

TITLE PAGE

Title: Lost in translation: a multi-level case study of the metamorphosis of meanings and action in public sector organisational innovation

Authors: Catherine Pope¹, Glenn Robert², Paul Bate², Andrée le May¹, John Gabbay³

¹School of Nursing & Midwifery, University of Southampton, Highfield SO17 IBJ, UK

²Centre for Health Informatics and Multiprofessional Education (CHIME), Royal Free and University College Medical School, University College London, Highgate Hill, London N19 3UA, UK

³Wessex Institute for Health R&D, Biomedical Sciences Building, University of Southampton, SO16 7PX, UK

Corresponding author: Catherine Pope.
School of Nursing & Midwifery,
University of Southampton,
Highfield
SO17 IBJ,
UK
Tel: +44 (0)2380 598293
Fax: +44 (0)2380 598308
Email: cjp@soton.ac.uk

Running title: Lost in translation

Word count: 8241 (excluding title and references)

Acknowledgements

The research on which this paper is based is funded by the UK NHS Service Delivery and Organisation R&D Programme.

ACCEPTED FOR PUBLICATION IN 'PUBLIC ADMINISTRATION'

Lost in translation: a multi-level case study of the metamorphosis of meanings and action in organisational innovation

This paper explores the early implementation of an organisational innovation in the UK National Health Service (NHS) - Treatment Centres (TCs) - designed to dramatically reduce waiting lists for elective care. The paper draws on case studies of eight TCs (each at varying stages of their development) and aims to explore how meanings about TCs are created and evolve, and how these meanings impact upon the development of the organisational innovation. Research on organisational meanings needs to take greater account of the fact that modern organisations like the NHS are complex multi-level phenomena, comprising layers of interlacing networks. To understand the pace, direction and impact of organisational innovation and change we need to study the interconnections between meanings across different organisational levels. The data presented in this paper show how the apparently simple, relatively unformed, concept of a TC framed by central government, is translated and transmuted by subsequent layers in the health service administration, and by players in local health economies and, ultimately in the TCs themselves, picking up new rationales, meanings, and significance as it goes. The developmental histories of TCs reveal a range of significant re-workings of macro policy with the result that there is considerable diversity and variation between local TC schemes. The picture is of important disconnections between meanings, that in many ways mirror Weick's (1976) 'loosely coupled systems'. The emergent meanings and the direction of micro-level development of TCs appear more strongly determined by interactions within the local TC environment, notably between what we identify as groups of 'idealists', 'pragmatists', 'opportunists' and 'sceptics' than by the framing (Goffman 1974) provided by macro and meso organisational levels. While this illustrates the limitations of top down and policy-driven attempts at change, and highlights the crucial importance of the front-line local 'micro-systems' (Donaldson & Mohr, 2000) in the overall scheme of implementing organisational innovations, the space or headroom provided by frames at the macro and meso levels can enable local change, albeit at variable speed and with uncertain outcomes.

INTRODUCTION

Many of the organisational changes imposed on the NHS in the past five decades have been specifically targeted at the problem of waiting lists. One element of waiting is especially problematic, namely the one million people waiting, often for several months, for elective (planned) surgery. Having been encouraged to maximise the use of available capacity, hospitals are faced with the problem of protecting facilities for planned admissions against apparently unpredictable fluctuations in emergency admissions and the 'blocking' of beds by patients who for medical or social reasons cannot be discharged. In other countries, as in the private health care sector in the UK, this problem is typically resolved by separating – often physically – elective and emergency care. Surgicentres in the USA are perhaps the exemplar for this, providing facilities for planned surgical care and allowing patients the convenience of pre-booked admission.

The focus of this paper is on the latest in a long line of central initiatives directed at the waiting list problem and designed to increase throughput and improve the elective admission process. This initiative is a major organisational innovation, now referred to as a Treatment Centre (TC).

Treatment Centres

TCs entail both new buildings and/or the redevelopment of existing treatment spaces, and service redesign. Their aim is to increase throughput and capacity, thereby dramatically increasing the number of elective surgical operations undertaken each year. This innovation involves clinical, support and managerial staff, and health care commissioners and planners, and it entails significant technological and organisational change.

The development of TCs (figure 1) can be traced back to initiatives in ambulatory care in the UK in the 1990s. Of these, the Ambulatory Care and Diagnosis centre (ACAD) at the Central Middlesex Hospital Trust, had a high public profile and a ‘flagship’ status and is cited as a pioneer of TCs. *The NHS Plan*, published by the Department of Health in July 2000, set out the Labour government’s radical action plan for the NHS. While several TCs were clearly under development as ‘ambulatory care centres’ before this publication, the Plan committed the NHS to have eight operational ‘Diagnostic and Treatment Centres’ and a further 12 ‘in development’ by 2004. In fact, by early 2004 there were 23 NHS Treatment Centres (TCs) classed as operational (i.e. treating patients), and a further 24 sites in development. In addition, the private health sector was awarded contracts to provide some 20 ‘independent sector treatment centres’ (IS-TCs). It is expected that approximately 80 TCs will be open in England by 2005 (www.doh.gov/waitingbookingchoice/shorter-waits.hm, accessed 02/12/03).

INSERT FIGURE 1 ABOUT HERE

TCs range from self-contained, sometimes purpose built facilities through to ‘virtual centres’ using operating lists and accommodation within an existing hospital. Some focus on a single specialty, for example orthopaedics, others cover a range of specialties. Most TCs aim to treat patients who require relatively short lengths of stay (usually less than one week). Activity ranges from 600 to 7000 finished consultant episodes per annum, but the aim of the combined NHS and IS-TC programme is to provide an extra 270,000 procedures per annum by 2005 (www.modern.nhs.uk/scripts/default.asp?site_id=31 accessed 02/12/03).

One of the key concepts in policy implementation studies has been the Straussian idea of negotiated order (Strauss 1978; Strauss et al 1963) and the role of negotiation between actors in understanding organisational change (Barrett 2004). The aim of this paper is to understand the different meanings attached to TCs, and the ways in which meanings and definitions of the situation determine actions which come to define the innovation. There is a growing literature around policy studies (Fischer, 1993; 2003), policy and governance (Newman, 2001) and policy analysis (Bacchi, 1999) which uses and develops variants of discursive analysis to explore the “language of policy, its relation to the social environment and to the practice of language reproduction” (Greener, 2004: 304). This paper is therefore part of a wider trend within organization studies (Grant et al, 2004) placing greater emphasis on discursive forms of analysis in the study of organizational change and innovation generally and - more specifically - public sector policy making and implementation. Health policy in the UK has been explored using discourse analysis (Fairclough, 2000; Greener, 2004) and thus many of the issues we highlight in this paper resonate with these broader discussions of the language, formulation and nature of contemporary health care policy.

Our choice of research method (see below) reflects our commitment to understanding what the participants see themselves doing and how an organisational reality is enacted (Weick 1995) through social action. We are, however, concerned to move beyond a narrow focus on micro level interactions to capture the multiple loci of meaning making in the wider health system. Inspired by House et al (1995) and more recent work by Exworthy and Powell (2004) our interest is not with a single organisation or echelon of the NHS, but rather with the interconnections and interdependencies of meanings operating at different levels in this large and complex system. For the purpose of this paper we focus on meanings generated at three levels – macro, meso and micro. Our argument is that at each of these levels a *framing* of TCs is constituted which provides conceptual or cognitive structures which shape both how TCs are viewed and, in turn, how they are enacted (Goffman 1974; Snow et al 1986). Our access to TCs at an early stage of their implementation provides a unique opportunity to look at different levels at which meanings are generated and sustained via the interactions and day-to-day work within the health system. Our premise, following Blumer, is that “a network or an institution does not function automatically because of some inner dynamics of system requirements; it functions because people at different points do something, and what they do is a result of how they define

the situation in which they are called upon to act” (Blumer, 1969:19). We suggest that the change process brought about by definitions of the situation and subsequent actions, given the very nature of the meanings involved, is dynamic, complex and connected. This paper describes how relationships between different meanings developed at macro, meso and micro levels in the health care system interact to produce variation in an organisational innovation called a Treatment Centre as enacted in the NHS.

The data presented here - taken from our ongoing case studies in eight TCs - consist largely of interviews within the individual TCs and documentary analysis relating to other echelons of the NHS. We have undertaken site visits to familiarise ourselves with each TC, conducted over 130 interviews with key informants (users, staff and external stakeholders), observed eight formal meetings and collated documentary evidence, official papers, web based material and media reports (written and audio) about the wider Treatment Centre programme.

THREE FRAMES

In this paper we are interested in three frames: government, modernising and TC. These frames are just three of a potentially long list of existing or potential framings of TCs, but they provide exemplars of frames which we see as at once distinct and interconnected during the early phase of TC evolution. These frames are located at different organisational levels: the government frame is located at the macro level of health policy and politics, the TC frame is rooted in the micro level enactment of TC policy and the modernising frame, we suggest, is located at a meso level somewhere in between these. To clarify this last point, we use the term ‘meso’ here to indicate an intermediary level, rather than a middle layer of the organisation such as a regional division. In fact, in terms of allegiances the modernising frame, provided by the NHS Modernisation Agency, is much more closely allied to the centralised macro level policy making than to the local TCs.

INSERT FIGURE 2 ABOUT HERE

The origins of TCs lie in macro level health policy enacted by the Department of Health (DH) whose responsibility is to provide advice and execute ministerial policy. The policy around TCs is situated within a wider context of a large scale political programme of health service and public sector reform directed by the Labour government since it came to power in 1997. TCs are one of a number of key health service initiatives. These include *Patient Choice* a scheme by which all patients will be offered a choice of four or five places for elective care once their GP has decided that a referral is required.

(<http://www.dh.gov.uk/PolicyAndGuidance/PatientChoice/Choice/fs/en>) and *Foundation Trusts*, “independent public benefit corporations... modelled on co-operative and mutual traditions” introduced by the Health and Social Care Act 2003 as a means of transferring ownership and accountability from central government to a locality

(http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/NHSFoundationTrustArticle/fs/en?CONTENT_ID=4062806&chk=4RDYwZ).

The DH provided a policy framework for what were originally called Diagnosis and Treatment Centres (DTCs) in *The NHS Plan* (DH 2000) and this was elaborated in the subsequent *Delivering the NHS Plan* (Secretary of State for Health 2002). The broad ideas in these key documents were developed in the political arena and via the news media and the DH instituted its own ‘TC programme’ to feed into these debates. While government and DH could legitimately be viewed as distinct frames, for us the unifying feature of this frame – which we refer to as the ‘*government frame*’ is the explicitly ‘P’olitical driver behind the policy formation undertaken by the politically neutral civil service at the DH.

The TC idea had to be developed into a blueprint which encapsulated the direction of government framing and provided a strategy for its realisation. The idea had to be operationalised and this was undertaken by the NHS Modernisation Agency, a national agency established in April 2001 “to support the NHS and its partner organisations in the task of modernizing services and improving experiences and outcomes for patients.”

(www.modernnhs.uk/home/default.asp?site_id=58&id=151269 accessed 15/01/04). The Modernisation Agency is organisationally separate from DH but some of its activities around TCs overlap. For the purposes of this paper we see the Modernisation Agency as occupying a meso level, intermediary role, albeit not fully integrated into the formal organisational hierarchy of the NHS (see figure 2) and providing a second, distinct, ‘modernising’ frame. The Modernisation Agency’s TC Programme, officially launched in February 2002, is part of a larger DH ‘Waiting, Booking and Choice’ programme. The key feature of the Modernisation Agency which interests us here, is its role in operationalising TC policy. We argue that the framing of meaning by the Modernisation Agency is directed both downwards, to the micro level, individual TCs, but also upwards, to the macro level of government policy making.

The TCs themselves are located within micro level health organisations and a local ‘community’ of hospital and primary care providers. The frame closest to the ground where the rhetorical discourse is translated into patient care, is provided by the individual TC. This is where the ideas provided by the government and modernising frames are, in theory at least, enacted.

We are interested in how the meaning of TCs is framed at different organisational levels in the NHS, but we also want to examine the relationships between different framings. The connections and disconnections between frames, we suggest, explain the varying pace, direction and impact of this organisational innovation and ultimately its success or failure. To explore this we focus on three aspects of each frame; *definition* (i.e. what are the defining characteristics of TCs according to this frame?), *rationale* (i.e. what is their justification or purpose according to this frame?) and *presentation* (Goffman 1959) (i.e. what are the means by which the concept of TCs is represented within this frame?).

GOVERNMENT FRAME

Definition

The definitional components of the government framing of TCs centre on separating emergency and elective services, delivering services faster (thereby increasing throughput), and encouraging the use of both private sector and NHS facilities. The first of these - the separation of elective from emergency work – is clearly stated in *The NHS Plan* and other sources (c.f. http://www.diagnosticandtreatmentcentres.com/information_resources/index.asp accessed 03/01/02 now closed). *Delivering the NHS Plan* referred directly to TCs as “fast-track surgery centres” (Secretary of State for Health, 2002:16) and that expanding capacity would “enable people to get faster access to diagnosis and treatment” (ibid). The involvement of the private sector in providing NHS services was the result of a new concordat with private providers, heralded in the *NHS Plan* (Secretary of State for Health, 2000:44).and in *Delivering the NHS Plan*(Secretary of State for Health, 2002:26).

Rationale

The government’s rationale for TCs was to significantly reduce waiting times as part of the drive to improve patient care. Targets of a maximum 3 months wait for an elective admission were set and TCs were seen as a vital mechanism in achieving these targets. Placing the macro-level management of TCs under the umbrella of the DH ‘Waiting, booking and choice programme’ underscored this. *The NHS Plan* argued that the separation of elective and emergency care afforded by TCs would allow them to “concentrate on getting waiting times down” (op cit:44).

Presentation

Much of the presentation of the government frame is via the various documents already described. While most of these relate to the whole NHS, the language applies equally to TCs. What is striking is the aspirational tone of the language used. *The NHS Plan*, for example, has 325 instances of the word ‘new’ (‘new’ practices, ‘new’ relationships, ‘new’ roles, etc), 70 instances of the word ‘reform’ (radical ‘reform’, far reaching ‘reform’, etc), 12 instances of the word ‘radical’ (e.g. ‘radical’ change, ‘radical’ process) and 5 instances of ‘transformation’, not to mention the ‘revolution in patient care’ that was to be brought about. Such transformational aspirations contrast starkly with some of the incremental changes actually implemented within our case study TCs, described below.

While the focus of this paper is on NHS TCs, it is worth mentioning that the presence of independent sector TCs (IS-TCs) has forced the government to rebut various political critiques about the use of the private sector. Alongside these political debates another presentational form is apparent. This concerns changing the name of the innovation from DTC to TC. This change appeared mostly un-remarked upon at the macro level, although some of our interviewees at the micro level commented on or joked about it. Originally, the government referred to the ‘Diagnosis and Treatment Centre’ (DTC) programme (sometimes using the word ‘*diagnosti*’ instead of ‘diagnosis’) making explicit reference to investigative and surgical treatments. However, by the Autumn of 2003, apparently at the instigation of the new health secretary, John Reid, DTCs were re-branded as ‘Treatment Centres’ and the reference to diagnostics was dropped. We are not aware of any official statement about this re-branding; press releases, government websites and the like were altered to refer to TCs instead of DTCs. This name change is a useful reminder of the dynamic nature of frames. The language of TCs has evolved alongside their introduction. Whilst this subtle change of name may not seem central to the government framing of TCs, even an apparently minor shift in presentation can impact on how the innovation is understood at other levels (see our discussion of definition within the TC frame, below).

MODERNISING FRAME

Definition

The role of the Modernisation Agency is to support service improvement by helping staff and managers in the NHS redesign services around ‘the needs and convenience of the patient’. Consequently, the modernising frame definition is more clearly focused than that offered by the government frame. A particular facet of the Agency’s definition of TCs is its specification of the core characteristics of a TC (see figure 3):

INSERT FIGURE 3 ABOUT HERE

As with the name of the new centres within the government frame, there have been shifts in this definition over time: other lists of the core characteristics of a TC have appeared with subtle differences in wording. One of the chief features of the numbered list is that it suggests that each item may be checked or affirmed once achieved. Yet on closer inspection the list is vague: to take just two examples, nowhere are ‘high-volume’ activity (item 2) or ‘significant’ additional capacity (item 9) quantified. As we will show, lack of specificity provides crucial room for manoeuvre for those creating and re-creating meaning within other frames.

Rationale

The ‘characteristics’ presented on the Agency’s TC website (see figure 2) use a definitional language which echoes phrasing from the government’s modernisation project - described as the

'largest and most systematic quality improvement effort anywhere in the world' - and used elsewhere in related documents (such as *the NHS Plan*). So whilst emphasising the government's split between elective and emergency care, the rationale of the modernising frame is also 'new ways of working' achieved through formal service (process) redesign techniques. As the head of the Modernisation Agency TC programme explained "creating capacity is vital, but if it happens without redesigning services and developing new ways of working, we will have failed." (Nicholson, 2004:1). Whilst the defining characteristics of a TC provided by the Modernisation Agency connect with the government's ambition to increase productivity and thereby reduce waiting lists, these are not quite as central for the Modernisation Agency because their main aims are 'modernisation' and supporting frontline staff to think and act differently. The Agency's representation of the TC concept (see below) is shaped by their focus on modernisation and embedded with the stylised language and terminology of NHS modernisation ('redesign', 'radical', 'empowerment', 'innovative', 'new ways of working' etc). While both the government and modernising frames are ostensibly geared to implementing TC policy, already we see how the rationale for TCs is transformed, even between these two apparently closely connected frames.

Presentation

The Modernisation Agency TC Programme had two core elements: a learning and support network for those involved with implementing TCs locally and a 'step-guide' (a practical guide published on the web and in CD-ROM format, to aid those developing a TC). An important presentational element of the modernising frame is located in regular 'National Learning Events' "designed to establish the DTC concept ... they have given a platform to international, world renowned experts to share best practice and brought together DTC teams from all over the country to meet and exchange their own experiences." (NHS Modernisation Agency 2003:4). In addition the on-line step-guide provides detailed advice covering some 90 specific topics (ranging from 'business case development', through 'job descriptions' to 'marketing').

TC FRAME

Definition

Our eight case study sites provide a picture of the emerging TC frame. We have suggested that the definition of a TC within the government frame takes in three elements: the separation of elective and emergency care, providing faster services, and encouraging partnerships with the private sector. The definitions encompassed within the modernising frame incorporate the first of these, but downgrade the other two at the expense of a focus on modernisation. At the level of the TCs meanings become altogether messier and more complex.

The modernising and government frames present TCs as if they are a single coherent entity, a clearly recognisable type of facility and service provision. On the ground there is far less coherence. Our 8 case study sites include:

- a single ward
- a day case unit with 28 day beds and two operating theatres
- a stand-alone specialty-specific centre
- a £20 million extension to a new hospital providing over 100 new beds.

Facilities vary from open plan wards to small bays for 4-8 beds and en-suite bathrooms; drab waiting areas with rows of nondescript chairs to large airy open spaces with curved glass walls and designer furniture; from battered wooden doors with simple, temporary signs to automatic glass doors. Even taking what has, up to now, been the unifying theme for the previously outlined frames – the separation of elective and emergency care - our case study sites vary. Seven have or will have a clear separation of elective and emergency services. One has provision for some ambulatory emergency work within the TC, a pragmatic decision thrashed out at senior

management meetings. Actors within this TC are aware that this decision provides an alternative definitional slant:

“My understanding is that [TCs] are or should be wholly elective, which is where the conflicts have come with the few emergency patients here. I think the majority of [TCs] are smaller than ours. My understanding is that quite a few of them are privately run, whereas this is run by us, the Trust. And that they will be doing different ways of working and pooling of resources and all that kind of thing.” Clinician, site D

At another site, the TC was initially developed in response to the Patient Choice initiative, which sought to enable patients to choose where they had surgery. Definitions at this site thus centred on capacity to meet ‘Choice’ demands, rather than the explicit need to separate emergency and elective work. Likewise while actors at this site felt that the original motive behind their TC was ‘progressive modernisation’ nobody had really given much thought to what the TC was. So while within the TC frame ideas about new ways of working are borrowed from the modernising frame they are, at this level, often reframed as this quote illustrates:

“It’s very much based on capacity. It’s very much based on new ways of working, trying to hit lots of targets and bring down waiting list initiatives, but also trying to have another dimension to the way that healthcare is delivered because so many people in an acute Trust don’t need to be in an acute Trust. [...] I think it’s far more acute-based but it is a bit more about breaking away from traditional methods of healthcare and saying, we can do things very, very differently. I think it’s a modern way of doing things. It’s very much geared on patient need, patient time, patient availability, again, to meet targets.” Manager, site D

The modernising frame argues that the TC programme should not simply be about new buildings or refurbishment. Yet at the local level the meanings of TCs are often entwined with their physical environment. ‘Modern’ is framed as emulating the facilities offered by the private sector:

“You often hear people walking through the door and they go, ‘Ooh, it’s just like a private hospital’ [...] I have never worked in a cleaner hospital and it’s beautiful and the domestic staff take great pride, it seems to me. And the place is always spotless and we have no infection and that makes a big difference.” Manager, site C

A connection with the private sector idea introduced in the government frame is made at the local level, but its meaning is transformed: here, TCs are not about partnership with the private sector rather they are about mimicking the environment of a private hospital within the NHS.

So some, but not all, TCs connect with the government and modernising frames about separating elective and emergency care. They draw on modernisation but rework it to focus on patient need, and introduce new variants, such as adopting the look and ‘feel’ of private health care. These shared and transformed definitions are not the only ones employed by the TC frame. New definitions are also offered. Some sites are defined as extensions to an existing hospital building. Site A for example is a small self contained unit on one floor. By contrast site D is a large new building linked to an existing modern facility. The TC in each of these cases is defined by some actors as simply ‘additional’: Some stand alone sites do not define themselves as a TC:

“it seems like at the beginning [TC] was just this hospital.... which the Trust took over and... quick; let’s get it all open and get it started, and by the way down the track it’s also now going to be a DTC. [...] I guess there is, as far as we book patients the way we’re meant to and we admit them on the day of the operation and we use care pathways, but to me that isn’t radical... that’s the way things should be anyway. If you’re looking at taking things a bit further and have nurse practitioners doing pre-admissions or having innovative ways of doing things, we’re certainly not doing that.” Manager, site C

Some of these ambiguities of definition can be linked to shifts in the government frame’s presentation mentioned earlier. The change from DTC to TC was confusing for some sites - as one interviewee remarked “Suddenly we lost our ‘Diagnosis’ in our DTC”.

Rationale

While the rationale for TCs presented in the government and modernising frames seems relatively clear cut - reducing waiting lists and modernisation - local justifications are the result of more complex 'negotiations' between different groups or 'players' within the TC. Analysis of our case study data provides insight to how frames are formed. As a way of making sense of what was happening at each of the sites we delineated four key groups of players that appear crucial to the framing of meaning for TCs. These 'ideal type' groupings – which we characterised as opportunists, pragmatists, idealists and sceptics - illustrate the nature of the stories presented to us to explain the development of our case study TCs. *Opportunists* see TCs as a chance to do something (rebuild, expand, renew), often something that had already been planned or was developing. *Pragmatists* focus on local, practical issues, notably delivering care. *Idealists* embrace the broader vision and underlying philosophy of TCs. *Sceptics* view TCs as essentially risky endeavours and attempt to resist top-down attempts at change - they urge caution and try to temper the extremes of idealism or opportunism. These perspectives interact to shape the development of individual TCs and form further lines of connection and disconnection with the macro and meso frames.

Two of our case study sites pre-dated the TC programme. To those involved in their development, these organisational innovations provided a way of solving other local problems or achieving targets other than, or at the very least additional to, those of the TC programme presented at the macro and meso level. Micro level organisations (hospital Trusts) used the national TC programme as an opportunity to get capital funding to finance projects they had been hoping to implement for some time. Our case studies provide several examples of such opportunism. At one, a relatively small hospital serving a growing population, a project group wanted to expand day surgery. Following the announcement of TC funding and with encouragement from the Strategic Health Authority (one of eight geographically based authorities that "in effect manage the NHS on behalf of the Department" of Health (Department of Health 2002:5)) the project group developed a bid for a TC to provide far-reaching day surgery services. Another site had a low dependency unit functioning as a patient hotel that was under used and costly, while its main hospital was overstretched and suffering crippling bed shortages. The patient hotel was transformed into a TC to resolve these twin problems. At yet another site, the purchase of another hospital by the NHS was opportunistic:

"A little bit of it was opportunistic its fair to say, the hospital, just down the road that had come onto the market. Splendid facilities and at a time when in terms of capacity we were pretty tight it's fair to say. So (a) opportunistic but (b) also [the chief executive] and the Board had started to think through a different model of offering particularly surgical activity ... at the time the thinking was the high volume, low cost kind of stuff. Pile them high, sell then cheap. That was the initial idea: here's this hospital, we have pressure in term of our elective capacity...wouldn't it be a good idea if we went down the line of the US surgicentre model."
Manager, site C

As well as this opportunist view there was a more pragmatic perspective which was about 'getting on with delivering good quality care'. Sometimes the TC afforded an opportunity to actually deliver this care, or to be recognised as doing so, as these quotes illustrate:

"The TC gives me and people in this trust an ideal opportunity to do it properly, to set new standards, to change communication and staff attitudes." Manager, site D

"We're starting to say to them, we're going to shine, you always have done but now the spotlight is on, so carry on doing what you're doing in the way you've done it and the excellent service you provide, but now people are going to notice". Clinician, site H

For such pragmatists, care delivery could be improved in line with the ideas enshrined in the modernising frame. In the case of site F, the development of the TC allowed a group of innovative *idealists* to ride the wave of modernisation and push towards new ways of working. This partly centred on a training course on process mapping, led by enthusiastic innovators associated with the TC. The course was opened up to a wider hospital staff and the ideas spread. In this way the TC was seen as a way of redesigning the delivery of care and engendering an

important shift in mentality. At this and other sites, the idealists really connected with the ideology of the modernising frame and talked of “transforming patient experiences” and “focusing on the ‘wellness’ (rather than the ‘illness’) model of patient care”.

Opportunism, pragmatism and idealism were not the only possible responses to TCs at the micro level. Some actors were more risk-averse, tempering the plans of the idealists and opportunists. *Sceptics* saw the rationale for TCs as coming from outside the TC frame; for example the separation of emergency and elective care was seen as simply another unwanted organisational change imposed by the DH, or part of broader (party) political manoeuvring:

“on one level I see it [the TC] as cutting down waiting lists, taking the workload off other hospitals; on the other level I see it as a government initiative to get elected at the next election..” Manager, site C

Sceptics were often concerned with the impact of the TC on other areas, such as risk management or models of care delivery:

“There are clearly great difficulties. Some Trusts and consultants in those Trusts quite legitimately, in my view, feel that if they’ve seen a patient in outpatient, investigated them and discussed an operation with them, it is very demoralising to see that patient go up the road and have a stranger do their procedure. [...] You have very un-joined-up patient care which may certainly crunch your numbers but I think leads to consultant dissatisfaction, professional dissatisfaction, poor morale and ultimately, I think, to poor human relations” Clinician, site A

Presentation

The definition and rationale for TCs within the micro frame both transformed and introduced new meanings. The signifiers used in this frame reflect this. Echoing the confusion within the government frame about the name of the new centres, there remains considerable confusion about what TCs are or should be called. Of our case study sites (which were all part or wholly funded under the Treatment Centre programme) four do not make reference to the TC name and are called *Hospital*, *Elective Centre*, *Day Care Unit* and simply *Ward One*. Another has steadfastly refused to change its name from ‘DTC’ and continues to have signage around the site proclaiming this now redundant term. Such issues may be especially acute during the construction of new centres when new TCs lack an identity within the host organisation: for example, at two sites we observed that reception staff at the main hospital had not heard of the TC under that name. At other sites it was clear that staff did not identify with the TC (as a concept or as a reality):

“I think probably a lot of the staff are quite confused as to what we are. The senior staff would know we’re a DTC. I don’t know if a lot of people would necessarily know what that means. But then we’ve also got ‘Patient Choice’ and we’ve got ‘NHS Elect’ and we’ve got the ‘Orthopaedic Network’ and so I think it’s quite easy for people to get confused..[...] If you said ‘do you know you’re a DTC?’ they’d probably say ‘Yes’. But if you said ‘what do you think [this] is?’ I don’t know how many of them would come up with that.” Manager, site C

Such confusion is another potential disconnection between the TC frame and the government and modernising frames.

Another difficulty for the TC frame in connecting with the macro or meso frames relates to the unique form of each local TC. The model represented in *The NHS Plan* or the Modernisation Agency websites implied a physical entity, a building, a dedicated staff and a distinct patient group. The everyday reality of the individual TCs is less neat, more imprecise. As one actor pointed out the macro level meanings described:

“a glossy building with identifiable presence that a minister can come down and cut a ribbon on.... It has to be glossy and sexy, something you can feel and hold. ... The ACAD is a wonderful building, for example which ministers can go to and show off. The same isn’t true of the sort of thing we are developing here. And that presents a ‘presentational problem’.” Manager, site F

DISCUSSION

Figure 4 summarises how each frame provides different meanings and yet each is ‘about’ the organisational innovation called a TC. Previous analyses of frames have tended to locate meanings at a single level, but we suggest that definitions of the situation and subsequent action (i.e. the development of TCs) arise across and from the partial connections between frames at multiple levels. We are not arguing that particular framings of meaning are necessarily located at particular organisational levels, but in the case of TCs, the government, modernisation and TC frames are located, respectively, at macro, meso and micro organisational levels. In order to understand the dynamics of the success or failure of the TCs as an organisational change it is vital that the linkages between frames and across these different levels is explored.

INSERT FIGURE 4 ABOUT HERE

The government and modernising frames are connected by their shared rationale of cutting waiting and increasing productivity: yet there are clear differences of emphasis. In the government frame the meaning of TCs is intertwined with politically driven ideas about partnerships with the private sector, yet because of its remit the modernising frame excludes this referent and instead emphasises new ways of working, innovation and modernity. The government frame is thus altered to suit the context of the modernising frame. Although both these macro and meso frames are ostensibly equally concerned with implementing government policy, this shifting emphasis is suggestive of weak connections between them, reminiscent of Weick’s (1976) “loosely coupled systems”. The modernising frame borrows some but not all of the set of meanings provided by the government frame and we begin to see disconnections and transformations of meaning. However, the disjuncture between frames is far greater when we compare these macro and meso level framings of TCs with the definitional reality of the TCs themselves. It is to this we now turn.

At the micro level there are important lines of connection. For example most of the TCs see the elective/emergency split and the drive to cut waiting lists as axiomatic. But the micro-level realisation of each TC is not a simple amalgam of meanings from the macro and meso frames. The presence of opportunists and idealists in particular generates new micro-level meanings that are reflected upwards. As we see it, there are three important disconnections between the frames we have discussed. These revolve around:

1. the role of the private sector
2. the nature of change (second or first order)
3. the provision of additional capacity

There is a significant disconnection between the government and modernising frames around the role of the private sector in TCs. Partnerships between the NHS and private sector do not feature in the modernising frame. There is a more fundamental line of disconnection between the government and TC frames on this point. Far from wishing to enter into partnership, the individual NHS TCs are hostile to the IS-TCs which they see as privileged to such an extent by the government that they may undermine their own long-term plans.

There are also important disconnections regarding the nature and scale of the change being brought about. We suggested earlier that the modernising frame and the government frame are full of the aspirational language of second order ambition (i.e. they speak of fundamental organisational transformation). Yet for all the transformational rhetoric there is as yet little evidence of radical change at the micro level. The high hopes espoused by the language of second order change often become ‘lost in translation’ and dampened at the local level into superficial, incremental (i.e. first order) change, as these quotes illustrate:

“I’m not aware of anyone nationally capturing all these new ways of working. There’s lots of great words being said - I’m a great one for picking up what people have done and adding to it

or learning from it - but I don't think that's there yet because of the pace of programme. It's very much more of the same." Manager, site D

"It's more or less a transcription of what happens anyway really. It's a little bit streamlined, speeded up, although it's most probably done, at least partially, with the smoothness of the operation in mind." Clinician, site F

The presence of such limited first order change (incremental, "more of the same") rather than second order transformation (radical change, "modernisation") echoes other top-down attempts at organisational change. Brooks and Bate's (1994) analysis of a change programme in the British civil service in the late 1980s/early 1990s found a similar picture of underachievement where the local context acted against top-down attempts to introduce transformational change. In their proposed matrix of possible scenarios for a change programme (see figure 5) they suggested that the British civil service was unlikely to move towards transformation (planned or unplanned, boxes III and IV) but that it would either stay the same (box I) or take on less radical elements of the change programme (box II). The above quotes from some of our TCs exemplify this last quadrant.

INSERT FIGURE 5 ABOUT HERE

Perhaps the most important disconnection, and the one representing the greatest threat to TCs, centres on capacity. One of the main concerns confronting existing TCs is over-capacity. Several sites face huge uncertainty about future fluctuations both in terms of the numbers of patients they are likely to treat and the case-mix of those patients. Many TCs are already doing far less work than planned (or envisaged in their targeted activity levels). At least three of our eight case study sites are operating at significant financial deficits. The reasons for this are complex. There is often little scope for aligning the strategies of neighbouring parts of the organisation. Information flows between those sending patients (PCTs and other hospital Trusts) and the TCs are often poor. Predictions of future demand may be little more than 'guesstimates' based on the previous years' activity and are further confused by other initiatives (not least of which are Patient Choice - a scheme that seeks to allow patients to choose the hospital they are treated in - and uncertainty surrounding the future role of IS-TCs). Some of the earlier TCs found that, having calibrated capacity on the basis of treating particular sorts of cases (typically the most routine patients with the least co-morbidity) they were sent more complex patients who required longer and less predictable stays, slowing down throughput. Others found that problems with booking arrangements and reluctance from other local hospitals to refer patients to these new organisations introduced unexpected delays. The development of several TCs (including IS-TCs) in the same geographic areas has created far greater capacity (and choice) than planned. Snow et al suggest that frame alignment is the "linkage of individual and [organisational] interpretative orientations, such that some set of individual interests, values and beliefs and [organisational] activities, goals and ideology are congruent and complementary" and is a necessary condition for participation in, for example, social movements. (Snow et al, 1986: 464). In perhaps a supreme example of non-frame alignment, Sir Nigel Crisp, the Chief Executive of the NHS, when challenged in a Parliamentary Select Committee with the view that competition from private TCs would result in under-use of the NHS TCs, argued:

"What we have said to the NHS locally is 'You must make sure you use that capacity'.[.] .. as we move into the process of giving patients choice about where they go, if they believe that they can go to x quickly and it is a high-quality facility and they may have to wait longer, even if it is some way out of town, then they may desire to come to x. I think that will help fill capacity. *We are not at over-capacity.*" (Select Committee on Public Accounts Minutes of Evidence. Examination of Witnesses (Questions 1-19). Wednesday 26 November 2003. Sir Nigel Crisp, KCB, and Ms Margaret Edwards. Emphasis Added.)

Such a view contrasts starkly with the perceptions of front-line staff working in many NHS TCs suffering the financial consequences of over-capacity. And in a subsequent speech he added:

"in terms of surgical centres. I don't think we have overcapacity now and I presume they are talking more about [the situation] when new centres come on line[...] We need more capacity

so we can offer choice and there is some contestability. If everything is operating at 100 per cent that is stultifying. We need enough dynamicism (sic) to allow for some contestability.” (Health Services Journal 25 June 2004. Speech from NHS Confederation Conference)

Once again we see the disconnection between frames: within the government frame overcapacity for TCs means competition, flexibility and the promotion of patient choice, but within the TC frame, it means financially crippling deficits, an un-level playing field with IS-TCs and conflicting policy streams. The resulting uncertainty tends to work against transformational change.

It is worth reiterating that there is a temporal dimension to framing. The meanings we have described are not fixed, they are developing and changing over time as new connections and disconnections emerge. As the TCs continue to develop we may see more of the influence of the kinds of groups we have identified at the micro level. The financial difficulties created by under-use of TC capacity for example may lead to greater input from sceptics within the local frame. It seems likely that in response to concerns about overcapacity and financial viability some of the TCs will pull back from transformation, and become more firmly located in boxes II or I of figure 5.

Returning to the Straussian idea of negotiated order, we have found only sporadic evidence of negotiation in the early stages of the implementation of TCs, between the frames we have described. Such negotiations as occur have usually centred on specific communications such as the construction and discussion of business cases for TCs, where the proponents carefully build elements of the macro rhetoric into the presentational discourse, but use them less tangibly in the day-to-day reality of the TC. Within the individual TCs few actors appeared fully cognisant of the Modernisation Agency framing of TCs and this simply served to widen the implementation gap between policy and implementation. That said, our analysis does not take account of other intermediary or meso-level frames, such as the Strategic Health Authorities, Primary Care Trusts or host Trusts, where there may be more direct negotiation with TCs. Exworthy et al’s analysis of an earlier government strategy (on reducing health inequalities) described such a situation as ‘expectations at the top [being] dashed locally’ (Exworthy and Powell 2004; Exworthy 2002; Pressman and Wildavsky, 1973). Exworthy et al (citing Powell, 1997) argued that that “the vertical dimension in the NHS is a weak transmission belt for policy machinery” (Exworthy et al 2002:83). In the case of health inequalities strategies they suggested that this is because of clinical freedom. In the case of TCs we suggest that weak transmission results from the shifts of emphasis between the frames we have described, the marginal nature of the Modernisation Agency’s engagement with local TCs, the presence of opportunists, pragmatists, idealists and sceptics at the micro level, and the fact that all of these actors are engaged in solving problems at their own level of the organisation, while ensuring acceptable (but still loose) coupling with the concerns of other frames.

We have shown that there is considerable variation in how TCs are developing. On one level this could simply be seen as evidence of an implementation gap (Marsh and Rhodes 1992) and another example of the failure of top-down approaches to organisational change. We feel that the picture for the TC programme is more complicated. Unlike Schofield (2004) we do not see the lack of congruence between policy and micro level outcome as the result of lack of competence on the part of those implementing policy. Rather we see the macro and meso frames providing a necessary conceptual (and political and organisational) space for organisational innovation. In framing meaning as they have done they - largely inadvertently - provide a kind of ‘headroom’, which opens up an opportunity for actors at the micro level to construct something of their own. This headroom can be likened to the opportunities for exercising individual discretion in people processing (Lipsky 1980; Prottas 1979) that produce variants to apparently rigid bureaucratic rules. What is interesting about the case of TCs (and we suspect other public sector organisational changes) is that macro and meso framings provide a collective space for groups of actors (such as opportunists or idealists) to enact an adapted version of the organisational change. It is not clear whether this is a deliberate strategy or accidental. Our sense is that it is the latter. The policy language has the initial appearance of prescription - a blueprint

for TCs - with 'core characteristics' and requirements, and a meso level presentation of the frame (via Learning Events, for example) that can be seen as attempts to reinforce this and so on. Yet because the macro and meso frames are not rigid, actors at the micro level are able to improvise within and around their frame. As they enact TCs, new meanings emerge. The metamorphosis of TCs is determined locally. The local solutions then feed back to inform the other frames: for example, the evolution of the Modernisation Agency 'blueprint' was partly based on intelligence gathered from monitoring the development of the disparate local TCs.

What does this imply for the study of innovation and organisational change? Clearly, we need to understand it much more as a dynamic process in which meanings are framed and reframed at different levels. We need to understand the connections and disconnections between frames and how these relationships change over time. We have demonstrated that some frames provide an organisational headroom or space that enables the transformation of meanings and creates new frames. The relationships between frames at different organisational levels shape the outcome of organisational change. In the case of TCs the strength of the connections between macro, meso and micro framings will determine whether the local enactment of TC policy becomes 'lost in translation' or results in the government's intended transformational change. Either way, the enactment of TCs at micro level will entail each locality finding new meaning(s) for its own TC.

References

Bacchi, CL. (1999) Women, policy and politics: the construction of policy problems London: Sage

Barrett S. (2004) Implementation studies: time for a revival? Personal reflections on 20 years of implementation studies. Public Administration 82(2): 249-262

Bate SP. (1997) Whatever happened to organizational anthropology? A review of the field of organizational ethnography and anthropological studies. Human Relations 50(9):1147-1175.

Blumer H. (1969) Symbolic interactionism perspective and method Engelwood Cliffs, New Jersey: Prentice Hall

Brooks I, Bate SP. (1994) The problems affecting change within the British Civil Service: a cultural perspective. Br J Management 5(3):177-190.

Carlisle D. (2003) Call of the wild. Health Services Journal (18 September):12-13

Chief Executive. Chief Executive's Report to the NHS. May 2004

DH (DHSC) (2003) Letter to SHAs May

Donaldson MS, Mohr JJ. (2000) Exploring innovation and quality improvement in health care micro-systems. A cross-case analysis. Washington: Institute of Medicine

Exworthy M, Berney L, Powell M. (2002) 'How great expectations in Westminster may be dashed locally': the local implementation of national policy on health inequalities. Policy & Politics 30:79-96

Exworthy M, Powell M. (2004) Big windows and little windows: implementation in the 'congested state'. Public Administration 82(2) 263-281

Fairclough, N. (2000) New Labour, new language? London: Routledge

Fischer F. (2003) Reframing public policy: discursive politics and deliberative practices Oxford: Oxford University Press

- Fischer F and Forester J. (1993) The argumentative turn in policy analysis and planning
Durham; Duke University Press
- Gioia DA, Schultz M, Corley KG. (2000) Organisational identity, image and adaptive instability,
Academy of Management Review 25(1): 63-81
- Goffman E. (1959) The presentation of self in everyday life. NY: Doubleday
- Goffman, E. (1974) Frame analysis. Boston: Northeastern University Press
- Grant D, Hardy C, Osrick C, Puttnam L. (2004) The Sage handbook of organizational discourse
London: Sage
- Greener, I. (2004) The three moments of New Labour's health policy discourse. Policy & Politics 32(2): 303-316
- Helms Mills, J. (2003) Making sense of organisational change London: Routledge
- House R, Rousseau D, Thomas-Hunt M. (1995) The meso paradigm: a framework for the integration of micro and macro organisational behavior. Research in Organizational Behavior 17:71-114
- Lipsky M (1980) Street level bureaucracy: dilemmas of the individual public services. New York: Russell Sage
- Marsh D, Rhodes R. (1992) Implementing Thatcherite policies: audit of an era. Buckingham: Open University Press
- Mayor S. (2003) Privately run surgery centres for NHS patients proposed. British Medical Journal 327:640
- National Audit Office (2003) Hip replacements: an update. Report by the Comptroller and Auditor General, HC 956 session 2002-2003 NAO: 17 July 2003
- NHS Modernisation Agency (2003) Diagnosis and Treatment Centres. Measuring for success. Internal discussion document, NHS Modernisation Agency.

- Nelson EC, Batalden PB, Huber TP. et al. (2002) Microsystems in health care: Part 1. Learning from High-Performing front-line clinical units. The Joint Commission Journal on Quality Improvement 28(9): 472-493
- Newman, J. (2001) Modernising governance: New Labour, policy and society London: Sage
- Nicholson J. (2004) Untitled article by the Director of the Modernisation Agency TC Programme. Cutting Edge (Spring) 2:1
- Prottas J. (1979) People processing: the street level bureaucrat in public service bureaucracies. Lexington MA: DC Heath
- Reed M. (1992) The sociology of organizations: themes, perspectives and prospects. New York: Harvester Wheatsheaf
- Schofield J. (2004) A model of learned implementation. Public Administration 82(2) 283-308.
- Secretary of State for Health. (2000) The NHS Plan: a plan for investment, a plan for reform. Cm 4818-I London: HMSO
- Secretary of State for Health (2002) Delivering the NHS plan: next steps in investment, next steps in reform. Cm 5503 London: Department of Health
- Snow DA, Rochford EB, Worden SK, Benford RD. (1986) Frame alignment processes, micromobilization and movement participation. American Sociological Review 51:464-481
- Strauss A. (1978) Negotiations: varieties, contexts, processes and social order. San Francisco, CA: Jossey-Bass.
- Strauss A, Schatzman L, Ehrlich D, Bucher R, Sabshin M. (1963) The hospital and its negotiated order. In Freidson, E (ed) The hospital in modern society. New York: Free Press
- Weick KE. (1976) 'Educational organisations as loosely-coupled systems,' Administrative Sciences Quarterly 2:1-19.