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Street-level diplomacy? Communicative and adaptive work at the front line of implementing public health policies in primary care

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Abstract

Public services are increasingly operating through network governance, requiring those at all levels of the system to build collaborations and adapt their practice.   Agent-focused implementation theories, such as 'street-level bureaucracy', tend to focus on decision-making and the potential of actors to subvert national policy at a local level. While it is acknowledged that network leaders need to be adaptable and to build trust, much less consideration has been given to the requirement for skills of 'diplomacy' needed by those at the front line of delivering public services. In this article, drawing on theoretical insights from international relations about the principles of 'multi-track diplomacy', we propose the concept of street level diplomacy, offer illustrative empirical evidence to support it in the context of the implementation of public health (preventative) policies within primary care (a traditionally responsive and curative service) in the English NHS and discuss the contribution and potential limitations of the new concept. The article draws on qualitative data from interviews conducted with those implementing case finding programmes for cardiovascular disease in the West Midlands. The importance of communication and adaptation in the everyday work of professionals, health workers and service managers emerged from the data. Using abductive reasoning, the theory of multi-track diplomacy was used to aid interpretation of the 'street-level' work that was being accomplished.

Keywords

Introduction

Primary care policy is shifting from traditional response-mode delivery to preventative healthcare and the more active management of long-term conditions. At the front line of much of this work are allied health, para-professionals and community health workers who, while having access to very little hard power are nonetheless required to negotiate persistent tensions at the interface of the primary care and public health agendas, as well as being (or even embodying) a bridge from healthcare professionals to the general practice community. Operating within the context of a health system that increasingly resembles a 'network' rather than a 'bureaucracy' (Rhodes 2007), we examine the everyday work of these people by examining their roles in relation to agency-based theories of implementation (Lipsky 1980, John 2013). We propose that a new concept of 'street-level diplomats', drawing on diplomatic theory from international relations, is a useful way to theorize the communicative and adaptive work that underpins the role.

Background

The organisational structures of English primary care, contractual obligations and the nature of associated medical work have changed considerably over the last quarter century (Checkland 2004). Historically, GPs have always provided care in response to patients' requests but in England a key contractual change in 1990 tied some practice income to limited health promotion activities such as screening and immunisation services (Lewis and Gillam 2002) and further changes in 2003 incentivised chronic disease prevention (Shekelle 2003). Changes to the existing order implicitly question current practices and invariably create additional work in an already pressurised service. Therefore, they have been contested at all levels to some extent (Harrison and McDonald 2008).

Clinical epidemiology and public health perspectives, based on probabilistic risk, have been highly influential at health policy level, contributing to the codification of research into evidence-based

guidelines and often termed 'scientific-bureaucratic medicine' (Harrison 2002). In England, National

Service Frameworks (NSF) were introduced to standardise care delivery, for coronary heart disease

and other conditions (Hippisley-Cox and Pringle 2001, Department of Health 2004). Globally, it is

expected that individualised, demand-led consultations will form a smaller proportion of primary

healthcare teams' work (Bodenheimer, Chen et al. 2009). A recent review concluded that there is

insufficient good evidence on health improvement interventions in primary care and that GPs tend

to focus on individual patients rather than on population approaches (Peckham, Falconer et al.

2015).

Cardiovascular disease (CVD) is the main cause of morbidity and mortality in England (British Cardiac

Society, British Hypertension Society et al. 2005) and there are continuing efforts to improve

prevention services. Underpinned by national guidelines (National Institute for Health and Clinical

Excellence 2011), CVD targeted case finding programmes, informed by health economic evaluation,

target preventative services to those with highest risk of CVD in order to improve effectiveness and

cost-effectiveness of preventative healthcare (anonymized references). Targeted case finding

programmes typically involve gaining access to GP practices; running a computer algorithm through

existing electronic patient records to stratify patients by CVD risk; inviting patients for assessment;

discussing risk; and encouraging them to reduce risk by taking medication, changing lifestyle or both

(anonymized references). These programmes have been shown to increase the number of high-risk

patients started on antihypertensive and statin treatment (anonymized reference) and to be cost-

effective as, across all age ranges, targeted case finding is more efficient than universal case finding

in healthy adults (anonymized reference).

Across England, various approaches have been used involving existing or additional specialist CVD

nurses, community pharmacists, health trainers and others. These have been funded by the NHS and

local government, including specific programmes to address health inequalities (anonymized

reference). Socio-economically disadvantaged groups, particularly men, are much less likely to

access preventative services, particularly those provided opportunistically in routine care (Banks 2001). However, it is important to note that a major constraint in the targeted case finding model in any attempt to tackle health inequalities was its absence of links to a wider community strategy. A co-ordinated engagement with local government could influence some of the wider determinants of health but at the time of the intervention major structural changes (abolition of Primary Care Trusts and the move of public health to local authorities in 2013) limited some of these options. While the intervention might be a success, within its own terms of reference, and have some potential to address health inequalities (Mathers, Taylor et al. 2016), wider policy success (McConnell 2010) is more elusive in the field of health inequalities (Exworthy, Berney et al. 2002, Exworthy, Blane et al. 2003).

In 2009, annual NHS 'Health Checks' in England and Wales were introduced for all adults aged 40-74 for stroke, heart disease, diabetes and kidney disease prevention, although there has been significant variation in the way this policy has been implemented (Artac, Dalton et al. 2013). The Sandwell targeted case finding project (piloted in 2005) may have been influenced the Health Check policy as the project was Highly Commended in the Information-Based Decision Making category of the Health Services Journal Awards 2007 & Sandwell PCT won the Primary Care Organisation of the Year in the Health Services Journal Awards 2008. The rollout of the complete evaluation project (anonymized ref) overlapped with the introduction of NHS Health Checks and the project was modified to meet with the mandatory requirements of the NHS Health Checks and absorbed into the NHS Health Checks programme. While the universal approach of NHS Health Checks is in tension with the more cost-effective approach offered by targeted case-finding, both approaches are fundamentally different to the traditional responsive mode of primary care, while still being medically-driven, rather than focusing on the social determinants of health. Our empirical interests lay in exploring the everyday work (Gale, Thomas et al. 2016) of those implementing case-finding programmes.

Theoretical framework

This research was conducted in the British context where network governance, with high levels of interdependence between actors, predominates (Bevir and Rhodes 2003, Bevir and Rhodes 2003). Politics post-Thatcher in the UK has reduced bureaucracy, yet, ironically, multiplied the actors and made more complex the processes required to deliver public services (Rhodes 2007). While the NHS retains some characteristics of hierarchical/bureaucratic and market governance, as well as network governance (Exworthy, Powell et al. 1999), the value and validity of applying theories of network governance to the health system have been well established in the literature (Addicott 2008, Kuhlmann and Allsop 2008, Velotti, Botti et al. 2012). In primary care, this is particularly relevant, because it is primarily delivered by independent contractors (general practitioners in partnerships), who collaborate with other practices, pubic and third sector organisations (Pickard, Sheaff et al. 2006).

As Rhodes argues, while bureaucracies are reliant on rules and authority and markets on competition and finance, policy networks are characterized by a reliance on trust and diplomacy (Rhodes 1998). He argues for more interpretative research that focuses on the beliefs and practices of the people in policy networks (Rhodes 2007: 1259). Indeed, Barley and Kunda (2001) have argued that theoretical approaches to understanding post-bureaucratic organizing have been 'hampered by a dearth of detailed studies of work'. We make the case in this article that diplomacy is not only relevant for steering and managing networks (Ferlie and Pettigrew 1996), but also for those at the front line of implementing policies. To develop this argument, we draw primarily on two theories: the sociological concept of street-level bureaucracy (Lipsky 1980) and multi-track diplomacy (Diamond and McDonald 1996) borrowed from international relations (see Methods below for critical discussion of theorisation process). Our hybrid concept – *street-level diplomacy* – aims to

make the communicative and adaptive work of front-line healthcare workers more visible in the theoretical debates around the everyday practice of implementing health policies.

A major contribution of Lipsky's concept of street-level bureaucrats comes from his observation of an inherent paradox in their work:

> *On the one hand, the work is often highly scripted to achieve policy objectives that have their origins in the political process. On the other hand, the work requires improvisation and responsiveness to the individual case (xii).*

Lipsky argued that because many public servants operate with a high degree of discretion and autonomy in resource-limited conditions, they can profoundly influence the outcomes of the policies they are employed to enact. He concluded that:

> *the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out (xiii).*

Lipsky's work continues to have considerable influence in the analysis of the implementation of public policy (Hill and Hupe 2014, Hupe, Hill et al. 2015), within the broad 'bottom-up' tradition of implementation research, despite the criticism it has received for potentially overemphasizing the levels of local autonomy (Matland 1995). While we take the prevention agenda and the associated epidemiological evidence of health risks as our start point, which is more in line with a 'top-down' approach, our primary interest was to explore, through an interpretative and decentred lens (Yanow 1999, Bevir and Rhodes 2003, Wagenaar 2014), the everyday work of implementation. Therefore, we wanted to avoid any assumptions that implementation was a straightforward administrative process. Indeed, most English General Practitioners (GPs) are not employees and remain 'independent contractors' exercising considerable autonomy in their consultations. Scholars have argued that Lipsky's description is broadly applicable to GPs (McDonald 2002, Checkland 2004),

although there is some recognition that increasing drives for accountability to the objectives of organisations has limited street-level bureaucratic decision-making and 'liberated' them from such dilemmas (Taylor and Kelly 2006). Patients closely resemble 'non-voluntary' service users, generally remaining with whoever they are registered (Greener and Mannion 2009, Lewis and Longley 2012). Resource limitations constrain practice and incentivise 'processing' patients quickly and efficiently (Gillam and Pencheon 1998, Wilson and Childs 2006). Although performance measures have been introduced (Department of Health 1998) there remain heated disputes about the definition and measurement of performance in general practice (Mountford and Shojania 2012, Valderas, Fitzpatrick et al. 2012).

GPs exhibit many of Lipsky's outcomes – routines are established and strategies are invented to cope with uncertainty, thus public policy is operationalised and localised (Exworthy and Frosini 2008). Therefore, services may be delivered in ways unintended by (or even opposite to the conception of) policy makers or managers. For instance, staff may find 'workarounds' if new regimes offer barriers to their daily practice (Halbesleben, Savage et al. 2010, Robbins and Galperin 2010). However, Lipsky's work focuses very much on the activities of decision-making and judgements about access to limited resources. It focuses much less on relationships and the 'soft' skills required to engage, build trust and persuade within networks. Lipsky and others have also tended to stress how policies can be subverted in their implementation (Exworthy, Berney et al. 2002) rather than on how policies can be implemented despite organisational and cultural barriers.

Diplomatic theory has a long history of understanding of the process of building successful and productive relationships between two or more communities (Black 2010). In international relations, the threat or use of force ('*hard power*') remains a central issue. However, the development of global communication technologies and the application of systems approaches to diplomatic theory in the 1990s led to renewed interest in economic and cultural avenues for enabling collaboration and gaining influence ('*soft power*') and multi-track diplomacy explores the complexities of this

process (Diamond and McDonald 1996). It stresses the need for communication at all levels, via formal and informal 'tracks'. Further developments on putting multi-track diplomacy into practice, have articulated 'practice-orientated principles' that detail specific approaches to diplomatic work, a framework for making sense of the ways in which diplomatic relationships can be opened up and the nature of involvement with partners through building relationships (see Figure 1). Finally, multi-track diplomacy highlights that the overall goals of diplomacy are not the imposition of one's will on another but 'soft' power, i.e. facilitation, empowerment and ultimately transformation (Diamond and McDonald 1996, Notter and Diamond 1996).

It is worth noting that in a clinical context, the soft power of GPs can persuade patients to override their own preferences rather than sharing the decision (Gale, Greenfield et al. 2011, Virdee, Greenfield et al. 2015). Lukes (1974) refers to preference shaping as the 'third dimension' of power because it obviates the need for force. Soft systems approaches have been applied to healthcare (Checkland and Scholes 1999, Goddard, Mannion et al. 1999) and political historians have noted the importance of managers adopting the role of diplomat during the 'consensus management' era (1948-1983) of NHS history (Harrison and Lim 2003). However, no previous work that we are aware of has systematically examined the applicability of principles derived from diplomatic systems analysis to everyday work within the healthcare system.

In this article, we propose the concept of street-level diplomacy, offer illustrative empirical evidence to support it in the context of the implementation of public health (preventative) policies within primary care (a traditionally responsive service) and discuss the contribution and potential limitations of the new concept, and possible future directions for research.

Methods

Study Design and Research Team

We adopted an interpretive perspective informed by agent-focused approaches to interpreting implementation (Lipsky 1980, Rhodes 2007). The multi-disciplinary research team had backgrounds in primary care, nursing, service management, medical sociology, and health services research. Our theoretical perspective ran through the study, from our emphasis on the everyday work of social agents, to use of qualitative methods designed to capture sense-making and reflection on practice, to our analysis which was focused on the actions and explanations for actions that implementers explored in their accounts and the interrogation of theory through our emergent findings (Bradbury-Jones, Taylor et al. 2014).

Setting, intervention and ethics

This study of cardiovascular disease prevention took place within a wider programme of work to promote inter-professional and inter-organisational applied health research involving universities and NHS Trusts with the aim of translating findings into clinical practice (Collaborations for Leadership in Applied Health Research and Care – Birmingham and the Black Country). Ethical approval was obtained from the [anonymized] Life and Health Sciences Ethical Review Committee. The focus of the study was on Sandwell, a district within a large conurbation in central England, characterised by industrial decline, social deprivation, ethnic diversity and relatively high levels of mortality and morbidity. This had been the site of the pilot for the CVD case finding programme and the place where the new service was most developed and embedded (anonymized reference). We also interviewed comparable people in adjacent geographical areas to explore whether themes and processes were local or more universal. In all areas, 'high risk' patients were identified from patient records and then invited for assessment in their own general practice. In Sandwell, they were seen by a project nurse, who asked the GP to prescribe if drugs were required. Patients who were in the 'intermediate risk' category were invited and assessed by a health trainer. In Solihull, patients were seen by a project pharmacist, who either prescribed drugs if needed directly, or referred to the GP

for prescribing. In Stoke-on-Trent, there was a flexible model whereby the assessment could be by staff employed within the GP practice or by those employed by the primary care trust.

Access, recruitment and sampling

Participants were selected purposively from primary care organisations and all had been involved in implementing case finding programmes. The sampling strategy aimed to capture accounts of different implementer perspectives, including those who were in a leadership or management role and those who were on the front-line and engaging directly with the public and patients. We stopped conducting interviews with implementers once we felt we had reached saturation of our central emergent analytic category of adaptation and collaboration that eventually developed into the concept of street-level diplomacy. However, the wider project continued to recruit participants and develop other emergent themes. Access was granted through programme managers who were involved with the research. Participation was voluntary and informed written consent was taken prior to interview.

Interviews were conducted with 18 people that were involved in implementing similar case-finding schemes. The overarching leadership for the programme of work came from an academic, who was medically and public health trained and had an honorary post in Sandwell alongside his University post. Other leaders within the system included a public health director, a GP who was the clinical champion for the programme in her locality, and a public representative who sat on the steering group for the academic programme of work. In management/administrative roles were programme managers (n=3), service managers (n=2), a strategic lead for primary intervention programmes, a research manager and a project co-ordinator. In practice-based roles were a CVD nurse, CVD pharmacists (n=2) and health trainers (n=4). These all came from different GP practices in the region. In addition, a public health registrar conducting a similar case finding project in relation to diabetes was interviewed.

Data collection

Face-to-face, semi-structured interviews lasting between 45-90 minutes were conducted between June 2010 and August 2011 by the lead author with the purpose of exploring everyday practice and its relationship to the wider policy agenda. The interviews covered: strategies for local implementation of case finding; the barriers and facilitators to implementation; issues around concordance and adherence to medication or lifestyle interventions; participants' views on preventative medicine; their experiences of the relationship with the University, and issues around the sustainability of case finding in the current policy and financial climate. Interviews were audio recorded, then transcribed verbatim.

Data management, analysis and theory development

We took a grounded theory approach to analysis using abductive reasoning (Timmermans and Tavory 2012). Interviews were audio-recorded and transcribed. All data were managed using NVivo 8 and an initial descriptive thematic analysis was conducted inductively by the second author. Data were managed in a 'Framework' matrix allowing comparison across and within cases (Ritchie and Lewis 2003, Gale, Heath et al. 2013). Emerging themes were discussed within the team and differences in interpretation were resolved by discussion. One of the early interpretations that emerged from this initial analysis was the difficulty of operating in unengaged or even 'hostile' contexts. Participants all described the process of building relationships and overcoming suspicion and resistance both with primary care practitioners and the local communities.

This led us to a further literature search on the theme of diplomacy. Advice was taken from senior academics with experience in this field to help us identify multi-track diplomacy as an appropriate guiding theory. Subsequently, following similar work examining implementation science theory (McKillop, Crisp et al. 2012), template analysis was employed for secondary analysis of the data (King

2004, Waring and Wainwright 2008). This involved re-reading transcripts to identify the extent to which they espoused, illustrated, contradicted or supplemented the principles of multi-track diplomacy. Borrowing theory from other disciplines is not an unproblematic exercise (Kellert 2008). Within social and organizational sciences, there has been concern about the overreliance on 'theory borrowing' from other disciplines (Oswick, Fleming et al. 2011) and potential loss of conceptual power (conceptual degradation) in the transfer across disciplines (Bailey 2001). What we propose is 'informed disciplinarity' (Lattuca 2001) or an auxiliary relationship between disciplines (Klein 2010), i.e. using the concept of 'diplomacy' from political science as an analytic tool to enhance our theory, rather than proposing any reciprocal arrangement.

After our template analysis was complete, we conducted member checking (Koelsch 2013) around the concepts of diplomacy that we had developed. A 'feedback event' was hosted by the project in November 2012 (for interviewees and their colleagues attended by 14 people) in which the research team presented preliminary findings, identified misunderstandings, stimulated discussion and addressed omissions. Contemporaneous notes were made by five facilitators. This was not a data collection exercise, but served to allow us to sense-check our early interpretations with those involved in the programme of work. As part of the wider project, data were collected on the perspectives of GPs (GP CPD event attended by 30 GPs), of patients (in depth photo-voice interviews with 5 patients) and of community health workers (photo-voice interviews with 11 health trainers), but these data will be reported elsewhere.

On the basis of feedback from these events, the usefulness of thinking about 'diplomacy' as a central part of the everyday inter-professional and patient-facing work of implementers was confirmed. We do not make claims that our new concept of street-level diplomacy is comprehensive in its analysis, but that it is an essential part of the work and particularly that it complements Lipsky's focus on bureaucracy. While bureaucracy stresses the exercise of discretion in decision making and the development of rules and procedures within hierarchical systems, diplomacy focuses on the

communicative, adaptive and cultural parts of 'street-level' roles in policy implementation in networks. Other potentially fruitful lines of enquiry and analysis that emerged from the data have not been explored here. For instance, an interesting emergent theme was around the embodiment and identity of the workers (Alvesson and Willmott 2002, Moffatt, Martin et al. 2014): i.e. their own embodied practice and behaviours in relation to prevention, their commitment to the values embedded in prevention and how they related their work to their own personal career ambitions. This theme is being explored in further empirical work.

Findings

First, we present our findings in relation to the 'street-level' quality of the work being done by those implementing health checks through case-finding. Lipsky identified that SLBs operate with relatively high levels of autonomy and discretion in relation to 'non-voluntary' clients, primarily the public. However, the aim of the high level policy is to produce organisational and cultural *change* (towards a more 'preventative' outlook) in primary care and so there is an additional tension between those driving the change and those being required to change, that is the general practitioners (GPs and other primary health care staff, such as nurses, practice managers and receptionists. In this empirical case, the non-voluntary clients are both the patients, with whom the programme implementers are directly consulting, and the primary care staff with whom they are working (and who can grant them access or not to patients).

Our data confirmed that the concept of 'non-voluntary' was appropriate for both groups. Members of the practice population rarely requested to have their health risk status checked, yet if their health risk was found to be elevated, they were being asked to change their everyday health practices though taking medication or making lifestyle changes. (It was beyond the scope of this primary care initiative to look beyond individual behaviour to wider structural issues). GPs and other

staff were themselves operating in resource-limited conditions trying to deliver a primary care service to their community (Checkland 2004) and so the introduction of health checks through case-finding was requiring them to add another dimension to that work. Those implementing the case-finding programme have little access to hard power to coerce change. Patients could simply not respond to invitations to attend screening or not take prescribed medication and staff could deny access to their general practices:

> *their own family or friends has quite a strong influence on people's beliefs as to whether or not it's beneficial to take something (CVD_nurse_Sandwell)*

> *the GPs are small businesses … Apart from being the doctor, he's [sic.] also the boss, if you like, in the way they're run. And really it's akin to going into someone's home (service_manager_Sandwell).*

This observation highlighted the need for a dimension to our analysis that captured the exercise and negotiation of soft power. It is worth noting, however, that while it is important that people have the opportunity to access preventative services, that protection of the choice not to comply was also valued as an ethical principle: *"I suppose I also feel that people have the right to refuse providing they understand"* (public_involvement_representative).

Our data also confirmed that the implementers held a degree of autonomy and discretion in their work and were, therefore, able to influence the outcomes of the policy. Some aspects of the process were fixed and these were often, in fact, the ones related to decision-making (i.e. more bureaucratic elements), such as the algorithm to identify potentially high risk patients, the content of the letters sent to patients or the drugs or treatments that could be offered depending on the level of risk identified. However, workers had to adapt to the different health organisations and general practice communities in which they were working and, indeed, these skills were essential to the job:

it's not just randomly... There's still then a certain amount of looking and saying, 'Is this

patient suitable at this moment in time? … It could be something like they've recently lost

their husband (CVD_nurse_Sandwell)

It's totally different. They've [GP practices] got their own way of working and it baffles you

at first … I'm quite used to this IT system and this structure,' and then you get to another one,

'Oh, it's totally different!' … You have to remember to have one hat on for one place, one hat

on for another place (health_trainer_Sandwell)

Second, we explore the 'diplomatic' character of the work being carried out and how it applies

within the healthcare context. Participants described how they worked hard to secure 'entries' into

the communities they engaged with and the practices they operated in. While finding entries looked

different for leaders and front-line staff, the search for an 'invitation' and assurances of 'long-term

commitment' characterized both sets of practices.   Gaining entry to the practices and buy-in for the

concept of case-finding was made possible by the reputation of the main researcher on the project

and his preparatory work to engage influential clinical colleagues, including the Director of Public

Health, cardiologists, managers, the chair of the professional executive committee (PEC) of the local

Primary Care Trust and the medicines management team. This individual could reasonably be

described as a 'policy entrepreneur' (Kingdon 1984, Oborn, Barrett et al. 2011) defined as people

who 'from outside the formal positions of government, introduce, translate, and help implement

new ideas into public practice' (Roberts and King 1991) given his pioneering of the economic model,

his driving of the pilot and his influence at national decision-making committees (such as NICE).

However, even once CVD nurses, pharmacists and health trainers were invited to primary care

organisations, they had to work to make things as palatable as possible:

Be nice, be sensible be organised, you know. We very much push the point that you won't have to do anything. You know, we set up our own clinics, we do all our own administration (CVD_nurse_Sandwell)

Entries to the local community were in some ways more challenging. Many communities in the West Midlands are deprived and often termed 'hard to reach' because of factors such as economic situation, illiteracy or ethnic identity. In Sandwell, it was recognised early on that failure to engage the local population was a significant risk in the successful implementation of the project by the programme implementers who had long-term experience of working in the area. The decision was made by those in leadership positions within the implementation team to search for health trainers through local job centres (rather than the central NHS jobs system). The extra time and resource implications of doing it this way were recognised but considered important by the team:

Working with people that didn't have any academic qualifications at all but really good life skills with setting up community football teams and getting people from deprived areas to engage; so they've got really positive skills (service_manager_Sandwell).

The payoff was rich local knowledge, trust and rapport with the community which front line staff articulated as essential to their success:

I've done 15 years in the community … in finance, with debt management. I've run junior youth clubs … they know me … because sometimes if they have a letter and they can't read it, I know Dan who worked for the [Community] Centre, many a time he's had people go in 'Can you read this for me, I've had a letter come, I don't know what it's for.' And they'll say 'Oh it's only for Jenny, you just need to go the doctors on this day.' And then they'll come. (health_trainer_Sandwell (Jenny), Jenny and Dan are pseudonyms).

The time and work required to engage people in the programme, build relationships, develop trust and ultimately build partnerships with the community and the practices is substantial. Multi-track

diplomacy proposes that engagement requires a demonstration that you are a committed, reliable and engaged partner. In the healthcare context, this involved showing that you can bring benefit to the practice and the patients:

> *Because I was getting people in and they were attending their appointments rather than quite a higher volume of DNAs before … And then once you, sort of after a month or so, people are starting to lose weight, that was encouraging, and then doctor sort of starts referring more people to you. So it's building up a rapport, not only with patients but with doctors as well (health_trainer_Sandwell).*

It requires that you offer your guidance without telling others what to do. For practices, this means recognising the GPs' jurisdiction over their practices and putting in the time needed:

> *GP engagement its cost me hundreds and hundreds of hours but now we're in, now we're working the practices actually it's very easy (service_manager_Sandwell)*

and for patients it means not judging or lecturing but listening and supporting:

> *I think when you're trying to put messages out there, if you can put it in a way, like a diplomatic way, you're not, sort of, judging people. I think that once you start judging … you come across as a bit cold, it's not gonna go down too well. (health_trainer_Sandwell)*

The three approaches to diplomatic work identified in multi-track diplomatic bring together principles that may be familiar from discussions of clinical trust or forms of community development work, but offer a new configuration, that needs to be enacted both by implementation leaders and front-line staff. The first – cultural synergy – involves respecting the cultural wisdom of all parties involved. All those involved in implementing the programme felt strongly that there was no one-size-fits-all approach as different GP practices and different local communities had different needs

and characteristics. In some cases, this involved speaking community languages, but often it was more related to understanding how a community operated:

> *if they talked to somebody at their own level who has their understanding, who speaks their language or dialect, or just uses the terminology...for instance, in Sandwell people in Tipton speak very differently to people in Blackheath, and for any of them to come from the six towns to come to West Bromwich is a day trip for an awful lot of people. I know some people find that quite difficult to understand … we've got somebody working that lives on the patch or not far off. So she's got really good understanding. She understands about being unemployed because this is the first job she's had (service_manager_Sandwell)*

We also identified this approach in our data from the other three localities in the ways that leaders had consciously adapted the Sandwell model (anonymized reference) to work with their own context:

> *We call our Health Trainers 'Lifestyle Coaches', so we felt that, locally it was more acceptable to this population … so it's the same model, well it's slightly tweaked (GP_Stoke).*

> *we were seeing by putting the Project Support Workers into a practice, they were educating the practice as well, they weren't just doing the screening, they were raising awareness of the whole programme by talking to the receptionists and the whole team … because we from public health, we can't be everywhere (programme_manager_Stoke)*

The second approach to diplomatic work - the use of 'multiple technologies' – was widely acknowledge both by leaders and front line staff, i.e. approaching challenges from a variety of different angles. At a strategic level this might involve providing evidence to support the intervention, undertaking networking and providing continual feedback, while at front line, this involved having various tools available and tailoring them to the individual or practice concerned, such as different ways to explain the concept of risk to patients:

> *we very much use the calculator for … to demonstrate with smokers, 'Here's your risk as you*
>
> *stand at the minute. If you didn't smoke, so I'll make you a non-smoker, look, you don't even*
>
> *need that medication (CVD_nurse_Sandwell)*

or using a variety of tools such as food plates, food labels and recipes to encourage behaviour

change:

> *It may be cholesterol one week; it may be the food plate; it could be, as you say, looking at*
>
> *food labels. So I think we all work in different ways but we've all had the training to do all*
>
> *those ones. But again, we tailor the sessions to that client. Sometimes it's just about putting*
>
> *your pen down and listening and not, sort of, trying to push anything*
>
> *(health_trainer_Sandwell).*

The third approach to diplomatic work - learning from everything – was central to the ongoing

adaptation of practice in this context of building collaboration across cultural boundaries:

> *It's like when I first started here I always used to dress up and now they say they'd rather*
>
> *come and see me in my jeans or in my joggers because I'm normal … When they're with me*
>
> *they get what they get [laughs]. I'm from round here as well, so (health_trainer_Sandwell).*

and organisational boundaries, such as the informational technology infrastructure:

> *I think it's hard to try and create the correct IT systems to transmit the correct data, see my*
>
> *advantage is I work in the practices and I work on this side … And so when you can see both*
>
> *sides of it, it's thinking what is that solution which I definitely think is IT related and I am*
>
> *working quite hard to try and work with the Public Health people in smoking and weight*
>
> *management … incorporating their referral pathways into an NHS health check*
>
> *(pharmacist_Solihull).*

The final principle of multi-track diplomacy is 'overall goals' and this is where the traction of the concept is particularly obvious, bringing together a variety of insights, possibly familiar to a range of working contexts, into a coherent theory related to working between networked organisations – diplomatic activity does not seek to enforce or coerce, but to facilitate through assisting partners to take responsibility for their own changes. For patients, this involved giving them the choice:

> *we're supporting, we're not, sort of, telling and I think, and that's why our service is very good because we're giving the ownership to the client as opposed to saying, 'Okay, you shouldn't be doing this' (health_trainer_Sandwell)*

For GP practices, this involved giving them time to explore their reservations about the programme before imposing it on them:

> *we had quite a few emails exchanged before that [board meeting], and then it happened … that really helped to facilitate it. It's not that they didn't want that to happen, it's just making them realise of the evidence base behind it, and getting rid of some of the misunderstandings they may have about the project (pharmacist_Solihull).*

The overall aim of diplomatic work within this healthcare context is transformation and catalysing changes within individuals or organisations to build better understanding and communication across groups. As one interviewee put it, *'the main recommendation was really to actually transform primary care'* (director_of_public_health_Stoke). This meant that changes needed to be seen as part of 'core business' for the general practices:

> *I haven't financially incentivised [GP practices] and I've no intention of doing so. If we incentivised it heavily, and places around the country are doing, it might increase the speed of implementation, but you're not changing the culture behind it and it will stop at the point the money stops because it's not seen as part of the core business (service_manager_Sandwell).*

A final demonstration of cultural change came from one of the health trainers, who noted that:

> *One of the GPs here actually came to see me as a Health Trainer client for how to lose weight*
>
> *… And then I found out some of our colleagues the same thing had happened to them; the*
>
> *GPs and nurses had referred themselves to the Health Trainer for healthy eating*
>
> *(health_trainer_Sandwell).*

Discussion

In this article, we offer a new conceptual approach to thinking about policy and guideline implementation and change by pulling together two bodies of health policy literature – modes of governance and implementation of public policy – to explore bottom-up implementation approaches within the context of network governance.   By drawing on diplomatic theory from political science and international relations, we have extended Lipsky's influential sociological concept of street-level bureaucracy to identify and conceptualise as street-level diplomacy a hitherto neglected communicative and adaptive skill set in the everyday work of those responsible at the front line for implementing policies. The concept builds on Lipsky's observations that those at 'street-level' have high degrees of discretion and relative autonomy from organisational authority. Street-level diplomats, in the context of implementing public health policies in primary care, have discretion both in terms of the way they interact and negotiate with their colleagues within the GP practice and in the ways that they engage with the communities that they are from. With their local knowledge, street-level diplomats have autonomy to adapt and frame the delivery of the intervention for the local area. It is worth noting that in this context, the 'street-level' workers shaped but did not *subvert* the policy, as Lipsky described that street-level bureaucrats could do. The concept recognises that street-level diplomats have very little 'hard power' in the system and rely on their ability to persuade and engage to transform the field of practice that they are entering

(Bourdieu 1977, Fligstein and McAdam 2011). Over time, through deploying skills in street-level diplomacy, implementers became familiar faces in the local environment, adapt their practices and build communicative trust (cf. Brown 2008).

The concept of street-level diplomacy is particularly relevant to public services that are delivered at least partly though networks rather than solely through markets or bureaucracies. While research attention has been given to the individuals and contexts in which change is embedded (Becker 1970, Checkland 2004, Smith, Mackintosh et al. 2012), there has been less attention on understanding the actual everyday work of 'outsiders' to general practice trying to drive the change. However, the presence of workers at the hinterland between two organisations and professional cultures has been examined previously and the concept of 'boundary spanners' (Honig 2006) has been used, and we would argue that street-level diplomacy could be a useful concept to explore in relation to this workforce. There are also parallels with other literature exploring agents in service change and the links between these are potential directions for future research. For instance, analysis of senior NHS managers' narratives on success has built on institutional perspectives (Scott 2008) and highlighted the importance of practical tacit knowledge accumulated from years of experience, the powerful alignment of personal identity to the NHS 'brand' values and the value of rich social networks as a resource for information, support and ideas (Macfarlane, Exworthy et al. 2011). Managers repeatedly refer to adopting the 'right' management style for particular situations. This depends on deeper normative and cultural-cognitive institutional underpinnings to a far greater extent than more ephemeral regulatory structures (Scott 2008). Our findings suggest effective micro-project management depends on similar processes as the participants in this study made very similar claims about tailoring style to context.

Other emerging themes in our data were that *street-level diplomats* employed hard-won life experience in their day-to-day work, shared a belief in the value of effective CVD prevention in their communities, while also being critical of the limits of their intervention to change the structural

constraints in their clients' lives, and engaged with supportive peer group structures for ideas, advice and information. While this intervention was structured around epidemiological risk (Gale, Thomas et al. 2016), rather than 'community' or 'place' primarily, there are potentially important theoretical links here to community health development work (Bhattacharyya 2004), community research (Israel, Schulz et al. 1998, Israel, Krieger et al. 2006) and the broader empowerment literature as it relates to health promotion (Laverack and Labonte 2000, Laverack 2006) that are beyond the scope of this paper, but are being explored in further empirical work.

There are limitations to our empirical study. Although we took care to sample people involved at different levels in the implementation of the programme, we interviewed a limited number of people, and have not included the perspectives of the primary care providers or patients in this article. We chose to focus in this article on the experiences of the implementers given our theoretical interest in their everyday work (Barley and Kunda 2001) and Rhodes' call for interpretive work on diplomacy in networks. However, this kind of street-level diplomacy is relational as it involves working between interests, and as such there is much scope in future research to explore in more depth the interactional dynamics of street-level diplomacy, through analysis of qualitative data from the voices of those working in different parts of a network and the public who experience related interventions. A second limitation is that, following Lipsky's approach, this research has focussed on universal processes and issues rather than attempting to describe, measure or analyse the organisational context in detail (accepting that it varies widely). Future research specifically systematically comparing different contexts would potentially be very insightful. However, within the scope of this paper, we have provided some contextual detail enabling readers to make judgements about the extent to which the concept may be transferable to their own context (Polit and Beck 2010). All those interviewed were involved in a specific family of case-finding programmes related to the primary prevention of physical health conditions (CVD and diabetes). It is likely that if

similar studies were conducted in other areas at the interface of the public, primary care and public health, or other sectors of health and social care, such as mental health or the care of older people, that contextual differences would be identified. Although network governance is growing internationally (Pollitt and Bouckaert 2011), it is much less clear from this research whether the concept would be transferable to political systems that remain more bureaucratic in form, i.e. that do not operate and deliver public services within a network governance framework, but this could be verified by further research.

Implications for practice and policy

Our research formed part of a long-standing collaboration with public health and primary care in the West Midlands, particularly Sandwell, and after we fed back our findings to our health service partners (see Methods above), this concept was actively used to help think through workforce development and leadership strategy. The working practices discussed in this article are particularly relevant in the context of national reorganisation of the health system, when many public health functions (such as health trainers) were outsourced to community interest companies - CiCs (Billis 2010) who were then competing for contracts. These new hybrid organisations (part public, part third sector), employing community health workers (Cook and Wills 2012, Singh and Chokshi 2013, Visram, Carr et al. 2015, Mathers, Taylor et al. 2016) and working closely with volunteers and community champions (Macdonald, Kontopantelis et al. 2009, Rogers, Bury et al. 2009), need to articulate their value and contribution of their staff to primary care who were the new commissioners in the reorganised system. The authors continue to collaborate with regional CiCs around workforce and leadership development.

The concept of street-level diplomacy also had relevance within primary care. The traditional structure of primary care assumes the primacy of patient contact, in responsive mode. GPs, as street level bureaucrats within the context of an increasingly pressurised primary care, are likely to respond to street level diplomats from external organisations who offer them tailored solutions rather than additional complex demands. Therefore, being able to engage GPs in a different way (as collaborators in a collective preventative health enterprise) is likely to be improved when attention and value is given to relational and adaptive processes.

A final significant implication of the concept, is that previous literature in the field of interpretative policy analysis has focused on the tendency of 'street level' health professionals to subvert policy (Exworthy, Berney et al. 2002), but they can in fact be drivers of policy. This is interesting in the context of recent national policy with its emphasis on greater clinical leadership – 'more power to clinicians...to deliver improving quality and outcomes' (Department of Health 2012) and longitudinal studies are needed to identify the influence of new structures (clinical commissioning groups) on GP behaviour (Checkland, Allen et al. 2013, Walshe 2013). The primary function of health professionals is to provide frontline care but acting as modifiers to policy may be seen as a latent function. These key latent functions deserve more attention. In this instance, they appear to have implemented national and local policy because, first, they believed in it (public and private goals were aligned); second, they were recruited specifically for the role and had no other competing responsibilities or agenda, ensuring high motivation and effectiveness; and third, they brought, acquired and developed the skills of *street level diplomats*.

Given the coherence of our new concept of street-level diplomats with wider observations about the changing nature of the public services and public servants (Needham and Mangan 2016) continued reorganisation of services along networked lines, the requirements for more public engagement, inter-professional working and integration of health with social care, we would argue that that the concept is very likely to be transferable to many other fields in the public sector.

Concluding remarks

In summary, we argue that our new concept of street-level diplomacy complements Lipsky's influential concept of street-level bureaucracy. The contribution of our concept is that while building on the important observation that policies are enacted at 'street-level', it highlights the work – and the sheer time – needed for the softer side of implementing policies, in particular adaption, flexibility and tailoring of the programme to the local needs and characteristics of both the community served by a service and the primary care providers that host that service. While many of these skills – listening, trust and rapport-building, cultural sensitivity – are already noted in the literature, they have not previously been brought together in this configuration, nor explicitly linked to the political context of growing network governance in public services, or the implementation of public policy. Street-level diplomacy is most relevant in a system characterised either by collaboration within networks in a system or by partnerships and shared decision-making with the public (or both), rather than bureaucracy, hierarchy and traditional (medical) authority. In short, insights from international relations can be used to extend and introduce nuance to theory on modes of network governance.

In order to determine the transferability of this concept, further micro-level study of potential street level diplomacy in other policy contexts in needed. In addition, it would be useful to undertake methodologically complementary research, using ethnographic and observational methods to delve further into everyday practices and interactions. From a policy perspective, further work could examine what makes for a virtuous cycle of policy interaction with 'street level' health workers.

Acknowledgements

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