The Sustainability and Spread of Organizational Changes

Modernizing healthcare

Edited by

David A. Buchanan,
Louise Fitzgerald
and Diane Ketley

The Sustainability and Spread of Organizational Change

This important new addition to the *Understanding Organizational Change* series examines issues affecting the sustainability and spread of new working practices. The question of why good ideas do not spread, 'the best practices puzzle', has been widely recognized. But the 'improvement evaporation effect', where successful changes are discontinued, has attracted less attention. Keeping things the way they are has been seen as an organizational problem to be resolved, not a condition to be achieved. This is one of the first major studies of the sustainability of change focusing on the example of the NHS, by a unique team of health service and academic researchers. The findings may apply to a variety of other settings.

The agenda set out in 2000 in *The NHS Plan* is perhaps the largest organization development programme ever undertaken, in any sector, anywhere. The NHS thus offers a valuable 'living laboratory' for the study of change. This text shows that sustainability and spread are influenced by a range of issues—contextual, managerial, political, individual, temporal. Developing a processual perspective, this fresh analysis considers policy implications, and strategies for managing sustainability and spread. This book will be essential reading for students, managers, and researchers concerned with the effective implementation of organizational change.

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Series editor's preface

It is an accepted tenet of modern life that change is constant, of greater magnitude and far less predictable than ever before. For this reason, managing change is acknowledged as being one of the most important and difficult issues facing organizations today. This is why both practitioners and academics, in ever growing numbers, are seeking to understand organizational change. This is why the range of competing theories and advice has never been greater and never more puzzling.

Over the past hundred years or so, there have been many theories and prescriptions put forward for understanding and managing change. Arguably, the first person to attempt to offer a systematic approach to changing organizations was the originator of Scientific Management, Frederick Taylor. From the 1930s onwards, the Human Relations school attacked Taylor's one-dimensional view of human nature and his over-emphasis on individuals. In a parallel and connected development, in the 1940s, Kurt Lewin created perhaps the most influential approach to managing change. His planned approach to change, encapsulated in his three-step model, became the inspiration for a generation of researchers and practitioners, mainly – though not exclusively – in the USA. Throughout the 1950s, Lewin's work was expanded beyond his focus on small groups and conflict resolution to create the Organization Development (OD) movement. From the 1960s to the early 1980s, OD established itself as the dominant Western approach to organizational change.

However, by the early 1980s, more and more Western organizations found themselves having to change rapidly and dramatically, and sometimes brutally, in the face of the might of corporate Japan. In such circumstances, many judged the consensus-based and incrementally focused OD approach as having little to offer. Instead, a plethora of approaches began to emerge which, whilst not easy to classify, could best be described as anti-OD. These newer approaches to change were less wary than OD in embracing issues of power and politics in organizations; they did not necessarily see organizational change as clean, linear and finite. Instead, they viewed change as messy, contentious, context-dependent and open-ended. In addition,

unlike OD which drew its inspiration and insights mainly from psychology, the newer approaches drew on an eclectic mix of sociology, anthropology, economics, psychotherapy and the natural sciences, not to mention the ubiquitous postmodernism. This has produced a range of approaches to change with suffixes and appellations such as emergent, processual, political, institutional, cultural, contingency, complexity, chaos and many more.

It is impossible to conceive of an approach which is suitable for all types of change, all types of situations and all types of organizations. Some may be too narrow in applicability whilst others may be too general. Some may be complementary to each other whilst others are clearly incompatible. The range of approaches to change, and the confusion over their strengths, weaknesses and suitability, is such that the field of organizational change resembles more an overgrown weed patch than a well-tended garden.

The aim of this series is to provide both a comprehensive overview of the main perspectives on organizational change, and an in-depth guide to key issues and controversies. The series will investigate the main approaches to change, and the various contexts in which change is applied. The underlying rationale for the series is that we cannot understand organizational change sufficiently or implement it effectively unless we can map the range of approaches, and evaluate what they seek to achieve, how and where they can be applied, and, crucially, the evidence which underpins them.

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Foreword

The NHS Plan (Department of Health, 2000a) established an ambitious organization development programme, providing unparalleled opportunities radically to rethink, redesign and thereby to improve patient care. The NHS Modernisation Agency was created in 2001 as a national body to support this change process across the service. The size and challenge of the change agenda were unparalleled anywhere in the private or public sector. It is important to recognize that most service improvements were not straightforward one- or two-dimensional changes, but involved complex combinations of changes to organization structures, roles, systems and procedures, clinical practice, inter-organizational collaborations, and in some cases to physical facilities as well.

As NHS Modernisation Agency staff around the country shared experience on developments and progress, two problems quickly became evident. These concerned the sustainability and spread of new working practices. Some clinical services would find a way to achieve, for example, dramatic reductions in patient waiting times, but would then struggle to maintain that performance level, more or less gradually regressing to their previous position. This was described in one Agency report as 'the improvement evaporation effect'. Similarly, while one clinical service had developed an effective way to reduce waiting times, other services did not then apply those methods. In organization theory, this is called 'the best practices puzzle'. While experience varied from one location to another, these sustainability and spread problems were frustrating both for local project leads and for national Agency staff, particularly as the questions that they faced over those issues were disarmingly simple: 'You've solved that problem; why have you gone back to how things were before?' 'If unit *x* can make those changes and meet those targets, why can't unit *y* do the same?'

Consequently, the Research into Practice team was established to shed light on those two broad sets of questions. The team worked initially with the National Booking and Cancer Services Collaborative Programmes, and subsequently with a number of other initiatives. Three attributes of the team and its work were significant. First, the researchers were recruited from

within the health service, and most had clinical backgrounds. An external team could have taken much longer to become familiar with the specialized programmes and their issues, and thus to establish presence and credibility, and to generate useful findings. Second, the team worked in close collaboration with local and national staff responsible for those service improvement programmes, ensuring that the research was conducted 'close to the customer', with a good understanding of end-user interests and needs. Third, research methods were not based on biomedical practice, with the apparatus of randomized controlled trials, but involved instead a range of qualitative methods appropriate to the study of dynamic processes in different and rapidly evolving organizational contexts.

The team's work has generated a number of significant lessons. First, sustainability and spread are closely linked. Sustainability problems can inhibit spread, and the manner in which new practices are spread can either enhance or jeopardize sustainability. Second, the terms sustainability and spread defy precise definition; they are better seen as categories of problems sharing common properties. Third, these are complex processes that unfold over time, influenced by numerous related factors at different levels of analysis. Fourth, there are no simple tick-box checklists for managing these issues effectively. We know what kinds of factors, issues and processes are important influences on sustainability and spread, but timing and context determine which issues are likely to be significant. So, rather than a mechanical factor-based approach, this suggests instead a diagnostic perspective, involving management attentiveness and vigilance, sensitive to the combinations of issues that respectively support or jeopardize these processes in a given context. Paying attention to those issues may not always guarantee sustainability and spread, but can certainly improve the odds.

The NHS Modernisation Agency was disbanded in June 2005. How should its successor organization, the NHS Institute for Innovation and Improvement, build on this work? Three issues in particular stand out. First, with regard to the spread of 'best practice', it is clear that, in almost every case, significant adaptation or customization is required to make new methods, approaches, systems and arrangements work effectively in another context. Very few innovations in service delivery can be 'copied' as they stand, without some tailoring to fit. The staff involved need to learn the issues, and develop adaptations that are relevant to their particular setting. That development process takes time, particularly where the changes are multi-faceted. Second, with regard to sustainability, while it is important that some changes are sustained and developed, it is also clear that some changes should be allowed, if not encouraged, to decay. Circumstances evolve, and rigid methods that are not adaptable prevent staff from implementing further relevant changes and improvements.

Finally the significance of timing, sequencing and pacing runs through all of this work. Some less complex changes can spread with surprising speed, if other conditions are also in place. However, that seems to be uncommon. Indeed, attempts to implement and spread changes too rapidly can damage the impact and sustainability of those improvements, and also jeopardize further spread if the appropriate conditions are not in place. Efforts to sustain changes beyond their useful life are also damaging. The role of the NHS Institute for Innovation and Improvement involves supporting the rapid adoption and spread of new ideas, facilitating the swift implementation of changes that will benefit both staff and patients. The evidence presented here demonstrates the importance of having a number of factors in place: that local teams have access to sources of good practice and generalizable evidence; that they are able to develop systems for local learning and discovery to enable them to experiment and adopt new practice; that performance management and incentive systems support improvement; that local leaders manage the appropriate timing, sequencing and pace of change to increase the probability of effective and sustained improvements in patient care. There are no 'magic bullets' or shortcuts, but many ways to increase the likelihood of effective, sustainable, wholesale change. These are important lessons as we move into the next stage of NHS system reform.

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Preface

Sustainability and decay, spread and containment

In 2004, the National Health Service (NHS) employed 1.3 million people in England, making it the third largest organization on the planet. Only the Chinese Army (2.3 million) and the Indian State Railways (1.5 million) had more staff. The NHS had an annual budget of £85 billion (expected to rise to over £100 billion by 2008), exceeding the combined sales of Microsoft and Tesco. It employed around 397,000 nurses and midwives, 117,000 doctors, and 38,000 managers and senior managers (Department of Health, 2005a). *The NHS Plan* (Department of Health, 2000a) launched a 10-year, government-inspired 'modernization' initiative, with numerous performance targets and deadlines. This was the largest and most systematic organization development initiative ever undertaken, in any sector, anywhere. One of the 'core principles' (p.5) was that 'The health and social care system must be shaped around the needs of the patient, not the other way round', reflecting the view that the service was run primarily in the interests of the organization and its staff. The central themes of the change agenda were thus customer orientation, patient choice, and cost-effectiveness. The aim was to make patient focus a defining feature of the service; the phrase 'patient-centred' appears 10 times in the 140 pages of *The NHS Plan*. To achieve changes in organization culture, and to meet those targets on time, many changes in working practices were required.

The research reported here was conduced by a team working in the NHS Modernisation Agency (hereafter 'the Agency'), a body established in 2001, initially responsible for stimulating and leading national service improvement programmes. The way in which the role of the Agency evolved is explored in Chapter 1. From studies of parts of the modernization agenda, this book aims to contribute to understanding, debate, and practice in the field of organizational change in general, and with particular reference to healthcare. This aim extends to organization theory, knowledge management, practice, and policy concerning strategies for organizational change and service improvement across the public sector.

How many targets?

The exact number of performance targets in *The NHS Plan* (Department of Health, 2000a) was unclear. No explicit number was given, and the word ‘target’ appeared only 57 times in the document. However, one Agency manager told us that she had counted over 320. The subsequent ‘NHS Plan Implementation Programme’ (an internal Department of Health planning document) identified 98 targets for 2001–2002 alone, covering most aspects of the service: access, waiting times, cancer services, capacity and IT infrastructure, coronary heart disease, children’s services, mental health, quality improvement and patient focus, care of the elderly, public health, workforce and skill mix, communications across the service, and the implementation of performance management. *The NHS Cancer Plan* (Department of Health, 2000b; 2005d) identified 82 targets for cancer services. The National Service Frameworks for other clinical services similarly identified their own targets. From *The NHS Plan* and *The NHS Cancer Plan*, the Agency produced in 2001 a summary identifying 31 waiting times targets for inpatients, outpatients, and booked admissions, to be achieved in a phased manner between December 2000 (‘all urgent cancer referrals to be seen within two weeks’) and 2008 (‘maximum wait for inpatient treatment reduced to three months’). In shifting the language from ‘modernisation’ to ‘improvement’ (Department of Health, 2004a), targets became ‘key commitments’, and at the time of writing the performance of acute hospitals was being monitored on around 40 measures. Whatever the number, the health service since 2000 became a ‘target-rich environment’.

This book focuses on two issues that the Agency encountered at an early stage. One concerned *sustainability*. Priorities were established, resources were committed, staff were recruited, changes were implemented, performance improvements were achieved. In many cases, those gains continued. However, experience varied. In some cases, performance levels fell back to where they began. Why this should happen was unclear.
A second issue concerned *spread*. A hospital, say, or a specialty, a clinic, or a doctor, developed a better way to carry out a particular process, deliver a service, or meet a target. Once again, while some new practices were quickly adopted by others, other approaches were not more widely used, despite the demonstrable benefits. These variations in experience, with regard to sustainability and spread, represented threats to the modernization agenda, prompting research into the causes, in order to find ways to overcome the ‘decay’ of improvements, and the ‘containment’ of good ideas, and to increase the spread of new ideas and working practices more widely. Our working definitions of these terms are:

Sustainability The process through which new working methods, performance enhancements, and continuous improvements are

maintained for a period appropriate to a given context. The opposite of sustainability, where change is not maintained and benefits are lost, is *decay*.

Spread The process through which new working methods developed in one setting are adopted, perhaps with appropriate modifications, in other organizational contexts. The opposite of spread, where changes at one site are not adapted and adopted by others, is *containment*.

The central argument of this book is that the sustainability, decay, spread, and containment of new working practices are processes influenced by a combination of contextual, processual, organizational, political, and temporal factors, affected also by attributes of the substance of the changes under consideration. These intertwined processes are fragile and vulnerable, and can take significant periods of time to unfold. In particular, attempts to accelerate the process of spread can be damaging. Relevant theoretical constructs (explored later) for understanding these processes include theoretical narratives and probabilistic explanations, involving cumulative effects, conjunctural causation, and path dependency. Consequently, there is no simple policy directive or effortless management strategy to guarantee either the durability of new working practices or their wide and rapid spread. Political and media commentaries often imply that injections of public funds for healthcare must have instantaneous and demonstrable results. However, it seems that national policy and local management must operate instead with a more realistic framework of expectations concerning the pace of adoption of 'best practice', and also the period over which gains can be maintained.

This is not an argument that change in healthcare is doomed to be glacial, incremental, and transient. On the contrary. Significant improvements in service delivery have been achieved and, while not instantaneous, some have been implemented with impressive speed, especially where a favourable conjunction of factors has been in place. Public sector healthcare is conventionally regarded as cumbersome, bureaucratic, slow, and outmoded in comparison with commercial practice. That stereotype is oversimplified and inaccurate. For those employed in the NHS, the pace of recent change has been breathless. The focus on customer care and performance improvement has been pervasive.

Neither is this an argument that modernization has been without problems and is now complete. It is a safe prediction that any organization attempting change on such a scale will combine successes with mistakes, meet difficulties, and find that the project consumes more time and resources than anticipated. The pace of change and the rate of performance improvement will rarely meet either political or public expectations. A systematic evaluation will require an evidence base wider than that which underpins

this book. However, this study of the processes of sustainability and spread offers a useful lens through which to consider the wider dimensions of organizational change. Commercial enterprises have much to learn from the culture of creativity, innovation, and strategic change in healthcare, from the techniques and outcomes of process redesign, and from the new models of working practice and inter-organizational network relationships that have been developed.

Objectives

This book draws on the work of a unique research team, working in the Agency from 2001 to 2005. Team members included healthcare leaders, managers, and researchers, most of whom had clinical qualifications and experience. Considering the potential threats to modernization with regard to sustainability and spread, the objectives of this book concern:

1 The *sustainability* or *improvement evaporation problem*: we explore the processes through which new working practices are maintained and developed in some settings, while they regress and decay in others.
2 The *spread* or *best practices puzzle*: we explore the processes through which new working practices in healthcare are either contained where they were first implemented, or are adapted, adopted, and subsequently transferred to other units.
3 *Implications*: we identify the theoretical, practical, and national policy implications of this experience of major organizational transformation in healthcare.

The book has three parts, concerning context, experience, and implications.

The **context** part introduces the modernization agenda, and explains the role of the Agency, as a national organization development body, in facilitating change. Several of the chapters in the following part are based on studies of two of the Agency's main programmes: the National Booking Programme and the Cancer Services Collaborative Programme. As these initiatives recur throughout the volume, *Chapter 1* explains the background to *The NHS Plan*, and describes the roles of the Agency and the Research into Practice team. *Chapters 2 and 3* respectively summarize the literature relating to the sustainability and spread (or diffusion) of change. While diffusion of innovation is a well-established research tradition (concentrating more on product innovations than on working practices), several commentators note that the sustainability problem has attracted less attention (Ham *et al.*, 2003; Greenhalgh *et al.*, 2004). These chapters argue for a perspective that views sustainability and spread as ongoing processes to be understood in relation to the contexts in which they unfold.

The **experience** part reports studies of different initiatives in the modernization agenda.

Chapter 4 explores the views of staff in national lead roles in the booking and cancer collaborative programmes, with regard to influences on the sustainability and spread of the new working practices associated with those initiatives. Staff experience demonstrates that these processes are closely linked, and are affected by a complex set of factors, including the substance of the changes, key roles and relationships, and modes of individual engagement. Staff views also highlight the significance of collective leadership, the protracted timescales required for effective change, and the role of the organizational context.

Chapter 5 considers the nature and causes of scepticism and resistance to modernization among healthcare staff who might be expected to welcome ways to improve patient care. This study showed that the roots of scepticism and resistance lie not exclusively with the individual, but also with the history and culture of a professional organization, elements of the change substance, and aspects of timing and context. Overcoming resistance depends on understanding the benefits, and on the tailored interventions of skilled change leaders.

Chapter 6 examines the nature and achievements of the National Booking Programme. The aim was simple: let patients choose appointment dates. However, defining a 'booked appointment' was problematic and controversial, but critical as the proportion of patients 'booked' was a performance target. To achieve this simple aim, complex process redesign was necessary, involving changes to roles (clinical and administrative), procedures, computing systems, physical facilities, and inter-organizational collaborations. The spread of booking was inhibited by confusion over the concept and by medical scepticism, as there was little evidence to show that booking improved quality of care. Sustainability, however, was reinforced by the benefits to staff and patients.

Chapter 7 continues the focus on booking, shifting from a national perspective to the experience of an acute hospital, Parkside NHS Trust. This again shows how sustainability and spread are affected by organizational context, and by aspects of the change substance, process, and timing. Issues influencing receptiveness to booking included key people in lead roles, good relations between management and medical staff, a history of successful change, and the presence of a dedicated process redesign team. Good preplanning and timing were also critical to sustainability and spread; booking was first piloted in a small number of receptive areas, where evidence was accumulated, before the underlying principles were shared more widely. Booking was not compatible, however, with some clinical specialties.

Chapter 8 takes a fresh look at the role of change leadership, arguing that change can be driven effectively by staff at all levels of the organization, in positions not normally identified as leadership roles, operating quietly ‘below the radar’. Those staff often have a number of advantages: length of service, depth of local knowledge, established relationships with powerful colleagues, credibility, and political sensitivity. Their role is in sharp contrast with the fashionable stereotype of the visionary, transformational, charismatic senior executive. While such dispersed change leadership may be vital to achieve the scope of change required in healthcare, their role is not always recognized, supported, or rewarded.

Chapter 9 also explores the experience of an acute hospital, Walkerville NHS Trust, with sustaining and spreading cancer collaborative programme methods. The context for these changes was complex, involving the development of new inter-organizational processes and relationships between individuals, teams, hospitals, and networks. Sustainability and spread were supported by continuity of strategic goals, and by good relationships between managers and medical staff. Managers played a covert role in transferring ideas across organizational and professional boundaries, but there was little evidence of senior medical staff sharing new working practices and information with each other. Teamwork, and the collection of service-specific performance data, were instrumental in maintaining the focus on this initiative.

Chapter 10 examines the implementation of ‘rapid access’ prostate cancer assessment, one of the ‘high-impact’ changes in cancer care. Driven by national targets for waiting times, the spread of this initiative was dependent on consultant urologists, whose autonomous decisions led to differences in practice, between hospitals, and also in the same urology department. Rapid assessment does not necessarily lead to better treatment for this disease. Consequently, some clinicians did not adopt the approach, prioritizing clinical evidence above the preferences of patients for quick test results which significantly reduced their anxiety. The cancer collaborative staff, working with clinical teams, had little impact on medical staff.

Chapter 11 considers the change from traditional triage methods in hospital accident and emergency departments to ‘see and treat’. This new approach spread rapidly to most emergency departments in England, apparently triggered by two factors: the visibility of the problem (lengthy queues) in emergency departments, and national waiting times targets. However, those factors were not sufficient to explain the diffusion process, and numerous other issues were also significant, including the straightforward substance of the changes, the absence of a complex decision process to implement, the nature of the accompanying communications, the wider support infrastructure for this initiative, and the visibility of the benefits (no queues).

This is an example of 'conjunctural causation', where the outcomes of interest are generated by a particular configuration or cluster of events and factors.

The **implications** part considers the contribution to theory and practice with regard to organizational change in general, and the sustainability and spread of new working practices in particular. *Chapter 12* develops a processual perspective, drawing on the concepts of theoretical narrative, cumulative effects, conjunctural causation, and path dependency, to explain the sustainability and spread of operational innovations. *Chapter 13* also argues for new ways of conceptualizing change processes, involving modes of thinking that are more circular and less linear, regarding traditional 'cause and effect' as less relevant than conjunctural forms of causation, where outcomes follow from the shifting configurations of a range of factors operating in particular contexts over time. Relatively intangible, this mode of thinking encourages new ways of approaching the practical management of change, sustainability, and spread processes. Three policy implications are explored: the role of a central 'organization development' unit, the implications of performance targets, and expectations with regard to time lags between legislating outcomes and the demonstration of tangible progress towards those goals. *Chapter 14* considers the methodological issues raised by this research, conducted during a period of rapid change, by a team employed by the organization under analysis, funded by the internal customers for the findings.

We hope that this book will be of interest to four sets of readers. First, our primary readership concerns participants on leadership and management development programmes focusing on change, organizational behaviour, and public sector management, and candidates on Masters degree programmes. Second, the book will be relevant to healthcare practitioners in project lead, process redesign, and change implementation positions. Many such roles at national and local levels combine managerial duties with service improvement and (occasionally) research responsibilities. The combination of theory, empirical evidence, practice, and policy will therefore appeal to this group. Third, the content will also be of interest to academic researchers and instructors working in the fields of organization development and change. While the content will be of generic relevance, this work will appeal in particular to healthcare management and public sector specialists. Fourth, the argument of the book will be relevant to health service staff in senior change leadership, policy formulation, and performance management roles. Many such staff have moved from 'front line' healthcare positions, and are familiar with the issues and change initiatives covered in this book, if not with the underpinning theoretical perspective and the implications of our findings.

These readership groups are not as discrete as they appear. Many healthcare managers are responsible for, or are engaged with, internal research and service improvement projects, and many are also enrolled in postgraduate degree programmes, working on their own projects related to healthcare management issues. Many academic researchers in this field (including the editors) are engaged in practice with the service through advisory positions on committees, boards, steering groups, and project teams. These apparently diverse populations share a number of overlapping concerns with research and practice relating to change and modernization in the public services in general, and healthcare in particular.

Terminology

Attentive readers will note inconsistencies in the spelling of 'ise' and 'ize' words. The use of 'z' is widely regarded as American. That is typically not the case. For most such words, the 'z' is correct English, for historical, etymological, and phonetic reasons. Our editorial policy is thus to follow correct English spelling, with reference to *The Oxford Dictionary for Writers and Editors*. The NHS Modernisation Agency is an exception, as it was given this title by *The NHS Plan*.

Some readers may also feel uncomfortable with the use of the term 'modernization', which is associated with national political rhetoric and agendas, applied across the public sector, as well as with substantive efforts to improve the health service. The term is often used indiscriminately, suggesting that the benefits must be clear and unquestionable, which is a suspicious presumption; staff, patients, and carers may not always benefit from, or agree with, ideologically inspired initiatives. The symbolism, implying that the health service is not modern, but old-fashioned and out of date, is yet another false generalization. However, the term is retained here for two reasons. First, this was the label given to the NHS Modernisation Agency which was initially responsible for driving service improvement initiatives in pursuit of *The NHS Plan*'s objective to develop a more patient-centred healthcare organization, and to meet the plan's many targets. The Agency also supported the research reported here. Second, the term was in widespread use at the time of this research, and offers a convenient shorthand for the broad, systemic, and ambitious organizational change and service improvement agenda that the health service has sought to develop. It is interesting to observe, however, that by 2005, most staff had stopped using this once fashionable term altogether, referring more often instead to transformation and reform.

The terms 'sustainability' and 'spread' have been chosen deliberately. These terms were used by the Agency to articulate recurring concerns. The term

'spread' also distinguishes these issues, in part, from commentary on diffusion of innovation (Chapter 3), which tends to focus more on new products than on multi-dimensional organizational changes. Before research in these areas began, Agency staff, including our research team, phrased the sequence 'spread and sustainability' in a taken-for-granted manner. But what is the temporal logic here? Does change or innovation first need to spread, across more than one area, before attention turns to sustaining new practices? Or is it necessary for those advocating new methods first to demonstrate that these can indeed be sustained, before others will adopt the approach? The temporal logic can thus run in either direction, depending on context. The terms sustainability and spread are reversed throughout the book to reflect these possibilities.

Other terms that can cause confusion are 'medical' and 'clinical'. Following dictionary usage, 'medical' refers to doctors (who practise medicine). In Britain, the most senior doctors and surgeons are known as consultants. 'Clinical' refers to everyone (i.e. clinicians) involved in treating patients, including nurses, pharmacists, radiographers, physiotherapists, dieticians, occupational therapists, phlebotomists, and other clinical professions. Note that a reference to clinical staff can thus also include doctors and hospital consultants.

Another potentially confusing term is 'trust'. Terms now used to describe healthcare providers in Britain include, for example, primary care trust, acute hospital trust, ambulance trust, mental health trust, or just plain 'trust' where the context indicates which organization is being discussed. The first NHS trusts were created in 1991, as a result of government policy giving providers a degree of freedom (or 'earned autonomy'; Department of Health, 2002b) from central control if they demonstrated satisfactory performance levels and a commitment to patient-centred care, and devolved greater responsibility to clinical teams. Trusts were funded not by the Department of Health directly, but through service-level agreements with their local strategic health authorities (previously regional offices of the Department). For example, most hospitals (primary care trusts were a later development) adopted a form of clinical directorate structure, in which consultants became part-time managers for their specialties, often becoming responsible for large numbers of staff and significant budgets (the clinical directorate for surgery in a medium-size district general hospital might have an annual budget of over £10 million, for example). In the 1990s, applying for, and being granted, trust status was thus a key objective for most providers. From 2004, following another policy initiative, trusts meeting specified performance criteria (concerning patient care, financial performance, and corporate governance) could apply for Foundation Trust status. This was a controversial policy, which granted trusts considerably more financial freedom, while significantly increasing

local involvement in trust management which would become accountable to an independent regulator.

While the terminology of trust status should not detain us here, these policy shifts have implications for sustainability and spread, for two sets of reasons. First, the time and effort required to prepare a successful bid to upgrade the status of your organization, over what is often a lengthy period of time (several months to several years), cannot be overestimated. This burden does not fall only on management, as clinical (including medical) staff are also involved in helping to meet the performance criteria and then to prepare the details of the application. Involvement in a corporate exercise of this kind often means that less attention is paid to other items on the agenda, which for that period may be regarded as less important, such as sustaining and spreading organizational changes. Second, these bids invariably rely on the organization's ability to demonstrate satisfactory performance on a number of predefined measures. Activities, areas, services, and processes not linked to those measures are thus also given lower priority, and attract less attention, than those which will generate a stronger assessment profile. One reason why new working practices are more likely to remain contained, and why improvements are more likely to decay, is because they have simply ceased to be important in a context that gives other issues and measures a higher priority.

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Part I
Context