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Framing a Movement for Improvement: Hospital Managers' Use of Social Movement Ideas in the Implementation of a Patient Safety Framework

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Introduction

It is widely acknowledged that programmatic improvements are difficult to realise in healthcare (Dixon-Woods et al. 2012). It is argued, for instance, that clinicians often resist changes that are imposed upon them, or appear to be motivated by managerial or political interests. Where changes are imposed they may have limited congruity with healthcare professionals, and perhaps most significantly they are seen as challenging professional values, identities and jurisdictions. To overcome these well-recognised problems of implementing and sustaining improvement, leaders of change are encouraged to create the necessary 'receptive context' or 'culture' for improvements to be realised (Pettigrew et al. 1992).

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Reflecting wider transitions in public sector governance, there has been increased interest in collaborative and participatory improvement methodologies that help create receptive contexts (Dixon-Woods et al. 2012). These encourage frontline clinicians to share unique insights and experiences through the co-design or co-production of 'bottom-up' improvements. This is exemplified by the Institute for Health Improvement's (IHI) Breakthrough Collaborative series, bringing together clinical 'learning communities' that participate in structured improvement activities to develop, implement and share best practice. More recently, it can be seen with the upsurge of interest in methodologies such as experience-based co-design, which offer an alternative to evidence-based top-down reforms (Bate and Robert 2006).

Within this context, there has been sustained interest in social movement strategies to engender 'grassroots' change. In broad terms, social movements are associated with collective action that is (usually) orientated towards changing established social or political institutions (Crossley 2002; Jasper 2010). For healthcare improvement advocates, social movements offer novel lessons for engaging and empowering clinicians to shape the implementation of service improvements (Bate et al. 2004a). The popularity of these ideas can be seen with the 'Million Change Agents' framework (Bate et al. 2004b), the NHS England (2016) 'Health as a Social Movement' programme and the Health Foundation's (2016) 'Q Fellows'.

Notwithstanding the potential for social movements to engender healthcare improvement and influence health policies more broadly, in this chapter, we hope to encourage policymakers, improvement advocates and scholars to reflect upon how social movement ideas are adopted and applied as a method of improvement. More significantly, we encourage advocates to recognise the 'dark sides' of social movements, to consider how appeals to empowerment and improvement associated with collective action can mask more insidious change, and to recognise that grassroots change is not always benign in intent.

Specifically, we suggest that the adoption of social movement ideas by some improvement advocates resembles an instrumental strategy for engaging and empowering clinical communities in relatively prescribed 'positive' change. This may exacerbate the undercurrents of power and

ideology inherent to healthcare systems and undermine the collective basis that social movements require. We elaborate this view, looking in particular at the way service leaders use framing strategies to orchestrate movement ideas to engage clinicians in 'grassroots' improvement (Wallace and Schneller 2008).

Learning from Social Movements?

For the purpose of our study, we conceptualise social movements as collective action that is manifest through networks of 'grassroots' activists, motivated by the desire to change prevailing social or political institutions (Crossley 2002). We also recognise that social movements can have conservative goals for maintaining social institutions, and may evolve from emergent local action to become developed 'social movement organisations' with formal leadership and structure. In the healthcare context, social movements have garnered attention because of their potential to challenge and transform institutionalised ways of organising and delivering care (Brown and Zavestoski 2004; Banaszak-Holl et al. 2010).

Of particular interest to our chapter is the way quality improvement advocates have adopted social movement strategies to achieve healthcare improvements. In their review chapter, Bate et al. (2004a) argue that many healthcare workers are engaged in top-down improvement initiatives that involve implementing centrally planned and managed change programmes. However, such initiatives often struggle to realise change because they fail to engage and enthuse frontline staff. As an alternative, social movements may tap into the 'latent potential' for change found across healthcare systems, and secure 'wider and deeper participation in a movement for improvement' (Bate et al. 2004a, p. 64).

Drawing on the work of Bate et al. (2004a, b), our chapter is interested in how framing strategies are used by service leaders to build movements for improvement. Frames are social constructs that, when communicated, influence how actors interpret and make sense of a given situation (Goffman 1974). The analysis of frames and framing is a prominent theme within social movement research, which examines

how collective narratives are constructed to shape the meanings and motives of individuals, and in turn align individual action with the aspirations of the collective movement (Benford and Snow 2000; Snow 2004; Oliver and Johnston 2000). In practical terms, Benford and Snow (2000) identify three core framing tasks: 'diagnostic framing', identifying the need for action or the problem; 'prognostic framing', defining the parameters of action; and 'motivational framing', identifying what drives engagement and sustained involvement.

Whilst early social movement research focused on the collective and organic nature of movements, thereby downplaying the role of leadership (Goodwin and Jasper 2014), contemporary research suggests that leaders are central to the formation and mobilisation of movements, especially in framing the need for change, inspiring and motivating diverse stakeholders, and devising strategies for change (Ganz 2013; Morris and Staggenborg 2004). For example, Zald et al. (2005) distinguish between senior leaders who determine the 'priorities' for change and middle-level leaders who identify 'possibilities' for change. Developing a more critical interpretation, however, it is possible to see leaders as imposing particular interests upon local communities rather than representing the interests of grassroots communities. This can be seen in (2015) analysis of the *Action for Happiness* movement, which shows how prominent national figures imposed aspiration for change onto local communities. In such cases, politicisation is far from 'bottom-up' but orchestrated by senior advisors.

The Case Study

Our chapter examines how healthcare leaders sought to 'build the movement' (Director of Nursing) to inform the implementation of improvement techniques. Our chapter is not concerned with the techniques themselves, rather the framing strategies used by leaders to engage and empower frontline clinicians in 'grassroots' improvement activities. The research involved an organisational case study of one NHS hospital's use of social movement approaches to implement a portfolio of quality improvement (QI) interventions. The hospital

was identified following a desk-based review of QI projects across the English Midlands, where three hospitals were identified as using social movement approaches.

The selected organisation was a medium-sized District General Hospital with around 500 beds, including medical, surgical, emergency and maternity services. Between 2013 and 2015, the Executive Board tasked senior hospital managers and clinical leaders with devising and implementing a revised QI framework that reflected policy recommendations, best practice and innovations in other sectors. The framework comprised of five elements: (a) a 'Stop the Line' and rapid problem-solving technique to address quality concerns (Sugimori et al. 1977); (b) PDSA cycles to address local improvement challenges (Walley and Gowland 2004); and (c) a new incident reporting system to document safety breaches for the purpose of organisational learning (Barach and Small 2000). These were supported by (d) a leadership development programme, and (e) a broadly conceived culture change programme (Berwick, 1994). Our study focused on the utilisation of social movement ideas as a means of implementing this QI portfolio. The implementation of this new framework was explicitly shaped by managers' conscious adoption of social movement ideas to communicate with and engage staff. In this chapter, we examine the framing strategies used to engage, enrol and empower staff in the change initiative.

Data were collected over twelve months and involved a combination of non-participant observations, semi-structured interviews, focus groups and textual analysis. An initial set of interviews (11) were carried out with senior managers (4), senior medical and nursing leaders (2), leaders of the change initiative (3) and quality and safety managers (2). These considered the development of the QI initiatives and the rationale for using a social movement approach. Observations were undertaken in hospital management offices, team briefings, training events and management meetings, focusing in particular on the interaction between management and frontline staff. Over ninety hours of observation were recorded in field journals. A second phase of data collection involved interviews (23) with 'campaign leaders' located across hospital departments, to understand the further operationalisation of the communication strategy. Finally, three focus groups were undertaken with staff from

different areas of the hospital, including two focus groups with nursing representatives (10), one with allied health professionals (4) and one with support and administrative staff (5).

Observation records, verbatim transcripts and selected documents were analysed following an interpretative approach (Corbin and Strauss 2014). This involved coding data to describe the framing strategies of leaders and to understand the effect on the wider workforce. Our analysis looked at the way service leaders, following a social movement approach, constructed and communicated framing strategies as a means of engaging and empowering frontline clinicians in a supposedly 'grassroots' improvement campaign. The analysis was informed by Benford and Snow's (2000) classification of framing tasks, where we look at the ways problems are diagnosed, interventions are promoted as offering solutions and beliefs and values are articulated for securing commitment. Although we present these as distinct activities, in many cases they overlapped, with diagnostic frames juxtaposed or interwoven with prognostic frames. We then look at the responses and reactions of frontline clinicians to these different framing strategies, especially whether they help build a movement.

Building a Movement for Improvement: Managers' Framing Strategies

To introduce the findings, it is useful to describe the broader context of managers' framing activities. As outlined above, senior hospital managers had devised a new Quality Improvement (QI) portfolio in response to external and internal pressures for change. Whilst developing this, managers reflected on the past difficulties of implementing QI methods within the hospital, and actively sought innovative methods to engage staff and support the uptake of change. Senior managers reported appraising various approaches, ultimately deciding to follow a social movement-type approach. This idea reflected some senior managers' broader understanding of social movements and also the growing popularity of social movement methods in health improvement. In following

this approach, managers developed a range of engagement and communication activities, including workshops, training, celebrations and pledge campaigns. This included the formation of local action groups (LAGs) to 'spread the word' across the hospital. We examine the type of framing strategies used when engaging staff both directly in a variety of forums and indirectly through communication media.

The Patient Safety 'Problem'

In the early days of formulating their 'campaign' to promote the QI framework, managers' interactions with staff tended to highlight two problems. The first and most prominent of these related to patient safety. This was framed in ways that linked broader external pressures to internal issues. The apparent consequence of this was that managers presented themselves as reacting or responding to the need for change, not as the originators of change. In other words, they distanced themselves from the pressures for change.

Looking more closely at how managers framed the problems of patient safety, three interlinked issues stood out in their communications with staff. The first related to the problems experienced in other hospitals and the idea that patient safety was a system-wide problem. As one manager suggested:

> [we need to] remind staff that we are not immune to the problems faced by the wider health service.

The recently published inquiry into poor quality care and patient deaths at Mid-Staffordshire hospital (Francis 2013) provided a powerful reference for managers when engaging with staff. In training and induction events, for example, managers talked about the risks of 'being another Mid-Staffs'. Managers also made frequent references to the 'headline' findings and recommendations from the inquiry, such as the duty of care that all professionals should have for their patients. In this way, managers seemed to be linking the high-profile experiences of this

hospital to the need for change, or rather renewed professionalism, within the everyday practices of frontline clinicians to 'safeguard their patients'.

> We have to do these things, we can't afford to be another Mid-Staffs … good is not good enough. That's our mantra. (Manager of Quality)

The second way managers presented the problem of patient safety was to emphasise broader changes in the policy and regulatory landscape. In management briefings, for example, senior managers explained to departmental managers and clinical leads about the expectations and requirements of agencies such as the Care Quality Commission (CQC), and local care commissioning, professional associations and patient representative groups. A forthcoming visit from the CQC was often highlighted as a major driver for change and precipitating the introduction of the new QI framework. Again, managers seemed to distance themselves from the root cause of the change, and present themselves as a 'buffer' between the demands of external 'inspectors' and the internal changes needed across the hospital.

> So, we know the CQC will be paying us a visit and we need to get our house in order. They will be looking at all our governance arrangements … so we all need to make sure we are on top of our game. (Operations Manager)

In contrast, the third way managers talked about the problem of patient safety was with reference to specific issues or concerns detected in the hospital. These were discussed in general meetings, but more often when engaging with clinicians and leaders from individual departments. For example, when meeting with leaders from the operating theatres reference was made to a recent incident involving missing swabs, and when speaking with doctors and nurses of the elderly care ward reference was made to patient falls. In this way, hospital managers used existing incident reporting and risk management data to link the wider expectations for change to local issues that front-line clinicians could

identify with. This not only made the need for change seem more real to clinicians, but also made it difficult for clinicians to offer any opposition; as managers seemed to be targeting documented 'problems' within these areas to justify change:

> We know you've had problems, every department has … things like patient falls will happen… What you've got to do is make it so they are less likely to happen and when they do happen we all learn. (Presentation to Care of the Elderly Ward)

There was also evidence of subtler diagnostic framing around the problems of implementing change and improvement within the hospital. This was largely overshadowed by the broader problems of patient safety, but it had an important role in justifying the particular 'campaign' approach adopted by managers. A common concern amongst managers was that they felt front-line staff were 'fed-up' with change, and that there was change fatigue across the hospital:

> We know you have had a lot of change to deal with. We've tried several things in the past and not all of them have been as successful as we hoped but that doesn't mean we can stop trying to do things better.

Managers also explained to staff that many of the problems of implementing change in the past were down to the naïveté of senior leaders in thinking change could be imposed upon staff or that structural changes were the only way to change frontline practices. By highlighting their previous shortcomings, managers seemed to be representing themselves, and the approach now being taken, as in some way different or more mature. In several meetings, for example, managers talked about their own learning, which largely centred on recognising that change had to come from the clinicians themselves, and that managers could, at best, support and facilitate the change process. Again, this seemed to de-emphasise the agency and influence of managers, and relocate responsibility for improvement with frontline clinicians:

> It has to come from you. I can't make your service safer. Only you know what is going on, and my role is to make it easier for you to make things better.

Learning from Others for Grassroots Improvement

To communicate with staff about the problems facing the hospital, it was common for hospital managers to promote ideas and solutions for how these 'diagnosed' problems might be resolved. This type of prognostic framing focused on the potential for certain interventions to enhance patient safety, but also included more subtle suggestions about how frontline staff might implement these interventions.

Managers' interactions with staff often involved explaining and justifying the proposed QI framework: Stop-the-Line, PDSA, incident reporting, leadership development and culture change. This was framed along three lines. The first was to argue that these solutions were based on QI methods developed and used successfully in other 'high-risk' or 'high-performing' industries. In training sessions, for example, both senior and departmental managers highlighted the 'proven' benefits of the Toyota Production System (or Lean Thinking), how PDSA was internationally recognised as an effective method of problem-solving and how incident reporting was commonplace in the aviation sector. These lines of reasoning are widely accepted and resemble something of a cultural trope within the 'folklore' of QI, articulating unquestioned assumptions about the benefits of 'borrowing' improvement methods from other sectors:

> We have had this [incident reporting] for several years now, but we are far off the likes of BA or Virgin in their safety reporting. It's not just about the serious events, it's the everyday things that we take for granted. (Departmental Manager)

The second framing strategy used to justify the proposed methods focused on the way such improvement methods had already been successfully translated and adopted:

> Look at the car industry. They have been doing these kinds of improvement works for decades and look at how things have improved. Not just car safety, or airbags, you know, but the way they are made, with fewer and fewer defects. (Quality Manager)

For managers, this demonstrated that these ideas could be effectively integrated into healthcare practice, and that their hospital could replicate the performance improvements witnessed at other exemplar hospitals. Although reference was occasionally made to other regional NHS hospitals, especially a local teaching hospital, managers more often talked of the approaches developed in famous US hospitals, such as the Virginia Mason hospital. One Quality Manager frequently made reference to Charles Kenney's book *Transforming Healthcare* which described the improvement made at Virginia Mason. This text took on some form of sacred status with senior hospital leaders and the Quality Manager distributed copies to department leaders and trainers.

> It's a brilliant book. It shows how hospitals can, or should be run. It's not rocket science or anything, really, but what is impressive is how they have achieved it. (Manager of Quality)

The third justification for adopting the proposed QI framework centred on the recommendations made in recent high-profile patient safety reports and inquiries, especially the Mid-Staffordshire Report (Francis 2013). In particular, managers focused on the need for culture change, so that patient safety, compassion and the sense of duty was central to all aspects of work. Significantly, managers seemed to suggest that the most effective ways to create a safety culture were through embracing the proposed QI interventions, because, as outlined above, they have proven utility in assuring safety.

As well as justifying the proposed QI methods themselves, managers also talked with staff about how these methods could be more effectively implemented through staff taking greater responsibility for QI:

> We have got to become a safer service, where patients can feel confident in the care we give to them. You can do this easily by reporting things

> that concern you, by putting your hand up and saying 'stop' when you are concerned, by constantly asking questions of how you can make patient care better. (Trainer)

Although managers rarely talked openly with clinical staff about following a social movement approach, they often talked about the change process as a 'campaign', asked staff to 'pledge' support and routinely made reference to the idea that frontline staff could take ownership of interventions.

> The Trust has thought a lot about how we can work together, we really want to avoid a sense of you and us… We want to help you to help yourselves. And that's what we think the framework will do. (Quality Manager)

Considerable emphasis was placed on providing staff with a broad 'set of tools', but with the espoused expectation for frontline staff to use these tools within the context of pre-existing clinical governance. As such, managers presented themselves as supporting and enabling, rather than commanding or managing staff. Part of this was to encourage staff to participate in LAGs, which championed the proposed QI methods and offered focused training and support for clinical departments. Although these groups appeared to be concerned with supporting clinicians to work with specific QI methods, it was also clear that they offered staff limited scope to modify QI methods or devise alternative techniques. Despite the claim to promote local ownership, in many ways these groups often seemed more concerned with managing the implementation of change, but in ways that gave the impression of local ownership.

> There is a timetable for implementation, and we are working with clinical teams to make sure everything is up and running by the launch date. A lot of what we are doing is training, showing colleagues how to run an effective 'swarm' [rapid improvement circle] and who to call for support. (Group Leader)

Significantly, managers' engagement with frontline staff often emphasised the idea that patient safety was ultimately the responsibility of every clinician, as part of their professional duty of care. Despite framing patient safety as a 'system' issue, this approach seemed to relocate responsibility for quality and safety (back) with clinicians, whilst recasting managers and service leaders as responsible for ensuring the necessary QI methods are in place, and staff are appropriately trained; rather than having direct responsibility for safety.

Reactions at 'Grassroots' Level

There was widespread agreement amongst hospital staff that the quality and safety of patient care was a priority. Staff also appreciated that external and regulatory factors placed considerable pressure on the hospital to improve standards and care quality. Significantly, clinicians seemed to be of the view that hospital managers were not the source of such pressures, and therefore not 'behind' the new QI framework; rather, managers were seen as necessarily responding to these pressures on behalf of the hospital. As such, managers were, to some degree, successful as framing themselves in a less strategic and more responsive light, which might account for clinicians' relatively sympathetic response:

> What with the CQC visit and the demands of commissioners and the Department [of Health], it is no wonder the exec are putting in a new strategy. (Departmental Manager)

> We don't want to be another Mid-Staffs. It was terrible what happened there and it's so easy to forget about the simple things. So anything that helps with that is welcome. (Ward Nurse)

Despite broad support for the need for change, some were more critical about the planned changes across the hospital. Although staff were familiar with incident reporting and PDSA, many were sceptical about the learning and improvement these tools enabled. As shown by others, doctors were especially critical of the ways these systems were operationalised (Waring 2005). In particular, doctors were critical of the way

reporting and risk management processes were aligned with managerial processes and decision-making and not with local governance arrangements. Some described how alternative forms of case review and peer review could be equally useful in promoting improvement. Similarly, PDSA was seen by some as 'beguiling simplistic' with the assumption of reviewing performance, but that the reality of undertaking PDSA could be time-consuming and complex. Underpinning these views there appeared to be a deep-seated concern about the use of improvement techniques from other industries:

> PDSA is a lot more complicated than they let on. It's not just a four stage audit process, it requires proper resourcing and specialist skills to manage the process. (Doctor)

More significant criticisms were reserved for the way managers articulated the idea that clinical teams would have significant influence and control over the QI framework. There was widespread support for the idea that staff could tailor and modify interventions to align with pre-existing procedures or local needs, but many questioned whether this was really possible:

> They have told us that we can change how we report locally, but when we asked to change the form and data capture, we were told we couldn't… So I am not sure what we can change. (Ward Manager)

Despite many participants recognising that a lack of clinical engagement had hampered past improvement initiatives, there remained scepticism that the types of engagement described by managers was in any sense 'real'. For some, the campaign approach and the introduction of LAGs to 'spread the word' seemed superficial and contrived. In this sense, some clinicians saw it as an underhand way for managers to influence staff without giving the impression of influence.

> If you look past all the glitz of the campaign and actually look at what is being implemented, it is just another improvement policy, and all this talk of doing things differently seems like a smoke-screen. (Doctor)

> What they are proposing is different and I like that, it shows they (Executive) are willing to try new things. But really I am not sure they mean what they are saying about us having local control and us shaping the agenda. (Senior nurse)

Concluding Remarks

Our study examined how hospital managers adopted social movement ideas to promote 'grassroots' quality improvement. Focussing on the framing strategies used by managers, we found interlinked examples of diagnostic, prognostic and motivational framing (Benford and Snow 2000). Diagnostic framing was primarily constructed around the problem of patient safety, which, significantly, presented hospital managers as more passive conduits for reform rather than strategic operators. This might be seen as a strategic framing technique given well-documented instances of professional resistance to more proactive forms of management. It was also significant that managers talked relatively less about the problems of implementing change, focussing on the problem of safety instead of the problem of changing clinician behaviours. This might be because such issues were expected to provoke concern and resistance amongst staff, and it was therefore more prudent to focus on the problem of safety; as one manager said, 'no one can argue against improving patient safety'. Echoing this, managers' prognostic framing centred on proven techniques for improving quality, drawn from other industries or exemplar healthcare providers. Again, there was relatively little emphasis on the type of campaign or movement approach. Where this did become clearer was in relation to frontline clinicians having more influence or control on how the proposed QI methods were implemented and operating locally. Here, LAGs, comprising senior clinical leaders, were presented as supporting staff to work with the new or revised procedures. However, clinicians raised concerns about the extent to which this local influence was real, and saw the changes as often prescribed, which created some tension as it potentially threatened the autonomy of healthcare professionals. To overcome this, managers repeatedly developed more motivational frames around the importance

of caring for patients, improving the quality of care and restating the importance of professional duty.

In the processes of building or mobilising a social movement, framing involves constructing particular problems, and the solutions to these problems, in ways that attract and align individual interests to those of the movement, and as a basis for collective action (Benford and Snow 2000; Oliver and Johnston 2000). In our study, the framing centred on the problem of patient safety and the relevance of the proposed QI methods. There was little or no mention of the need for collective or grassroots action, beyond the idea that clinicians should take greater responsibility for patient safety and have scope to influence how hospital policies could be locally implemented. This might suggest that despite growing interest in following social movement-type approaches, and supporting grassroots or emergent change, the managers in our case were not explicit about following this approach.

Earlier, we asked more critical questions about whether leaders 're-align' interests to reflect those of the prescribed movement agenda. Our study found that managers were strategic in the selection of issues and interests to focus on in their framing activities, which positioned them as not forcing change upon staff, and as giving staff greater opportunities to influence change. However, the study also found that managers had a clearly worked out and relatively prescribed QI framework, and that staff had only limited scope to influence the form and operation of this framework. It might be argued that managers' use of a social movement approach, as reflected in the framing activities, was a more deceptive strategy for countering resistance and securing professional support for what, at face value, promised to be emergent and locally owned, but might also be seen as highly prescribed. As such, managers' adoption of social movement ideas in our case study seemed to have little concern with fostering and framing bottom-up improvement work, but function rather as a means for reducing resistance to a relatively prescribed top-down improvement framework.

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