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Achieving and sustaining profound institutional change in healthcare: Case study using neo-institutional theory

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ABSTRACT

Change efforts in healthcare sometimes have an ambitious, whole-system remit and seek to achieve fundamental changes in norms and organisational culture rather than (or as well as) restructuring the service. Long-term evaluation of such initiatives is rarely undertaken. We report a secondary analysis of data from an evaluation of a profound institutional change effort in London, England, using a mixed-method longitudinal case study design. The service had received £15 million modernisation funding in 2004, covering multiple organisations and sectors and overseen by a bespoke management and governance infrastructure that was dismantled in 2008. In 2010–11, we gathered data (activity statistics, documents, interviews, questionnaires, site visits) and compared these with data from 2003 to 2008. Data analysis was informed by neo-institutional theory, which considers organisational change as resulting from the material-resource environment and three 'institutional pillars' (regulative, normative and cultural-cognitive), enacted and reproduced via the identities, values and activities of human actors. Explaining the long-term fortunes of the different components of the original programme and their continuing adaptation to a changing context required attention to all three of Scott's pillars and to the interplay between macro institutional structures and embedded human agency. The paper illustrates how neo-institutional theory (which is typically used by academics to theorise macro-level changes in institutional structures over time) can also be applied at a more meso level to inform an empirical analysis of how healthcare organisations achieve change and what helps or hinders efforts to sustain those changes.

Introduction

Contemporary health services are characterised by near-continuous change on a relatively small scale. Less commonly, changes may involve inter-organisational and cross-sector components in a large-scale, whole-system transformation effort. Here, we consider transformational change, and the challenges of sustaining such change long-term, through the lens of neo-institutional theory, applied to a case study of an ambitious long-term change effort.

In 2003, the London-based Guys and St Thomas' Charity made £15 million available to support a four-year partnership (the 'modernisation initiative') between two acute hospital trusts, two primary care trusts, community groups, patient groups and the independent and voluntary sector in the context of a multi-ethnic, inner-city population with high turnover and multiple diverse health and social care needs. Three services – stroke, kidney and sexual health – were selected by competitive bidding to receive £5 million each for 'wholescale transformation' aimed at making healthcare more efficient, effective, and patient-centred. Our team were external evaluators of the modernisation initiative from 2003 to 2008. In 2010, we were invited by the Charity to return to the case and evaluate what if anything had been sustained and how the programme had evolved and adapted.

There are many versions of neo-institutional theory. The one proposed by DiMaggio and Powell (1983) and further developed in relation to healthcare by Scott, Ruef, Mendel, and Caronna (2000) has its roots in organisational sociology. Institutions, defined as social structures that have achieved a high degree of resilience, are influenced by three broad types of social forces or 'pillars': regulative (laws and contracts which stipulate what *must* happen), normative (assumptions and expectations about what *should* happen) and cultural-cognitive (taken-for-granted scripts and mental models about what generally *does* happen) (Scott et al., 2000). Each pillar offers a different rationale for legitimacy, by virtue of being

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(respectively) legally sanctioned, morally (e.g. professionally) authorised, or culturally supported. The three pillars are analytically separable, but at an empirical level they tend to be intertwined. Mirroring these three pillars, institutional change may be attempted by three fundamental mechanisms: *coercive* (by altering regulative pillars, as in top-down restructuring); *normative* (by altering the expectations of what is right and reasonable) or *mimetic* (for example, when organisations seek to copy what they consider to be a model of best practice) (DiMaggio & Powell, 1983).

Scott observed that healthcare systems sometimes seek to achieve 'profound institutional change', which he defined as follows: it is multi-level (involves new roles for individuals and/or new organisational forms), discontinuous (not merely incremental), and characterised by new rules and governance mechanisms (both informal norms and formal regulatory systems), new logics (that direct, motivate and legitimate the behaviour of actors in the field), new types of social actors (both individual and organisational), new meanings (associated with the attributes or the behaviour of actors in the field or the effects associated with them), new relations among actors (especially exchange and power relations), modified population boundaries (the boundaries separating organisational populations, organisations, customary activities, and personnel blend and blur), and expanded, reduced or realigned field boundaries (Scott et al., 2000). By 'field', Scott implicitly drew on Bourdieu's definition of the term as a "a space of [social] positions and position-takings" (page 30) (Bourdieu, 1993), thus emphasising the relational and cultural aspects of social systems.

External forces for change can be categorised into two types of environments: material-resource (which includes demand-side factors such as demographics and supply-side factors such as physician availability, technologies and external grants) and institutional (comprising institutional logics, institutional actors and governance systems) (Scott et al., 2000). Institutional logics are socially shared, deeply held assumptions and values that form a framework for reasoning, provide criteria for legitimacy, and help organise time and space (Friedland & Alford, 1991). Through the duality of structure and agency, institutional actors function as both carriers and creators of institutional logics (Giddens, 1986). They participate in both the material-resource environment (as 'consumers' or 'suppliers' of health services) and in the institutional environment (possessing institutionally-defined identities, capacities, rights and responsibilities; and by making meaning from their perceptions and experiences) (Scott et al., 2000).

The UK National Health Service (NHS) is a collection of organisations that share, to a greater or lesser extent, a common mission and values. Until fairly recently, they also shared a common regulatory and funding structure, but from around 1998 the different countries within the United Kingdom developed different political-regulatory mechanisms (Hughes & Vincent-Jones, 2008). While the NHS is sometimes colloquially referred to as a 'national institution' and depicted by staff and patients as a homogeneous 'brand' maintained more or less continuously since 1948, it is more accurate to consider it as a heterogeneous and evolving organisational field which is exhibiting a growing degree of divergence (Checkland, Harrison, Snow, McDermott, & Coleman, 2012; Hughes & Vincent-Jones, 2008).

Early research on the NHS using neo-institutional theory considered how the field was changing (or not) as a result of coercive, normative and mimetic forces (Currie & Guah, 2007; Currie & Suhomlinova, 2006; Hughes & Vincent-Jones, 2008; McNulty & Ferlie, 2004). Recent critiques that neo-institutional analyses have tended to privilege the study of structure over agency and theory over empirical findings (Battilana, Leca, & Boxenbaum, 2009; Suddaby, 2010) have prompted a new research tradition focussing on empirical questions at the meso level of organisational life (such as how commissioning is enacted in the UK National Health Service (Checkland et al., 2012)) and/or on the micro level of how individual staff members, through their dispositions and actions, make organisational life meaningful and reproduce and/or change the field (Lockett, Currie, Waring, Finn, & Martin, 2012; Macfarlane, Exworthy, Wilmott, & Greenhalgh, 2011).

In this paper, we sought to contribute to this emerging tradition emphasising the empirical value of neo-institutional theory by undertaking a secondary analysis of a longitudinal study of whole-system transformational change.

Description of the case

The charity-funded modernisation initiative, introduced in Background Section, included over 30 work streams representing a diverse range of projects. Change methodologies used in the transformation programme in 2003–8 included [a] collecting and applying 'best evidence'; [b] coordinating and streamlining services; [c] recruiting, redeploying and training staff; [d] promoting and supporting self care; [e] involving patients and carers in quality improvement; and [f] ensuring diversity of provision to allow patient choice (Greenhalgh et al., 2009). All of this was supported by tools and techniques for quality improvement, including systematic data capture with rapid feedback loops (plan-do-study-act cycles), a cadre of dedicated service improvement facilitators, and substantial effort in strategic human resource management (Greenhalgh, Macfarlane, Barton-Sweeney, & Woodard, 2012).

Early business plans envisioned three key transitions in the underlying logic of the services: [a] from a focus on diseases to a focus on the needs and priorities of patients; [b] from episodic and predominantly acute care to coordinated care packages that addressed the entire illness journey including (where appropriate) prevention, follow-up, rehabilitation and end-of-life care; and [c] from occasional, one-off 'audit' projects to a culture where quality improvement occurred continuously. These transitions were defined and operationalised somewhat differently in the different services and in different parts of the same service.

The infrastructure for supporting the modernisation initiative in 2003–8 was an 'offshore' organisation by which staff were temporarily employed, and from which (it was anticipated) they would return to the NHS and continue in new or revised old roles after the funding period ceased. It was thought that this design would overcome much of the institutional inertia of the NHS and provide an officially-sanctioned and safe space for people to think creatively and try out new models of care and ways of working.

Temporary governance structures established to deliver and oversee the modernisation initiative had included an over-arching modernisation board chaired by one of the acute trust Chief Executive Officers, as well as operational-level management groups for stroke, kidney and sexual health services which brought together numerous stakeholders (from the NHS, community and third sector), sometimes with competing ideologies, visions and agendas. By the time we returned to do the follow-up evaluation, the programme-specific governance structures had long been dismantled and its various activities had either ceased or transferred to new infrastructures and funding streams. As planned, most staff had been redeployed in the local health economy.

Full details of the methodology, sampling frame and key empirical findings of the follow-up evaluation have been published elsewhere (Greenhalgh et al., 2012). Briefly, we collected documents, routine activity statistics, patient questionnaires and key informant interviews and used narrative as a structuring and synthesising device to build the story and make sense of unfolding events in context (Stake, 2005). As in all complex longitudinal case studies, there was considerable work involved in identifying, organising and