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# The Diffusion of An Organisational Innovation: Adopting 'Patient-Focused Care' in an N.H.S. Hospital Trust

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## *ABSTRACT*

This paper deals with the diffusion and adoption of an organisational innovation, 'Patient Focused Care', at a British Hospital Trust. We will be discussing how PFC emerged in the U.S. context, was propagated by policy-makers, and judged worth adopting by organisational decision-makers. In providing an analysis of the case, we are attempting to bridge the gap between the policy context on the one hand, the organisational context on the other hand. The paper shows the importance of the 'local' context in shaping the adoption of a 'global' organisational innovation. The 'appropriation process' will play out in context-specific ways in terms of conflicts between managers and expert professionals; the way the 'foreigness' of the innovation plays out; and the way public policy-makers can influence the appropriation process. Most importantly, the paper intends to show how the cognitive boundaries of the N.H.S. as an 'organisational field' are beginning to move beyond national borders.



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## *Introduction*

This paper deals with the diffusion and adoption of an organisational innovation, 'Patient Focused Care' (PFC), at a British Hospital Trust. We will be discussing how PFC emerged in the U.S. context, was propagated by policy-makers, and judged worth adopting by organisational decision-makers. In providing an analysis of the case, we are attempting to show how actors within an organisational field, the N.H.S., were confronted by a 'problem', for which no solutions seemed available within the boundaries of the organisational field (OF). Under such conditions, actors will search outside OF boundaries. In order to achieve this we have structured our paper as follows: firstly, we are looking at the literature about imitation of organisational practices, including the role of national and sectoral boundaries. This section is centred around the introduction of the 'New Institutionalism'. Secondly, there is a section on methodology and research methods; this is followed by a discussion of the global / U.S. context of the emergence of PFC. Fourthly, there is a section dealing with the appropriation process at organisational level – we have in fact integrated a discussion of the literature with our case material. Finally, there are summary and conclusion.

## *The Diffusion of Organisational Innovations: Crossing the Boundaries of the 'Organisational Field'?*

Across the world, not only firms but also public sector organizations have found themselves increasingly accountable to their respective stakeholders, and have thus perceived great pressure to change. At the same time, business schools, journals, magazines, and, of course, the Internet have hugely accelerated the rate at which information flows between organizations and across borders. Given the internationalisation in the world economy, it is often foreign companies, which provide models and templates that invite imitation. Firms are increasingly under the expectation by their resource providers that they "benchmark" themselves with world-class rather than national standards. According to Kanter, Jick and Stein (1992, p.30), 'Benchmarking' describes a process by which " ... organizations actively seek to emulate role models perceived to be successful, aided by experts and educators that promulgate popular models."

We have long known that in the face of uncertainty and ambiguity organisational decision-makers find it tempting to copy standards of evaluation and performance from other organisations (March and Olsen, 1976; Thompson, 1967, 84-93). The existence of interorganizational networks often contributes to innovative practices diffusing between organizations (Rogers, 1983; Thorelli, 1986). Kochan et al. stressed the role of professional networks in order to account for diffusion of organisational policies, in the sense of apparently successful policies or remedies spreading between organisations thus ensuring that "organizations tend to become more alike" (1986, p. 52).

Templates or ‘strategic recipes’ are shared within a sector, primarily within the national borders of a society (Smith et al. 1990; Child, 1988; Dacin 1997). Inter-organisational networks within a sector can function as a mechanism for the diffusion of innovative practices. A complementary angle is provided by Haunschild’s (1993) and Haunschild & Miner’s (1997) argument that board interlocks play a central role in mimetic behaviour and Deephouse’s (1996) argument that in *regulated* environments (such as banking and, by inference, the health care sector), imitation provides legitimacy. Haveman (1993) argued that "organizations imitate organizations within their population, as the actions of these organizations tend to be more salient than the actions of organizations in other populations". Those organisations viewed as important competitors will be monitored more closely (ibid. 596-7). In particular actions of organisations in the same sector, which possess high visibility and prestige, mainly gained through seemingly superior performance, will influence other organisations. Practices, which can be found at such organisations, will become *sectoral recipes*: leitmotivs that guide reorganisation in other organisations. By relying on sectoral recipes, management teams can demonstrate to their 'relevant audiences' that they are taking (effective) action to tackle competitive or funding challenges. But how can we make sense of those processes of organisational imitation that largely ignore sectoral boundaries?

For this purpose, let us take a step back and remind ourselves that DiMaggio and Powell’s (1983) intention was to account for the "startling homogeneity of organizational forms and practices" (ibid. p.148) which can be found in a society, and which is due to the role of the "great rationalizers" of the second half of the 20th century (ibid.), namely the state and the professions. DiMaggio and Powell distinguished between competitive isomorphism, which is more prevalent where free and open competition exists, and institutional isomorphism, which explains the behaviour of organizations seeking institutional legitimacy (DiMaggio and Powell, 1983; Powell and DiMaggio, 1991). State coercion in the form of legislation and regulations as well as normative professional standards elicit uniform organisational responses, thus reducing variety. Many of those very institutions and processes which carry this process of inter-firm diffusion are still predominantly nation-based, including informal exchanges between staff, governmental agencies, board interlock, trade associations, professional associations, unions, by consultants, advisory services, formal and informal educational institutions, experts, trade publications and the movement of employees. Based on DiMaggio and Powell's approach, Orru et al. (1991) found a substantial degree of what they termed intrasocietal isomorphism which makes competitors within the same society more similar to each other, and can actually enhance economic efficiency (ibid. p.363)

Whilst DiMaggio & Powell (1983) had emphasized, against Weber, that rather than ‘market rationality’, i.e. a form of mimetic isomorphism, coercive (i.e. political) and normative (through professionalisation) isomorphism had, in fact, been unexpectedly strong forces between 1920 and 1980 in creating processes of making organisations more similar to each other. Somewhat paradoxically, the concept of ‘mimetic isomorphism’ has dominated the reception of DiMaggio & Powell’s seminal contribution (Mizruchi & Fein, 1999).

The DiMaggio & Powell argument can be developed in a number of different directions: one of these being national isomorphism or 'Societal Effects'. Societal Effects exist in that, at least initially, legitimation pressures are specific to countries or societies (Maurice et al. 1980; Sorge, 1991; Mueller, 1994): the appointment of individuals with private sector backgrounds to positions of non-executive chairmen in NHS Hospital Trusts is a legitimation device given the specific national U.K. context. An Italian hospital, for example, might not derive enhanced legitimacy by adopting this particular practice. As far as normative isomorphism is concerned, there is similarly isomorphic reproduction within national borders: in the U.K., the Royal Colleges as professional bodies have mainly driven the development of standardisation of medical practices with the use of protocols and guidelines (Morgan 1997). Lastly, the coercive dimension is primarily national because of the prevailing national character of legislation. Isomorphism helps an organisation secure its reproduction and survival: indeed, as firms become more successful "they increasingly have to follow the norms and practices of that society if they wish to recruit high quality labour and elicit higher levels of commitment from employees." (Whitley, 1992, p.274). The 'National Business System' school emphasises the national dimensions of organisational fields, including cognitive belief structures which regulate collective behaviour, but are specific to national institutional contexts (Whitley, 1994a, 1994b, 1992, 1991, 1990; cf Hellgren & Melin, 1992). When legitimacy pressures are very strong, like in highly regulated environments, once societies are locked into a certain way of doing things, one might be in a position to identify a Weberian 'iron cage' restricting the ability of a country to learn from other countries. One could perhaps be tempted to view law and medicine as exemplars of such iron cages. In this sense, an organizational field in strongly regulated environments has traditionally been *national*.

However, because of de-regulation in many organizational fields, including the hospital sector, these apparent iron cages have become seriously brittle (Mueller, 1994). In fact, Fennel & Alexander (1987, p.471) described the U.S. hospital industry as highly fragmented:

> "Hospitals have no uniform, predictable response to various environmental pressures; different segments of the industry are more or less influenced by different types of pressure."

Organisations facing particular difficulties may gain incentives to change even though this causes them to *diverge* from the established norms of their sector. In the hospital sector this incentive is often produced through financial pressure (Edwards et al. 1998). Where a 'national' sector is being diagnosed as 'weak', 'inefficient', 'uncompetitive' some form of learning is likely to ensue: but this can take place nationally across sectors, or globally within a sector. Indeed, what we have seen is that, partly because of a powerful ideology, sectoral boundaries have been lowered and the restructuring of the UK public sector has been influenced by ideas from the private sector: management practices, financial responsibility, budget accountability and competition. In NHS Trusts, the appointment of private sector non-executive chairmen was intended by government policy makers to accelerate the infusion of new business practices from the private sector.

Indeed, both trans-societal and national professions (eg consultants, academics) have been effective in diffusing models of organizing between organizations. The 'globalisation argument' would have us believe that this process increasingly ignores the existence of national borders. The lean production model, for example, appeared to diffuse fairly rapidly between automobile companies in different countries. Kidger (1991) observed "that a body of ideas on good practice is emerging on a world-wide basis." (p.150) Personnel administration procedures " ... flow from organization to organization, sector to sector, and even country to country ... " (Meyer and Scott, 1992, p.2). Consultancies learn from companies whilst applying their own knowledge to them, thus becoming a transmission belt between firms. For example, the management consultants McKinsey were described as having played an important role in diffusing the M-form structure (Child, 1988), again across national borders. Furthermore, the powerful ascendance of transnational agencies, consultancy companies and global brands throughout the second half of the 20$^{th}$ century (Barnet & Cavanagh. 1994), in conjunction with market competition becoming the over-riding principle of legitimation, can be seen as casting doubt on the proposition of national isomorphic reproduction. The globalisation discourse is varied, wide-ranging and cannot be reviewed here. Suffice to say that a whole range of factors appeared to have facilitated mimetic managerial behaviour to ignore national borders, and to take foreign examples as exemplars worthy of imitation. This paper will attempt to show that in a traditionally firmly nationally embedded OF like the N.H.S., solutions to pressing problems were sought outside the traditionally defined boundaries of the OF.

## ***Data Collection and Methodology***

This research follows a qualitative, grounded theory methodology, using the *constant comparative method* (Strauss and Corbin 1994). This method is especially suited to the current research, being widely used in research on organisational change in professional settings, especially health care and education (Denis, Langley and Cazale 1996; Radwin 1998; Cusick 2000; Newcombe and Conrad 1981; Kozma 1985; Renolds 1992). The project was initiated through a series of (ten) interviews with the board team (including both executive and non-executive directors), of 'West London' Hospital. These interviews were followed up by both participant observation (one of the researchers was a member of the board team), and non-participant observation (another of the researchers was a frequent observer of board meetings and discussions between various board members). During this period a number of informal discussions were held with board members, and a full set of public and non-public board papers was collected. At the end of the study period a further series of (twelve) interviews was held with the board team. The final twelve interviews were carried out with the (eight) members of the board team who remained in place throughout the research period, together with (four) other members of the board who were not interviewed in the initial interviews.

The initial interviews were designed in order to understand the role of each member of the board team, and to elucidate the differing views of each of these Board members. The final series of follow up interviews invited the Board team to give their views on developments and the

functioning of the Board Team over the two years elapsed since the initiation of the research. This research design allowed us to study the mindset and the logic of action of different actors. In order to provide a framework to this research and to provide focus for the various areas of negotiation and agenda setting revealed, some emphasis was placed on the financial crisis which swept over the Trust at a time when it was engaged on a major reengineering exercise. Our evidence comes primarily from Board level and is therefore predicated upon the proposition that the board has played the role of an important change agent over the last five years or so.

## ***The Emergence of an Organizational Innovation in the US Social Policy Context***

In discussing managerial knowledge between globalisation and local contexts, the health sector is an interesting case example as it has not played a significant role in the literature on cross-border diffusion of innovation. Partly because diffusion agencies increasingly operate across national borders, as in the case of multinational consulting companies, partly because of increasing willingness to learn from other countries, there has been increasing diffusion of templates or sectoral recipes *across* national borders - 'privatisation' and 'contracting out' are only the most publicised and visible examples (Mossialos & Le Grand, 1999). Health care provision provides us with an activity which is typified by an extraordinary degree of national convergence in clinical practice, financial management problems faced and, in the developed world at least, by a growing and emergent culture of "managerialism" (Politt, 1993). The latter is beginning to co-exist - sometimes more successfully than at other times -, with the ethos of traditional health professions.

The cross border nature of learning in this context is illustrated by the number of publications, which purport to help health care system designers learn from each other in terms of management, finance and clinical practice (Mossialos & Le Grand 1999; Yach & Bettcher 1998a,b; Weil 1997; Busse and Schwartz 1997; Lenaghan 1997; Nuffield Institute for Health & NHS Centre for Reviews and Dissemination 1996). Yach and Bettcher (1998a) cite the Director General of the World Health Organisation as stating, for example that:

> *The global [health] development strategies needed to address … complex and inter-related problems [which] will require innovative, intersectoral interventions, involving a high degree of international cooperation and political will (p. 736)*

The extent to which there is political involvement in the development of these strategies varies from country to country, both in the level of openness to other systems, and in the degree to which 'recipes' from other organisational fields are appropriate. There are, however, some models which are widely copied, such as the use of diagnosis related groups (DRGs) in costing health care interventions (Kerres and Lohmann 2000, Mossialos and Le Grand 1999). Market reforms, which encourage competition between health care providers, or between health care

purchasers (Mossialos and Le Grand 1999) have been common features of health care reform during the last decade.

Whilst the market has had a greater impact on the US health care system, due to its large private sector, Yach and Bettcher's (1998a) argument for:

"

- *Global intersectoral action through transnational cooperation and partnerships, for example, between the health sector and trade/finance sectors both within countries and at the international level. …*
- *Global research programs that concentrate on developing cost-effective technologies. …*
- *Ongoing comparative assessments and cross fertilisation of experiences regarding health system reform*."

has had an impact far beyond the American system, as governments (often following the advice of academics and consultants), have adopted market (and quasi-market) solutions to encourage a greater level of efficiency and transparency in health care delivery.

*Sectoral Recipes* in health care may be influenced, not only through learning from other sectors, or from the leaders within the national sector, but also from providers in other countries. Indeed, the American Institute of Medicine advocated that:

> *"[T]he United States should lead from its "unsurpassed" position of strength in the health sector. In partnership with other countries and international organizations, the United States can lend a great deal in the areas of research and development, surveillance, education and training, and coordination and leadership."* (Yach and Bettcher 1998b p.740)

Policy statements such as these can lend legitimacy and urgency to mimetic processes of organizations seeking out best practices and, conversely, other organisations advocating their best practices. At the same time, the different health care delivery systems in use throughout the world mean that problems in the transportability of differing systems of learning and practice are thrown into sharp relief. Despite this proviso, there have been some major catalysts in the NHS driving the search for new practices from abroad. Policy statements thus link back the national arena with the transnational arena (Mueller, 1994) and extend the boundaries of the OF. The 'Isomorphism', 'National Business System' and 'Societal Effect' literatures have typically neglected this dimension where public policy-makers connect the national agenda with those from other countries.

### *The British NHS As A National Organisational Field*

The study is based on the 'West London' Hospital Trust ('West London Hospital'), a medium sized District General Hospital in London. The hospital serves an ethnically and socially diverse population, with conditions such as sickle cell anaemia and HIV at above average prevalence. The hospital has been at the forefront of some innovative clinical practices. These may be seen in particular around the hospital's pioneering of the ambulatory and diagnostic care concept in the UK, and the collaborative care concept, in conjunction with a community health trust and local social services. In common with other NHS acute hospital trusts, 'West London Hospital' has a number of different stakeholder groups which must be consulted, persuaded, and / or informed about the activities and strategies of the trust. Prime amongst these are the Health Authorities and GP fundholders / Primary Care Groups – Trusts, CHCs, Department of Health, and staff groups.

The political position of these various stakeholder groups has emerged during the constant reorganisation experienced over the fifty years the UK NHS has existed. The growth of management (as opposed to administration), in the NHS has been a drawn out process, always long on rhetoric but often short on real change, and has often been a case of 'shuffling the boxes'. The attempts to create a managed NHS may be seen to have begun in 1974, based on the 1972 Grey Book (Dopson 1997). Seven hundred NHS authorities established by the 1948 Act of Parliament, which set up the NHS, were replaced by two hundred District Management Teams (DMTs) and Community Health Councils (CHCs), the DMTs reported to ninety Area Health Authorities (AHAs), which in turn reported to fifteen Regional Health Authorities (Klein 1995). Area Health Authorities had a geographical area of responsibility approximately corresponding to local authority boundaries, whilst a district was expected to cover a population of approximately 250 000. District Management Teams were professional officers and (two) medical profession representatives whose reporting responsibility was to the Area Health Authority (Dopson 1997). Local lay representation was through the Community Health Council which were established in 1974, with the statutory responsibility "to represent the interests in the health service of the public" (Cooper et al. 1995). The 1974 reform of the NHS, whilst beginning a debate on managerialism within the NHS, and intended to improve the efficiency of the NHS, contained a number of flaws which made achieving this aim difficult (Klein 1995, Dopson 1997).

The DMTs were hampered by a consensual management model, in which decisions had to be agreed by the whole team, rather than by a majority vote. This gave the medical profession (or in fact any management group), an effective veto (Dopson 1997). There was also no correspondingly effective local lay representation as the CHC had only advisory or consultative powers (Cooper et al. 1995). The incoming Conservative government of 1979 inherited the findings of a Royal commission into the NHS, from which flowed the consultation document Patients First, arguing for a strengthening of the District Health Authority (with roughly the same geographical location the DMTs had, but with greater powers). The AHAs were to be abolished.

The 1980s were a decade of constant review of the NHS, its funding, structure and efficiency (Kline 1995). The Conservative government was highly critical of the efficiency of the NHS, at the same time it perceived early in the life of the government that dismantling the NHS would be politically dangerous, and probably ineffective (Kline ibid p189). This was, however, also the

decade in which comparison with templates from foreign health care systems and with other organisational fields began to take place in NHS planning. Bosanquet (1983) summed up the Conservative government's criticisms under six headings:

> **1 The NHS is a centralised monopoly through which government preferences are imposed on consumers.**
>
> **2 The NHS is a system which wastes resources in excessive bureaucracy.**
>
> **3 The NHS is inefficient, in the sense that it uses its resources less intensively than it might. For example the number of cases treated per bed has risen more in the US than in the UK.**
>
> **4 The NHS suffers from a major problem in medical emigration.**
>
> **5 The NHS has adopted systems of rationing through waiting lists which are much more unpleasant and unfair than the rationing that would come about through a market mechanism.**
>
> **6 The NHS has shown inflexibility and inability to adopt advanced methods of treatment.**
>
> **(P 155)**

These criticisms were similar to those contained in the 1983 report of the NHS Management Inquiry (Griffiths report), which introduced general management (rather than administration), into the NHS, and ended the 'consensus' era. In setting up the Griffiths inquiry the government bypassed the traditional Royal Commission model of review, bringing in a manager (Sir Roy Griffiths) from the retail field to evaluate the NHS. Griffiths concluded that "if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge" (Kline 1995).

Criticisms such as those above had led the Central Policy Review Staff[1] to suggest private health insurance for some sectors of the population in keeping with the more free market US model (Riddell 1991; Kline 1995, Timmins 1995; West 1998). However the political sensitivities mentioned above, and the potential transaction costs involved in private health insurance led to such radical solutions being rapidly rejected. Indeed Lawson (1992) uses the US case as an example to show that private health insurance, far from being a route to improving the efficiency of the NHS, would be highly detrimental.

> *"There are in practice only two ways in which health care can be financed. One is by the taxpayer, and the other through the individual taking out an insurance policy. The latter method, which is the basis of the US system, inevitably results in a massive further escalation in the cost of health care – even in the UK it is not unheard of for bills to be*

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[1] A Whitehall think tank during the Thatcher period.

*higher when it is known to the provider that an insurance company will foot them; this in turn means insurance premiums that are so high that the taxpayer has to come to the rescue of those who cannot afford them."* **(p.613)**

Despite these reservations US ideas still had a major impact on the reform of the NHS, and in 1985 the American academic Alain Enthoven put forward the idea of an internal market based on the US HMO model, with budgetary autonomy devolved to District Health Authorities (this was similar to ideas presented by the Institute of Economic Affairs over a twenty-five year period). Diffusion agents like Enthoven operate at the level of applying models to a new national, sometimes organisational context. According to Dent (1993, p.266) "Enthoven's intervention and advocacy of the HMO model was therefore crucial in permitting the introduction of market principles within the NHS without privatization." Ham and Hunter (1988) discuss the case of Guy's hospital which adopted the 'Clinical Directorate' model, previously untried in the U.K., but already in operation at Johns Hopkins Hospital in Baltimore. There is a management board and 14 clinical directorates each headed by a senior clinician.

The culmination of the scrutiny the NHS experienced throughout the 1980s was the review started in 1988, and ending in the White Paper "Working for Patients", which created an internal market, with hospitals being permitted self governing Trust status, and larger GP practices gaining control over a portion of their own budgets to use in purchasing services from hospitals. The introduction of 'Trustification' into the British NHS during the early 1990s resulted in an acceleration of the pace of change within the organisations providing the majority of health care in the UK  A number of new organisational arrangements were introduced, including new ways of working such as relationships based upon contracts, new organizational forms such as trusts or private-sector style boards and new roles such as purchasing (Ashburner, Ferlie & FitzGerald. 1996, p.5).

Especially CEOs and Finance Directors in the newly established Trusts were taking on much broader managerial roles than in the old-style NHS. The emergence of the internal market in the UK NHS, was then, at least in part the result of the incorporation of influences, both from abroad, and from other sectors.

## *Extending the Cognitive Boundaries of the Organisational Field: The Case of 'West London' Hospital Trust*

The changes outlined above can be explained as evidence of ideologically (market liberalism), driven restructuring, and an attempt by government to break a professional stranglehold on the NHS (Kline 1995 p203). This amounted to a radical change of the environment within which health care providers in the UK operated.  Although there are obvious political dangers in allowing hospitals to fail within a public sector market, the financial performance of business units became more transparent with the publication of individual annual reports.  Management

boards modelled on the private sector came into being and were, at least in the eyes of some actors, tasked with a more 'corporate', financial responsibility in their role providing public sector services.

> *We are owned as a business by the nation through public dividend capital. We are not a private enterprise activity and so we fit within a much wider system of national priorities for the NHS as a whole … The Chair of a Trust is appointed by the Secretary of State, essentially by the Department of Health. This gives you a special role in relation to the taxpayer and public responsibility … So there is a public sector role to ensure efficiency, effectiveness, value for money and that there is no abuse in the spending of public funds. (**Interview with chairman 'West London Hospital', January 1997**)*

'West London's position, however, made it uniquely suited to its development as a potential exemplar of global learning in health care organisation. The reforms of the 1980s and 1990s in the UK NHS resulted in a spate of hospital closures and mergers by the end of the 1990s. 'West London' (which was a first wave Trust), was threatened with closure during the early 1990s and was faced with organisational threats which placed great pressure on management to consider adopting innovations in order to ensure survival. Organisational change in response to a financial crisis is a common pattern in the history of the N.H.S.: Ham and Hunter (1988) discuss the case of Guy's Hospital.

Here it is possible to consider Swan & Clark's (1992) decision episode framework analysing the diffusion of innovation in four episodes: agenda formation – selection – implementation – usage. The local situation in which 'West London Hospital' was operating meant that the organisation was faced with a very clearly defined threat against which to *Set an Agenda*. Indeed Hurst's (undated) study of Patient Focused care in the NHS, which shows 'West London' as an early adopter of this strategy, also highlights the need for such innovation in terms of survival. In a strategic planning document the 'West London' Board faced the prospect that:

> *It is widely recognised that fundamental changes have been taking place within the acute sector for the past twenty years. Arguably, these changes - and more – are set to exponentially increase and impact during the first decade of the next millennium. Any potential organisational change must seek to anticipate and meet these pressures and opportunities. Simple administrative, bureaucratic and organisational changes, which do not recognise these trends will be short-sighted and relatively fruitless.*

Faced with an uncertain future, 'West London' was, then, forced first to carefully consider and then *select* strategies, which could ensure its survival and future success. In attempting to ensure this survival 'West London Hospital' chose to follow a radical innovative change programme rather than relying on merely doing 'business as usual' better.

The central idea that 'West London' 'imported' into the UK health arena was *Patient Focused* Care. The concept of patient focused care was first introduced into the UK in 1988 by the UK arm of the American based Consulting firm Booz Allen and Hamilton (Morgan 1993). This concept was epitomised through two main projects in the hospital during the 1990s, the *Protocolisation of medical care* and the *Ambulatory Care and Diagnostic Centre (ACAD)*.

The first of these ideas to be adopted was that of protocolisation:

> *"In November 1991, 'West London' Hospital NHS Trust ('West London Hospital') began implementing patient focused care (PFC) principles in two pilot areas (with the view of eventually extending this philosophy of care throughout the entire hospital). As the focus for the programme, 'West London Hospital' adopted [the following key elements]:*
>
> - *Care organised according to clinical protocols*
> - *A unitary patient record*
> - *Care delivered by teams of multi-skilled staff members*
> - *A simplified process*
>
> **(Hurst, undated)**

These are core principles of Booz Allen Hamilton's (1988) model. Indeed, both Morgan and Layton (1997) and Hurst (undated) identify the United States as being the template for patient focused care and the protocolisation required to implement it, Hurst going further and identifying Booz Allen Hamilton as the conduit of transmission:

> *"According to Pitt (1993 p.27) patient focused care evolved from the San-Francisco Planetree healthcare programme in 1985. Two years later patient focused care was introduced to the United Kingdom health care professionals by Booz Allen and Hamilton management consultants…"*

The diffusion of organisational innovations from the U.S. to the U.K. (Kogut, and Parkinson, 1993; Kogut, 1990) or Japan to the U.K. (Elger & Smith, 1994) has been dealt with before in the literature, even if not especially for public sector organisations. Here we can begin to identify both the uncertainty surrounding the implementation of the national change process was creating in the planning of 'West London Hospital's' future, and the emergence of search processes in response to this uncertainty. Faced with structural changes beyond their own control, the management of 'West London Hospital' can be seen to be searching for a model, which will create a more stable future. As the national model is developing along market lines it could be seen as logical to adopt a model taken from successful organisations in the same field that have already demonstrated the success of the model. The model, must, however be adapted to the local setting. Here local can be taken to mean, both local to the UK NHS in general, and local in terms of 'West London Hospital's' immediate regional catchment. In adopting a suggestion from

the innovation management literature we could call this process 'appropriation' (Clark & Staunton, 1989; Hislop et al. 1997; Kamoche & Mueller, 1998): implementing an innovation which looks good 'in theory' or looks good somewhere else requires 'articulation' in specific new settings: this includes adapting it; selling it to the main stakeholders; carrying along the main principally interested parties; and negotiating the politics involved.

'West London Hospital' shows aspects of both mimicry and innovative leadership. The hospital is innovative in introducing the patient focused care concept into the UK setting, and in this sense does not conform to classic institutional theoretical models, which restrict themselves to national isomorphic reproduction of organisational practices. At the same time the organisation has, in the face of uncertainty, rather than developing a bespoke solution, copied a model, which has been proven in a different national setting:

> *The North American pilot (so called pioneer) sites are a few years ahead of the United Kingdom*
> **(Hurst, undated).**

The Director of Nursing and Quality at 'West London Hospital' and others at 'West London Hospital' were well aware of the global context of PFC, and make a point of stressing the proven nature of the innovation:

> *"Clinical protocols and medical guidelines have long been used by individual professional groups. This is particularly so in the United States, where the use of pathways* ***[Protocols]*** *of care is well established."* ***Interview with Graham Morgan (Director of Nursing & Quality 'West London Hospital')***

The ability to point out that the model being adopted is not untried within the professional organisational field legitimises its introduction into a new 'spatial' area. In this way 'West London Hospital' is able to reap the benefits of being innovative, whilst at the same time, arguing that it is following a tried and tested route. *This allows the organisation to manage professional conservativism, and strategic organisational risk simultaneously* – cross-border innovation is thus advantageous as it allows the organisation to have the cake and eat it. Significant reputational benefits can be expected without incurring significant risks.

This use of globally tested models was especially evident in the case of the move towards accelerated discharges from hospital, with the creation of the *Collaborative Care* team concept out of the previous *Hospital at Home* and *Bridging* team concepts:

> *"The concept of hospital at home originated with 'Hospitalisation a Domicile' in France in 1961 and has been implemented in a number of other countries, including the United States, Canada, and the Netherlands…" (Shepperd and Iliffe (1998)*

The use of this model did not rely merely on the proven nature of the concept outside the UK NHS environment, but also on the fact that it represented incremental change in the way in which cases were handled. The C*ollaborative Care* concept may be 'marketed' either as a step development of the *Hospital at Home* and *Bridging team* concepts, or as a new (to the UK), concept imported after international comparison.

The appropriation process means that seemingly attractive global ideas will not automatically be embraced, however, unless they address agendas, which have formed in the local context. In this sense, innovations are 'embedded'. In the 'West London Hospital' case, the local situation has facilitated the embrace of new ideas. First of all, protocols allowed 'West London Hospital' to manage its patient throughput more effectively (improved care quality), more efficiently (reduced costs), and more speedily. All of these addressed items on 'West London Hospital''s agenda. More specifically,

> *"The impetus for change was saving money but the idea of the collaborative care team fitted in to the longer term strategy of the trust which was to re-engineer care and as part of that process to look at a reduction in patient beds. We had already done some research on elective surgical care and knew that there were a range of conditions primarily within orthopaedics, gynaecology, urology where after a day the care required could appropriately be given at home. When you reduce the length of hospital stay you do not necessarily reduce the length of time that care is required. Patients will feel as lousy as they have always felt but it is about identifying and mapping out the clinical process to apportion where appropriate care should be delivered and so the setting up of the team met the strategic objectives of the trust, and at the same time reduced costs by closing almost two wards."* ***Interview with Director of Nursing & Quality at 'West London Hospital')***

This 'double payoff' is echoed in the literature (Parkes and Shepperd 1998; Cochrane Stroke Group 1998; Evans 1993 and Kollef et al. 1997), both from the UK and from North America. Indeed, Hurst (undated) identifies better care as the number one reason for adoption of PFC in the US (88%), with lower costs as 2$^{nd}$ most important (55%), and [organisational] survival as 5$^{th}$ most important (37%). It is instructive to consider discussion of length of stay in hospitals in the global context: reforms throughout the EU and America have centred on a change in funding criteria, away from per diem payments for hospital stay towards DRG[2] based case fees, which give an incentive to reduce length of stay faster than would otherwise be the case (Mossialos and Le Grand 1999; Arnold and Paffrath 1998). In the UK the focus on length of stay has included quality in terms of patient satisfaction and hospital acquired infections (Struelens 1998).

Adoption of global models into NHS organisations is, potentially, made particularly difficult in that the NHS is an organisation in which the collision of clinical and managerial agendas provides the ground for conflict (Lorbiecki, 1995). Such conflicts are especially likely where

[2] Diagnosis Related Group, in which a case fee is paid on the basis of average expected costs.

change is substantial and where the drivers for change are not purely clinical. Denis et al. (1996) showed that:

> *"substantive change under ambiguity requires collaboration: more specifically the formation of a tightly knit group of actors that can perform specialized, differentiated, and complementary roles in moving the organization in the desired direction."*

Where this group approach is not present, or breaks down, then, state Harrison and Pollitt (1994):

> *"conflict **will** occur (as indeed has been the case) when managers press professionals to behave in ways which the latter do not want"*

The need for cooperation in implementing the change process was acknowledged in the development of protocol based nursing and collaborative care at 'West London Hospital' and it was indicated that acceptance of protocols for PFC at 'West London Hospital' was achieved in part through the

> *"appointment of a facilitator with a clinical background and with credibility among the clinical professionals within the organisation" (Morgan and Layton undated)*

It is essential to recognise that benchmarking of 'best practices' in the NHS is potentially problematic. Any drive to improve efficiency might well lead to a loss in effectiveness as clinical professionals withdraw their goodwill. Crucially, clinical doctors did not object to the introduction of new innovative practices, as they were perceived as potentially addressing two *professional* objectives: firstly, to serve the local community (patients); secondly, to employ the re-engineering project in order to modernise and provide a much improved service to patients through cutting waiting lists, smoother passage through the system, and the more systematic delivery of treatments (protocols). Similarly, Ackroyd & Bolton (1999, p.377) found a "natural alliance emerging between doctors and managers" in implementing a new pattern of service provision in a gynaecological ward.

The need for such acceptance is demonstrated in the experience of developing the ACAD project. A new state-of-the-art hospital was to be constructed in two stages: the UK's first purpose-built ambulatory care and diagnostic centre (ACAD) and the Brent emergency care development (BECAD). The ACAD centre received Treasury approval in 1995. The ACAD project, which separates elective patients from emergency admissions was politically controversial in the UK, although it had already been proven successful in Austria, Switzerland and the USA (Mayo Clinic). This is in line with DiMaggio & Powell's (1983) but also Whitley's (1994a, 1994b, 1992, 1991, 1990) analysis in that national borders are described as presenting substantial often insurmountable obstacles to isomorphic diffusion processes. In order to drive change forward there was a perceived need to sideline those interests whose identity is reproduced along national,

historical, mainly normative lines of isomorphism. These lines of conflict are forcefully expressed by the 'pro-innovation' chairman:

> *"We should not run the project and plan on the basis of reactionary and negative tendencies of consultants and nurses ...The consultants will do as they're told – it's a process of re-education-they're all young (Chairman ['West London Hospital'])"*

That the ACAD project was a "transformation of the old 'West London Hospital' service … [intending] to separate elective and emergency care" was a concept accepted in some way by all at 'West London Hospital'. That it would "provide reduced cost and improved elective care to the NHS and other purchasers"' or that it "will offer clinicians the opportunity to extend the range of care which can be accomplished in the ambulatory mode" was, perhaps, more contentious. That "ACAD presents an important NHS opportunity to realise the benefits of complete reorganisation of clinical care protocols and staffing arrangements from a zero base", was not a positive message to all the actors involved **(quotes from ACAD Full Business Case 1996)**. It is these micro-political constellations that will decide the fate of a 'global template'.

Within the ACAD business plan specification there were a number of key features, which were designed to improve patient flow, thus improving efficiency, reducing waiting lists and increasing patient satisfaction, whilst providing medical care at a 'cutting edge standard'.

The ACAD project leader was a non-medically trained hospital management board member, who **also** had lead responsibility for the Clinical Policies Group. The medical staff focus groups were not fully integrated into the project implementation structure (see ACAD Implementation Structure chart below). Almost inevitably, tensions grew which threatened the ACAD concept. The ACAD project included much which would change the routine of medical management quite radically, in the way in which referrals to the facility are dealt with:

> "At present there are a number of factors which adversely affect waiting list and theatre list management as follows:
>
> - In general GPs refer to specific consultants resulting in persistent over and underloading by consultant, thereby affecting the Hospital's overall activity levels; …
>
> The ACAD project will be responsible for reviewing the management of waiting lists. It is envisaged that ACAD based "scheduling staff" will be responsible for elective care waiting list management taking over this responsibility from staff working in clinic offices. The ACAD project will review and optimise the following:
>
> - Scheduling pre-assessment;
> - Pre-assessment;
> - Assigning a To Come In (TCI) date;

- Scheduling tests & investigations associated with elective care;
- Cancellation and re-book … **(ACAD Business Specification documentation)**

Given that the project documentation quoted above was drafted by the (non-medically qualified), project leader it is, perhaps, unsurprising that tensions arose around this project. At the same time, a familiar pattern was being followed in terms of the model followed. The project was designed to enable 'West London Hospital' to perform well in a political climate, which was demanding reductions in the waiting times for elective procedures, at the same time as setting stricter guidelines over the processing of emergency admissions. In order to ensure that both groups could be handled effectively they were to be separated and managed. Whilst this response to uncertainty had been employed elsewhere, 'West London Hospital' was again at the forefront of innovation in the UK. This 'lead' was gradually turning into a favourable reputation and praise from prominent corners. ACAD was opened by Prime Minister Tony Blair in September 1999. In his preliminary remarks the Prime Minister acknowledged the reputation 'West London Hospital' had won for innovation:

> I am absolutely thrilled to be here … I have just been so excited by what I have seen here. This is the future for the National Health Service. I was talking to a lady … who saw her doctor and booked the appointment the same day. Two months later her cataract operation was done. I have heard about those people working in breast cancer surgery who are able to get people in within two weeks and then on the same day tell whether they are clear or if they need more work. And this is what the future of the health service needs to be … You are the pioneers of the new National Health Service. (Tony Blair, ACAD launch, September 1999)

The ACAD centre was also favourable discussed in a Financial Times article dated 08 April 2000 which emphasized the pioneering status of ACAD in the U.K. The use of an Ambulatory Care and Diagnostic centre also requires a radical change in the way in which treatment is administered and scheduled:

> To optimise the use of theatre facilities it will be necessary to schedule surgical interventions based [on] the availability of resources and expected patient recovery times. This approach will require radical changes to the existing theatre and recovery management process, where currently theatre lists are controlled by consultants and held manually by medical secretaries.
>
> The ACAD project will be responsible for reviewing and optimising the following:
>
> - Scheduling theatre usage (based on theatre availability, patient recovery times and availability of recovery "bed slots" 1st, 2nd, 3rd stage);
> - Scheduling patients and staff;

- Multi-disciplinary working; … (ACAD Business Specification documentation)

Ackroyd & Bolton (1999, p.376-7) discuss how organisational changes initiated by management led to significant patient throughput increases at a gynaecological ward. They, however, focus on the implications for working practices of nurses. What in the ACAD documentation is couched here in 'technospeak' and neutral management language has wide ranging implications in terms of changes in professional autonomy, work practices and job roles of clinical staff (cf. Harrison, 1999). Improved scheduling management and facilitation of cross-disciplinary / cross-functional working are core elements of private sector best practices:

> "The Hospital currently uses manually supported clinical protocols for pre-assessment and surgical procedures. The protocols are designed to enhance the clinical care by providing a vehicle for multi-disciplinary working and capturing the patient records as part of the clinical process. The ACAD project will be responsible for enhancing the use that is made of clinical protocols to deliver improvements in the following areas:
>
> - Theatre and recovery management;
> - Clinical audit and research; capturing clinical information;
> - Medical legal requirements. …
>
> It is expected that the re-engineering undertaken during the ACAD project will result in new job roles being defined and implemented. The definition and agreement of the new roles and their associated terms and conditions of employment is the responsibility of the ACAD project. **(ACAD Business Specification documentation)**

These changes are not restricted to scheduling and protocols but encompass also clinical practice.

> "[General anaesthetic will] be induced on the table, as **all** preparation is done. Therefore, anaesthetic rooms are not needed for all theatres, one only to be provided and to serve two theatres." **(ACAD project documentation)**

These changes represent the processes of mimetic isomorphism, which is the most commonly referred to isomorphic process. U.S. is most heavily predicated on focusing on this process (Mizruchi & Fein, 1999), reflecting the ideological bias of U.S. society, where it is preferable to discuss competitive behaviour rather than power and coercion. Institutional isomorphism occurs in this situation as a response to uncertainty over the future of the particular hospital site, and the NHS in general. Management seek to avoid risk to themselves and to their organisation, through the adoption of models which have already been proved in the same field, albeit in another national setting. At the same time members of the medical profession engage in normative isomorphism, using the norms and codes of their profession (education, specialist knowledge veto,

both legally mandated, and informal - but effective), to oppose those parts of change, which they do not like. Professional concerns about 'unsafe' changes in working practices can act as a powerful obstacle to change. Implied are questions of throughput management, more efficient usage of expensive equipment and room facilities. We know from the literature that where managerialism touches on questions of professional control and established working practices, a contest will ensue. This may even include attempts to invoke the power of professional status gradients, in order to maintain existing control and status. Not surprisingly, therefore, on October 3rd 1996 consultants from the department of urology and lithotripsy wrote:

> "*It is important that we do not regard the ACAD centre as being a facility that would revolutionise clinical practice. The investigations and treatment that patients require will not change overnight, nor will the pattern of referrals from local GP's. the way in which the facilities are used must be orchestrated around the requirements of those surgical disciplines which will be using the facility most.*
>
> *Service departments, eg, Radiology and Anaesthetics, cannot be the prime movers in the way in which the organisation works. The illnesses that patients have and the management thereof will not change fundamentally because of ACAD…*"

This letter indicates an attempt by an existing powerful professional subgroup to protect its boundaries, and to do this by appealing to existing professional values. This letter represents the very real possibility of the ACAD project becoming unstable or failing because of the lack of ownership of its aims, objectives and processes by the main body of the medical profession within the Trust. Here was the beginning of a period where management, in implementing the 'global' model had failed, adequately, to address the 'local' issues and had therefore failed to build consensus within the wider organisation and the crucial professional groups. This episode also shows that the actual implementation of an (organisational) innovation will look differently, depending on the specific context into which it is introduced. It had thus endangered the success of the project's legitimacy and diffusion potential:

> "A large group of sixty staff, including thirty consultants, met with the steering group on 31st October in order to voice their worries about ACAD…

Another consultant expressed his concern very strongly in an interview:

> *This is a ludicrous concept to have operating theatres without anaesthetics. Even before a clinician can scrub hands after a patient is operated on, the next patient comes. (consultant ['West London Hospital'])*

Professional concerns, i.e. normative isomorphic processes emerge as in contradiction to mimetic learning processes. Put differently: Mimetically-based learning faces normatively-based resistance. Indeed, the literature tells us that disagreements over the meaning and implications of certain 'events' are always possible, and different groups in the organisation will develop alternative stories that interpret the same experience differently (Meyer and Rowan, 1977). This is an especially likely outcome where managers need to co-ordinate their agenda with the agenda of professionals, such as medical doctors. Uncertainty, (re)negotiated orders, negotiating political power and especially finances are also cited as catalysts for change – change referring to unfreezing the existing organisational model and re-freezing a new one (Denis et al. 1996; Light 1995; Tiffany and Lutjens 1998). Indeed Denis et al. (1996) identify some actors within a Canadian hospital change situation identifying financial pressure as "an opportunity rather than a threat …: '*the current period is fantastic for me, because it's during budget constraints that you invent things that hang together'*." At 'West London Hospital' the threats to organisational change are similar to the ones discussed by Denis et al. (1996) and the outcome is also comparable. The consultant body was to be integrated into the process:

> "[CEO] reported on the Consultant ACAD Evening on Thursday 31st October. [NED, Project Director, and CEO] updated the attendees and concluded that a medical staff Focus Group should be created. It was agreed that [Project Director and Medical Director] would report back to the next [steering group]
>
> Design issues on anaesthetic rooms would be addressed. [Project Director] to report back to the next SG." (Minutes of Steering Group Meeting 5th November 1996)

This quote demonstrates not only the strength of feeling being aroused among clinical professionals, but also their ability to modify management agendas. The exact outcome of this micro-political contest, is the subject of another paper (Mueller et al. 2000).

### *Summary, Conclusion and Implications*

We have assessed the impact of a standard model of organisational change and client provision in relation to a single organisational context. We conclude that normative, mimetic and coercive isomorphism are all present in the construction of organisational change in the health sector, and the interplay between the differing professional and professionalizing actors involved. In order to successfully analyse change in the political climate surrounding health care delivery institutions attention must be paid to all three types of isomorphism at varying points throughout the process of innovation in NHS hospital Trusts. Global innovative practices – such as Patient Focused Care and collaborative Care Teams - were embraced and relatively successfully implemented as a result of the specific local situation at 'West London Hospital' which, originally, was characterised by threat of closure and a specific population mix, the latter putting premium urgency on speeding hospital patient throughput.

The paper looked at the importance of the 'local' context in shaping the adoption of a 'global' organisational innovation. Most importantly, we attempted to show that the cognitive boundaries of the OF have started to breach national borders, even though resource dependencies and legitimation are still largely national. Defining the new boundaries of the OF becomes therefore ambiguous and problematic: whilst the N.H.S. is still basically a national field, cognitive learning is taking on a more global orientation. In this sense, the *local connects directly with the global*, and the global organisational innovation will be appropriated in *locally*-specific, rather than *nationally*-specific ways:

(1) the absence of anaesthetic rooms was problematised by some clinical professionals demonstrating that the adoption process at local level was not unproblematic
(2) the 'foreign' origin of the innovation played out advantageously: the innovation, whilst already been tested, can still provide the kudos of being a pioneering organisation
(3) public policy-makers influence the appropriation process: their role is not restricted to coercive legislation

As far as (1) and (2) are concerned, management's role is important here, and this goes beyond the more typical contributions from institutionalist theory that de-emphasizes agency. As coercive, normative and mimetic pressures and processes conflict, executives need to mediate between these demands. Whilst an NHS Hospital Trust, as a professional service organisation, is different from a private sector company, the latter also have different types of experts such as engineers, accountants, lawyers etc. In many ways therefore, organisations' executives will need to mediate the claims emerging from mimetic isomorphic pressures rather than simply implementing such isomorphic processes.

The third point is, perhaps, crucial in explaining the findings of Mizruchi and Fein (1999). Attempts by government at coercive processes for change, and subsequent organisational homogeneity are evident in the NHS reform process, but the direct success of these attempts has been limited by the health professions' (especially medicine's) ability to resist structural change, and once that change is imposed, to reduce its impact by their interaction within the new structures (Mueller et al. 2000). Interestingly in our case, public policy-makers have attempted to influence mimetic learning by encouraging organisations to seek out best practices. This particular aspect has not been discussed in the existing literature where only government's coercive role is described. In some way then the impact of normative isomorphic process is played out as a foil to coercive isomorphic processes, so that although both are to be seen, they take on a subservient role to the mimetic processes. The main impact of both may in fact be argued to be the creation of the instability and uncertainty required as a catalyst for public sector organizations, first to seek innovations, and then for these innovations to be spread rapidly through the field.

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