

MANAGING CHANGE IN HEALTH AND SOCIAL CARE

by

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SYNOPSIS

This PhD by Publication has investigated contemporary management of change practice in health and social care. Through eight case studies it explores change within different sectors, roles and organisations within national, regional and local systems. More successful change programmes are better able to understand their contexts, to design change theories that will work within these contexts, to fully implement the activities planned on the basis of these theories, and to have the resources and autonomy to complete the programme to its conclusion. Despite the relative success of some programmes, there are common opportunities for change management practice to be improved. These include - the meaningful engagement of service users throughout the process; setting of intermediary and final outcomes that provide opportunity for formative and summative evaluation, and in the use of relevant data to enable reflective change practice. It would also appear that despite the considerable body of knowledge regarding management of change this rarely explicitly influences change programmes and therefore stronger collaboration between academia and practice is still required. A pragmatic approach in which different academic fields collaborate to directly respond to the problems faced in practice would be beneficial.

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SECTION 1: INTRODUCTION

“Thinking begins in what may be called a forked-road situation, a situation which is ambiguous, which presents a dilemma, which proposes alternatives. ... In the suspense of uncertainty, we metaphorically climb a tree; we try to find some standpoint from which we may survey additional facts and, getting a more commanding view of the situation, may decide how the facts stand related to one another.”(Dewey 1910, p11)

By its very nature, change is often conceptualised as something different to the present, a break from the past, in which people, services, organisations or systems move to an altered, and hopefully better, state. Whilst this new situation may indeed be something different and potentially unfamiliar, the experience of undergoing change is though something familiar to us all (Doherty et al 2014, Marris 2014,). Those working in health and social care services could be forgiven for thinking that they have to undergo change more than most in their professional lives. Over recent years these sectors have undergone fundamental changes in their governance, their organisations, their funding, their incentives and their career paths to highlight but a few. The underlying cultures and schemata which underpin the work of these sectors have also been expected to change towards more integrated, person-centred and asset based principles. And this is occurring in a time of considerable economic instability in which global markets and the economies of nations seem more vulnerable than ever.

Despite how familiar change is though, certainty about how to successfully manage change remains elusive. History is littered with worthy policy intentions, thoroughly evidenced best practice guidance, and visionary partnership strategies whose implementation have failed to be realised along with their expected improvements in outcomes. This is despite the considerable body of research and accompanying theory that has been built up over several decades regarding the positive management of service, organisational and system change. This knowledge base incorporates a diverse range of academic fields of study which in turn draw upon the broader traditions of psychology, sociology, anthropology and economics. In the academic world these fields are often considered in semi-purist isolation, with their heritage protected by those who favour this field over the others (Nilsen et al 2013, Moulin et al 2015). Such boundaried thinking can result in a loss of the creative opportunities that could arise from considering the insights and approaches of other fields (Schofield 2001, Bozeman 2013, Gray et al 2015).

A siloed view of the management of change also fails to reflect actual practice, in which those tasked with achieving change will commonly draw upon whatever they see as potentially helpful (Miller et al 2013, Doherty et al 2014). In the practice world, understanding of change is much more hybridised (and some would say bastardised), with a pick and mix approach to nuggets of wisdom and guidance and a common preference for texts that provide accessibility if not always academic rigour (Fendt et al 2008, Waldorff et al 2015). Furthermore researchers appear often to

poorly understand how those who may decisions about change actually use evidence in practice (Oliver et al 2014) and the research base on change is better developed in some services than others. The latter is particularly the case in social care, which has received much less attention than its better funded cousin of health (Miller et al 2015). The eclectic approach of practitioners, and its lack of respect of academic traditions, is perhaps understandable in the face of mounting pressure to deliver services that efficiently achieve desired objectives for service users, communities and organisations (Walshe & Rundall 2001). It also presents dangers in that insights can be valid for particular types and contexts of change but not others, and successes will not replicated without key conditions and enablers in place (Fauth & Mahdon 2007).

This PhD by publication has sought to explore current management of change¹ within and across the different levels and units of the health and social care system – vertical and horizontal, internal and external to organisations, senior and frontline, professional and service user, and purchaser and provider. It follows a ‘pragmatist’ knowledge paradigm, with an emphasis on pursuing knowledge that helps to solve current problems of practice. This introductory report seeks to provide an overview of the research and how the publications link together around the central theme (section 2), the main points of learning within individual case studies and through comparative inter-case study comparison (section 3), and a summary of the contribution to knowledge and practice (section 4). Section 4 also outlines key

¹ Management of change is defined as ‘a purposeful attempt to introduce new ways of working and outcomes within health and social care services’.

limitations of the work and personal learning of the researcher. Following the references of the introductory report in Section 5, the main body of the thesis is then presented in the form of the individual publications (section 6).

SECTION 2: AIMS AND NATURE OF THE RESEARCH

2.1 Aim

To critique current management of change in health and social care services and positively contribute to improved future practice.

2.2 Research questions

- 1) How are contemporary change programmes within health and social care planned and delivered?
- 2) What are the change activities within these programmes and how do the local change theories expect these to lead to outcomes within their understood contexts?
- 3) What intermediary and long-term outcomes were achieved and how do these compare with what was expected?
- 4) What management of change practices are connected with the successful achievement of outcomes?
- 5) How can academic study and practice contribute meaningfully to the practice of change?

2.3 Knowledge Paradigm

Whilst they may not always be explicitly recognised or communicated, paradigms fundamentally shape how researchers perceive the world around them and the knowledge that is relevant (*ontology*) and therefore the lines and approaches of investigation that they pursue (*epistemology*) (Doyle et al 2009, Feilzer 2010). The

underpinning paradigm we ascribe to will inform, if not dictate, our understanding of values (*axiology*) and the overall research design (*methodology*). Debates regarding research paradigms are often presented as a binary choice between ‘positivism’ and ‘interpretivism’ with the two traditions incompatible and vying to win precedence over their rivals (Howe 1985). In such polar debates, the former is summarised as believing in a concrete reality which can be discovered by objective and value-free observations that deductively test out theory (Bryman & Becker 2012, Duberley et al 2012). Quantitative methods are often connected with the positivist tradition. Interpretivism perceives that reality is not one entity as such but is socially constructed, varies between person and group, and changes over time (Moriarty 2011, Silverman 2013). Interpretivist research is therefore concerned with flushing out the richness of views and the assumptions that lie behind them, with the researcher an engaged and potentially influencing factor within the evolving dynamic. Interpretivist researchers accept that they bring values to their work and must be cognisant to these. Qualitative methods are commonly connected with such research.

Johnson and Onwuegbuzie (2004) highlight that despite these seemingly irreconcilable differences there are similarities between these two classic paradigms. This includes use of empirical data to respond to the questions of interest, incorporation of safeguards to ensure findings are trustworthy, and (in social science) a shared interest in how people interact with each other and with their environments. The pragmatic research paradigm builds on these similarities and proposes that these traditional knowledge paradigms should be seen as a continuum rather than as opposites – an ‘anti-dualist’ stance (Feilzer 2010). It originates within the

American philosophical movement of the same name from the early 20th century which sought to address impasses between alternative metaphysical standpoints by proposing that the value of a philosophical concept is the degree to which it leads to practical consequences rather than the strength of its argument or the foundation on which it is built (see e.g. Thayer 1982, Hildebrand 2005). Pragmatists were interested in consequences, and sought to express core values of democracy, freedom, equality and progress in their actions (Cherryholmes 1994, Johnson and Onwuegbuzie 2004). They anticipated that people will shape their environment and their environment will shape them and encouraged creative dialectical processes between those with alternative viewpoints (Fendt et al 2008, Hammond 2013).

Research within the pragmatic paradigm is therefore concerned with solving practical problems in the real world (Feilzer 2010) and seeks a virtuous cycle between *truth* and *action* (Fendt et al 2008). It views the world as both constructed and real, recognises that understanding can change over time, and encourages 'eclecticism and pluralism' in theoretical deployment (Johnson and Onwuegbuzie 2004). The starting point is not to align oneself to a positivist or interpretivist paradigm, but rather the problem that one seeks to understand and what could actually be done to respond to it (Bryman 2009, Wayhuni 2012). Problems to a pragmatist are situations in which there are multiple options with no obvious contender for selection (Ackoff 1962). Pragmatic research should involve an *abductive* process which alternates between deductive and inductive reasoning, *inter-subjectivity* in which those with different viewpoints work together to achieve a common aim, and *transferability* of findings through providing sufficient details of the context to enable others to decide if these

can be generalized to their setting (Morgan 2007). Pragmatism supports methodologies which draw on quantitative and qualitative methods as appropriate to the phenomenon and will use any combination that will shed light of useful relevance (Doyle et al 2009). 'Reflection on action' and 'action on reflection' is at the heart of the pragmatic process, and it is therefore a helpful paradigm for action research and reflective management practice (Fendt et al 2008, Hammond 2013).

The focus on research that leads to action, willingness to explore different perspectives, emphasis on values, and resistance to be pigeon holed to one classic paradigm over another supported pragmatism as the paradigm behind this thesis. Pragmatism is of course not free from criticism. These include the clarity with which researchers provide a rationale for selecting some potential lines of action enquiry over other contenders, its ability to deal with views of reality that may be false but which are practically helpful and similarly truthful views which have no obvious practical benefits, and the influence of values outside of the researcher in guiding what they study in practice (Mertens 2002, Johnson and Onwuegbuzie 2004, Taatila & Raij 2011, Hammond 2013). To address these criticisms, it is recommended that 'pragmatism' as a paradigm should not be confused with pragmatic 'expediency', that pragmatists must pursue quality of design and reject of 'sloppy' research, and that transparency should be used to promote discussion of values and decision making over methods (Denscombe 2008, Feilzer 2010, Hammond 2013, Bishop 2015).

2.4 Research design

The overall research design has been that of comparative case study. Case study research is commonly used in both health and social care research with 'cases' ranging from individual service users to multiple organisations (Shaw and Gould 2001, Yin 2009, Robson 2011, Gilson 2012). There is the potential for confusion regarding what is being meant by 'case study research' with the term being used loosely to denote both overall design and methods for data collection and analysis (Fitzgerald & Dopson 2009, Moriarty 2011, Simons 2015). This study draws on the following interpretations - 'research situations where the number of variables of interest far outstrips the number of datapoints (Yin 1999, p1211), 'a research strategy which focuses on understanding the dynamics present within single settings' (Eisenhardt 1989, p534), 'an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a 'real life context' (Simons 2009, p21), and 'a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence' (Robson 2011, p136).

The benefits of using a case study design are that it provides timely insights into what outcomes have been achieved from an initiative and how these occur (Moriarty 2011), enables exploration of blurred boundaries between context and phenomenon in which experimental control of variables is not possible (Fitzgerald & Dopson 2009, Yin 2009) captures dynamic relationships between key actors and institutions (Gilson 2012), and provide opportunity for developing theory that can then be tested out

through further investigation (Eisenhardt 1989). The methods within a case study are usually qualitative but can include quantitative elements, with an expectation that the methods will be multiple and designed to reflect the research questions and the complexity of the case study (Yin 2009, Moriaty 2011, Buchanan 2012). Flexibility in methods is allowed as the research progresses in order that new emerging lines of enquiry can be pursued (Gilson 2012), though there is also a need for structure if the purpose of the study is more confirmatory meaning that a balance has to be struck (Robson 2011). Single unit cases (*holistic*) can be used to explore a theory in context (critical) or provide an opportunity to consider in less common and unique circumstances (*extreme*) (Yin 2009). It is also possible to undertake multiple case studies which are embedded in the same organisation or from separate entities which can then be used in the replication or extension of theory discovered or tested in pilot cases (Eisenhardt & Graebner 2007, Fitzgerald & Dopson 2009, Yin 2009).

Criticisms of a case study methodology include that it is not possible to derive generalizable findings from single cases and the danger that researchers look for and interpret data to confirm their existing preconceptions (Flyvbjerg 2006). Key to responding to these potential weaknesses is ensuring that issues of quality are addressed, and that flexibility is not taken as an excuse for sloppiness in design (Gilson 2012). Internal and external validity and reliability may be different to more classic research designs but are still vital elements that need due consideration (Yin 2009). Recommended features of quality case study designs are – being clear about what the ‘unit’ of cases are and how these have been selected; providing rich description and analysis, including context and varying perspectives of stakeholders;

and using multiple data sources with transparency regarding their selection and connected sampling (Yin 1999, Moriaty 2011, Yin 2009, Fitzgerald & Dopson 2009, Robson 2011, Gilson 2012).

A comparative case study design was selected for methodological, philosophical and practical reasons. Methodological as it reflected the nature of the research questions through its emphasis on understanding how a phenomenon is experienced by multiple stakeholders and its interaction with context. Philosophical as there was a commitment to support change programmes to respond to local problems and share learning with other localities and service areas. Practical in that the role of the researcher requires engagement with multiple small to medium change programmes. In total eight case studies were selected as this number is seen as ideal in order to enable generalization and retain internal validity (Eisenhardt 1989). A purposive and convenience sampling of case studies (Table 1 & 2) was used to provide different examples of the management of change in health and social care (Robson 2011). This included within levels of the health and social care system (micro, meso, macro), sectors (acute, primary and social care), organisational forms (public, private and third), roles (purchaser, provider, policy), and patient populations (mental health, learning disability, older people). Reflecting good practice in case study design, the data from each case study was not pooled but rather each study was treated individually with comparison and contrast between them (Yin 2009, Gilson 2012). Methods (see below) were tailored to each individual case study rather than having commonality across the whole (Fitzgerald & Dopson 2009). Analysis was initially undertaken within case studies and this was followed by exploration of cross-case

patterns and comparison with previous literature (Eisenhardt & Graebner 2007, Buchanan 2012).

Table 1: Overview of case studies

Case study number	Management of change through...	Overview	Submitted publications
CS1	Learning and development	Funded by the regional health authority and association of directors of adult social services, the development programme brought together commissioners, senior managers and lead clinicians in a development programme in which they worked collaboratively on a local priority.	PB1
CS2	Integrating organisational structures	National policy to encourage local areas to structurally integrate commissioning and /or provision of community health and social care services into a single organisation.	PB2
CS3	Self-advocacy	Independently facilitated self-advocacy group introduced by a mental health trust to empower patients on a secure ward and enable scrutiny of its practice.	PB3
CS4	Commissioning new provision	Commissioned service to address 'wicked problem' of multiply excluded homelessness through provision of hostels and floating support.	PB4

CS5	Alternative organisational forms	National policy giving NHS community health services staff the option to spin-out their services into new organisations.	PB5 PB6
CS6	Increasing market diversity	Good practice expectation that commissioners would actively encourage and support third sector organisations to deliver publically funded health and social care services.	PB7 PB8 PB9
CS7	Clinical leadership in primary care	Clinical Commissioning Group programme to encourage and enable general practices to introduce enhanced service offers and develop innovative schemes to divert activity from acute hospital to community setting.	PB10
CS8	Person centred practices	Provider programme to change direct practice in residential care for people with a learning disability through training, individual budgets and technology.	PB11 PB12

Table 2: Case study typology

Case study	Levels of system			Sectors			Organisational Forms			Role			Population		
	Macro	Meso	Micro	Acute	Primary	Social	Public	Third	Private	Provide	Purchase	Policy	MH	LD	OP
1		X		X	X	X	X			X	X				X
2	X	X			X	X	X			X	X	X	X	X	X
3		X	X	X			X			X			X	X	
4			X			X		X		X			X		
5	X	X			X	X	X	X		X	X	X	X	X	X
6	X	X				X	X	X		X	X	X	X		X
7		X	X		X		X		X	X	X				X
8		X	X			X			X	X				X	

2.5Methods

Methods were individually selected for each case study on the basis of what would be appropriate to explore the particular example of the management of change and its context (Fitzgerald & Dopson 2009) (Section 6) (Table 3). All case studies include a range of qualitative methods, and a number had mixed methodologies which incorporated both qualitative and quantitative methods (Cresswell & Clark 2011, Robson 2011, Bryman & Becker 2012). Action research was a feature of the case studies in which it was possible to provide emerging data to support developmental dialogue with those participating in the change programme (Reason & Bradbury 2008, Koshy et al 2011, Cox 2012). Individual ethical approval was granted for all, including the potential to use data within further publications.

Table 3: Summary of methods in case studies

Method	Case studies
Interviews	1,2,3,4,5,6,7,8
Observations	3,7,8
Focus groups	1,3,4,7,8
Documentary analysis	2,4,5,6,7,8
Secondary data analysis	4,6,7
Survey	1,6,8

2.6 Analytical Framework

Within each case study the data gathered was subjected to a bespoke analytical process relevant to its individual purpose (Section 6). In addition, to summarise the findings of each case study and enable inter-case study comparison a common analytical framework and process was developed (Fitzgerald & Dopson 2009, Yin 2009, Cresswell & Clark 2011). This was based on the concepts of 'context', 'mechanisms' and 'outcomes' which are deployed widely in evaluation and applied research (see e.g. Pawson & Tilley 1997, Blamey & Mackenzie 2007, Coryn et al 2011).

Context is factors of importance separate to the focus of change and the connected change activities (although the context can sometimes be a focus of attention too). This includes *internal* and *external* contexts, with the former referring to the organisation(s) in which the change is occurring and the latter to the financial, social, policy and other relevant characteristics of the environment in which the organisation(s) inhabit. *Internal* factors include those relating to the organisation as a whole, and that relating to the individual actors or teams (see e.g. Kaplan et al 2010, Hill & Hupe 2014, Fulop & Robert 2015, Kringos et al 2015).

Mechanisms incorporates the *change theory* (local assumptions that underpin the choice of change activities to achieve the desired outcomes) and *change activities* (the activities that are planned and undertaken to implement these change theories) (e.g. Ferlie & Shortell 2001, Blamey & Mackenzie 2007, Powell et al 2009, Braithwaite et al 2014, Colquhoun et al 2014, Davidoff 2014, Moulin et al 2015) Change theories can be informed by wider social science theories (*wider theory*) of which there are numerous

suggested in connection with the management of change (e.g. Rhydderch et al 2004, Grol et al 2007, Hill 2013, Nilsen et al 2013, Kuipers et al 2014, Miller et al 2015).

Outcomes includes *intermediary* (the short-term consequences of the change programme which can indicate if implementation has been successful) and *long-term* (the ultimate outcomes that the programme is expected to make or contribute towards) (e.g. Coryn et al 2011, Proctor et al 2011, Chaudoir et al 2013).

The analytical process began with understanding the context which appeared to have been understood by those instigating the change (Stage 1), the planned change theories which informed the mechanisms and the corresponding change activities (Stage 2), and the outcomes that were expected (Stage 3). It then compared these expectations with what was experienced in practice (Table 4). This worked backwards from what outcomes were achieved (Stage 4), the implementation of change activities (Stage 5) and if the original change theories were adhered to and proven to be correct. Finally analysis returned to the context and what elements significantly influenced the achievement of the programme's objectives. The framework enabled analysis of both process and content of the case studies and a comparison between what was *assumed* in relation to how change would be managed, and what was actually the case.

Table 4: Analytical framework and process

Stage of Analysis	Summary of stage	Overview
Stage 1	Context: Understood	What were the key social, economic, policy and practices contexts that were seen as being important to those planning the change? What were the problems that they wished to be addressed?
Stage 2	Mechanism: Planned	What were the change theories that underpinned the programme? What change activities were planned to deliver these theories of change?
Stage 3	Outcomes: Expected	Who were the key beneficiaries and what were the intermediary and long term outcomes expected?
Stage 4	Outcomes: Realised	What outcomes were realised and for which beneficiaries?
Stage 5	Mechanism: Delivered	What change activities were delivered in practice and did these reflect the change theories?
Stage 6	Context: Experienced	What were the key contextual factors that were actually experienced?

SECTION 3: LEARNING FROM THE WORK

3.1 Learning from individual case studies

CS1 Learning & Development	
Element	Summary of Case Study findings
Context: Understood	Commissioned in response to the broader austerity measures and financial pressures due to demographic changes and the financial cuts on social care. The development of CCGs was introducing new individuals and organisations into an already fragmented landscape.
Context: Experienced	Above, plus... previous partnership arrangements in the localities, instability of organisations and job roles, and the local strategic priorities of the organisations / partnerships. Professional identities of participants, and their personal confidence in inter-professional practice.
Mechanism: Planned	<i>Change theory:</i> individuals within the commissioning and delivery of health and social care services were not able to collaborate due to a lack of understanding of each other's roles and accountabilities and insufficient skills to collaborate across organisational and policy boundaries. <i>Change activity:</i> a structured educational programme containing evidence based taught sessions, team tasks, and action learning sets. Local teams would work collectively on a shared priority.

Mechanism: Delivered	<p>The programme was delivered as planned, except for the learning sets which were not seen as priority by the participants. Where there was a supportive local context, the participants generally engaged with the change activities and these were experienced as helpful enablers for joint working. Those teams with an unclear brief and unsupportive local context had less practical and intellectual engagement.</p>
Outcomes: Expected	<p><i>Intermediary outcomes</i> were for participants to find the sessions enjoyable and rewarding, and for them to develop attitudes, skills and knowledge which would facilitate collaborative working.</p> <p><i>Long-term outcomes</i> were for participants to demonstrate behaviour that would enable health and social care services to become more efficient and improve outcomes for service users and their families.</p>
Outcomes: Realised	<p>On the whole the learning opportunities were seen as positive, and most participants had a greater awareness of the importance of inter-professional working. Self-assessment of key change management skills had improved, as had understanding of colleagues' roles and professions. Five teams reported that changes to services had been made locally as a result of the programme, although improved efficiency and user outcomes were yet to be achieved (or at least measured). Two localities made little progress with their priorities and failed to complete their business case.</p>

CS2: Integrating organisational structures	
Element	Summary of Case Study findings
Context: Understood	Perceived difficulties in partnership working between health and social care services that were seen to be resulting in poor user experience and inefficiencies in use of health and social care budgets. The responsibility of separate organisations for the commissioning and delivery of health and social care services contributed to this fragmentation. 'Health act flexibilities' introduced to enable local integrated arrangements.
Context: Experienced	As above plus...separate funding accountabilities, national policy frameworks, performance and inspection regimes and workforce structures. Local history of poor (or in some cases good) joint working between local authorities and health bodies were a strong determinant of the level of trust in the new arrangements. There were numerous complications relating to information technology, pay and conditions, and financial systems that took considerable time to address. Finally, changes in national policy and /or austerity cuts meant that care trusts were not permitted to continue commissioning and providing and/or were not seen as financially effective.
Mechanism: Planned	<p><i>Change theory:</i> services being delivered and / or commissioned by the same organisation would enable shared management, governance, processes and incentives and so more integrated planning, purchasing and delivery.</p> <p><i>Change activities:</i> legal option of care trusts, pilot scheme,</p>

	<p>guidance and approval process with final sign-off by the secretary of state. Responsibility of the individual care trusts and their local partners to decide on the new organisational arrangements. Initially suggested that localities in which partnership working was deemed to be poor could be 'forced' to set up a care trust.</p>
<p>Mechanism: Delivered</p>	<p>All of the planned mechanisms were provided. However the option to be a care trust which commissioned and provided community health services was subsequently removed through the Transforming Community Services initiative.</p>
<p>Outcomes: Expected</p>	<p><i>Intermediate outcomes:</i> no targets were set (or publicised at least) for number of care trusts but initial expectations from ministers were that they would become common arrangements.</p> <p><i>Long term outcomes:</i> loosely described benefits for service users, staff working within services, and in use of resources.</p>
<p>Outcomes: Realised</p>	<p>There were only 12 care trusts created in total between 2002 and 2010, and no more than 10 at any one time. There appeared to be process benefits for many in bringing together commissioning and provision, but these were not always or indeed generally translated to improvements in care or financial efficiency. Benefits for some staff in terms of greater career opportunity were also highlighted. Leaders of most care trusts would not though repeat their development which suggests that they were not seen as providing overall value in comparison with previous arrangements.</p>

CS3: Self-advocacy	
Element	Summary of Case Study findings
Context: Understood	National context was that people with a learning disability within secure environments were particularly vulnerable to abuse from staff and other patients, and that they lacked confidence in speaking up for their rights. The local context was that staff and many patients within this ward had transferred from a long-stay campus, and the trust was keen to demonstrate its commitment to the rights of patients.
Context: Experienced	As above plus...many of the patients were lacking in confidence and benefitted from the opportunity to consider and communicate their interests. There were those though who were unable or unwilling to engage in the group. Whilst some peripheral changes were made to practice, ward staff remained unaware and unaffected by the work of the group due to their existing culture and leadership.
Mechanism: Planned	<p><i>Change theory:</i> if patients were provided with independent support and had direct access to senior managers they would be able to strengthen their self-advocacy skills and the staff within the ward would be more accountable. As a consequence the risk of abuse would be less and the care would be improved.</p> <p><i>Change activities:</i> an external advocacy group facilitated weekly forums with patients in which no ward staff could attend. Forum was chaired by a patient, and would discuss the issues of concern to the patients. It would also support regular audits of</p>

	key areas of practice within the ward.
Mechanism: Delivered	The planned change activities were introduced. The manner in which the group was facilitated was seen as key, and with a different style it was thought the impacts would have been less. The ability of the facilitators to network 'behind the scenes' was another key enabler to changes being achieved.
Outcomes: Expected	<p><i>Intermediary outcomes:</i> greater openness and transparency regarding care on the ward and increased confidence of patients.</p> <p><i>Long term outcomes:</i> wellbeing of patients was improved and the care was of a higher standard.</p>
Outcomes: Realised	Senior managers, senior clinicians and some patients reported that the forum had led to greater scrutiny of nursing practice, that some patients had developed communication and assertiveness skills, and that there had been tangible changes to the environment of the ward and some practices within it. Nursing ward staff members were not convinced that the forum made any contribution to openness and transparency, and believed that any changes would have been introduced without the influence of the group.

CS4: Commissioning new provision	
Element	Summary of Case Study findings
Context: Understood	The locality concerned had a population of individuals who experienced multiple exclusions on the basis of homelessness, mental health problems, drug and/or alcohol dependency and being victims and/or perpetrators of crime. Mainstream homeless provision was not able to respond to their needs, and there was often fragmented and inadequate support from statutory agencies.
Context: Experienced	As above....plus higher levels of demand than anticipated meant that people who would benefit from the service were not always able to access it. Service users did not always respond positively to the environment and support.
Mechanism: Planned	<p><i>Change theory:</i> through providing safe and stable accommodation service users would be able to engage with treatment and support services. These interventions would support recovery and an ability to live independently.</p> <p><i>Change activities:</i> Higher staffing ratios, experienced staff, and design of accommodation A multi-agency steering group would improve co-ordination between services and professionals.</p>

Mechanism: Delivered	The service was able to accommodate service users with this level of need and key workers liaised successfully on the whole with external agencies. However, there was not agreed approach to identifying when individuals would be ready to leave and working towards this goal.
Outcomes: Expected	<p><i>Intermediary outcomes:</i> service users would be safe, have any immediate health and personal care needs addressed, and start to access support for any dependencies or mental health problems.</p> <p><i>Long term outcomes:</i> service users would move into more independent accommodation, not return to homelessness, and be less reliant on public sector funding and services.</p>
Outcomes: Realised	120 multiply excluded individuals were supported between 2007 and 2012. Feedback from service users and external stakeholders was this led to improvements in personal health and wellbeing and reduced demand on crisis services such as A&E and the police. However approximately 1 in 6 people were evicted. Lack of agreed pathways to alternative accommodation meant service users remained longer than expected. Some service users returned to temporary accommodation or rough sleeping.

CS5 Alternative organisational forms	
Element	Summary of Case Study findings
Context: Understood	National NHS policy encouraged a greater diversity of providers to facilitate greater competition. Many NHS staff and senior managers were seen to be reluctant to encourage non-NHS providers or to work within them. There was a broader interest in the potential of social enterprise as a vehicle for efficient and effective deliver of public services. Transforming Community Services required Primary Care Trusts to divest themselves of direct service delivery.
Context: Experienced	As above plus...the regional and organisational contexts in which the staff groups concerned played a considerable role, in particular the interest and support for spinning-out. The views of commissioners continued to have considerable influence once the social enterprises were launched through additional funding awarded and the degree of trust and flexibility they would allow within contracts.
Mechanism: Planned	<p><i>Change theory:</i> social enterprises would be better able to deliver innovative and cost-effective health care services as the staff within them would be freed from public sector bureaucracy and attract new funding streams. Increased staff engagement due a new sense of loyalty and commitment to their employer. The RtR would provide new entrants into local NHS markets and so increase competition.</p> <p><i>Change activities:</i> introduction of a 'right' for such proposals to</p>

	be considered by a PCT board, guidance, short-term funding, guaranteed contract, support from external experts, national network and learning sets.
Mechanism: Delivered	Some groups of staff took up the option, with a proportion encouraged to do so by senior management. In many localities there was no interest or staff groups voted against the spinning out, and in others the senior management declined to promote or refused to give permission to proceed.
Outcomes: Expected	<p><i>Intermediary outcomes:</i> social enterprises would be created by community health staff to deliver NHS services. No targets appear to have been set for the number or their spread across the country.</p> <p><i>Long term outcomes:</i> general aspiration that the new organisations would result in general improvements in the health and wellbeing of local communities through staff being more engaged and freer to innovate. It was also hoped that there would be savings for commissioners.</p>
Outcomes: Realised	In total 42 social enterprises were launched. These were unevenly spread across the country, with some regions having several and others none at all. Approximately 10% of community health service staff employed in PCTs were transferred with a budget of just under £1 billion. Long term outcomes are not being gathered for the programme as a whole and there are no independent evaluations as yet of individual organisations. Their senior leaders are generally confident that they are starting to see improvements in staff engagement, delivering efficiencies, and new innovation in service delivery.

CS6: Increasing market diversity	
Element	Summary of Case Study findings
Context: Understood	There was potential room for further expansion of the delivery role of third sector organisations. This could both introduce or broaden innovations within the market, and also provide additional competitive pressures for other providers. Commissioners and their institutions are not always aware of the breadth of the third sector, and how to engage them positively in procurement processes.
Context: Experienced	Above plus...concerns that transferring increased resources out of the public sector would result in reduced publically owned provision and could be seen as 'privatisation', structural change leading to disruption of commissioning functions, greater policy emphasis on achieving short term savings, and NHS providers suffering major financial challenges.
Mechanism: Planned	<p><i>Change theory:</i> commissioners required greater information on what constitutes the third sector and to be persuaded of the potential benefits of engaging them in delivery. As a consequence they would alter their commissioning practice which would result in greater funding for the third sector to deliver services and/or greater engagement within competitive tendering.</p> <p><i>Change activities:</i> policy statements outlining the strengths of the third sector and expectations of government, good practice guidance setting out the main barriers in procurement and how</p>

	these can be overcome, and pilots to gather evidence of innovative practice.
Mechanism: Delivered	All of the expected change mechanisms were introduced, however the engagement of commissioners with this material was inconsistent and in some cases negligible. The experience and views of commissioners, and the commissioning organisations' policy regarding third sector's role in delivery were stronger influences.
Outcomes: Expected	<p><i>Intermediate outcomes:</i> commissioning practices would change and as a result the third sector would deliver an increased breadth and depth of health and social care services. Other providers would respond to the increased competitive pressures.</p> <p><i>Long-term outcomes</i> would be improved cost effectiveness and quality of all providers, and better outcomes for patients / service users and their communities.</p>
Outcomes: Realised	Some third sector organisations have increased their delivery of publically funded health and social care services. However others have found competitive procurement challenging and have reduced their delivery and in some cases folded. Some aspects of commissioning practice has changed, however other elements less so. Third sector organisations report that due to restrictive specifications they have been unable in some cases to provide a creative response and that whilst there is an expressed interest in more outcome based contracts many commissioners are not clear how to move to such a model.

CS7: Clinical leadership in primary care	
Element	Summary of Case Study findings
Context: Understood	National policy encouraged new models of primary care based around larger provider groups as an alternative to acute services. Locally there were inconsistencies in the range and quality of services provided by general practice, and previous attempts to improve these had only had partial success.
Context: Experienced	As above plus...there were experienced general practitioners who were willing to lead change but had not had the opportunity or incentive to do so. Pressure from non-selected practices was such that the CCG board did not feel they could withhold additional funding until the end of the pilot. Other health and social care agencies were not able to engage or respond to changes suggested by the general practices.
Mechanism: Planned	<p><i>Change theory:</i> general practices would be motivated into adopting new services and approaches through financial reward and competition with peers. Groupings would provide a more stable base for introducing such change, and would be able to influence and support their members to improve quality. Stating outcomes rather than activities would lead to greater innovation.</p> <p><i>Change activities:</i> competitive selection process, outcome based specification with funding up front (ie rather than payment on performance), and a regular learning set with mandatory attendance. Learning would be communicated to other</p>

	practices following pilot.
Mechanism: Delivered	The competitive selection process, payment in advance and learning sets were all delivered. The CCG decided to allow other practices to have access to additional funding before pilot was finished.
Outcomes: Expected	<p><i>Intermediary outcomes:</i> enhanced and consistent offer of primary care services, and stronger partnerships within general practice groupings. Also hoped that there would be some diversion of activity from acute to community.</p> <p><i>Long term outcomes:</i> innovative models developed in pilot could be rolled out leading to major savings.</p>
Outcomes: Realised	The general practices delivered the enhanced offer and inconsistencies in quality were addressed. Relationships between practices were strengthened either through existing formal partnerships working better or new partnership structures such as federations or super-partnerships. Diversion from acute services was yet to be achieved other than through the required enhanced offer and no actual savings had been delivered.

CS8: Person centred practices	
Element	Summary of Case Study findings
Context: Understood	The national context was that people with a learning disability were living longer, and there are more young adults with complex physical and behavioural needs. Funding for social care was being whilst national policy was emphasising greater personalisation and control. Local council wanted to achieve considerable savings within its learning disability commissioning budget, and these homes were seen as expensive and in some cases outdated. Provider was keen to be seen as an exemplar of good practice to secure future contracts.
Context: Experienced	As above plus...many staff did not trust their employer, with some divisions between ex-NHS staff and those recruited by the organisation. Community resources to replace or complement the support for staff were not identified or were difficult to access for individuals with these needs.
Mechanism: Planned	<p><i>Change theory:</i> staff did not fully understand personalisation, and therefore changing their thinking and practice would lead to improved outcomes. Technology would reduce reliance on staff to meet the needs of residents, and control over their funding would enable the residents to have consumer based power.</p> <p><i>Change activities:</i> person centred care planning processes, training for staff and managers, learning sets for managers, individual service funds and assistive technology.</p>

Mechanism: Delivered	<p>Training and support for managers was provided – this was cascaded to some staff but due to departure of managers many staff members were not able to undergo the development. Assistive technology was installed in all homes but individual service funds were abandoned. Person centre plans were developed for most residents but these were not renewed annually.</p>
Outcomes: Expected	<p><i>Intermediary outcomes:</i> all service users would have a person centred plan and individual service fund, managers would train staff and oversee the new processes, and each home would deploy range of assistive technology.</p> <p><i>Long term outcomes:</i> service users would have a better quality of life, council would make savings, and that the provider (and technology company) would gain new contracts.</p>
Outcomes: Realised	<p>Most service users had new person centred plans. Managers were trained and reasonably confident but the majority left the company. Assistive technology was installed in all of the homes – some of this was used in practice but not all. Quality of life of most service users had not improved, and savings were found through different means. Technology company was able to increase its sales but the care provider chose not to publicise its involvement.</p>

3.2 Learning from inter-case study comparison

3.2.1 How successful were the change programmes in achieving their stated outcomes?

Multiple beneficiaries were articulated within all of the programmes including service users, communities, staff members and the public purse. Most expressed these in broad terms which reflected general policy priorities, and almost none developed (or at least published) detailed outcomes and targets for the change programme. Interim objectives were sometimes provided (e.g. CS1 & CS8) but not thoroughly connected with the final outcomes. Few introduced bespoke performance frameworks or specific targets with progress being inferred through wider monitoring processes. For example CS4 used the Supporting People performance framework which focussed on supported housing measures rather than general wellbeing, and did not reflect the complexity of need of service users. It was seen by commissioner and provider as having limited relevance and at times acting a distraction. CS7 did though develop a bespoke framework which included new outcome measures along with existing monitoring data. This proved to be clearer and better understood by the general practices in relation to the development of the specified services, but more muddled and therefore less impactful in relation to more holistic wellbeing outcomes. Despite improving service user outcomes and experience being an expectation in all case studies, again there were few targets or data systems relevant to this aspect of their change.

The limitation in outcomes makes objective evaluation of success problematic. For example in CS5 ten percent of community health staff spinning-out to social enterprises would be a major achievement if only occasional take up was envisioned, but less so if

the hope was for twenty percent. Furthermore the outcomes that could be analysed were often the intermediary rather than the longer term outcomes. Within these limitations it is possible to comment on interim if not final outcomes, and to state that some have delivered a fair proportion of their planned interim outcomes (e.g. CS1, CS3, CS4, CS5 & CS7). There were two programmes which appear to have largely failed to achieve their planned outcomes (CS2 & CS8), and all missed some of their expected outcomes (e.g. CS3 and CS7) and/or to be successful in all localities / population (e.g. CS1, CS2, CS4, CS5 and CS7).

It is possible that for some programmes being ambiguous about the outcomes was a deliberate strategy to avoid future criticism and for others the gap was due to a lack of recognition, time or capacity. Even when more concrete outcomes were sought by those instigating the change had considerable difficulty in conceptualising, setting and articulating these to those responsible for delivery. For example in relation to preventative services (CS6) local authorities hoped that providers would suggest outcome measures but TSOs were uncertain what was of interest to commissioners and data that would be accepted. In CS7 it became practically and politically easier for the CCG to resort to more traditional process measures despite significant support from more innovative groupings for an outcome based approach. A key role for the researcher with the action research case studies was therefore to facilitate discussion on what they wanted to achieve and how these could be evaluated meaningfully in the time and resources available.

3.2.2 What were the change theories and connected planned change activities?

In some case studies change instigators were national government with senior management acting as implementers (i.e. directors / boards / elected members) (CS2, CS5 & CS6) whereas in others senior management instigated the change (CS1, CS3, CS4, CS7, CS8). Therefore the same level of management was the 'top' in some change programmes but further down the chain in others. The 'top' was essentially determined by the level that had the power to dictate that the change would happen, with power being connected with hierarchy in organisation or system, and/or control of resources. The programmes all ultimately hoped for change in the practice of frontline practitioners as a means to achieve the outcomes. The detailed scope of the change activities did though not always reach to this micro-level and instead set out causal changes in organisational or commissioning behaviour. Even those which detailed frontline practice (CS3, CN4, CS7 & CS8) recognised that such 'top-down' specification had limits and contained an expectation of frontline discretion. This could be interpreted as recognition that each service user was unique requiring practitioner innovation, and/or a lack of understanding from the top as to how the changes could actually be made resulting in the uncertainty being delegated (or arguably dumped) to those at the frontline. Whatever the motivation, the common pattern was one of a change being initiated from the top with an aspiration that the change would then be owned and enhanced by those responsible for direct delivery. Similarly, most of the change programmes were designed with both planned and emergent elements, with the top instigating level devising planned elements that would generate momentum for change and provide a set of parameters that practice would then develop within.

Most change instigators saw the opportunity to change being held by those lower in the hierarchy, even if this top-level had some responsibility for the problem. For example, in CS2, national legislation, policy priorities, performance monitoring and funding allocations contributed to local fragmentation yet the intervention was targeted at the local level rather than national divisions. In CS4 commissioners oversaw the network of services through which service users were falling between, but rather than join these services up they choose to add another service. It could be that instigators recognised their contribution but felt unable to influence it, or that that they saw problems as primarily due to poor practice from those 'at the bottom'. There were two notable exceptions to this – in CS7 the CCG recognised their previous commissioning practices had not encouraged innovation in general practice and sought to change themselves as well as the practices, and in CS3 senior management wanted on-going engagement with service users to shape their own leadership.

All the change theories had an element of rational change approaches in which practical interventions would result in the required response. This would be achieved through alteration of the governance processes (CS3), new responsibilities of boards to work across health and social care (CS2) and alternative organisational forms (CS5), opportunity to gain (or not lose) finances (CS4, CS5, CS8), or presenting a reasoned argument regarding adopting the change (CS2, CS5, CS6). Information connected with the latter was presented through training, guidance, and/or reports based on pilot evaluations and other research. The majority of the change programmes also included transformational elements on the basis that if the actors saw the world differently this would alter how they perceived and therefore responded to a problem or opportunity.

Such paradigm shifts included the role and competence of the third sector (CS5 & CS6), that service users had a right to direct their care (CS8), and that general practitioners could act as social entrepreneurs (CS7). About half of the programmes recognised the emotional challenge that would be connected with the change and introduced corresponding supports for the key players. These were generally in the form of learning networks (CS5 & CS8) or action learning sets (CS1, CS5 & CS7). Financial incentives in the programmes included continuation (or threat of loss) of existing funding and/or access to new resources, with the latter including short-term support to enable change to happen (CS1, CS5 & CS7) and/or medium term funding to sustain the delivery of new services or practices (CS4 & CS6). Financial incentives also included the possibility that the new arrangements would be more efficient and/or effective and so help the locality or organisation cope with the demands of wider financial pressures (CS1, CS2, CS5, CS6, CS7 & CS8). Vocational incentives assumed commitment of the individuals and teams concerned to provide good care, fulfil their professional values, and enhance their career opportunities. All of the programmes included multiple change activities, with common elements of training and development (CS1, CS5, CS7, CS8), provision of guidance and good practice (CS2, CS5, CS6, CS8), sharing a normative vision (CS2, CS5, CS6, CS7, CS8) and an element of competition (CS1, CS4, CS5, CS6, CS7). Service user engagement was a core expectation of most although few specified what this would look like. Additional resources were sometimes in the gift of the change instigators through wider initiatives (CS5 & CS7) or capacity/ underspend in existing budgets (CS1 & CS3). Other required securing additional specific funding (CS4 & CS8). Some change instigators had sufficient power to mandate engagement in the change activities (CS3, CS4, CS8) but this did not

mean that the changes were successful and being forced to engage could lead to resistance.

Apart from market based theories in commissioning (CS1, CS4, CS5, CS6, CS7)(Sanderson et al 2014), none of the change programmes explicitly drew on field(s) appeared to inform their change theory and activities. In view of the underlying academic thinking and empirical research this is surprising and a little depressing. It is possible to connect academic fields of study with each programme and which may have been reflected albeit it unconsciously - improvement science (CS1, CS7 & CS8)(Graham et al 2006, Straus et al 2013, Lobb & Colditz 2013), quality improvement (CS3, CS7, CS8)(Seddon & Caulkin 2007, Powell et al 2009, Nadeem et al 2013, Radnor & Johnston 2013), organisational development (CS2, CS3, CS5, CS8) (By 2009, Bushe & Marshak 2009, Cummings & Worley 2009), and policy implementation (CS2, CS5, CS6) (Lipsky, 1980, Exworthy & Powell 2004, Winter 2012, Hupe & Hill 2015). Most can be said to have adopted the idea of the health and social care system, with organisations interacting across their individual boundaries in order to transfer funding, information and other resources (Katz & Kahn 1978). Complex adaptive systems thinking can be seen in the inclusion within many of positive visions to motivate and inspire these free actors to choose to engage and follow the suggested direction (Glouberman & Zimmerman 2002, Burnes 2005). There was not a purity of and exclusivity to a field, and instead those leading would draw on principles reflective of one field or another without being conscious of doing so. That said, it would appear that there is a lot more that could have been gained from the wider academic study within this field. The publications linked to the case studies drew on further theories of relevance, for example, inter-professional learning (CS1), culture (CS3),

complexity (CS4), organisational change (CS6, CS7 and CS8). Where there was opportunity for theoretical insights to be shared within the case study research process it was of considerable interest for the local implementers.

3.2.3 What management of change practices were connected with the successful achievement of outcomes?

The more successful change programmes (CS1, CS3, CS4, CS5, CS7) varied in their size and scale, the change activities that were deployed, the 'level' which instigated the change, their engagement (or not) of external support and the degree of radical transformation that they involved. The level and source of resources available to them were also diverse, although it may be crucial that all were able to maintain these during the life of the programme. Key to their success appears to be that their understanding of context and the nature of the problem in question enabled them to predict what activities would lead to the expected outcomes. This includes the degree to which the top-down initial steps would result in constructive (in the terms of the change programme) emergent responses from the practitioners and managers. These programmes incorporated positive rewards for individuals and their organisations, but also had more negative pressures contained within them or their contexts. For example, a common motivation for the staff groups who spun out of the NHS was to avoid a more negative organisational option for their services (CS5), and general practices were anxious about being left behind in the national move for larger provider groupings (CS7). These more successful programmes were also able to implement their planned change activities within the expected timescales.

The less successful programmes (and the unfulfilled elements of the more successful ones) suffered from three common weaknesses (or problems in pragmatist terminology). The first problem was that aspects of their change theory were incorrect and /or insufficiently broad and deep. So for example, a single organisation did not always enable health and social care professionals to work together and had high transactional costs (CS2), local communities did not appear to have resources that could be accessed by service users within the care homes (CS8). The new service could provide safe accommodation and facilitate engagement with specialist services, but could not lead the transition to more independent accommodation (CS4). GPs were able to make changes in the services that they offered, but not to influence external organisations such as the community health service provider and the local authority (CS7). Few of the change theories considered in any depth how service users and communities should be positively engaged. CS8 did seek to achieve this in relation to new care planning processes and the paradigm that underpinned them and this may have led to improved wellbeing if these activities had been able to continue.

The second problem was in fully understanding the context. Whilst all expressed awareness of contextual factors which proved to be accurate, their understanding (as much as can be gathered from the available evidence) was incomplete in all cases and majorly flawed in a few. For example, there was an apparent failure to recognise that the local authority would require savings before these would be delivered by the programme (CS8) and that national policy fragmentation would provide particular challenges for a single health and social care organisation (CS2). A key issue in many was variations in local contexts – this affected both national and regional programmes in which the local

unit of relevance was a local authority or ccg (CS1, CS2, CS5 & CS6), or within organisational programmes in which the local unit of relevance was a service or group of services (CS7 & CS8). There were also for some major alterations in the context which could undermine the planned activities and which may not have built into the programme design (e.g. restructurings with local authorities (CS1, CS7 & CS8)).

The third problem was not keeping to the planned mechanisms throughout the programme. This was on the basis of change theories being eventually seen as too difficult or risky (e.g. move from outcome to process based targets(CS7), because a different change theory took precedent (e.g. need for NHS purchasing and providing to be separated (CS2)) or because the change instigators gained different priorities (e.g. commissioners focussed on stability of NHS providers (CS6)). Change activities were also not implemented because key implementers did not follow through with the required actions. For example, there was considerable variation between regions in the promotion and support for social enterprises (CS5). Few of the programmes could or chose to mandate that the key actors should engage with the activities, and for those that did (CS3 & CN8) this forced participation had limited impact due to a failure to change the paradigms of those concerned and/or the ability of the change instigators to monitor and force through the response to the activities was limited. Generally engagement relied on setting out an aspirational vision that that would inspire the key actors and / or a competitive element. This worked best when the two were combined together, and competition was about status and resources (e.g. CS1 and CS7).

SECTION 4: CONCLUSION, LIMITATIONS AND WIDER CONTRIBUTION

4.1 Conclusion

“But suppose that each becomes aware of what the other is doing, and becomes interested in the other’s action and thereby interested in what he is doing himself as connected with the action of the other. The behaviour of each would be intelligent; and social intelligent and guided.” (Dewey 1947, p37)

This PhD by Publication has explored contemporary practice regarding the management of change in health and social care. It has found that change is still predominantly instigated from those ‘at the top’ with the power to require others to follow their lead (Todnem By 2005, Buchanan & Badham 2008, Nielsen et al 2013, Hill & Hupe 2014). That said, most change programmes also recognised that those on the frontline were key to achieving improved outcomes and therefore encouraged local innovation (but within defined parameters). There remains a need for implementing bodies within different sectors and levels to join up to provide ‘windows’ for change and to avoid wasteful duplication and clashes in priorities (Exworthy & Powell 2004, Kuipers et al 2013). Commissioning and the move to more market orientated governance have given those purchasing services additional levers for change (Le Grand 2009, Bovaird et al 2012, Sanderson et al 2015). However this has also led in some situations to greater fragmentation, disincentives for collaboration and the disruption of existing relationships (Hudson 2011, Rees et al 2014). The rise of commissioning has introduced a new set of roles, which whilst not formally professions, bring further diversity to an already congested set of inter-disciplinary relationships and connected collaborative

competences (Cameron 2011, Reeves 2012). As expected the deeply held beliefs and socialisation processes of organisational culture provide key contextual elements (Meyerson & Martin 1987, Mannion et al 2004, Schein 2010). Some difference can be found between the cultures of the public, private and third sectors but also much similarity, with the current emphasis on competition potentially encouraging greater uniformity and reducing distinctiveness (Miller 2013, Hall et al 2015). Leadership, and in particular the balance between clinical and managerial roles, the deployment of transformational and transactional approaches, and the authenticity of personalised care visions, is also vital (Powell et al 2009, Alban-Metcalf & Alimo-Metcalf 2010, Dixon Woods 2012, West et al 2014). The strength and nature of team working is a further important influence on engagement with and implementation of change programmes (Lemieux-Charles & McGuire 2006, Richter et al 2011).

The key learning from the case studies is that in the current health and social care system more successful change programmes are better able to understand their contexts, to design change theories that will work within these contexts, to fully implement the activities planned on the basis of these theories, and to have the resources and autonomy to complete the programme to its conclusion (Greenhalgh et al 2004, Glasgow & Emmons 2007, Landaeta et al 2008, Lobb & Colditz 2013, Rafferty et al 2013). Recognition of those instigating change of the contribution of their level to the perceived problems and a willingness to improve their own practice and impacts helps to address contextual barriers which may otherwise frustrate the change programme even if well planned and implemented. Despite the relative success of some programmes, there are common opportunities for change management practice to be improved. These include -

the meaningful engagement of service users throughout the process; setting of intermediary and final outcomes that provide opportunity for formative and summative evaluation, and in the use of relevant data to enable reflective change practice. It would also appear that despite the considerable body of knowledge regarding management of change this rarely explicitly influenced practice within the case studies, and therefore stronger connection between academia and practice is still required (Fendt et al 2008, Oliver et al 2014, Gray et al 2014). Taking the pragmatic approach, there could much benefit for all concerned for greater collaboration across academic fields to respond to the problems faced by those in practice.

On a personal basis the undertaking of the PhD has been an intense, challenging and ultimately rewarding experience. During the past five years it has provided the structure for an apprenticeship in research practice and facilitated opportunities to learn from those more experienced in this craft. It has involved exploration of fields of study that were hitherto unknown in any detail or depth and in doing so opened up new worlds of empirical knowledge and theoretical perspectives. It has demonstrated that opportunities to enable dialogue and shared activity across the practice-academic boundary is one of personal interest and motivation, and that to do so (as in so many inter-professional collaborations) requires credibility to both communities. Going forward it is recognised that there is still much to learn, with a firmer grasp of quantitative and economic methods high on the agenda.

4.2 Limitations

Whilst the research design of the individual case studies and the PhD as a whole is based on sound principles and methodology it is recognised that there are limitations to the work. Key limitations are presented below with suggestions for future research projects that could respond to these limitations:

- Theory development: the research has essentially been exploratory in nature, developing rather than testing out emergent theory. Further comparative case study work in which case studies provide the opportunity to test these theories out in ideal and extreme contexts would be interesting.
- Service user perspectives: The interests of service users were a focus of all case studies and they were engaged where possible. Research that saw change within services primarily from the perspective of service users would provide valuable insights.
- Practice of change: there were opportunities to talk to those facilitating the change programmes in all the case studies but this was limited in some case. When it was possible to observe change practice over a longitudinal period this provided rich insights. It would therefore be positive to seek opportunities for more ethnographic research, particularly in social care which is so under-researched at present.
- Measurement of impact: It would have been ideal if all case studies had measures and data that enabled a more objective and/or robust view of their outcomes. Working with the practice community to develop relevant, practicable and

meaningful approaches to setting and evaluation of outcomes would be beneficial.

4.3 Wider contribution

A pragmatic paradigm suggests that what dictates the value of knowledge is the degree to which it leads to practical change. This PhD has attempted to share knowledge as it has emerged and to provide accessible but robust insights to support timely improved management of change practice. All of the case studies have been converted into journal articles, book chapters and / or conference presentations (with further articles planned from CS7 in particular, and the PhD as a comparative case study). This is in addition to organisational reports, dissemination events and workshop discussions which were provided in connection with the individual case studies. The learning, and indeed 'problems' that were encountered in the fieldwork, have also inspired further research and a range of practitioner orientated resources. These include a project for the School for Social Care Research regarding the management of change with adult social care services (Miller et al 2015 and PB12) with the subsequent development of an on-line change management resource by the Social Care Institute for Excellence², contributing chapters to downloadable guides of good practice with accompanying webinars and events (PB13), and articles for professional journals and websites.

² <http://www.scie.org.uk/publications/elearning/organisational-change-in-social-care/index.asp>

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SUMMARY OF PUBLICATIONS

Number

PB1	Inter-professional workplace learning: a catalyst for strategic change?
PB2	The care trust pilgrims
PB3	Changing organisational culture: another role for self-advocacy?
PB4	Multiple exclusion homelessness: is simplicity the answer to this complexity?
PB5	New development: spin-outs and social enterprise: the 'right to request' programme for health and social care services.
PB6	Spinning with substance? The creation of new third sector organisations from public services
PB7	Mental health commissioning: master or subject of change?
PB8	Singing from the same hymn sheet? Commissioning of preventative services from the third sector
PB9	Older people's prevention services: Comparing perspectives of local authorities and the third sector
PB10	Liberating the change? A bottom up approach to improving general practice
PB11	Transformation of Residential Care Homes: Stage 1 evaluation presentation
PB12	Transformation of Residential Care Homes: Final evaluation report
PB13	Managing change in social care
PB14	Prevention and independence in adult social care

PUBLICATION 1

Miller, R., Combes, G., Brown, H., and Harwood, A. (2014), Interprofessional workplace learning: a catalyst for strategic change?. *Journal of interprofessional care*, 28(3), 186-193.

ORIGINAL ARTICLE

Interprofessional workplace learning: a catalyst for strategic change?

Robin Miller, Gill Combes, Hilary Brown and Alys Harwood

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Abstract

The integrated care development programme (ICDP) was a continuing interprofessional educational programme for health and social care managers and commissioners. Multi-professional strategic teams from a single locality participated in university and workplace-based learning activities centred on the development of an integrated business plan to address a local priority for improvement. The evaluation used participant self-assessment, semi-structured interviews and group discussions to assess achievement of expected impacts on the participants, their organisations and partnerships, and patient/service user outcomes. The findings indicate that whilst those employed in management and commissioning roles had considerable experience of working across professional and agency boundaries they derived individual benefits from a workplace IPE programme. The principles of design and delivery developed in pre-registration and clinician/practitioner IPE courses also applied to those working at a more strategic level. Organisational impacts were reported, but 6 months post-programme evidence was not yet available of significant improvements in patient outcomes and /or financial efficiencies. Individual motivation, team dynamics and support from line managers all affected the extent to which individual and organisational impacts were achieved.

Keywords

Commissioner, continuing education, integrated care, interprofessional education, workplace learning

History

Received 5 January 2013

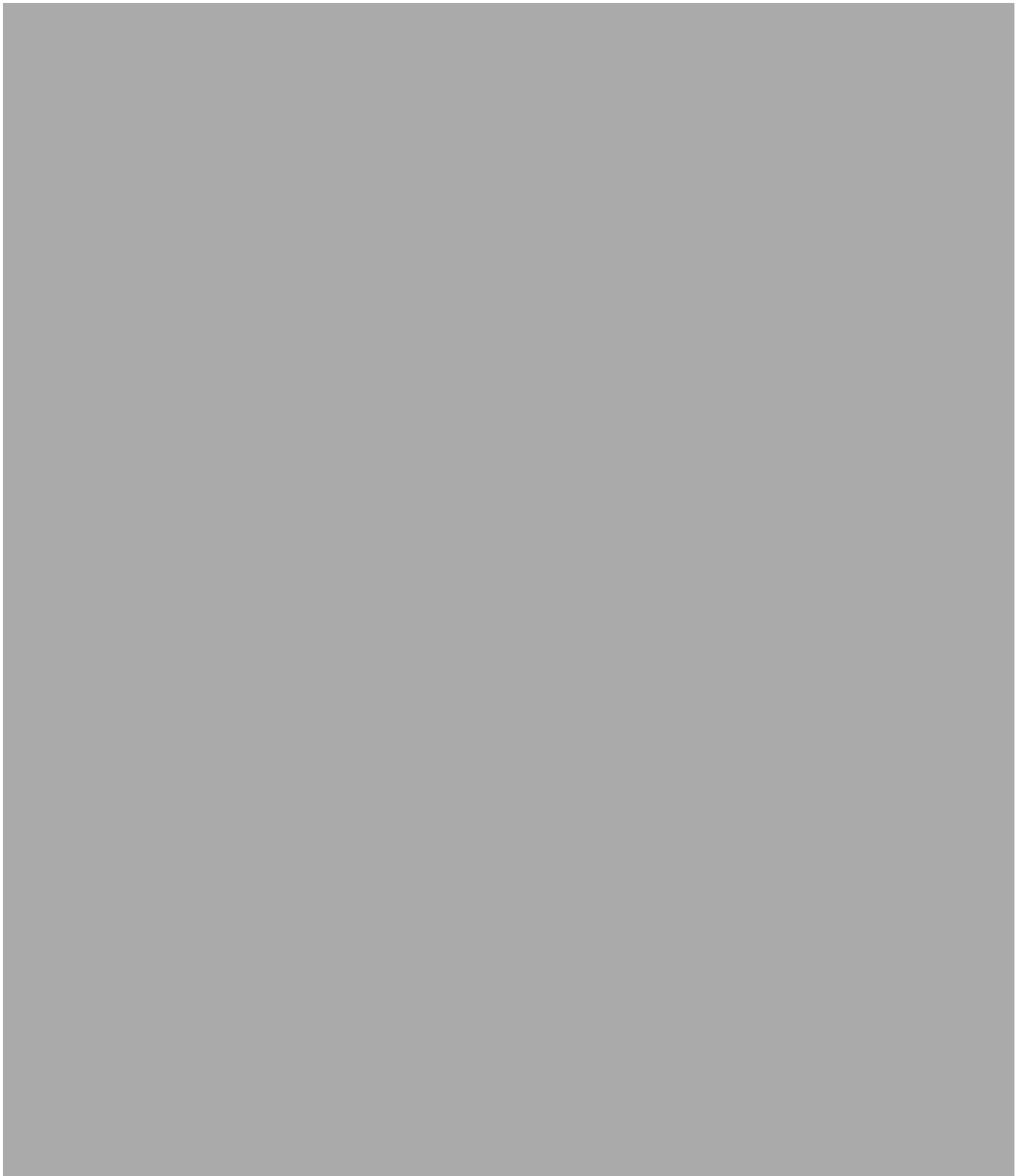
Revised 10 November 2013

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CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)





PUBLICATION 2

Miller, R., Dickinson, H. and Glasby, J. (2011), The care trust pilgrims. *Journal of Integrated Care*, 19(4): 14-21

The care trust pilgrims

Robin Miller, Helen Dickinson and Jon Glasby

Robin Miller is a Senior Fellow, Helen Dickinson is a Lecturer and Jon Glasby is a Professor of Health & Social Care, all are based at the Health Services Management Centre, Birmingham, UK.

Abstract

Purpose – *This paper seeks to reflect on English care trusts as an example of a structural approach to integration.*

Design/methodology/approach – *All current care trusts' chief executives were invited to participate in a semi-structured interview exploring their experiences. Themes from the interviews were combined with findings from literature and policy review.*

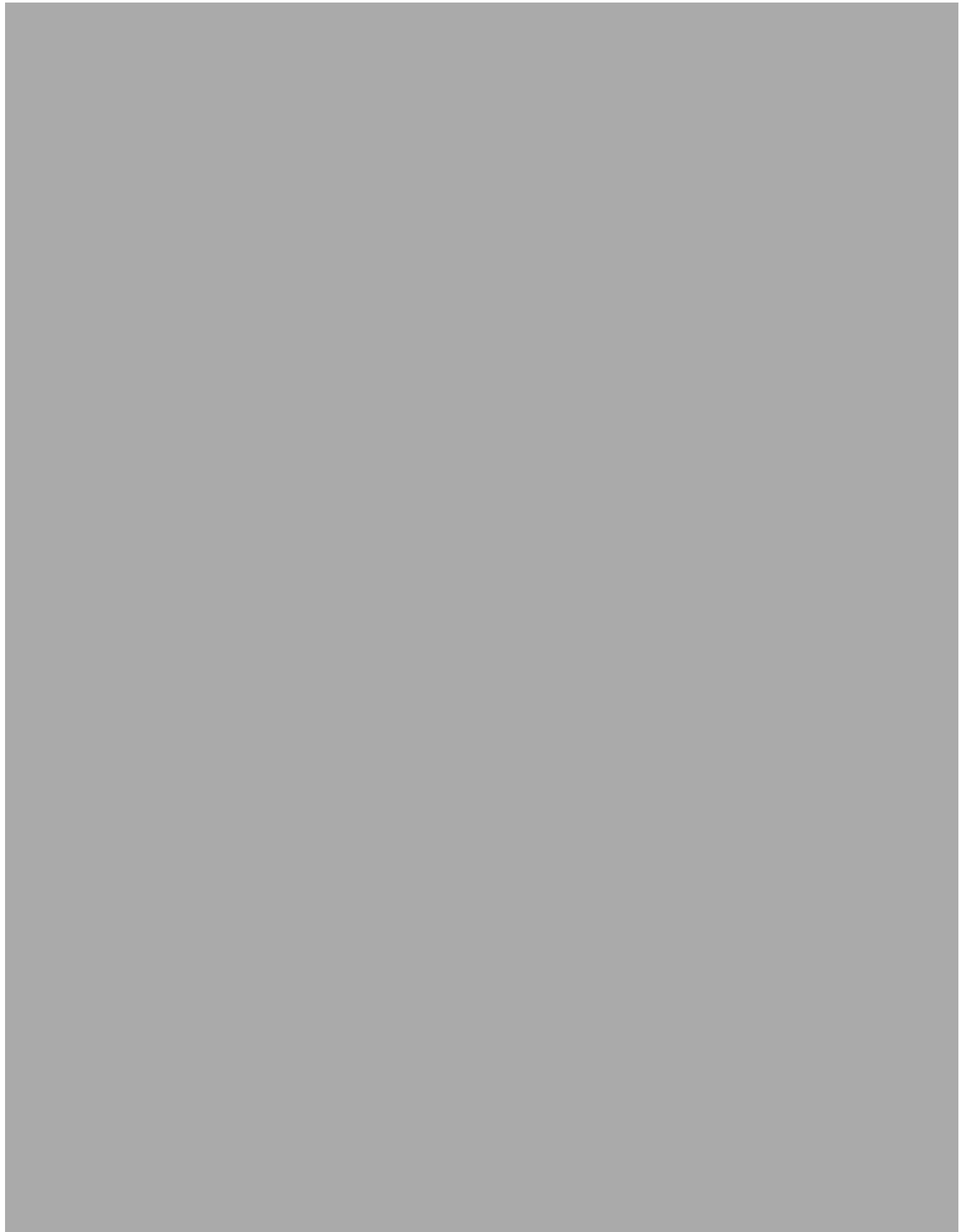
Findings – *The current care trusts can identify a number of advantages from combining health and social care into a single organisation. Equally, they also experienced many of the anticipated difficulties, and in hindsight half of those interviewed would recommend other options to achieving better integrated working. Whilst the "commissioning" function of care trusts will not survive beyond March 2013, "provider" care trusts look set to continue and indeed expand their service delivery. They will be joined both by new integrated social enterprises delivering health and social care.*

Practical implications – *The experiences of care trusts show the limitations of a single organisational structure as a means to achieve better integration and the impact of a changing national policy landscape on local initiatives. The findings suggest that the current legal flexibilities for integrated working should remain to enable local areas to decide how best to achieve their priorities and to realise the importance of addressing local cultural, practical and leadership issues along with structural barriers.*

Originality/value – *This paper provides a reflection on the ten years since the option of care trusts were available in England and adds to the current literature which focuses on individual care trusts' development and impact.*

Keywords *Care trust, Health care, Social care, Integration, Partnerships*

Paper type *Research paper*



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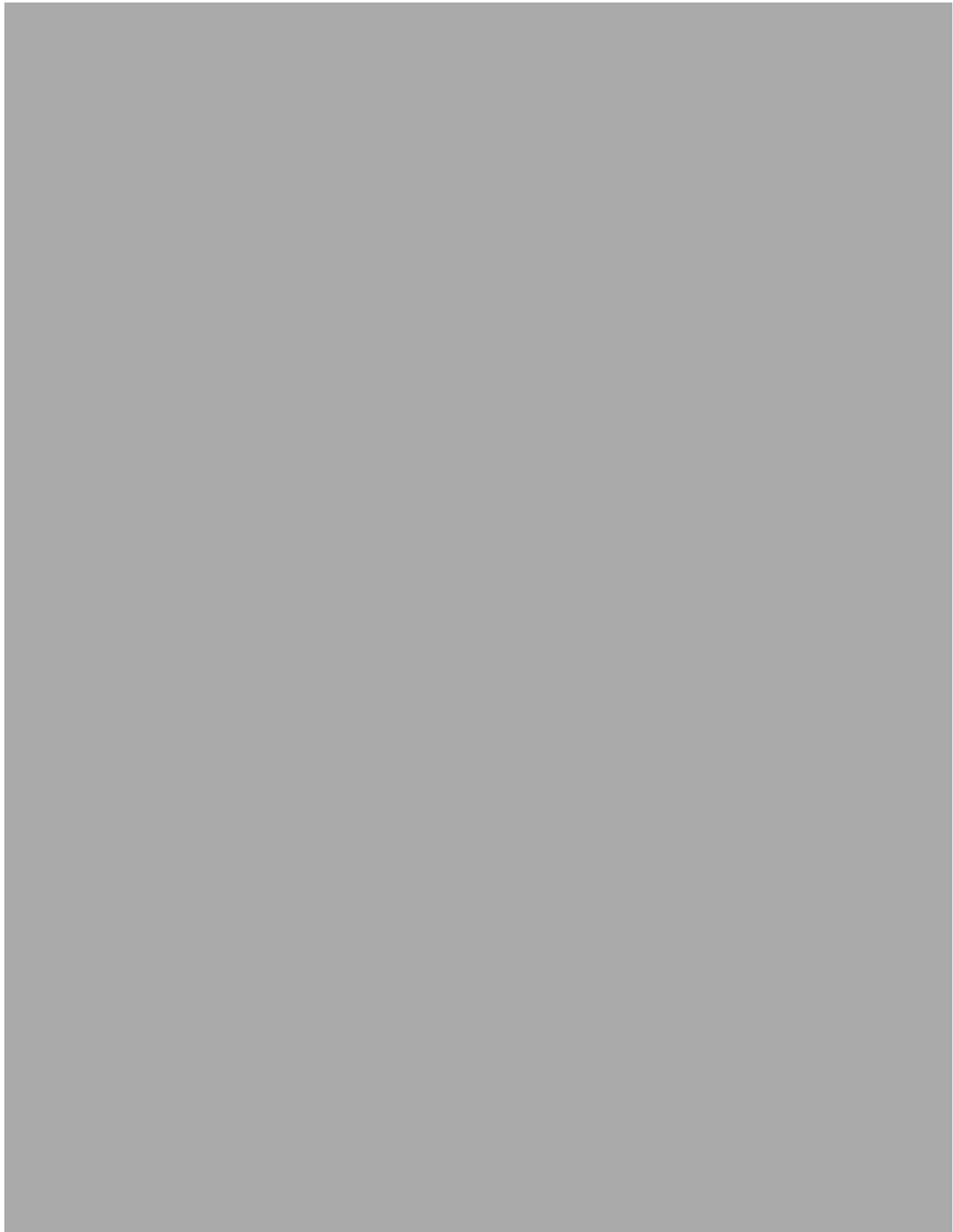
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2012 Highly Commended Award

presented to **Robin Miller**

for the paper "The care trust pilgrims"

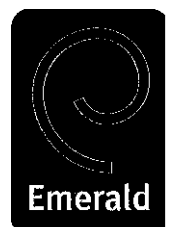
in the journal **Journal of Integrated Care**
Vol. 19 No. 4, 2011



Rebecca Marsh
Editorial Director
Emerald Group Publishing Limited



Jim Bowden
Emerald Literati Network Manager
Emerald Group Publishing Limited



Research you can use

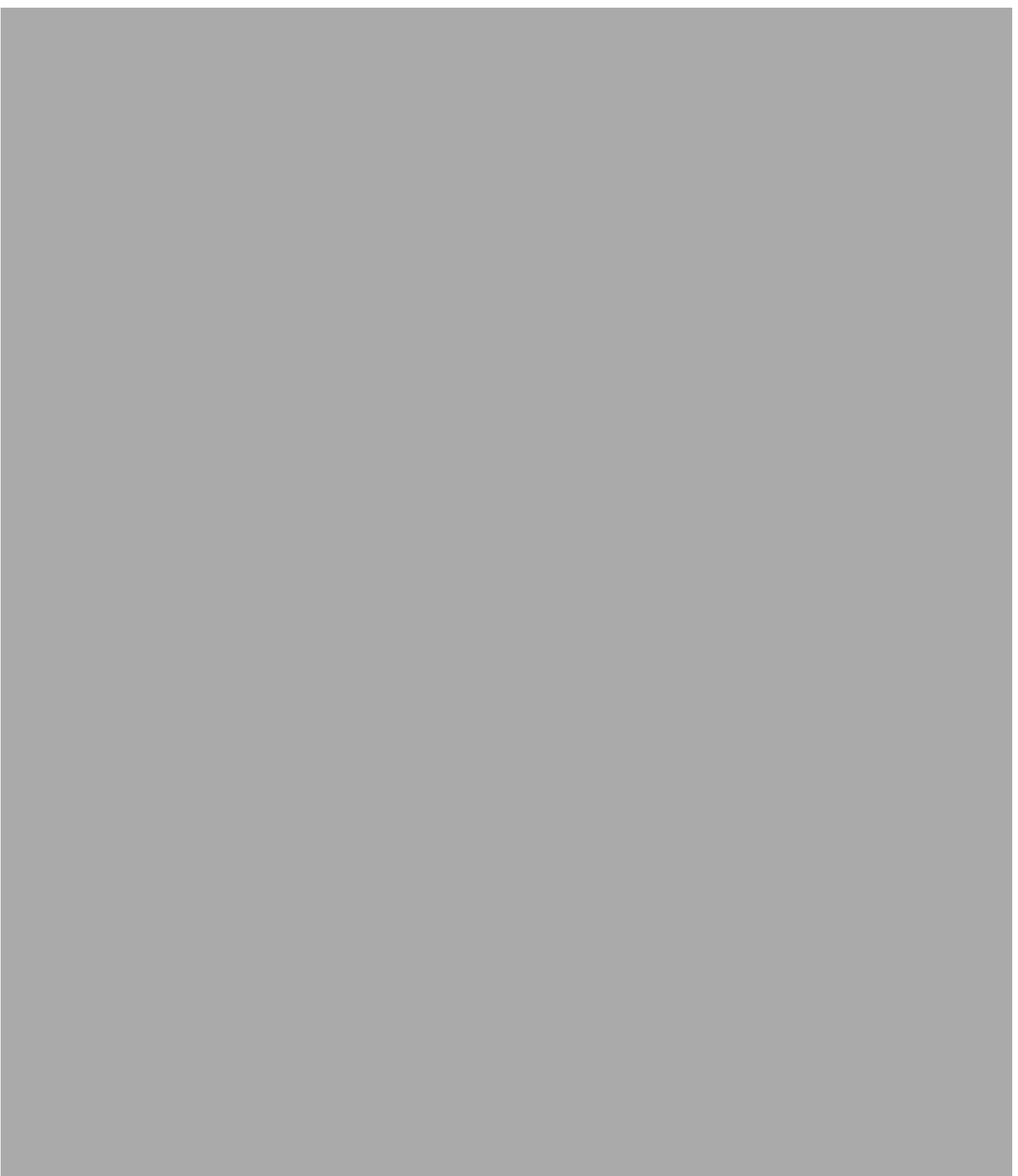
CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)

A large, solid gray rectangular area that occupies the majority of the page below the header. It is intended for the author to provide a confirmation of authorship for joint publications.



PUBLICATION 3

Miller, R. (2015), Changing organisational culture: another role for self-advocacy?. *Tizard Learning Disability Review*, 20(2), 69-76.



Changing organisational culture: another role for self-advocacy?

Robin Miller

Robin Miller is Senior Fellow at the Health Services Management Centre, University of Birmingham, Birmingham, UK.

Abstract

Purpose – Improvements in organisational culture are a common recommendation of enquiries into system failure and an aspiration of policy. The purpose of this paper is to explore an initiative to change culture in a low-secure service through the introduction of a self-advocacy group.

Design/methodology/approach – An independent evaluation was carried out by a university research team. A theory-based methodology was deployed with qualitative data gathered through observations, interviews and focus groups.

Findings – Culture change was reported by senior managers and clinicians in relation to the transparency of the service, decision making regarding resources, and engagement of patients in redesign. Self-advocacy group members reported a different relationship with senior management which in turn enabled greater influence in the organisation. Achieving these impacts relied on independent and skilled external facilitation, support from senior managers, and a calm and democratic atmosphere in the meetings. Ward staff were kept at an arms-length from the group and were less certain that it had made any difference to the way in which the ward operated.

Research limitations/implications – The research was only based in one organisation and the impacts of the initiative may vary with a different local context. Research in a wider sample of organisations and culture change initiatives will provide greater insights.

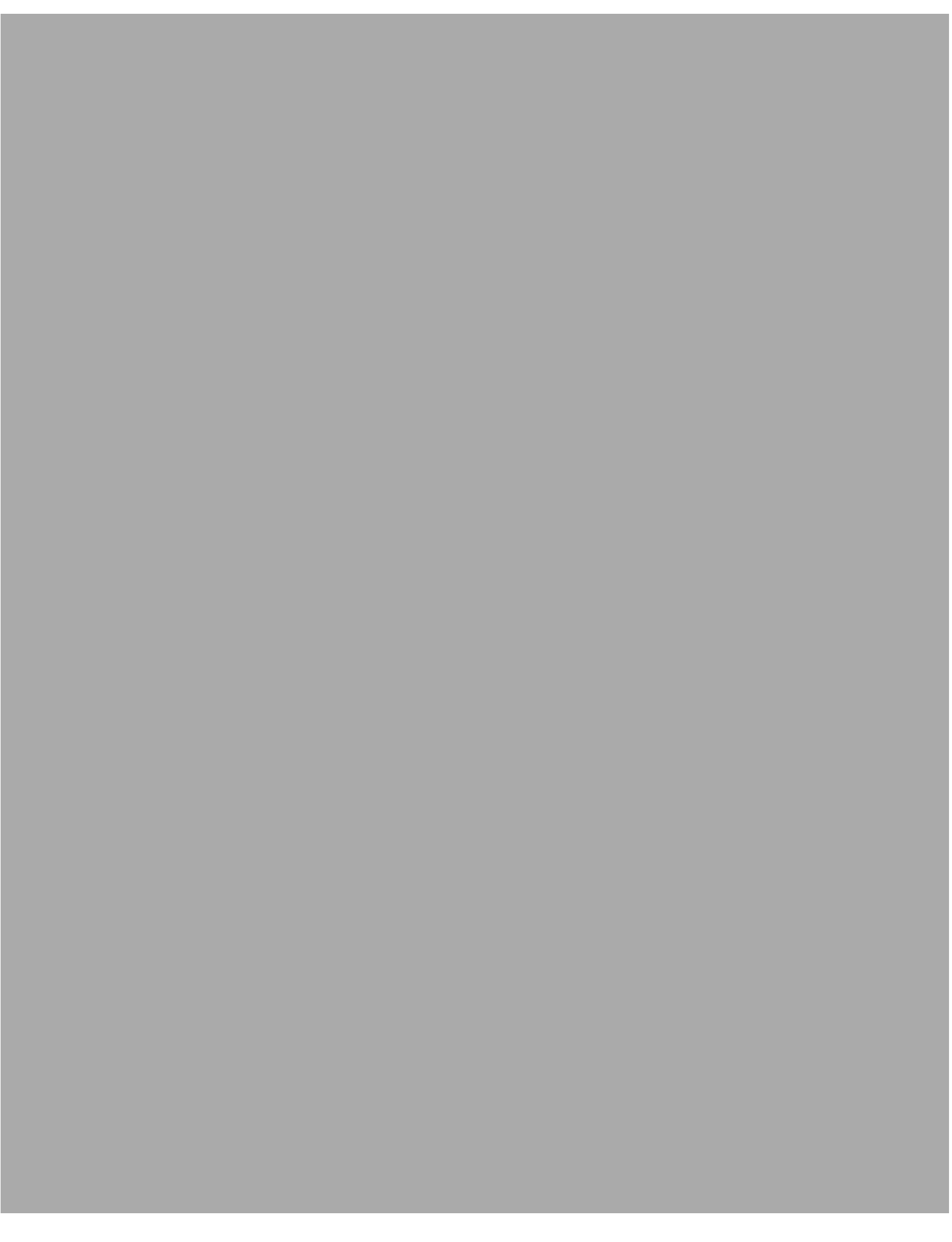
Practical implications – Self-advocacy groups can lead to organisation culture change alongside benefits for individual group members but require funding, external and independent facilitation, and organisational endorsement and support.

Originality/value – This paper adds to the limited literature regarding culture change in secure services and services for people with a learning disability in general and also to the understanding of the impact of self-advocacy groups.

Keywords Culture, Organizational change, Learning disability, Culture change, Low-secure services, Self-advocacy

Paper type Research paper











PUBLICATION 4

Miller, R., and Appleton, S. (2015), Multiple exclusion homelessness: is simplicity the answer to this complexity? *Journal of Integrated Care*, 23(1), pp23-34.

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Multiple exclusion homelessness: is simplicity the answer to this complexity?

Multiple
exclusion
homelessness

23

Robin Miller

*Health Services Management Centre, University of Birmingham,
Birmingham, UK, and*

Steve Appleton

Contact Consulting, Witney, UK

Abstract

Purpose – The purpose of this paper is to explore integration and complexity through the evaluation of a case study service which supports multiply excluded homeless people.

Design/methodology/approach – A mixed methods theory based evaluation. Data gathering included semi-structured interviews with external stakeholders, analysis of referral and outcome data, focus groups with frontline staff members and managers, and interviews with people living in the service.

Findings – The service was highly rated by its stakeholders due to its ability to meet the immediate needs of many individuals and to facilitate access and engagement with community and specialist resources. However, not every individual responded to the support that was an offer, and a number were unable to access the service due to the nature of their needs or a lack of capacity in the service. Whilst the service was able to engage community and specialist services this often appeared to be within the parameters set by these services rather than flexibly around the needs of the individual. **Research limitations/implications** – The research is based in one case study service and findings may not be transferable to different local contexts and providers. However, the findings are consistent with previous studies.

Practical implications – It is possible for commissioners to intervene in the complexities that multiply excluded homeless people experiences through the introduction of a new service. However, this is unlikely to address all of the gaps and fragmentation that people in these circumstances face. It is therefore important that partners are sensitive to such limitations and have a shared willingness to respond to continuing gaps and shortfalls.

Social implications – Despite specific national policies people continue to experience multiple exclusion homelessness which suggest that more still needs to be done to prevent people from this extremely disadvantaged social circumstance. Whilst specialist services can provide excellent support the response is still fragmented for some people meaning that work to better integrate their responses must continue.

Originality/value – The paper contributes to the evidence base of support models for multiple excluded homeless people and the factors that can enable a housing support service to respond to such needs. It also provides comment on the relevance of the concept of complex adaptive systems to the study of integration.

Keywords Commissioning of care services, Complex needs, Complexity, Integrated care, Housing related support, Multiple excluded homelessness

Paper type Case study

















CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)



PUBLICATION 5

Miller, R. Millar, R. and Hall, K. (2012), New development: spin-outs and social enterprise: the 'right to request' programme for health and social care services. *Public Money & Management*, 32(3): 233-236.

New development: Spin-outs and social enterprise: the 'right to request' programme for health and social care services

Robin Miller, Ross Millar and Kelly Hall

The 'right to request' policy encouraged and supported National Health Service (NHS) community health staff in England to 'spin out' services into independent social enterprises. This article considers the processes and outputs of the initiative and reflects on the likelihood of positive outcomes for patients being achieved. It highlights lessons for future programmes seeking to transfer services out of public ownership.

Keywords: English NHS; right to request; social enterprise; spin-outs.

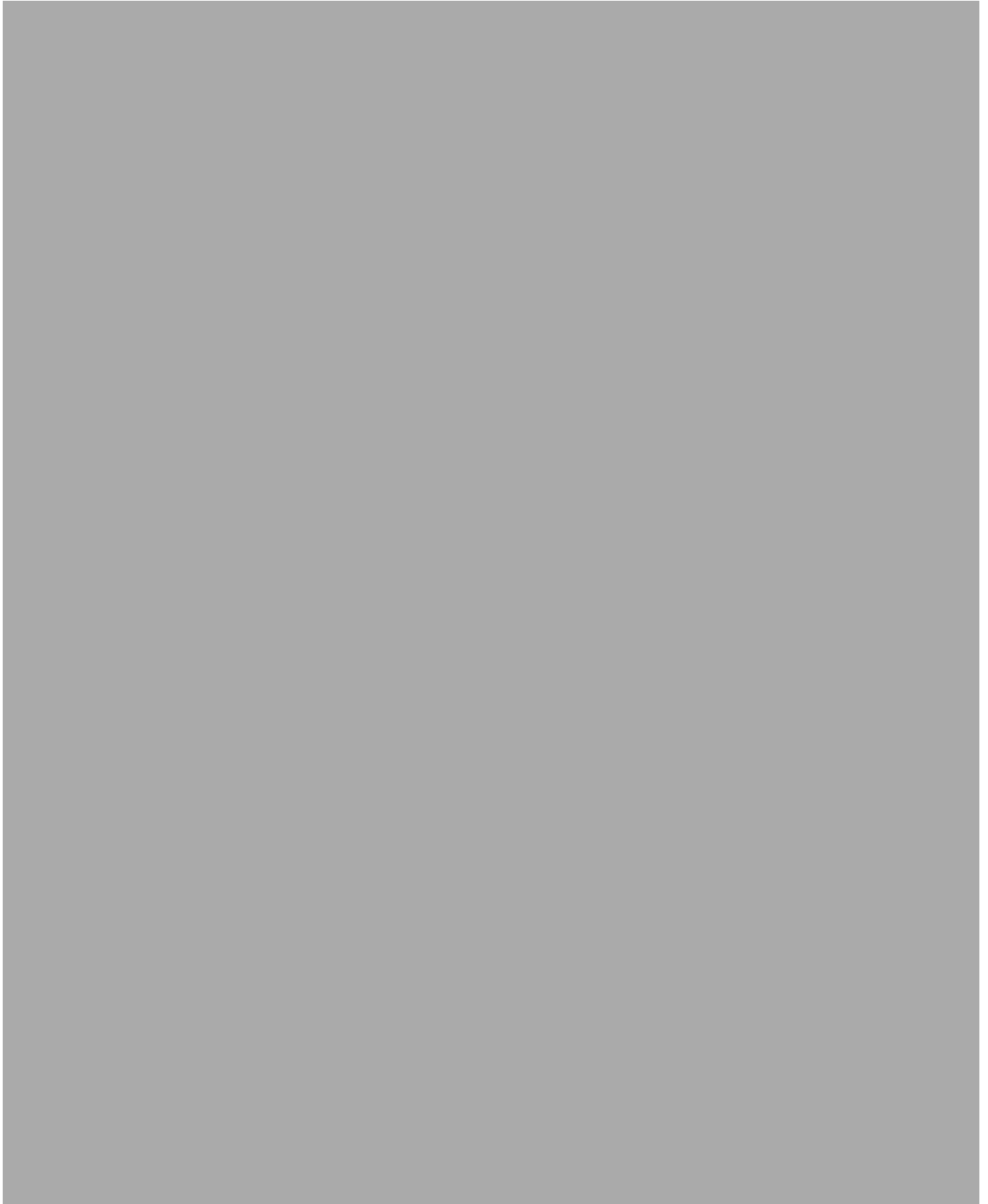
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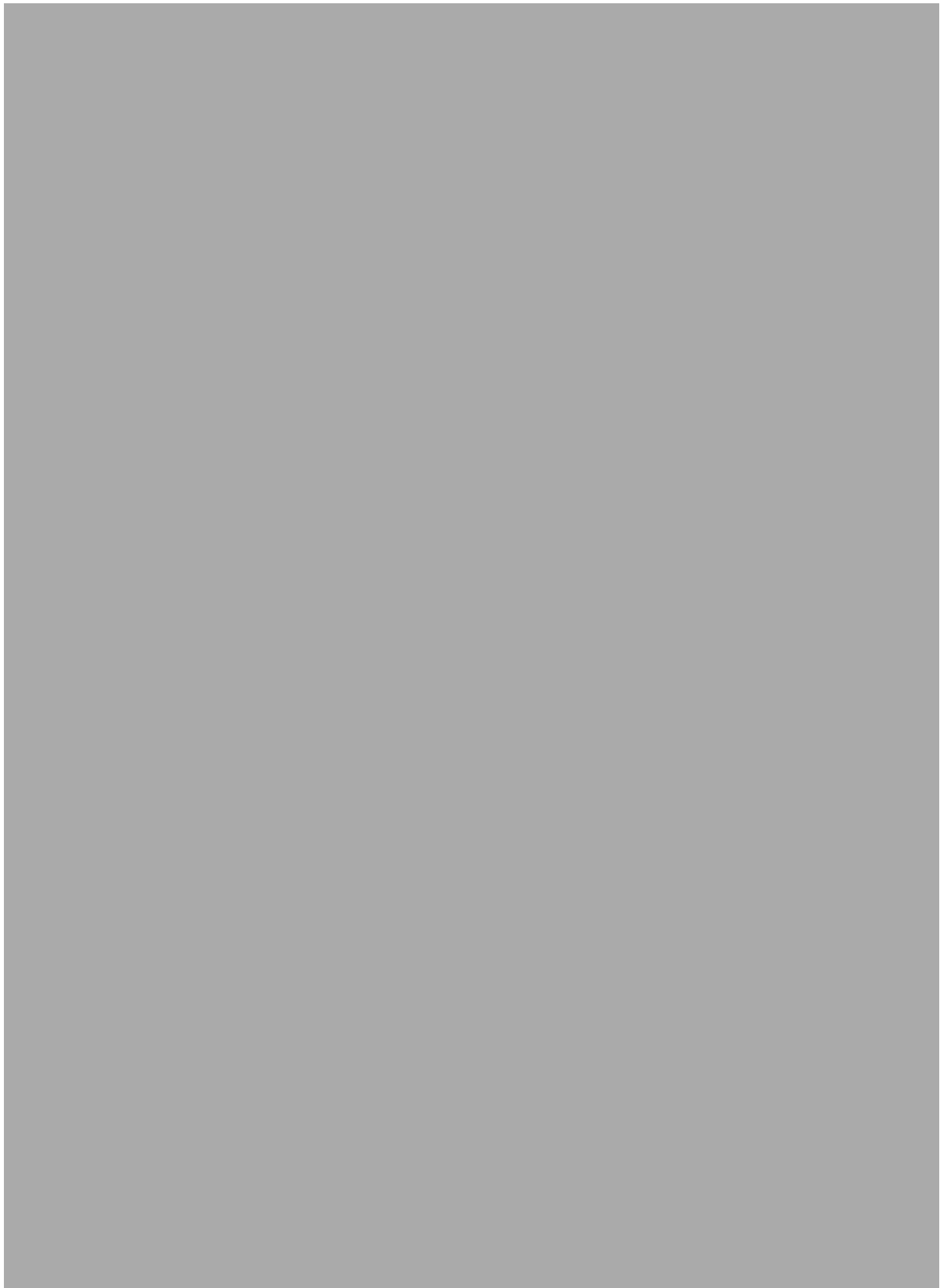
PUBLICATION 6

Miller, R. and Lyon, F. (2016), "Spinning with substance? The creation of new third sector organisations from public services", in Rees, J. & Mullins, D, (ed) *The Third Sector's Role in Public Service Delivery: New Roles and enduring challenges?*, Bristol: Policy Press.
(Chapter and book has been peer reviewed and accepted for publication).

Chapter 5 – Spinning with substance? The creation of new third sector organisations from public services

Robin Miller & Fergus Lyon







the 1990s, the incidence of *S. flexneri* has increased in the United Kingdom [10]. In the United States, *S. flexneri* has been reported to be the most common serotype of *Shigella* isolated from children with shigellosis [11].

There is a paucity of data on the epidemiology of *S. flexneri* in the United Kingdom. In the 1970s, *S. flexneri* was the most commonly isolated *Shigella* serotype from patients with shigellosis in the United Kingdom [12]. In the 1980s, *S. flexneri* was the most commonly isolated *Shigella* serotype from patients with shigellosis in the United Kingdom [13].

In the 1990s, *S. flexneri* was the most commonly isolated *Shigella* serotype from patients with shigellosis in the United Kingdom [14]. In the 1990s, *S. flexneri* was the most commonly isolated *Shigella* serotype from patients with shigellosis in the United Kingdom [15]. In the 1990s, *S. flexneri* was the most commonly isolated *Shigella* serotype from patients with shigellosis in the United Kingdom [16].

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the 1990s, the number of people in the UK who are employed in the public sector has increased by 1.5 million, from 2.5 million in 1980 to 4 million in 1998. The public sector has also become an important employer of people with disabilities, with 1.5 million people with disabilities employed in the public sector in 1998, compared with 1.2 million in 1980.

There are a number of reasons why the public sector has become an important employer of people with disabilities. One reason is that the public sector has a long history of employing people with disabilities. In the 19th century, the public sector employed people with disabilities in a number of different roles, including as clerks, typists, and stenographers.

Another reason why the public sector has become an important employer of people with disabilities is that the public sector has a number of different departments and agencies, each of which has its own specific needs. This means that the public sector can employ people with disabilities in a wide range of roles, including as clerks, typists, stenographers, and in a number of other roles.

A third reason why the public sector has become an important employer of people with disabilities is that the public sector has a number of different policies and procedures in place to support people with disabilities. These policies and procedures are designed to ensure that people with disabilities are able to work in the public sector on an equal basis with people without disabilities.

There are a number of challenges that the public sector faces in employing people with disabilities. One challenge is that the public sector has a number of different departments and agencies, each of which has its own specific needs. This means that the public sector can employ people with disabilities in a wide range of roles, including as clerks, typists, stenographers, and in a number of other roles.

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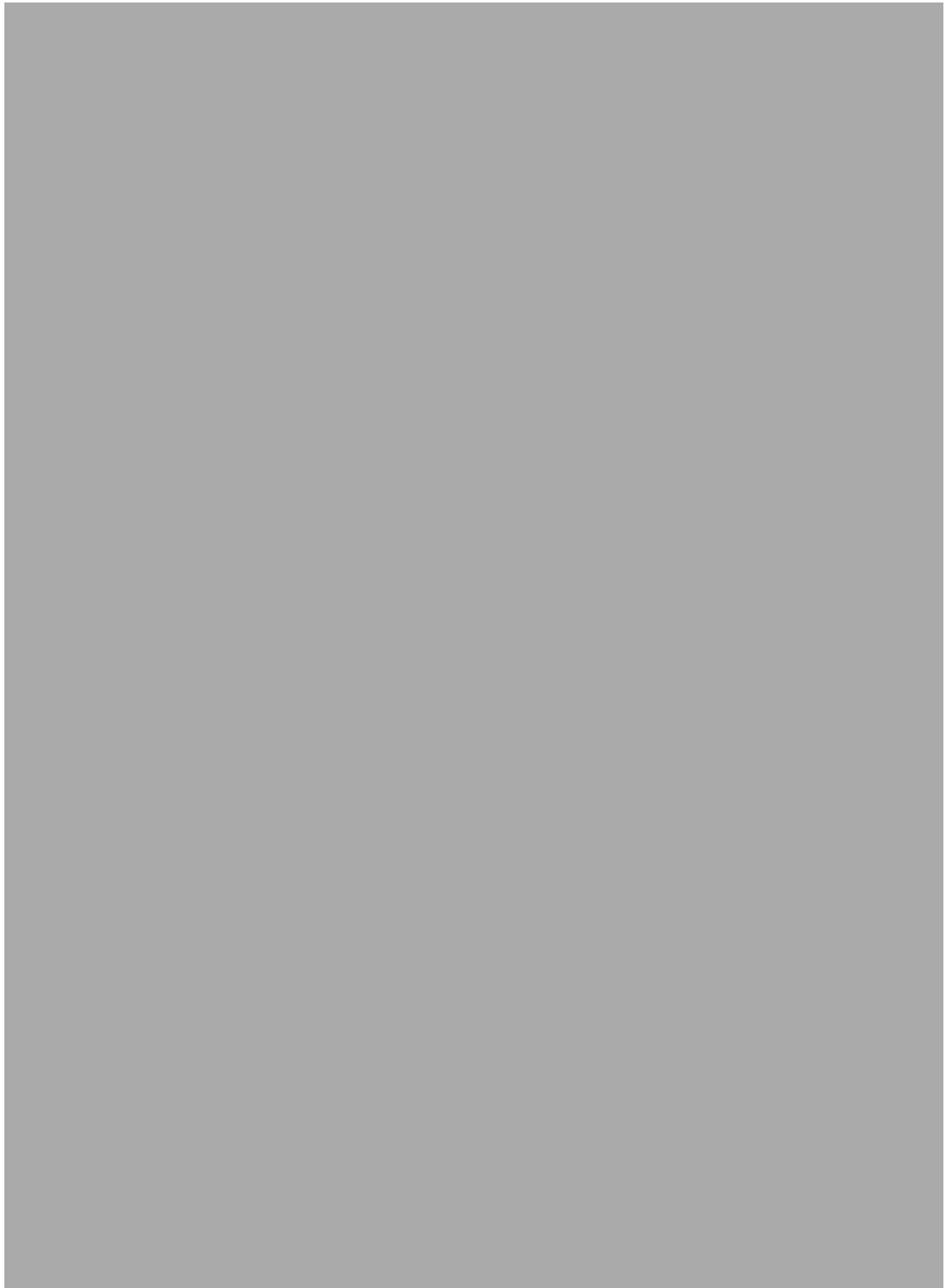
An eighth challenge is that the public sector has a number of different policies and procedures in place to support people with disabilities. These policies and procedures are designed to ensure that people with disabilities are able to work in the public sector on an equal basis with people without disabilities.

A ninth challenge is that the public sector has a number of different policies and procedures in place to support people with disabilities. These policies and procedures are designed to ensure that people with disabilities are able to work in the public sector on an equal basis with people without disabilities.

The first part of the paper discusses the importance of the research and the objectives of the study. It then presents a literature review of the existing research on the topic. The second part of the paper describes the methodology used in the study, including the data collection and analysis techniques. The third part of the paper presents the results of the study, and the fourth part discusses the conclusions and implications of the findings. The paper concludes with a summary of the main points and a list of references.

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The first part of the paper discusses the importance of the research and the need for a new approach. It then presents a detailed description of the methodology used in the study, including the selection of participants and the procedures for data collection and analysis. The results of the study are then presented, showing the effectiveness of the proposed approach in improving the performance of the system. Finally, the paper concludes with a discussion of the implications of the findings and suggestions for future research.

The second part of the paper focuses on the theoretical aspects of the research. It explores the underlying principles and concepts that guide the development of the proposed approach. This section provides a comprehensive overview of the state-of-the-art in the field and identifies the key challenges that need to be addressed. The theoretical framework is then used to inform the design and implementation of the system, ensuring that it is grounded in sound scientific principles.

The third part of the paper describes the practical aspects of the research, including the development of the system and the evaluation of its performance. This section provides a detailed account of the various components of the system and how they are integrated to achieve the desired results. The performance of the system is evaluated using a range of metrics, and the results are compared to those of existing systems to demonstrate the superiority of the proposed approach.

The fourth part of the paper discusses the broader implications of the research and its potential applications. It explores the ways in which the findings of the study can be used to inform the design and development of other systems and to address real-world problems. The paper also discusses the ethical considerations associated with the use of the system and the need for transparency and accountability in the research process.

CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)

PUBLICATION 7

Miller, R., & Rees, J. (2014), Mental health commissioning: master or subject of change?. *Mental Health Review Journal*, 19(3), 145-155.



Mental health commissioning: master or subject of change?

Robin Miller and James Rees

Robin Miller is a Senior Fellow, based at Third Sector Research Centre/Health Services Management Centre, University of Birmingham, Birmingham, UK.

Dr James Rees is a Research Fellow, based at Third Sector Research Centre, University of Birmingham, Birmingham, UK.

Abstract

Purpose – The purpose of this paper is to explore change within the commissioning of third sector mental health services in England.

Design/methodology/approach – A case study methodology based on survey and interview data of a sample of third sector organisations and commissioners within an English conurbation.

Findings – Normative commissioning models based on sequential cycles were not fully implemented with the main focus being on the procurement and contracting elements. There were examples of commissioning being an enabler of service improvement but overall it seems to have been limited in its ability to bring about whole system change. Barriers included commissioners' capacity and competence, ineffectual systems within their organisations, and fragmentation in commissioning processes between user groups, organisations and sectors.

Research limitations/implications – The case study conurbation may not represent practice in all urban areas of England and there may be particular issues of difference within rural localities. The view of private and public sector providers and those working in Commissioning Support Units were not sought.

Practical implications – To lead whole system change the commissioning function needs to be adequately resourced and skilled with better integration across public sector functions and organisations. Greater emphasis needs to be placed on implementing the full commissioning cycle, including the engagement of relevant stakeholders throughout the process and the practical application of outcomes.

Originality/value – This research adds to the limited body of empirical work regarding commissioning in mental health.

Keywords *Mental health, Change, Outcomes, Integration, Commissioning, Third sector*

Paper type *Research paper*



Mental Health Review Journal

2015 Highly Commended Paper Award

is awarded to

Robin Miller

for the paper

Mental health commissioning: master or subject of change?



Tony Roche
Publishing Director
Emerald Group Publishing Limited



Jim Bowden
Head of the Emerald Literati Network
Emerald Group Publishing Limited



CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)

PUBLICATION 8

Miller, R., Allen, K., Mangan, C. and Glasby, J. (2013), Singing from the same hymn sheet? Commissioning of preventative services from the third sector, *Journal of Integrated Care*, 21 (5), 288 – 299.





Singing from the same hymn sheet? Commissioning of preventative services from the third sector

Robin Miller

*Health Services Management Centre and Third Sector Research Centre,
University of Birmingham, Birmingham, UK*

Kerry Allen

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Birmingham, UK*

Catherine Mangan

*Institute of Local Government Studies, University of Birmingham,
Birmingham, UK, and*

Jon Glasby

*Health Services Management Centre, University of Birmingham,
Birmingham, UK*

Abstract

Purpose – The purpose of this paper is to explore the delivery of preventative services for older people from third sector organisations (TSOs) and the extent to which current commissioning arrangements enables the aspirations of policy to be achieved.

Design/methodology/approach – Semi-structured interviews with key-contacts within a sample of TSOs which had been identified by directors of Adult Social Services as delivering one of the top three preventative interventions in their local authority area.

Findings – There was evidence of considerable trust between local authorities and TSOs and as a consequence TSOs were given autonomy to develop holistic and integrated models of delivery that supported rather than diverted the TSOs' core missions. Both sectors found it difficult to set target outcomes and connected performance frameworks for preventative services. As a consequence a major element of the commissioning cycle is not being completed and TSOs cannot be confident that they are using their resources as effectively as possible.

Research limitations/implications – This study was based in one English region, and would benefit from being extended to other English regions and home nations.

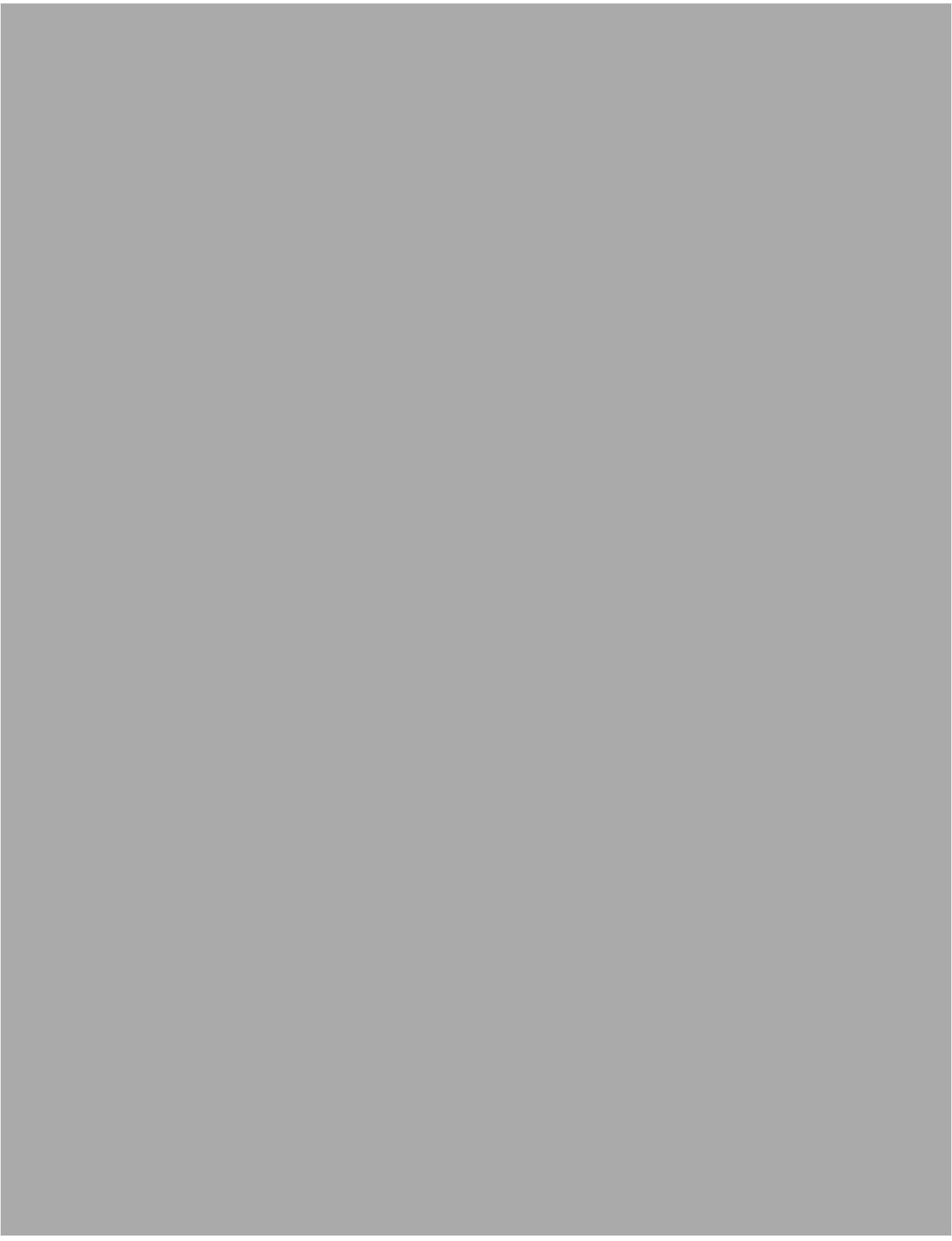
Practical implications – Universities, policy makers, commissioners and the third sector need to work together to develop common outcome frameworks for preventative services and to gather consistent data sets that can be more easily synthesised to give a “realistic” understanding of the impact of different interventions and delivery models.

Originality value – The paper contributes to the limited evidence bases of commissioning of TSOs and preventative services.

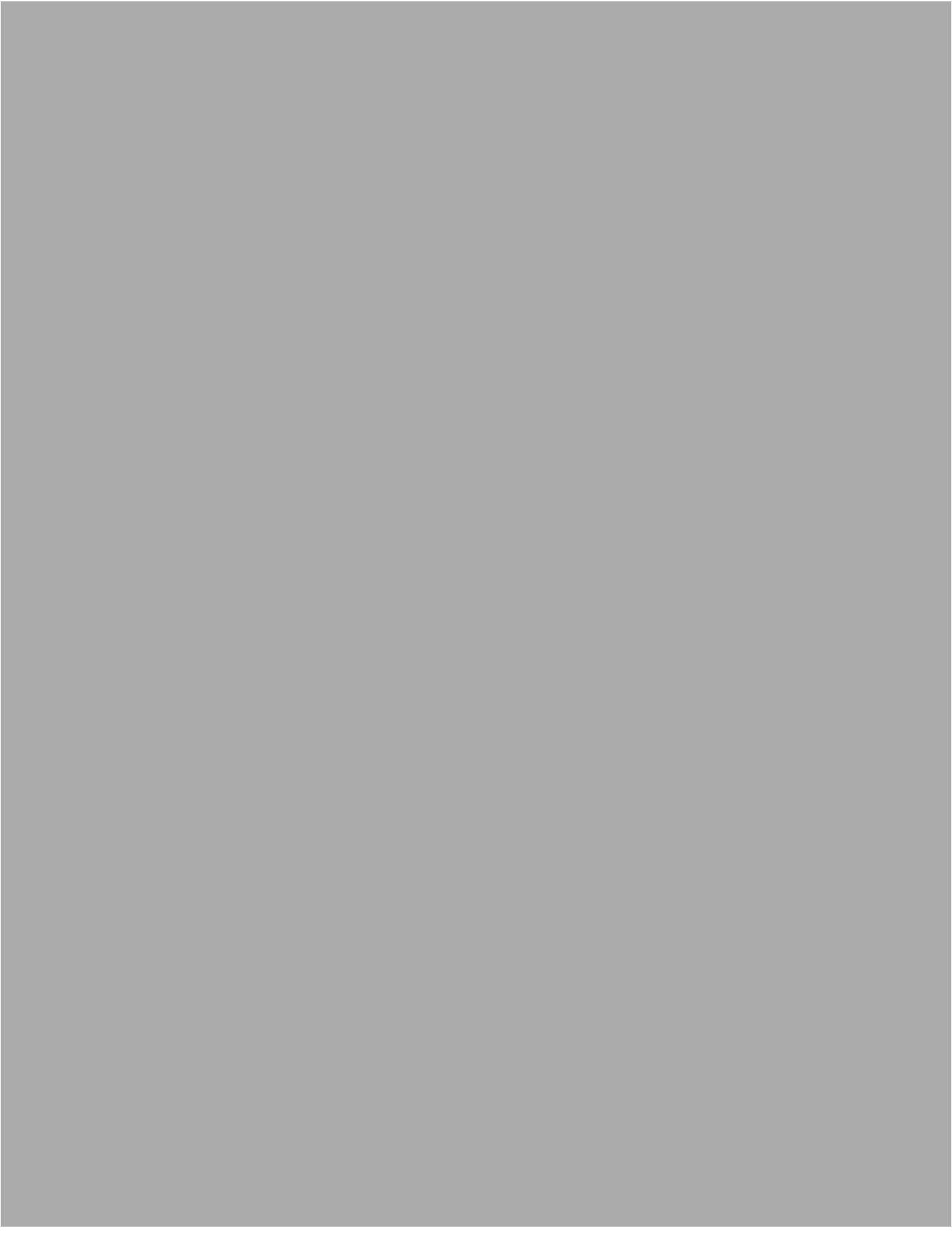
Keywords Older people, Outcomes, Integration, Third sector, Commissioning of care services

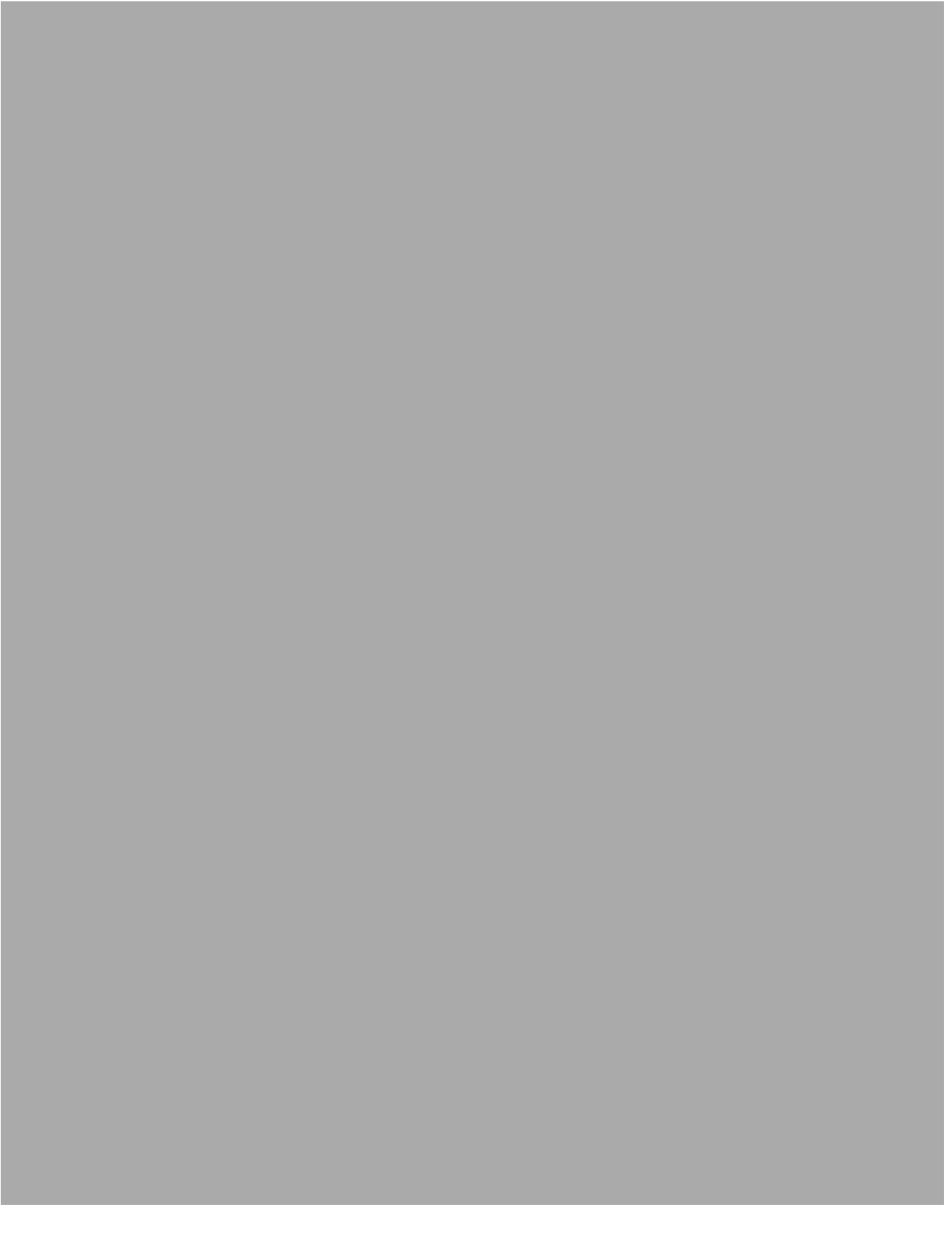
Paper type Research paper













CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)



PUBLICATION 9

Miller, R., Mangan, C. and Allen, K. (2013), *Older people's prevention services: Comparing perspectives of local authorities and the third sector*. London: NIHR School for Social Care Research.

Older people's prevention services: Comparing perspectives of local authorities and the third sector

KEY POINTS FROM THE RESEARCH

- n Overall TSOs and their local commissioners enjoyed positive relationships. They demonstrated shared understandings of their respective roles and largely met each other's expectations throughout the commissioning process.
- n Differences can be identified in commissioner and TSO provider perspectives of the main purpose of prevention. While local authorities tended to focus on preventing older people needing social care services in the future, TSO's emphasis was on improved quality of life for individual older people.
- n TSOs had holistic and wide ranging notions of what can constitute a preventative service for older people.
- n Both TSOs and commissioners found it difficult to set outcomes for preventative services and to understand how best to measure performance in achieving these.
- n TSOs stressed the importance of their relationship with the individual leading on the commissioning of their service area within the local authority.
- n TSOs displayed a strong interest in developing better outcome evidence, especially in an insecure funding environment. Sometimes with limited capacity and resources, they would welcome the potential of dialogue with commissioners and researchers to develop relevant frameworks.

Third Sector Organisations (TSOs) have historically played a significant role in the delivery of adult social care. Often seen to be associated with qualities such as strong community links, access to disadvantaged groups and innovative practice, TSOs remain a popular choice with local authority commissioners as providers of preventative services.

This study explored the views of both locally commissioned TSOs and national organisations providing preventative services for older people.

The research identifies positive aspects within the current arrangements but also gaps in respect of setting and understanding of outcomes and a reliance on personal relationships within the commissioning process. These shortfalls must be addressed if local authorities and TSOs are to ensure that they effectively work together to maintain older people's quality of life and prevent reliance on acute or long term care.

BACKGROUND

Third sector organisations (TSOs) continue to be substantially engaged in all aspects of social care delivery, including residential care and domiciliary care, in advocacy and representation, and in supporting people manage their personal budgets¹. A previous SSCR-funded study of social care services² identified that local commissioners sought little evidence around outcomes from TSOs who were providers of preventative

The study represents independent research funded by the National Institute for Health Research (NIHR) School for Social Care Research (SSCR). The views expressed are those of the authors and not necessarily those of the NIHR, SSCR, Department of Health, or NHS.

NHS
National Institute for
Health Research



services. TSOs were instead encouraged to develop their own ways of monitoring services and measuring impact. This contrasted to the arrangements for reablement services. These were seen as one of the top investments in prevention services by all the local authorities within the initial study and were largely directly provided by local authorities. Unlike the TSOs, reablement services had clear outcome targets based on the reduction of service use and improvements in the older person's quality of life.

In light of these findings this added value study set out to explore in more depth the commissioning of preventative services from TSOs by the public sector. It examined how the public and third sector understood the aims of such services and the extent to which their relationship helped or hindered these being achieved.

An overview of the preventative services provided by the TSOs in the study is provided in Table 1.

What is the purpose of preventative services?

Both parties recognised the important role of preventative services in maintaining or improving the quality of life of older people. However, there were differences of emphasis regarding the main purpose of preventative services. Local authorities viewed reduction in use of public sector (and in particular local authority social care) funded resources as the priority. For TSOs the most important impact was maintaining or improving the older people's physical and mental wellbeing and reflected the TSOs' missions and organisational values:

We work with commissioners all the time so I know that what they're looking at is – we've got reduction in beds; how do we keep people out of hospital? But I think there is a quality argument as well, which is that whatever country we're citizens of, then we should be enabled to have the best experience of being a citizen of that country, regardless of age (TSO).

What led to TSO services being developed?

Approximately half of the preventative services had been initiated by the TSOs and then funding obtained from the public sector.

The need for a service arose from gaps in provision being identified through TSOs' engagement with older people who participated in their networks and / or accessed existing services, with the TSO then developing a response to address this need (see Table 1). This was often approached in an emergent and iterative process in which the service response was refined and improved:

As part of that meeting with the service users, we used that to talk about the kinds of things that we were trying to develop and what services they wanted to see. We did that face to face. People also come into our offices through the restaurant, and they used to have flyers on the tables and things for people to come in to talk about if they were interested. So there's a number of different ways of finding out about people's want and then trialling them, piloting them (TSO).

This differed from the way that the local authority-based interventions, such as reablement and telecare, had developed. Although local factors were taken into consideration, managers of this type of intervention described a much quicker and less user-led process. National level guidance and funding processes were identified as having a much stronger influence in shaping the initiation, timing and model of these services.

The remainder of the services had been initiated by the local authority and then TSOs funded (sometimes through competitive tender) to provide this service. While the initial vision may have come from the local authority, the TSOs still had considerable flexibility in how these were actually delivered and integrated with their other service offers.

What was the relationship between local authority commissioner and TSO?

Expectations of local authorities and TSOs regarding their respective roles were largely shared. The overall relationship reflected the aspiration of third-public sector partnership outlined in 'intelligent commissioning' models, which emphasise the importance of TSOs being seen as partners and not just as contracted providers³. For instance, as hoped by commissioners, the TSOs appeared to be focussed primarily on benefits to older people rather than their own organisational growth,

Table 1 Preventive services provided by TSOs

TSO	Preventative service provided by the TSO	How was this initiated?	How is it currently funded?
A	Befriending through volunteers	From community development work	Largely local authority with occasional grants from other organisations
B	Befriending through paid worker	From community development work	Local authority funded.
C	Dementia cafes and support workers	Collaboration between local group and local authority	Local authority funded
D	Disabled facilities grants, handy man service, advice and information on repairs, organise and supervise building work, moving from large to smaller housing options	Local authority tender opportunity	Local authority with direct charging of older people for some services
E	Floating support and social groups	Local authority tender opportunity	Local authority
F	Older people led exercise and support groups	From consultations with older people	NHS
G	Information and advice, exercise classes, social groups, visiting service	Through consultations with older people	Local authority and income from insurance business run by the TSO
H	Advice, information and assessment in relation to assistive technology	Originally in-house local authority service and won tender	Local authority
I	Domestic work, shopping and gardening	Local authority approached TSO to deliver service	Local authority

engaged older people in order to understand service gaps, tried to respond flexibly and holistically, and were willing to openly share information on their performance with their commissioners.

Local authorities were generally not prescriptive about what was expected in terms of outcomes or overbearing in terms of required performance data, and seemed willing to give the TSOs the space to respond as they thought best to the needs of the older people concerned. All of the TSOs were delivering services that they saw as in line with

their core mission and which were funded by local authorities. Rather than forcing the 'mission drift' that has been associated with TSOs being reliant on public sector funding⁴, the commissioners were supporting them towards 'mission accomplished'. TSOs placed considerable value on the autonomy they had been granted to develop and deliver their services.

The relationship with the individual undertaking the commissioning role was seen as vital. TSOs were concerned about the overall funding for preventative services being

reduced or lost altogether, and the potential of competition from private and other third sector providers. Adding to this anxiety were changes in the key individuals through recent local authority restructurings which were thought to be putting their key commissioning relationships at risk:

...lots of people have left [the] council and there are no longer people there with knowledge of our organisation. This means we are trying to get time to explain what we do as they are not now aware (TSO).

What outcomes were being measured?

TSOs identified a desire for assistance in working out how to best measure the outcomes and impacts of their services. Some felt that despite having an intuitive understanding that they provided valuable services for older people, they were failing to capture the full impact.

In particular, interviewees reflected on the danger of assuming that if a service had been provided then the desired outcome, such as prevention of admission to residential care, had been achieved. To strengthen their approaches many TSOs were using externally produced tools and working with external evaluators. They would welcome greater guidance from their commissioners about what was expected from preventative services and from researchers regarding outcome frameworks for preventative services.

CONCLUSION

The relationship between local authority commissioners and TSOs appears to be principally one of trust and flexibility which has been developed through contact between individuals. However, both lack a shared understanding of how to set outcomes and

ABOUT THE STUDY

This study explored the views of nine locally commissioned TSOs and two national organisations, which provide preventative services for older people. Senior managers were interviewed about their views of the purpose of such services, how the TSO understood their impacts, and their experience of being commissioned by the public sector.

The results were added to previous research with local authorities to build a picture of the local authority and third sector relationship.

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Kerry Allen (k.allen@bham.ac.uk)

measure impact on beneficiaries. This limits commissioners' capacity to understand the preventative work of individual TSOs and may lead to missed opportunities to shape and improve the local health and social care system.

Within a financially pressured and turbulent policy context many TSOs in this study would welcome assistance in developing evidence about their outcomes, along with clearer direction about local commissioners' expectations.

A challenge remains in how best to help TSOs to set clear objectives and demonstrate their impact, without stifling their holistic and needs-driven approach to development and delivery.

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CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)



PUBLICATION 10

Miller, R. (2015), Liberating the change? A bottom up approach to improving general practice, *International Health Conference St Hugh's College, Oxford, 25-27 June 2015*

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Bottom up approach to improving general practice

Robin Miller, University of Birmingham
r.s.miller@bham.ac.uk



The background....

- Previously improvement in general practice (GP) was led / dictated by government / purchasers
- Current priorities - moving care out of hospital into the community, self-management, health promotion and prevention
- CCG membership organisations (CCGs) lead purchasing of secondary health care
- National body leads on primary care
- Larger provider configurations for GP



COMMISSIONER LED: *TOP DOWN*



PROS

- Consistency of expectation and availability
- Prioritise across conditions & groups
- Address provider self-interest

CONS

- Limited capacity
- Providers have expertise & insights
- Lose front line innovation by clinicians
- Hard to enforce in reality



“In the past I've put a lot of work into something but it went nowhere because it then went somewhere where I had no control over it ...it's just some decision was made somewhere that that wasn't appropriate at that time or somebody was busy doing something different”

”“We've always been a practice that tried to innovate... it can be frustrating sometimes when you feel that there's just no reward for innovation”

‘Achieving Clinical Excellence’

- CCG covers an inner city population of 715,000, 105 member practices & budget of £900 million
- Groupings of general practices given money per patient to deliver enablers and achieve patient & population level outcomes (& savings)
- No stipulation (initially) regarding how the broader outcomes were achieved
- Competitive process to be part of ‘pioneer’ programme

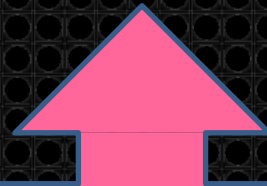


PROS

- Multiple ideas
- Greater connection with patients & communities
- Clinical innovations that respond to local need
- Speed of response
- Flexibility

CONS

- Inconsistency in quality & offer
- Conflict with interest as business
- Population inequalities may not be recognised
- Willingness to share



PROVIDER LED: *BOTTOM UP*



“Game changing, I mean, I don’t remember anything ever coming out in this manner with that degree of high level of trust....an opportunity to show that trust can be repaid back and we can make the change.. we know with this we have control over it and if we decide we want to do something we can make it happen”

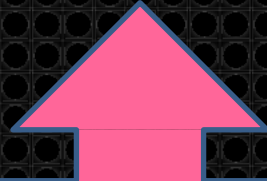
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INITIATED FROM THE TOP



ACE Programme



LED FROM THE BOTTOM



CONTEXT

Policy

Locality

Relationships

Quality

MECHANISMS

Grouping

Funding

Freedom

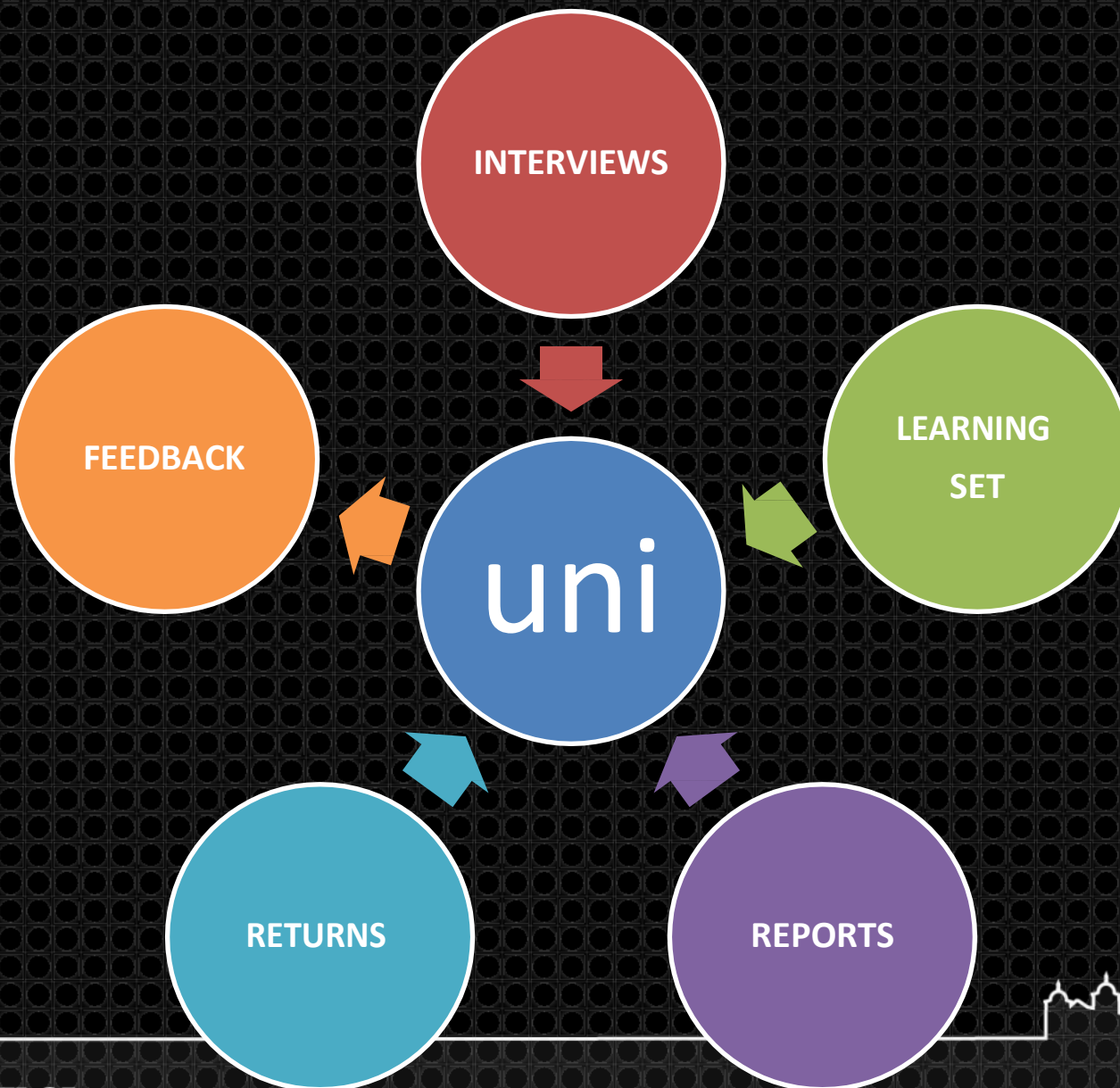
Learning

OUTCOMES

Quality

Holistic Care

GP Partnerships



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AN INSPIRATIONAL STUDENT EXPERIENCE AT A LEADING GLOBAL UNIVERSITY

MECHANISMS

GROUPING

FUNDING

FREEDOM

LEARNING

- Larger pioneers worked better
- No difference through formality
- Funding enabled innovation
- Feelings of unfairness
- Sense of liberation & autonomy
- New relationship with CCG
- Sets valued but also frustrating
- Anxiety about wider sharing

OUTCOMES

QUALITY

HOLISTIC CARE

PARTNERSHIP

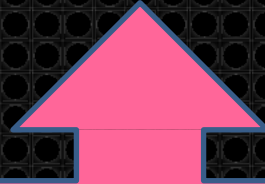
SAVINGS

- Improvements in local offer
- Variation in approach
- Local innovations but fragile
- Little progress with other agencies
- Strengthening of all groupings
- Inter-grouping relationships
- Some acute activity stopped

START

INITIATED FROM THE TOP

ACE Programme



LED FROM THE BOTTOM



MID-PROGRAMME

INITIATED FROM THE TOP



ACE Programme

LED FROM THE BOTTOM

END-PROGRAMME

INFORMED FROM THE TOP

**ACE Programme
Enablers,
Experience, Activity**

Local

LED FROM THE BOTTOM

UNFREEZE

Funding, threat,
competition



MOVE

Local variation &
innovation



FREEZE

More
detailed
specific-
ication
Acute
services
not funded

CONTENT

Congruent with best practice , local needs & aspirations of groupings

Process based targets
were divisive



PROCESS

Funding, competition, freedom (but with targets) & learning sets

Engaging wider membership

CONTEXT

Increasing competition, emphasise on scale & lack of funding

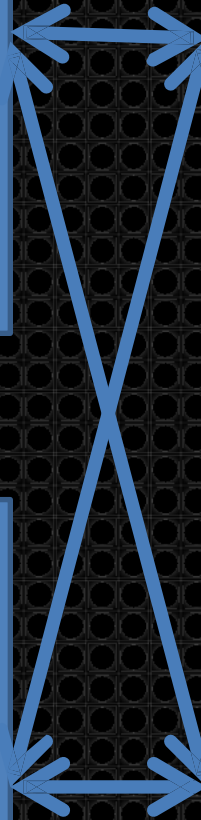
Sense of vulnerability within grouping



INDIVIDUAL ATTRIBUTE

Personal capacity – supported by formal infrastructure & backfill

Understanding of improvement



In conclusion....

“I'm aware that I actually have an opportunity to put some of these things into practice- before, I would just passively listen and say, 'I hope someone else is going to have a think about that.' But now, I know that I can make it happen.”

PUBLICATION 11

Miller, R., Mangan, C. & Brown, H. (2014) *Transformation of Residential Care Homes: Presentation of Stage 1 Findings*, HSMC: Birmingham.

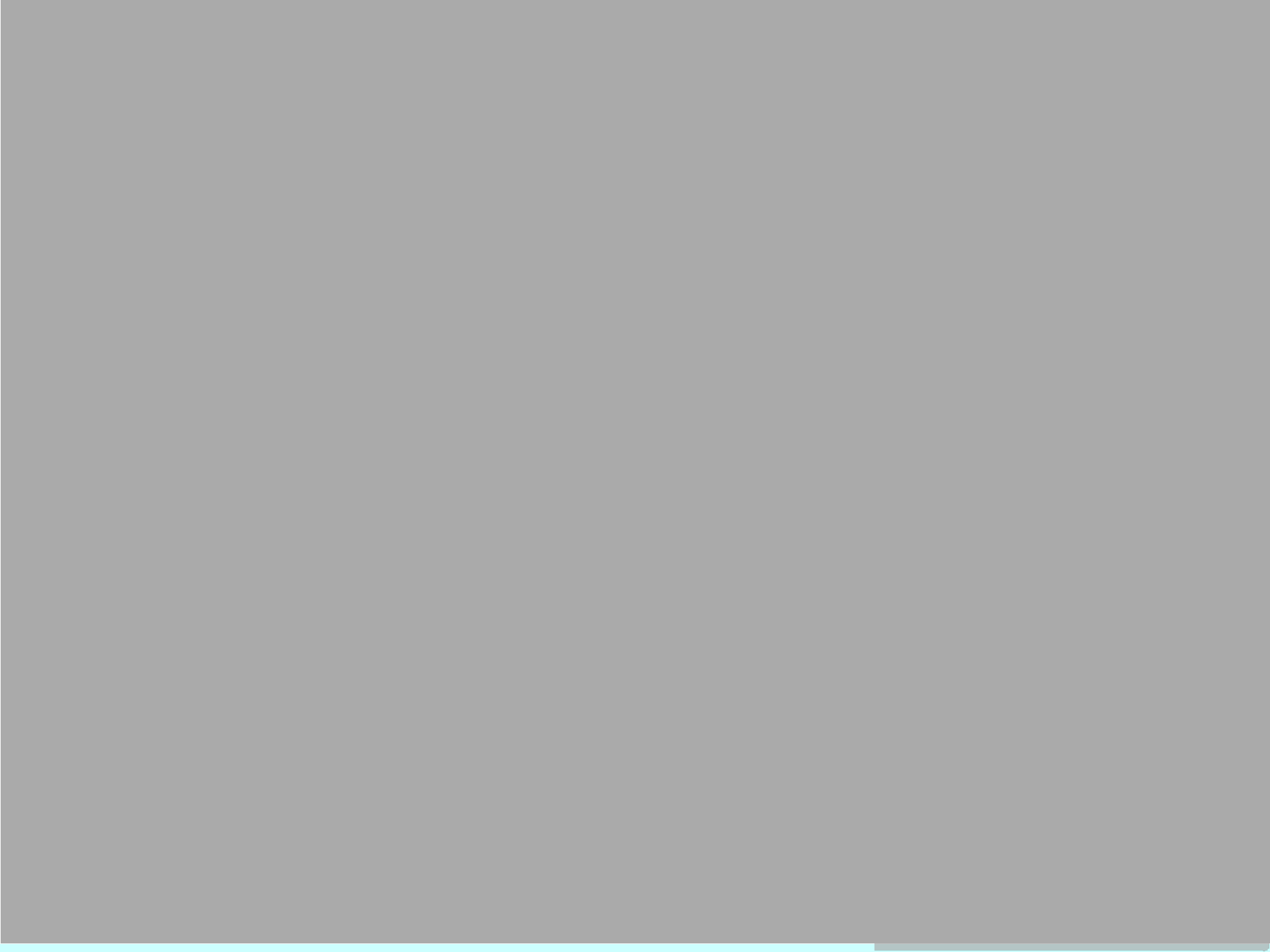
















CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)

PUBLICATION 12

Miller, R., Mangan, C. & Brown, H. (2014), *Transformation of Residential Care Homes: Final Evaluation Report*, HSMC: Birmingham.

CONFIRMATION OF AUTHORSHIP (JOINT PUBLICATIONS)

PUBLICATION 13

Miller, R. & Freeman, T. (2015), *Managing change in social care*, SSCR, London.

Research findings

Managing change in social care

KEY POINTS FROM THE RESEARCH

- n Successful management of change is a core requirement of the role of all adult social care managers in all settings and sectors.
- n Change management is less researched in adult social care than in some other industries and sectors, including health care, and lessons may not be always be simplistically transferrable due to the different contexts, challenges, stakeholder and cultures.
- n Organisational change often involves asking people to accept new arrangements that they may not be familiar with or indeed initially endorse. Agreed underlying principles are important to guide practice in such circumstances and to ensure that the values that undermine social care practice are maintained.
- n Organisational change and the setting of outcomes from such change should be co-produced with those who will access the services concerned.
- n A successful change process can be a means to develop trust between stakeholders and gather learning for future initiatives.
- n Action research, Appreciative Inquiry, Lean and Soft-systems Methodology are approaches which have potential relevance within adult social care services, but none are likely to work in all contexts. There are a range of management tools which can support their successful implementation.

This project aimed to address the gap in knowledge regarding organisational change in adult social care.

A review of general and social care specific change literature was completed and combined with discussions with people who lead change and those who have experienced it to develop a set of 'principles of change management in adult social care'.

Building on these, key 'approaches to change' (overarching frameworks to guide a change process) and 'change management tools' (methods to understand or support a specific aspect of the change process) were identified and subject to further literature review.

Four key change approaches were selected as being most likely to be consistent with the principles of social care change on the formal evidence of the literature review and the practice experience of the project stakeholders. The strengths and limitations of each are summarised below.

The full report of this project is a compendium of change in social care which includes reviews of relevant approaches and interventions and examples of how they can be applied to common change scenarios encountered by adult social care managers.

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- n Sufficient capacity and resilience of the team leading the change, good project management, and support from senior management are vital for any change approach to succeed.

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NHS
National Institute for
Health Research

BACKGROUND

Organisational change is an integral part of the life of a social care manager, either initiating within their own service or contributing to programmes begun elsewhere. Whatever their size, pace, objectives and approach, change projects encounter common challenges, including securing necessary support from key stakeholders, being clear about outcomes, co-ordinating activities to timescales, and sustaining improvements. While the process of organisational change appears difficult in most sectors, social care has particular complexities due to the vulnerability of many of the people it supports, its interconnections with other professions and agencies, and the public scrutiny of failings in its work. There is little empirical evidence on how change can be successfully achieved in social care organisations. This project sought help team and service managers by bringing together generic evidence on organisational change within academic literature and the experiences of those who have led and participated in such initiatives in adult social care.

FINDINGS

Social care change management principles

Organisational change management involves assisting people to move from an arrangement that is familiar and with which they may feel comfortable to something which is new, uncertain and which may initially feel threatening. This can lead to anxiety and stress being felt by people who access a service and their families, and also by staff who work in the services. Leading a change process is difficult, particularly when there are a range of options and a lack of agreement about which is the best one. It can be helpful for those responsible for leading organisational change to have a set of principles to guide the process they follow and their decisions. This reflects adult social care more generally, in which principles help to shape how underlying values (or 'what people commonly believe is worthy or valuable') can be applied in direct practice, including situations which are contested and difficult (BASW 2012). Common principles are the need to uphold the rights of all, to promote the welfare and inclusion of those who are disadvantaged, and to

ORGANISATIONAL CHANGE PRINCIPLES

Successful change management in adult social care should...

1. Be co-produced with users and carers and facilitate positive engagement with staff and other stakeholders
2. Be based on a clear purpose with defined timescales, outcomes and indicators
3. Be well planned and co-ordinated with flexibility to adapt to other changes that emerge
4. Be sensitive to local governance and political processes to ensure initial agreement and long-term support
5. Be an opportunity to promote learning and development, and develop trust and partnerships between stakeholders

recognise and build on the assets of individuals and their communities (Waine et al 2005). Principles can act as a common binding vision of what is important, a compass to guide direction and a standard by which those leading change can evaluate their practice.

As there was no agreed national set of organisational change principles in social care, the project team built on previous work by Skills for Care (2009), SCIE (2007) and the perspectives of change experts and wider stakeholder groups, to develop one (see Box). This were used to consider relevant change approaches highlighted in the literature and to develop guidance about how the selected approaches could be used in practice.

A literature review was completed to identify 'approaches to change' and 'change tools' commonly deployed within the field of organisational development. An 'approach to change' is defined as an 'overarching framework that can guide a change process' and a 'change management tool' as a 'method which can be used to understand or support a specific aspect of the change process'. Examples of the latter would be stakeholder mapping exercises, organisational diagnostic methodologies, engagement processes, and direct interventions. An advisory group including representatives of people who access services, wider partners, service providers and commissioners provided insight into change

within adult social care and the principles that should underpin it.

Consultation was undertaken with change practitioners and national social care leaders on the emerging principles and a short-list of approaches and tools identified, from which four overall approaches to change, and a number of tools, were selected and subject to further literature review. Finally, additional consultation with the advisory group and the change practitioners helped to identify change scenarios commonly encountered by adult social care managers which could be used to illustrate the practical application of the approaches and tools.

Four approaches to change

The four overall approaches to change selected are:

1. Action Research arose within the field of organisational development to better enable those affected by a change to participate in the enquiry and decision-making process. It seeks to analyse an issue from a range of perspectives, generate possible solutions, and test the ability of the chosen solutions to respond to the original issue. It involves cycles of collecting and analysing data, joint consideration of what can be learnt and taking action on the basis of these discussions.

Key strengths: Through seeking to engage stakeholders so actively action research can support the involvement of people who access services and their families in the change (principle 1). It is based on collective learning about an issue and so potentially promotes trust and partnership working (principle 5), and, therefore, may also develop a more holistic understanding of the issue and the desired impacts (principle 2).

Key weaknesses: There is a danger that the people leading the action research process can take on the role of experts and, hence, for their views to dominate (principle 1). The costs of working with an external party may prevent the approach being supported by senior managers (principle 4). Stakeholders may be reluctant to share more negative views within a collaborative process and therefore inhibitors of change may not be uncovered (principle 2). Finally, managers may set out to follow an action research process, but if they

are not aware of its core principles and methodologies they may be unable to implement it properly (principle 3).

2. Appreciative Inquiry (AI), in contrast to many traditional approaches to change which focus on what is not working as a means to avoid similar problems in the future, seeks to understand the positives and to use these as a platform for improvement. It is based on the premise that services will move towards the positive images that people have of them. It follows a process which seeks to identify the best of what could be, discuss what should be and then taking action to create what will be. AI seeks to overcome individual and team resistance to change through generating a common and inspirational vision, and does not start with a set premise about what the end result will be. Rather, the future gradually unfolds through conversations, stories and discussions.

Key strengths: AI emphasises the assets held by stakeholders, including people who access services and people who work in them, and the importance of involving them (principle 1). It has the potential to develop and strengthen networks between stakeholders, including senior managers and politicians and so create foundations for future action (principles 4 and 5).

Key weaknesses: Through not starting with set objectives it may conflict with the need for social care organisations to respond to specific expectations of policy and contracts (principle 2). People who are not involved in the process may find it hard to engage with radical proposals (principle 4).

3. Lean was developed initially within Japanese car manufacturing and has been used within a variety of industries including health care. It begins by seeking to understand the value of a service or process, primarily from the perspective of people who access it but also that of other stakeholders. Value adding activities are mapped out, along with those that are seen as wasteful through adding delay, duplication, and diversion from more beneficial activities. Lean is therefore particularly relevant for improving organisational processes, for example the referral, assessment and care planning pathways used by care management teams. As

well as removing waste, the change centres around developing 'pull' rather than 'push' in the system – i.e. the next stage in a process is ready to do the necessary task rather than only doing so because it is under pressure from early stages.

Key strengths: In understanding and enhancing the value of a services Lean can provide a clear purpose and objectives for a change (principle 2). Whilst senior support within an organisation is required, Lean is grounded in the views and experiences of people who access and work in services and therefore can be an opportunity to enhance their engagement (principle 1) and to learn together about what is important (principle 5). It emphasises the need to be structured in the improvement process and to break this down into achievable steps (principle 3).

Key weaknesses: If too focussed on adhering strictly to the methodology then lean practitioners can find it difficult to accommodate the complexity of social care (principle 3). The terminology within Lean and its industrial heritage can make it feel somewhat alien and lacking in relevance to users and carers, frontline staff, and indeed operational managers (principle 1).

4. Soft-Systems Methodology (SSM) was developed in response to 'hard systems approaches' that focus on using technology and processes to achieve objectives. SSM recognises that stakeholders may have different understandings of the purpose and problems of a service and, therefore, how it can be improved. SSM provides a process through which different stakeholder viewpoints can be shared in order to build agreement on what the changes will be. It does not assume that consensus can be reached but rather looks for compromises.

Key strengths: SSM emphasises the importance of engaging different stakeholders and valuing their perspectives (principle 1). Through encouraging dialogue and discussion it may also lead to people developing a fuller understanding and being more willing to accommodate the wishes of others (principle 5). As it makes the purpose of a change process clear, it creates the potential for the setting of clear outcomes and relevant measurements (principle 2).

Key weaknesses: Concerns have been raised about the time and cost implications of following the process which may make it difficult to get endorsement by senior managers (principle 4). There is also a danger that through seeking to take on board all viewpoints more radical and potentially unpopular changes may not be achieved (principle 2).

CONCLUSION

Through literature review and the experiences of those engaged in adult social care this project has identified four overarching approaches to managing change. However, none of the four approaches appear to fulfil all of the principles of social care change and, therefore, care needs to be exercised in their implementation. The lack of empirical evaluations of their adoption may reflect the limited awareness of such approaches by managers and their organisations. Greater awareness and confidence in applying different methodologies in isolation or combination will improve managers' competence to achieve change. It will also open the door to capturing practice-based evidence on what has worked and also what has not. Whatever the methodology, meaningful and sustained support from an organisation and its funders are vital to ensure change processes are not compromised. Ensuring those leading changes have sufficient capacity and resilience is crucial to enable them to see the process and future change projects through.

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PUBLICATION 14

Miller, R. (2015), "Prevention and independence in adult social care" in RIPFA (2015) *Re-imagining social care*, Totnes: RIPFA

Chapter Two

Prevention and independence in adult social care

Robin Miller

