managers in service improvement. Clinical-management roles and the constraints faced by individuals holding such roles are evaluated in the wake of their identification as 'key players' in the implementation of service-improvement in Section 8.1. Finally, Section 8.4 presents an unanticipated finding regarding the benefits of network groups, both in and across organisations, in the generation and implementation of service improvement. The first topic addressed in the chapter, that of the actors involved in the initiation and implementation of top-down and bottom-up change is discussed in Section 8.1.

Section 8.1: Roles in the initiation and implementation of service improvement

This section describes those involved in the initiation and implementation of service-improvement change. This is done on a case-by-case basis, with an aggregate analysis presented as a conclusion to the section. To place this discussion in context, Appendix 10 provides an overview of *all* of the service improvements, including those external to cardiology, identified by the respondents in each case. Appendix 10 also provides an overview of the specific changes in which individual respondents were involved. Establishing the existence of service improvement was the first stage in the analysis of change roles and of itself constituted a significant finding. However, in this section, the primary issue of concern is those holding roles in these service improvements. Differences were observed in the holders of change-related roles for bottom-up and top-down change. As a result, these are

discussed separately for each case. Section 8.1.1 considers roles in the initiation and implementation of bottom-up service-improvement in the voluntary hospital.

8.1.1 Initiation and implementation of bottom-up service improvement in the voluntary hospital

This sub-section describes the individuals who took responsibility for the initiation and implementation of bottom-up change in the voluntary hospital. To begin, Table 8.1 provides an overview of the changes initiated, the individuals by whom they were initiated, the actors involved in their implementation and the outcome of the change. The latter is important as not all changes were completely successful. The table indicates that issues encountered in the implementation of a change were often linked to a lack of consultant support. This arose as a particular issue in progressing changes from initiation to implementation. To make this critical issue more salient to the reader, a decision was made to discuss the initiation and implementation of service improvements in the same sub-section. Providing more detail than the table with regards to specific change processes, Appendix 11 provides examples of 'tracer issues', as discussed in Section 6.4.2. Following Fitzgerald et al. (2006) 'tracer' issues are significant service improvements enacted in the clinical area, identified by an individual respondent and traced from initiation to implementation in the interviews. A discussion of those responsible for initiating and implementing bottom-up service improvement in the voluntary hospital follows Table 8.1. Crucially, while Appendix 11 provides overviews of examples of bottom-up service improvement in the voluntary hospital, it indicates that external liaison occurred in some changes, most commonly regarding funding and staffing; the focus in this context is on internal change-related roles. Additional factors beyond role level and external to the organisation that affect service improvement are discussed in chapter 8.

Both Table 8.1 and the examples provided in the appendices indicate that in the voluntary hospital consultants have a significant role in both the initiation and implementation of bottom-up change processes. While nurses and AHPs at the clinical-manager level also initiate change, the data presented in Table 8.1 indicate that non-consultant clinicians need to acquire support from a sponsor or leader for their ideas to progress from initiation to implementation.

Table 8.1: Initiators and implementors of bottom-up service-improvement in the voluntary hospital

Bottom-up change initiated	Initiator	Actors involved in implementation process	Outcome
Change in use of three acute cardiology beds in CCU from 24 hour to day-case beds	Consultant 1	Overseen by the consultant but implemented by the nurse	Allows patients from 3 linking hospitals to be seen quickly
Establishment of new service and associated unit	Consultant 2	Led and implemented by 3 consultants. Funding gained from outside of the organization, but no external involvement in implementation	Now providing services to 3,500 outpatients per annum
New echocardiography equipment and rooms	Consultant 3	Led by consultant with chief cardiac technician adopting a liaison role for implementation. Chief cardiac technician felt excluded and desired more input	Rooms and equipment now operating
Increase in staffing levels in CCU and cardiology wards	Clinical nurse manager 2 Coronary care unit	Nurse led. Eventually implemented by nurse with management. Not initially supported by consultants or management. Progress achieved via involvement of unions. Has made management more responsive	Number of nurses increased from a total of 17 to 40
Further increase in staffing level in cardiology ward	Clinical nurse manager cardiology ward	Nurse led, with consultant ratifying and HR involved in implementation. Initially not supported by consultants/management but formal case presented. Prior involvement of unions on similar basis facilitated change.	Staffing level raised
Provision of psychology service for additional service area in cardiology	Clinical psychologist	Psychologist led and implemented. Initially not supported by consultant & no progress. Progress made when consultant support gained.	Limited services now available for patients in new service unit
Restructuring of resuscitation department	Resuscitation Training officer (RTO)	Done informally by RTO She liaised with administration.	Acquisition of additional space
Standardised cardiac-arrest number	Resuscitation Training officer (RTO)	RTO initiated. ratified by CPR committee and Medical Executive. Had consultant sponsor. Implemented by general services dept with RTO	Now same as other hospitals in region
Equipment for cardiac unit	Clinical nurse manager2 (CNM2)	CNM2 led and implemented, with consultant sponsorship. Bypassed nursing structures and involved consultant to speed process.	Request presented by consultant and equipment obtained
Attempted	Cardiac	Cardiac rehabilitation co-ordinator	No progress,

expansion of service capacity in cardiac rehabilitation	rehabilitation coordinator	led. Not implemented as hard to get support from cardiologist & manager due to their multiple interests.	providing same level of services as smaller public hospital presented
Bottom-up ideas and input into plans for new laboratory	Clinical Nurse Manager Cardiac catherisation laboratory	Led and implemented by CNM2 Cath Lab. Unsuccessful from process perspective – much ill-feeling. Nursing and AHP input ignored until issues encountered in process. Remedied but bottom-up input still not actively sought.	Input ignored; change process encountered major issues. Limited bottom-up components later integrated
Introducing a medical led cardiac-arrest team review	Resuscitation Training Officer	Led by RTO. Lack of consultant support prevented progress.	Not supported by consultants

This role was predominantly, though not exclusively, filled by the consultant. Nursing and AHP clinical managers could also liaise with their respective line managers in this regards, however they tended to bypass these individuals and liaise with consultants. However, as indicated by Table 8.1, after the ratification of the changes they were predominantly implemented by heads of departments, who tend to be clinical managers. In fact, regardless of who initiated the changes, nurses and AHPs holding clinical-management roles were responsible for implementing the majority of them. For example, in the transition from the 24 hour to day beds in the CCU the consultant initiated the change, but once ratified it was implemented by the CNM2 who was in charge of the unit. Nonetheless, where consultants act as sponsors for a change, they tend to adopt a continuing oversight role during the implementation process.

Interestingly, the voluntary hospital was the only organisation where completely unsuccessful initiatives were reported. Lack of success, in each instance, was linked to the absence of consultant support. As this is a potentially significant finding, the role adopted by the consultant, and the role structures in the organisation are discussed in relation to their impact on service-improvement in Section 8.2. Prior to this, Section 8.1.2 outlines patterns in the initiation and implementation of top-down change in the voluntary hospital.

8.1.2 Initiation and implementation of top-down service improvement in the voluntary hospital

Top-down change refers to policy or senior-management initiated change. Interestingly, although the research was undertaken in the wake of the cardiovascular strategy, only one policy-led top-down change was discussed by non-senior management respondents.

Discussion of top-down change amongst the senior-management team occurred in broad and non-cardiology-related terms. This may be related to the fact that a number of years had elapsed from the start of the cardiovascular strategy and associated discussions regarding financial allocations. In describing the broad manner in which top-down change is initiated, the senior-management team described their active monitoring of the external environment to identify opportunities for top-down change (Director of Finance, DCEO, Director of Nursing). The director of finance noted that the organisation monitors the priorities of the Department of Health and Children, the Health Service Executive and the network in which the hospital is a member, to identify the areas in which funding is available. This was identified as an important process as there are only a limited number of strategies being promoted at any one time. For example, at the time of data-collection, initiatives straddling the community and hospital sectors had been identified as a key target (Director of Finance, Voluntary Hospital). The development plan for the organization, submitted to the HSE, was also used by the senior-management team as a vehicle to initiate top-down change. Each year the development plan for the organisation is grossly overstated relative to what the organisation receives (Director of Finance, Voluntary Hospital).

> *By knowing where the priorities are from a HSE level, or a DOH level, that's an advantage. But that's not to say that we're always successful at that. Our proviso plan would be, in many cases it would be completely overstated, it would have the costing of our desired developments of fifty million, whereas in any particular year, we're lucky to get a couple of million from the government.* (Director of Finance, Voluntary Hospital)

Interestingly, no front-line or clinical respondents made reference to personal involvement in top-down change. The only top-down change identified in cardiology by the respondents was the significant increase in cardiologists employed by the hospital (from two to seven), due to the cardiovascular strategy. However no respondents identified themselves as playing an active role in this regards. The lack of responses from front-line respondents regarding the initiation or implementation of top-down changes from the cardiovascular strategy may be indicative of lesser consultation and involvement of staff in such change-processes. Thus, while nurses, head's of departments and AHPs are pivotal in the implementation of small-scale, bottom-up changes, they may be more peripheral to the process in top-down or larger-scale formalized and project-managed initiatives. Section 8.1.3 now turns attention to the initiation and implementation of bottom-up change in the public hospital.

8.1.3 Initiation and implementation of bottom-up service-improvement in the public hospital

'There were times when you'd try to implement change and found it difficult more so than it didn't get done. It'd get done in the end. But sometimes there would be a lot of persuasion involved.

– Clinical nurse manager 2 Coronary care unit, Public Hospital

This sub-section describes the individuals who took responsibility for the initiation and implementation of bottom-up change in the public hospital. As was the case in the voluntary hospital, an overview of all of the changes referred to by respondents is provided in Appendix 10, with examples of specific changes, presented as tracer issues, available in Appendix 12. To provide a more immediate context for the description of those initiating and implementing service-improvement, Table 8.2 provides an overview of the changes initiated, the individuals by whom they were initiated, the actors involved in their implementation, and the outcome of the change.

In the public hospital, which has one cardiologist, bottom-up changes were initiated by both the consultant and clinical managers. The hospital had a clearly articulated vision for the cardiology department, developed by the consultant in conjunction with nursing and AHP staff at the emergence of the cardiovascular strategy. This provided an overarching strategy and reference for development that could be used to support the case for a particular service-improvement initiative (Chief Cardiac Technician). In addition, a cardiology user's group provided a multidisciplinary forum for the negotiation and ratification of developments, meaning that the final decision on implementing an initiative did not solely rest with the consultant.

Table 8.2 indicates that, as in the voluntary hospital, the implementation of changes initiated by the consultant fell to clinical managers from nursing and AHP backgrounds. However, the manner in which both these changes and the service-improvements initiated by the nursing and AHP clinical managers were implemented by the clinical managers differed significantly from the voluntary hospital. Once the consultant established a broad vision for a department, he devolved responsibility for the implementation of specific initiatives and the further development of the department to the departmental heads.

Thus the consultant in the public hospital was more of a figurehead, rather than gate-keeping to move changes from initiation to implementation. While there is arguably some element of a gate-keeping role evident, it is much less absolute than in the voluntary hospital. Once ratified, generally at a later stage of development than in the voluntary hospital, the implementation of changes occurs in a devolved and local manner, led and implemented by

Table 8.2: Initiators and implementors of bottom-up service-improvement in the voluntary hospital

Bottom-up change initiated	Initiator	Actors involved in the implementation process	Outcome
Development of echocardiographic service	Initiated by the consultant as a lone crusade.	Planned by the consultant and implemented by the cardiac technician. Overseen from a distance by the consultant.	Developed from non-existence to a service-provision dept with four full time staff and equipment. Cardiac technician was highly frustrated at plateau of progress and outstanding equipment requirements
Development of cardiac rehabilitation service	Initiated by consultant.	Implemented by the cardiac rehabilitation co-ordinator. Consultant devolved authority to her and oversaw process from a distance	Service now provides phases one to four cardiac rehabilitation to approx 180 patients per annum. Some outstanding issues causing frustration
Development of an education booklet and leaflets for cardiac rehab	Initiated by the consultant who approach the pharmacist regarding the project. The pharmacist then led the project.	Implemented by the pharmacist, who liaised with the consultant as required.	A booklet for patients was produced. This contains information about the medication prescribed to patients, and why they are taking it.
Pharmacy-led education programme for cardiac rehab	Led by pharmacist who was approached by cardiologist	Implemented by the pharmacist. No consultant involvement once initiated. Liaised with cardiac rehabilitation co-ordinator	Provide group based education about medicine prescribed to cardiac rehabilitation patients.
Provision of resuscitation training on behalf of a local charity.	Resuscitation training officers (RTO) group in the West approached a local charity	No objection from cardiologist or senior managers. Implemented by RTOs in conjunction with local charity. Community groups and local leaders engaged in fundraising	Basic and advanced life support training and AED [23] training provided to the community. 4 AEDs purchased and installed in the local area
Compilation of clinical guidelines for CCU	Clinical nurse manager 2 CCU	Implemented by CNM2. Ratified by nursing development unit and director of nursing	Amended guidelines now in use in the unit

[23] An AED is an Automated External Defibrillator, used to resuscitate people who suffer from cardiac events

heads of departments who are nursing and AHP clinical managers. The differences between the cases are further explored in Section 8.1.7. Prior to this, Section 8.1.4 outlines the initiation and implementation of top-down change in the public hospital

8.1.4 Initiation and implementation of top-down service improvement in the public hospital

In the public hospital the approach to initiating top-down change at the senior-management level was relatively reactive, in contrast to the pro-active orientation in the voluntary hospital. While the voluntary hospital monitored Department of Health and HSE priorities, the director of finance in the public hospital noted that that while there is a development plan for the hospital, *'a lot of our capital projects and a lot of our strategic moves are decided at HSE level or perhaps at national level.'* (Director of Finance, Public Hospital) An example of this was the decision at the national level to merge services between the public hospital and another hospital in the region, after a department of health reviewed services in the area. The HR manager and CEO of the hospital echoed the sentiment that the service plan submitted by senior management is not the central impetus for service improvement and change. The HR manager, CEO and director of finance emphasised that funding is given from a different perspective, determined at the network and HSE level. According to the HR manager, one result of this is that those involved in making suggestions to amend the service-plan for the hospital often become disenchanted.

The senior-management team did display evidence of having considered the initiatives they wished to develop. Specifically, *'we would have our own strategies indeed to try and move forward'* (Director of Finance, Public Hospital). However, they did not describe engaging in environmental monitoring of the Department of Health or HSE as was the case in the voluntary hospital. In marked contrast to the perception in the voluntary hospital of opportunities to manage the environment, the general manager in the public hospital was disenchanted and frustrated at her capacity to decide the service improvements that should be implemented, and her capacity to influence the environment to move these service improvements from initiation to implementation. This issue is further discussed in chapter 8.

In a highly interesting finding, the individual who managed to have the hospital incorporated into the cardiovascular strategy through environmental monitoring for opportunities was the consultant. This consultant provides an interesting example of the interplay between bottom-up and top-down initiatives for service improvement. The cardiologist initiated service improvement in cardiology with personal attempts at fundraising in the early 1990s. Resources acquired were used to establish both echocardiography ultrasound departments.

This consultant provides an example of a clinician, with no formal managerial or administrative role, who took responsibility for what was essentially a bottom-up strategic vision for cardiology in the department. He liaised externally with health boards and the Department of Health to ensure that his hospital received funding under the cardiovascular health strategy, asserting that *'we had to fight for it, but we got it'* (Consultant, Public Hospital). The consultant's fundraising facilitated a significant component of the bottom-up initiatives in the hospital, and led to further changes being funded under the cardiovascular strategy. While the changes funded under the strategy could be described as top-down changes, they came about as bottom-up initiatives, pursued by a consultant. Regardless of their classification as top-down or bottom-up initiatives, the implementation strategy differed little between the changes implemented in the hospital. For example, one initiative funded under the cardiovascular strategy was the development of the cardiac-rehabilitation service. This was initiated by the consultant, with implementation devolved to the cardiac rehabilitation co-ordinator. The similarity in implementation strategies across bottom-up and top-down changes in the public hospital may be related to the smaller-scale of the changes evident in the organization relative to the voluntary hospital. Comparisons are made across the three cases in Section 8.1.7. However, prior to this, Section 8.1.5 and Section 8.1.6 consider the initiation and implementation of service-improvement in the private hospital.

8.1.5 Initiation and implementation of bottom-up service improvement in the private hospital

It could come from the ground up; it could be some consultant saying they've been to a conference and there's a new ... it could be from clinical people themselves, like the radiographers saying there's a new way to do this now. It's different. All suggestions are always received and looked at.

– Head of Finance, Private Hospital

This sub-section describes the individuals who took responsibility for the initiation and implementation of bottom-up change in the private hospital. As in the previous two cases, an overview of all changes referred to by respondents is provided in Appendix 10, with examples of specific changes, presented as tracer issues, available in Appendix 13. Similarly, Table 8.3 provides an overview of the changes initiated, the individuals by whom they were initiated, the actors involved in their implementation, and the outcome of the change.

In the private hospital, head's of departments, the QM and CSM were the central actors in initiating bottom-up change, as outlined in Table 8.3. Although, according to the CSM, the 14 cardiologists also initiated bottom-up initiatives, the consultants interviewed focused more specifically on top-down changes.

[The consultants] are not a shy bunch. They would always be coming and saying to [the CEO] "you should be looking at this."' (CSM, Private Hospital)

Table 8.3 indicates that the pattern of initiation of bottom-up change in the private hospital is markedly different from that in the other two cases. Except for those changes initiated by them, consultants have no role in moving service-improvement changes from initiation to implementation. Where changes need to be ratified, they are ratified with the CEO through the CSM or directly with the CEO rather than through a consultant.

Consultants also do not have any role in the implementation of service improvements initiated by non-consultants - even in an oversight capacity. An exception to this is when the service

Table 8.3: Initiators and implementors of bottom-up service-improvement in the private hospital

Bottom-up change initiated	Initiator	Actors involved in the implementation process	Outcome
Expansion of radiographers role	Radiography manager	Supported by CEO. Led and implemented by the Head of Radiography, who consulted with her department and liaised with the consultant radiographer.	Radiographers now take responsibility for areas previous undertaken by consultant. Successful method to keep good staff but problematic process.
Extended working day and weekend work introduced for radiography lab and MRI scanner	Radiography manager	Supported by CEO. Led and implemented by the Head of Radiography, who consulted with her department.	Service now provided evenings, weekends and bank holidays
Development of medication cardex for cath lab	QM	QM initiated process after medication incident reported. Nurses key link in designing and implementing the change but ratified by consultants	Development of pre-preprinted medication cardex for use in cath lab. Pilot ongoing.
New department with increased space for cardiac technicians	Chief cardiac technician	Required support of CEO. Led by chief cardiac technician and implemented with assistance of project-manager	Extra space acquired
Additional staff	Chief cardiac technician	Chief cardiac technician presented business case to CEO.	Allowed provision of additional services and greater volume of services
Improving management of free lab sessions	CSM	Initiated and implemented by CSM	Free slots offered immediately to consultants on first-come basis

improvements have implications for the consultant. For example, a medication cardex development was ratified with the consultant who worked in the clinical area to which it was to be applied. Outside of such instances, the heads of departments, who are all clinical managers, and the QMs and CSMs, who hold overarching roles, took direct responsibility for the implementation of service improvements in their departments. For large-scale changes such as the expansion of the cardiac technician's area, the clinical manager worked in conjunction with formal project managers to oversee developments. Section 8.1.6 considers themes in the initiation and implementation of top-down change in the private hospital.

8.1.6 Initiation and implementation of top-down service improvement in the private hospital

In the private hospital, top down change was initiated in four ways. Firstly, it was initiated by the board. Secondly, it was initiated by senior management monitoring the external environment; thirdly by pursuing perceived financial opportunities; and fourthly by senior-management responding to internal issues. These are outlined in this section.

> *So [the board] may see something that's happening in the States and they may suggest it.* (Director of Finance, Private Hospital)

Monitoring of the external environment and competitors were evident as a source of change at both the board and senior-management level (Director of Finance, CSM, CEO, Private Hospital). When monitoring identified potential financially lucrative initiatives these were pursued by the senior-management team. A specific example was provided by the CEO who noted that the cardiovascular strategy, in combination with the business opportunity offered in cardiology, led to expansion in the service. The CSM also explained the development of the service in this manner, describing cardiology as *'a good money area'* that had provided a business opportunity (CSM, Private Hospital).

Another example of top-down change initiated through pursuit of perceived financial opportunities was evident in attempts to attract an additional consultant to the clinic. The chief cardiac technician noted that the low number of cardiologists working in electrophysiology studies had led to the abandonment of the service when new equipment was required. The investment wasn't justified at that time. However when an additional consultant with an interest in electrophysiology required this investment to attract him, the decision was made by the CEO. Thus the financial benefit of the additional consultant led to a top-down initiative to introduce an electrophysiology service.

An example of the fourth mechanism for initiating top-down change, a response to an internal issue, was provided by the director of nursing. She initiated the nursing-adaptation programme in response to ongoing recruitment difficulties.

> *That would have come more from [the DON] because she would be the person doing the recruiting in conjunction with the recruiting agency.* (CNM2 Cardiac Unit, Private Hospital)

> *Whereas before this I had to try to get them in to [other hospitals] and I couldn't get them in and I wasn't happy that I wasn't in control and at the same time I had student nurses who weren't getting enough clinical experience in [other hospitals] coming up here and I was thinking here I am, I'm good enough for students. But anyway I won and I got the adaptation and we went live with it.* (Director of Nursing, Private Hospital)

In contrast to the bottom-up initiatives in the private hospital, the top-down initiatives tended to be formally managed by project managers. These managers worked in conjunction with the CSM and heads of departments, as appropriate.

Section 8.1.7 compares the three cases regarding those responsible for the initiation and implementation of service improvement.

8.1.7 Comparison across cases in the initiation and implementation of service improvement

As outlined in the introduction to this chapter, this section will compare the findings across cases. These findings will also be discussed with reference to previous research into the initiation and implementation of service improvement in the UK context as a contextually different but available benchmark, and with reference to the broader literature.

- **Comparison across cases**

Firstly, the findings in this section provide significant insight into the extent of change. Interestingly, across all of the cases, more bottom-up than top-down changes were discussed by respondents. In addition, the three cases emphasise that job roles in healthcare, with the exception of the innovative CSM and QM roles in the private hospital, tend to be focused upon service delivery rather than service improvement. As a result, the findings from all three cases indicate that front-line service providers who do not hold line manager or other management roles do not feature strongly in the initiation or implementation of change, across all professions. This can be related to the fact that no provision is made for this in their roles. In addition, the cases emphasise that a significant number of the changes are led by

committed individuals, making service-improvement processes fragile and vulnerable. While it is easy to identify who actually initiates and implements changes, with the exception of the private hospital where responsibility for departments was devolved to heads of departments, there was little clarity regarding who actually holds responsibility for service improvement. Finally, in no case did poor relationships between clinical groups manifest as a barrier to change. Relationships between clinical groups and clinicians and management were good in all cases, with the exception of the voluntary hospital where tension between nursing and management about staffing levels was evident. This may have been related to a gap in the organisation hierarchy, with cardiology lacking a CNM3 to mediate between CNM2 and the assistant director of nursing level.

The most significant difference across the cases was the absence of consultants from the ratification and oversight of service-improvement changes in the private hospital. This was a particularly significant finding given the centrality of consultants in these processes in the voluntary hospital and the consultant's oversight role, in addition to his defining role in creating a departmental strategy in the public hospital. As a result of the absence of consultants, the heads of departments in the private hospital, in conjunction with the QM and CSM, had significant autonomy in the initiation and implementation of service improvement.

While there was little difference between the voluntary and public hospitals in the actors involved in the initiation and implementation of service improvement, the level of information made available to non-consultant clinical managers, their level of input into the planning of the implementation, and their level of control in the execution of the implementation differed significantly between the two cases. A lack of meaningful involvement and control in the voluntary hospital had implications for the progression of the service improvements, and particularly awareness of the minutiae of potential and actual issues (DCEO, CNM2 Cath Lab, Chief Cardiac Technician, Voluntary Hospital) Iterative analysis led to the identification of two factors that account for the differences in the individuals involved in the initiation and implementation of service improvement across cases and the different levels of autonomy evident: the role structures in place and the role adopted by the consultant. These can be considered as role-related constraints in the initiation and implementation of service improvement and are further explored in Section 8.2.

Outside of the private hospital, where clinical managers *'have a lot of autonomy. We're let manager our own departments'* (CNM2 Cardiac Ward, Private hospital), the job definition of clinical managers arose as an issue. Specifically, there was a lack of provision for service improvement as a component of basic job roles that arose amongst the nursing and AHP

departmental heads, incumbent in clinical-management roles. For example, in the voluntary hospital, among the non-consultant clinical managers, there was universal emphasis on operational management. The resuscitation training officer was the only individual to explicitly mention a service development or strategic component to her role. However, this was constrained by her administrative duties and a lack of resources. Similarly, in the public hospital the chief pharmacist was the only clinical manager or head of department to identify the service-improvement component to her role. She pro-actively and successfully pursued this. While the director of nursing did describe the role at clinical nurse manager 2 level as *'operational plus strategic, with regards to the development of their ward'* (Director of Nursing, Public Hospital), the assistant director of nursing asserted that they focus on operational and clinical management, and this is the definition adopted in practice. Thus issues are evident in the role definition and role clarity of clinical managers with regards to service improvement. Due to the central role of clinical managers in the initiation and implementation of service improvement, their roles are analysed further in Section 8.3. Prior to this, attention in this section turns to comparing the findings regarding service-improvement change roles with the UK experience, and with the broad literature in the area.

- **Comparison with UK**

This sub-section draws on the findings of the partially-replicated research project conducted by Fitzgerald et al. (2006b) as a basis for comparison. This comparison is undertaken on the basis that similarity in the findings may strengthen confidence in the Irish research or draw attention to differences that may merit further attenttion.

In the UK the majority of service-improvement changes were led by clinical managers. These clinical managers did not invariably perceive or define themselves as change leaders or agents. Where service improvements were led by general managers they appeared to encounter greater difficulty. Interestingly, in Irelamd, clinical managers were also the most prevalent initiators and implementors of change. However, in contrast to the UK, general managers did not feature in the initiation or implementation of bottom-up service improvements in any case, with the exception of the private hospital. In that context the CSM and QM, who both had clinical backgrounds, were active in change. While general managers were involved in monitoring for strategic and top-down changes, such changes were much less prevalent in the voluntary and public hospital when compared with the level of bottom-up service improvement. Crucially, in both contexts, individuals adopted change-related roles in an extra-discretionary capacity, as an addition to their basic job roles.

In the UK, the initiation and implementation of service-improvement change, while sometimes led by individuals, was found to be most effective when centred upon management trios such as the general manager, the head of a clinical unit and another senior manager. Other individuals provided support as appropriate. In contrast, in Ireland, changes tended to be led by committed individuals in isolation, making service improvements more fragile. This significant difference may be related to the absence of clinical-directorate-type structures in Ireland. The closest finding to the UK situation manifested in the voluntary hospital, where the hands-on involvement of the consultant effectively led to duos, albeit clinical or clinical-management duos, involved in the implementation of change.

While the UK findings provide support to previous research pertaining to collective leadership (Denis et al., 1996, 2001, 2002), Fitzgerald et al. (2006b) also extended these findings. In particular, Fitzgerald et al. (2006b) found that dispersed leadership, involving staff from different levels in the organisation, and from different professional backgrounds, increased the effectiveness of service-improvement change. They defined dispersed leadership as encompassing

- A supportive senior-management team, willing to become involved in facilitating change;
- Clinical managers and senior managers moving changes forward; and
- Individual clinicians willing to undertake specific tasks.

In Ireland, although the above three groups were not all formally represented in specific initiatives, all of the cases had senior-management teams willing to facilitate change. Senior management did however differ in their pro-activity in initiating change. Finally, all cases had clinical, although not senior, managers moving changes forward.

Finally, the UK findings emphasised the smaller scale and more fragmented nature of the service-improvements led by clinicians. While clinicians were not found to be active in a prevalent manner in service-improvement in Irish hospitals, some of the changes initiated by clinical managers at the departmental level were localised, small scale, and not part of a wider strategy. As a result, the impact of such service-improvements in Ireland, as in the UK, is limited. Attention now turns to comparing the findings with the broader literature on roles and service improvement.

- **Comparison with the broader literature regarding roles and service improvement**

Of the five roles identified as central in service delivery in Section 5.2, namely the board, doctors, nurses, management and clinical managers, two emerged as particularly central in the initiation of change. These were doctors, specifically consultants, and clinical managers. In addition, senior management played a significant monitoring role in the private and voluntary hospital, though this manifested in more change in cardiology in the private hospital. In the voluntary hospital, the significant size of the hospital, with multiple service areas, in conjunction with significant strategic distractions, lessened the impact of this for cardiology. In the implementation of change, consultants and clinical managers were pivotal, with general managers playing a facilitative role for larger-scale change. While the above suggests a residual role for nurses in service improvement, this was not the case. Nurses in clinical-management posts were responsible for initiating and implementing significant numbers of service-improvements.

Politicking at an organisational level was not raised to any significant degree by respondents. This was surprising given Buchanan and Badham's (1999) presentation of this as an often necessary component of change-agent roles.

The working relationships were generally very positive: some tension was evident between management and clinical managers in the private hospital about prioritisation of consultant needs. The latter was driven by the centrality of the consultant to the financial viability of the private hospital, as patients are referred to individual consultants rather than to the hospital. While the relationships were generally positive, they did meet Engestrom et al.'s (1999) description of 'knotworking', with inter-professional relationships in service improvement premised on goal-focused, rather than continued collaboration, as previously described in service-provision by Reeves and Lewin (2004). While Ashburner et al. (1996) previously found that relationships between clinical groupings were variable, this was difficult to evaluate in this context because changes tended be implemented by individual clinical groups in conjunction with the consultant. The 'silo' nature of service-improvements in Irish hospitals may be related to the social and cognitive barriers between professions described by Ferlie et al. (2005).

Attention now turns to role structures and the role adopted by the consultant to explain the differences between individuals involved in the initiation and implementation of service improvement across the cases, and the evident levels of involvement and autonomy. The factors are considered as role-related constraints on the initiation and implementation of service-improvement change. At the end of Section 8.2 an integrative pictorial overview of the

findings of Section 8.1 and 8.2 is presented to address the first research question; 'Who holds change-related roles, how are such roles enacted in and affected by role-related constraints and what works effectively?'

Section 8.2 Role-related constraints in the implementation of service improvement

The role structures evident in each case and the role adopted by the consultant were found to have an impact on those involved in initiating and implementing service improvement, and the level of consultation with multidisciplinary stakeholders regarding the service-improvement process. These issues are described and discussed for each case, and drawn upon in explaining the cross-case differences evident in Section 8.1. The role structures and role adopted by the consultant are presented for each case, and followed by an overarching analysis. Section 8.2.1 begins with an overview of these factors in the voluntary hospital.

8.2.1 Role structures and the role adopted by the consultant in the voluntary hospital

There are no formal roles or organization processes dedicated to harnessing bottom-up change in the voluntary hospital. Although nurses, AHPs and non-consultant clinical managers can liaise with their respective line managers regarding potential service-improvements, they tend to bypass these systems and liaise with consultants. This is justified on the basis that even very minor initiatives progressed much more speedily with the support of the consultants (CNM2 CCU, Cardiac rehabilitation co-ordinator, Chief cardiac technician, Voluntary Hospital).

> *If I want to get something done I'll go to one of the consultants, yeah... I found that Nursing Management wouldn't listen to me at all as the CNM2 in the Unit, and I constantly went to [name] the consultant in charge of the whole cardiology service, I constantly was at his door.* (Clinical Nurse Manager CCU, Voluntary Hospital)

Once initiatives have been presented to and agreed upon by the consultants, the consultants take responsibility for presenting the proposed initiatives to management for ratification, if necessary. As a result of these structures, consultants have significant influence over those changes which move from initiation to implementation; they have a gate-keeping as well as figurehead and leadership role in the harnessing of bottom-up change. This gate-keeping role pertains to both the changes supported by them, and the level of multidisciplinary involvement. Although adopting a 'clinical representative' role in liaising with management, the consultants failed to engage in consultation with clinical managers or front-line staff. In describing their involvement in the actual implementation of bottom-up service-improvements,

several multidisciplinary respondents articulated their desire for greater participation and information during the planning and implementation phases. (Chief cardiac technician, clinical nurse manager, cath lab, cardiac rehabilitation co-ordinator, Voluntary Hospital). For example, the cardiac technician felt excluded from decision making and indeed from the information loop:

> *There were times when it would have been nice to be a bit more involved, a bit more informed as to what's happening, a few times it was "Oh [name] we're not doing that until the week after." There was a little bit of that; there weren't any multidisciplinary meetings to discuss it and I felt there should have been really. It would have been much better.* (Cardiac Technician, Voluntary Hosptial)

One strong example of the exclusion of nursing and the AHPs from the decision-making process of a service improvement was evident in the installation of a second cardiac catherisation laboratory. There was no consultation with non-consultant clinicians in the formal planning group for the catherisation lab project.

> *There weren't any multidisciplinary meetings to discuss it and I felt there should have been really. It would have been much better.* (Chief Cardiac Technician, Voluntary Hospital)

> *They don't sit down with the people who are the stakeholders and talk with them about what the plan is and then listen to them about their difficulties or how they see a problem. That doesn't really happen very well.* (CNM2 Cath Lab, Voluntary Hospital)

> *I was quite frustrated at that time because it wasn't discussed with me. I was there in the meeting and was told it was going to happen in 2 days time.* (CNM2 Cath lab, Voluntary Hospital)

In hindsight, the CNM2 catherisation lab, chief cardiac technician and deputy CEO noted that the lack of AHP and nursing involvement in the process led to significant and unanticipated issues emerging.

> *And as with everything the devil is always in the detail. The big-ticket stuff is never missed; what's missed is functions or presumptions that are made particularly by consultants that by magic nurses will become sherpas and donkey stuff all over the place! It's really a patriarchy approach that's wrapped up in healthcare where women just look after the shop and the boys go off hunting and come back every so often.* (Deputy CEO (DCEO), Voluntary Hospital)

> *There's learning to be derived from it. I think if one was doing it again I think one would certainly hear the voice more of the non-consultants who have the in-the-trench understanding of the minutiae of issues that do matter in fact because it's the little things that matter.* (DCEO, Voluntary Hospital)

Thus the issues encountered in the implementation of service improvement pertained to information, and meaningful participation in decision making. These experiences may reflect broader issues regarding the relative status and power of professions, in accordance with the 'patriarchy approach' identified by the DCEO above.

The implications of such difficulties are three-fold. Firstly, the lack of supportive processes from nursing and other management structures has created a pivotal role for the consultant in the service-improvement process. There is a broad perception that it is only with the leadership or figurehead of the consultant that potential changes can move from initiation towards implementation. Secondly, this difficulty has led to the bypassing of line managers and a reliance on informal actions to get things done. Thirdly, whilst consultants can act both as key agents and patrons of changes initiated by nurses, AHPs and clinical managers, problems arise when consultants do not embrace the potential service improvement presented to them because the informal system provides no basis for redress. Thus, service improvement initiated by non-consultants that failed to receive consultant support got lost in the organisation. In the voluntary hospital, the absence of a formal system for harnessing bottom-up change has two further implications at the role level. These are the failure to recognize change as a component of any respondents' role, marginalising the role of clinical managers and the adoption of informal actions and the bypassing of formal systems to achieve change. The informal system also lacks any impetus for active engagement with multidisciplinary staff, leading to discontent regarding the level of input among this grouping.

Interestingly, the voluntary hospital was the only hospital where unsuccessful changes were discussed, which may be related to the significant levels of frustration outlined above. Lack of success in each instance was linked to the absence of consultant support, which undermined service improvement. As outlined in the tracer issue overview in Appendix 11, in one instance a nurse called in the union and closed down a ward as a method of bypassing the consultant-centred service-improvement structure. As indicated by Table 8.1, the consultant-centred role structures, which are reflected in processes of bottom-up change in the voluntary hospital, require a relationship with the consultant premised on ingratiation or revolt to achieve the ratification of initiatives. Overall, significant issues were encountered in the voluntary hospital, with regards to both the harnessing of non-consultant-led changes (moving them from initiation to implementation), and the level of multidisciplinary involvement evident throughout the process. In contrast to the voluntary hospital, the role adopted by the consultant in the public hospital, in conjunction with the role structures in place, makes the initiation and implementation of service improvement more inclusive and devolved.

8.2.2 Role structures and the role adopted by the consultant in the public hospital

While there are no formal systems for harnessing bottom up change in the public hospital, the consultant has created a de facto system of devolution with responsibility delegated to department heads who are predominantly clinical managers. These individuals are guided by a clear and jointly developed vision for the department, which allows the consultant to ratify decisions at an advanced stage of planning. In some cases the ratification occurred when the plans for the improvement were almost complete and the oversight was from a much greater distance than that evident in the voluntary hospital. As a result, the nursing and AHP clinical managers had greater control over the implementation of service-improvement changes than that evident in the voluntary hospital.

> *We just said we'd do it. Told [the consultant] at a meeting and he said 'ok, that's brilliant'.* (Cardiac rehabilitation co-ordinator, Public Hospital)

> *I did most of the ground work. And then I'd go to [the consultant] to check it* (Cardiac rehabilitation co-ordinator, Public Hospital)

> *It was ourselves, we wanted to get involved* (Resuscitation Training Officer, Public Hospital)

> *It was only cardiac rehab, myself and I think I would have given all the information leaflets to [the consultant] just to make sure that he was happy with the content as well.* (Pharmacist, Public Hospital)

An additional forum in which to present potential service improvements is the cardiology user's group. This provides a multidisciplinary forum for the further negotiation and ratification of developments, if contested.

Once an initiative has been ratified, by either the consultant in isolation or within the cardiology users group, the consultant liaises with the medical director and management, as required, to progress initiatives. Thus bottom-up development is more negotiated than in the voluntary hospital. For example, the chief cardiac technician, who had built up the electrocardiogram service, asserted that *'it was just myself, basically'*. She would attend key meetings with the consultant, provide information, outline the departments' needs and build their case for resources. This style of working may have been facilitated by the much smaller scale of the organization relative to the voluntary hospital. Nurses and AHPs also notified their line managers of the changes planned and undertaken, although the consultant remained the key link.

Three key issues emerged from this front line and clinical management involvement in facilitating and implementing change. The first was the potential for and experience of isolation and the aligned importance of networks of individuals in similar roles. This theme is developed in Section 8.4. The second issue is the importance of slack in facilitating bottom-up change. This has previously been identified as a facilitating factor in strategic change (Greenwood & Lachman, 1996b). The issue of slack at the role level is particularly important, as bottom-up change tends to be an addendum to basic roles (Fitzgerald et al., 2006b). The positive impact of slack was evident in the resuscitation-training department, which engaged in an initiative in the community. This was facilitated by a higher level of staffing than found elsewhere. The third issue pertains to the danger for frustration at stalled attempts at change to turn to disenchantment (Cardiac Rehabilitation Coordinator, Chief Cardiac Technician). Although one consultant described the frustration of front line clinicians as a *'necessary tension, spurring on service development'* (Lead Clinician for Cardiology, Voluntary Hospital), the danger of frustration turning to disenchantment emerged in interviews with front-line clinicians and service managers. While frustration can act to spawn attempts at service-improvement, disenchantment can engender the opposite. This was evident in the emotional assertion of the chief cardiac technician that her attempts to facilitate change were failing in the face of resource constraints. For her *'Nothing has happened, nothing will happen. I don't know why I bother.'* (Chief Cardiac Technician, Public Hospital). This was an important assertion as it was made in a context where significant change had happened. *She* had been instrumental in building up an electrocardiogram from one untrained part-time member of staff to a department with a chief cardiac technician, a senior technician and two qualified junior staff. However her frustration at that point pertained to equipment requirements which, while relatively modest, would have significantly enhanced the day-to-day experience of work for the department. These included an emergency trolley and defibrillator. More senior individuals within the organisation – and indeed within the other cases – attributed equipment-related issues to the failure to depreciate buildings and equipment in the Irish hospital sector, discussed further in Section 9.3. A third role-structure model with a markedly different role for the consultant is evident in the private hospital and discussed in Section 8.2.3.

8.2.3 Role structures and the role adopted by the consultant in the private hospital

In contrast to the consultant-centred role structures in the voluntary hospital, and the partially devolved role structures in the public hospital, the role structures in the private hospital can be classified as fully devolved to heads of departments. Further notable characteristics regarding the harnessing of bottom-up change in the private hospital include (1) management encouragement of bottom-up change; (2) the formalized process for engaging with consultants and staff; (3) the pro-activity of and particular emphasis on engaging with

consultants; (4) the presence of environmental and departmental monitoring at clinical and head-of-department level. The DON noted that this is actively encouraged:

> *You keep your ear to the ground and somebody might come in with a new idea or for a new machine.* (Director of Nursing, Private Hospital)

The QMs role has institutionalized this objective in the organization, which she described as *'the only way to go.'* (5) Changes are expected to meet defined business and quality-based criteria to be implemented.

In the private hospital, a meaningful formal invitation to engage in bottom-up change is extended to non-consultant front-line staff through a variety of organizational processes and innovative roles. Responsibility for harnessing bottom-up change has been devolved to individual departmental heads. All of the department heads have significant clinical backgrounds, are provided with relatively significant autonomy and also have responsibility for HR. There are also clearly understood criteria for ratifying initiatives that are financially oriented. Business cases are submitted on this basis. There is a strong culture of 'piloting' changes. In addition, an innovative quality manager role has been introduced to harness bottom-up initiatives organization-wide. As further support to bottom-up change in cardiology, a process-improvement role has evolved into a CSM role. All of the above-mentioned processes are focused on non-consultant staff. In contrast, remuneration structures encourage consultants to focus on service provision, rather than departmental management. Their concerns are separately addressed through quarterly meetings, concerned with

> *any improvements, any service enhancements that are needed, are they happy with the equipment they've been provided with and that sort of stuff and also can we do things differently; if we can provide a service at a lower cost we can keep our margins down.* (Head of Finance, Private Hospital)

In conjunction, these formal channels and the focus on the consultant as a 'customer' managed separately from other staff, leaves a residual role for consultants in moving non-consultant identified, bottom-up changes from initiation to implementation, as in the public and voluntary hospital. While these innovative and devolved role structures bypass the consultant in identifying and implementing bottom-up change with potentially significant repercussions for organizations attempting to manage dysfunctional relationships, there are some negative side-effects associated with this role structure. These are discussed below.

While these role structures do facilitate bottom-up change in the organization and allow more multidisciplinary involvement than in the other cases presented, there are some negative

consequences. The first issue is an orientation towards changes that meet financial criteria. Respondents noted that this constraint can be a benefit when initiatives are cost effective, but problematic otherwise.

> *Sometimes management might be slow because management can't see the same financial advantage and they're slow if that's not forthcoming.* (Consultant surgeon, Private Hospital)

> *If the thing made sense from a business point of view it got done very quickly whereas you could be at it for years in the public hospitals and get nowhere.* (Consultant 2, Private Hospital)

> *And there's cost effectiveness but eventually everything is sorted out.*(Clinical nurse manager, Cath lab, Private Hospital)

Some staff found these constraints stressful. In addition, the financially driven focus on the consultant as customer has implications for the rest of staff, who have little authority in initiatives management perceive as related to consultant satisfaction. Different experiences in departmental and consultant-related changes are outlined by the radiography manager:

> *MRI ... it was basically easy for me to manage because I had total control over it, and it was what we wanted to give the patients, whereas in the Cath lab it was what the consultants wanted and that was very different, so I had less control over.* (Radiography Manager, Private Hospital)

The implications of these different role structures, and the varying roles adopted by the consultants are now considered across the cases.

8.2.4 Comparison across cases regarding Role structures and the role adopted by the consultant

Based upon the preceding analysis, Figures 8.1 and 8.2 provide a pictorial overview of the findings from Sections 8.1 and 8.2, which pertain to roles in the initiation and implementation of bottom-up and top-down service-improvement change. Figure 8.1 presents the cases in a continuum, according to their success in harnessing bottom-up changes. Harnessing refers to moving changes from initiation to implementation. Figure 8.1 particularly emphasises the role adopted by consultants in service improvement, which, in conjunction with the role structures in place, can act as either a constraining or enabling influence on change-related roles. Specifically change-related roles were centralised around the consultant in the voluntary hospital, were partially-devolved in the public hospital, and almost fully devolved in the private hospital. The different levels of devolution had implications for the level of multidisciplinary

Figure 8.1: Who holds change related roles, how are such roles are enacted in, and affected by, role structures and what works effectively in bottom-up change? (Level of harnessing of change refers to extent to which initiatives are moved from initiation to implementation)

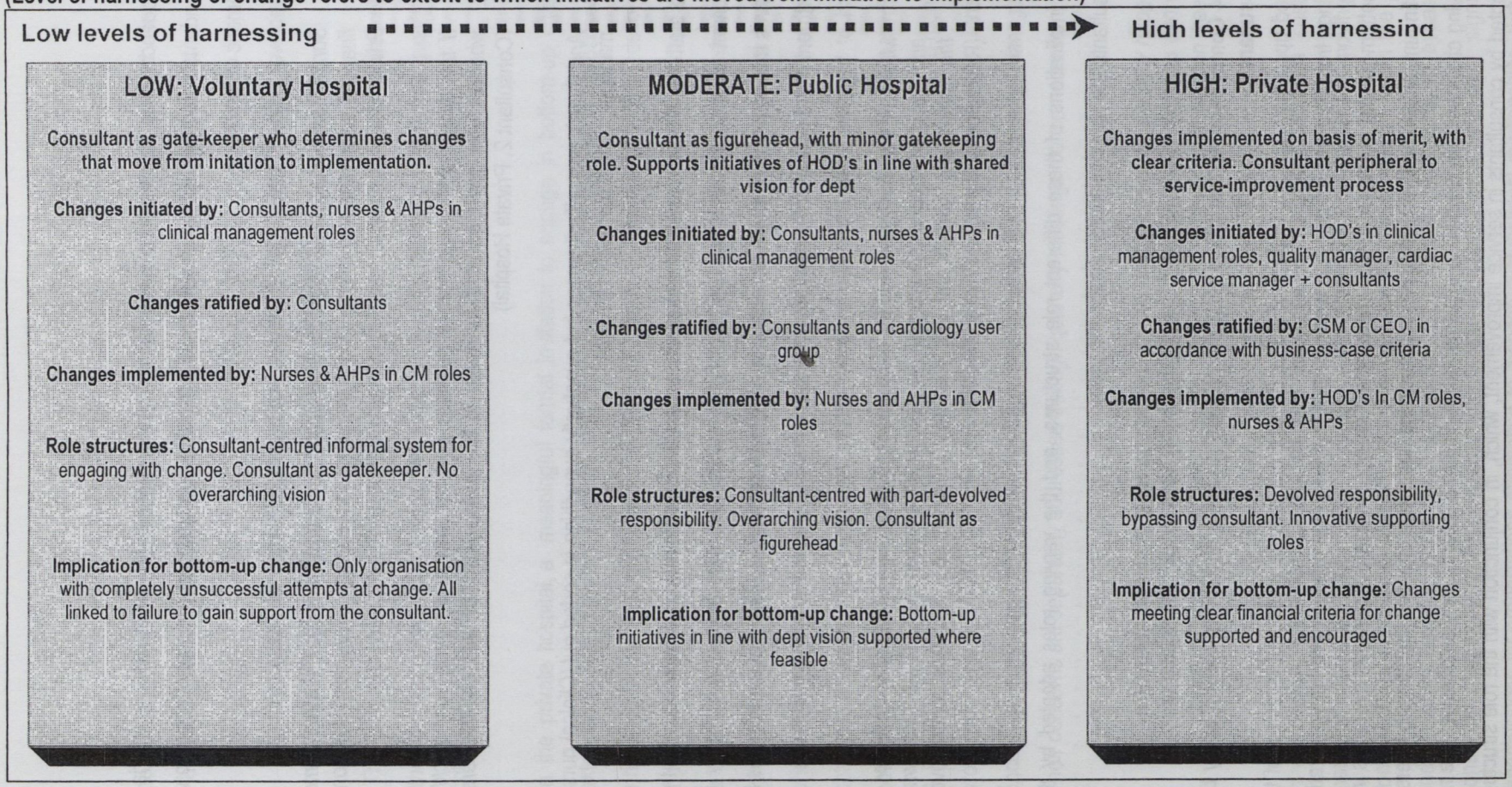
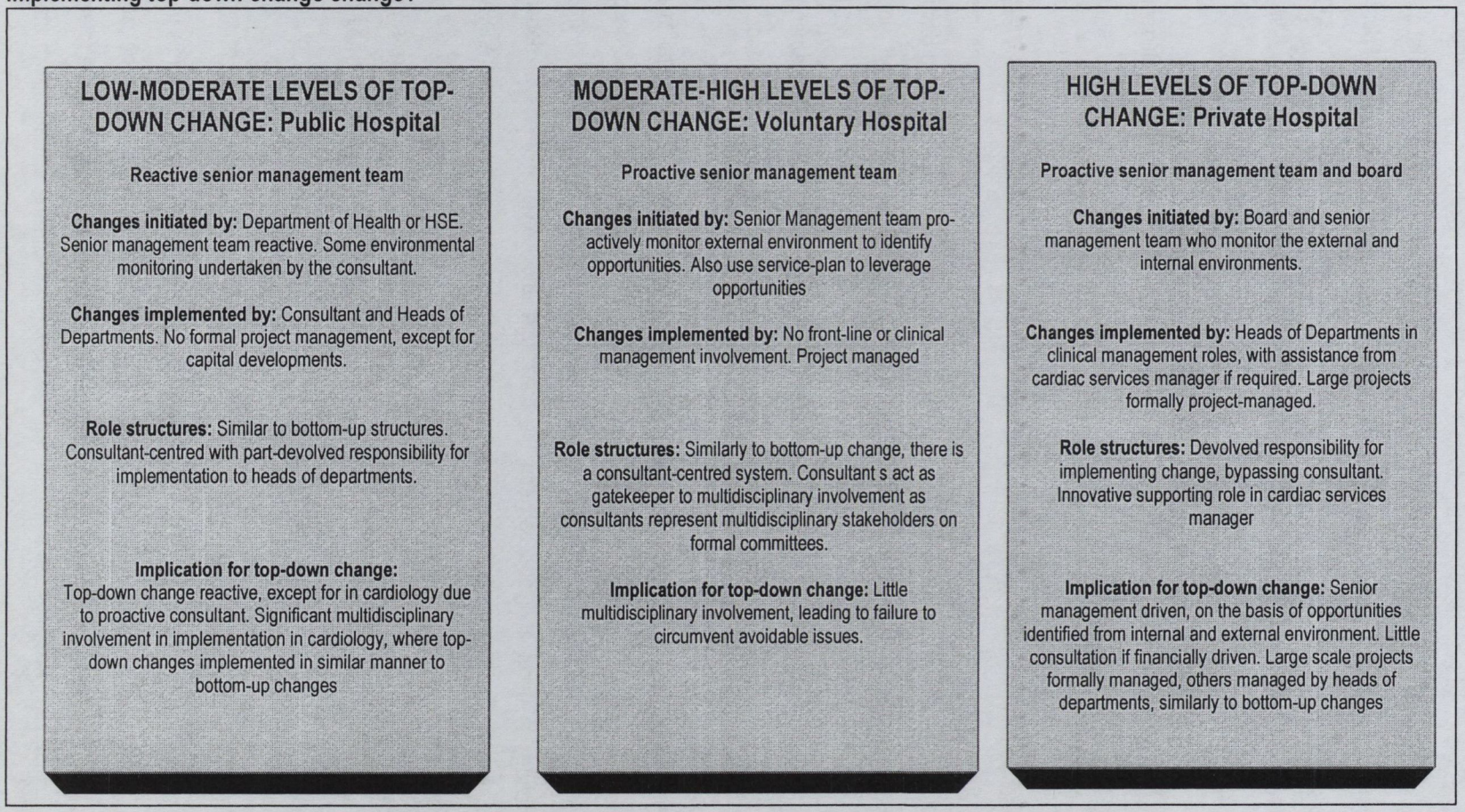


Figure 8.2: Who holds change related roles, how are such roles are enacted in, and affected by, role structures and what works effectively in identifying and implementing top-down change change?



involvement and control in the initiation and implementation of service-improvement change, the implications of which are four-fold. Firstly, multidisciplinary involvement facilitates the identification of appropriate changes and provides a broader pool of expertise for decisions regarding change (Fitzgerald et al., 2006). Secondly, it engenders embracement of those changes selected, whether top-down, or bottom-up. Thirdly, it can improve the implementation process by including multiple stakeholders. It is on this premise that devolved forms of change leadership have been advocated (Fitzgerald et al., 2006b). Fourthly, by creating regular contact between disciplines, multidisciplinary involvement in change can strengthen relationships and increase understanding. For Fitzgerald et al. (2006), these arguments underpin the introduction of roles spanning clinicians and managers.

While service-delivery and improvement is ostensibly provided through multidisciplinary teams, the change-related roles and relationships evident in this study emphasise professional segregation and fragmentation in spite of the positive nature of the relationships reported. In the public hospital, where inter-professional relationships were most successfully managed, as judged by multidisciplinary involvement in change, relationships were engendered by the cardiology users group and an external initiative discussed in Section 8.4: the regional implementation structures for the cardiovascular strategy, in which multidisciplinary staff participated. Nonetheless, taken together, Sections 8.1 and 8.2 provide evidence of stratification between professional groups in the initiation and implementation of service-improvement. While the role structures in the private hospital support service improvement, they reinforce stratification by creating an intra-departmental focus. Similarly, the role structures and the role adopted by consultants in the voluntary hospital fail to address the silo nature of hospital working. Finally, while the role structures in the public hospital are most successful in engendering multi-disciplinary engagement with service improvement, this tended to occur in dyads between the consultant and individual heads of departments, although it was supported by the cardiology users group and staff involvement in regional-implementation groups. The role stratification evident across the three hospitals is a role and not a person-based issue. Similarly, levels of multidisciplinary involvement are significantly linked to both the role structures in which consultant roles are embedded, and the personal style of the role incumbent holding a consultant role.

- **Comparison with the UK**

An interesting issue arises in comparing these findings to the UK. While variations in service-improvement roles were evident across cases in that context, this was not related to variations in role structures. This difference between the UK and Ireland may be related to the standardisation of role structures in the UK associated with the introduction of the clinical-

directorate model. However, the Irish findings regarding the benefits of devolved responsibility for change in public and private hospitals align with Fitzgerald et al.'s (2006) findings regarding the benefits of dispersed leadership in the UK. They found that greater success was evident in service-improvement change where dispersed leadership was evident. They identified the specific characteristics associated with dispersed leadership as having (1) a supportive and active senior-management team who are willing to become involved in facilitating changes; (2) clinical managers and senior clinicians providing leadership, advice to colleagues, negotiating for resources and constantly pushing the change forward; and (3) individual clinicians (of all professions and backgrounds) willing to undertake specific tasks.

In addition to dispersed responsibility for change roles, which focuses on allocating particular responsibilities to specific role incumbents, the Irish findings presented in this thesis also emphasise the potential for using role structures to support service improvement. For example, Fitzgerald et al. (2006) tentatively suggested that change initiatives may be impeded where gaps in dispersed leadership are present. Such gaps may take the form of a level in the organisation that lacks support for espoused changes, or the lack of a facilitator or opinion leader in a key professional grouping. Formalising the role structures for change, through methods such as establishing specific roles with responsibility for service improvement, as in the private hospital, may help to ameliorate the potential for and impact of such gaps. In support of this argument, Buchanan (2003) found that the existence of project-management structures facilitated the continuance of change in a hospital, even with a loss of key leadership figures. To conclude this section, a comparison with the broader literature outside of the UK is undertaken.

- **Comparison with the broader literature**

Figure 8.1 suggests that specific role structures may be of benefit in managing or overcoming the barriers to inter-professional relationships in contexts of change, discussed in Section 5.4. Specifically, the finding regarding role structures relates to previous research, which has suggested the need to overcome social and cognitive boundaries between groups to facilitate change (Ferlie et al., 2005a).To clarify, the patterns of inter-professional relationships evident in the voluntary hospital, associated with consultant-centred role structures, can be classified as 'knotworking', as per Engestrom et al. (1999) and Reeves and Lewin (2004), based on establishing and re-establishing links via brief interactions. In contrast, more sustained inter-professional relationships were evident in the public hospital, associated with a partial devolution of responsibility for service improvement to departmental heads. Finally, the consultant was by-passed and excluded from inter-professional relationships in the private hospital on the basis of fully devolved role structures. As Fitzgerald et al. (2006a) have found,

where relationships between clinical groupings are problematic they impact the provision of care and the implementation of change; bypassing the consultant in this manner may be of significant benefit where relationships are dysfunctional. However, overcoming social and cognitive boundaries and establishing sustained collaborative relationships may be more desirable in the longer term, an outcome that may be supported by the introduction of a partial-devolution strategy, and an associated clear role structure for change.

Section 8.1 has identified clinical managers as key agents in the initiation and implementation of service-improvement change across the cases. As a result, their roles are further explored in Section 8.3.

Section 8.3 The pivotal role of clinical managers in service-improvement change

The purpose of section is to investigate the role of clinical managers in the delivery of service-improvement change. This investigation is undertaken in the wake of the identification of clinical managers as 'key agents' in the initiation and implementation of service-improvement change across the three cases. In addition, clinical managers have been identified as pivotal in service-improvement in prior research (Fitzgerald et al., 2006b). In exploring clinical-management roles, this section remains focused on the first research question. Having identified that clinical managers do indeed hold change-related roles, this section further explores the specific individuals who hold clinical-management roles, queries the enactment of those roles, describes the role-related constraints faced by clinical managers, and evaluates what works effectively. The data presented is based on interviews with seventeen clinical managers across the three cases. As per Table 8.4, seven of these clinical managers were from the voluntary hospital, three were from the private hospital and seven were from the public hospital. This table outlines the clinical and managerial roles held by individual clinical managers, and whether individuals incumbent in clinical-management roles defined themselves as clinical managers. The data presented draws upon interview questions two through eight, nine, twelve, fifteen, and sixteen through nineteen. These questions are detailed in the interview schedule, presented in Appendix 3.

8.3.1 Who holds clinical-management roles in Ireland?

For this project, following Fitzgerald et al. (2006), a clinical manager refers to an individual with significant clinical and managerial responsibility. This definition led to some individuals being classified in this group without necessarily perceiving themselves as such. These

individuals are identified in Table 8.4. Crucially, the issue of what constitutes 'significant' managerial responsibility did arise. While *significance* was initially evaluated on the basis of time spent on managerial duties, this led to clinical individuals being classified as clinical managers on the basis of administrative rather than management tasks. Respondents whose tasks were entirely administrative, as in the case of the resuscitation training officer in the public hospital, have been identified in the table and text of this section.

Table 8.4 provides an overview of who fulfilled clinical-management roles across all three types of hospitals. It indicates that in the voluntary hospital, the two consultants interviewed and all of the CNM2 level nurses with the exception of the cardiac rehabilitation co-ordinator undertook clinical-management roles. The cardiac rehabilitation co-ordinator (CRC) was an exception. She was initially appointed as the CRC at the CNM2 level, but her role was later redefined as a clinical nurse specialist role. In addition, two AHPs held clinical-management roles according to the definition adopted but did not perceive themselves as clinical managers.

In the public hospital, a medical-director role was introduced and held by a consultant. In addition, two nurses held clinical-managements posts. Finally, as in the voluntary hospital, two AHPs holding head-of-department roles were acting as clinical managers. In the public hospital the CNM2s perceived themselves as clinical managers, with a more varied response from AHPs. Of the AHPs interviewed, only the chief pharmacist perceived herself as a clinical manager. The chief cardiac technician did not, although she met all of the definitional requirements. Finally, the cardiovascular nurse and resuscitation training officer were operating on the boundaries of clinical management, engaged in predominantly administrative rather than management roles. While the resuscitation training officer had been informed that he wasn't a manager by his line manager, the cardiovascular nurse excluded herself on the basis that she provides training rather than direct clinical care.

In the private hospital, there were no consultants in clinical-manager roles. However, two AHPs in head-of-department roles and a CNM2 were operating in clinical-management roles. While the chief cardiac technician perceived herself as a clinical manager, the radiography manager didn't. Similarly, the CNM2 catherisation lab did not define herself as a clinical manager, presenting herself as a dedicated manager.

Table 8.4: Clinical-management roles

Role	Clinical Tasks	Managerial Tasks	Self-definition as clinical manager?
VOLUNTARY HOSPITAL			
Lead clinician cardiology	Clinical role	Management of department Chair of consultant group in private hospital Sits on board of private hospital	Yes
Consultant cardiologist	Consultant cardiologist	Manager of one service unit in cardiology Secretary of Medical Board	Yes
Clinical Nurse Manager Level 2 CCU	Clinical role, predominantly supervisory	Management of CCU	Yes
CNM2 Cath lab	Clinical role	Management of Cath Lab	Yes
CNM2 Cardiology ward	Clinical role	Management of ward	Yes
Chief 1 Cardiac Technician	Chief 1 Cardiac Tech	Co-management of dept. Predominantly clinical	No (Predominantly clinical)
Resuscitation Training Officer	Training role	Management of dept	No (Predominantly training/preparation)
PUBLIC HOSPITAL			
Medical Director	Consultant role	Medical Director	Yes
Cardiac rehabilitation co-ordinator	Clinical role	Management of Dept	Yes
Resuscitation Training Officer	Clinical role	Administration Management of course arrangements	No (Has asked if manager, and informed by organization that not)
Chief Cardiac Technician	Clinical role	Management of Dept Administration	No (Perceives self as technician)
CNM 2 CCU	Clinical background. Only practices if reqd by circumstance	Management of Dept	Yes
Cardiovascular nurse	Developing & training in clinical guidelines	Management of dept and link to community and region Audit	No (No direct clinical care provided)

Chief Pharmacist	Clinical role	Management of Dept	Yes
PRIVATE HOSPITAL			
Radiography manager	Small clinical role, by choice	Management of dept	No
Chief Cardiac Technician	Clinical role	Management of dept	Yes
CNM2 Cath lab	No clinical role	Management of dept	No (Self- defines as Manager)

Table 8.4, in conjunction with the overview across the cases provided above, indicates that across the cases clinical managers fall into three predominant groupings. These are (1) consultants with significant managerial responsibility; (2) head's of departments or AHPs, who maintain clinical practice; and (3) clinical nurse managers. Interestingly, clinical nurse managers who are identified as clinical managers in their titles do not always retain clinical practice. For example, the CNM2 CCU in the public hospital was operating on the boundaries of clinical management, describing her role as managerial.

Across the cases, the consultants and clinical nurse managers all perceived themselves as clinical managers with greater variability in self-perception among those in AHP roles. One interesting response emerged from a consultant in the public hospital who vehemently objected to being classified as a clinical manager. As a result, he has not been included in Table 8.4. However, his role entailed strategic planning for his department and liaison with all of the sub-units on a monthly basis. He also adopted de facto clinical-director and clinical-governance responsibilities. The variability in self-perception among AHPs in clinical-management roles may be indicative of underlying issues regarding role clarity and ambiguity.

Across all the cases, clinical managers were most predominant at sub-unit rather than unit or senior-management level. However, examples of senior clinical managers were evident in the public and voluntary hospitals. These senior clinical managers held consultant posts. In the public hospital only one clinical manager, the medical director, was operating at senior-management level. The remainder of the clinical managers, operating at sub-unit level, engaged in clinical, operational, supervisory, advocacy and liaison roles. Similarly, in the voluntary hospital, two consultant clinical managers engaged in some strategic service-development, as well as operational management at the unit level. The nursing and AHP clinical managers focused on operations, and retained some residual involvement in service provision. Finally, in the private hospital, sub-unit-level clinical managers, who had both nursing and AHP backgrounds, engaged in operational and clinical management, with some

employee advocacy and liaison roles. The private hospital was the only organisation to lack consultants in clinical-management roles. This can be related to the incentives provided to consultants to focus on service delivery rather than service improvement or departmental management, outlined earlier in the chapter.

Across the cases a significant number of clinical managers had a small or negligent clinical role. Specifically, these individuals are the two consultants and the CNM2 CCU in the Voluntary hospital, the CNM2 CCU in the public hospital and the radiography manager and CNM2 cath lab in the private hospital. As a result, the next sub-section considers whether clinical managers are moving into management, before considering the role-related constraints faced by clinical managers. The question of whether clinical managers are moving into management pertains to how these roles are enacted both in contexts of service delivery and service improvement. It also has implications for the legitimacy of and value provided by clinical managers, as the premise of their unique offering is that they have managerial and clinical roles (Hoff, 1999a).

8.3.2 Enacting clinical-management roles: Are clinical managers moving into management?

As CNM2 you've position of nurse manager, but who doesn't really get involved in ward work very much.

– CNM2 Cardiology ward, Voluntary Hospital

The extent to which the clinical managers maintain clinical activity varied widely with the lowest levels of clinical practice among the clinical nurse managers. Amongst the consultants, both of those interviewed in the voluntary hospital indicated a progression into management over time. The medical director in the public hospital had not been in his post sufficiently long for such a dynamic to be evident. Nonetheless, across all clinical-management groupings, the managerial aspect of roles appeared to be expanding. This raises the question of the maintenance of legitimacy, which underpins the desirability of maintaining clinical practice (Ashburner et al., 1996, Schneller, 1997).

Illustrating the management focus within the clinical nurse-manager grouping, the CNM2 CCU in the public hospital asserted that *'Most of what I do is management'*. This was similar to the CNM2 CCU and CNM2 Cardiology Ward in the voluntary hospital, and the CNM2s in the private hospital. An exception to this was the CNM2 catherisation lab in the voluntary hospital, who maintains a clinical practice. Although the CNM2 CCU from the public hospital initially wished to maintain her clinical practice, she found this difficult due to the volume of work she faced.

> *Initially when I started out in this role I looked after patients as well, I found, I was overwhelmed by it. I couldn't ... I continued to do it but, what I do now is, I'm allocating the nurses to look after the patients. And I look after the nurses.* (CNM2 CCU, Public Hospital)

The contextual factors affecting each unit impacted on the nature of the clinical-management role held by each nurse manager. For example, the CNM2 cardiology ward in the voluntary hospital had a ward with low education levels among the staff. As a result, she was unable to do managerial work during the day, instead focusing on education and supervision. Instead, she took it home to do in her own time or on her days off. She described this as *'a nightmare.'*

> *You end up doing a lot of managerial things when you're at home, or on your days off.* (CNM2 Cardiology ward)

Amongst the AHP clinical managers, the level of clinical involvement varied. In the private hospital the devolution of HR added significantly to clinical managers' non-clinical responsibility. While the radiography manager tried not to do a lot of clinical work, the chief cardiac technician maintained clinical involvement on a daily basis, though not for the full day. In the voluntary hospital, the chief cardiac technician retained a major involvement in clinical and training tasks, with operational management and administration comprising the remainder of her role. While the resuscitation training officer would have preferred to spend a greater period of time on service provision, she emphasized the *'phenomenal amount of administration'* (RTO, Voluntary Hospital) and the significant component of her time expended on minor administrative and management tasks. She referred to

> *the frustrations of lack of resources, having to do the photocopying, having to wash the dishes, having to call the electrician to change the lightbulb, not having – this sounds like big excuses – not having the time to develop policies to underpin clinical training and clinical work, that is frustrating. And that for me in this hospital ... I know I would spend 70% of my time at the computer or at the desk, administrating, ordering, sorting, communicating.* (RTO, Voluntary Hospital)

Similarly, the RTO in the public hospital asserted that twenty five to thirty percent of his time was spent doing administration to support the courses he runs. For him, the time *'spent doing secretarial work or the clerical work to support the courses ... takes me directly away from training, which takes me away from the job that I'm paid to do'* (Resus training officer, Public Hospital).

Although the level of clinical involvement retained by consultant clinical managers was variable, similar to the group discussed above, the general trend among the consultant

grouping was for an increasing management orientation over time. An exception to this was evident in the private hospital where the consultants were not involved in clinical-management roles. Instead, their contracts were oriented towards service provision as self-employed contractors. In the voluntary hospital, the two consultants interviewed both had significant managerial responsibility with an evolution towards a predominantly managerial orientation over time. The lead consultant *'devoted myself to developing the cardiology service'* (LCC, Voluntary Hospital), with additional roles as chair of the consultant's group in the private hospital, and a member of the board of directors. These latter two roles had been added to his portfolio six years previously. The consultant cardiologist in the voluntary hospital took responsibility for the running and strategic development of one sub-unit in the cardiology department that was externally funded. He acted as the day-to-day manger of the service, in terms of the medical, administrative and financial component. He considered his role *'more and more managerial.'* (Consultant Cardiologist, Voluntary Hospital). He presented this as a natural and appropriate evolution, evident both among his Irish colleagues and in his experience in the US. One key component of his role is fundraising from companies to keep his unit going.

This section has identified an increasing emphasis on a managerial orientation to enacting clinical-management roles – which may, as intimated by the lead consultant cardiologist in the voluntary hospital, be related to the adoption of service-improvement oriented roles. However, a more operational rather than strategic or service-improvement-oriented focus is evident among non-consultant clinical managers. This may be related to the lack of a specific strategic or service-improvement remit for them, with the exception of the private hospital. Addressing such role-clarity issues may augment the already significant role that clinical managers play in service improvement, in spite of their predominantly operational orientation. Another issue to be addressed, as raised by the CNM2 cardiology ward in the voluntary hospital, are the pressures of day-to-day service delivery and increasing administrative responsibility, which may distract clinical managers from service-improvement. A degree of role slack is desirable. The next sub-section considers constraints on clinical-management roles, which may have continuing implications for service-improvement processes.

8.3.3 Constraints on clinical management roles

In his assertion that the 'clinicians in management' initiative in the public hospital was a good idea in theory but required some fine-tuning in practice, the medical director raised two concerns, echoed across the respondents. These were the interrelated issues of authority and budgetary control. Both have potentially significant implications for clinical managers

involved in implementing service improvements. With regards to authority, the overarching feeling was that

> *If you have someone in a managerial position, a senior managerial position, they must have authority. I think the main problem again is funding.* (Medical Director, Public Hospital)

The medical director further emphasised the link between meaningful authority and budgetary control, explicating the difficulty of overseeing change without resources. *'You're quite limited if you don't have independent budgetary control. The only strategies you can develop are cost-neutral.'* He presented this as the key obstacle to operating in a strategic manner. Instead, he perceived his role as reactive – responding to the concerns of the moment *'a bit like a TD and a constituent clinic.'* For him, this presented issues for the future, in terms of attracting clinicians into management:

> *If you have a system whereby clinicians are put into relatively powerless positions, or buffer positions or … if your function is signing a lot of documents, you are going to turn clinicians off doing that.* (Medical Director, Public Hospital)

A consultant from the private hospital, who had held a clinical management post as a director of a unit in a separate organization, held a similar view to the medical director. When questioned regarding his experience he asserted that it was an *'absolute waste of time'* (Consultant Cardiac Surgeon, Private Hospital). For him, as for the medical director in the public hospital, the structure was limited by the lack of a dedicated budget controlled by the unit:

> *It didn't work. It wouldn't have worked unless it was given a budget and control of our budget. But we never were given that.* (Consultant Cardiac Surgeon, Private Hospital).

> *I would like to have [a strategic orientation], but again you must remember that you're limited, you're quite limited if you don't have independent budgetary control.* (Medical Director, Public Hospital)

Also at the senior-management level, the director of nursing in the public hospital related the lack of budgetary control to a lack of incentivisation in the system.

At the operational-management level, the CNM 2 CCU in the public hospital desired budgetary control of her unit. Similarly, budgetary control was also desired by the chief cardiac technician and the consultant cardiologist in the public hospital. Both indicated that this would facilitate them responding to local-level service-improvement imperatives.

> *I would like to have my own budget, for the unit. Because sometimes you can see things that if you did have your own budget you would do things differently and do them more economically.* (CNM2 CCU, Public Hospital)

While this theme was also raised by the CRC in the voluntary hospital, she did not wish to have direct responsibility for managing a budget.

> *I would see it as being a benefit to have a cardiology budget but I think you would need to have somebody perhaps at a CNM3 level that would actually manage the spend. I don't feel that CNM2 level when you're trying to look after the patients that you can also turn around and be in charge of budgets and be in charge of staff.* (CRC, Voluntary Hospital)

It is interesting to note that the issues of authority and budgetary control are closely intertwined. Of particular interest is the fact that individuals at all levels and across roles presented increased budgetary control and authority as desirable in facilitating changes that range from the strategic to the operational.

Additional issues pertaining to service-improvement encountered by the clinical managers included the difficulty of managing across professions. Both the CNM2 CCU in the public hospital and the CNM2 catherisation lab in the voluntary hospital felt that their capacity to manage their units and engage in service development was undermined by their responsibility for the running of their units, while only having authority over the nursing staff.

> *And really you have responsibility only for the nursing as such but it's a multidisciplinary team. ... It can be difficult at times because sometimes you have that authority.* (CNM2 Cath Lab, Voluntary Hospital)

> *I'd love, I think, to have more authority over all members of staff who work in the unit. What I mean by that is that I really would be just responsible for the nurses and the care assistants.* (CNM2 CCU, Public Hospital)

In spite of the positive working relationships between consultants and clinical managers in the voluntary hospital, there remained evidence of tension between clinicians' perception of fairness at the micro level and managers' perceptions at the level of the patient population, as suggested by Montgomery (2000). For Montgomery, it is in such contexts that the boundary-spanning roles of negotiation, communication and conflict mediation are most valuable. An example is provided below;

> *A complicated patient, it's just a practical example that comes to mind, and it creates all sorts of difficulties for us, it reduces our ability to turn over the bed and to treat*

> *more patients, which is the main issue. It may not be appropriate, we may have done as much as we can for the patient, they may be better off in a step-down type facility. But to manage that process, clinician involvement is critical.* (Financial Controller, Voluntary Hospital)

One consultant clinical-manager outlined his understanding of the pressures placed upon managers:

> *There's a continuous schizophrenia about hospital management, in terms of the management side of things. Even though they wouldn't admit it officially, their bottom line is to make sure the budget balances. And I can understand it from their perspective, that's the barometer by which they'll be measured by the local health authority or by the HSE. So for instance if they're suddenly 20% over their budget no matter what they've done with that money, no matter how excellent that investment has been they'll be slapped ... so they focus on the budget whereas we're continually focusing on service development.* (Consultant Cardiologist, Voluntary Hospital)

Thus, the core challenges faced by clinical managers included the issues of meaningful authority linked to budgetary control, cross-professional management, limited access to management among non-consultant clinical managers and conflicting perceptions of fairness, leading to tension in relationships. To conclude consideration of clinical-management roles, Section 8.3.4 provides an overview of those holding clinical-management roles, the challenges faced by them and how this relates to the UK and broader international experience.

8.3.4 Overview of findings pertaining to clinical managers: Clinical Management as operational management

Section 8.3 has considered who adopts clinical-management roles in Ireland, how they are enacted and the role-related constraints clinical managers face. This section provides an overview of these factors across the three cases in addition to raising issues pertaining to effectiveness.

With regards to the issue of who holds clinical-management roles, there were three groups evident – consultants, AHPs and clinical nurse managers. In the enactment of these roles, there was a marked difference between CNM2s, AHPs and consultants. While the CNM2's and AHPs were positioned at a relatively low organisational level with an operational focus, consultants operated in a much more strategic, service-development and proactive manner at a higher level, albeit within constraints Nonetheless, in spite of the relative strategic orientation among consultants, the overarching focus on administrative and operational rather than strategic management was emphasized by the medical director in the public hospital.

The most significant difference across the cases was the absence of consultants from clinical-management roles in the private hospital.

In enacting their roles only four respondents, the chief pharmacist in the public hospital, the CNM2 CCU in the voluntary hospital, the radiology manager in the private hospital and the chief cardiac technician in the private hospital identified service improvement as an explicit component of their roles. Thus, service improvement as an explicit rather than an extra-discretionary element of clinical-management roles was only seen in the private hospital, with one exception in each of the public and private hospitals.

> *We're just maintaining what we have and constantly reviewing what we're doing and trying to see well how can we do it better.* (CNM2 CCU, Voluntary Hospital)

No respondents articulated a desire for greater strategic involvement. Although the director of nursing in the public hospital asserted that the CNM2 role is *'operational plus strategic, with regards to the development of their ward'*, the assistant director of nursing asserted that, in practice, the CNM2 roles are focused on operational and clinical management. The latter assertion was supported by the CNM2 respondents across all three hospitals. Thus in exploring the finding regarding the stratification in Irish clinical managers, the predominant nursing and AHP groupings of Irish clinical managers were further differentiated from those in the US and UK by their low-level position, evident across the organisations.

The extent of the operational orientation evident amongst clinical managers appears to also be influenced by the role structures in their organisations, which affect the degree of responsibility afforded to clinical managers. The most functional orientation amongst clinical managers was evident in the voluntary hospital. This organisation exhibited limited devolution of responsibility at the unit level. In the public hospital, although some attempts at service development by unit-level managers were evident, these were implemented in line with the overarching strategy for the unit, so the full strategic weight did not fall to the clinical managers. In addition, some of these initiatives were relatively minor. For example, the CNM2 cardiac rehab in the public hospital changed the name of a service. Thus the operational orientation of non-clinical managers appears mediated by (1) whether the individual is a consultant or non-consultant clinical manager and their associated level in the organisation; (2) organisational roles structures, and the degree of responsibility afforded to clinical managers; and (3) organisational processes such as performance management and the explicitness of criteria for change. The latter were evident in the private hospital.

- **Comparison with the UK**

A key finding to emerge from this research is the fact that there is no standard way to define what a clinical manager is or does. In fact, there appears to be some stratification in this regard, across consultant, nursing and AHP groupings. This is an important finding because research to date particularly in the US (Hoff, 1999a, Schneller, 2001, Montgomery, 2000), though also in the UK (Marnoch, 1996, Willcocks, 1994, Llewellyn, 2001) has tended to focus on clinical managers as an undifferentiated grouping, or on clinical managers from medical backgrounds.

In exploring clinical-management roles in service-improvement, Fitzgerald et al. (2006b) found a lack of a coherent work identity, with a lack of awareness of clinical management as a speciality, and a substantial number of clinical managers not wishing to remain in management. Similar findings were evident in the Irish context, with the lack of a coherent work identity compounded by the three forms of clinical-management roles in operation. In terms of the role undertaken, outside of the consultant clinical managers and those in the private hospital, the findings confirmed that clinical-management roles in Ireland are predominantly operational. This aligns with the findings of Fitzgerald et al. (2006b) in the NHS. However, in contrast to the UK, Irish clinical managers have informally undertaken a significant role in the initiation and implementation of service improvement.

> *In terms of role enactment then, we found a narrow focus within the roles as enacted by the clinical managerial hybrids tracked. The focus 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.* (Fitzgerald et al., 2006b: 169-170)

For Fitzgerald et al. (2006b), the operational focus of staff is a pessimistic finding. However, in this context, the finding may just be reflective of the early stage of development of clinical-management roles in Ireland. Schneller et al. (1997) have identified the development of clinical-management responsibilities in the US, from internal and operational roles similar to those outlined above towards more external and strategic roles. The attempts, albeit constrained, of senior clinical managers to actively engage in strategic management are certainly encouraging in this regards. Nonetheless, the three factors outlined above, which mediate the degree of strategic or operational involvement of the respondents, may be useful in ameliorating the situation and particularly in extending the potential for strategic involvement to non-consultant clinical managers. The fact that many Irish clinical managers were evident at lower organizational levels than in the UK, managing individual departments rather than overarching units, may be related to the low prevalence of the clinical directorate

structure in Ireland, the relatively recent advocacy of this form of management as discussed in Section 5.5.4 and the constraining role structures evident in some hospitals as outlined in Section 8.3 above.

- **Comparison with the broader literature**

The issue of whether clinical managers are moving into management is one which relates to their legitimacy. The clinical-manager role has been presented as a strategy to reconcile professional and managerial agendas. However Hoff (1999a) suggested that as clinical managers make different contributions to managers, striving for management credibility can undermine the clinical credibility that facilitates their unique contribution. On this premise, the drift of clinical managers into management undermines the potential contribution of such roles. For Hoff (1999a) the best method of reconciling this tension is for clinical managers to differentiate themselves from traditional managers. In this context, nurse managers in particular appear to be drifting towards management roles. The experience among the second AHP clinical-management group was more variable, and there was an indicative trend in the voluntary hospital over time towards an increasing orientation to management among consultant clinical managers. Clarifying the desired contribution and specific role of clinical managers could help to stem the drift into management. The variable drift towards management, evident in Ireland, is not dissimilar to international trends, with Hoff (1999a, 2001a) finding that over half of clinical management respondents to his surveys did not practice medicine.

In the next and final section of this chapter, attention turns to the role of intra and inter-professional networks in facilitating service-improvement.

Section 8.4: Facilitating relationships to facilitate change

This section presents an unanticipated finding pertaining to the final aspect of the first research question. To remind the reader, the first research question was; *Who holds change-related roles, how are they enacted in and affected by role-related constraints and what works effectively?* Section 8.4 specifically addresses one unanticipated role-related factor, intra and inter-professional networks that can facilitate the effectiveness of individuals enacting their roles in service improvement. Discussion regarding the facilitation of networks and relationships emerged from several questions on the interview schedule. Specifically discussion emerged from question ten, which asked respondents who their most significant relationships were with through work; question fifteen, which pertained to changes that the respondent felt could allow them to perform their role more effectively; and discussion of the implementation of specific changes, which was discussed under question seventeen.

Respondents particularly emphasised the formal regional implementation structures set up under the cardiovascular strategy. To follow up on this unanticipated theme, interviews were conducted with the Principal Officer in charge of the cardiovascular strategy based in the Department of Health and Children. Two interviews were also conducted with chairs of regional implementation groups, and one interview was conducted with a regional implementation group co-ordinator. However, prior to outlining the role fulfilled by the regional implementation structure and the espoused benefits identified by respondents, attention is drawn to the experience of isolation, particularly among the AHP respondents in the study, underscoring the necessity of network development for maintaining motivation and ideas to engage in service improvement. Informal networks were also emphasised by respondents, particularly in the private hospital, and these are also outlined in this section.

On the basis of responses received, isolation is much more likely to occur among AHPs such as the CRC cardiac technicians. This can be attributed to their physical location outside the ward and the fact that while such AHPs are members of multidisciplinary teams, they tend to deliver their services in isolation. The theme of isolation was most strongly articulated by the two AHPs in the public hospital, who offer an illustrative example of how isolation can negatively affect the initiation and implementation of service improvement, and how networks can ameliorate such negative effects. Their different experiences, on the basis of both membership and non-membership in the regional implementation structures, clearly illustrate the capacity of networks to (1) address the issue of isolation, which acts as a de-motivating force for service improvement, and (2) the capacity of networks to enhance the initiation and implementation of service improvement.

As outlined here, in the public hospital the consultant engaged in generating a broad vision for the cardiology department and then delegated responsibility for the delivery of this vision to individual heads of departments. In that hospital, two individuals who were both highly successful in their service-improvement endeavours, referred to the potential for isolation in their attempts at service improvement. This potential was particularly acute for them as they were specialists, meaning they were without colleagues engaged in similar roles to support them in their attempts at service improvement. The CRC noted the need for a network of similar individuals. *'I think where it's a nurse problem you can deal with it. But if it's departmental ... I think you're kept very standalone. You do need someone to directly link to'* (CRC, Public Hospital). She was fortunate enough to gain an external network of individuals in similar roles via a sub-unit of the regional implementation group. As well as providing links to individuals, this also provided an overview of developments in the region, which acted as a catalyst for further change. The loss of that external network structure was felt very keenly at

the end of the strategy; *'Once that went, we were lost'* (Cardiac rehabilitation co-ordinator, Public Hospital).

The chief cardiac technician in the public hospital experienced similar difficulties. While a member of the cardiology users group, she felt isolated from other developments in broader cardiology service. Brought into the hospital to build up the electrocardiogram service, she noted her lack of knowledge regarding structures in the hospital as a significant and de-motivating deficit, exacerbated by her lack of awareness regarding where such information could be obtained. Overcoming these obstacles was made more difficult by the standalone nature of her role. She too desired greater awareness of the actions of others, both in her role in other hospitals in the region, and in the hospital itself. For her, the first would have buoyed her confidence and enthusiasm while the second reflected her individual sense of isolation on a day-to-day basis. Although supported by the consultant, she had only a monthly formal meeting with him.

Although both of the respondents noted the potential for isolation and the desire for awareness regarding developments in their area, their experiences differed greatly. One benefited markedly from an external network, while the other struggled to develop a social network in the hospital, confidently construct a vision of the service and implement it. Their different experiences emphasise the value of both formal external and regional network structures and meaningful social networks within the organisation. The formal regional networks that supported the CRC were implemented as an innovative initiative in the cardiovascular strategy (Principal Officer, Department of Health) and appear strongly valued by the individuals who participated in them. For those acting as change leaders and facilitators, the groups provided ideas, support and motivation. Other respondents who identified the importance of the regional implementation groups were the CRC, CNM2 cath lab and lead consultant cardiologist in the voluntary hospital, and the resuscitation training officer in the public hospital.

> *And at that stage it became about implementation. And the old health boards were asked to take on the implementation. The only one that took it seriously at first was the [ ] Regional Health Authority. And that was due to two remarkable women, whom you should interview. ... But they were very enthusiastic, very hard working and they, we did something which no administrators had even done before. ... They enlisted the help, or actively supported those of us who were trying to do things.* (Lead consultant cardiologist, Voluntary Hospital)

Although outside of the regional implementation groups, staff in the private hospital also engaged in relationship building with individuals in similar roles across organizations. In

contexts of service improvements, individuals in this organization arranged site visits even internationally, to see and learn from others. The DON, CSM, chief cardiac technician, and CNM2 cath lab had all made external visits. In addition, the radiography manager, CNM2 cath lab and chief cardiac technician had links with individuals in equivalent roles in other organizations. Thus the issue of relationship building was evident across the three cases. Next, we consider more fully the role fulfilled by such networks, and specifically the regional implementation groups.

- **The role of the regional implementation groups in service improvement**

The regional implementation groups were introduced to facilitate the implementation of the cardiovascular strategy, as outlined in chapter 4.

> *Their job was to look at regional priorities and feasibility. … So there was a whole job of getting 211 recommendations, sixty million euros and a whole job of getting the macro level recommendations to work down into regions. And that was the job of those groups. And each of those in turn engaged a project manager. … They were our eyes and ears on the ground in the region.*(Principal Officer, DOH 11.07.06)

At the regional level the implementation groups were helpful in identifying regional priorities, distributing resources and monitoring implementation. At the organisational and role levels the implementation groups provided legitimacy to proceed with service development. Through liaison with others in similar roles they also facilitated peer mentoring and support and the provision of ideas and advice and generated informal communities of practice. The project manager for the voluntary hospital's region who oversaw the regional implementation group described her role in the following terms:

> *So we had the two things; getting everyone to work together, but also making sure that everyone was doing what they were, what somebody had signed up to do. So that was my role.* (Project Manager, Cardiovascular Strategy, Voluntary Hospital Region)

The regional implementation groups were the only component of the formal cardiovascular implementation structure mentioned by respondents. These groups played a valuable though varied role at macro and micro levels. Their form and modus operandi was determined by the regional co-ordinator for each area. This provided flexibility to respond to local priorities. At the macro level the roles included ensuring equitable regional distribution of funds derived from the strategy (Consultant, Public Hospital), and determining which organizations would lead in specific areas (Lead Consultant Cardiologist, Voluntary Hospital). Of particular

concern for the consultant in the public hospital was that funds did not de facto gravitate towards the larger organisations in the region. Initially the regional implementation group, of which the public hospital was a part, met once a month, but this reduced to once every couple of months as the strategy progressed. A similar dynamic was evident in the voluntary organization.

In the public hospital the group was discussed by four individuals. These were the consultant cardiologist, the CRC and the RTO, all of whom had direct involvement in the group. It was of pronounced benefit to the latter two from a peer-mentoring and support perspective, as they held roles outside of the organisational mainstream. In the voluntary hospital, it was discussed by the lead consultant cardiologist, the CRC and the CNM2 cath lab. Interestingly, the RTO in that organization did not mention the group.

At the regional level, there were differences in the level of stakeholder involvement in the development of blueprints for action. Ideally, action planning should include stakeholders from the outset. This can increase perceptions of transparency and satisfaction with final allocations. In the voluntary hospital region, the implementation group brought together representatives from each of the hospitals in the region with the aim of determining which organisations would lead in specific areas. This strategy worked very well.

> *We put a forum together, and we were told that we were mad, getting everyone around the one table together, and it actually was one of the reasons why an awful lot of stuff is achieved in the hospitals. It worked really well ... and I have to say they were incredible themselves with how they moved and they took on a collective responsibility.* (Project Manager, Cardiovascular Strategy, Voluntary Hospital Region)

> *The [number] hospitals that were involved in the [area], we met, and we sat down over a morning and we divided up everything. And we agreed at professional level which hospitals would like to be responsible for which things.* (Lead Consultant Cardiologist, Voluntary Hospital)

In the public hospital region, representatives from the hospitals were not brought together, and the consultant was highly concerned that the organisation was going to be by-passed in developments. However, having a formal regional structure in place was useful in making a case for the hospital.

> *The cardiovascular strategy started. And for a while it looked like this hospital would be nearly entirely left out. We weren't a hospital at all, we were ... So I had to get very involved in that. Write serious letters ... And I was very concerned that we wouldn't get cardiovascular strategy money. Now at the end of the day we did. We had to fight for it – but we got it.* (Consultant, Public Hospital)

'It was very important, that regional thing was very important to make sure hospitals got their fair share to implement the strategy. (Consultant, Public Hospital)

Although not involved in the regional implementation group, the chief cardiac technician in the public hospital drew attention to her desire for a similar type of inclusive mechanism for individuals. Her isolation in attempting to develop her department raised the importance of peer mentoring and support, a theme also raised by the CRC in the public hospital. She was fortunate enough to gain an external network of individuals in similar roles via a sub-unit of the regional implementation. As well as providing links to individuals, this also provided an overview of developments in the region, which acted as a catalyst for further change. These needs could be fulfilled by a structure other than the regional implementation group. For example in the second public hospital, which was not incorporated into the thesis due to issues of scale, when the regional implementation group had fulfilled its briefing, the members continued meeting but changed the focus to education, exploring developments in the area and peer support. This was an innovative move, as in the public hospital the regional implementation group lost its momentum once it had achieved its objective (RTO, Public Hospital).

Recommendations for the improvement of the implementation group model included (a) having a centralised group with responsibility for developing policies and procedures (RTO, Public Hospital). This would reduce duplication of effort across hospitals. (b) Increased feedback regarding why specific change processes stalled (Cardiac rehabilitation manager, CNM2 Cath Lab, Voluntary Hospital) and (c) Having identifiable 'project leads' for specific changes at organizational level (CNM2 Cath Lab, Voluntary Hospital).

- **Comparison with UK**

Unlike the managed clinical cancer networks in the NHS, outlined in Section 5.5.9, the focus of these groups was on the implementation of service-improvements, delineated by the cardiovascular strategy rather than by service provision. A key feature of differentiating these groups from the cancer networks was the early establishment of the distribution of funding, which eliminated competition for resources. This was of significance because an incompatibility between the goal of knowledge sharing and competition performance management has been found to undermine the exchange of best practices in cancer networks in the UK (Addicott et al., 2006).

While the regional implementation group was helpful in ensuring distribution of resources and responsibility at the macro level, at the micro level they also served to create uni- and multi-profession social groupings which acted as forums for knowledge sharing and peer mentoring. Similar to the situation outlined in the UK by Ferlie & Pettigrew (1996), these clinical networks played an important role in inter-organisational communication and contact. The sharing of best-practice and knowledge transfer across professional groups was facilitated by what Addicott et al. (2006), cited in Section 5.5.9, described as a *'sustained platform of joint activity and local learning'*, underpinned by policy objectives and funding. In Ireland, the network functions of local learning and peer support were important in facilitating change, particularly where the change agents were in marginal or peripheral roles, such as the CRCs and RTOs. These roles operate in parallel with main care structures. The implementation groups facilitated knowledge sharing and learning, which were central to the effectiveness of these roles. They also provided participants legitimacy to act as change agents and proceed with service developments. The groups also acted on ideas generated but not included in the strategy. One example of this was an attempt to provide weekend catherisation lab coverage for urban hospitals. While the initiative failed, it was a good example of how the group was used to generate cross-institutional links. While such networks have been associated with the development of shared cognition through socialization, interaction, knowledge sharing and experience (Addicott et al., 2006), this was not directly emphasized. However, that is not to imply that it did not occur as a result of the functions described above.

Conclusion

This research is concerned with how service-improvement change processes are implemented through people who act within constraints. The specific purpose of this chapter was to describe, analyse and explain the research findings pertaining to the first research question:

> *Who holds change-related roles, how are they enacted in and affected by role-related constraints and what works effectively?'*

In so doing, it has outlined the actors who take responsibility for the initiation and implementation of service-improvement. Across the public and voluntary hospitals consultants and clinical managers are central, with clinical managers and an innovative departmental management and quality management role evident in the private hospital. The pattern of initiation and implementation differed markedly in the private hospital, with no role

for the consultant in service improvement. This hospital was also the only case in which roles had an explicit rather than extra-discretionary focus on service improvement as opposed to service delivery. It was also the only case in which a general manager, the CSM, was identified as having a practical involvement in service improvement.

The absence of general managers from the findings is potentially significant, as is the finding that service improvement tended to be led by individuals rather than groups. In exploring top-down rather than bottom-up change, different levels of proactive monitoring was the most significant difference evident, an issue further explored in chapter 9. In exploring the differences between those involved in initiating and implementing service improvement across the cases, iterative analysis led to the identification of role structures and the role adopted by the consultant as a role-related constraint on clinical managers in enacting their roles, and particularly on their degree of autonomy and the degree of multi-disciplinary engagement. While previous research emphasized overcoming social and cognitive boundaries to facilitate the spread of change, this research raises the benefits of focusing on organisation and role structures as well as individuals in the facilitation of bottom-up change. Crucially the innovative and devolved role structures presented in the private hospital case bypass the traditional leadership role of the consultant and have potentially far-reaching implications for the implementation of bottom-up change in healthcare. However, the partial devolution of responsibility for departmental management and service improvement to departmental heads in the strategy, evident in the public hospital, was identified as more desirable from a relationship-building perspective. Relationship building played an important role in the findings, with the majority of service improvement implemented in silo form by isolated individuals liaising with a limited number of actors.

Further consideration of clinical managers as key agents in change led to the identification of a stratified group with representation from consultants, AHPs and nurses. In addition to background, clinical managers are differentiated by their level in the organisation, correlated to their level of pro-activity and strategic orientation. Specifically, non-consultant clinical managers have a predominantly operational focus, operate at low organisational levels, and, in spite of their pivotal role in service-improvement, could be used more effectively in Ireland. Finally, the chapter considered the potential for networks to support the implementation of change. The regional implementation structures for the cardiovascular strategy provided significant impetus to the initiation and implementation of both policy-led and bottom-up change, and could provide a future model to assist both top-down and bottom-up initiatives.

This chapter draws attention to the fragility of implementation structures for service improvement in the public and voluntary hospitals. In these contexts there is no single individual with responsibility for service improvement. It is difficult at all stages of the change process to identify who is ultimately responsible in all but private hospital. In a related vein is the question of where service-improvement knowledge lies. If, as in the voluntary and public hospitals the knowledge is very concentrated, then improvement is fragile if anything happens to the individual who holds the service-improvement information. Buchanan (2003) alluded to this issue, which is highly salient in the Irish context. In the ensuing chapter, attention turns to additional factors at the organisation level that facilitate and hinder the implementation of service-improvement change.

Chapter 9: Capacity and climate for change: Identifying facilitating and hindering factors beyond role-level

This thesis aims to answer three research questions. Chapter 8 addressed the first research question, which asked who holds change-related roles, how such roles are enacted in and affected by role-related constraints and what works effectively. This chapter addresses the second research question, which aims to identify the contextual factors beyond role level that facilitate or hinder the implementation of service–improvement change. In addition, similarly to chapter 8, this chapter addresses the third research question, which asks whether there are systematic differences between the voluntary, public and private hospital in the research findings. Hence this chapter is concerned with the contextual factors that constrain or enable service-improvement change processes. The specific purpose of this chapter is to describe, analyse and explain the research findings pertaining to the second research question:

> *What contextual factors beyond role level facilitate or hinder the implementation of service –improvement change?*

The findings presented are predominantly focused at the organisation level, although some organisational-level constraints are ultimately determined by environmental factors. Hence, the findings describe, analyse and explain the organisational and environmental-level factors that constrain and facilitate individuals as they initiate and undertake service improvements. In comparing the findings across the cases, the chapter also addresses the third research question about the existence of systematic differences across the three cases. The data presented is primarily drawn from analysis of responses to interview questions. However, during analysis, responses were cross-referenced with observational notes and secondary data.

Information regarding the factors facilitating and hindering individuals in their service-improvement endeavours was primarily derived from questions sixteen and seventeen on the interview schedule (see Appendix 3), which explored the implementation of specific changes, or tracer issues, with respondents. As outlined in chapter 6, this data was used to develop narratives of the changes in which respondents were involved, including the issues they encountered. Where issues and positive experiences were mentioned during interviews, respondents were probed to generate additional data. In addition, questions fifteen, eighteen and nineteen further facilitated exploration of hindering and facilitating factors. Question fifteen asked respondents to reflect on changes to role, organisation or other factors, that would allow them to perform their roles more effectively. Question eighteen asked respondents to think of any changes recommended under the cardiovascular strategy, or in

which they were involved that were difficult to implement or that failed to be implemented and why. Finally, question nineteen asked respondents what they would do differently in hindsight, and many respondents used this question to comment on the constraints encountered by them. In addition, analysis drew upon factors present in the literature that were not mentioned by respondents as either hindering or facilitating change.

The findings are presented in four separate sections, three of which build on each other. As in chapter 8, findings in each section are initially presented on a case-by-case basis followed by an overarching analysis and comparison across the cases. Similarly, to conclude each section findings are compared with the UK, which, although a different context, does provide a benchmark of experience. The findings are also compared with the themes raised in the broader literature review, and particularly those described in chapter 4.

The chapter addresses four subjects. The first subject, addressed in Section 9.1, pertains to the *desired* and *actual* role of the HR function, as well as the delivery mechanisms for HR services in Irish hospitals. This role is considered despite the marked absence of HR from the responses of respondents in all sites, and in spite of the identification of change-management facilitation as a primary role for HR (CIPD HR Survey Report, in Francis et al., 2006). The absence of HR from interview responses is consistent with previous critiques regarding the underperformance of the HR function in hospitals in Ireland (National Health Strategy Consultative Forum, 2001) and the UK (Fitzgerald et al., 2006b). The second topic, presented in Section 9.2, considers two inter-related constraints on service-improvement processes which, for the public and voluntary hospital, are determined at the environmental level. The desired and actual role of the service-planning and accounting systems in the public and voluntary hospital are delineated and discussed, and contrasted with the private-sector approach to finance, service planning and accounting systems in the private hospital.

The third subject considered, in Section 9.3, is a significant contribution of the thesis. This section describes and analyses the interaction between governance, accounting and service-planning systems and explains their effect on the capacity for change at the organisation level. Capacity for service improvement and change refers to how the prevailing set of conditions affects the ability of the organisation to initiate and implement service improvement. To conclude, Section 9.4 presents the configuration of factors affecting the climate for change in Irish hospitals. The climate for change refers to the motivation for exercising the available capacity for service improvement in an organisation. The climate for change is discussed with reference to the capacity for change, although the two are not directly correlated. The climate for change across the cases is affected by levels of strategic

distraction, senior-management support and the role structures in place. Hence, this section brings together findings from chapters 7, 8 and 9, to present a configurational finding. Hence, Section 9.4 integrates the major organisation and environmental-level findings regarding the factors facilitating and hindering service improvement, presented in Sections 9.2 and 9.3, with the role-related constraints on service-improvement, identified and discussed in Section 8.2, and the governance systems and levels of strategic distraction detailed in chapter 7.

The first topic addressed in the chapter – that of the desired and actual role of the HR function – is discussed in Section 9.1.

Section 9.1 The role of the HR function

The role of HR is not understood in the health service. The role I was used to serving in other organisations is not at all the same as what I would expect.

– HR Manager, Public Hospital

Data regarding the HR function was gathered from questions ten, twelve, thirteen, fifteen, sixteen, seventeen, eighteen and nineteen of the interview schedule (see Appendix 3). In addition, a search across all responses was undertaken for any mention of HR practices or service-delivery, the HR department or the role of the HR function. Crucially, the HR function was *not* identified as a supporting or facilitating factor in service improvement by any non-HR respondent across the three cases. In addition, there was a marked absence of *any* reference to the role of the HR function among non-managerial respondents, with the exception of the medical director in the public hospital. This contrasts significantly with the prior identification of HR as providing a key supporting role in change in other contexts (Stace & Dunphy, 1991). In the light of Fitzgerald et al.'s (2006b) similar findings in the NHS, the limited role of the HR function in hospitals is an issue meriting further exploration. Specifically, Fitzgerald et al. found that HR specialists in the NHS did not facilitate change and that the HR function is overly distanced from the clinical workforce in that context. As a result, this section considers the perceived, desired and actual role of the HR function across the three cases, as well as the structures through which HR is delivered. To further understand the cause of the discrepancy between the desired and actual role of the HR function, and the limited perception of the value-added by HR across organizational levels, the challenges encountered by the function are outlined. These concerns are initially described and discussed on a case-by-case basis, with an aggregate cross-case analysis subsequently presented.

9.1.1 The role of the HR function in the voluntary hospital

This section discusses the perceived, desired and actual role of the HR function in the voluntary hospital, as well as issues encountered and the delivery mechanisms in place.

- **The perceived role**

In analysing the perceived role of the HR function in the voluntary hospital, the most distinguishing attribute of responses was the absence of *any* non-managerial references to the HR function. However, reference was made to the function by three members of the senior-management team; the deputy CEO, the director of nursing and the director of finance. Significantly, all three emphasized the positive relationship between the senior-management team and the HR function. In addition, the director of nursing emphasized the progress being made in improving the role and impact of the function. The desired role for the function is further explored below.

> *I met with the Director of HR and we identified where the gaps were ... and we've made huge inroads into introducing policies procedure, best practice in the HR, training conflict management, negotiating.* (Director of Nursing, Voluntary Hospital)

- **The desired role**

In the voluntary hospital senior management desired a strategic orientation for the HR function. This was being proactively pursued through ongoing departmental restructuring, which had begun in 2005 after the appointment of a new director of HR in late 2004. The 2005 annual report noted that *'this role is intended to assume a new strategic importance'*, with the appointment perceived as an opportunity to move away from a personnel type model, towards a more strategic orientation (Director of HR, Voluntary Hospital).

> *There has been a commitment to using [HR] with a particular focus historically and now there's certainly a renewed commitment on the part of senior management here to see it play a broader and more prominent role with line managers out there and in terms of its sphere of influence.* (HR Director, Voluntary Hospital)

The new, and as yet incomplete structure for the HR function entailed a move to a more devolved structure and the incorporation of responsibility for the management of *all* staff into the HR function because historically medical and nursing administration was located outside of the HR function.

The first development, the move to a '*more devolved model for HR, as opposed to what might have been a greater sense of control*' (Director of HR, voluntary hospital) entailed passing responsibility for some operational-type tasks to line managers. The second development,

that of establishing a unified HR function with responsibility for the management of all staff, involved a change from the historical structure of workforce management in the hospital. Previously, workforce management was divided between three separate departments; the HR/personnel department, Medical Administration and Nursing HR. Medical administration was historically separate, with a loose reporting relationship to HR. Nursing HR was led by a senior nurse manager who reported to the director of nursing. In effect, this meant that the HR function did not deal with nursing or medical staffing. The vision for the new HR department contrasted significantly with the pre-existing fragmented structure. It was described by the HR director as follows;

> *The vision at the outset was that we wanted a unified HR function rather than having a separateness there and we were looking to have consistency and uniformity in terms of how the business was being done in things as straightforward as policies and procedures.* (HR Director, Voluntary Hospital)

The restructuring of the HR department entailed the establishment of five new divisions, each with a division head. A sixth division was also under construction at the time of data collection. The five divisions were (1) Resourcing and retention, (2) HR Services, (3) Learning and Development, (4) Employee Relations, and (5) Nursing HR, with the restructuring of (6) Medical HR underway. The role of medical administration was being broadened to include HR as well as an administrative component.

- **The actual role and delivery of HR**

Hence, the actual role of the HR function in the voluntary hospital was in flux, with an ongoing attempt to move from an operational to a strategic orientation, and to envelop the management of all workers in the same functional unit. The change in focus occurred at the time of several appointments at the senior-management level, including the director of HR, the director of nursing and the director of ICT. The simultaneous appointment of these individuals provided a significant opportunity for renewal, as how the roles knit together was open to influence at that time.

In addition, two specific HR roles, both pertaining to employee relations, were identified by the HR director. The first entailed the implementation of a partnership[4]. This was formally in operation in the hospital since 2001, involving management, staff and unions. The director of HR also saw the function as supporting the implementation of larger-scale changes, by managing industrial-relations issues:

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[4] Partnership refers to joint consultation between employers, employees and potentially unions to achieve joint goals. It implies a commitment to a longer-term relationship and is a particular approach to industrial relations Boyle, R. 1998. ***Partnership at the organisation level***. Dublin: Institute of Public Administration.

> *There had been a strong consultative and partnership type approach taken in trying to get people on board. Then finally the industrial relations bit came into play which was well what's in it for the staff in terms of some inducement and they by virtue of what was happening for other staff.* (HR Director, Voluntary Hospital)

While the HR department was focused on achieving a strategic orientation, and the new model had received *'absolute commitment'* from senior management, the HR director noted that achieving a strategic orientation was unlikely due to the nature of healthcare service. This has previously been characterized as complex, professional, knowledge-based (Fitzgerald et al., 200b) and pluralistic (Bate, 2000).

> *Certainly I think we can all talk about trying to move towards that [strategic orientation] but at the end of the day there's, by virtue of the service, even people at a senior level are going to find themselves very into the operational end of things.* (Director of HR, Voluntary Hospital)

Hence, while the HR department in the voluntary hospital was attempting to move towards a strategic orientation, the director of the function had limited expectations regarding the potential success of this process. Nonetheless, the function was moving towards a unified structure, incorporating responsibility for HR, for all staff. With regards to the role of HR in service improvement and change, the only perceived role was for HR to address any potential or actual industrial-relations issues arising.

HR in the voluntary hospital was delivered through a variety of mechanisms, at different levels. Strategic development was undertaken by the director of HR in conjunction with the senior-management team. At the managerial level, the HR function took responsibility for liaising with unions. Finally, at the operational level, responsibility for operational HR had traditionally been delegated to departmental heads. However there was some perception that operational responsibilities were becoming increasingly centralised through the restructuring process. This was an interesting finding as the move towards centralisation suggests a personnel-management focus, while the attempt to attain a strategic orientation is more consistent with a human resource management model.

> *And then what happened then this year is that you're getting memos out around the hospital saying that CNM2's can't sign off holiday sheets or they can't sign off maybe sick leave and stuff like that, it has to go to a further level, up to a higher level. ... I've done it for fifteen years.* (CNM2, Voluntary Hospital)

Attention now turns to the perceived and actual role of the HR function in the public hospital, as well as the challenges encountered in that context. Unlike the public hospital, the HR

function in the public hospital was referred to by a non-managerial respondent, albeit in an unflattering manner.

9.1.2 The role of the HR function in the public hospital

> *HR is a toilet. Anything they don't want to handle 'Send it over to HR and it'll disappear.' This is the tradition of the health service. So we're always the baddy.*
> – HR Manager, Public Hospital

- **The perceived role**

In the public hospital, HR was absent from the responses of non-managers, with the exception of the medical director. This indicates that it was not providing support to those identified as most central to service-improvement activities in chapter 8. Among the managers, HR was discussed by the assistant director of nursing, finance director and general manager, as well as by the HR manager himself. With the exception of the assistant director of nursing, who desired better integration with the department, more unanimity on shared goals and greater physical proximity, there was little even implied perception of value-added by the function or potential in this regards.

> *[HR] should be there beside me, working with me, as opposed to them over there and I here. ... I think the HR department and all these areas need to be integrated more.* (Assistant Director of Nursing, Public Hospital)

In fact, most respondents were critical of the HR function. The finance director asserted that HR failed to pro-actively support organisational functioning, adopting the stance that if nothing is undertaken, the department can't be blamed for things going wrong. Similarly, two managers suggested that HR tends to engage others in their work without quid pro quo;

> *I'm doing some of [HR's] work and they are doing, well they are not doing mine (laughing), but you know what I'm saying.* (Assistant Director of Nursing, Public Hospital)

> *I have noticed a tendency for a lot of HR and personnel functions to devolve to the medical directorate. And I have a tendency to devolve them back!* (Medical Director, Public Hospital)

Although upon specific questioning regarding the role of the function, the general manager described HR being core to the organisation, they did not mention it of their own accord throughout their interview. *'HR is a very fundamental role. It is one of the core departments'* (General Manager, Public Hospital). The desired role for HR is considered below.

- **The desired role**

Similar to the voluntary hospital, the public hospital aspired towards a strategic orientation for the HR function. However, in the public hospital, constraints of understanding, influence, budgetary control and a poor-quality relationship with the senior-management team precluded this. These are discussed later in this section. To address these issues, the finance director would have preferred for each directorate to have its own HR employee, decreasing the role of the central HR function. The actual role of HR is discussed below.

- **The actual role and delivery of HR**

HR in the public hospital was predominantly delivered through the HR function. Any strategising was led by the HR manager in isolation, due to his poor relationship with the senior-management team. Similar to the voluntary hospital, at the managerial level the HR function took responsibility for liaising with unions. Finally, at the operational level, while the department attempted to devolve responsibility for operational tasks to line-managers, there was some resistance to this in the organisation. This dynamic was identified by the HR manager, and is illustrated in the above quotes from the assistant director of nursing and medical director.

In the public hospital, the HR manager's self-reported role entailed dealing with industrial and employee-relations issues and providing strategic advice to management. However the veracity of the latter feature of his role was challenged by two members of the senior-management team. The remainder of the department was involved in IR, salary administration, pension administration, increments and recruitment. Salaries were dictated centrally but administered locally. Similarly, negotiations were done centrally with the unions on benchmarking for support staff and implemented locally. While the HR department does do a monthly report, it does not get feedback upon this (HR manager). For the HR manager the role of HR is

> *Local, dealing with local small issues. Trying to advise management on local issues. The macro issues tend to be over your head.* (HR Manager, Public Hospital)

The HR manager asserted that he defines his own role because *'direction is loose, or probably non-existent'*. He had queried the vague nature of the job description upon interview (six years previously), but no further clarification was provided. He attributed the lack of clarity regarding his role to a lack of understanding of the role of HR in the health service. This lack of understanding has led to an incongruence between what the HR manager perceives the role of HR to be and how it is actually executed. While he described the role of HR as strategic in relation to change and service planning, he was disenchanted that nothing had

come of the significant time invested in this. This issue is one of several encountered by the HR function in the public hospital.

> *We would have seen ourselves inputting directly into the service plan; strategically suggesting certain things that we felt were important. That did happen, the service plans were done, but literally nothing happened as a result.* (HR Manager, Public Hospital).

- **Issues encountered**

In addition to a lack of return on the investment into strategic planning through the service plan, the HR function encountered three issues. At the environmental level, the primary issue encountered was a lack of understanding regarding the role of HR in the health service, undermining the capacity for HR to adopt a strategic orientation (HR Manager, Public hospital). In addition, the perception of the function was being damaged through a common misperception of HR as the source of issues regarding recruitment, when in fact delays in recruitment were determined by HSE-level processes. At the organisation level, the HR function suffered due to a poor relationship between the HR manager and the remainder of the senior-management team. The presence of a latent issue was not raised by the HR manager, but was supported by two senior managers. Finally, the function suffered from a historical and culturally embedded expectation that the HR function should undertake line-manager responsibilities.

At a strategic level, the HR manager attributed some of the difficulties encountered in achieving his desired role for the function to a lack of understanding of the role of the HR function in the health service. He noted that in the private-hospital sector, which he had experience abroad, the role was much more well defined and well understood. *'The human resource function there would be very defined and the role defined.'* (HR Manager, Public Hospital) In the hospital he described HR as filling a vacuum for issues that management is either unwilling or incapable of dealing with.

> *It's almost like there's certain decisions being made – or not being made – where HR steps into the void.* (HR Manager, Public Hospital.).

Overall the HR manager asserted that while the department aims to be strategic, HR doesn't *'have the clout, if you want to put it that way. It isn't seen as the role, it doesn't happen, literally, and we don't have the budget to drive it. So what I'm doing at the moment is facilitative.'*

At an operational level, the HR manager emphasised the negative impact that issues with recruitment were having on the perception of HR in the organisation. These issues stemmed

from slow responses from the HSE to requests to advertise a position or ratify appointments. Similar delays in responses were experienced in the voluntary hospital, indicating that this issue stems from the HSE-level.

> *It's almost like HR are a nuisance. ... They see it as HR blocking them trying to get people hired. This is a position I've been trying to have advertised for three weeks.* (HR Manager, Public Hospital)

A second operational issue identified by him was the fact that many of the roles of line managers were devolved to HR. This including dealing with absenteeism. The HR manager identified a culture with a historical premise whereby HR undertook all of the responsibilities of the line managers. This frustrated him as he felt that this went beyond the duty of the department.

Hence, the HR function in the public hospital adopted an operational orientation in practice, fulfilling a servicing function. Although, similar to the voluntary hospital, there was a desire to move towards a strategic orientation, barriers to this process were identified. These included a lack of status and lack of understanding of the role of the function, a misplaced perception of HR (rather than HSE processes as a source of delay in recruitment, leading to a loss of goodwill), a poor relationship with the senior-management team and a culture of HR undertaking the duties of line managers, which placed significant strain on available resources. Crucially, and as in the voluntary hospital, no respondents in the public hospital with the exception of the HR manager mentioned HR as a support to change processes or service improvement. Before a cross-case analysis is presented, Section 9.1.2 considers the role and service-delivery structure of the HR function in the private hospital. This differed markedly from the two cases presented to date.

9.1.2 The role of the HR function in the private hospital

In the private hospital, HR was not mentioned by any respondents, with the exception of the CSM and the director of nursing who described its structural position in the organization. There is no specific HR department in the organisation, with responsibility for HR devolved to heads of departments as an operational responsibility. The director of nursing acts in an advisory and consultancy capacity to heads of departments as required.

> *I deal with HR issues in an advisory role because each Head of Department and each manager has a responsibility for HR. They have local autonomy and responsibility and I have an advisory role helping out with policies in an advisory capacity.* (Director of Nursing, Private hospital)

The responsibility of heads of departments for HR and service-planning and development meant that operational HR requirements and issues associated with service improvements were addressed locally, and no issues were reported in this regards.

Crucially, while the delivery of operational HR occurred through heads of departments, supported by the director of nursing, the CEO was strategically aware regarding the management of different workforce groups. While he did not explicitly refer to himself as undertaking HR-related strategising, this was implicit in his responses, and evident in the initiatives he introduced. Among these was the introduction of a liaison role for consultants in the form of the CSM. The director of nursing also adopted a strategic orientation to workforce management, gaining accreditation to run a nursing adaptation programme, a six week programme required by non-Irish-trained nurses prior to their entry to the workforce.

Figure 9.1 provides a summary of the above descriptions, presenting the actual, desired and perceived role of the HR function across the three cases. The Figure is accompanied by a discussion of the classification of the function for each case, according to the potential roles for the HR function identified in chapter 5. In addition, Table 9.1 describes the locus of HR service-delivery across the cases. Cross-case analysis is presented in Section 9.1.4.

9.1.4 Cross case-comparison

The core focus of the HR function, as outlined in chapter 5, is to ensure that service-related issues are effectively addressed by management (Walker, 1992). Hence, this section engages in comparison of the findings across the cases, with regards to the role and delivery of HR. The findings are also discussed with reference to previous research regarding the role of the HR function in service-improvement in healthcare from the UK, and with regards to the broader HR literature.

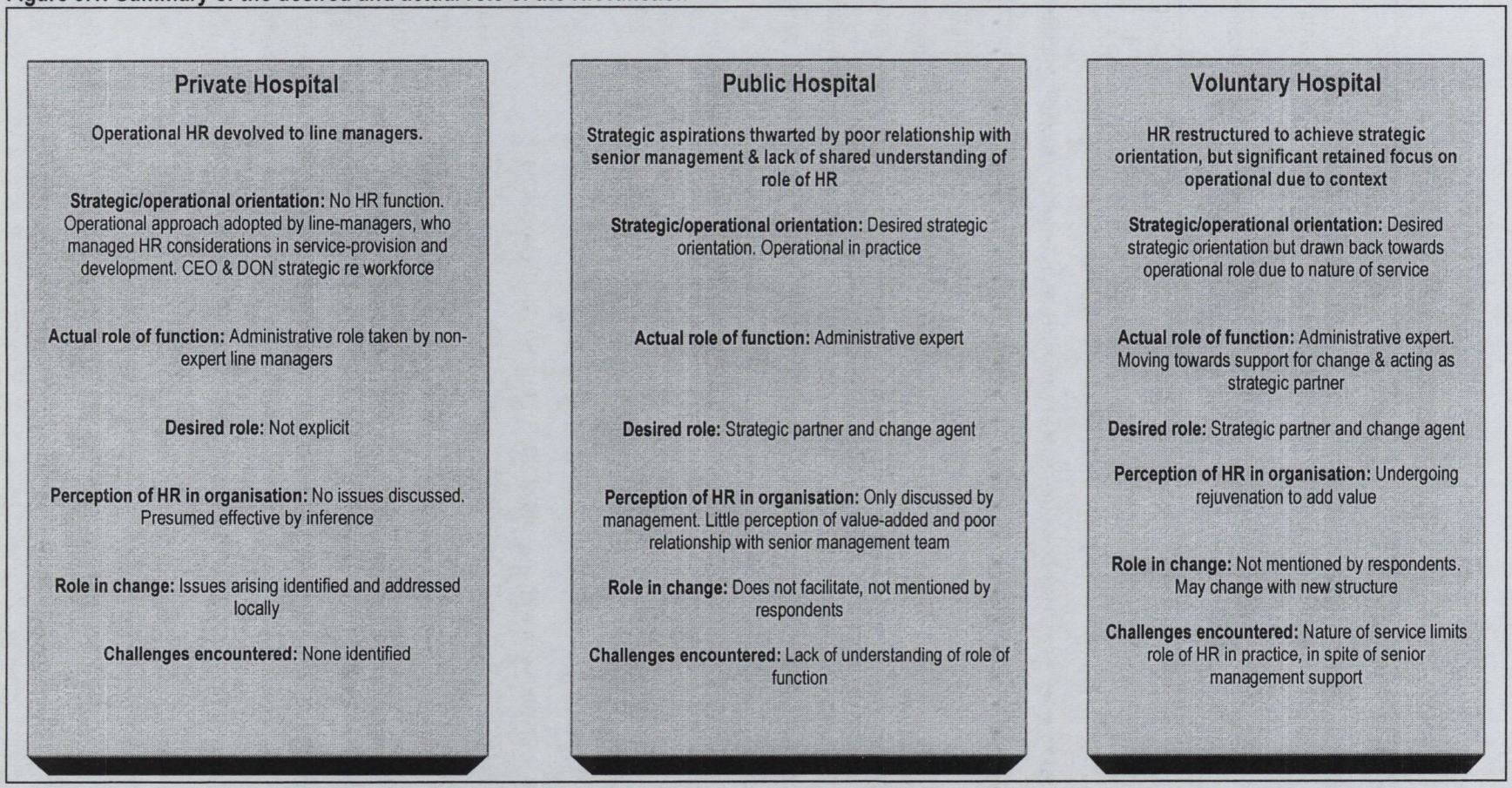
- **Comparison across cases**

In analysing the role of the HR function across the cases, the most significant finding concerns the absence of responses from non-senior-managerial respondents in the public and voluntary hospital. This is a crucial finding as non-senior managers, specifically consultants and clinical managers, were identified as critical actors in the initiation and implementation of service improvement described in chapter 8. Hence, the HR function is not providing support to the central actors involved in the initiation and implementation of service improvement. This key finding suggests a significant deficit in the role of the HR function.

The role undertaken by the HR function in each organisation can be classified according to the four potential HR roles delineated by Ulrich (1997). These are (1) strategic partners; (2) change-agents; (3) administrative experts and; (4) employee champions. Both the voluntary and public hospital aspired towards the strategic-partner and change-agent roles. While the voluntary hospital was restructuring their department to attain this, the HR director in that context was aware of the constraints imposed upon him by the professional nature of the organization. In practice, he anticipated that an operational orientation would remain. Nonetheless, the structure of the HR department, in conjunction with the positive relationship with senior management, facilitated a greater strategic orientation than in the public hospital. In that context, a poor relationship with the senior-management team, and a lack of a coherent vision for the HR function across the managers, led to the adoption of an administrative expert role, rather than achieving the desired strategic-partner or change-agent role . The lack of agreement among senior management over the role of HR in the public hospital was consistent with Bartram et al.'s (2007) finding that CEOs, senior managers and HR managers differ in their perception of strategic HR. In the private hospital, devolution of HR tasks to front-line managers was evident, in line with the trend identified by Francis and Keegan (2006). While this devolution led to an operational orientation, the simultaneous possession of responsibility for the development of their departments and HR by heads of departments meant that the HR implications of service improvements could be directly addressed by line managers. Overall, the focused attempt to gain a strategic orientation in the voluntary hospital contrasts significantly with the marginal operational focus in the public hospitals, and the operational focus in the private hospital. Interestingly, with regards to service improvement, the devolved structure and operational focus in the private hospital worked most effectively. This was due to the responsibility of heads of departments for service improvements and the strategic development of their departments. The locus of HR delivery across the cases is considered in Table 9.1.

The challenges encountered by the HR function were most clearly discussed in the public hospital and were determined at both the environment and organisational levels. The predominant issue in that context was identified as a lack of understanding of the role of the HR function, compounded by a poor relationship between the HR director and senior-management team among other issues. In the voluntary hospital, the issues encountered in adopting a strategic orientation are discussed in the comparison with the broader HR literature, presented below. These issues pertained to the difficulty of adopting a strategic orientation in a complex, professional service firm, in which unconnected strategy-making is

Figure 9.1: Summary of the desired and actual role of the HR function



evident. Nonetheless, in contrast to the public hospital, the HR function in the voluntary hospital was supported through a good relationship with the senior-management team. The differences in the delivery of HR across the cases are presented in Table 9.1.

Table 9.1: The locus of HR delivery across the cases

Level of HR	Voluntary	Public	Private
Operational	Historically provided by Line Managers, but a move towards centralisation was evident	Provided by HR dept, but with attempts to devolve to line managers	Heads of Departments
Management	HR function dealt with unions	HR manager dealt with unions	Not applicable
Strategic	HR director in conjunction with senior-management team	None	CEO and Director of Nursing

Interestingly, as referred to above, the most effective HR service-delivery model for facilitating service improvement was that adopted by the private hospital. In that context the separation of strategic planning and operational service delivery was highly effective. In addition to the effectiveness of service-delivery, the problems encountered in attaining a strategic orientation in the voluntary and public hospital contrast significantly with the successful CEO and director of nursing strategising in the private hospital, particularly regarding workforce segmentation. These findings raise questions regarding the appropriate locus of HR delivery in complex professional service organisations, particularly at strategic and operational level.

Next, attention turns to comparing the findings with the role of the HR function in UK hospitals.

- **Comparison with the role of the HR function in UK hospitals**

The findings regarding the role of HR in health service are in-line with those of Fitzgerald et al. (2006b) and Hyde et al. (2006a), who found the HR function in healthcare to be under-developed and lacking in capacity. Specifically, Fitzgerald et al. (2006b) found that HR specialists rarely had a role in facilitating change, and that there was limited evidence of development processes to support staff in change or other roles. Unfortunately there has been little research regarding the delivery mechanisms for HR in the NHS. Next the role of the HR function and issues encountered in this regard are discussed.

- **Comparison with the broader HR literature**

The lack of a role for HR as a support to service improvement is indicative of its lack of status and power in organisations, a feature previously outlined by Kamoche (1994) and Legge

(1978), but increasingly addressed in corporate settings (Ulrich, 1997). In this research, the lack of leverage afforded to HR, in conjunction with its struggle to provide services beyond the administrative and operational levels, in conjunction with the centralisation of service provision in the public and voluntary hospital, is reminiscent of old-style personnel management. In marked contrast to the aspiration for a strategic partner role for HR in the public and voluntary hospital, the HR functions across the cases could best be described as 'clerical bureaucracies'. An example of the challenge of providing HR in complex professional service firms with multiple workforces was provided in the voluntary hospital's struggle to achieve a strategic orientation. This illustrated that, even with senior-management support, the potential for a strategic approach towards HRM in healthcare is uncertain, due to the complexity of the service, the professional nature of the organization and the difficult of strategizing, particularly in non-private sector hospitals, because of politicization and unconnected strategy-making (McMillan, 2004). Hospitals are not alone in having difficulty in managing professionals. Other professional contexts such as education face similar challenges. However, there remains significant scope for the HR function to support and develop professionals to greater facilitate change.

The second issued raised by the nature of healthcare service is the difficulty of strategy-making and implementation in hospitals. A fundamental issue not articulated by respondents, but raised by McMillan (2004), is that unconnected strategy-making tends to be found in hospitals. In such situations, where individual units have sufficient autonomy to pursue their own strategic change activities without reference to any central vision or plan, a lack of clarity regarding overarching goals emerges. The lack of a clear and overarching organization strategy is, in turn, problematic for any attempt to introduce a strategic HRM function because this aims to support and implement organization strategy. In addition, strategic management in healthcare is complicated by the inefficient allocation of resources due to inappropriate incentives, often linked to politicisation in health services (Maynard, 2005). This undermines management systems by creating a focus on satisfying political or short-term demands at the expense of evidenced-based decision making or longer-term strategy-making. Strategic management, and in turn, strategic HRM can therefore be undermined by political and other distractions. Inefficient and unclear strategizing in healthcare may correlate with the lack of a clear understanding of the role of the HR function in hospitals, and may particularly undermine attempts to implement a strategic approach to human resource management. Greater clarity and autonomy in strategy-making at the organization level may support the development of a clearer role for HRM, particularly in moving it away from the administrative expert and employee champion roles, towards the strategic partner and change-agent

functions. Currently, however, the difficulties associated with strategy-making in hospitals undermine attempts to move towards a strategic HRM orientation.

Hospitals are dependent on the implementation of the strategy by front-line staff, supported by operational and senior management. Training across all of these levels and the facilitation of relationships between them could be of benefit to change initiatives. However such roles were not being undertaken in any of the cases examined in this research. Generating the capability of individuals is a promising avenue to improve the contribution of the HR function to strategy implementation and service improvement. Should the above issues fail to be addressed, the separation of HR strategising and service-provision, as in the private hospital, may provide a promising alternative for organisations. Next, Section 9.2 moves to consider the constraints imposed by the accounting and service-planning functions as a precursor to considering the configurations of factors affecting motivation to change at the organization level.

Section 9.2 Service planning and accounting systems

Similar to the data on the HR function, data regarding service planning and accounting systems were gathered from questions ten, twelve, thirteen, fifteen, sixteen, seventeen, eighteen and nineteen of the interview schedule (see Appendix 3). In addition, a search across all responses was undertaken for any mention of service-planning or accounting systems. Discussion of service-planning and accounting systems was particularly prevalent in responses to question fifteen, which asked respondents to discuss three changes which would make their roles more effective.

As in Section 9.1, this section outlines the desired and actual role of service-planning and accounting systems on a case-by-case basis before engaging in a cross-case analysis and comparison. The cross-case comparison emphasises the significant difference in the private hospital's approach to finance, accounting and service-planning. Interestingly, neither service-planning nor accounting issues were raised in the research, which has been partially replicated in this thesis. As a result, the separate comparison with UK-based research evident in other sections is not undertaken for this topic. However, comparison with the broader literature is undertaken. Interestingly, unlike the case of the HR function, where there was a clear desire across the public and voluntary hospital to move towards a specific orientation to HR, the desired role for accounting and service-planning systems was defined in relation to their perceived failures. As a result, the desired roles of the accounting and service-planning functions, defined in relation to their perceived failures are delineated, prior to outlining the

actual role of these structures in practice. Concerns raised include (1) the need to plan for depreciation; (2) the emphasis within the system on money being spent properly rather than effectively; (3) the lack of standardisation in costing systems across organisations; and (4) the lack of integration between the service plan submitted to the HSE and the actual financial allocation made to the organisation. In the first instance, the desired and actual role of the service-planning and accounting systems in the voluntary hospital is discussed.

9.2.1 The role of service-planning and accounting systems in the voluntary hospital

In the voluntary hospital the two issues encountered with regards to service-planning and accounting systems both interfered with the desire for efficient strategic planning to ensure the effective allocation of resources. The specific issues encountered were the inability to plan for depreciation and the diminutive annual planning cycle. These issues were predominantly raised at the senior-management level (Director of Finance, DCEO, General Services Manager). However, depreciation was also discussed by the Lead Consultant Cardiologist.

Interestingly, the desire and need to plan for depreciation was strongly articulated across both the public and voluntary hospital. The failure to depreciate plant and equipment was identified by the lead consultant cardiologist as the single largest flaw in the health service:

> *The biggest single flaw in the Irish health service has been the failure of the state to depreciate public property. ... It's the reason that our hospital plants are so dated and inadequate. It's the reason we have MRSA. Because we can't replace and refurbish the wards and the equipment and the hygienic facilities to modern standards, because we don't depreciate. No industry would survive doing that.* (Lead Consultant Cardiologist, Voluntary hospital)

As a result of this system, equipment must actually cease working or become dangerous to use before an application to replace it can be made:

> *I mean it's a serious flaw in the system that you cannot provide for the replacements to your equipment and have it as an allowable expense in your account. Because then you could plan your replacements and do it on a logical basis, but it doesn't work like that at all. We apply every year for the funds we need, and we sometimes have to make the decisions to actually just buy the equipment and go on hoping that at the end of the year we'll get a capital grant to cover it.* (Director of Finance, Voluntary hospital)

However, introducing an equipment depreciation budget would require a change at the environmental level, as this is determined by the HSE-level service-planning and accounting systems. The issue was identified as

> *A HSE and Government issue, you know. Because they would clearly have a problem immediately, probably on a cash-flow basis, if they brought it in. You would have these charges and the accounts would suddenly take a dive.* (Director of Finance, Voluntary hospital).

As a caveat, the director of finance in the voluntary hospital noted that while the issue should be addressed, some savings are incurred by the current system. He explained this saving through the fact that *'some equipment will last and there'll be nothing wrong with it'.* In contrast, taking account of depreciation in accounts leads to the planned replacement of equipment, which can occur even if the equipment is in safe working order.

The second issue identified by respondents in the voluntary hospital was the overly-tight nature of the budgeting and service-planning cycle. The director of finance and general services manager (Voluntary Hospital) noted that extending the budgeting and service-planning cycle would allow more logical planning and greater efficiencies in capital expenditure. It would also have positive implications for the horizon of strategic planning, with continuing effects for the HR-function capacity to support service improvement and change, as outlined in Section 9.1.4

> *Funding comes in one-off bundles but you're not thinking strategically about the physical building and there's a huge impact on how good the quality of the services are. (General services manager, Voluntary hospital)*

In terms of the actual role of accounting and service-planning systems in the voluntary hospital, the director of finance had a greater degree of strategic awareness about service developments and the role of the finance function than his counterpart in the public hospital. This may have been due to the former's participation at the board level. For example, in outlining how service development occurs, the director of finance in the voluntary hospital noted that some services develop in an organic or unplanned manner, aligned to changes in medical practice, expertise or available medication. Decisions to support such service-developments are based both on the efficacy of the service and a strategic decision at the organisation level regarding whether the organisation should be taking a lead in this area. As there tends not to be specific funding for such development, a secondary decision is made regarding whether to apply for funding in arrears.

The desired and actual role of the service-planning and accounting functions in the public hospital are delineated in Section 9.2.2.

9.2.2 The role of service-planning and accounting systems in the public hospital

As in the voluntary hospital, the desired role and content of service-planning and accounting systems in the voluntary hospital was defined in relation to perceived issues. At the organisation level, there was a desire for devolved budgeting among some clinical managers and senior managers. Further issues, linked to environmental-level constraints included the desire for planned depreciation, a more efficient model for the management of capital expenditure, a move away from emphasis on spending money properly towards an emphasis on spending money efficiently, a desire for standardisation in costing situations and ameliorating the perceived under-emphasis on the balance sheet. However, the latter issue was contested by the director of finance in the voluntary hospital.

At the organisation level, the medical director, director of nursing, HR manager and two CNM2s affirmed their desire for devolved budgeting. This was presented as desirable from an efficiency and equity perspective. The argument for efficiency was premised on awareness of local needs. Issues that affect the organization but which need to be addressed at environmental level are discussed below. The first issue raised was the need to plan for depreciation, which was strongly articulated across both the public and voluntary hospital.

> *We don't have an equipment depreciation budget. So when something is on its last legs, every time it happens, it's a crisis. There's no planning.* (Medical Director, Public Hopsital).

The second issue raised at the environmental level concerned the emphasis on money being spent properly rather than effectively. The director of finance in the public hospital attributed this to the fact that *'people within the finance function have more of a stewardship role than a strategic role'.* This ineffective use of resources is exacerbated by the HSE, who continually gives grants at year end when money becomes available, due to under-spending by another department (Director of Finance, Medical Director, Public Hospital). This money is provided with a limited window for spending. While the hospitals attempt to manage this efficiently, the emphasis on spending the money quickly means that those who receive it are not necessarily those with the most acute need. This issue was raised by both the public and voluntary hospitals (Medical Director, Director of Finance, Public Hospital, General Services Manager, Director of Finance, Voluntary Hospital). One way to ameliorate this and other general inefficiencies in service planning, would be to extend the duration of the budgeting and service-planning cycle. The director of finance and general services manager (Voluntary Hospital) noted that this would allow more logical planning and greater efficiencies regarding capital expenditure.

The third issue raised at the environmental level pertains to the lack of standardisation in costing systems across organizations. For the director of finance in the public hospital, costing is an area in healthcare in Ireland that has been poorly developed and is not standardised. As hospitals in the region use different costing systems, funding allocations are therefore awarded on the basis of incomparable returns. For him, *'in order to compare like with like across the border, there really is some need for standardisation in accounting systems.'* This situation has negative implications for equity in funding decisions. A second issue raised regarding the HSE accounting system pertains to a perceived under-emphasis on the balance sheet in the hospital accounting systems in Ireland. *'We are not managing the situation when we are not managing the balance sheet, because the balance sheet is one of the true indicators as to how you are performing; what is the return on your investment?'* (Director of Finance, Public Hospital). However this assertion was contested by the director of finance in the voluntary hospital.

Finally, the director of HR in the public hospital raised concern regarding the lack of integration between the service plan submitted to the HSE and the actual financial allocation made to the organisation. He attributed this to a system-level failure.

With regards to the actual, rather than desired role of accounting and service-planning systems in the public hospital, the director of finance adopted an operational and accounting-focused, rather than strategic, orientation. He identified his main role being to keep the books balanced and ensure that everything is in order for an audit. He also co-ordinates service planning. A service-plan is completed and submitted to the HSE on an annual basis. Based on this, an annual budget is allocated for service provision and equipment. When a new piece of equipment is required, staff '*write an account of what is wrong with what you have and why you need something new.'* (CNM2 CCU, Public Hospital). The CNM2 CCU noted that there is flexibility within the system to substitute items desired prior to their being purchased.

Section 9.2.3 outlines the marked contrast in the private hospital's approach to finance, service-planning and accounting systems, relative to the stewardship orientation in the public hospital and the somewhat more strategic orientation in the voluntary hospital.

9.2.3 The role of service-planning and accounting systems in the private hospital

The great thing about working in the independent sector is decisions are made very quickly. It's very clear; you look at clinical need and business cases and it's not as complicated. There's not as many stakeholders and there's not as much jumping through hoops.

– Director of Nursing, Private Hospital

While the desired and actual role of the service-planning and accounting systems in the public and voluntary hospital were defined in relation to their perceived failures and deficits, respondents in the private hospital emphasised the improvement, efficiency and clarity of criteria associated with the business model in getting things done (CSM, QM, Consultant Cardiologist 2, Director of Nursing, Consultant Cardiac Surgeon). These benefits are discussed below. The business model adopted for service planning and accounting is premised on the generation of business cases, to evaluate the clinical need and potential return from a specific initiative. The CSM linked the ease of getting things done to the clarity of the criteria for evaluating proposals.

> *It's kind of easy to get things done here. Basically it's very yes and no; we know the protocol for things if you want something. You know business cases have to be done up, and you have to make arguments and there has to be a return on investment. So you know going to the board, if you are putting a paper to the board, whether it will get passed or not.* (CSM, Private Hospital)

This model operates outside the yearly planning cycle of the public and voluntary hospitals and is not influenced by the political or union imperatives they have to manage (CEO, Private Hospital). Interestingly, the only issue encountered in service-planning and accounting systems was the continuing impact of the constraints placed on public organisations (CEO, Private Hospital). For example, due to the yearly budgeting cycle in public hospitals, when the private hospital offered a deal to reduce the price for a particular scan on the basis of a multi-year contract, only one organisation agreed.

> *So basically they're continuing to pay a premium price for the product, the rack rate for the product, because they can't commit themselves to anything more than a year. Because the government thinks only in terms of year to year contracts and it is these sorts of anomalies that I struggle with.* (CEO, Private Hospital)

The perceived efficiency and service improvement associated with the business model are discussed below.

Efficiency in getting things done: Based on his experience across the public, voluntary and private sector, the consultant cardiologist noted that it is much easier to achieve change in the private hospital sector. Upon questioning whether this was linked to lesser levels of hierarchy

or bureaucracy, he noted that, in fact, the key issue was the existence of a competitive environment, which provides an impetus for change;

> *The basic thing is that you have a competitive environment in the private sector and it's in the interest of the hospital and everybody to move forward and do things better and try to cultivate a decent service. The public sector is totally stagnated and the objective is to maintain the status quo and do as little as possible.* (Consultant cardiologist, Private Hospital)

Similarly the consultant cardiac surgeon emphasised the efficiency associated with the business model. He noted that it is

> *far more efficient, because you could sit down with [CEO] or [CEO in a private hospital elsewhere] and you could say 'Look, we have a plan here'. And if the thing made sense from a business point of view it got done very quickly. Whereas you could be at it for years in the public hospitals and get nowhere.* (Consultant Cardiac Surgeon, Private Hospital)

For the consultant cardiologist

> *probably the advantage to working in the private sector is that you actually get work done.* (Consultant cardiologist, Private Hospital).

Service-improvement: The consultant cardiologist also linked the business orientation to higher levels of service improvement in the private sector. This was supported by the radiography manager in the private hospital, who asserted that in the public sector *'one hospital won't actually step out of line'*. Relatedly, in terms of making a case for a service improvement, the CSM noted that working in the private sector allows a level of access to the board and other members of senior management that would be unlikely to occur in the public sector.

> *The exposure that you get in the private hospitals to everybody; it's not as tiered as it would be in the public. (CSM, Private Hospital)*

Having described the markedly different experience of accounting and service-planning systems in the private hospital, Section 9.2.4 systematically analyses the differences across the cases.

9.2.4 Cross-case comparison of the role of service-planning and accounting systems

Interestingly, unlike the case of the HR function, where there was a clear desire across the public and voluntary hospital to move towards a specific orientation to HR, the desired role for accounting and service-planning systems in the public and voluntary hospital was defined in

relation to its perceived failures. In both the public and voluntary hospitals the concerns articulated regarding accounting and service-planning systems spanned organisation and environment levels. Most organization-level priorities were determined by environmental factors, in particular the accounting, depreciation and service-planning structures outlined by the HSE and Department of Health and Children. At the organisational level, the desire for devolved budgeting was also raised. More specifically, concerns included (1) the need to plan for depreciation, (2) the emphasis within the system on money being spent properly rather than effectively, (3) the lack of standardisation in costing systems across organisations, and (4) the lack of integration between the service plan submitted to the HSE and the actual financial allocation made to the organisation. Relative to the private hospital, the accounting and service-planning systems in the public and voluntary hospital really constrained service-improvement capacity, related to issues of bureaucracy and hierarchy. However potentially more significant were overarching issues regarding the capacity and autonomy to approve service improvements not included in service plans and outside of the normal planning cycle. One interesting contrast to emerge between the voluntary hospital and the private hospital was the explicit distancing of the organisation from a business model in the voluntary hospital, compared to the explicit focus on this within the private hospital. In describing the role of the finance function within the voluntary hospital, the director of finance noted that

> *A health provider is an entirely different organisation to a commercial firm and financial issues very often are secondary. ... And how you manage expense and all that goes with it are entirely based on the patient's need, rather than any commercial decision.* (Director of Finance, Voluntary Hospital)

This contrasts strongly with the perspective adopted in the private hospital:

> *Because it was a commercial opportunity for us, we've made huge changes to our cardiology services.* (CEO, Private Hospital)

The commercial orientation in the private hospital led to a situation whereby initiatives meeting business criteria are quickly implemented, regardless of the service-planning cycle. The director of nursing and two consultants emphasised the efficiency associated with this. The different orientation to finance in the private hospital is underscored by the aims of the board and independence in finance systems. Lower levels of bureaucracy in the private hospital were also related to increased efficiency in the private sector by the consultant cardiologist, CSM, QM and head of finance in the private hospital:

> *I can bring about change much more effectively in the sense that it is not bureaucratic.* (QM, Private Hospital)

> *In comparison to the public hospitals etc there's very little bureaucracy, and I think, very little hierarchy. To me you get things through quicker.* (Head of Finance, Private Hospital)

Based on his experience across the three sectors, the consultant cardiologist in the private hospital asserted that outside of the private sector, it was quite difficult to effect change.

> *You can't get them done. No. [pause] Fullstop.* (Consultant cardiologist, Private Hospital).

The issues raised in the cross-case comparison, which are similar across the voluntary and public hospital but markedly different between those organisations and the private hospital, are explored with regards to the broader literature in the ensuing section.

- **Comparison with the broader literature**

The themes raised across the public and voluntary hospital include those formally identified but not yet addressed in the Irish health service and outlined in chapter 4. These themes include the failure to relate budgets to output, variations in accounting practices within and between regions (Robbins, 2004), the annual budgeting cycle (Byrne, 2006; Hyndman et al, 2003), and the failure to reward or facilitate the efficient use of resources. However, these features have not previously been related to service-improvement endeavours. Recommendations to address these issues are presented in chapter 10.

The next substantive section, Section 9.3, builds on the findings of this section, to consider how service-planning and accounting systems act in configuration with levels of strategic distraction and governance systems, to affect the capacity for change at the organisational level, across the cases.

Section 9.3: Capacity for service-improvement change: The configurational effect of accounting, service-planning and governance systems

This section discusses the capacity for service-improvement change within and across the three cases. Capacity for change refers to how the prevailing set of conditions affects the ability of the organisation to initiate and implement both top-down and bottom-up service-improvement initiatives. This subject is further developed in Section 9.4, which discusses the climate for change across the cases. The climate for change refers to the level of motivation or support for change in the organisation. While capacity is affected by the configurational influence of accounting, service-planning and governance systems, the climate for change is

affected by the level of capacity, which acts in configuration with levels of strategic distraction, senior-management support and role structures.

This section describes and explains differences in the capacity for the initiation and implementation of service improvement across the three cases. These differences are explained with reference to the constraints imposed by the accounting and service-planning systems described above, which act in conjunction with governance systems to affect the capacity for change. As a reminder regarding accounting and service-planning systems, the lack of depreciation of plant and equipment was raised as an important issue in both the public (Head of Finance, Consultant, Medical director) and voluntary hospitals (Lead consultant, Consultant, Head of Finance, DCEO). The issue stems from system-level structures and undermines the organisations' capacity to plan in the longer term. Further implications include distraction from day-to-day service provision and bottom-up change. These complications are exacerbated by poor service-planning systems in the public and voluntary hospitals.

Key issues encountered with regards to service-planning systems included the desire for longer planning horizons, considering organizational input so that funding is provided in line with local priorities, and clarity regarding criteria for implementing change. In addition, planning for service improvement is precluded in the voluntary and public hospitals by the failure to receive the letter of determination outlining the level of funding provided for a particular operating year until the third quarter of that year. This precludes service-development planning due to uncertainty regarding available funds. This is exacerbated by the yearly nature of the planning and funding cycle. The yearly cycle also leads to recurrent problems in the distribution of funding, particularly where funds become available at year end with a limited window for spending. This leads to inequitable distribution, as it is not necessarily those most in need who receive funding but rather those who are most organised. One way to ameliorate this and other general inefficiencies in service planning, would be to extend the duration of the budgeting and service-planning cycle. The capacity of the public and voluntary hospital to engage in service improvement was strongly constrained by these issues.

The interaction between the factors discussed in this section – governance, accounting and service-planning systems – emerged through iterative cycles of analysis and conversations with colleagues regarding the findings after the case study histories and first-stage analysis were completed. The governance related data draws on the case overviews provided in chapter 7, while the accounting and service-planning data was presented in the preceding

section. Discussion of differences across sectors by respondents was also encouraged through interview questions twelve, thirteen and fourteen of the interview schedule (see Appendix 3). The capacity for change is initially outlined on a case-by-case basis for each organisation. A cross-case analysis ensues. However, as Section 9.4 builds upon the findings presented in this section, a comparison with the literature is postponed until the findings of the latter section are presented. Section 9.3.1 begins by considering the capacity for change in the voluntary hospital.

9.3.1 Capacity for service-improvement change in the voluntary hospital

The voluntary hospital displayed a moderate capacity for change. While constrained by the rigid and externally determined nature of their accounting and service-planning systems, as detailed in Section 9.2 and re-emphasised in the introduction to Section 9.3 above, the hospital had more discretionary autonomy and was more strategically proactive at the senior-management level than the public hospital. Strategic pro-activity was discussed in chapter 8 with regards to the initiation of top-down service improvement. The emphasis in this section is on explaining the organisation's relative autonomy. Both strategic pro-activity and the organisation's relative autonomy were facilitated by the existence of a board of governors, who mediated between the HSE and the hospital in determining how the hospital should be managed. However this board was itself subject to constraints. As detailed in chapter 7, the board of governors operated in parameters laid down by the owners of the hospital, a religious order, and the HSE. The deputy CEO described the hospital as retaining self-governance and self-management. However while the organisation retained *'a fair degree of autonomy'* (DCEO), the significant levels of funding received from the state, and the restructuring of the health service were identified as affecting discretion in the management of the organization and the allocation of funds by management (Board member, DCEO, Director of HR, Consultant Cardiologist). The perceived greater autonomy of the voluntary hospital, relative to public-sector hospitals and the commensurate threats are discussed below.

The implications of perceived greater autonomy relative to public hospitals were discussed by six respondents at the senior-management and consultant level. For the HR Director there were two implications in terms of organisational functioning. The first was increased flexibility about how business was conducted and the second was a greater propensity and capacity for reflexivity regarding the implications and desirability of changes in the broader context:

> *I think at two levels; probably there's more flexibility internally in terms of how business is being done and maybe I think on occasions there's a view that while certain things might be happening out there in the wider system that we have an inclination or a disposition to take a critical look at and say 'Would that be right for*

> *us?'... but I think there is a greater disposition to say 'Look, just because it fits with what maybe the Health Board model as it was, that's not necessarily going to be the right one for us.* (HR Director, Voluntary Hospital)

Similarly, the consultant cardiologist emphasised the organisation's relative flexibility and capacity to facilitate entrepreneurial and other changes, even if not financially.

> *So maybe there's more things happening here than would have happened in a public hospital and I suppose the development of Cardiology here to some degree probably reflects that.* (Consultant cardiologist, Voluntary Hospital)

The director of nursing in the voluntary hospital noted that the organisational structures and processes in both of the voluntary hospitals in which she had worked were of greater use, specifically with regards to the structure of the accounting and HR systems. One effect of this was greater efficiency in decision-making processes. This assertion was supported by the directors of HR and finance in the public Hospital. Specifically, the director of HR in the public hospital noted that the time period for recruiting individuals was significantly higher in public rather than voluntary hospitals, due to the need to have appointments ratified and the fact that advertisements are placed by the HSE.

For the consultant cardiologist, general services manager and HR director in the voluntary hospital, being a voluntary organisation may provide more scope for service improvement, and greater discretion regarding organisation processes. This situation had a historical premise, with the mission effectiveness coordinator noting,

> *down through the years when we would be looking for things in development, I've never seen it in writing, but people in the Department of Health would have said, 'Well, you are a voluntary hospital, get on and do it if you want to.* (MEC, Voluntary Hospital).

One contemporary example provided by the consultant cardiologist was the provision of funding for an additional cardiologist via fund-raising, with the organisation agreeing to provide medical insurance. The general services manager also emphasised the presence of discretion regarding processes in the organisation. He asserted that *'I think because we're a voluntary hospital we have the freedom to operate a little bit more creatively than those that are being run by direct remote control'* (GSM, Voluntary Hospital). This freedom is supported at the senior-management level, with *'an acceptance at corporate level that we need to get to a particular point, but how we get to it may be different to how others do it, and that's a positive thing.'* (GSM, Voluntary Hospital) The director of HR emphasised the exercise of discretion in relation to the staff ceiling, noting the fact that

> *The voluntary ethos ... I think there's, to some degree, what I might describe as operating on the forgiveness principle in the sense that if we feel that there's bona fide reasons from a service or patient care perspective that we need to do something ... and if we can resource those notwithstanding the inconsistency in relation to the headcount, are we going to do it or are we going to do nothing.?* (Director of HR, Voluntary Hospital)

As a result of such discretion, the DCEO described the voluntary hospital as currently retaining self-governance and self-management, with the hospital network manager operating in a liaison rather than an executive role. While he acknowledged that the organisation retained *'a fair degree of autonomy'* at the time of data collection, he emphasised that this will most likely change over time, due to the significant element of financing provided by the HSE. Concern in this regard was also raised by the mission effectiveness co-ordinator.

> *The golden rule is that he or she who has the gold, rules. And we get 95% of our funding through the HSE now.* (DCEO, Voluntary Hospital)

> *'If you do take public funding, which we do, have you to comply exactly with what the public funder, now the HSE says you must do? In all the statements heretofore that have come out from the HSE and from other bodies before that, they always have said that they would respect the ethos and the principles of the various denominations, but [place] was the first time it arose.* (Mission Effectiveness Coordinator, Voluntary Hospital)

In addition to financing, a further threat to autonomy and discretion was identified by the DCEO. This pertained to attempts to standardize relationships with the voluntary hospitals, bringing them into the same structures as the public hospitals.

> *There seems to be a wish to bring the voluntaries into line under the National Hospitals Office pillar ... but I think one of the huge benefits to the system of voluntarism is the autonomy that comes from within voluntarism that allows for fast change and manoeuvrability and adaptation.* (DCEO, Voluntary Hospital)

Prior to the change to the regional structure of organization in the health service, which had been introduced seven years prior to data-collection, the organisation had more direct contact with the Department of Health and Children. This was described as 'very helpful' by a senior manager on the basis that having direct access and ongoing relationships assisted in securing funding. With the advent of the HSE the level of direct access has further declined. The hospital's interests are now represented by a network manager who has responsibility for several other hospitals in the region. As a result, the network manager has multiple interests and is also fighting for money with seven other health networks. In describing the impact of these changes on the hospital, the senior manager asserted that it is now '*more difficult*' to have the *'right'* contacts. This could be described as the standardisation of the relationships

between individual hospitals and the HSE. However, the DCEO noted attempts by voluntary hospitals to respond to such attempts through strategic alliances with other hospitals and education-oriented institutions. The hospital is also actively engaged in stakeholder management.

In conjunction, the configuration of the voluntary hospital's accounting and service-planning systems with its semi-autonomous board, and HSE attempts to manage its autonomy through the standardisation and distancing of relationships, led to a moderate-to-high capacity to engage in service-improvement in the voluntary hospital. The constraints on the capacity to initiate and implement service improvement and change were derived from constraints on service planning and accounting and increasingly constrained autonomy in governance and management. Nonetheless the organisation had significantly more flexibility and capacity to facilitate and initiate service improvements and change, relative to the public hospital. Section 9.3.2 now considers the capacity for service–improvement in the public hospital.

9.3.2 Capacity for service-improvement change in the public hospital

This section discusses the capacity for change in the public hospital. As previously detailed, capacity for change refers to how the prevailing set of conditions affects the ability of the organisation to initiate and implement service improvements.

The second case, a public hospital, exhibited a poor capacity for change at the organisation level. This was attributable to a significant lack of autonomy at the senior-management level, due to the governance structure in place. Specifically, as a public hospital the organisation had less autonomy than the voluntary hospital, due to the absence of a board. Instead decisions were made by the general manager, but could be over-ridden by regional-level managers in the HSE. The poor capacity for service improvement was further exacerbated by the constraints imposed by the accounting and service-planning systems, detailed in Section 9.2 and in the introduction to Section 9.3. Unlike the voluntary hospital, the public hospital had no flexibility in these systems.

The public hospital was governed through the regional health services structures. Specifically, there was a 'network manager' for all of the hospitals in the region who acted as a link between the individual hospitals and the central administrative body. This was a relatively new structure and the general manager articulated a sense of disempowerment and frustration associated with it. Of particular concern was the locus of decision making. This

was being moved away from the hospital manager and towards the regional-authority level. These concerns were strongly and clearly articulated:

> *Outside of here you are blocked and you are questioned and at the end of it then you are saying 'God, am I not the person best to know what is what, and what is needed?* (General Manager, Public Hospital)

> *I feel I am becoming more of a puppet. And it is demoralising in some ways, when you really put your energy behind something.* (General Manager, Public Hospital)

The HSE-led governance structure emphasised oversight and stewardship, which were most evident in the accounting systems.

> *Spent properly seems to be more important than spent efficiently. That is because of the stewardship role and I tick the box to say yeah the million is gone over there. I might have been able to buy it for a half a million but it is gone over there and all of those boxes are ticked. And here is me the turkey, bought for Christmas.* (Director of Finance, Public Hospital)

The stewardship orientation had negative implications for change capacity. In addition, the strategically reactive nature of the senior-management team, because of their lack of autonomy, further undermined capacity. The assertion of the director of finance that their top-down changes tend to come from the HSE rather than the organisation has already been reported in discussion of the initiation of top-down service-improvement in chapter 7. This relates to the lack of autonomy at the senior-management level caused by the governance structures delineated above.

Both the consultant and general manager in the public found it highly frustrating that they had to contact regional HSE headquarters to get things done. Overall, the capacity for change in the public hospital was poor. It was significantly limited by the minimal autonomy of the senior-management team, an issue exacerbated by constraints on service planning and accounting.

Section 9.3.3 considers the capacity and climate for change in the private hospital.

9.3.3 Capacity for service-improvement change in the private hospital

This section discusses the capacity for service-improvement change in the private hospital. To remind the reader, service-improvement capacity refers to how the prevailing set of conditions affects the ability of the organisation to initiate and implement service improvements. The capacity for service-improvement change in the private hospital was high.

However, this capacity was conditional on the initiatives meeting defined business and quality criteria.

> *If we can provide the best possible patient care that people want to buy at a price that the insurance companies are willing to pay, and we can make money.* (Director of Finance, Private Hospital)

This high capacity for change was underpinned by an independent board, who emphasized financial and quality-related targets. Ten specific financial and quality-related targets were set annually by the board, which had strong representation from financial investors. Board targets were deliberately cascaded down the organization, with the CEO afforded significant autonomy in how they were attained. In addition, accounting and service-planning systems facilitated changes, which were evaluated on the basis of business cases. As outlined in Section 9.2, explicit criteria for evaluation were in place, and reflected the financial and quality-orientation of the board. Initiatives meeting these criteria were speedily implemented and not constrained by a specific planning cycle.

Section 9.3.4 now analyses the capacity for change across the cases.

9.3.4 Cross-case analysis of capacity for service-improvement change

The capacity for change across the cases has been identified as moderate in the voluntary hospital, low in the public hospital and high in the private hospital. The constraints encountered in the public and voluntary hospital pertained to the nature of governance, accounting and service-planning systems, which act in configuration. However, a significant caveat is required with regards to the private hospital. It exhibited a high capacity for change, but was only open to initiatives that met stringent quality and financial targets.

While the constraints of service-planning and accounting systems have been detailed in Section 9.2 and in the introduction to this section, the impact of the governance structures across cases was formally analysed in this section. These varied in the levels of autonomy afforded to management and the orientations adopted as a result. The governance structures can be variously classified as oriented towards balancing books (voluntary hospital); oversight and stewardship (public hospital) and; financial and quality outcomes (private hospital). These differences led to variation in both the capacity for change and the objectives of change across the hospitals. In the public and voluntary hospitals change-objectives pertained to patient care, equity and efficiency while the objectives in the private hospital coalesced around business-related objectives as well as the quality of care. In the private hospital, where objectives were aligned with staff priorities, they appeared to be budget-neutral or of benefit to the organization. Following Chambers (2006), the voluntary and private-sector

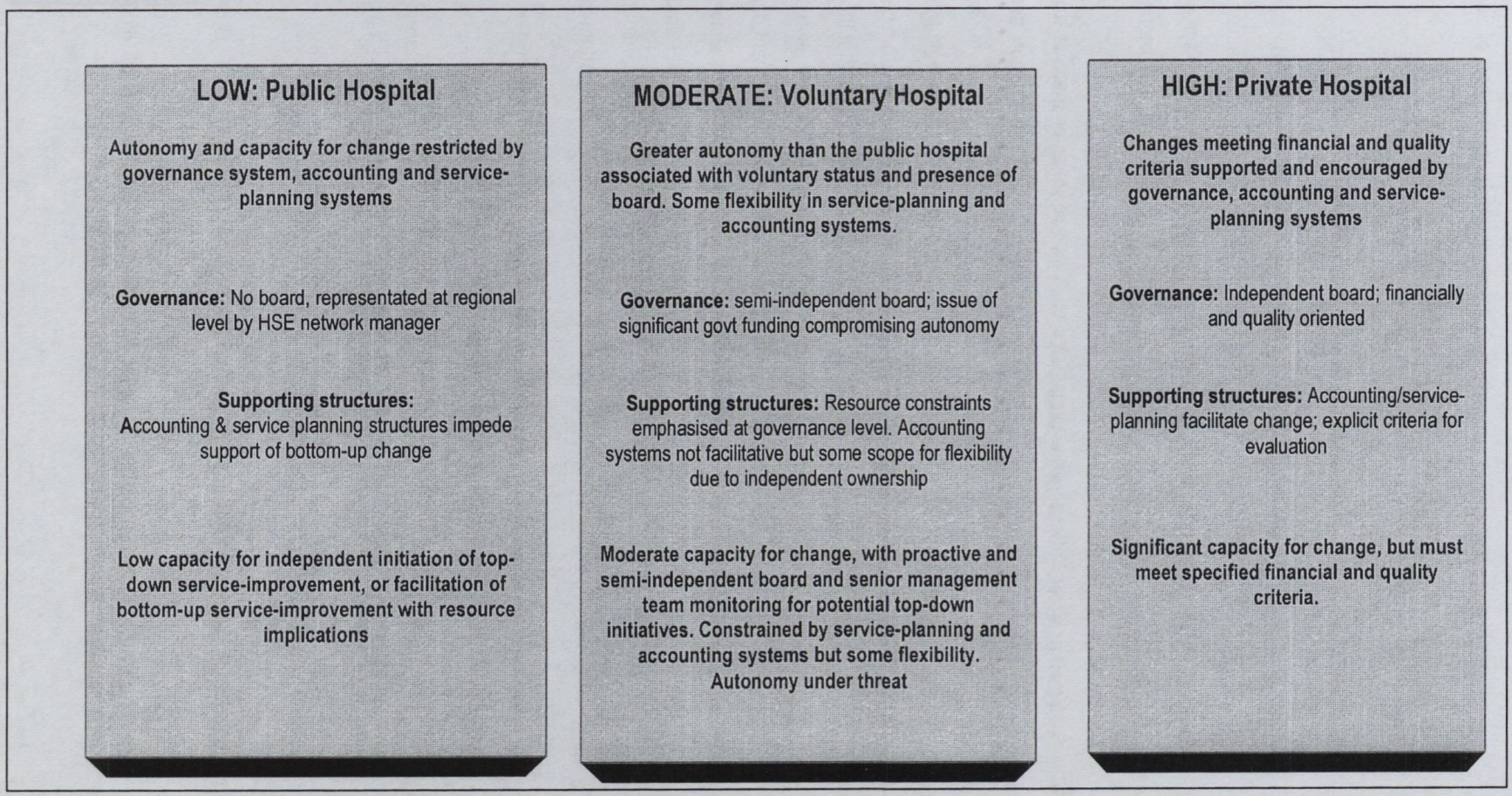
boards were oriented towards performance, with the public-sector governance structure oriented towards conformance. Within this, following Pomey et al. (2007), an agency model of governance was evident in the private and public hospitals. A stakeholder model was evident in the voluntary hospital, which was attempting to manage its relationships to preserve its autonomy. In line with the findings by Greenwood et al. (2007), the private-sector governance structure proved most useful in supporting service improvement, with greater monitoring of opportunities, both within the environment and the organisation.

In addition to governance structures, the accounting and service-planning structures in each hospital variously constrained and facilitated the service improvements undertaken. Overall, governance systems affected the level of autonomy to facilitate change, with service-planning and accounting systems further constraining autonomy in the public and voluntary hospital. A typology of the capacity for change across the cases is provided in Figure 9.2 overleaf.

Across the public and voluntary hospital, respondents noted their perception that historically voluntary hospitals had more autonomy than public hospitals. For the respondents in the public hospital, this manifested in lower levels of bureaucracy (Director of Finance, Director of Nursing, Medical Director, Chief Pharmacist), longer planning horizons (Director of Nursing), the capacity to recruit staff more easily and speedily (Director of Nursing, HR Manager, Chief Pharmacist, CRC) and the proactive and 'can-do' ethos associated with the voluntary sector (Director of Finance, General Manager, RTO). The assistant director of nursing noted that, historically, in her experience, voluntary hospitals had more autonomy than state hospitals. Similarly, the consultant in the public hospital noted that, in his experience, voluntary hospitals held more, though not much autonomy. For him, their degree of autonomy was increasingly limited by their link to the Department of Health and Children, and the fact that they were the predominant funder. The theme of decreasing autonomy was also strongly developed in the voluntary hospital, indicating that the capacity for change in the voluntary hospital may decrease in the future.

This section has discussed the three factors acting in unison to affect the capacity for change across the cases. Discussion of capacity refers to how the prevailing set of conditions affects the ability of the organisation to initiate and implement both top-down and bottom-up service-improvement initiatives. This theme is further developed in Section 9.4, which discusses the climate for change across the cases. The climate for change refers to the level of motivation or support for change in the organisation. Section 9.4 considers whether the issues of climate

Figure 9.2: Typology of Capacity for change



and capacity are linked. The climate for change is affected by levels of strategic distraction, senior-management support and the role structures in place. Due to the consideration of whether the findings of the two sections inter-relate, the implications of the findings of the two sections are discussed in tandem and with reference to the literature, at the end of Section 9.4.

Section 9.4 Climate for service-improvement change

This section builds upon Sections 9.2 and 9.3, and draws together further findings from chapters 7 and 8 to provide a holistic overview of the factors at role, organisation and environment levels that affect the climate for service-improvement change in and across the three cases. The climate for change refers to the extent to which there was a willingness to exercise the available capacity for service improvement in an organisation. This section considers both the factors affecting the climate for change, and whether there is a direct relationship between the capacity and climate for change. The climate for service-improvement change, which can also be considered as the motivation to engage in service-improvement change, was affected by the levels of strategic distraction, senior-management support and role structures in place. Hence, this section brings together findings from chapter 7, 8 and 9 to present a highly significant emergent finding. This finding suggests that the level of strategic distraction and management support in an organisation, as well as the role structures in place, work in constellation to create a climate for service-improvement change. Considering these factors in tandem is important, as it is not alone sufficient to answer the first and second research question in isolation, as has been undertaken heretofore in chapters 8 and 9. Rather, it is also crucial to consider how the findings act in configuration. The impact of this configuration of factors is considered with regards to both bottom-up and top-down service improvements.

The relatively short length of each case overview reflects the prior development of each point drawn upon, throughout chapters 7, 8 and 9. Section 9.4.1 begins by outlining the configurational effect of these factors in the voluntary hospital, and whether the capacity and climate for service-improvement change are similar in that context.

9.4.1 Climate for service-improvement change in the voluntary hospital

Some of the reason that things don't get done is that there's almost a structural imperative to slow things down; to have the optical illusion that we're actually doing a lot of things. But because there's resource rationalisation which isn't acknowledged ... it takes too much

– Deputy CEO, Voluntary hospital

The Voluntary Hospital, with a moderate capacity for service-improvement change, had a poor climate for bottom-up service improvement and a moderate climate for top-down service improvement. Overall, there was a low motivation to engage in change at the organisational level due to the resource rationalisation described in the above quotation, and the high levels of strategic distraction described in chapter 7. These factors worked in conjunction with the consultant-centred model of bottom-up service-improvement to create a particularly poor climate for bottom-up initiatives. However, a moderate climate for top-down service-improvements was created through the significant strategic monitoring in place to identify top-down service improvements, as detailed in chapter 8.

In his financial overview for the period studied, the CEO described the financial situation as 'very difficult', with service levels constrained and priority given to service provision rather than development. Staff recruitment was restricted and cost-savings exercises were implemented. Strategic distractions, as detailed in Section 7.2.10, included an ongoing significant capital development and consolidation of the hospital's strategic position, in light of the restructuring of the Irish health service administrative structures. In addition the hospital was cultivating strategic alliances to consolidate its strategic position in health service. As a result, while resource-neutral and top-down service improvements with resources attached were facilitated, there was a poor climate for bottom-up service improvements or others with resource requirements. Hence, there was overall a low level of motivation to engage in service-improvement change. The relatively inflexible, externally-determined nature of the organisation's accounting systems exacerbated the issues related to strategic distractions and resource rationalisation.

Section 9.4.2 now considers the climate for service-improvement change in the public hospital.

9.4.2 Climate for service-improvement change in the public hospital

Surprisingly, given the poor capacity for service improvement identified in Section 8.3.2 and in the face of significant strategic opportunities and threats outlined in Section 6.1.10, the public hospital provided a supportive context for service improvement and change. This was primarily attributable to the senior-management team and consultant cardiologist who, in conjunction, had created an organization culture that was supportive of service improvement where feasible. This support led to the development of an entrepreneurial culture in the cardiology department.

> *Many of the managers that have been here, and the first manager that I would have dealt with, I would have found very supportive. Personally very supportive. And a time, mind you, when funds were hard to get.* (Consultant cardiologist, Public Hospital)

> *They saw me as somebody 'Here's a guy who's come to [Public Hospital], wants to develop the service, goes out every second night of the week raising funds for the hospital.' You are respected once you do, I guess. That makes it much easier to go to management. To say 'look guys, I'm working for the hospital, you work for me, help me out' And they do.* (Consultant cardiologist, Public Hospital)

The specific strategic distractions encountered included a possible downgrading in status. While the hospital had ongoing capital development, this was not a major distracting factor. The support of the senior-management team was undermined in practice by the same inflexible and externally-imposed accounting and service- planning systems evident in the voluntary hospital and the lack of autonomy which led to a low capacity for change. In spite of these challenges, the support of senior management provided a productive environment for entrepreneurial staff, for resource-neutral changes and externally-resourced changes. Hence, this management support provided a fertile environment for the bottom-up service-improvements achieved through the adoption of an entrepreneurial outlook by the consultant, the devolution of authority to department heads and the acquisition of resources through fund-raising and the cardiovascular strategy. However, as outlined earlier, the climate for top-down service improvement was reactive, rather than proactive. This was due to the lack of senior-management control over decision-making, with significant decisions often over-ridden at regional level. Having outlined the surprising combination of a low capacity for service improvement with a supportive climate, it is important to consider what specifically led to this anomaly. This can be attributed to the support of senior management for service improvement and change, which may potentially be related to the small scale of the organisation. The positive implications of scale were discussed by six respondents (Director of Nursing, Medical Director, Assistant director of nursing, Chief Pharmacist, CNM2 CCU, Director, RTO). The respondents who mentioned this theme linked it to the effectiveness of organisational processes and outcomes.

> *Working in a small hospital, it's easier to get things done, because you meet face to face with that person.* (RTO, Public Hospital)

> *It's that small, and I do think that it makes a huge difference when you are trying to plan things and get things done.* (Chief Pharmacist, Public Hospital).

Several respondents noted that the scale of the organisation facilitates important impromptu and informal liaisons, which further facilitate change. These can occur in the corridor (Chief

Pharmacist) or the coffee shop (RTO), among other areas. *'I think because you know [the consultant] well, and you can stop on the corridor, you can do a lot of business on the corridors here (laughing) and things move quicker. Here it is a small enough place for things to happen.'* (Chief Pharmacist, Public Hospital)

Section 9.4.3 considers the climate for service-improvement change in the private hospital.

9.4.3 Climate for service-improvement change in the private hospital

The private hospital provided a highly supportive climate for service-improvement change to those initiatives that met its financial and quality-oriented criteria. Interestingly, in an opposing development to the voluntary hospital, as outlined in Section 7.3.10, the climate for change was augmented by strategic distractions including increasing competition, caused by policy-level support and tax breaks for private hospitals. The hospital had also undertaken significant infrastructural development in an attempt to consolidate its' strategic position. The changes in the environment, the planned capital development of the hospital and competition for consultants were occupying much attention at the board and strategic levels. However, the need to maintain profitability led to a continued focus on service-improvements meeting quality and financial criteria. The ratification of such initiatives was not constrained by a particular planning cycle.

Senior-management support for initiatives meeting clearly defined criteria had been structurally embedded into the organisation. For bottom-up changes this had been achieved through the devolved and innovative role structures created. These had explicit responsibility for harnessing bottom-up changes in-line with explicit criteria. While the head of finance noted a willingness to optimize costs among the self-employed consultant staff, some other staff struggled to manage the stress associated with their awareness of the 'organisation as a business'.

> *There is pressure to keep it all afloat. I suppose we don't get involved in the money end of it at all, but we know that it's part of it; keep the business going. So that's important.* (CNM2, Private Hospital)

Changes were also actively sought at the board and senior-management levels, with both pro-active in this regards. Nonetheless, while the climate for service improvement was highly supportive, it was only so for initiatives meeting clearly defined criteria. Section 9.4.4 analyses the climate for service improvement across the cases.

9.4.4 Cross-case analysis of the climate for service-improvement change

This section provides an analysis of the climate for service-improvement change across the cases. This analysis is followed by a comparison with the literature, which makes reference to the issues of both capacity and climate for change. Capacity for change was discussed in Section 9.3.

This section has emphasised that context, in the form of strategic distraction, senior-management support, and role structures, all of which vary across cases, significantly impacts upon the climate for harnessing top-down and bottom-up service-improvement change. As a reminder, role structures vary from the consultant-centred, consultant-as-gatekeeper model in the voluntary hospital, to the partially-devolved role structure in the public hospital, where the consultant acts as a facilitator. Finally, the private hospital introduced innovative and devolved role structures that bypassed the consultant. Thus, governance, accounting and service-planning systems influence the capacity to change, affect role and relationship structures in conjunction with levels of strategic distraction and senior-management support, and affect the climate for service improvement and change. Interestingly, as per Table 9.1, which presents the differences in the capacity and climate for service improvement across the cases, the capacity for change, or how the prevailing set of conditions affects the ability of the organisation to initiate and implement service-improvements, is not directly correlated with the climate for change in each organisation. The climate for change refers to the extent to which there was a willingness to exercise the available capacity for service-improvement in an organisation. Although the public hospital had limited capacity to initiate top-down or facilitate bottom-up change, the supportive senior-management climate and devolved role structures led to support for bottom-up service-improvements, which ultimately facilitated the organisation's inclusion into the resource allocation for the cardiovascular strategy. In contrast, in the voluntary hospital, significant senior-management distractions decreased the climate for both top-down and bottom-up change, in spite of greater autonomy and discretion than was evident in the public hospital. The climate for bottom-up service-improvements not led by consultants, was further decreased by the consultant-centred role structures adopted.

Table 9.2: The capacity and climate for service-improvement change across the cases

	Voluntary	Public	Private
Capacity for service improvement	Moderate	Poor	Good
Climate for top-down service improvement	Moderately Supportive (Strategically proactive but distracted)	Reactively Supportive	Proactively Supportive
Climate for bottom-up service improvement	Poor for non-consultant -led service improvements	Supportive	Proactively Supportive

Figure 9.3 and Figure 9.4 overleaf present typologies of the configuration of the climate for change, and also take account of the capacity for change. Specifically, Figure 9.3 presents the findings regarding the climate for top-down change across the organisations, and Figure 9.4 presents the findings regarding the climate for bottom-up change across the organisations. Prior to this the findings of Section 9.3 and 9.4 are discussed with regards to the extant literature.

- **Comparison with the broader literature**

The findings of Sections 9.3 and 9.4 add significantly to existing research on cross-sectoral comparisons in healthcare. To date, cross-sectoral comparisons in the healthcare context have tended to focus on descriptive characteristics and outcomes of care, rather than organisational processes (Ferris & Graddy, 1989; Hollingsworth, 1986; Schlesinger & Gray, 2006). In contrast, this research focuses on management and organisational processes. This is justified given Doyle et al.'s (2000) survey-based finding that the experiences of change, including implementation and relationships, varied between the public and private sectors and also between management levels. This research has provided insight into the factors which may account for cross-sectoral differences in change processes. Crucially these dynamics may not have been illuminated without the cross-sectoral comparative dimension in the research.

The cross-sectoral comparison has been particularly valuable in drawing out the issues affecting the capacity for change, namely accounting, service planning and governance systems. These have been illustrated to vary across the cases, with implications for discretion, autonomy and ability to engage with bottom-up and top-down service improvement. In addition, the cross-sector comparison has led to greater insight into the factors affecting the climate for change, specifically levels of strategic distraction, governance

systems, senior-management support and role structures. The comparison has also provided insight into the interaction between the capacity and climate for service-improvement change.

The provision of insight into the impact of constellations of particular contextual factors on the capacity and climate for change follows two recent and critical additions to the literature on context. The first has noted that change is differentially impacted by configurations of characteristics from the context (Dopson & Fitzgerald, 2005b; Fitzgerald et al., 2006). For Fitzgerald et al. this makes a theoretical contribution to the literature in moving away from considering cause-and-effect relationships and towards what Goldstone (2003) termed 'conjunctural causation'. In this form, combinations, rather than individual factors, are significant sources of influence.

The second development emphasizes that context is an interactive process rather than a backdrop to change (Dopson & Fitzgerald, 2005a; Jones, 2007). Having taken account of these ideas, this thesis has begun to provide insight into the *specific* combinations of factors which affect processes of both bottom-up and top-down down service-improvement change. These combinations affect the (1) levels of capacity to change at the organizational level and (2) the climate for exercising the capacity to change. Although providing a complex interpretive framework, the relationships between capacity and climate to change, underpinned by governance, accounting and service-planning systems, levels of strategic distraction, senior-management support and role structures, reflect the multifaceted and interactive reality of organizational life. These relationships also emphasize the uncertainty associated with change-management, which is enacted within and through constellations of contextual and other factors. While these factors begin to account for differences in the level and sources of bottom-up and top-down service-improvement change, the nature of their interactions remains somewhat ambiguous. Nonetheless the findings do have practical implications at a number of levels. These are discussed in chapter 10, where an evaluation of the research delineates its implications for both research and practice. Prior to this, an overview of this chapter is provided.

Figure 9.3: Typology of Factors influencing the climate for top-down service-improvement across organisations

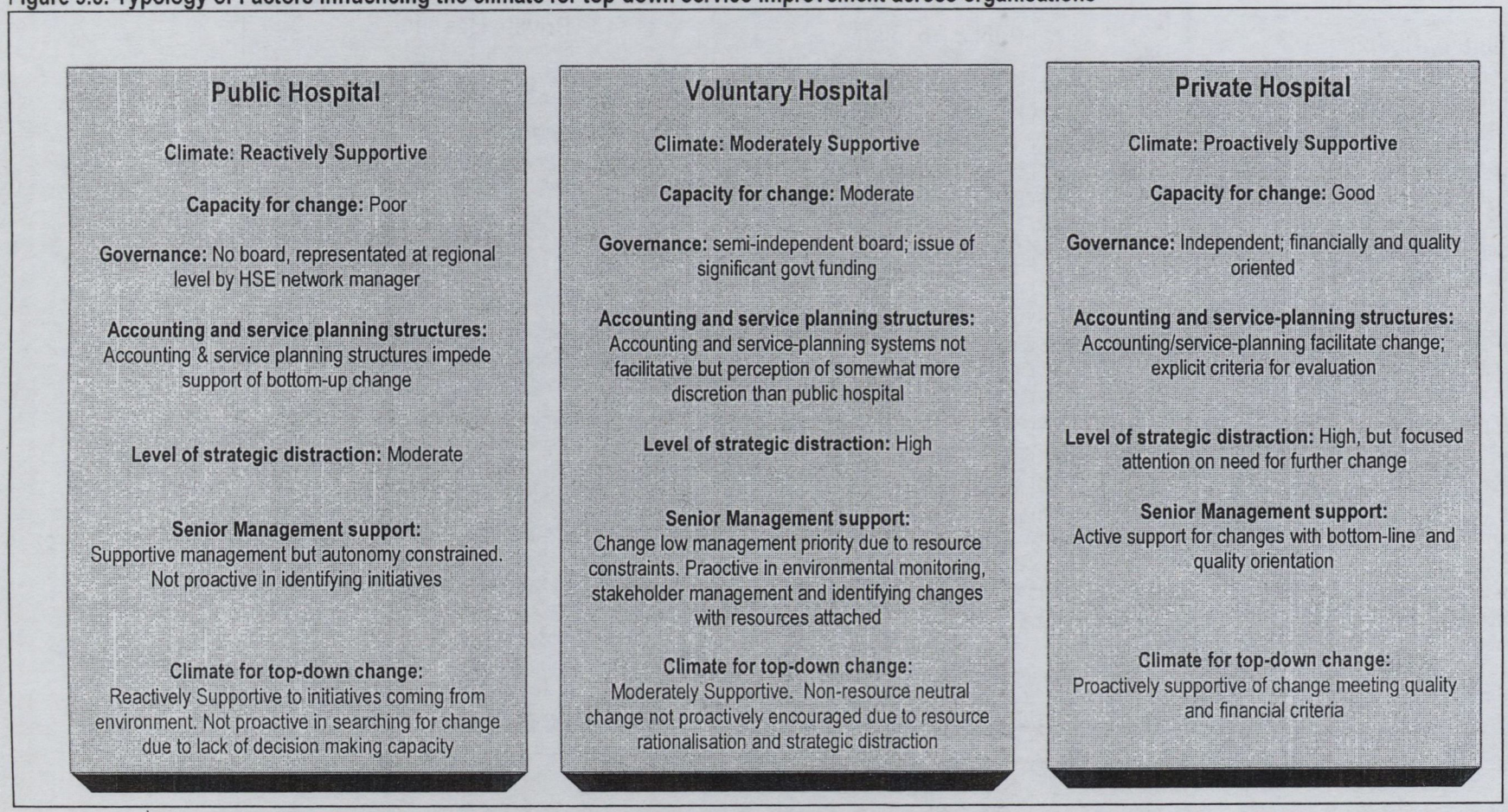
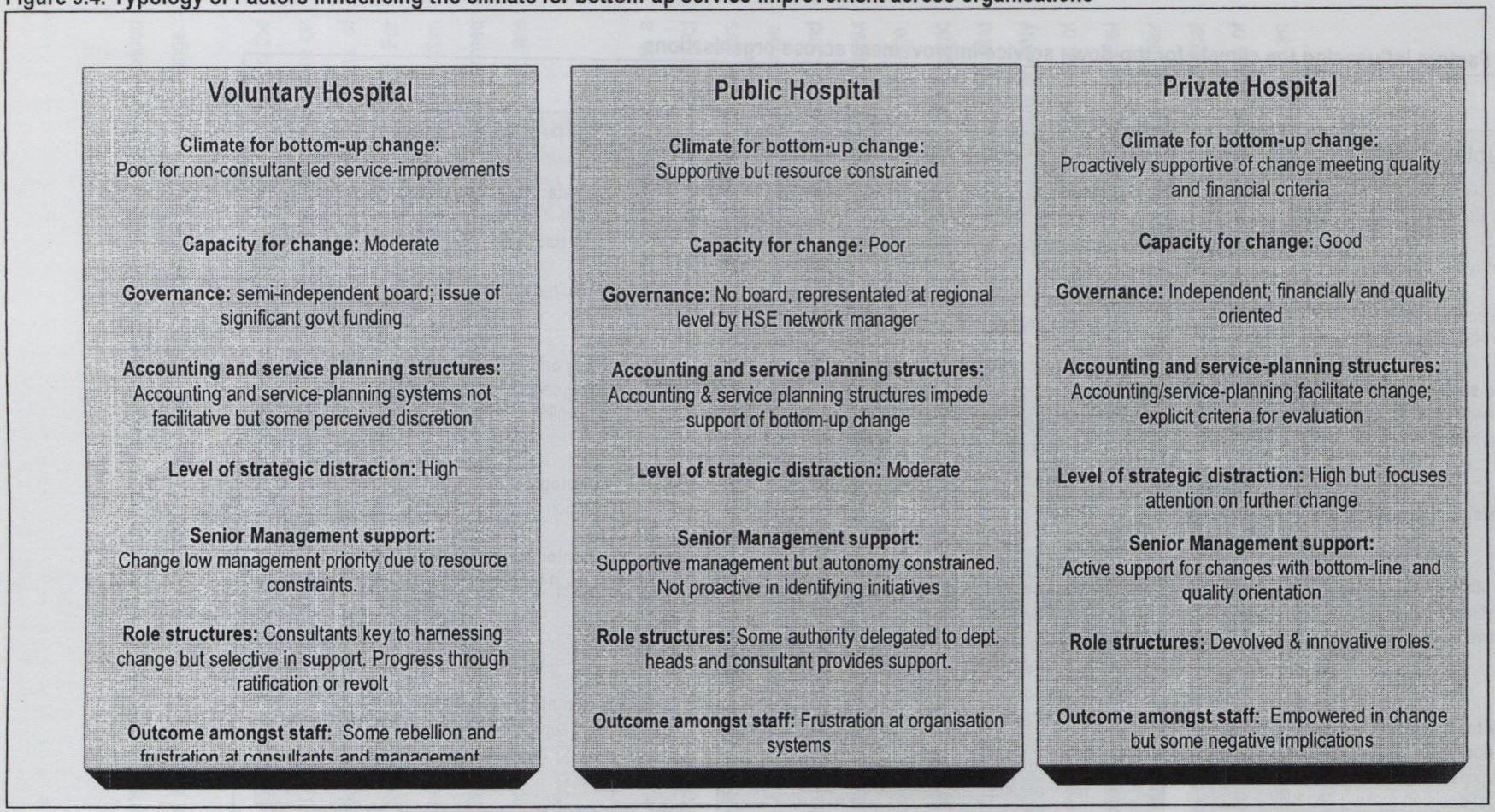


Figure 9.4: Typology of Factors influencing the climate for bottom-up service-improvement across organisations



Conclusion

This research is concerned with how service-improvement change processes are implemented through people who act within constraints. The specific purpose of this chapter was to describe, analyse and explain the research findings pertaining to the second research question,

> *What additional contextual factors, beyond role level, facilitate or hinder the implementation of service –improvement change*

The first section of this chapter identified the under-utilisation of the HR function in hospitals. Outlining the actual and desired role of the HR function, it identified the clerical-administrative role fulfilled in the three hospitals, in spite of the aspiration towards a strategic and change-related role in the public and voluntary hospital. The role of HR across the hospitals was constrained both by the nature of the service and the lack of understanding of the role of the HR function.

Crucially, there was a marked lack of responses regarding the role of HR from those identified as central actors in initiating and implementing service improvement in chapter 8 – consultants and clinical managers. The role of the HR function in service improvement was limited to addressing industrial relations issues, in both the public and voluntary hospital. The most effective HR structure evident was that of the private hospital, where responsibility for HR devolved to heads of departments, meaning that the HR implications and requirements of service-improvement processes were addressed locally. A similar structure was desired by the director of finance in the public hospital.

The second section of the chapter identified the constraints imposed by the accounting and service-planning systems evident in the public and voluntary hospital. Although the implications of these constraints were evident at the organisation level, they were determined at the environmental level. Issues encountered included (1) the inability to plan for depreciation; (2) emphasis in the system on money being spent properly rather than effectively; (3) a lack of standardisation in costing systems across organisations; and (4) a lack of integration between the service plan submitted to the HSE and the actual financial allocation made to the organisation. These issues led the desired role for service-planning and accounting systems being defined in relation to their perceived deficits. Crucially, these issues have previously been identified at the policy level but have yet to be addressed. The accounting and service-planning systems evident in the private hospital provided a marked contrast to the above, facilitating service improvements in an efficient manner.

The third section of the chapter built upon the findings pertaining to accounting and service-planning systems. It considered how these work in configuration with the governance systems in place to create a climate for change. The final section of the chapter then considered the factors influencing the climate for change, which refers to the motivation to exercise the available capacity for change. These factors included the levels of strategic distraction, senior-management support and the role structures in the organisation. This section also considered the relationship between the capacity and climate for change, and found that the two were not deterministically linked. The implications of the findings from this chapter and chapter 8 are evaluated and presented in chapter 10. In addition to considering the implications of the findings, and presenting recommendations on that basis, chapter 10 also explicitly addresses the third research question, which asked whether there were systematic differences between the findings of the first and second research questions, across the cases.

Chapter 10: Overview, Recommendations and Research Evaluation

This chapter presents an overview of the key findings that emerged from the three research questions posed and answered in this thesis, in addition to raising some questions associated with emergent findings not directly related to the research questions. Notwithstanding the configurational research findings presented, a significant contribution of this research remains the provision of previously non-existent base-line data regarding those involved in the initiation and implementation of service improvement in Ireland, and the factors that facilitate and hinder them. In light of the significant deficit of research in this area, the high level of stakeholder and policy interest and the emerging acceptance of the importance of research pertaining to service delivery and organisation in Ireland, this is a valuable contribution. Furthermore, this endeavour has facilitated the informed identification of an agenda for future research.

This chapter has five components. The first section provides a brief synopsis of the content of the entire thesis. Reminding the reader of the content of the literature review re-contextualises the findings with regards to the theory, context and practice in which the research was embedded. Similarly, providing an outline of the methodology highlights the process through which the key findings were obtained. The second section provides an overview of the major and other findings from each research question. The third section considers the contribution of the findings. As the contribution of the findings to the existing literature has already been delineated throughout chapters 8 and 9, section 10.3 focuses on the contribution of the findings to theory, methodology, policy and practice. To conclude this section, an overview of the findings, the basis on which they make a contribution and the resulting recommendations are presented in table form. The fourth section considers the shortcomings of the research and, to conclude, the fifth section identifies potential themes for further research.

Section 10.1 Overview of the context and content of the thesis

This thesis was undertaken in a context of significant environmental change and increased funding in the Irish hospital sector and in the wake of the implementation of the national cardiovascular strategy. In conjunction, these factors provided a fertile research environment. Firstly, exploring the implementation of top-down and bottom-up service improvement was facilitated by the existence of the cardiovascular strategy. Secondly, the fact that the national cardiovascular strategy addressed one of the limited care areas in which private hospitals provide services was fortuitous and significant in providing the opportunity to engage in comparative research. Thirdly, the collection of data occurred at a time when developments in

the external context made aspects of hospital identity particularly salient, facilitating cross-sector comparisons. Specifically, these developments include the restructuring of the HSE, perceived as a threat to the autonomy of voluntary hospitals through the standardisation of relationships with public and voluntary hospitals. In addition, the policy move to support the development of private hospitals through tax breaks created a context whereby already established organisations attempted to consolidate their strategic and competitive position.

To address the rising interest in the effective implementation of service-improvement, this thesis began by providing an overview of the change-literature in which the thesis was embedded, followed by a review of the specific form of change of interest; service-improvement. The initial review of change led to the identification of the processual approach as particularly appropriate for this partial-replication research, as it emphasised the context as well as the content and process of change. Having explored the processual approach, the literature review then elaborated on the dimensions of the historical and current internal and external context delineated in the processual approach. While the analytic and research focus was predominantly on the internal context of the cases undertaken, the partial replication of a UK-based study required the delineation of difference between the two contexts. In addition, the research findings emphasised the constraints imposed by some elements of the external context on service improvement. The final literature-review chapter outlined the literature pertaining to the roles and relationships in healthcare, in which service improvement is embedded.

The research-design chapter set out the three research questions, addressed in the ensuing section, and justified the adoption of a case-study approach with a processual orientation. It also presented a strong case for the value of replication studies, which has been upheld by the variation as well as the similarities in the findings from the two studies. Next, section 10.2 provides an overview of major and other findings.

Section 10.2 Overview of major and other findings

This section provides an overview of the major and other findings of the research which are organised in response to each of the three research questions posed. These are later summarised in Table 10.1 which also presents the associated contribution and recommendations for each.

The first research question asked *Who holds change-related roles, how they are enacted within the role structures in place and what works effectively?* The findings from this research

question were presented in chapter 8. However, prior to summarising the major findings pertaining to this first research question, it is important to re-emphasise that establishing the existence of service improvement was the first stage in the analysis of change-related roles and, of itself, constituted a significant finding. Of significant interest was the fact that across all cases more bottom-up than top-down service improvements were uncovered.

Nonetheless, the major finding emerging from the first research question was the fact that change-related roles were predominantly held by consultants and clinical managers, with the exception of the private hospital where consultants were by-passed in bottom-up service-improvements. Crucially, the enactment of change-related roles tended to be adopted as an extra-discretionary responsibility, as job roles, with the exception of those in the private hospital, tended to be focused on service-delivery rather than on service improvement. As a result, front-line service-providers were markedly absent from the initiation and implementation of service-improvement. A significant number of changes were led by highly committed individuals. However, the enactment of change-related roles was hampered by a lack of clarity regarding the allocation of responsibility for service improvement.

The second major finding at the role level was the capacity of the role structures in place to constrain or enable individuals in their change-related roles. Specifically, role structures and the role adopted by the consultant affected the efficacy of moving initiatives from initiation to implementation and the level of multidisciplinary participation and control in service improvement. The partial devolution of responsibility for service improvement to heads of departments was advocated on the basis that it was most successful in engendering multidisciplinary engagement with service improvement. However, full devolution of responsibility was identified as a viable strategy in contexts where poor relationships between consultants and other clinicians are evident. Interestingly, the consultant role appears to be more authoritarian in the Irish context than in the UK.

The third role-related finding identified the pivotal but underutilised role of clinical managers in service improvement. The exploration of the clinical-management role identified three sub-groups across whom the enactment of the role varied. Other than consultants, there was a predominantly operational focus. The majority of clinical managers, excluding those in the private hospital, undertook service improvement as an extra discretionary role. Issues encountered in the enactment of the role pertained to a lack of authority, budgetary control and different perceptions of fairness between clinicians and managers.

Finally, chapter 8 identified the role of networks in facilitating service-improvement. At the regional level these helped to identify regional priorities, the distribution of resources and the

monitoring of service-improvement implementation. At the organisation and role levels the networks formed through the implementation group structure provided legitimacy to proceed with service development, peer-mentoring, support, ideas and advice and generated informal communities of practice.

Attention now moves from role level to consider additional factors at the organisational and environmental levels affecting the delivery of service-improvement change. The second research question asked *What additional factors beyond role level influence the effectiveness of service-improvement?* The research findings pertaining to this question are set out in chapter 9. The three major findings are the configuration of factors which affect the (1) capacity and (2) climate for service-improvement across the cases, and (3) the relationship between the capacity and climate for service-improvement. The capacity for service-improvement was defined as the prevailing set of conditions that affect the ability of the organisation to initiate and implement both top-down and bottom-up service-improvement initiatives. The capacity for service improvement has been linked to the nature of and configurational interaction between governance, accounting and service-planning systems. The second major finding focused on the climate for service improvement, defined as the extent to which there was a willingness to exercise the available capacity for service improvement. This finding considered role-level and organisational-level factors, explaining the climate for service improvement with reference to the context of the organisation in the form of the level of evident strategic distraction, senior-management support and the role structures in place. The third major finding was the absence of a direct or strong relationship between the capacity and climate for service improvement. In conjunction these findings comprise a theoretical contribution to the change literature in the hospital context. Theory refers to an overarching explanation for observed and/or anticipated findings, and can be built or developed (Hambrick, 2007). In this context, theory development has occurred. Specifically, the thesis has presented a two-stage theory of the capacity and climate for service-improvement. This theory is two-staged as the capacity and climate aren't directly linked. While both can be considered in isolation, considering the two in tandem can provide insight into the level of service-improvement achievement of an organisation, within capacity constraints, and can also help to identify the source of issues encountered – whether at environmental, organisational or role level. The finding regarding the factors influencing the capacity for service-improvement has extended prior theory regarding the climate for service-improvement (Pettigrew et al., 1992, Ashburner et al., 1996). (The climate for service-improvement has previously also been known as an organisation's receptivity for service-improvement.) This is an important contribution, particularly as the findings are counter-intuitive, with the capacity for service-improvement not directly linked to the climate.

Prior to developing the configurational results which led to the theoretical contribution outlined above, chapter 9 outlined the desired and actual role of service-planning and accounting systems across the hospitals and the constraints imposed by these systems in the public and voluntary hospitals. In addition, the failure of the HR function to support the critical actors in service improvement was identified as a significant deficit. The difficulties encountered by the HR function in achieving its desired strategic role, and the most effective locus of responsibility for delivering HR-related activities were delineated. Specifically, the devolution of responsibility for HR to departmental heads, in conjunction with senior-management responsibility for strategising regarding the workforce appeared most effective for supporting both service delivery and improvement.

Finally, the third research question considered whether there are *'systematic differences between voluntary, public and private hospitals in the dimensions considered in questions (1) and (2)?'* Systematic findings did emerge across the cases, and have been emphasised in the cross-case comparisons at the end of each section in chapters 8 and 9. However, the most striking and systematic difference evident was between the private hospital and the other two cases. The most significant difference evident in the private hospital was the proactive focus on identifying and implementing bottom-up and top-down service-improvements that met clear evaluative criteria. The hospital's role structures, organisational processes, senior-management orientation and proactive board all supported this endeavour. A further systematic difference was evident in levels of autonomy evident across the hospitals. Reference to autonomy in this context pertains to senior-management autonomy and the level of discretion available in service planning, accounting systems and recruitment. On all of these dimensions the public hospital was most constrained, the voluntary hospital was less so, and the private hospital was minimally constrained. These issues had continuing implications for service improvement, and merit the further exploration of cross-sector differences in organisation and management processes. To date, consideration of cross-sectoral differences in healthcare has tended to focus on outcomes. Next, Section 10.3 delineates the specific contribution associated with these research findings.

Section 10.3 Delineation of contribution

The findings of this thesis enable a contribution to be made to theory, literature, policy and practice. As the contribution of each finding to the literature has been delineated throughout chapters 8 and 9, this section focuses upon the broader contribution to theory associated with

the findings, consideration of the methodological implications of the research, and the emerging policy and practice implications.

10.3.1 Contribution to Theory

This thesis has extended prior theoretical work regarding the climate or receptivity for change in healthcare organisations. While generating similar explanations for the factors affecting the climate for change as previous research, through cross-sectoral comparison the empirical analysis has led to the extension of this work to include the factors affecting the capacity of an organisation to engage in service-improvement. This extension would have been highly unlikely without the sectoral-level comparison and had a more quantitatively oriented methodology been adopted. Not alone does this theoretical development justify by cross-sectoral research design, but it also emphasises the merits of partial-replication, which will be further discussed in section 9.3.3.

In addition to the major theoretical contribution detailed above, the research has begun to explain the differences in organisation processes across sectors. Previous research has emphasised outcome, rather than process-based, differences across sectors in healthcare. This thesis, in focusing on processes, has begun to fill in the 'black-box' of understanding regarding the cause of such outcomes. Crucially, in addition to the Irish healthcare sector, the research makes a case for studying cross-sector differences in management and organisation processes in healthcare in Canada and the US. In those jurisdictions differences may be even more pronounced, as the voluntary hospital sector receives a significantly lower proportion of their funding from public sources. Hence, in addition to raising the potential benefits associated with the perceived greater autonomy afforded to voluntary hospitals, the research adds weight to the need for international research into cross-sector differences.

Although the position and autonomy of Irish voluntary hospitals is in flux due to the restructuring of the Irish health service, the findings do draw attention to the role of non-profit organisations in public-service provision. In particular, the findings raise questions regarding the degree to which the current health-service restructuring is undermining the historical capacity and autonomy of voluntary hospitals to respond flexibly to issues arising in the environment. More generically, this issue can be conceived as whether health policy should move towards centralisation and standardisation, as is the case in the Irish policy context, or whether decentralisation and devolved control is more appropriate. This thesis has highlighted some of the more negative implications for service-improvement arising from centralisation and the associated reduction in autonomy.

10.3.2 Empirical and literature contributions not directly related to the research questions

A variety of themes not directly related to the research questions posed were raised in the study and are considered in this section. Firstly, one theme strongly emphasised in the literature but not strongly represented in the data, is considered here on the basis that its absence may be significant. This pertains to the literature on leadership constellations in strategic change (Denis et al., 2001, Denis et al., 1996, Buchanan, 2003), outlined in Section 4.6.4. These authors refer to constellations of leaders – typically leadership trios of a consultant, nurse and manager – working together to implement top-down or significant change. In contrast the findings from this research, presented in chapter 8, indicated that in Irish hospitals changes were initiated by consultants, nurses and AHPs, represented to management by consultants, ratified by managers, and implemented by nurses and AHP's. Thus, while similar actors were involved in the implementation of these changes, the structure of their interaction differed from the constellations previously presented. As a result, the issue is raised of whether there are potentially different forms of leadership for service improvement rather than strategic change.

Secondly, Section 8.3 followed Fitzgerald et al (2006) in defining a clinical manager as an individual with significant clinical and managerial responsibility, regardless of whether they were formally recognised as such. Interestingly, several individuals who were significantly engaged in service-improvement and who met the above definition of a clinical manager did not have a formal clinical management role. In fact, those in formal clinical management roles such as the medical director in the public hospital and a notable number of the clinical nurse managers were typically engaged in more variable and lower levels of service-improvement initiatives than those without formal clinical management roles. The fact that those without formal clinical management responsibility, such as the consultant in the public hospital and the resuscitation training officer in the voluntary hospital, were leaders in service-improvement terms raises significant questions about the efficacy of the current clinical management role structures and merits further exploration.

Thirdly, the thesis provided significant insight into the context and operations of a private hospital organisation. With expansion of this hospital type ongoing in Ireland this is a particularly valuable contribution.

10.3.3 Methodological contribution

The adoption of a processual approach was advocated on the basis of the need to take account of the context, content and process of change in research. However, in addition to being apposite for the research questions posed, using the approach in an international partial-replication study proved particularly valuable. The exploration of the dynamics underpinning similarities and differences in findings between the seminal UK study and the findings presented was a valuable additional lense to analysis, prompting further interrogation of the data at numerous points. The international dimension of the study also lent notable insight into the commonalities in the challenges and enablers in service-improvement processes in healthcare. Similarities in findings across the Irish and UK study lent weight to the perceived robustness of the conclusions drawn, with context the predominant explanation for differences. The magnitude of the influence of context was notable, and has implications for the design of future international comparative studies. While basic considerations such as differences in terminology (such as the definition of a medical director) can be relatively easily accommodated, the partial replication strategy emphasises the broader influence of national and lower-level contextual influences on the responses received and indicate the importance of taking account of context at a number of levels in international comparative research.

The above lessons were made more salient through the explicit incorporation of context into data analysis. In this way, this thesis has expanded the application of the processual approach. As per Section 3.4, the approach has previously been critiqued for considering context in an explanatory role, rather than incorporating it into analysis of patterns of causality.

In addition to the benefits already associated with the approach outlined in chapter 3, the research process undertaken for this thesis has emphasised the value of this approach for any researcher unfamiliar with or operating in a particularly complex research context. While methodological textbooks, theory and practice advocate the choice of a particular method and methodology on the basis of the research problem, undertaking this thesis has emphasised the need to take account of the researcher's level of contextual knowledge. As a crude explanation, it would have been nearly impossible for this candidate to design an appropriate questionnaire on the basis of my level of knowledge of the Irish health system and the cardiovascular care area. However, undertaking contextual interviews and being in a position to follow up on unanticipated responses from respondents both with them and through other avenues was of significant benefit in generating contextual knowledge, an awareness of the language adopted in the care area and in pursuing significant emergent themes. For

example, the flexibility of the approach facilitated my pursuit of the theme pertaining to the importance of networks and the integration of additional respondents into the research.

The approach also proved highly valuable in making contacts. Across each of the cases my physical presence led to a snowball-type access to respondents. This was highly significant as having a personal introduction or making a personal link contributed to gaining meaningful responses. Nonetheless, as Ireland is a small country, respondents did have concerns regarding confidentiality. These were most easily addressed through face-to-face discussions and explanations. However, it remains challenging to undertake relatively small-scale qualitative research and maintain confidentiality in small contexts such as Ireland where respondents are relatively easy to identify.

10.3.4 Contribution to Policy and Practice

This section considers the recommendations that emerge from the key findings in the thesis. At role level these pertain to appropriate role structures, improving the impact of clinical-management roles, and facilitating relationships and networks to facilitate change. At the supra-role level, recommendations pertain to improving the performance of the HR function, improving the performance of accounting and service-planning, and managing the capacity and climate for service improvement through a configurational approach to management.

- **Appropriate role structures**

The fragility of service-improvement implementation and the concentration of service-improvement knowledge identified in chapter 8 raises an issue regarding the locus and longevity of service improvement. If, as in the voluntary and public hospital, service-improvement knowledge is very concentrated, then improvement is fragile. Initiatives can be undermined in the event of turnover or illness. Buchanan (2003) alluded to this issue: he found that formal systems for change ameliorated this problem, allowing changes to progress even when key leadership posts became vacant. While his research explored the implementation of top-down change, the facilitating role of formal structures and change roles in bottom-up service improvement were evident in the private hospital in this study. However, the full devolution of responsibility for service improvement to heads of departments in that organisation was not found to be a panacea. In fact, the partial-devolution of responsibility for service-improvement change to heads of departments, in conjunction with the development of an overarching vision for the department was argued to be the most productive role structure for the initiation of change implementation.

- **Improving the impact of clinical-management roles**

Currently, Irish clinical managers undertake a limited scope of activities, with a predominant emphasis on operational management and some undertaking of supervisory, advocacy and liaison roles. This contrasts with the significant range of roles identified among clinical managers in the US and UK. These three boundary-spanning roles took the form of quality assurance, communication and conflict mediation (Betson & Pedroa, 1989, in Montgomery, 2000). In addition, clinical managers undertook negotiator (Montgomery, 2000, Schellner, 1997, Dunham et al., 1994), strategic planning and capital decision-making roles (Bodenheimer and Casalino, 1999, Scherer, 1999). Therefore there is significant scope for expansion of the roles undertaken by clinical managers in the Irish context, and particularly in the strategic and boundary-spanning domains. The literature on clinical managers emphasizes that roles bridging clinical and managerial groups are important. However the clinical-management roles in the public and voluntary hospital predominantly focus on operational rather than strategic management, maintain clinically based relationships and do not emphasise change management as a central component. From a pragmatic perspective, the findings illustrate that the low-level of non-consultant clinical-management roles in Ireland hinder the boundary-spanning and strategic orientation, which has been identified as valuable in other contexts. Suggestions for augmenting the potential contribution of such roles in Ireland include increasing the devolution of strategic responsibility and meaningful authority to non-consultant clinical managers. This would serve to broaden their relationship groupings and meaningful impact. An alternative is to increase the emphasis on higher-level clinical-management roles. However, a decision regarding whether such roles would draw upon a broader than medical base would need to be addressed in such an instance, as currently all senior clinical-management roles are held by consultants.

- **Facilitating relationships and networks to facilitate change**

Section 8.4.3 indicated that facilitating intra-professional relationships across institutions fills a peer-mentoring and peer-support function, as well as acting as a source of ideas for change. This finding is particularly interesting, as concern with relationships in change in the academic literature has predominantly emphasized the relationships in direct implementation of change, rather than broader relationship groupings which facilitate and impact upon both the initiation and implementation of initiatives. Thus the intra-profession peer-mentoring function is potentially highly significant from a practitioner and academic perspective, and is deserving of greater attention. In addition, the regional distribution aspect of the macro function of the regional implementation groups increased satisfaction with the transparency of the initiative, where all parties were involved. Thus, this finding extends the perceived value of networks from facilitating service provision, into a valuable tool for generating and implementing

change. On this basis, facilitating and supporting relationships is advocated in service-improvement contexts. However, as previous literature exploring the role of networks (Addicott et al., 2006, 2007) indicates, competition for resources can undermine knowledge sharing. Negotiating resource allocation at the outset of the process, as occurred in the voluntary hospital's region, is advocated.

- **Improving the performance of the HR function**

Chapter 8 noted that greater strategic clarity would facilitate the move towards the strategic orientation and change-agent role for HR, desired by the HR managers. In addition, a greater facilitation of training and development for individuals supporting or facilitating change has been identified as of potentially significant benefit. The low levels of management training evident across non-managerial respondents, particularly in the public and voluntary hospitals, are outlined in Appendix 8. From a policy perspective, the strategic clarity required necessitates the facilitation of longer-term strategic planning, by the HSE. Currently, the yearly planning cycle constrains the public and voluntary hospital. In addition, these organizations require a greater policy-level commitment towards training and development. There is also a potential role for HR in facilitating the relationship groups and networks advocated above. The HR function is a significantly under-exploited resource lacking a clear role and status. Consideration of how to deliver different HR strategies for workforces in the same organisation has been raised by the research, and merits significant managerial consideration.

- **Improving the performance of accounting and service-planning systems**

Chapter 8 emphasised the strong need for an extended planning horizon in the public and voluntary hospital, which requires a change at the HSE level. In addition, the need to plan and account for depreciation, to avoid crises and a distraction from service-provision and service-improvement, was raised.

- **The configurational nature of management**

Chapter 8 has emphasised the impact and interaction of role-level, organisation-level and environment-level factors on service-delivery and improvement. From a policy perspective, this requires addressing of issues encountered at the organisation level, but determined at the environmental level, such as accounting and service-planning systems and insufficient levels of senior-management autonomy. From a management-practice perspective, in

Table 10.1 Overview of key findings, Recommendations and Contribution

THEME	FINDINGS	RECOMMENDATIONS	CONTRIBUTION
ROLE LEVEL			
Actors involved in initiation and implementation of bottom-up change	- Service-improvement often led by committed individuals, making initiatives fragile, and individuals open to disenchantment - Consultants and clinical managers/heads of departments initiate change, which is predominantly implemented by clinical managers/HODs. Consultants act as gatekeepers and facilitators, except in the private hospital, where they were excluded. - Little clarity regarding who has responsibility for initiatives	- Incorporate service improvement into role definitions and create formal roles and processes to facilitate bottom-up change. This will facilitate continuance of initiatives in event of turnover, limit gaps in the supporting structure for change and create awareness of who is responsible for change -Challenges associated with front-line involvement in facilitating and implementing change include the potential for isolation and frustration, ameliorated by involvement in networks, as recommended below	Pragmatic and literature contribution - Supports prior findings of benefits of dispersed leadership - Suggests mechanisms to manage challenges - Identifies absence of general managers relative to UK findings
Actors involved in initiation and implementation of top-down change	- Less consultation and involvement of multidisciplinary staff evident in top-down change in private and voluntary hospital - HSE service planning system not reliable. Senior management team proactive in all but public hospital, which may be linked to constraints on the latter's autonomy	- Include all stakeholders from the outset to avoid unanticipated issues emerging and a loss of support and good-will. - Organisations require meaningful authority regarding planning for change, in conjunction with clear evaluative criteria	Policy contribution - Suggests link between governance structures, autonomy and the identification and implementation of top-down change.
Role structures and role adopted by consultant as constraining or facilitating influences on service improvement	Role structures and role adopted by consultant impact on those involved in initiating and implementing service improvement and level of consultation with multidisciplinary stakeholders Partial devolution of responsibility for service improvement to HOD's most desirable strategy for improving spread and quality of relationships and engendering multidisciplinary involvement Full devolution of responsibility for service improvement to HOD's useful strategy where consultant-AHP relationships poor	- A partial devolution of responsibility to department heads, in line with an overarching vision for the department. This facilitates the identification of appropriate changes from a broad pool of expertise, engenders buy-in, and can strengthen relationships. A full-devolution approach is advocated where a poor relationship between the consultant and multidisciplinary staff is evident	Practical Contribution - Recommends particular role structures and strategies to support service improvement in contexts of normal and poor inter-professional relationships

THEME	FINDINGS	RECOMMENDATIONS	CONTRIBUTION
Role and impact of clinical managers in Irish hospitals	- Three groups of clinical managers evident in Ireland. - Except for consultant-held roles, most clinical management roles are low level and operational. Operational focus mediated by (1) whether the role holder is a consultant; (2) the presence of organisational processes such as performance management and the explicitness of criteria for change; and (3) organisation roles structures, which affect responsibility afforded to clinical managers. - There is evidence of a shift towards management amongst CM's. This is clearly evident among clinical nurse managers, has been indicated by consultant responses and is variable among AHP's. - Issues of meaningful authority & budgetary control raised as constraints - Only clinical managers in the private hospital, and senior clinical managers, working across managerial and clinical groups	Further research differentiating between groups is required Incorporating a strategic and service-improvement remit into roles and performance management structures and creating roles structures and criteria for change could support service improvement. There is a need to clarify and support the desired contribution and roles of clinical managers, who are performing a more limited range than elsewhere. Measures may include attempts to address the drift into management if appropriate and the introduction of more clinical-management roles at higher levels. Meaningful authority, linked to budgetary control and cross-professional management is necessary to facilitate response to local needs and a strategic orientation	Literature, policy, pragmatic contribution - There has been no prior research into the roles of clinical managers in Ireland - Provides an overview of the current roles of clinical managers, the discrepancy between the roles performed elsewhere and recommendations to manage the challenges encountered
Role of uni- and multi-professional groups in facilitating change	- At regional level groups help to identify regional priorities, distribute resources and monitor implementation - At role level provide motivation, support, ideas for change through knowledge sharing and can develop in education forums for communities of practice.	- Establish and support networks to facilitate service improvement - Groups should have focused remit for service improvement - Avoid competition for resources associated within group by dealing with such issues at outset	Pragmatic and literature -Identifies networks as valuable in service-improvement. Extends perceived value from service-provision focus prevalent in the literature to the generation and implementation of change

THEME	FINDINGS	RECOMMENDATIONS	CONTRIBUTION
SUPRA-ROLE LEVEL			
Desired and actual roles of the HR function and effective mechanisms for service-delivery	- HR not a support for service improvement or change - Voluntary and public hospital aspired towards strategic and change-agent roles but engaged in administrative expert and employee champion roles - Perception that role and scope of HR misunderstood in health service - Moving towards strategic orientation problematic due to professional and complex nature of service, difficulty of strategy making in hospitals - Separation of strategic planning and operational service delivery in private hospital most effective mechanism of delivery	- HR should be providing training to those involved in service improvement and change, specifically clinical managers and consultants - Difficulty of strategy-making in hospitals undermines attempts to move towards HR. Greater clarity and autonomy in strategy making may support development of clearer role for HRM. This may require a change at HSE level to extend the service-planning cycle - Separation of strategic planning re workforce from operational function may be effective	Pragmatic and literature -Identifies underperformance of HR function in change, supporting previous findings in UK -Identify methods to clarify role of function and improve performance
Desired and actual role of service-planning and accounting systems	Previously identified issues, such as failure to relate service plans to budgets, variations in accounting practices and costing, the annual budgeting cycle and failure to reward efficient use of resources, related to progress in service improvement Desired role for function defined in relation to perceived failure	- Extend service-planning horizion - Standardise accounting systems to facilitate comparability - Relate budgets to service plans submitted	Pragmatic and policy - Identifies how issues in service planning and accounting affect climate for change, and how these issues can be ameliorated
Capacity for service improvement	- Identified configuration of factors affecting capacity for service improvement: accounting, service planning and governance systems	- Improve accounting and service-planning systems as above - Increase autonomy in governance and management	Theoretical, policy, pragmatic and literature contribution Identifies specific configuration of factors affecting climate for service improvement extending literature re context and prior theories regarding implementation of change in healthcare which focused solely on climate/receptivity.

THEME	FINDINGS	RECOMMENDATIONS	CONTRIBUTION
Climate for service improvement	- Climate for service improvement affected by levels of strategic distraction, management support and role structures.	-Provided insight into impact of specific constellations of contextual factors on moving change from initiation to implementation.	Pragmatic and literature contribution Adds to literature on context Practical implications for facilitating service improvement
No direct relationship between capacity and climate for service improvement	- Climate for service-improvement not determined by capacity for service improvement	- Lack of capacity for service improvement does not preclude significant success	Pragmatic contribution - Emphasises benefits of senior management support and role structures for service improvement
Differences across sectors in findings and the blurring of boundaries between sectors?	- Public Hospital greatest autonomy and efficiency in moving changes from initiation to implementation Perception of greater autonomy in the voluntary rather than public hospital - Some perceived blurring of boundaries between public and voluntary sector on basis of funding and externally imposed service-planning & accounting systems - Difficult to consider whether nonprofit organisations remain so under all definitions, as environment still in flux	- Increase autonomy of public and voluntary hospital - Generate clear criteria for service improvement - Adopt partial-devolution strategy for role structures	Literature and pragmatic contribution - Supports need for further research into differences in management processes across sectors - Need for further research to address conceptual debates regarding classification of voluntary hospitals as nonprofit organisations.

addition to the implications delineated in chapters 8 and 9, managers need to recognise both the direct and configurational implications of their activities. In addition to providing support for service-improvement, even in the face of strategic distractions, as some of the configurational factors influencing service improvement are determined at the environmental level, senior managers may need to engage in significant stakeholder management. Table 10.1 provides an overview of the key findings, the recommendations emerging and the basis on which they make a contribution. Next, Section 9.4 evaluates the research and considers its shortcomings.

Section 10.4 Evaluation and Shortcomings of the research

Specialization there is and there will be, but it ought not to be in terms of the more or less accidentally built disciplines as we know them. It should occur along the lines of problems, the solution of which requires intellectual equipment traditional belonging to...several disciplines.

– C Wright Mills, 1959: 155

As this research is contextually embedded and draws on a configuration of influencing factors, the literature review could be criticised as fragmented and lacking depth in parts, drawing as it does on a significant number of traditionally separate research areas. Ideally, as a result, each of these areas could have been explored in greater depth. However, constraints upon space precluded this. While the literature review and associated analysis could be criticised on this basis, the structure of both the thesis and literature review reflect the context-embedded, configurational and messy reality of organisational life. This is often excluded from single-discipline research and, as a direct consequence, from the results produced. The literature review and anlaysis presented in this thesis mark an attempt to mediate between considering the discipline and context-specific minutiae influencing individuals in organisations, and broader configurational patterns which influence organisational life. As such, it adopts a middle-way between Dawson (1994, 2003) and Pettigrew's (1987, 1990) approaches to processual research – attempting to maintain attention to the detail provided by respondents, while identifying generalisable themes.

Although providing a complex interpretive framework, the identification of the factors influencing the capacity and climate for service-improvement reflect the multifaceted and interactive reality of organizational life. These relationships also emphasize the uncertainty associated with change-management, which is enacted in and through constellations of contextual and other factors. While these factors begin to account for differences in the level and sources of change, the nature of their interactions remains somewhat ambiguous. Nonetheless, the findings do have significant practical implications, delineated above.

In undertaking this research endeavour, four issues arose about the research design: encountering mixed levels of analysis, managing ethical issues of confidentiality and consent, undertaking the number of cases, which precluded literal replication, and desiring additional data in support of emergent themes.

The issue of analysing data and drawing conclusions at a variety of levels arose during this study, as intimated in Section 6.4.2. As an exploratory study, the focus was on identifying factors at the role and organisation levels, which affected processes of change. Due to the mixture of levels of analysis, the role and relationship sections of the case studies, which pertained to the individual, were analysed separately from the remainder of the data. In the discussion of tracer issues, influencing factors at both individual and organisation levels were raised. During analysis, an attempt was made to separate data pertaining to influences on roles and role enactment from that pertaining to organisational features and processes. This separation was maintained in the presentation of the data in chapters 8 and 9, until the presentation of the final configurational finding. While working and deriving conclusions across levels proved challenging, it was ultimately rewarding as discussion of the key findings has illustrated. Although Yin (2003) advocated generating case designs focused either upon the individual or the organisation, this piece of work, and particularly the configuration of factors identified across levels, indicates that mixed-level analysis may yield powerful insights.

Managing confidentiality proved challenging throughout the research. While the confidentiality of the cases and individuals was a condition of entry to the organisation, the small scale of the Irish hospital sector makes individual organisations relatively easy to identify on the basis of contextual detail.

The greatest shortcoming of the research design was the limited number of cases undertaken. As discussed in chapter 6, a six- rather than three-case design would have strengthened the findings by providing literal as well as theoretical replication. However, as discussed in chapter 6, a trade-off between the number of cases and the quality and depth of analysis arose, as the number of respondents increased through snowball sampling. On the basis of the paucity of prior research, a decision was made to undertake three in-depth cases, and pursue emergent themes through future research.

The final shortcoming of the research is inextricably linked to the exploratory nature of the study and the attempt to identify emergent themes in the Irish context. While the partially-replicated study (Fitzgerald et al., 2006b) did provide a basis for deductive analysis and

informed the conduct of the interviews, where emergent themes have been identified, a greater volume and depth of data would have increased the robustness of the findings. However, the inability to predict the emergent themes meant that opportunities to clarify and probe deeper into these topics during interviews were lost. Nonetheless, in spite of the lack of literal replication and a desire for a greater depth of data in some areas, the themes provide a significant agenda for future research in which emergent findings will be further explored and tested. The agenda for future research is presented in Section 10.5 below.

Section 10.5 Agenda for further research

The agenda for future research in this context is determined by both methodological and content considerations, and by the exploratory nature of the study. From a methodological perspective, the benefits of literal replication would suggest exploring the findings presented in additional case study sites. However, the time-lag between data collection in the first and second set of cases could undermine the quality of the replication. As a result, an alternative approach is to explore the themes raised in other clinical areas. Such an approach would test both the robustness of the findings and whether they can be generalised beyond cardiovascular care. In addition further areas for exploration include the diversity of clinical-management roles, entrepreneurs in hospitals, the role of clinical-directorate structures, HR delivery in complex professional service organisations, separating the impact of service-planning and accounting systems and the position of voluntary hospitals in the health-service. These are discussed below.

- **The diversity of clinical-management roles**

To date, much of the literature on clinical managers has focused on doctors in management or examined clinical managers without differentiating between individuals from different backgrounds. However, this research indicated significant differences in the tasks and challenges faced by the three groups of clinical managers, with particularly salient differences between consultant and non-consultant clinical managers. This finding strongly suggests the need for further research into these differences. Such research should take account of (1) the differences in form and impact of clinical managers at different levels of the organization; (2) the role, structural and processual underpinnings in the private hospital, which allow sub-unit-level clinical managers to adopt a strategic orientation and span clinical and managerial groups; and (3) the tendency to move towards management, and how this can be addressed.

- **Entrepreneurs in hospitals**

The findings presented in chapter 8 suggest that individual entrepreneurial individuals such as the consultant in the public hospital and the consultant in the voluntary hospital, can achieve highly significant developments if supported. Identifying the characteristics of such individuals and how they might best be supported is a potentially high-yielding strategy for service improvement and worthy of significant further research.

- **The role of clinical-directorate structures**

Chapter 6 drew attention to the clinical-directorate structure in operation in the public hospital. Interestingly, no non-managerial respondents, with the exception of the medical director, referred to the impact of these structures on organisational processes or service improvement. While the consultant did refer to his support for the principle of involving medics in management, the medical director was critical of the efficacy of his own role. As a result of the deficit of responses on the facilitating role of the clinical-directorate structure with regards to service improvement or provision, there is a need to evaluate the desired and actual role of clinical-directorate structures in Ireland, and how they affect day-to-day management and service-improvement. This is important in light of policy advocacy of these structures, currently being piloted throughout the country.

- **Delivering HR in complex professional service organisations**

The research implications of the professional nature of hospitals, the complexity of healthcare services and the difficulty of strategy making in hospitals, raised in Section 9.1.4 are two-fold. Firstly, there is a need for a greater understanding of the current, actual and desired roles of the HR function from a variety of stakeholder perspectives. What is particularly interesting across the three cases presented is the advocacy for the devolution of operational responsibilities to line managers across the three cases, and the resistance to this among line managers in the public hospital. This intimates that the desired role for the HR function may vary across stakeholder groups. Secondly, from a pragmatic perspective, there is need to consider how to improve the performance of the HR function, both in terms of the desired roles for the function, and the delivery of HR services. While these issues have been raised in healthcare, the delivery of HR in complex organisations with multiple workforces is a broader dilemma in the HR field.

- **Separating the impact of service-planning and accounting systems**

Crucially, because accounting and service-planning systems are related (whose budgets provide an outline of the service-plan in financial terms; Byrne, 2006), further research is required to separate their influence on change. There was insufficient data to do so on the basis of responses received. However, this was unsurprising given the emergent nature of

this theme. Additional data, in conjunction with further qualitative analysis and potentially principal-component analysis, would contribute to greater clarity regarding the relative contribution or influence of each.

- **The position of voluntary hospitals in the health-service**

The findings presented in chapter 9 emphasised a perception that historically the voluntary hospitals had greater autonomy than the public hospitals, but that this was increasingly subject to threat on the basis of the significant level of government funding received and the restructuring of the HSE. Although the additional perceived discretion was emphasised as highly valuable, further research may be required as to whether this is maintained in the future.

Conclusion

This chapter has provided an overview of the context and findings of the research and the associated contributions to theory, literature, policy and practice. These have been usefully summarised in Table 10.1. Furthermore, the chapter has evaluated the research, highlighting shortcomings, and emphasising the associated opportunities for future research. To conclude, the chapter has clearly demarcated an agenda for further research in the Irish hospital sector. Through its provision of previously non-existent base-line data regarding the actors initiating and implementing service-improvement in Irish hospitals, and the factors which constrain and enable them, this thesis has begun to address the significant deficit in healthcare service-delivery and organisation research in Ireland. Through pursuit of the research agenda presented, it is hoped that the knowledge base in this domain will be meaningfully augmented in the future.

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APPENDICES

APPENDIX 1: Blurring sectoral boundaries?

Ambiguity, confusion and complexity characterise definitions of the public sector (Greenwood et al., 1993). A common approach to defining the public sector is to contrasting it with the private sector. The most commonly cited goals of the private sector are shareholder ideology and the profit motive (Friedman, 1962). In contrast, the public sector is broadly concerned with formulating and implementing public policy. Alternative classifications differentiate between enterprises and agencies (Dahl & Lindblom, 1953), or the ownership and funding streams of organisations (Wamsley & Zald, 1973 in Rainey & Chun, 2005). However, presenting the public and private sectors as distinct spheres of activity is misleading. Greenwood and Wilson (1993) assert that the public sector achieves many of its goals with the aid of the private sector. In fact, *'the line between "private" and "public" has now become so blurred that it is difficult to tell where government leaves off and private business begins"* (Nigro and Nigro, 1973 in Greenwood and Wilson, 1993, 7-8). Implied in this statement is a much lesser division between the two sectors that is commonly suggested. In fact, Greenwood and Wilson illustrate the extent of the inter-linkages between them in their assertion that public organisations set the parameters within which policy is generated, while policy is implemented with the aid of private organisations. Thus the two sectors are closely linked through hybrid forms of organisation, regulation and inter-influence through advocacy and contracting (Rainey & Han Chun, 2005). Skelcher (2005) refers to the phenomenon of 'hybridity', defining this as an organisation that has both public and private orientations. Hybridity is a phenomena associated with an indistinct boundary between public and private interests, as a result of the close engagement of private and non-profit organisations in the provision of public services. Such organisations result from the decision of governments to buy, rather than make, their resources, and are increasingly justified by the advocacy of the 'Third Way' (Giddens, 1998). Hybridity, as a concept, is one way to resolve the debate regarding the blurring of boundaries, referring to how government and private actors can work together. The entwined relationship between the public and non-profit sector can be presented in a similar vein, although, unlike the instance of the private sector, the two are not traditionally presented as diametrically opposed. Of particular note for this research, Brock, Powell and Hinings (1999) indicate that the management of professionalized organisations such as hospitals and management consultancies, differs little between the public and private sectors.

Reviewing research on the differences between public and private sector management, Rainey and Han Chun (2005) note conflict in research exploring differences in (1) operating environments; (2) transactions with the operating environment; (3) goals, roles, structures and processes and (4) comparative performance. However their review indicates some coherence around four themes. The first consistent finding is that most public managers encounter greater influence from institutions and processes designed to ensure accountability, and by non-profit oriented goals, than managers in the private sector. The second consistent finding is that managers in high-ranking and externally oriented public-sector posts will be more engaged with, and constrained by, political and governmental processes. As a result, they have more constrained and shared authority than their private sector counter-parts. The third consistent finding is that management in private firms generally have advantages in operational efficiencies, however understanding of how and why such advantages are derived requires further research. The strongest difference between the two sectors pertains to incentive structures. Tying pay to performance was found to be more difficult in the private sector. Finally, they emphasise that many factors, such as size, task, function or industry characteristics, can influence organisations and their management more than their sector (Rainey & Han Chun, 2005).

The clear trend towards integrating the private sector focus on efficiency and effectiveness into the public sector has been particularly explicit, if not entirely successful, in the UK. These concepts are particularly emphasised in the early models of new public management, which centred on efficiency, and downsizing and decentralisation (Ferlie et al., 1996a). Irish policy level rhetoric also indicates a strong centralised shift in this direction (Department of Health and Children, 2001b). However, in spite of these developments many commentators suggest that the adoption of private sector management techniques is not always appropriate in the public sector, due to its distinctive nature. Greenwood and Wilson's (1993) analysis of the introduction of private sector managerial techniques to the public sector indicates that there is much to gain. However, they also found that the public sector has a distinctive political element, as well as deeply embedded cultural norms. They question the extent to which cultural change can occur in such a context, without changing the structure of the sector itself, not merely the people within it.

APPENDIX 2: Recommendations from the Cardiovascular Strategy

The cardiovascular strategy makes recommendations for health promotion structures and public health strategies, primary care, pre-hospital services, hospital services, cardiac rehabilitation and information systems, audit and research. However, only those pertaining to the acute hospital sector and those from other sections with implications for the acute hospital sector are outlined here. This is due to the focus on the acute sector in the research. Within the cardiovascular strategy each recommendation has a number. These are of the format R5.2, where R refers to recommendation, 5 refers to the chapter of the strategy in which it is found and 2 refers to the recommendation number within the chapter. These have been preserved in this context to facilitate cross-referencing.

Health Promotion and Public Health recommendations with implications for acute care
The first set of recommendations within the strategy fall under the rubric of 'Health promotion and public Health'. Several of these relate to acute care and are outlined below.

The first (R5.2) emphasises the need to promote health and prevent disease, via reorientation of the health services. The need for an implementation programme and budget to manage this is noted. The second, (R5.17) asserts that evidence based health promotion programmes should be incorporated into the health services provided to older people and pregnant women. The third (R5.57) asserts that a set of indicators should be nationally agreed to assess progress in attaining targets for cardiovascular disease.

In the second implementation report, it is noted that many hospitals have joined the Irish National Health Promoting Hospital Network, which now has 64 hospitals. This network is a member of the World Health Organisation's international movement. It aims to inter-link hospitals with other health promotion approaches. Some hospitals within this have a hospital based HPH co-ordinator, which many affect progress against various strategic goals.

Primary Care recommendations with implications for acute care
In addition, six of the recommendations made for Primary Care have implications which are related to acute care. These include (6.22) agreeing a protocol for patient care for patients with cardiovascular disease with general practice. The second (6.26) requires agreeing protocols for shared care for patients with diabetes. The third (6.48) asserts that guidelines for the treatment of chronic cardiovascular and related conditions in general practice (angina, heart failure, post-AMI, post-stroke, peripheral vascular disease, diabetes) should be agreed nationally and adapted for use at local level. Fourthly, it is asserted that (6.49) protocols for shared care should be agreed for patients with chronic cardiovascular and related conditions who are referred for assessment and treatment in an acute hospital. Fifthly, (6.5) a pilot project should be undertaken to provide improved hospital-based support for general practitioners caring for patients with chronic cardiovascular conditions. Finally, (I6.7) the ICGP and the Irish Cardiac Society should agree clinical guidelines for the management of patients with chronic cardiovascular conditions, including protocols for shared care.

Pre-hospital care recommendations related to acute care
Of patients dying from fatal coronary artery disease, 50% will die within two hours of the onset of symptoms. The chain of survival entails (1) Early access to emergency medical services (2) Early cardiopulmonary resuscitation (CPR) (3) Early defibrillation and (4) Early advanced cardiac life support (ACLS) (Department of Health and Children, 1999). On this basis, recommendations are made regarding pre-hospital care. The three which are of import for acute care include R7.16, which asserts that an audit standard of 90 minutes from 'call to needle' should be accepted in Ireland. Closely linked to this is the need to create better systems for providing pre-hospital emergency care, which entails linking with first responders

and GPs in the community. In addition, R7.18 asserts that immediate steps should be taken to ensure that all patients with a suspected AMI benefit from early administration of aspirin.

One example of success in this context is illustrated in the second report on implementation (Department of Health and Children, 2002), whereby one hospital located in a predominantly rural county provided equipment and training to GPs, who could then manage cardiac emergencies within the community. Each GP also receives a grant towards emergency care equipment to improve the quality of care in the community. Those involved in its implementation included the consultant cardiologist and support staff at the hospital, GPs, the ambulance services, the department of General Practice at the local university, The Irish College of General Practitioners and the Primary Care Units of the Western and Mid-lands Health Board. This illustrates the degree of cross organisational co-operation required for such changes.

Recommendations for hospital services

In addition to the peripheral implications of recommendations pertaining to public health, primary care and pre-hospital care, forty five recommendations pertaining to thirteen sub-areas of hospital care are made within the strategy. These are premised on the fact that, in conjunction with an ageing population, the fall in the death rate from CHD, will lead to an increased need for angiography and interventional cardiology. In addition, a new epidemic of cardiovascular disease, namely heart failure, is emerging in the Western World. The primary recommendations for acute hospital services are (1) the provision of the additional consultant cardiologists, support staff and facilities required to meet the service specified; (2) improved access to diagnostic and invasive treatments; (3) appropriate equipment, staffing levels and staff training for acute hospitals, regional and tertiary referral centres and; (4) a range of clinical guidelines and protocols in respect of the appropriate care of patients in the hospital sector. (Department of Health and Children, 2002). Overall, the waiting list for cardiology procedures fell by 24% from June 1999 to June 2002, in line with the overall reduction in waiting lists for that period. The waiting list for cardiac surgery fell by 75% during that time (Department of Health and Children, 2002)

Treatment of acute Cardiac Conditions

The first set of eight recommendations pertains to the treatment of acute cardiac conditions. These are outlined below.

1. R8.1 A resuscitation training officer should be appointed in each general hospital and at least one whole-time resuscitation training officer per health board area
2. R.8.2 Education campaigns to encourage patients and relatives to seek help soon after the onset of symptoms should also highlight the benefits of taking aspirin
3. R8.3 A 'call to needle' time of 90 minutes should be accepted as the audit standard in Ireland
4. R8.4 Patients requiring thrombolysis should receive it within 30 minutes of arrival at the Accident and Emergency department.
5. R8.5 Pending the implementation of a national coronary care information system, a further census to CCUs should be undertaken to assess the extent to which thrombolysis is being given within the time recommended internationally.
6. R8.6 Each health board should convene a group to establish protocols for the efficient administration of aspirin and thrombolysis to AMI patients.

By 2002 21 additional hospital based resuscitation training officers were recruited, providing ongoing training to international standards in most hospitals in the country (Department of Health and Children, 2002). 12,000 people were trained in basic life support over 2001-02. In addition, 910 individuals were trained in Advanced Life Support in 2001.

The second set of recommendations pertains to the **Management of Heart Failure**

7. R8.7 All patients with heart failure should receive evidence-based treatments, particularly ACE inhibitors, beta-blockers should also be prescribed for patients with mild to moderate heart failure.
8. R8.8 Protocols should be agreed for the diagnosis and management of heart failure in different health service settings in Ireland – acute hospitals, general practice and shared care between hospital and primary care.

Secondary prevention

Secondary prevention refers to the prevention of progression and recurrence of illness in patients with an existing cardiovascular disease. Much of this is addressed via primary care. It is premised upon changes in lifestyles, modifying risk factors and using drug therapy.

9. R8.9 Secondary prevention, including support for necessary lifestyle changes, should be an integral component of care in all patients with cardiovascular disease.
10. R8.10 As in R6.22, protocols should be agreed at national level for shared care of patients with chronic cardiovascular disease, with special attention to secondary prevention.
11. R8.11 Different models of providing hospital-based secondary prevention services should be considered by each hospital to ensure that all cardiovascular patients benefit from comprehensive risk assessment and management. Where necessary a co-ordinator of patient care should be appointed to facilitate this.

Modification of the patient's risk factors

12. R8.12 Risk factors for recurrence should be assessed and appropriately managed in all patients with cardiovascular disease.
13. R8.12 (1) All patients with cardiovascular disease in who there are no contraindications should be on long-term treatment with a beta-blocking agent. (2) After an AMI all patients in whom there are no contraindications should be on long-term treatment with a beta-blocking agent. (3) All patients with left ventricular dysfunction, with or without overt heart failure, particularly post=-myocardial infarction, should be on ACE inhibitors.

Coronary Care Units

Coronary care units refer to areas which are designed and staffed to provide immediate treatment at the onset of cardiac arrest.

14. R8.14 Each hospital admitting patients with acute cardiac problems should have an appropriately trained physician.
15. R8.15 Each hospital admitting patients with acute cardiac problems should have a CCU with adequate staff and facilities. Where deficiencies exist in CCUs with regard to number of beds, equipment and staffing, such deficiencies should be remedied. Ongoing staff training should be provided, including secondment to tertiary referral centres.
16. R8.16 Each hospital should establish links between the emergency medical service, the Accident and Emergency Department and the CCU to implement 'fast track' policies for thrombolysis to agreed protocols.
17. R8.17 Health boards and hospitals should examine the facilities available for the assessment of acute chest pain in order to provide timely access to cardiac assessment for patients with recent onset on chest pain and to avoid unnecessary admissions.

The second implementation report in 2002 indicated that the staffing levels of CCU's were gradually increasing. One hundred and twenty seven extra CCU nurses and other specialist

staff were employed at mid 2002. In addition the number of CCU beds had been increased and facilities and equipment were also being upgraded with the assistance of strategy funds.

Cardiac Investigation Areas and Facilities
These recommendations are premised on the fact that most patients who develop heart disease need specialist assessment.

18. R8.18 Each hospital admitting patients with acute cardiac problems should have a Cardiac Investigation Area with appropriate staff and facilities.
19. R8.19 Each acute hospital should have echocardiography facilities. Each such hospital should have a physician with training to carry out these investigations. Each region should have one cardiologist with specialist expertise in echocardiography.
20. R8.20 Regional cardiology centres should have adequate facilities and staff for non-invasive assessment of patients.
21. R8.21 As new forms of cardiac investigation become standard, they should be added to hospital facilities.

Invasive Angiographic Facilities (Cardiac Catherisation Laboratories)
Seven public and two private hospitals provided these facilities at the time of the report. The recommendations were premised on the need for new facilities in some areas, and on having proper refer arrangements where services were relatively close at hand.

22. R8.22 Angiographic facilities should be provided as close as possible to the population served. A cardiac catherisation service should be developed or specific referral arrangements agreed for those health boards in which there is no such service at present.
23. R8.23 Day case facilities should be made available specifically for angiography and maintained as an essential component of this service.
24. R8.24 It is recommended that immediate action be given by hospitals providing an invasive cardiology service to developing ambulatory cardiology care centres, which in the future may be extended to provide day case angioplasty and other interventions.

Percutaneous Transluminal Coronary Angioplasty (PTCA)
This refers to a technique used to treat cardiac diseases without resorting to full surgery.

25. R8.25 It is recommended that provision be made for 1,200 PTCA procedures per million population by the year 2002.
26. R8.26 Those centres carrying out angioplasty should have appropriate nursing, technical and other staff back-up, plus the necessary funding.
27. R8.27 A feasibility study should be carried out of the likely number of emergency procedures and the costs of providing an out-of-hours PTCA service.
28. R8.28 It is recommended that cardiologists involved in interventional cardiology should perform at least 100 PTCA procedures per annum.

Intracardiac Electrophysiological Studies (EPS) and Pacing
This refers to establishing and correcting cardiac rhythms. They were not hugely prevalent at the time of the strategy, with 200 EPS procedures completed in 1998. However, they have since increased in prevalence.

29. R8.29 It is recommended that an EPS service including ablation be developed in selected tertiary referral centres.
30. R8.30 It is recommended that a cardiologist be appointed in each region with expertise in cardiac pacing. Regional pacing facilities should be established.

Permanent pacing rates should be at the European average and more sophisticated physiological pacemakers should be used.

Cardiology services: Access and co-ordination

At the time of the report access to cardiology services was geographically uneven, prompting the following recommendations.

31. R8.31 National structures should be established to facilitate the orderly development of services in tertiary referral centres.
32. R8.32 National protocols should be developed for the application of evidence-based treatments for cardiac diseases.
33. R8.33 A cardiovascular committee should be established in each health board region to oversee the provision of all services from primary care to cardiac surgery to ensure equal access by all patients in need of a service. National protocols should be adapted as appropriate to local circumstances. Links should be established between the cardiology services and services for patients with diabetes, other vascular disease and services for older patients. Particular attention should be paid to clarifying where responsibility lies for provision of secondary prevention and rehabilitation services.
34. R8.34 There should be formal referral arrangements between acute general hospitals, regional and tertiary centres to facilitate access to more sophisticated diagnostic and treatment services.
35. R8.35 Particular attention should be paid to the co-ordination of services in the Eastern Region. There should be a balance in the distribution of specialist expertise across geographic areas within the region.

Patients with special needs (Congenital Heart Disease and Cardiac Diseases of Genetic Origin)

These recommendations are premised on the fact that increasing numbers of individuals are surviving into adult-hood with congential heart disease and other genetically linked diseases.

36. R8.36 There are a total of three consultant paediatric cardiologists. One further paediatric cardiologist should be appointed to achieve a ratio of one per million total population.
37. R8.37 Cardiologists should be appointed to provide a service for patients with Grown-up Congenital Heart Disease and to take a special interest in cardiac diseases of genetic origin.

Staffing Requirements

The cardiovascular strategy found that Ireland had five cardiologists per million population, compared to an average of 49 per million in Europe. Thus there is an apparent comparative shortage, which is the basis of recommendations within this section.

38. R8.38 All tertiary referral centres should have a minimum of five consultant cardiologists. Selected centres should have specialists in EPS
39. R8.39 Regional centres which are performing diagnostic tests, including angiography, and inserting pacemakers, should have at least two cardiologists.
40. R8.40 As in R8.14, each acute general hospital should have a physician with appropriate training in cardiology.

From a situation where Ireland had 29 cardiologists at the start of 2002, seventeen new posts were provided over the course of eighteen months.

Other Staff Requirements

Outside of consultants, the strategy notes a lack of specialist nurses and cardiac technicians able to provide care to intensively ill cardiac patients.

41. R8.41 Each hospital that admits patients with acute cardiac conditions should ensure that competent staff are on duty at night and at the weekend to care for such patients.
42. R8.42 Nursing staffing levels should be examined as a matter of urgency. Appropriate steps should be taken to acquire and retain the skilled nursing staff necessary for a modern cardiology service.
43. R8.43 Technical and secretarial staff should be appointed to support the proposed developments in cardiology services

Audit in Cardiology

On the basis of inadequate baseline data on numbers of patients, resources available and outcomes of treatment, recommendations were made regarding the conduct of audits.

44. The CHAIR project to monitor admissions to CCUs should be implemented (R10.11). Other recommendations about cardiovascular disease registers should also be implemented; these relate to the establishment of registers of all invasive procedures including angiography, angioplasty and electrophysiology interventions, the development of a patient-based information system and further development of the Irish Cardiac Surgery Register.
45. R8.45 Protected time should be made available to cardiologists for clinical audit, research, teaching and continuing education.

In terms of implementation of the above recommendations, the Cardiovascular strategy asserts that;

1. I8.1 The Department of Health and Children should establish appropriate national structures to co-ordinate the development of services in tertiary referral centres, to facilitate formal referral arrangements between such centres and appropriate catchment areas and to develop national protocols for evidence-based care.
2. I8.2 Each health board should establish a regional committee to support the development of high quality evidence-based services and to liaise with the structures established at national level.
3. I8.3 Comhairle na nOspideal, in association with the Medical Council, should take responsibility for the review and reclassification of all relevant cardiologist and physician posts.
4. I8.4 The Department of Health and Children should provide funding for the medical, nursing, technical and other staff and for the facilities necessary to provide accessible cardiology services within appropriate time frames.
5. I8.5 Hospital managers should implement relevant recommendations; they should establish systems to ensure that all patients with cardiovascular disease benefit from evidence-based acute care and secondary prevention; each hospital should appoint a resuscitation training officer.
6. I8.6 Each healthboard should appoint at least one wholetime resuscitation training officer.
7. I8.7 The Department of Health and Children should establish a national surveillance systems for cardiovascular disease (R19.1) Priority should be given to the development of a coronary care register (R10.11)

Cardiac Rehabilitation

Cardiac rehabilitation is the final section of the Cardiovascular Strategy. It refers to activities undertaken to favourably affect the underlying cause of the disease. It is not an isolated form of therapy, but needs to be integrated into the whole treatment. In Ireland programmes tend

to be outpatient based, and concentrate on patients in the first few months after AMI or cardiac surgery. The ten recommendations made regarding cardiac rehabilitation in the Health Strategy call for (1) every hospital treating patients with heart disease to provide a cardiac rehabilitation service; (2) the service to be consultant led, multidisciplinary, exercised based and involve family members; (3) trained co-ordinators to be part of every programme and (4) a standardised form of audit to allow comparison between programmes (Department of Health and Children, 2002).

Rehabilitation is usually considered in four phases. Phase 1 is the inpatient stay. Phase 2 is the immediate (2-6 weeks) post-discharge period. Phase 3 is the intermediate (2-6 months) post discharge period and Phase 4 is the long term maintenance period. The first two phases of care are delivered as part of the inpatient and immediate post-discharge care. The unqualified term 'cardiac rehabilitation' is used to refer to Phase 3 programmes. This typically entails providing education on risk factors and compliance with treatment, psychological and psychosocial support and structured exercise training. Phase 4 normally involves the continuation of exercise training. At the outset of the cardiovascular strategy, only a few hospitals had structured cardiac rehabilitation services (Department of Health and Children, 2002). However by the second report on implementation, Phases I and II were available in every hospital treating patients with heart disease, while Phase III was available in 29 hospitals, compared to 12 in 1998. In addition, Phase IV is being developed in a small number of hospitals.

Appendix Figure 1.1: Scheme for patient management incorporating rehabilitation after myocardial infarction or cardiac surgery (Department of Health & Children, 1999)

PHASE I	
	EXPLANATION AND INFORMATION ↓ Medical ↓ Risk factors ↓ Medication ↓ Work prospects ↓ Prognosis MOBILISATION PRE-DISCHARGE EXERCISE TEST
ANGIOGRAM	REHABILITATION SECONDARY PREVENTION ↓ Beta-blockers ↓ Aspirin ↓ Anticoagulants
PTCA – CABG	↓ Standard ↓ Modified programme ↓ Unsuitable
	HOME
PHASE II	CONTINUED MOBILISATION LINK TO HOSPITAL GP INVOLVEMENT
PHASE III	EXERCISE TEST – functional assessment Exercise training formal group sessions ↓ Dietician ↓ Psychologist ↓ Vocational counsellor

	↓ Pharmacist EXERCISE TEST – training assessment
PHASE IV	OUT PATIENT REVIEW Continued exercise as prescribed Intermittent reinforcement of advice

Recommendations made under the remit of rehabilitation are outlined below;

1. R9.1 Every hospital that treats patients with heart disease should provide a cardiac rehabilitation service
2. R9.2 The programme should be multidisciplinary and usually exercise-based. Information should be provided in a variety of formats and family members should be involved.
3. R9.3 Consultant leadership is necessary to develop and maintain programmes. This should most appropriately be provided by a cardiologist or the senior doctor dealing with cardiac patients.
4. R9.4 All rehabilitation programmes should have a trained co-ordinator. An appropriate grading should be applied to these posts within the health services
5. R9.5 A standard form of audit should be agreed nationally to allow comparison between programmes. Individual programmes should evaluate their outcome.
6. R9.6 Phase I (in-hospital) cardiac rehabilitation should be part of the routine management of cardiac patients, with protocols and audit mechanisms to ensure that full coverage of relevant issues is achieved for each patient.
7. R9.7 Phase II (early post-discharge) cardiac rehabilitation needs further evaluation before definitive management strategies can be recommended. A co-ordinated programme of research is needed to identify needs, current practice in Ireland and elsewhere and possibilities for intervention. Funding is required to conduct this research.
8. R9.8 Phase III (intermediate post-discharge) cardiac rehabilitation has been extensively researched. We recommend the model widely used internationally.
9. R9.9 Phase IV: The Irish Association of Cardiac Rehabilitation strategy in preparation will provide the desired structured approach to long-term management.
10. R9.10 Provision of adequate funding for staff training, equipment and facilities needs to be made available as a matter of urgency.

Progress on these objectives outlined in the second report on implementation
An appropriate career structure for cardiac rehabilitation co-ordinators was being considered at the time of the second report on implementation. In addition, research was being conducted on the use and format of a cardiac rehabilitation audit system for Ireland was ongoing. This aimed to facilitate more informed decision making.

Regionally, 109 individuals, forming multidisciplinary teams, have been appointed to develop cardiac rehabilitation services. Of these, 45 were additional cardiac rehabilitation co-ordinators. These each received training, assisted from the Irish Heart Foundation. The report did note however, that while some hospitals had received minor capital funding to develop rehabilitation, services in a number of locations are being provided in accommodation which is too small or otherwise inappropriate.

The second report on implementation noted that the this model of structured care can reduce readmission rates and improve the quality of life. As a result, fifty professionals involved in the care of patients with heart failure received training on heart failure management using funding provided under the strategy.

Rehabilitation Implementation

1. I9.1 The IACR should assist the Department of Health and Children in identifying the gaps in current services so as to plan and cost the provision of a comprehensive, accessible cardiac rehabilitation service throughout the country.
2. I9.2 The Department of Health and Children should publish a plan and timetable for the development of cardiac rehabilitation services
3. I9.3 The IACR should agree a format and implement an audit system for cardiac rehabilitation programmes.

Information Systems, Audit and Research

This section of the report is premised on the need for accurate and reliable data on the extent of cardiovascular disease in order to address its prevalence in the population and to implement preventative and appropriate treatment strategies. The recommendations broadly concern (1) the establishment of a surveillance system for cardiovascular disease, which should be disseminated to professionals and the public. (2) The development and implementation of guidelines for health promotion, disease prevention and for the clinical care of patients. (3) Finally, the report recommends the conduct of research to support the prevention of cardiovascular disease and the treatment and rehabilitation of patients with cardiac disease. More specifically, the following recommendations have been made;

1. R10.1 A cardiovascular disease surveillance systems should be established. The surveillance system should;

- Analyse and report on routinely collected data (mortality data and the Hospital in-patient Enquiry HIPE)
- Access information from cardiovascular registers
- Access information from population surveys of disease symptoms and medical history, health behaviour and risk factors for cardiovascular disease
- Make information accessible and proactively disseminate it to health professionals and to the public
- Provide information to support clinical audit and the planning of health services

Mortality Data

2. R10.2 In the hospital setting the cause of death section of the death certificate should
3. R10.3 Research should be undertaken into the quality of the evidence on which death certificate diagnoses are made in Ireland. The extent to which an increase in the autopsy rate is required to improve the accuracy of death certificate diagnosis should be investigated.
4. R10.4 A national validation exercise should be undertaken using case histories to examine variations in the assignation of cause of death within Ireland
5. The Annual Report on Vital Statistics should be published within two years following the events to which it relates. There should be more in-depth reporting on mortality trends.

Morbidity Data

There are a number of sources of morbidity data for cardiovascular disease, namely;

- Hospital discharge statistics
- Prevalence surveys
- Prescription data
- Registers (both in the health services or population-based)

The recommendations within this section include

6. R10.6 National validation exercises should be undertaken at least every two years to check the accuracy of HIPE data for cardiovascular disease.

7. R10.7 The extension of the HIPE system to the private hospital sector should be encouraged and facilitated.
8. R10.8 There should be an annual report for HIPE to disseminate basic information on the data collected.

Prescription Data

9. R10.9 Potential sources of data on cardiovascular disease morbidity, such as drug cost reimbursement schemes, should be examined as part of the proposed cardiovascular disease surveillance system.

Prevalence surveys

10. R10.10 In order to acquire all relevant data, a population based CHD and stroke register should be established in a defined geographic area in Ireland

Coronary Care Register

11. R10.11 A pilot study for the development of a hospital-based register should proceed immediately. The lessons from this should be used to establish a national hospital-based register of coronary care.
12. R10.12 A patient-based information system should be established in at least one hospital referral centre to track patients from initial dagnosis.

Registers of Investigations and Interventions.

13. R10.13 A national register of angiography should be established.
14. R10.14 A national register of angioplasty and other cardiac interventions should be established.
15. R10.15 The scop of the Irish Cardiac Surgery Register should be extended to include all cardiothoracic surgeons
16. Mechanisms should be established to link records in the coronary care register and the registers of angiography, angioplasty and cardiac surgery.

Healthy Surveys

17. R10.17 Health examination surveys should be carried out every four to five years and a health interview survey in the intervening period.
18. R10.18 There should be complementary surveys of groups at high risk, for example, those from lower socioeconomic groups or those living in areas with high mortality rates.
19. R10.19 A protocol should be agreed for surveys of health behaviours among school pupils and young people.

Audit

20. R.10.20 Schemes should be established for clinical audit of the care of patients with cardiovascular disease.

Research

21. R10.21 Funding should be made available to undertake the priority research identified in this report

Implementation

I10.1 The Department of Health and Children should establish a surveillance system for cardiovascular disease.

I10.2 The Department of Health and Children should take the necessary steps to ensure the quality of death certification in Ireland, including training of medical practitioners and carrying out validation exercises.

I10.3 The Central Statistics Office should give priority to publishing the Annual Report on Vital Statistics within two years of the events to which the report relates.

I10.4 The Department of Health and Children and the Economic and Social Research Institute should implement the recommendations in relation to HIPE.

I10.5 The Department of Health and Children should continue to fund health interview and health examination surveys, including special surverys of those at increased risk of cardiovascular disease.

I10.6 The Health Promotion Unit of the Department of Health and Children should convene a group to agree a core protocol for surveys of health behaviour in school pupils and young people.

I10.7 The Department of Health and Children in association with service providers should ensure and fund the implementation of clinical audit schemes.

APPENDIX 3: Interview Schedule

Questions added to the original interview schedule are highlighted by the ** mark

Hospital Background (Additional question)

1. **Can you tell me about the history of this hospital?
    a) Prompt to see if respondent aware of whether the hospital is a public, voluntary or private hospital

Personal Background

2. What positions do you currently hold in the hospital (full job titles)?

3. What external positions (outside the hospital) do you currently hold?

4. How clearly defined are these roles?

5. In what three main ways have your roles and responsibilities changed in the past three years?

6. How is your performance in these roles monitored and assessed?

7. What management training/development/qualifications have you had which are relevant to your current posts?

8. Where do you expect to be in 5 years time?

Role Interpretation

9. Across those various roles, what are your key priorities?

    If necessary prompt:
    a) Can you give me examples of the kinds of tasks involved?
    b) Which do you see as management roles/responsibilities?

10. Who are the most significant others you have a relationship with. through work?

11. How do you influence these key individuals?

12. Is there anything distinctive about the way in which you work compared with colleagues in similar positions, here and/or in other hospitals?

13. **Would you work differently if you were in a private/public/voluntary hospital (ask appropriate two).
    a) Prompt re how or rephrase as 'does the fact that the hospital is a public/voluntary/private hospital have any effect on your daily experience or work? If so, how?'

14. **Would the status of a hospital ever influence your choice of role?

15. If you could make three changes that would allow you to perform your role or roles more effectively, what would those be?

Tracer Issues

Focus on changes and improvements in the cardiovascular arena, whether under remit the national Cardiovascular strategy or not

16. What have been the most significant service improvement changes in this area since 1999?
    (For senior management or board level respondents ask about cardiovascular services as a whole, then focus on particular issues.)

17. Can you explain these changes under the following headings? [ask questions for 2 specific changes]

    a) What changes have been put in place?
    b) Who have been involved in implementation roles?
    c) What external links have been significant?
    d) What internal links have been significant?
    e) What are the overall objectives of this change?
    f) What changes in emphasis or shifts in direction have taken place?
    g) What project management structures have been used?
    h) Your overall assessment of the change process to date?

18. **Can you think of any changes, either recommended under the cardiovascular strategy, or other initiatives, which were not successfully implemented or which were difficult to implement, and why?

19. The hindsight question: If you could go back and do it all again, what would you do differently?

APPENDIX 4: Case-study Template

Section	Contents
1. Setting	Location, physical facilities, outline of services, funding, hr - employment, recruitment and retention, local population profile, deprivation indices, technology.
2. Structure	Organization structure, committee and communication structures, job descriptions for Chief Executive, Clinical and Non-Clinical Directors, General Managers, other relevant roles. Internal political context in which decisions have to be made
3. History	Major events in recent history, changes to leadership, management and organization structure, new physical facilities, external events, culture.
4. External profile	Cardiovascular strategy targets, DOHC directives, media attention at local level, external quality indicators – Irish Health Services Accreditation Board, Comhairle na nOspideal, other external accreditation indicators or quality initiatives.
5. Finance	Current position; recent history - deficits, surpluses, recovery plans.
6. Strategy	Current business plan, major issues, strategic directions. Recent or forthcoming mergers. Planned changes, restructuring, modernization.
7. Attitudes	Results of staff attitude survey(s); patient surveys, formal complaints record, critical incidents.
8. Performance	Results showing how general reform and cardiovascular targets are met. Results of internal measures and audits.
9. Outer Context	Changes in competitors' strategies/competitive environment, government legislation, Changing social expectations, changes in the level of business activity, technological innovations, political, social, economic factors
10. Analysis: Documentation	What does site documentation reveal about the nature and specification of professional and clinical management roles, roles in change initiation and implementation, role relationships?
11. Analysis: Interviews	What do the interview data reveal concerning role interpretation, role enactment, and role relationships with respect to change and working relationships?
12. Analysis: Observation	What do observation data, casual and meetings, reveal about role interpretation, enactment, and relationships in change?
13. Conclusions:	Conclusions about the shaping role of organizational context

Context	with regard to change, receptiveness, roles and relationships.
14. Conclusions: Roles	Conclusions concerning role interpretation, enactment, and inter-professional relationships, and how they relate to change.
15. Conclusions: Relationships	Conclusions regarding relationships and how they help and hinder change.
16. Conclusions: Change	Conclusions concerning the nature of large-scale change in the professionalized organization and implications for practice.
17. Summary	Review of main findings of generic interest and findings for feedback to sites.

APPENDIX 5: Generic Interviewee List

Based upon the desired list of interviewees across levels in the seminal project, which encompassed senior managers, managers, consultants, nurses and allied health professionals in the specific care-area, the following were identified as the desired interviewees in each site. The list of those interviewed in each site is provided in Appendix 6.

Job Title
Board member, if appropriate
CEO
Finance Director
Director of Nursing
Director of HR
General Manager with responsibility for cardiovascular services
Clinical Governance Manager
Consultant/Lead clinician for cardiology or cardiovascular services
Medical Director/Clinical Director
Ward Manager
CNM2 Cardiac catherisation laboratory (if appropriate)
Chief cardiac technician (AHP)
Rehabilitation Manager
Resuscitation Manager
Medical Doctor

APPENDIX 6: Interviewee List by Site

Contextual Interviews

Interviews completed
Principal Officer, Department of Health
Lecturer in Health Service Management
Voluntary Hospital Region Chair of regional implementation group
Voluntary Hospital Region coordinator for regional implementation group
Public Hospital coordinator of regional implementation group
Consultant cardiac surgeon, critic of composition of strategy design group
Medical Director, Irish Heart Foundation
Note 1: Region C coordinator of regional implementation group no longer in post
Total: 7

Interviews in Public Hospital

Interviews Completed
Consultant Cardiologist
CNM2 CCU/ICU
HR Director
Pharmacist
Medical Director
Cardiac rehabilitation co-ordinator
Director of Nursing
Assistant director of nursing
General Manager
Finance Director
Chief Cardiac Technician
Cardiovascular nurse
Resuscitation manager
Total: 13

Interviews in Voluntary Hospital

Interviews Completed
Lead clinician for cardiology (Consultant cardiologist)
Additional Consultant Cardiologist
CNM2 Cardiology Ward
CNM 2 Cardiac catherisation laboratory
CNM 2 Coronary care unit
Clinical Psychologist.
Assistant Director of Nursing
Director of Nursing
Director of Finance
Assistant CEO

Director of HR
Mission effectiveness coordinator
General services manager
Cardiac Rehab coordinator
Resuscitation Officer
Chief 1 Cardiac Tech
Note 1: Medical Director not available for interview
Total: 16

Interviews in Private Hospital

Interviews Completed
CEO
DON
Director of Finance
Quality Manager
Cardiac Services Manager
Consultant cardiologist
Consultant 2
Consultant cardiac surgeon
Radiology Manager
Senior CNM2
CNM2 Cardiology ward
CNM2 Cardiac catherisation laboratory
Chief Cardiac Technician
Total: 13

Interviews in State Hospital 2

Interviews completed
Cardiac Rehab Co-ordinator (Invoived in strategy consultation group)
Cardiac Services Manager
Total: 2

APPENDIX 7: Coding Scheme

NVivo revision 2.0.163 Licensee: Aoife McDermott

Project: Aoife McDermott's PhD User: Administrator Date: 7/15/2007 - 18:55:09

NODE LISTING

Nodes in Set: All Tree Nodes
Created: 10/10/2006 - 16:13:35
Modified: 10/10/2006 - 16:13:35
Number of Nodes: 74

1 (1) /Roles

2 (1 1) /Roles/Role def - cm
How clinical managers define their role

3 (1 2) /Roles/Role def - clinical
Description:
How clinicians define their role

4 (1 3) /Roles/Role def - man
Description:
How general managerial representatives define their role

5 (1 4) /Roles/Discussion of nursing role
Description:
Discussion of changes or influences on nursing role

6 (1 5) /Roles/Other def of cm
Description:
How other organisational representatives define the role of the clinical manager

7 (1 6) /Roles/Multiple roles
Description:
Relating to general discussion of multiple or clinical management roles within the organisation

8 (1 7) /Roles/External
Description:
Discussion of external positions, outside of the organisation

9 (1 8) /Roles/Role clarity
Description:
Discussion of clarity or ambiguity of role definition

10 (1 9) /Roles/Role change - cm
Description:
Discussion of whether and how the clinical managers' role has changed

11 (1 10) /Roles/Role change
Description:
Other individuals' discussion of how their roles have changed

12 (1 11) /Roles/Priorities - cm
Description:
What the clinical manager defines as priorities within their role

13 (1 12) /Roles/Priorities - clinical
Description:
What clinicians define as priorities within their role

14 (1 13) /Roles/Prioties - man
Description:
What general managers define as the prioities within their role

15 (1 14) /Roles/Role comparison
Description:
Discussion of role comparison - within and between organisations

16 (1 15) /Roles/Ambition - cm
Description:
The clinical manager's plan for the future

17 (1 16) /Roles/Ambition
Description:
Other individuals' discussion of their plans for the future

18 (1 17) /Roles/Wish list - cm
Description:
Discussion of changes that would allow the cm to perform their role more effectively

19 (1 18) /Roles/Wish list
Description:
Other individuals' discussion of changes that would allow them to perform their roles more effectively

20 (1 19) /Roles/Performance man
Description:
Details of how individuals' performance is monitored and assessed

21 (1 20) /Roles/Accountability
Description:
Discussion of accountability arrangements within the organisation

22 (1 21) /Roles/Autonomy
Description:
Discussion of autonomy in the context of their role

23 (1 22) /Roles/Background
Description:
The background of the interview respondent

24 (2) /Training
25 (2 1) /Training/Man training - cm
Description:
Discussion of management training that clinical managers have had

26 (2 2) /Training/Man training

Description:
Discussion of the management training that general managers have had

27 (2 7) /Training/Man training - clinician
Description:
Discussion of management training that clinicians have had

28 (3) /Relationships
29 (3 1) /Relationships/Key relationships - cm
Description:
Key relationships that a clinical manager has

30 (3 2) /Relationships/Key relationships
Description:
Discussion of key relationships (Don't subdivide further as discussion of key relationships may be intertwined)

31 (3 3) /Relationships/Man - clin relationships
Description:
Discussion of relationships between managers and clinicians

32 (3 4) /Relationships/Influence - cm
Description:
Discussion of how clinical managers influence their colleagues

33 (3 5) /Relationships/Influence
Description:
Other individuals' discussion of how they influence their colleagues

34 (3 6) /Relationships/Medical - nursing relationships
35 (4) /Context
Description:
Data relating to the context of the cardiovascular strategy, the environment and organisational context, which is coming from the interview data and any documents which are coded

36 (4 1) /Context/Context of cardiovascular strategy
Description:
Any discussion of the context of the cardiovascular strategy, either it's establishment or implementation

37 (4 2) /Context/Environment & political context
Description:
Any discussion of or reference to the nature of the environmental or political context for change and hospital management

38 (4 3) /Context/Org History and Context
Description:
Major events in recent history, changes to leadership, management and organisational structure, new physical facilities, external events

39 (4 4) /Context/Cardiology
Description:
General discussion of cardiology as a clinical area and how it fits within the organisational framework

40 (4 5) /Context/Priority
Description:
The priority given to cardiology as a clinical area within the organisation

41 (4 6) /Context/Scale & Complexity
Description:
Details relating to the scale and complexity of the organisation (eg number of staff, beds, location, local population etc)

42 (4 7) /Context/Situation
Description:
Patient satisfaction surveys, financial situation etc

43 (4 8) /Context/Strategy
Description:
Current business plan, major issues, strategic direction of the organisation, planned changes etc

44 (4 9) /Context/Org structure
Description:
Discussion of org structure and implications

45 (4 10) /Context/Voluntary~healthboard~private
Description:
Discussion of whether this affects the respondent

46 (4 11) /Context/Regional implementation group
Description:
Discussion of regional implementation group

47 (4 12) /Context/HR
Description:
Discussion of role of HR from any individiual

48 (4 13) /Context/Accounting~service planning
49 (5) /Organisational changes~ Tracer Issue
50 (5 1) /Organisational changes~ Tracer Issue/General service improvement
Description:
Description of the most significant service improvement changes in cardiology since 2002

51 (5 2) /Organisational changes~ Tracer Issue/Service improvement 1
Description:
Description of the primary service imrpovement upon which the tracer description is based
52 (5 3) /Organisational changes~ Tracer Issue/Service improvement 2
53 (5 4) /Organisational changes~ Tracer Issue/Inception of the change
Description:
Description of how the change started and the impetus behind it.

54 (5 5) /Organisational changes~ Tracer Issue/Objectives of the change
Description:
The stated ovjectives of the change

55 (5 6) /Organisational changes~ Tracer Issue/Change story
Description:

The events which have taken place; the changes which have been put in place. As far as possible, the change story told in the respondents own words.

56 (5 7) /Organisational changes~ Tracer Issue/Implementation roles
Description:
Description of who have been involved in implementation roles and the part played

57 (5 8) /Organisational changes~ Tracer Issue/External links
Description:
Description of external links which have been significant

58 (5 9) /Organisational changes~ Tracer Issue/Internal links
Description:
Description of internal links which have been significant

59 (5 10) /Organisational changes~ Tracer Issue/Project management structures
Description:
Describe any project management structures in place

60 (5 11) /Organisational changes~ Tracer Issue/Outcomes achieved
Description:
What outcomes have been achieved

61 (5 12) /Organisational changes~ Tracer Issue/Overall assessment of success
Description:
the overall assessment of the change process to date

62 (5 13) /Organisational changes~ Tracer Issue/Issues encountered
Description:
Overview and explanation of issues encountered in all attempts to implement change

63 (5 14) /Organisational changes~ Tracer Issue/Hindsight question
Description:
If you could go back and do it all again, what would you do differently?

APPENDIX 8: Management training and associated benefits

In the course of the following discussion reference is made to formal, informal and 'other' qualifications. Formal qualifications refer to accredited qualifications in management or related areas (public administration etc). Informal qualifications refer to informal, short and unaccredited qualifications in management and related areas, whilst 'other' refers to additional training and development identified by respondents. Qualifications are outlined and discussed by role group. The situation in the public hospital is addressed first.

Management training in the public hospital

Appendix Table 7.1: Management training and discussion of associated benefits (Managers)

Role:	Org Level:	Success in service-improvement :	Qualifications /Previous Man Experience:	Felt Benefit of Management:
General Manager	Senior Manager	Overseen significant improvements	- Formal & Experience BA Public Admin Nursing background Worked in hospital, healthboard and primary care. Valuable cross-sector exp.	Need practical experience as well as man training. Had learning curve in post, but mentored by colleagues
Finance Manager	Senor Manager	Overseen significant improvements	- Formal CPA (accountant) Professional development Diploma in man. En route to MSc in Exec leadership	Man training very beneficial, at strategic and operational level
Director of Nursing	Senior Manager	Relatively new to org, but dynamic	- Formal, Informal & Exp H.Dip in Man Man Certs Prof Development Cross sector experience	Thinks you need an overview of management in all areas of health service
HR Manager	Senior Manager	Overseen transition and facilitated improvements	- Informal & Formal Degree in social science, postgrad in law Exp as HR Manager Dip from IPM Dip in HCM Short courses in man/mediation	Found mediation particularly interesting and others useful.
Assistant Director of Nursing	Senior Manager	Involved in nursing	- Informal & Formal Dip in Management Short courses Years of experience	Gain the most from experience

Themes raised by the senior managers included the importance of practical experience, mentoring, strategic rather than operational training and the benefit of cross-sector experience. All of the senior managers had some formal managerial training, with at least a diploma in management. This was in addition to their professional qualification or basic degree and numerous short courses. The Director of Finance was en-route to gaining a Masters in Executive leadership. Three of the senior managers, three had nursing

backgrounds (General Manager, Director of Nursing and Assistant Director of Nursing), while the financial manager was a certified public accountant and the HR Manager had a social sciences degree and a postgrad in law. Both the General Manager and Assistant Director of Nursing particularly emphasised the benefit of practical experience as well as formal training; *'I think you gain the most management from experience.'* (Assistant Director of Nursing). The General Manager benefited from an informal mentoring structure with her colleagues, as she did not have a significant amount of practical management experience in the hospital sector.

The General Manager and Assistant Director of Nursing both articulated the benefit of having cross-sector experience for their roles. Similarly, the HR Manager used his private sector role as a reference point for his activities. For the Director of Finance, a key benefit of his managerial training was the strategic and forward-looking focus engendered by it.

Appendix Table 7.2: Management training and discussion of associated benefits (Clinical managers)

Role:	Org Level:	Success in service-improvement	Qualification /Previous Man Experience:	Felt Benefit of Man Training:
Medical Director	Boundary spanner, senior clinical manager	Warfarin clinic	-Formal & Informal Diploma in medical Man. Formal man training from NHS. Exp from managing lab	Managing lab useful experience. Didn't refer to value of formal training.
Cardiac Rehab Co-ordiantor	Op and clinical management	Set up cardiac rehab services	- Informal Short course (8 weeks)	Opted to do it herself
Resus Training Officer	Op and clinical management	Expanded training program & community involvement	- Formal Diploma in Health services management	Formal training beneficial but does draw more upon experience
CNM2 CCU	Op and clinical management	Opening extra bed	- Formal 4 year healthcare management degree	Very beneficial in people management
Cardiovascular Nurse	Op and clinical management	Implementing chest pain guidelines	None	Felt it would have been beneficial particularly as the her role was new and evolving
Chief Cardiac Tech	Operational and clinical management	Developed unit. Now stagnant	- Informal Short Course	Benefits complemented by learning on the job
Chief Pharmacist	Operational and clinical management. More senior than CNM2 level	Expanded services offered. Developed pharmacy-led warfarin clinic	None. Are courses available, but tries to do clinical ones. Had four years managerial experience in retail pharmacy.	Experience useful, but clinical courses more important.

Of the seven individuals engaged in clinical management in the public hospital, three had a formal management qualification; two at diploma level and one at degree level. Of the remaining respondents, two had attended short-courses offered by the hospital and two had received no formal management training. Themes raised by the respondents included the value of on-the-job learning, which both complements and substitutes for formal training, and the tension/opportunity cost between clinical and managerial training. The benefits espoused by staff included assisting with the people and in one instance, financial aspects of management.

When questioned regarding the benefit derived from management training, two of those who had engaged in formal [non short course] management training did note that it had been beneficial. The two respondents who had completed diploma level training noted that they also drew heavily upon their experience and on-the-job learning. The CNM2 who had completed a four year degree noted that she found the formal training extremely helpful *'particularly in terms of the basic aspect of managing people; that you'd have to take everybody's views on board.'* (CNM2, CCU, Public Hospital) The CNM2 later asserted that she would like her own budget to manage her unit; a wish perhaps facilitated by her formal management training, where she had done budgeting and management accounting. The Medical Director, who was the most senior clinical manager to have engaged in formal management training did not explicitly refer to the value of this, either in terms of managing his laboratory, or in his senior-management role, which is interesting. He did however note the practical benefit of his experience in lab management.

Neither of the two respondents who had undertaken short-courses in management (Chief Cardiac tech and the Cardiac Rehab co-ordinator) articulated explicit benefit associated with the training. However this may have been implied in the cardiac technicians assertion that *'I did a course in it, and then it's learning on the job, really.'* (Cardiac tech, Public Hospital).

Of the two who had not engaged in formal management training, one individual felt that it may have been beneficial to her, particularly due to the evolving nature of her role (Cardiovascular nurse). The other prioritised clinical over managerial training.

Several respondents noted the tension and opportunity cost between clinical and managerial training. This is particularly evident among the more operational and clinically focused clinical managers. Whilst she had benefited from managerial training, the CNM2 CCU wasn't actively encouraging her staff to engage in this. She noted that *'they tend maybe to opt to do clinical stuff first, because that's basically what they're doing daily. .. but...certainly management is part of their role when I'm not here.'* (CNM2, CCU, Public Hospital). Similarly the Chief Pharmacist noted that she would prioritise clinical training *'To be honest with you, unless you think they are really, really valuable, I suppose I try to do the clinical courses more.'* (Chief Pharmacist, Public Hospital). The Chief Pharmacist was an interesting case, as whilst she had undertaken no managerial training, she was the individual most pro-actively engaged in service-improvement. It may be significant that she saw no benefit to formal management training. One way to circumvent this tension may be to introduce obligatory management training – similarly to as in the NHS for consultants – for particular posts. Respondents predominantly emphasised the link between management training and managing people rather than resources.

Clinician: The consultant cardiologist in the public hospital had received no formal management training. However the consultant did note that whilst consultants develop some people-management skills through their work he hadn't *'any doubt that that could be unequivocably complemented by something'* (Consultant, Public Hospital). In particular, he noted that whilst his current role requires people management, if it were to expand to encompass budgetary responsibility then formal management training would be necessary. *'I*

think that if doctors are to move into that area I would have thought that they were going to need a degree or a level of training or something.' (Consultant, Public Hospital).

The assertion regarding current capability without training was based upon a conversation he had conducted with an expert on health system analysis. Having asked his opinion regarding doctors and management, the expert had told him that for his role as it stands he had an intimate awareness of his own service, its equipment and staffing need and the fact that he was working continuously with people in his department meant that he *'had all the training you need.'* (Consultant Cardiologist, Public Hospital).

Management training in the voluntary hospital

Appendix Table 7.3: Management training and discussion of associated benefits (Managers)

Role:	Org Level:	Qualifications /Previous Man Experience:	Felt Benefit of Management:
MEC	Board	• Significant practical experience	• Not applicable
Deputy CEO	Senior Manager	• Masters in Economics • Masters in Business Studies • Management experience	• Necessary to have management training and practical experience
DOF	Senior Manager	• Accountant • Short courses with office of health mangement	• Accountant by trade and attends others as required
DON	Senior Manager	• MBA in Health service management • Other informal skills • Significant experience	• Exp and nursing insufficient • Need MBA to link meaningfully with corporate management team
DOHR	Senior Manager	• Degree in HRM • MBA • Experience in semi-state org	• Useful to have broad management training as well as HR
ADON	Manager	• No formal training	• Liaises with other ADONs when requires assistance

The senior management team was very well qualified, with all except the DOF having a broad management qualification at Masters level. Two of the senior management team had MBA's. All also had significant managerial experience, making their insight into the benefit provided by managerial training particularly meaningful. All emphasised the benefit of having a broad overview, particularly given the complexity of the group structure.

The DCEO asserted that in his opinion professional competence requires both training and practical experience. In addition to his background as an AHP he undertook a Masters in Economics and in Business Studies. The DOHR had undertaken a degree in HR and an MBA. He emphasised the benefit of the broad management perspective garnered from the latter, particularly given the complexity of the organisation.

> *'I did a primary degree in HRM and then I did an MBA subsequent to that to get a broader perspective than the HR piece, a combination I suppose. I think from the perspective of an organisation like this, where you're dealing with other disciplines, I think it's helpful.'* (DOHR, Voluntary Hospital)

The DON also had an MBA, though hers was specific to healthcare. She also underwent significant skills development through the years. She emphasised the importance and benefit

of the MBA in liaising with the senior management team, and making a meaningful contribution as an executive. She particularly emphasised the benefit of business and financial acumen in liaising with her colleagues;

> *'I need it because you can't sit comfortably with other members of the corporate management team where they're discussing issues relating to finance, balance statements and whatever. Also at the end of the day I have a budget. I control the largest proportion of the budget – they pay. Nurses are the largest number here.'* (DON, Voluntary Hospital)

The ADON had no formal management training, asserting that *'you learn it on the job really as you go.'* In addition she noted that there are eight ADONs and *'if you want a bit of help on something you know who to go to. There's always somebody there to go to.'* (ADON) However of all the respondents she was weakest in terms of her management capacity and vision for the service.

The next table outlines management qualifications amongst clinical managers. Outside of the consultants, who only had informal education, the clinical managers were well qualified. All of the CNM2's had formal qualifications at degree level. Similarly the CCT had a management degree. The RTO was the only non-consultant clinical manager to have no management training. Interestingly both consultants advocated the provision and benefit of managerial training. More detail is provided in the table overleaf;

Appendix Table 7.4: Management training and discussion of associated benefits (Clinical managers)

Role:	Org Level:	Qualification /Previous Man Experience:	Felt Benefit of Man Training:
LCC	Management	• Informal experience	• Felt management training and training in structures very important
CC	Management	• None	• Feels that the lack of training is a deficit
CNM2 Cath lab	Mid management	• Management Degree from RCSI • 15 year man exp	• Supports on the job learning • Necessary to get job
CNM2 CCU	Mid management	• Dip in First line Management • BSc Nursing Management	• Dip more beneficial as very practical. Degree abstract and hard to relate to her reality. More appropriate to senior management.
CNM2 Cardiology	Mid management	• Degree in management RCSI	• Useful for practical issues such as dealing with staff arriving late
RTO	Service provision	• None	• Other clinical priorities
CCT	Service provision	• BSC in Healthcare Management DIT	• Some aspects helpful and some not relevant

Consultant Clinical managers: The LCC had informal management training. He noted that he perceived the introduction of management training as very beneficial, and particularly wished to see insight being provided into how the hospital and healthcare *systems* work.

> *'You get some guy coming in at the age of thirty seven to forty two, that's a newly appointed consultant holding a contract with the HSE, and he doesn't have ac clue how he's supposed to function. He doesn't even know how his own hospital functions. Management training and training in systems; that's the one thing I would change.'* (LCC, Voluntary Hospital)

For the consultant cardiologist his lack of any management training is a deficit which impedes his efficiency. To compensate he works closely with a friend who is an accountant and who provides two days of his week to the Heart Failure Unit. The CNM2 Cath lab also emphasised the strong need for management training amongst senior medical staff. She based this assertion on the fact that they lack any management experience or training behind them, in combination with the fact that

> *'They spend their entire career saying 'get me' and it's been got for them. And now all of a sudden people are saying to them 'I can't do this' or 'I won't do that' or 'Can I have' and they're just like 'NO'. Because they don't know how to, communication isn't there and the people management skills. And I think they can find that quite difficult.'* (CNM2 Cath Lab)

Other Clinical managers: The CNM2 Cath lab had completed a 'degree course' in management. Although she had significant managerial experience she found it beneficial. As well as learning new things she noted that a benefit of the programme was insight gained into what she was doing well and how she could improve. In addition to the practical benefit afforded by the qualification, she noted that if she were to reapply for her own job now, she would not receive it without a managerial qualification. The CNM2 CCU had undertaken a diploma in First Line Management and a degree in Nursing Management. Similarly to the CNM2 cath lab she undertook the degree as she felt it could give her further insight into her role and how she could improve it. However she found the diploma of most benefit as it was practically oriented. In contrast she found some of the degree content abstract and difficult to relate to her day-to-day role. She noted that

> *'If I was higher up in management I might have been able to relate a little bit more, but for me, I'm in a practical job, it's a practical area, I need practical solutions to the problems that we face, and I found some of the thinking involved in the degree, I found it a bit far-fetched, you know.'* (CNM2 CCU, Voluntary Hospital)

The CNM2 Cardiology ward has also undertaken a degree in management. Like the CNM2 Cath lab and CNM2 CCU she felt that she should undertake some management training given that she was in a management role. The CNM2 Cardiology ward found the training beneficial, particularly for practical issues such as dealing with staff arriving late. She noted that there is no organisational or other support for staff making the transition from CNM1 to 2, or even moving from staff nurse to CNM1. As a result she asserted that *'I needed it for the job, and for my own benefit as well.'*(CNM2 Cardiology ward) The CNM2's clearly articulated a desire to benchmark for their managerial performance and identify areas for improvement. Whilst managerial training assisted in this regards, there is potential for this process to be further supported by a formal performance management system.

The CCT undertook the BSc in Healthcare management. This is a four-year part-time course. It is run for people in health professions who want some knowledge of management. Like the

CNM2 CCU she found some aspects of the training helpful, whilst she didn't see herself using others.

> *'Overall I think it was quite helpful, it gave an insight into how to organise things, if I need to talk to management about something, thinking about how to put a plan in place, if I'm looking for more staff or looking to expand service, how am I going to put in for it.'* (CCT, Voluntary Hospital)

The RTO was the only clinical manager to have no management training or qualifications. She noted that she has too many other and more pressing demands on her time to devote two years to study or even to take one of the short courses offered by the hospital. This raises the issue of support for those who wish to pursue managerial training.

Clinicians: The clinical psychologist had undertaken a diploma in management run by the hospital. She could not remember having derived significant benefit from it. The CRC asserted that while she had no formal management training she had undertaken the degree in nurse management which was very useful for her.

Appendix Table 7.5: Management training and discussion of associated benefits (clinicians)

Role:	Org Level:	Qualification /Previous Man Experience:	Felt Benefit of Man Training:
CRC	Service provision	• Degree in Nursing Management	• Very helpful
Clinical Pyschologist	Service provision	• Short internal course • 7 years experience at ADON/DON level	• Can't remember drawing upon this in practice

Management training in the private hospital

An overview of is provided in Table 9 and a discussion follows. A key theme was the comparatively high level of qualifications evident.

Table 9: Management training and discussion of associated benefits

Role:	Org Level:	Qualification /Previous Man Experience:	Felt Benefit of Man Training:
MANAGERS			
CEO	Senior Management	- Dip in accounting/ finance - Marketing exp - Exp in private public/hosp management	- No formal training when he started career.
Head of Finance	Senior Management	- Accounting - Exp in other industries - No broader training	- Moving to professional org different & challenging to relate to people w/o man training
DON/DON	Senior Management	- BA in Health Admin - MBA - Exp as ward sister	- Man Training imp to have credibility, works well with clinical background
Cardio-thoracic services manager	Management	- Qualification in project management - MBA in Healthcare Management	Peer mentoring & support imp, but MBA/ formal training 'best thing I ever did'

Quality Manager	Management	- Significant man exp Eire & abroad - MBA	- Not all aspects of training useful. People man/coaching most beneficial
CNM2 Cath lab	Operational & Clinical Management	- Dip in HCM - Short courses arranged by DON	- perceived as valuable - learn more via hands-on - some teaching not overly relevant
Clinical Manager			
Radiography Manager	Operational and clinical management	- Many short courses	- imp in gaining new perspectives - usefully supported by visits to other sites
Chief Cardiac Technician	Operational & clinical management	- IBEC course	- Good in dealing with conflict and managing expectations
CNM2 Cardiac Unit	Operational & clinical management	Informal training; several short courses	No felt lack
CLINICIANS			
Consultant Cardiologist	Clinical service provision	None indicated	Not discussed
Consultant Cardio-thoracic surgeon	Consultant & Directorate Lead elsewhere	None, all experiential	Recognised benefit of training, but felt many managers also under qualified in public sector

Managers: With the exception of the CEO and Head of Finance who have broad experience, the senior and middle management team within Private 1 is very highly qualified. It is certainly worth considering whether they are exceptional in this regards. The Head of Finance meets the common criteria of having a background in accounting. The CEO has the least formal qualifications of all the members of the management team. With a clinical background, he has experience of marketing in the pharmaceutical industry, worked in operations management in a public hospital in the UK and managed a private sector hospital in the UK. Whilst he has only a diploma in accounting/finance, he has broad experience. He noted that there isn't really formal training for hospital managers in Ireland, though MSc's and MBA's in healthcare are becoming increasingly prevalent. These have been taken by the DON/Director of Nursing, Quality Manager and Director of Cardiovascular Services. The cardiothoracic services manager had completed an MBA in Health Care Management, which is a joint degree between Smurfit Business School and UCD. Upon questioning regarding the benefit of the MBA, she replied that it was *'The best thing I ever did'* (Cardiothoracic services manager). The MBA is a mixed professional context, and two other members of staff have since completed the same degree (the quality manager and IT manager).

There is a formal mentoring programme within the organisation, whereby new managers can choose a mentor from among their colleagues (Cardiothoracic Services Manager); however a variety of reasons were provided for the pursuit of formal qualifications. These included (1) the importance of management training for credibility (DON); (2) the ratification of tacit knowledge (CSM) and (3) the benefit of information regarding people management/coaching. Whilst on aggregate the perception of management training was positive within the managerial grouping, two individuals – the quality manager and the CNM2 Cath lab – noted

that not all aspects of the training were useful, with the pragmatic components of most benefit. The CNM2 from the Cath lab had undertaken a Diploma in Healthcare management. However there was a marked level of difference in the level of management training among departmental heads, clinical managers and clinical respondents, with a heavy reliance on informal training, in comparison to the formal qualifications of the more senior managerial group.

Clinical Managers: The three respondents in the clinical management grouping were departmental heads, for the cardiac ward, cardiac technicians and radiographers respectively. All had undergone informal short-course management training. None expressed any felt lack at their level of training. All had found the courses of benefit. For the CCT the training was particularly useful in dealing with conflict and managing expectations, which she found difficult. Similarly, the radiography manager found the training useful in gaining new perspectives. However she noted that this was also assisted by visits to alternative sites. The pragmatic components of training were emphasised by this group.

Clinicians: Neither of the clinicians had any management training, and all of their knowledge was experiential. Whilst the consultant cardio-thoracic surgeon noted that many consultants could benefit from managerial training, he also emphasised the lack of training among hospital managers in general. This comment was made with regards to public-sector organisations.

Overview and emergent themes:

Overall the picture is one of relatively low-level management training, linked to personal initiative and drive. However the pattern in the private hospital was somewhat different to the other organizations. This may be linked to their sponsoring of formal education, and the organization and provision of short-course training. Nonetheless, like the other two cases, the picture below senior and middle management is one of disjointed and informal training, very much linked to personal initiative.

A common theme was the recognition of the importance of experiential learning. Key issues concern whether (a) the absence of formal qualifications equates to a lack of capacity or (b) whether managerial training increases confidence, efficiency and effectiveness. The issue of who pays for training and the cover required to attend courses is an important practice issue in ensuring that staff avail of these. Levels of management qualification appear to be higher than in the UK The most pronounced difference is within the clinical management group, which is particularly surprising as clinical managers are operating at a lower organizational level in the Irish context. A key issue is the number of managers coming from clinical backgrounds, and the apparent gravitation towards loss of practice over time. The issue of whether the career trajectory of managers from clinical backgrounds leads to a trade off between experience and know how, and system and clinical knowledge is important. It is also unlikely that this situation will improve without being systematically addressed. The fact that there was little evidence of clinical managers emerging as a profession complicates investment in training, as any investment will only provide returns in the short-term unless a viable long term career structure emerges for them.

APPENDIX 9: Deductive themes

From the seminal study

- Influence of context on change
- Link between the organisational context and service improvement progress
- The distraction of strategic plans, and their impact on service-improvement
- The nature of clinical managers roles
- The impact of the quality of relationships
- The role of HR in change

From the literature

- Dispersed leadership in change
- Key roles in change
- The HR function and its role in supporting change
- The quality of relationships and their implications for change
- Sector difference in management processes?

From case analysis

Environmental factors mentioned as influences on change or organisation processes

- Scale (public, private, voluntary hospital)
- Context – accounting systems and service planning systems (public, voluntary hospitals)
- Role of the regional implementation structures (public, voluntary hospital)
- Role of the HR function (public, voluntary hospitals)

Organisation level factors influencing on change or organisation processes

- Perceived benefit of clinical directorate structure (public hospital)
- Impact of strategic distraction of senior management (voluntary hospital)
- Nobody with ultimate responsibility for change 'nobody in charge'. But not like case from D. Buchanan's human relations article – no devolved responsibility of structures to keep things moving. (voluntary hospital)
- Power/roles/relationships has important links to who initiates, leads and implements change (all cases)
- Motivation for change – (1) what is it and (2) felt strength amongst respondents. Financial imperative strong in private hospital
-

Roles

- Innovative roles in the private sector
- Low level and benefit from clinical management roles (public and voluntary hospitals)
- Where does the improvement or change knowledge lie? If it is only with one or two people, generally the consultant, then the system and initiatives are quite fragile. (public, voluntary hospital)

From cross-case analysis, including interesting and surprising findings

Roles Theme 1: Who takes responsibility for initiating, leading and implementing change

- Differs across hospitals and according to scale of change

Roles Theme 2: Role, position and impact of clinical managers/ managers with clinical backgrounds

- Differences between medical and nurse managers. Consider link to role structure and autonomy
- Highly qualified but not strategic and no scope for them to move upwards into medical-director type roles. Underutilisation of a key resource.
- Consider literature in UK from circa 10 years ago. Similar themes re being overworked, lacking authority and lacking budget etc. Look back and see what components of the Irish findings mirror this. Is this a developmental thing; are the Irish findings reflective of a particular stage of development. Consider nurse managers here.

Roles theme 3: Innovative roles and dispersed leadership evident in private hospital.

- Innovative roles impact on boundaries between groups power balance in terms of the dynamic of power shifting away from the consultant. Could introduction of innovative roles (process improvement, quality improvement, delegating HR and autonomy/authority to line managers) be of benefit? Role of CEO also facilitator in this regards. Need to debate criteria of efficacy in this discussion.

Roles theme 4: Variations in prevalence of dispersed leadership associated with effectiveness of change processes?

Organisation level Theme 1: Motivation/Climate for change for change.

- In private change is linked to achieving increased efficiency/effectiveness which is linked to bottom line. Strong clarity of focus in Private hospital. In voluntary hospital there is a structural imperative to look like they are doing things without changing. The cause of this difference is linked to governance structures, motivation of board, autonomy and accounting systems. These limit capacity to which things can be achieved and therefore act as de-motivators. The implications of these motivations have huge impact for harnessing bottom-up change and links to innovative roles in this process.

Organisation theme 2: Climate for change linked to scale?

Organisation theme 3: Different employment relationships across sectors

- Different models of the employment relationship across groups in private hospital. Consultants are service provider and utilised in this capacity. Consultants feel supported (quotes re difficulty of achieving anything in public sector also support motivation part) so they just focus on service provision. However do however need to note negative/dysfunctional side-effects for other staff in this regards. Eg being forced to stay late etc. Refer to Atkinson

Environmental Theme 1: Facilitating relationships

- Important to do this as ensures all parties involved in change and also due to findings regarding frustration, demotivation and incentives for change. Facilitating relationships linked to scale and regional implementation structures.

Other emergent themes: disconfirming results/unexpected themes/surprising things/things found in literature but not reflected in findings

- **Leadership constellations in service-improvement change?**

These in the literature which are silent in the data can be interesting. Their absence can be very significant. One example of this is the literature on leadership constellations in strategic change (Denis et al). This seems to be less evident in these findings, with the exception of one large-scale change. Are there potentially different forms of leadership for service-improvement rather than strategic change? Could link as a scale issues or try to draw distinctions regarding the type of change. The implication is that you could need different forms of leadership/change agency for different types of change.

- **Influence of scale on resource acquisition and utilisation unexpected**

Larger scale is important in the acquisition of resources due to position and influence in network. However smaller scale is a greater facilitator of effective implementation of change. Supported by both small organisations.

- **Fragility of implementation structures**

Nobody in charge: hard to identify who is ultimately responsible for change in all but private hospital. Also issue of where improvement knowledge lies. If very concentrated, as is in all contexts, then improvement is fragile if anything happens to them. Relate to Buchanan's theme

- **Role of regional implementation group structures surprising (See briefing paper for HSE)**
    - Novel/marginal roles and giving support can help in change
    - Provide approval for change agency
    - Sharing learning and knowledge management key in effectiveness of new roles

APPENDIX 10: Changes identified by the respondents

This appendix outlines all of the changes mentioned as significant by respondents, and delineates the changes in which specific respondents were involved. Respondents were asked to name the most significant changes in their area over the previous three years, with the time period extended to five years by some respondents. Across all cases, outside of those directly involved in the implementation of the changes in cardiology there was only a very broad-brush awareness of the developments which had occurred in the department. Specific knowledge was localised. This may have been exacerbated by the timeframe in question; respondents were asked about the most significant improvement in the previous three years, but most drew on improvements which had occurred from the advent of the strategy, or which were outside the timeframe but they felt were most significant. Changes are grouped according to whether they pertain to the hospital as a whole or cardiology. Where there is a number in brackets after a service improvement on the list, this indicates the number of respondents who mentioned a specific change.

Changes in the Voluntary Hospital

Developments in cardiology:

- Increased clinical resources, consultants, clinical specialists, equipment, infrastructure and improvements in the structuring of cardiovascular interventions in the care-path of patients (DCEO)
- Second cardiac catherisation laboratory installed in late 2004 (4)
- Rapid chest-pain evaluation unit within the Emergency Dept so that patients are triaged at source (3)
- Increase in staffing levels in the CCU and cardiology wards from a total of seventeen to forty. *'Getting staffing levels, getting the skill mix right and getting the numbers'* (CNM2 CCU) There were 2 nurses in cardiology, which has now risen to 11, and 12 nurses in the CCU which has now risen to 29. (2)
- Heart Failure unit at second hospital in the group (2)
- Getting staffing and skill mix right with overseas nurses
- Expansion of the cardiac rehabilitation program from one program to two in 2000. This came about as a result of the cardiovascular strategy, but there hasn't been any major increase or improvement in the strategy since.
- Addition of psychology service for cardiac rehab and heart failure
- Transition of three acute cardiology beds in the CCU from 24hour to day-case beds (Allows patients from 3 linking hospitals to be seen quickly)
- Nursing staff have greater role in patient education in cardiology ward
- Cardiology ward now taking patients from day 2 post MI, where previously it was day 3 or 4
- Telemetry beds. These allow patients to be monitored outside of the ICU
- Changes to rostering system in cardiology unit. Staff can now request their own duty
- Direct access from GP, with GP referrals for stress testing
- Improvements in radiology
- New cardiac echo machines
- Additional echo room
- Increase from 2 to 7 cardiologists (though not all full-time) since 1998
- Restructuring of the resuscitation department
- Improvements in management of cardiac arrest, linked to training
- In process of getting accredited for advanced nurse practitioners in Heart Failure and Chest Pain evaluation

General Service Developments in the remainder of the hospital

- Establishment of company and healthcare group
- Transition from Board of Management to Board of Governors
- Development of advanced nurse practitioners
- Passing accreditation
- New Mental Health Unit
- New capital development
- Team-based performance management for ADON's
- Establishment of Head of HR operations Nursing and Medicine and restructuring of HR function (2)
- Replacement of outpatients with ambulatory care
- Establishment of a security service that belongs to the hospital
- Multidisciplinary approach to hygiene
- Investment in telecommunications infrastructure
- Improvement in booking structure for agency staff
- Change of cardiac arrest telephone number to standardise with other hospitals

The changes outlined below are the changes identified by each respondents as processes in which they played a role, and which were outlined by them. Specific change processes will be traced through their development in the ensuing section. In the public hospital senior management were not directly involved in the implementation of changes in cardiology. However in this context the DCEO did have involvement. This was due to the particular structure of his role.

Managers

Role	Changes in which they were involved
DCEO	↓ Cath lab ↓ Chest-pain evaluation unit
DOF	Aware of the following, but no direct involvement; ↓ Second cath lab ↓ Improvement in radiology facilities ↓ Chest pain assessment unit ↓ Heart failure unit
DOHR	No direct involvement in cardiology as only recently in post
DON	↓ In process of accreditation for advanced nurse practitioner in Heart Failure and Advanced Nurse Practitioner in Chest Pain Evaluation ↓ No direct involvement in other cardiology initiatives as only recently in-post
ADON	↓ Second cath lab ↓ Change in booking structure for agency staff
GSM	↓ Provides support in practical ways such as portering, cleaning cover or directional signage. But little awareness regarding impact for patients

Clinical Managers

Role	Changes in which they were involved
CNM2 Cath lab	↓ Provision of additional cath lab
CNM2 CCU	↓ Increasing in staffing levels in the CCU ↓ Transition of the 24hour beds to day-beds
CNM2 Cardiology	↓ Increased staffing levels in the cardiology ward ↓ Nurses more involved in patient education ↓ Cardiology unit accepting sicker patients ↓ Changes to rostering system in cardiology unit
LCC	↓ Chest pain evaluation and bypass system

CC	↓ Increase from 2 to seven cardiologists since 1998 ↓ Heart failure service
RTO	↓ Restructured Resus dept. Previously done as add-on to other roles.

Clinicians

Role	Changes in which involved
CRC	↓ Expansion of cardiac rehab from one to two programmes
Clinical psychologist	↓ Psychology service for cardiac rehab and heart failure

Changes in the Public Hospital

In the public hospital, outside of those directly involved in the implementation of the changes in cardiology there was only a very broad-brush awareness of the developments which had occurred in the department. Specific knowledge was very localised. One issue is whether the changes which had occurred were not considered to be significant, had occurred too far previously to be remembered by those not directly involved or whether attention was focused on the A&E development occurring at the time of data collection.

Developments in cardiology:

- The development of an Echocardiographic service, provided by four qualified staff
- The development of a Cardiac Rehabilitation Service, providing phase I – IV rehabilitation (3)
- Development of education booklets and leaflets for cardiac rehab
- Development of pharmacy-led education programme for cardiac rehab
- Fully staffed and equipped resuscitation department offering ACLS courses
- Training porters in the AED
- Community BLS, ACLS and AED training
- Support of community AED initiatives
- Expansion of CCU unit into ICU/CCU (2)
- Provision and support of thrombolytic kit to GPs in conjunction with pharmacy
- Pre-hospital emergency care initiative which encompasses chest-pain guidelines, audit and liaison with GPs
- Provision of CPR training to rehab clients and their families
- Provision of a coronary angiographic service
- Pharmaceutical research and clinical trials unit
- Needle to door time
- Tracker system for resources

General Service Developments in the remainder of the hospital

1. Ongoing A&E development (2)
2. Development of oncology unit (2001) (2)
3. Development of oncology day unit (3)
4. Development of stroke-care unit
5. Development of occupational therapy services
6. Provision of automated coagulation clinic
7. Introduction of Clinical Nurse Specialists and Practitioners
8. Expansion in consultant base with associated service developoment
9. Development of Pharmacy-laboratory led warfarin clinic
10. Expansion of pharmacy services to oncology day ward
11. Medication safety scheme
12. Pharmacists now review discharge prescriptions

The clearest overview of the developments in cardiology was unsurprisingly provided by the consultant cardiologist. For him the most significant developments had been the development of (1) the echocardiographic service; (2) the development of the cardiac rehabilitation service and (3) the resuscitation training department being fully staffed and equipped. (4) From the patients perspective the most significant development was identified as the ability to provide a coronary angiographic service and finally (5) the setting up of a pharmaceutical research and clinical trials research unit has been *'a feather'* as well. (6) Although he didn't mention the pre-hospital emergency care initiative, when prompted he noted his involvement in liaising with primary care to develop services for patients. Whilst he felt that this was significant, he was concerned that with the focus on community and community care, that there is insufficient attention being paid to the link between the community and the hospital. He asserted that *'in fact, I'd nearly focus more on that than I would anything else'* These developments were supported and emphasised by those engaged in their front-line delivery. Interestingly these front-line staff only focused on activity within their individual units, which may indicate a lack of awareness regarding developments in the broader context. For example the cardiac rehab coordinator outlined the development of cardiac rehab services from phase I to phase III and a form of phase IV. The cardiac resus officer noted that getting the ACLS course running, developing a programme of community training and training the porters in the use of the AED had been the most significant developments for them. Below, the specific changes in which respondents participated are outlined.

Managers

Role	Changes in which they were involved
General Manager	↓ No direct involvement in cardiology ↓ Involved in theatres ↓ Stroke care unit
Director of Finance	↓ Involved in monitoring funds for cardiac rehab
Director of Nursing	↓ No involvement in cardiology
Medical Director	↓ Facilitated through cardiology user group but no direct involvement. Hadn't been in post long
HR Manager	↓ No direct involvement
Assistant Director of Nursing	↓ Expansion of CCU unit (Opening of 7th High dependency bed. Opening of 8th ongoing) ↓ Facilitated cardiac rehab initiatives

Clinical Managers

Role	Changes in which they were involved
Cardiac rehab co-ordinator	↓ Move from Phase 1 to Phase 4 provision ↓ CPR provision for patients and families
Resuscitation Training Officer	↓ Provision of ACLS and resuscitation training services ↓ Community and external training services to make other units self-sufficient ↓ Community involvement in implementing and training AEDs
Chief Cardiac Technician	↓ Building up of echo service from 0 trained technicians to four
CNM2 CCU	↓ Change from 5 bedded CCU to eight bedded ICU/CCU ↓ Compiling of clinical guidelines at ward level
Cardiovascular nurse	↓ Introduction of chestpain guidelines ↓ Introduction of emergency care pack and training for GPs ↓ Audit of chestpain guidelines in the hospital

Chief Pharmacist	↓ Cardiac rehab information sheets ↓ Cardiac rehab education programme for medicines ↓ Pre-hospital emergency care project; provided and supported thrombolytic kit for GPs in the community. ↓ Warfarin clinic

Clinicians

Role	Changes in which involved
Consultant	↓ Development of Cardiac rehab service ↓ Development of Resus department ↓ Development of Echo service

Changes in the Private Hospital

In the private hospital, there was a general awareness of the changes in cardiology among the respondents. The clearest overview of the service-improvements undertaken was provided by the cardiovascular services manager. For her the most significant improvements were (1) two angio day-care units and (2) the second cath lab. Among front line staff, there was a significant emphasis on the changes in the nature of the service and the associated implications.

Changes within cardiology (Infrastructure/service development):

1. Development of a 'one-stop-shop'/standalone unit in cardiology. This allows patients to receive the treatments or tests identified as necessary for them on the day, rather than returning for a separate appointment.
2. Development of the second cardiac catherisation laboratory (x 4)
3. Decrease in cardiac surgery and increase in Interventional cardiology; There has been an expansion in the services provided to include rhythm abnormalities and electrophysiology studies in the Cath Lab (x 3)
4. Building of two angiography day-care units (x2)
5. Redevelopment of the diagnostic cardiology department
6. Increase in number of beds in cardiac ward
7. Investment in equipment eg cardiac CT

Changes in cardiology (People-related):

8. Additional cardiac technicians
9. Changes in working hours in the cardiac unit
10. Extension of working hours in radiography to include Saturday, Sundays and Bank Holidays
11. Approval received to employ a cardiology registrar
12. Introduction of the cardiovascular services manager

Changes within the broader hospital:

13. Development of an oncology day service and centre
14. Development of orthopaedic pre-admission programmes, leading to reduced length of stay
15. Investment in equipment eg PET CT
16. Extended opening hours
17. Introduction of the Adaptation programme for overseas nurses
18. New finance system
19. Changing charging structure for patients who don't have full cover for procedures

Below, the specific changes in which individuals participated are outlined by role group.

Managerial references to development in cardiology: The management team had a detailed awareness of specific improvements, though for the HOF and QM this was limited to changes in which they were involved. The following outlines the changes discussed by respondents as ones in which they had played a role. Of particular note is the significant extent of management and senior management awareness and involvement in the changes in the cardiology service. This contrasts with the low-levels evident in the public hospital.

Managers

Role	Changes in which they were involved
CEO	↓ Year on year increases in patient and staff satisfaction (with one exception) ↓ Second cath lab ↓ Expansion in services provided in cardiology; rhythm abnormalities, EP ↓ Investment in cardiac CT scanner (tells if you've had a heart attack)
Head of Finance	↓ New finance system ↓ Reduced length of stay ↓ Extended opening hours for scans etc ↓ Investment in equipment
DON	↓ Second cath lab (significant involvement) ↓ 2 angio day-care unit (significant involvement) ↓ Nurse specialist in cardiology ↓ Cardiac CT ↓ PET CT ↓ Oncology day-service ↓ Orthopaedic pre-admission programme (supported) ↓ Nursing adaptation programme (significant involvement)
Quality Manager	↓ One-stop shop in cardiology department ↓ Introduction of CSM role
Cardiothoracic services manager	Redevelopment of cardiology department, which involved; ↓ 2 angio day-care units ↓ Second Cath Lab
CNM2 Cath lab	↓ Second Cath Lab

Clinical Managers

Role	Changes in which they were involved
Radiography manager	↓ Extended working day in radiography lab and MRI scanner
Chief Cardiac Technician	↓ Electrophysiology studies ↓ Second cath lab (minor involvement) ↓ Extended department and opening hours ↓ Increased staff in department

CNM2 Cardiac Unit	↓ Accreditation for nursing adaptation programme ↓ Increase in interventional cardiology and associated changes in services provided ↓ Changes in working hours

Clinicians

Role	Changes in which they were involved
Consultant cardiologist	↓ Second Cath Lab ↓ Increased number of beds for overnight care

APPENDIX 11: Examples of service improvement changes from the voluntary hospital. Presented as tracer issues.

Voluntary Hospital Tracer Issue 1: Development of the second cardiac catherisation laboratory

Description of the change: The cardiac catherisation laboratory (cath lab) in the voluntary hospital was replaced with a brand new lab. This required the provision of a temporary lab whilst the new one was commissioned. The temporary lab was in operation from December 2004 until Easter 2005. During this time a new cardiac catherisation laboratory was installed, replacing the old one. The change process required the management of clinical and corporate components (DCEO). It was managed in two parallel components via an implementation plan. There was a project manager concerned with the transition between the temporary and permanent laboratories and a project manager concerned with the construction of the new laboratory. However there were common stakeholders involved in each.

Inception of the change: A new cath lab was required as the old one had exceeded its planned working life and had become dangerous. The lead consultant cardiologist wrote to the CEO asserting that the Cath Lab equipment was now dangerous and could no longer be used safely.

Objectives of the change: The DCEO described the objectives of the change as the provision of a new lab in order to increase both the quantity and quality of the services that could be provided.

Implementation roles: The consultants decided upon the change, which was ratified by the DCEO. In the implementation of the change, there were two project managers appointed within the hospital – one for the transition to the portable lab and the other in charge of installing the new lab. The manager in charge of the transition had other roles, however he spent a significant period of his time on the project. His primary contact was with a senior cardiologist. The nurses only became involved in the planning of the project in the very late stages. They were informed of the impending change two days prior to the arrival of the portable lab, at a cardiology department meeting. Whilst the lab came equipped with a table and a camera, it did not have the medical supplies associated with carrying out procedures. This and other logistical issues were queried by the CNM2 Cath lab at the meeting. The cardiologists did not give credence to them at that time. As a result the CNM2 Cath lab contacted the project manager in charge of the transition. She described him as a very nice, cooperative and pleasant man and he liaised with her. She had concerns regarding the practicalities of the portable cath lab and voiced them with him. These included practical issues such as access to the lab, space for parking the patient's trolley and health and safety issues, particularly regarding emergencies. After these issues were accepted by the transition project manager, he and the CNM2 cath lab had a meeting with senior staff, project management and management. After this meeting the transition project manager worked with the CNM2 for several weeks to surmount the issues. The nurses took responsibility for organising the move from to the temporary cath lab. This was described by the CNM2 as a 'huge' undertaking.

Four months later, when it was time to move back to the permanent cath lab, the consultants again informed the nurses of when they were going to move, and how the process would work. At that time the CNM2 cath lab approached the cardiologist, noting the need to ensure that proper shelving, storage and cath lab doors were in place. Again the cardiologists told her not to be concerned by these issues, excluding key stakeholder involvement. The CNM2 noted that the consultants were only concerned with having the table and the image intensifier. They neglected the peripheral details. The CNM2 Cath Lab inspected the lab and

contacted the project manager in charge of the new lab. She informed him that the electrical cabling was going to have to be moved, to make way for storage of the catheters. The project manager suggested that they provide a storage area outside but the CNM2 Cath Lab objected to this. A 'major battle' ensued, but the issues were resolved. For the CNM2 these issues arose *'because people are saying 'We're getting this' and nobody is looking at the practicalities involved in that.'*

Thus those involved in the implementation of the change were the project managers, the consultants, the DCEO and the CNM2 Cath lab. In addition the building staff were involved in implementing the structural changes and the nursing staff organised and implemented the physical moves between the permanent and temporary labs, and back again.

External links: The Department of Health had to ratify the expenditure on the new lab. The accounting system in the health service means that hospitals cannot provide for replacements to equipment by having this as an allowable expense in their accounts. Rather they have to apply annually for required funds or decide to purchase the equipment and hope that a capital-grant will be provided at year-end to cover this. The Director of Finance noted that the cath lab had a total cost of €1.5 - €2 million and was too large a gamble for the organisation to take. As a result they had to wait for spending approval.

The table and camera were sent out to tender due to the value of the contract. The tender involved both the procurement of equipment and the materials management component (DCEO). A temporary lab was leased from the UK for the duration of the work.

Three other hospitals in the vicinity provide care to the elective patients that were above the capacity of the temporary lab.

Internal links: For the transition project, the three cardiologists were involved. The DCEO initially ratified the project and then became involved in the implementation process when issues were raised by the CNM2 cath lab. Internal support services such as portering and other indirect services were drawn upon through the general services unit. Infection control was involved, to consider issues which arose in the temporary cath lab. Initially the DCEO had thought that the portable lab would arrive ready for use, but in fact ramps and shelters were required outdoors to make it usable.

The DCEO noted debate regarding the logistics of managing the service through the change. He noted the tension between management and consultants. Specifically, consultants wanted to maintain the level of service provision from the portacabin, whilst management wished to manage the activity levels.

The DCEO noted that this process was not without tension and frankness in the organisation.

For the development of the new cath lab a project manager and the cardiologists were the main implementation links. The CNM2 cath lab fought for involvement in the implementation, and her input was eventually taken on board.

The Assistant Director of Nursing in cardiology had not been involved as historically the lab had fallen under the theatres division. Whilst the cath lab was due, at the time of data collection, to move into the cardiology unit for administrative and management purposes, it is interesting to note that there was no mention of the involvement of Assistant Director of Nursing for the theatres in the change.

Project Management: Both components of the project were formally managed, with meetings of key people. These included the project managers, consultants, the DCEO and General Services, with representatives from the cath lab added at a later time. The DCEO

asserted that the process wasn't overly formalised, but was sufficiently structured to have direction, be able to identify gaps and outline how to address them. There was a project manager with responsibility for the transition from the existing cath lab to a portable lab, and also for the return journey. In addition there was a second project manager with responsibility for the new cath lab. He noted that whilst the larger issues were addressed, some of the details were missed. This was attributed to presumptions made by the consultants

> *'And as with everything he devil is always in the details, the big tickets stuff is never missed, what's missed is functions or presumptions that are made particularly by consultants that by magic nurses will become sherpas and donkey stuff all over the place! It's really a patriarchy approach, that's wrapped up in healthcare where women just look after the shop and the boys go off hunting and come back every so often. '* (DCEO, Voluntary hospital)

The CNM2 Cath lab was initially not involved in any of the formal project meetings, though gained involvement at a later stage. The CNM2 Cath Lab described the process as follows;

> *'I had never been invited to any of those meetings. It was always the big boys and that is something that's very wrong. What happened was 'oh we've it all organised, oh the cath lab is coming, oh everything is done' and I suppose the cardiologists told management what they wanted to hear, 'yeah its not going to cost you anything, its going to be just arriving and be fully equipped'* (CNM2 Cath Lab)

The CNM2 noted that there was no involvement of the stakeholders either in terms of informing them regarding the plan for the change, or whether the stakeholders saw associated issues. Not alone was this an issue at the introduction of the portable cath lab, but it also re-arose in moving back to the new lab. The CNM2 asserted that

> *'We need to start listening to what each section of the team is saying, particularly the CNM2 who knows exactly what's needed.'* (CNM2 Cath Lab)

Outcomes achieved: The new cath lab was installed and is now operating at full capacity.

Issues encountered: *'One of the biggest problems that we haven't learned yet I don't think, is that when you're going to implement change, that instead of just going off and saying this is what we're going to do, that they don't sit down with the people who are the stakeholders and talk with them about what the plan is and then listen to them about their difficulties or how they see a problem.'* (CNM2 Cath Lab)

Lack of stakeholder involvement was the key issue in the change process (CNM2 Cath Lab and DCEO). The CNM2 attributed this to the lack of management training among consultants. She noted that they are used to having people act on their orders in a clinical context, but that management requires much more communication and listening to extract cooperation. The exclusion of key stakeholders such as the nurses and AHP's from the change process, in combination with the large scale of the organisation meant that issues weren't identified until the implementation phases of the change process. The issues, which included plumbing, sluice and infection control concerns, were initially raised with the consultants. However it wasn't until they were brought to the direct attention of the project manager by the CNM2 Cath Lab that any remedial action was undertaken. Their meeting led to the identification of further issues, such as the need for a ramp, an outdoor shelter, insufficient room for all the staff etc. On this basis the CNM2 cath lab was included in a meeting with senior consultant and management staff, as well as the project management team. The DCEO had understood that the portable lab would arrive and be ready to use.

Overall assessment of success: In making assessments of success respondents differentiated between the change process and outcomes. The DCEO described it as follows;

'Overall it was a great success not without its mistakes.' (DCEO).

Overall he emphasised the need to include non-consultant stakeholders who were aware of the details which need to be addressed.

Although the cath lab was constructed and is now operating, the CNM2 cath lab described the process of change as extremely stressful, due to the lack of stakeholder involvement.

> *'Extremely stressful and I would have said that stress was probably pretty much unnecessary had I been brought on board and allowed to oversee it properly instead of having to sneak in to the room and get that changed and try and you know, you're having to go behind people's backs, tip toe around the place because its not being thrashed out.'* (CNM2 Cath Lab)

She also emphasised her concern that similar issues would arise again in the future. There are plans for an additional recovery room and potentially another cath lab. The CNM2 has started raising awareness regarding potential issues, but these do not appear to be taken seriously by the consultants. Nonetheless, the DCEO was very much aware of the issues which had arisen, providing an ally for the CNM2.

> *'I am already, already have started -.because I know the system -saying don't forget it won't be just a recovery room, with the recovery room will come, you need to have a sluice, you'll need to have a kitchen area, you'll need to have these other things that allows us to move, its not just a basic and I'm getting back yeah, yeah, yeah, yeah, well you've said that before and I said 'yes and I'm going to keep saying it because I know that I'm not being listened to and I know what's going to happen'.* (CNM2 Cath Lab)

Hindsight question: The CNM2 felt that there was little she could have done differently as her disapproval regarding the management of the process had to be acted upon by the consultants and other senior individuals individuals involved in the project.

The DCEO asserted that he would have engendered greater involvement from non-consultants.

> *'There's learning to be derived from it, I think if one was doing it again I think one would certainly hear the voice more of the non-consultants who have the in-the-trench understanding of the minutae of issues that do matter in fact because it's the little things that matter.'* (DCEO, Vol 1)

Voluntary Hospital Tracer Issue 2: New service and establishment of associated unit (Bottom-up initiative from cardiologists)

Description of the change: A new service, at that time not provided elsewhere in Ireland, was set up in the hospital. This was an important development both within the hospital and nationally. The service comprises inpatient and outpatient services, with outpatient services provided at a hospital with whom the organisation has a strategic alliance. The 2004 Annual Report for the hospital noted a desire to move some inpatient services to this other hospital, to relieve bed related pressure in the voluntary hospital. Over time the service has gone from being entirely funded by external funds, to being partially supported by the HSE. The outpatient service combines a chronic ambulatory facility, a primary care direct access facility and a weekly clinic to accommodate patients diagnosed in the community.

Inception of the change: The consultant cardiologist 2 (CC2) noted that the heart failure unit was developed in response to an awareness of developments in the service abroad. The CC2 worked with an internationally renowned cardiologist in this area during his time in the US.

> *'It's like any development in hospital medicine and probably in community medicine in this country, it doesn't come from the Dept of Health, it doesn't come from the HSE, it comes from individuals within areas in hospitals who decide that something they've seen abroad needs to be brought home and developed.'* (CC2, Voluntary hospital)

The service has been an area which Irish cardiologists have historically neglected. The CC2 asserted that there have been acceptable reasons for this neglect, and there was a need for it to be given importance and focus because of that. His two consultant colleagues gave the CC2 time to develop the service upon entry into the organisation.

Objectives of the change: To provide a service-provision unit within the hospital and to develop a model for care-provision that could be applied more broadly in hospitals throughout Ireland.

Implementation roles: The service was developed by the three cardiologists who were in the hospital at the time. The CC2 was brought back to Ireland by the lead consultant cardiologist (LCC). The LCC organised salary support for him from a pharmaceutical company and the Irish Heart Foundation. This seed funding provided him with an honorary lectureship at the university for which the hospital is a teaching base. The CC2 continues to be the day to day manager of the service, with regard to both the medical and administrative/financial component.

External links: The service unit is part of a six hospital European-wide that group are endeavouring to develop proper services in this area in Europe.

A pharmaceutical company and the Irish Heart Foundation provided financial support for the CC2's salary. He was instrumental in developing the service. The CC2 noted that he has ongoing liaison with corporate and other entities in fundraising for the unit. He described this as a symbiotic relationship between the medical and pharmaceutical groupings. Although generally a maligned relationship, this has provided him with unrestricted funds for service development.

> *'A lot of our colleagues in the pharmaceutical industry come in and have given unrestricted support. In other words, what I mean by that is they don't come in and say "we'll give you 20 grand a year to help your service if you promise to prescribe our agent or if you promise to give our….."* (CC2, Voluntary hospital)

The DOF noted that upwards of a million euro was provided to the service over the lifetime of the cardiovascular strategy. This was negotiated with the regional implementation group.

The Medical Director of the Irish Heart Foundation, who had retired as the LCC of the hospital by the completion of the field work noted that the service model which had been adopted between the voluntary hospital and its strategic ally was being used as a template to be expanded throughout the country. He asserted that several places were now interested in adopting it. He noted that whilst there is now nominal compliance with this service in most major centres it remains Cindrella-ish.

The pharmaceutical 'soft money' was the only support for the first two to three years of the service. After that time the DOH began to support certain components of the service.

However it does not fully support it. Currently the service has contact from circa twenty individuals in the hospital. This includes doctors, nurses, allied health professionals and secretarial support. Eight continue to be employed by soft money. These are individuals who the unit needs, but whom the hospital cannot support. The CC2 noted that the HSE is gradually taking more financial responsibility for the service. He envisages that in 3-5 years that the service` will be completely taken on by the Department of Health. He noted that

> *'What they're doing is just standing back from it a little bit and saying "well you prove what you're doing is effective by hard inputs and if you show it to be effective not only will we come in and support it but we'll probably take the model and encourage it to be used elsewhere". But I think to be fair the Dept has come in for a lot of criticism and rightly so for many things that they don't do or do. I think, to be honest, the way they're handling this is very effective.'* (CC2, Voluntary Hospital)

A friend of the CC2's who is a pharmacist with some financial training provides two days service to the unit a week, assisting with the financial management component. In conjunction with the CC they manage a budget of €500,000 per annum. Finally the unit has links with GPs in the development of the primary care admissions unit.

Internal links: The CC2 liaised with management to gain cooperation regarding the founding of the service. He noted that funding was the critical issue for hospital management. He noted that their primary concern was less about the need for the service and more about the cost incurred. He was not critical of management in this regards, noting that it was a function of how budgets are allocated in the health service. As he was looking for a limited amount of space and willing to providing funding for the staff, management were supportive of the initiative.

> *'And that's not a criticism of them because, again, the somewhat archaic way that our budgets are run in this country the hospitals get the budget from the government and from that budget everything has to be taken, they don't get a special budget to develop heart failure'* (CC2, Voluntary hospital)

Multidisciplinary management of the service was introduced in 2003. The clinical psychologist started up a psychology service and has been instrumental in campaigning for a broader rehabilitation programme. A physiotherapist now provides services.

The DON is in the process of getting accreditation for the Advanced Nurse Practitioner in the service area

The DOF was not involved in the early stage of funding negotiations for the unit. He asserted that this was different to the other strategies, such as the Cancer Strategy, where he had much more regular and involved contact with consultants and funders regarding identifying needs and making a case.

Project Management: The DOF noted that the establishment of the Unit was project managed as it involved identifying a location, redeploying staff, recruiting additional staff and negotiating funding with the cardiovascular strategy. The2 CC noted that he was centrally involved in pushing the project through, and that it was in a relatively informal manner upto the move to the second hospital. He described the project management process as follows;

> *'I mean what you do is you basically just say if you're going to do this you go out and get the funding, advertise for the people, scrounge the space within the hospital, we're now…the Heart Failure service is now based both here and [other hospital] so we have a floor of the [other] hospital out there.' (CC2, Voluntary hospital)*

Outcomes achieved: The service unit has been important for the visibility of the hospital in cardiology (CC2). The 2005 activity review asserts that the service continues to grow. It has a one year mortality rate of 16% for survivors of hospital admission. This compares favourably with international norms of greater than 30%. Furthermore the 4-year mortality rate for the population is 35%, again comparing favourably with international figures. The chronic ambulatory facility follows over 1,000 patients. One component of this is the Primary Care Direct Access facility, which facilitates GPs and patients directly contacting the service if they suspect that their medical condition is declining. In 2004 this accounted for approximately 20% of the work of the unit. The 2005 annual report noted that an audit suggests that this prevents 247 hospitalisations per annum, saving €1.37m for the hospital.

In 2004 3417 patients attended the out-patients services. This provides structured follow up of patients discharged from hospital. A weekly clinic was established in 2004 to accommodate patients diagnosed in the community.

The 2003 annual report notes that readmission rates for the underlying condition treated have fallen to single digits since the introduction of multidisciplinary management.

Issues encountered: The CC2 noted that heart failure is still a 'Cinderella' service. He asserted that it is difficult to get an effective message across as a lone or relatively isolated or minority voice. As a result he would like to see more consultants working in the area. In addition he noted that deficiencies in administrative support staff make it difficult for him to delegate.

He noted that the quality of the administrative support in the hospital is poor relative to the US. He asserted that this was not an individual criticism but rather a general observation. He noted that in the hospital he notices the good administrators, whereas in the US he had noticed the poor ones. He asserted that

> *'In the public system there are clock-watching issues and union issues, with people not wanting to take on new services and development initiatives without saying how can I get extra for myself. And that frustrates me a bit.'* (CC2, Voluntary Hospital)

Overall assessment of success: The CC2 felt that the manner in which the service-development was being handled by the HSE was very effective.

Voluntary Hospital Tracer issue 3: Building up staffing levels in CCU and cardiology unit (Bottom-up change from CNM2 Level)

Description of the change: The change involved an increase in staffing levels in the CCU and cardiology wards from a total of seventeen to forty. (CNM2 CCU) There were previously 2 nurses in cardiology, which has now risen to 11, and 12 nurses in the CCU which has now risen to 29. The unit is now the most highly staffed of all of the CCU's in the region (CNM2 CCU) The cardiology and CCU units have now been separated in management terms, which was previously not the case.

The change involved the creation of acceptance of the need for additional nurses in the cardiology ward and the gradual increase in numbers to a safe and acceptable level. The need for change was initially not accepted within the hospital, leading to the involvement of the unions by the CNM2. Eventually the cardiology ward was completely closed down, although the coronary care unit was kept running. Over time as additional staff were recruited the coronary care unit and cardiology ward were separated into two separate areas from a management perspective. They had previously been integrated.

Inception of the change: The CNM2 queried the level of staffing upon her appointment to the unit. She had been an external candidate and arrived in the hospital at the time of acute nursing shortages. She had responsibility for the CCU and the cardiology ward. There were 17 nurses for both areas, when there should have been a complement of forty. The impact of this in practice was that there would be two nurses employed by the hospital on duty, one in the cardiology ward and one in the CCU. The remainder of staff on each shift were comprised of agency staff. These did not necessarily have cardiology experience. As a result her key priority at that time was ensuring patient safety. For her first year in post (2000) she emphasised trying to get staffing to a safe level. By the end of the year neither the consultants nor nursing management recognised the issues in the unit. She felt that the lack of consultant support meant that management did not feel the issue was compelling. As a result the CNM2 took recourse to the Irish Nurses Organisation, for industrial relations support. The hospital's position was that all care areas were subject to similar problems and pressures. However the CNM2 felt that as a critical care area, the unit was receiving more acutely ill patients than elsewhere in the hospital. As a result she felt there was a particular requirement for sufficient staff with appropriate skills. When the issue wasn't addressed the CNM2 led the closure of the cardiology ward, with support from the INO. The decision to call in the unions was initiated by several incidences. These included the CNM2 CCU being called in on her day off and working 6 twelve hour shifts in a row to find herself without cover to relieve her of duty.

The CNM2 CCU asserted that whilst the decision to split the management of the cardiology and coronary care units had been made prior to her arrival, the closure of the cardiology rather than CCU care led to the changes being implemented. The CNM2 CCU described this division as making much more sense from a practical, nursing and patient care perspective.

Objectives of the change: The objective of the change was to have sufficient nurses with appropriate skills to safely run the cardiology ward and provide care to patients. Within the cardiology ward this allowed the acceptance of sicker patients.

Implementation roles: The CNM2 led the campaign for the recognition of the need for change. She liaised with the ADON and LCC. After this process failed she was supported by the INO, leading to the closure of the cardiology ward. The CNM2 oversaw the running of the CCU in the interim, and gradually re-opened the cardiology ward as additional staff were recruited. She noted that she went first to the cardiologists to make a case, as she found that nursing management would not listen to her. In general she found it more expedient to use the consultant as a liaison rather than going down the nursing management route. The general management team became involved as the dispute escalated.

External links: The INO were the key external links in the change process. The CNM2 CCU noted that there were involved in the process as a last resort. This route was only pursued after failed attempts to manage the change through liaison with consultants, nursing management and hospital management (CNM2 CCU). This action led to the issues being taken seriously and formally addressed. In addition the CNM2 cardiology ward noted that the Department of Health and Children had to lift ceilings on staff numbers to facilitate the expansion of staff numbers.

Internal links: Key internal links regarding staffing levels were the consultants, the ADON and the DON when the issues escalated. The original case was made to the consultants and ADON.

The decision to allow the cardiology ward to accept patients day two post MI was agreed with the assistant director of nursing, director of nursing and lead consultant cardiologist. The CNM2 cardiology ward had concerns regarding this development as the staff in the ward

were not cardiac trained. However a facilitator was provided to educate the student members of staff.

Project Management: The CNM2 Cardiology ward noted that there were formal meetings regarding the change, though not a formal project management structure.

Issues encountered: The CNM2 cardiology ward noted that initially there was resistance from the consultants, who felt that there wasn't a need for additional staff. However she had compiled documentation to support her case; namely that the admissions and discharges through the unit were among the highest in the hospital. In addition she had information regarding the procedures being undertaken and the levels of patient dependency. Similarly the CNM2 CCU noted initial resistance from management.

Outcomes achieved: There are now a total of forty staff across the two units, with 11 in the cardiology ward and 29 in the CCU. There are currently no vacancies. In addition, within the CCU every staff member now has the CCU course, bar three, who will undertake this in the next academic year. This is a significant change in both staffing levels and skills mix, as previously only five staff had the course.

The staffing levels in the cardiology ward have risen from two to eleven. This has allowed nurses to take on an expanded role in patient education. This entailed a significant change in the nursing role. In addition the increased staffing levels facilitate the transfer of patients to the unit from day two post myocardial infarction (MI), whereas previously this occurred from day three or four.

Since this change has been completed, the ADON is very particular to involve the CNM2 at the outset of initiatives. This is because she is feels that she would contact the unions again should issues arise. However whether this is meaningful participation is questionable as the ADON asserted

> *'I know the way to manage her and keep her involved and tell her everything and ask her opinion. And you would get her thinking **your way** once she's involved from very early on'* (ADON, Voluntary Hospital)

Overall assessment of success: The outcome if not the process of the change went well. The overall aim of achieving an appropriate staffing level and mix was attained. The CNM2 CCU noted that the unit is now the best-staffed in the region. The CNM2 cardiology ward asserted that after the need for additional staff was accepted the process moved smoothly in the cardiology ward, with the consultant ADON and herself working well together.

Hindsight: The CNM2 CCU asserted that she regretted calling in the INO. However she was unsure as to how she could have handled this differently given what she characterised as the insufficient support available to her. Nursing and general management needed to be more proactive in managing the situation. The CNM2 cardiology ward noted that she would have tried to have increased the staffing level before the ward re-opened. Trying to arrange meetings and care for patients made the process more difficult.

APPENDIX 12: Examples of service improvement changes from the public hospital. Presented as tracer issues.

Public Hospital Tracer Issue 1: Development of the cardiac rehabilitation department (Top-down)

Description of the change

Limited cardiac rehabilitation had been offered in the hospital until 1999. After that time extended service development occurred. Phase 1 had been offered from late 1998 from the wards. Phase 2 was introduced after that time, being integrated in a minimal format after the conduct of a stress test. Then in 1999 space was acquired in the organisation and phase three was introduced. A pilot phase 4 programme was developed in mid 2004, and has now been extended into an ongoing programme.

Inception of the change

The inception of the development of the cardiac rehab department occurred with the cardiologist. '*I wanted to set up here in [public hospital] a fully fledged rehab department. Because I believed that that was the right thing to do. And that's what happened.* ' (Cardiologist, Public Hospital)

The inception of phase 1 and 2 in their minimal formats occurred in Sept 1996 when the CRC was approached to see if she was interested in doing cardiac rehab. She was approached by the cardiologist through nursing administration. She then went on the training course and put her knowledge into practice after completing stress-tests. Phase three came about at the inception of both the CRC and cardiologist and was made feasible by the availability of space. There was a small bungalow in the grounds of the hospital in which retired priests used to live. A new house was arranged for them in the town. As a result the space in the bungalow became free. The consultant had put his name down as looking for space for cardiac rehabilitation since 1997. As a result they received first option on the use of the space. Phase 4 was introduced in response to patient responses on their questionnaire. The unusual structure was in response to patient demand. The physio's led the introduction of phase 4, and it was only in 2005 that the CRC became involved in direct service provision. She and the other nurse each take one evening of the phase 4 programme per week.

Objectives of the change

The objective of the change was to have a fully functioning cardiac rehabilitation service, offering from Phase 1 to Phase 4 rehabilitation. This entailed making the house a suitable area for offering a service. This included infrastructural and other changes.

Implementation roles

The maintenance supervisor, consultant and cardiac rehab co-ordinator were involved in the planning stage. Once this was completed the cardiac rehabilitation undertook responsibility for implementation, though the consultant had initiated the project. At the outset this entailed planning and ordering equipment. This included things such as desks, emergency equipment, monitoring equipment, tables, chairs etc. At a later stage the emphasis of the implementation role changed to service-development and delivery. The cardiac rehab co-ordinator noted that she would consultant would check the work completed.

> *'I did most of the ground work. And then I'd go to him to check it'* (Cardiac rehabilitation co-ordinator, Public Hospital)

In terms of service development, the initial work entailed designing and getting forms, patient details and outlining the format of each phase. That was completed by the CRC. The

development of phase 4 was initially led by the physios within the unit, but has since been supported by the CRC and colleague,

External links
There were no external links identified. The cardiac rehab co-ordinator asserted that there was no architect involved. £50,000 annually was provided from the Department of Health I can't remember how many years back.

Internal links: The consultant and maintenance supervisor were important internal links. The staff complement gradually increased over time, facilitating the extension of the service throughout the phases. A coronary care nurse came to the unit to cover the CRC's maternity leave, and then stayed upon her return. And then in February a physiotherapist was recruited.

The pharmacists produced a cardiac rehab information sheet for patients, with details about each drug that they are taking. They also provided an education session for the programme. The chief pharmacist identified the CRC as having been the key link during implementation however the leaflets were given to the consultant to ensure he was happy with them.

Project Management
The project was informally managed by the cardiac rehabilitation co-ordinator. She described this as *'hard going'*. The consultant noted that within the first year, when £50,000 was provided for developing the service, only seven or eight thousand went on rehab. He was very irritated by that.

Outcomes achieved
The physical transformation of the space was completed. This entailed drawing plans, knocking rooms and acquiring air conditioning.

In terms of service provision, they are now providing phase 1 to three rehabilitation with a phase four programme based in the hospital. Typically phase 4 is based in the community but this particular structure was adopted in response to patient demand. Interestingly the consultant did not consider this as phase four.

Overall assessment of success
While happy with the progress achieved (stating the 90% of the goals for the cardiology dept had been achieved) the consultant asserted that the lack of the psychological service in cardiac rehab it a major deficiency.

> *'There's a huge psychological component to heart disease and that's a huge deficiency. And there doesn't appear to be any sign of anybody taking any interest in it.'* (Cardiologist, Public Hospital)

In addition he noted that community-based phase four is lacking. This requires exercise centres and facilities close to patients' homes to stop them having to come into the hospital. Finally, he and the CRC noted the outstanding infrastructural issues within the department.

Hindsight question
The consultant and CRC didn't see anything they would have done differently in hindsight, given the constraints in which they were working.

Public Hospital Tracer Issue 2: Provision of Community AED and CPR Training

Description of the change
Community outreach programmes in AED and CPR were established and run, with the aligned provision of six AEDs in the region. The link with one town, described here as

'Greenfield' will be outlined in this section. This town went from a position having no AED's to having four, and to having a training programme for their use.

Inception of the change
The resuscitation personnel in the West approached Croi [a charity] to see if there was anything that they could do to assist with the charitable work they were doing in the community. Croi asked if the group would facilitate them in doing some CPR training. The RTOs in the region took responsibility for different areas, with each of the three RTO's in the public hospital taking responsibility for a town in the county. The RTO noted that the success of the initiative may have been linked to its timing in the wake of the death of a young footballer from Sudden Cardiac Death. This was a high-profile occurrence in the media.

Objectives of the change
The objective of the change was to provide assistance to Croi. Croi are a charity dedicated to pursuing and attaining the highest level of Cardiovascular Health Care for the people of the West of Ireland. Since 1985 they have funded and implemented a wide range of initiatives to improve Cardiac Services and Facilities in the region.

Implementation roles
The RTO implemented the training, but had cooperation from the local Chamber of Commerce and Croi. The RTO approached the Chamber of Commerce to access volunteers. He spoke at one of their meetings and did a demonstration. He received 18 volunteers for training, and provided training to them in the local health centre. He used this because it was a public access building with public liability covered. The RTO decided to have an age-based criteria for training; that the candidate was over 16. This was to avoid supervison of minors. The Chamber of Commerce compiled lists of names and every time they had six names they would hold a training session. The local fire officers were the first people to be trained. The representatives from Croi, the Chamber of Commerce, the fire-service and the RTO decided upon the location of the AED's. They chose areas such that the north, south, east and west of the town were covered.

External links
From the perspective of the overall initiative the RTO described it as a Health Service Executive/Croi/Community enterprise initiative, with various different stakeholders in the community getting involved.

In the first town in the area the local credit union and ESB offered support, while in Greenfields the local Chamber of Commerce group had held a golf classic to raise the money for the first AED. After this a benefactor bought one, and a second benefactor bought a third and a final benefactor donated. The enthusiasm within the local population was described as 'huge'

Having provided training to the local fire-service, they purchased their own AED.

Having installed the AEDs they had a formal press launch. They were covered by Nationwide, Five Seven Live, TG Ceathair, TV3, The Irish Times and The Sunday Independent.

Internal links
The idea was discussed at the resuscitation committee, which is chaired by the cardiologist. Consent to run with the project was granted in that forum. After that it was e-mailed through to the Head of the Directorate, and presented by him for consideration by the three directors and the general manager. He noted that normally the answer for initiatives is yes, once they are budget-neutral.

Project Management

Project management was informal, and initially overseen by the RTO. However the Chamber of Commerce later assumed responsibility for recruiting volunteers for training. In addition Croi assisted with strategic guidance.

Outcomes achieved
From a position of no AEDs in the community there are now four in the town discussed, with another two within the region. There are also two more ready to be put in place. There is also a fully trained complement of volunteers within the town. If an organisation approaches the hospital having purchased an AED the hospital has committed to train them.

Overall assessment of success
The RTO asserted that the involvement within the community had been a significant achievement in terms of both process and outcomes, and had appreciably raised the hospital's profile in the district.

Hindsight question
The RTO did not see anything that he would do differently in hindsight.

Public Hospital Tracer issue 3: Building up the ECG department (Bottom-up)

Description of the change
The echocardiography service has been developed from nothing to having four full-time and qualified technicians.

Inception of the change
The change was brought about by the consultant as a lone crusade.

Objectives of the change
The objectives of the change were to acquire the equipment necessary to establish a department and to staff the department with trained staff.

Implementation roles
There were two individuals who had been trained by the previous consultant to do ECG's and stress-tests. However as the level of work increased in the department an additional person was trained by the consultant.

External links
The consultant engaged in fundraising with the evenings in his own personal time. Upon acquiring equipment for the department there was a requirement to cover the salary of the staff member. This was covered by the department of health. This follows the model also seen in Vol 1 of establishing a service and getting the DOH to take responsibility for maintaining it. However the staff member supported was initially not a qualified member of staff, rather they were trained by the cardiologist. This occurred at the outset of the cardiovascular department. With that funds were allocated to allow the proper staffing of the department, both in terms of numbers and qualified staff.

Internal links
Management within the hospital were very supportive of his efforts.

> *'They saw me as somebody 'Here's a guy who's come to State 1, wants to develop the service, goes out every second night of the week raising funds for the hospital. You are respected once you do, I guess. That makes it much easier to go to management. To say 'look guys, I'm working for the hospital, you work for me, help me out. And they do.'* (Consultant, Public Hospital)

Project Management
The project was managed informally by the cardiologist.

Outcomes achieved
Funds were acquired over time to purchase equipment, convert an anaesthetic office department into an echocardiography facility and to acquire trained technicians.

Overall assessment of success
The consultant perceived this as a very positive process, as the echo department was attained. The chief cardiac technician noted that there were still some outstanding pieces of equipment required within the department.

APPENDIX 13: Examples of service improvement changes from the public hospital. Presented as tracer issues

Private Hospital Tracer issue 1: Development of a medication cardex

The development of a medication cardex for the cath lab was a bottom-up initiative. It is outlined below;

Description of the change
The change involved developing a pre-printed medication cardex for the specific use of the cath-lab.

Inception of the change
The change was initiated from a medication incident that had been reported several weeks previously. It had been reviewed by the quality manager, who discussed it with the consultant involved.

Objectives of the change
The objective of the change was to reduce medication incidents, which can occur because of writing, doses, clarity or when people are in a hurry.

Implementation roles
The quality manager and nurses were the key actors involved in the direct implementation of the change, although the consultants were included in the development and apply it on a day-to-day basis

External links
The only external link in the change-process was the printing company.

Internal links
The staff involved in the change included the consultants, the nurses in the cath labs, the quality manager and the pharmacist.

Project Management
While the process of incident reporting is formal, with a written report on incidents, the process of dealing with them is informal and does not include the clinical governance committee. Thus the project was informally managed by the quality manager. She noted that their insurers have commented upon the mature incident reporting system in the hospital, which is grounded in a no-blame culture. The QM emphasized the benefit of not having to write to the clinical governance committee vis a vis the incident, which meant that she could deal with it more speedily and directly herself.

> *'I don't have to write away to the clinical governance vis a vis that incident, and say 'Is it alright to talk to doctor whoever?' I will just go down and talk to him.'* (Quality Manager, Private Hospital)

The cardex was introduced on a pilot basis, with feedback pending at the time.

Outcomes achieved
The pilot was not complete at the time of the interview. However a previous attempt to introduce a cardex in a separate department involved a multidisciplinary group. Their pilot led to feedback regarding the inappropriate nature of the cardex. The QM hosted an emergency meeting which led to the cessation of the pilot and the re-embarkation on the project from first-principles.

'But I had to take the decision because I had to write off a lot of cardex's that were developed so I signed off. And I had to loose X amount of money on this, because they wouldn't have the power to do it.' (Quality Manager, Private Hospital)

Overall assessment of success

The QM was happy with the process at that time as all of the stakeholders had been involved and the change was progressing well.

Hindsight question

'You must involve all of the stakeholders from the very beginning and even if it's out of the goodness of your heart that you are not doing it, it doesn't work.' (Quality Manager, Private Hospital)

Initially the QM had decided not to include the consultants at the outset of the process. Rather she had decided to include them once a draft plan had been devised. However they were unhappy at not being included from the beginning. As a result the project had to return to the planning stage, and levels of trust with the consultants were compromised. This cost the project a year in terms of implementation (Quality Manager).

Private Hospital Tracer issue 2: Development of the second cath lab

The development of the second cardiac catherization laboratory was a top-down initiative. Aligned to this and hence mentioned within the section was the addition of beds aligned to the lab. In addition there was a need to ensure that CCT staff could support the electrophysiology studies the lab was designed to provide capacity for. The development of the change is outlined in this section;

Description of the change

An additional cardiac catheterization laboratory was constructed in the clinic to provide for an expansion in the level and nature of service provision. This was particularly linked to the provision of electrophysiology studies. Aligned to this change was an increase in the number of beds associated with the lab from four to twelve. A consultation phase with all of the staff affected occurred throughout the design phase. The cardiologists met the CEO and 'business-people' (consultant cardiologist). The final design was signed-off by all concerned. An order of magnitude and a work paper completed by the CSM and engineering manager were submitted to the board for approval by the CEO.

Inception of the change

The CEO initiated the change to attract an additional cardiologist to the hospital. The cardiologist's work was to include a significant amount of time-consuming electrophysiology studies in the cath lab. However there was little additional capacity available at the time and the consultant wished to undertake one and half days work in the lab per week. This was potentially of significant value to the organization. In addition, there was a general increase in the volume of interventional cardiology aligned with service developments, which was also creating a pressure for the change.

Objective

The objective of the development of the second cath lab from a process perspective was that it went in on time and on budget, without affecting existing levels of business (Cardiac Services Manager). From an outcome perspective both consultants and management desired the additional capacity from the lab. This was in response to the increase in electrophysiology studies, which are time-consuming to conduct, as well as general increases in interventional cardiology.

Implementation roles
The director of nursing described herself as having *'huge involvement'* in the process. Initially she and the Cardiac services manager (CSM) were involved, with the CEO sponsoring the change at board level. The CSM worked on the project from a process perspective. She designed the area and outlined the skills required for the nurses. After the plans were designed involvement expanded to include the nursing staff in the lab, cardiologists, porters, catering and infection control.

The DON emphasized the focus on involvement and ratification of the project amongst staff. This assertion was supported by the CNM2 Cath lab noted that she had involvement in decisions regarding the physical design and facilities in the lab. After the project was ratified the CNM2 cath lab and other clinical staff facilitated the builders, but the CSM, engineering manager and infection control were the major internal implementers. The CSM liaised with the clinical staff and building staff, while the engineering manager oversaw the technical aspects of the work and the infection control manager dealt with that issue.

External links
Externally the architects, surveyors and building contractors were involved in the project. Two external hospitals, one internationally, were involved in the provision of training to the Chief cardiac technician and another cardiac technician.

Internal links
Internally the CEO sponsored the change, with the DON available for practical advice and support for the CSM. The engineering manager was the significant link for the CSM regarding the building. Internally, specific links were the representative consultant cardiologist, the DON, radiologist, CCT and CNM2 Cath lab. The CSM also liaised with the heads of departments and otehr staff who were going to be affected as the worked progressed. The CEO, consultant and board member separately liaised with the CCT regarding the up-skilling of the cardiac technicians, to ensure they could support the provision of the electrophysiology services.

Project Management
The project was quite formally managed. The building component was particularly formal, and there were project meetings every week. These began during the design phase, and continued until the design phase was agreed by all. An order of magnitude and a work paper completed by the CSM and engineering manager were submitted to the board for approval.

As required, those who would be affected by the work were assembled. It was then decided how to work things through, with emphasis on how the patients were going to flow.

Outcomes achieved
The cath lab was completed on-time and on-budget.

> *'I think the achievement at the end of it was wonderful and we have another lab to offer the facilities.'* (CNM2 Cath Lab)

Overall assessment of success
The consultant cardiologist noted that once initiated the cath lab process worked well. However they noted that getting the change ratified had been a long process. The move towards implementing the change had come with the arrival of the new CEO six years previously.

> *'It had been pushed for many years. There was pressure on for a long number of years to move in that direction, and then the actual implementation was straightforward.'* (Consultant cardiologist, Private Hospital)

In terms of the actual implementation process, the CSM noted that the change was *'very controlled',* although at times there were some questions regarding the budget. She noted that she never felt stressed during the process, though she did experience some frustration in dealing with the staff, who

> *'found it a bit difficult. And that one week they are working from this system and then next week its coming in and its like ok guys, what we need you to do is go this way, and it just needs a little bit of patience. So there was quite a bit of managing of people. And that was probably the most stressful'* (CSM, Private Hospital)

The CNM2 described the cath lab change process as *'quite good really.'* The CCT evaluated the addition of electrophysiology services, to attract the additional consultant. She noted that *'there was no choice given, there was no choice of saying 'we don't have the people here with the experience to take part in this kind of work.' It was just a case of 'you'll have to manage.'* (CCT, Private Hospital) She noted that training was ongoing for the staff in the department. Whilst the outcome had been achieved, in terms of the provision of the service and the attraction of the consultant, there had been a degree of expectation placed upon the cardiac technicians regarding up-skilling, though they were supported in the process both by the consultant and the organization. The RM noted that her involvement in the process of change in the cath lab was more difficult than intra-department initiatives as she had less control over the outcomes. She asserted that this was because the change was structured to suit the consultants.

Issues arising

The CSM emphasized that issues encountered related to managing staff through the process of change. In particular she found the need to revisit the same staff concerns on a regular basis a bit frustrating. She also noted that where issues arose with the building project or other aspects of the cath lab change, the staff involved tended to vent their frustration on her. This applied both to the clinical staff and the cardiologists.

The largest people-oriented issue which arose was related to the fact that the nurses in the lab had become quite technically oriented, only doing procedures. The change involved the addition of beds aligned to the lab. This meant that the nurses had to staff the unit, admit patients and discharge them. The DON asserted that that was a challenge for them, which she was responsible for managing. The DON and CSM worked with the ward manager and three staff in the unit to explain the nature of the change and to 'win them over'.

Hindsight question

The CSM noted that in hindsight she would have closed the existing cath lab completely and rented in a mobile laboratory for the duration of the project. She noted that this would have reduced the time taken to complete the project, by allowing the builders to work without interruption or restriction.

> *'We had also agreed when they were allowed to do noisy stuff, and when they weren't. And occasionally we would have to go in and say 'Could you just hold it?' And so they would have to stop work or whatever. So if I was to do it again, I would get a mobile lab and shut down the lab totally.'* (CSM, Private Hospital)