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Inside the Black Box of Emergency Department Time Target Implementation in New Zealand

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ABSTRACT

Aimed at improving the quality of patient care in emergency departments, introduction of the 6 hour emergency department time target into public hospitals in New Zealand in 2009 provided an important opportunity to explore the implementation of public policy on the front line of public health services. It also enabled the opportunity to explore how targets work to promote change and improvement in service delivery, how they may result in unintended or adverse policy consequences, or result in varied policy impact across organisations.

This thesis presents qualitative research on implementation of the 6 hour emergency department time target in New Zealand. Four case study hospital sites were investigated to explore how the target was implemented and its consequences, and to identify the influence of context on the implementation process and outcomes. Sixty-eight interviews with clinical and management staff in the ED and wider hospital were conducted across the four case study sites over two rounds of data collection in 2011 and 2012, at which time a small number of documents concerning target implementation was also collected. Data analysis was thematic.

The findings from this research reveal that the thinking of staff implementing the target was shaped and constrained by their professional and hospital centred knowledge, perspectives and experience. Constrained thinking was also influenced by the medical institution and tensions between medical specialties in the acute hospital context. Addressing resistance, gaining buy-in and influencing change in staff behaviours, particularly of medical specialists in the hospital, were notable target responses. Process improvements and resource allocation, predominantly to the front of the hospital in the emergency department and other acute service units, helped speed the flow of patients through the ED and hospital. Pressure to achieve the target fostered change, learning and development, but also contributed to loss of morale, conflict and bullying. Pressure contributed to gaming of the target in the ED and to heightened concerns about quality of care for patients pushed through the hospital system more rapidly.
Factors at the local level of the organisation to influence target implementation included major structural interventions and their timing, the demand for acute service and resources available to respond, political history of the organisation, leadership approach to the target, and heightened complexity of the organisation’s services and clinical specialties.
ACKNOWLEDGEMENTS

My acknowledgements go to the 55 clinicians and managers who were interviewed in this study; little would have been possible without this. Your voluntary time and contribution was so important—thank you.

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To my beautiful daughter Gabby. It is tough to be a teenager and mother of a teenager at the best of times, let alone when both of us is distracted for four years and living on different planets. We have done it so tough together dear one. We are both better people, with a better future. Thank you. I love you.

To Greg - my serene and steady bull in a paddock- thank you, for your love and for listening.

"Ehara taku toa, he takitahi, he toa takitini".
DEDICATIONS

I dedicate this thesis to Tahi the Jack Russell Terrier, who passed away just before completion of the work. My beautiful little buddy and companion, I miss you and our walks and our talks together, and your warmth across my feet as I sit at the computer. Love and support to me of the most unconditional kind. I will remember you every time that I read this thesis (and most other days beside). Your paw prints are on every page.

For Mum and Dad.
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ABBREVIATIONS

CE/CEO  Chief Executive/Chief Executive Officer
COO    Chief Operating Officer
DHB    District Health Board
ED     Emergency Department
NM     Nurse Manager
NP     Nurse Practitioner
RN     Registered Nurse
SMO    Senior Medical Officer

GLOSSARY

Alpha ward  Generic term used in this thesis for acute service units of the hospital known by various names such as short stay or acute assessment unit
House Officer  A junior doctor during their first or second year of employment after graduation
Nurse Practitioner  Expert registered nurse who works within a specific area of practice that requires advanced knowledge and skills
Māori  Indigenous people or person of New Zealand
Registrar  A junior doctor who has been employed before appointment of registrar as a House Officer/Senior House Officer for at least two years and who has started a vocational training program to become an SMO
Staff Nurse  A registered nurse in a non senior nurse role
CHAPTER 1
INTRODUCTION TO THE THESIS

1.1 Introduction of the 6 hour ED Time Target in New Zealand—The Why of Research

In 2009, the New Zealand Ministry of Health introduced a national health target aimed at addressing problems with overcrowding and delays to treatment for patients in New Zealand’s public hospital emergency departments (EDs) (Ministry of Health, 2009). It was the first time, at least at a national level of government, that a cohesive health policy and performance target focused on ED length of stay had been introduced to the New Zealand health sector. The target, which applied to all public hospitals in the country, required that 95% of patients will be admitted, discharged, or transferred from an emergency department within 6 hours (Ministry of Health, 2009).

Targets, and other quantified performance measures in government policy, have a notable, if rather chequered history (Barber, 2008; Grizzle, 2002; Hood, 2007; Propper & Wilson, 2003). In the public management, health care and ED service setting, targets have garnered both support and criticism in the literature, such as the capacity for targets to improve performance of public services and stimulate change and learning, but also the ways in which they may foster unintended and negative consequences (Bevan & Hood, 2006b; Gubb, 2009; Kelman & Friedman, 2009; Van Herten & Gunning-Schepers, 2000a). The most controversial feature of the literature concerning the negative impact of targets is ‘gaming’, which involves behaviours in response to targets that may hit the target but miss the point (Bevan & Hood, 2006b).

Implementation of public policy similarly attracts a range of concerns, underpinned by a vast scholarship in the public policy and management sciences (see for example Barrett, 2006; Elmore, 1978; Hill & Hupe, 2002; Meyers & Vorsanger, 2003; Palumbo & Calista, 1990; Sabatier & Mazmanian, 1979; Winter, 2012). Central to contemporary literature in this field is the importance of front line public service delivery organisations, and front line public servants. It is at this level of government, according to the literature, that some of the concerns and issues which plague the
effectiveness and consequences of government policy might be better understood; namely, why some public policy and programmes appear to be successful in one sector or organisation, but not in others.

The complexity of health care organisation and management (Klein, 1982) renders an exceedingly difficult context for the implementation of policy reform. Professional, political, service delivery and cultural dimensions of health care organisation may account for a number challenges to the process and outcomes of policy implementation (Andersen & McDaniel, 2000; Hood, 2002; Plsek & Greenhalgh, 2001). This complexity of front line health care organisation contributes to the ‘black box’ experience of policy implementation (Palumbo & Calista, 1990a) for the ED time target, and may be where some of the answers to perennial questions regarding the success of government policy lie.

Introduction of the 6 hour ED time target in New Zealand, therefore, provides a crucial opportunity to explore not only the implementation of public policy on the front line of health service delivery, but also the use of targets to improve performance. It presents a significant opportunity to contribute to knowledge and practice in these fields and with this the effectiveness of government policy, not only in health care but the wider public sector.

1.2 Exploring How the Target is Implemented

In order to investigate the process and outcomes of implementation of the 6 hour ED time target in New Zealand, the research that is presented in this thesis has been exploratory in nature, has applied multiple-case study design and utilised qualitative methods. Such an approach lays open the complexities of the health care organisation for discovery and takes on the view of the hospital staff on the front line of health service delivery. The experience, the opinions, the insights and the actions of these staff are essential to building policy knowledge from inside the ‘black box’. The research questions posed by this study are thus:

- How did front line staff respond to and implement the ED time target and what were the consequences?
- How did context influence the process and outcomes of policy implementation?
1.3 The Researcher Journey

My role as the researcher and doctoral scholar in this study is founded on a long career as a registered nurse in the New Zealand health sector. Moreover, my specialised nursing field was in emergency care in a number of New Zealand’s EDs since 1994. I had been very much part of the world of overcrowded EDs and had experienced the profound impact this had on the patients I cared for, on my colleagues in ED and on my own professional nursing practice. My understanding and experience of the problems of ED overcrowding were consequently very tangible. I knew that something more had to be done to address what I believed, on so many occasions, to be appalling health service within New Zealand EDs.

Talk of the ED target in New Zealand pervaded my working world in emergency nursing in 2008 and 2009. I was both pleased and sceptical at the same time. Attempts to address the issues of overcrowding and poor quality care had long been part of my work as a nursing clinician, educator and manager in ED. Many patients that presented to ED that I had nursed, I believed, could have been cared for in the community; in accident and medical clinics, in rest homes, and in general practices and other primary care health services. The attitudes and behaviours of many medical staff that I had worked with in the hospital were dogmatic and entrenched in their own professional and service priorities. Ward nurses were a world away from life in the ED, and appeared to have the ability to avoid overcrowding of their own wards and departments. Likewise, I had limited understanding of the pressures of ward nursing, but believed that nursing services throughout the hospital could change some of the ways that they worked to help provide better care for acute patients. The target brought hope that things could change.

Yet I questioned and wondered if the target would work. I wondered too if the Ministry of Health understood the complex issues confounding EDs and acute care. Such wondering led me to this research and the opportunity to contribute to improving the working world of my professional peers and to the experience of patients. It also, invariably, offered the opportunity to contribute to health policy knowledge and practice in ways that my front line nursing work in health care could not.
1.4 Outline of the Thesis

Following this introductory chapter, in Chapter 2, I present a background for the study, which outlines the health system and service delivery context in New Zealand, and explores the problems and solutions of ED overcrowding and delays to treatment for patients. This chapter also outlines the policy itself, traces components of its formulation and health policy antecedents both in New Zealand and internationally. Critical commentary and implications for research are also identified.

Chapter 3 is a review of the literature across four large bodies of knowledge in the social sciences: policy implementation; performance measurement and management; organisation and management; and the sociology of healthcare. This review provides the rationale for the conduct of the research and implications for the research strategy applied.

Chapter 4 provides a detailed account of the research strategy for the study, beginning with the interpretive epistemology and ontology which underpins study design and methods. An outline of qualitative methods, multiple-case study design, case study selection and recruitment is provided. Participant recruitment, data collection and data analysis is described, which includes a comprehensive account of how the themes were developed at a global level (across all case study sites) and local hospital level (at each individual case study site).

Chapter 5 and Chapter 6 present the thematic findings of the research. In Chapter 5, global themes which represent high level themes common to all of the case study sites, identify the thinking, actions, consequences and context of target implementation. Themes for each of the case study sites in Chapter 6 provide a local story of target implementation and factors in the local context that influenced the process and outcomes of policy implementation.

Chapter 7 discusses the themes and study findings in relation to the research questions and then in relation to the literature. A comprehensive discussion of the contribution of the study findings to public policy and implementation literature is provided, followed by an outline of the implications of the findings for policy, practice and future research. In Chapter 8, I provide some concluding comments with regard to the research findings and the thesis.
1.5 The Shorter Stays in ED National Research Project

This research project is one of three streams of research contributing to the Shorter Stays in ED National Research Project (SSED NRP), which is funded by the Health Research Council of New Zealand. I assumed the role of Co-Principal and Māori Co-Principal Investigator in this project between 2010 and 2014, with project funding resourcing transcription services and some of the costs of data collection. Reference to the project within the thesis is made in Chapter 4 with regard to case study site selection and ethics approval. Reference is also made in Chapter 7 with regard to further research implications.

At the time of completing and presenting this thesis, the SSED NRP was still in progress. Further information regarding the project and other research streams and outputs is accessible on http://www.akhdem.co.nz/ssed-research/
CHAPTER 2

BACKGROUND TO THE STUDY

2.1 Introduction to the Chapter

The broad aims of this background chapter are to situate the study within the health system and service delivery context in New Zealand and to provide an understanding of why and how the 6 hour ED time target policy was introduced in this country. To achieve these aims the chapter commences with a brief introduction to the New Zealand health system. In the second section, I undertake a broad discussion of health service problems and solutions of ED overcrowding and delays to treatment. This discussion is supplemented by New Zealand Health and Disability Commission investigation and reports concerning the impact of ED overcrowding on patients, and media reporting on ED services in the country. An overview of the target itself, including national and international health policy antecedents to its introduction in New Zealand, is canvassed. The chapter summary includes some critical commentary with regard to the policy formulation activity and selection of the 6 hour ED time target for New Zealand, as well as identifying implications for review of the literature (Chapter 3) and the research strategy (Chapter 4).

2.1.1 Compilation and Release of the Report Recommendations to Improve Quality and Measurement of Quality in New Zealand Emergency Departments

The foundation for discussion in this chapter is a report entitled “Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments” (Working Group for Achieving Quality in Emergency Departments, 2008) (hereinafter in this chapter and in the discussion Chapter 7, I refer to this document as the Report, or by this citation). Released into the New Zealand health sector in December 2008, the Report was compiled by a New Zealand Ministry of Health emergency care sector advisory group, and was an influential policy document. Framed in quality improvement terms, the Report draws from a range of evidence and information to outline key characteristics of ED quality problems, their causes, effects and solutions, and provides a set of recommendations for the New Zealand Ministry of Health to address the problems.
Prior to release of the Report into the New Zealand health sector in May 2008, the New Zealand Ministry of Health and Counties Manukau DHB management representatives co-sponsored a national workshop attended by 70 health sector representatives. This workshop aimed to identify and discuss issues of quality of care in New Zealand EDs (Working Group for Achieving Quality in Emergency Departments, 2008). It was the first ‘visible’ national, multidisciplinary and collective endeavour in New Zealand to broach and explore the topic of ED service quality. A critical outcome of this workshop was the creation of a smaller Working Group with two key responsibilities; firstly, to advance recommendations of the workshop; and secondly, to contribute to Ministry of Health service review of hospital-based emergency services for Cabinet reporting (Working Group for Achieving Quality in Emergency Departments, 2008). The Working Group comprised emergency department clinicians (medical and nursing), hospital managers and Ministry of Health policy officials. Publication of the Report was an important outcome of all these activities.

2.2 The New Zealand Health System and Service Context

New Zealand’s health care system is dominated by public services, with government spending accounting for around 83% of total health expenditure. Private insurance and out of pocket spending accounts for around 16% of total health expenditure in the country (Gauld, 2012). Publicly funded health services include primary care as well as secondary and tertiary hospitals, with public hospitals making up the majority of hospitals in the country (Gauld, 2012). Primary health care is dominated by services delivered by GPs who are usually independent and self-employed health care providers but who receive government subsidy for services, predominantly through governance structures known as Primary Health Organisations (PHOs) (Gauld, 2012). The public health system is structured into 20 District Health Boards (DHBs), which are geographically defined and have responsibility for governing and administering public funding and planning for the needs of the population in their district (Gauld, 2012; Ministry of Health, 2011). DHBs also own and oversee the running of public hospitals. The New Zealand Ministry of Health advises the Minister, formulates policy, monitors performance of public health services and has a key role in implementing and enforcing legislation and regulations (Gauld, 2012; Ministry of Health, 2011). Strategic policy direction in the New Zealand health system in the last 15 years includes development of the primary
care sector and addressing health inequalities in the indigenous Māori population (Ministry of Health, 2000, 2001, 2002). Thus, New Zealand’s health system is characterised by a distinctive separation in the work of government; with national health policy development occurring within the Ministry of Health, and health service governance, funding, planning and delivery devolved to the DHB, hospital and primary care level of the system.

2.3 The Health Service Problems

2.3.1 Characteristics of ED Quality Problems

Problems in service delivery in New Zealand’s EDs had at least a 15 year history, prior to introduction of the 6 hour ED time target. The Report described that EDs in New Zealand can sometimes be overcrowded, which is a consequence of both the increasing numbers of patients presenting to ED and the increasing time which it takes to treat and then discharge or admit patients into hospital (Working Group for Achieving Quality in Emergency Departments, 2008). Overcrowding was also considered to be a consequence of lack of physical capacity and resources to manage increasing patient presentation numbers in some New Zealand ED facilities; particularly where services had not been upgraded or increased their bed capacity (Working Group for Achieving Quality in Emergency Departments, 2008). The Report also points out that overcrowding of EDs may result in sub-optimal care for patients including both treatment in corridors and/or long waits for treatment. Overcrowding and delays to treatment may in turn result in poor clinical outcomes, as well as reduced service efficiency and productivity. Hence, ED service quality problems were characterised by overcrowding, delays to and sub-optimal treatment, and poor clinical outcomes.

Evidence of the problems of ED quality that were canvassed in the Report arose from anecdotal evidence, government and other research reports in New Zealand and internationally. A ‘crisis’ in emergency department service quality is found in other health systems including the UK, USA, Australia and Canada (Fatovich & Hirsch, 2003; Guo & Harsall, 2006; Taylor, 2006; Trzeciak & Rivers, 2003). To improve the information on characteristics of ED service problems in New Zealand, the Ministry of Health undertook a national survey to gather data from the sector on trends
in ED presentation numbers, ED average length of stay (patient hours spent in the ED) and the prevalence of corridor stays in the ED (Working Group for Achieving Quality in Emergency Departments, 2008). The Report describes some of the key findings of the survey that notably included an overall 20 percent growth in total ED presentations (considerably larger than the national population growth rate of 6.7 percent) and a 34 percent increase in the total growth of patient hours in New Zealand EDs between 2003/2004 and 2007/2008 (Working Group for Achieving Quality in Emergency Departments, 2008). The Report also identified notable variance between different DHBs, in terms of both growing presentation numbers and patient hours, with a variety of local variables, such as DHB size and active management of ED demand, suggested as accounting for this variance.

Prior to introduction of the 6 hour ED time target, the only routinely collected national health data set of direct relevance to New Zealand ED performance was triage rates (Working Group for Achieving Quality in Emergency Departments, 2008). Triage rates had historically been one of several indicators of hospital performance reported by DHBs to the Ministry of Health. Triage is a clinical process that involves assessing urgency of patient presentations in the ED and assigning them to subsequent time based urgency categories, which in New Zealand are based on the Australasian triage scale (Australasian College of Emergency Medicine, 2005). Triage rates consist of the “percentage of all patients within the triage category in question who are seen within the maximum clinically acceptable treatment time for that category” (Working Group for Achieving Quality in Emergency Departments, 2008, p. 9). The Report described that persistently poor triage rate performance in many of New Zealand’s EDs, between 2001 and 2008, was evidence of sub-optimal treatment.

The Report did not reference any New Zealand based epidemiological or clinical research to further substantiate the ED quality problems in this country. However, anecdotal reporting of overcrowding and delays to treatment identified in the Report arose from discussion by ED clinical and management personnel at the ED workshop in May 2008 (noted earlier) and September 2008. Other opinions and research of note in the Report included those by Ardagh and Richardson (2004) and
Freeman (2008, cited in Working Group for Achieving Quality in Emergency Departments, 2008), all of whom were members of the Working Group. The Report indicated that, whilst a good deal more could be done to quantify the problems, the information available for analysis suggested that in New Zealand, overcrowding, corridor stays, delays to treatment and sub-optimal treatment in the ED had both gathered momentum and intensified in the five years prior to 2008.

2.3.2 Clinical and Financial Consequences

Whilst no New Zealand research was available or presented in terms of the clinical consequences of ED quality problems, the Report did present findings from four Australian studies deemed applicable to the New Zealand health sector. This research identified that overcrowding of EDs and delays to inpatient admission from the ED may be associated with increased patient mortality rates at 10 days (Richardson, 2006) and 30 days (Spirivulus, Da Silva, Jacobs, Frazer, & Jelinek, 2006) respectively, following ED presentation. Length of stay in the ED has also been linked to increased length of stay as a hospital inpatient (Liew, Liew, & Kennedy, 2003; Richardson, 2006). The importance of timeliness to treatment in the ED and other parts of the acute hospital system is emphasised in the Report; this includes reference to research on specific clinical conditions including stroke, acute myocardial infarction, sepsis, pneumonia, major head injury and fractured neck of femur (Working Group for Achieving Quality in Emergency Departments, 2008). The Report therefore cited this clinical research to reinforce how ED quality problems which exacerbate delays to treatment can subsequently impact on clinical outcomes for patients both in the ED and further along the acute care continuum.

With respect to financial implications, the Report noted the impact that ED length of stay has on inpatient length of stay and therefore hospital efficiency. However, there is no evidence in the Report to identify what, if any effect, ED quality problems had on inpatient length of stay and its possible financial implications in the New Zealand health sector. Rather, reference is made in the Report to two US studies which link overcrowding of EDs to foregone revenue from ED service provision and additional costs associated with longer stays in the ED (Working Group for Achieving Quality in Emergency Departments, 2008). This is not to suggest that there were not
financial implications arising from ED quality problems in New Zealand; rather, that the Report was limited to inference and logic in this regard.

2.3.3 Causes of ED Quality Problems

Key causes of ED quality problems were explored in the Report using an input, throughput and output (I/T/O) model (Working Group for Achieving Quality in Emergency Departments, 2008). Input or demand side causes of increased ED presentations and workload are driven by factors such as population growth and ageing, as well as the increased incidence of long-term conditions. Other demand side factors such as technological change and economic growth are also mentioned in the Report, although their precise relationship to demand for emergency services is not known. Other failings in the health system that may be symptomatic of the rising demand for ED services include issues in primary health care, chronic care and aged care residential management. For example, the Report described a health system pressure point, such as the inability of aged care residential services to accept discharged hospital inpatients, that could result in a knock-on effect on the movement of ED patients to wards. However, this description was not quantified in the Report.

The issue of patients appropriate for GP or primary care attending the ED instead, and driving the input side of the model, received notable address in the Report, primarily because it was considered an important and ongoing debate in the emergency care sector. Referring to a review of the issue and literature commissioned by the Australasian College of Emergency Medicine (Forero & Hillman, 2008), the Report authors emphasised that GP appropriate patients do not cause ED access block or overcrowding. Further, the Report noted that if 20 percent of patients in the lowest acuity categories typically placed in the ED (patients who are the least sick) were removed, it may only reduce ED workload by 3.5 percent and thus have marginal impact (Working Group for Achieving Quality in Emergency Departments, 2008). The Report then outlined a number of studies on the issue both in New Zealand and internationally and concluded that “significant numbers of primary care appropriate patients do present to EDs and that these would be better cared for elsewhere” (Working Group for Achieving Quality in Emergency Departments, 2008, p. 23). The methodological and conceptual limitations of these studies of GP appropriate presentations is noted
in the Report (e.g., what is primary care, whether this should be judged retrospectively and whose perceptions are important), alongside a wide gulf in research findings on GP appropriate presentations to ED (between 5 and 82 percent) that these studies identify (Working Group for Achieving Quality in Emergency Departments, 2008).

Throughput issues, or sub-optimal pathways within ED, primarily concern resourcing and technical inefficiencies, such as triage processes, insufficient ED staffing and beds, and inaccessible or inefficient diagnostic testing (Working Group for Achieving Quality in Emergency Departments, 2008). The Report considered three studies in the UK, US and Australia that indicated mixed findings on whether inadequate ED staffing causes overcrowding. In New Zealand, the Report described that recommendations by ED clinicians to improve staffing practice was not known to have changed or led to improvement in quality (Working Group for Achieving Quality in Emergency Departments, 2008).

The output side of the model, as discussed in the Report, has a singular focus on the concept of ‘access block’. Described as the most significant challenge facing EDs in the western world, “access block occurs when ED patients who require an inpatient bed are unable to get timely access, and therefore have extended stays in the ED” (Working Group for Achieving Quality in Emergency Departments, 2008, p. 34). Access block is primarily a consequence of inpatient overcrowding and is more likely to occur when hospital bed occupancy moves toward 100 percent capacity (Working Group for Achieving Quality in Emergency Departments, 2008). Inadequate physical beds in the hospital or bed management practice also contribute to inpatient overcrowding, whilst delays in inpatient specialist assessment of patients in the ED can further delay the process of admission (Working Group for Achieving Quality in Emergency Departments, 2008). Importantly, some reference is made in this section of the Report to aspects of hospital culture which can cause delays to admission of patients, such as the custom of inpatient speciality clinicians using the ED to hold patients indefinitely.
2.4 Health and Disability Commission and Media Reporting

As noted in the introduction to the chapter, this section provides additional information and reporting concerning the impact that poor quality care in New Zealand’s EDs and acute services had on patients. The discussion arises from a selection of Health & Disability Commission Reports and from mainstream media sources.

2.4.1 Health and Disability Commission Reports

The New Zealand Health and Disability Commission\(^1\) was established pursuant to the Health and Disability Commissioner Act 1994, and is a key organisation protecting the interests of health consumers in New Zealand. The jurisdiction of the Commission is low level and non-adversarial, it functions independent of government, has no powers of enforcement but may refer matters to the Director of Advocacy where litigation may be considered and pursued. Consumers or their families, and other third parties, such as concerned staff members, may make a complaint to the Commission, or the Commissioner may initiate an investigation if it is considered important to upholding the wider interests of the public. A key tool in the Commissioner’s armoury, by way of its report of findings, is that of making recommendations for change or improvements to health and disability services. The Code of Health and Disability Consumer Rights came into force in 1996 as a regulation of the Health and Disability Commissioner Act 1994. The Code confers 10 basic rights to consumers of health and disability services in New Zealand, including the right to be treated with respect (Right 1); the right to dignity and independence (Right 2); the right to services of an appropriate standard (Right 4); and the right to complain (Right 10). The Report referenced a small number of New Zealand Health and Disability Commission Reports to further evidence the impact of ED overcrowding and delays to treatment on patients. In this section, I feature six different Health and Disability Commission investigations and their published reports that are directly related to ED service.

\(^1\) Information on the New Zealand Health and Disability Commission and the reports discussed in this section can be found on the Commissions website - [http://www.hdc.org.nz](http://www.hdc.org.nz)
As early as 1998, the quality of emergency care in New Zealand was scrutinised by the Commission and published in the Canterbury Health Ltd\(^2\) Report (Health & Disability Commission, 1998). Detailing the investigation of a series of concerns, complaints and coronial inquests related to the death of seven patients at Canterbury Health between 1993 and 1996, the report highlights significant problems concerning the quality of patient care, both in the ED and acute admitting wards. Important findings in the report include less than optimal care provided to patients in Christchurch Hospital ED associated with overload and insufficient resources to manage acute demand resulting in corridor stays and delays to both medical assessment and diagnostic interventions (Health & Disability Commission, 1998). Tensions between clinicians and managers in the Canterbury Health organisation were also highlighted as staff negotiated the impacts and changes wrought by managerial and fiscal reform throughout the period of investigation. Significant issues in communication and engagement of clinical input into internal policy development also accounted for systematic failings in Canterbury Health (Health & Disability Commission, 1998). Therefore, whilst this very large Health and Disability Commission report does identify issues in ED quality of care, its broader importance in the New Zealand health sector, at the time, was in relation to management and clinical practice tensions and conflict arising from reform.

In 2001 the Commission investigated the death of a 64 year old male patient from pulmonary embolism secondary to DVT (Health & Disability Commission, 2001). Again, the Commission’s investigation highlighted overcrowding of the ED and insufficient clinical resources to manage patient care to an appropriate standard, as well as the pressure this environment placed on clinical decision making. As the Commissioner explained in this report:

It is a tragic story that highlights the risks associated with the increasingly common phenomenon of overcrowding in Emergency Departments throughout New Zealand. When departments are crowded, patients wait a long time for triage and medical assessment, and nursing resources are more thinly spread. Patient care may be jeopardised. This report highlights the need for Emergency Departments and District Health Boards to recognise the problem and respond appropriately (Health & Disability Commission, 2001, p. 2).

\(^2\) Prior to 2001, and during the period investigated by this particular Health and Disability Commission report, the key structures for organising public health services were Crown Health Enterprises (CHEs) and the subsequent Hospital and Health Services (HHS) management structures. Canterbury Health Ltd reflects these earlier structures.
Problems in ED service quality were highlighted by complaints and subsequent Health and Disability Commission investigations at Whanganui (Health & Disability Commission, 2007a) and Hutt Valley (Health & Disability Commission, 2007b) DHBs. In both of these investigations, where the patients concerned survived severe trauma injuries, the Commission identified the contributing factor of inadequate medical staffing practices. Such inadequacy was concerned with both the seniority, and the numbers of medical staff needed to deliver an appropriate level of care to match patient demand and acuity in the ED. In both of these investigations, individual clinicians and their employing DHBs were found to have breached the patients’ rights.

Almost nine years after the publication of the Canterbury Health Ltd Report, problems in quality of care at Christchurch ED were again highlighted by the death of 25 year old Dean Carroll in 2007 (Health & Disability Commission, 2008). Care being managed by a relatively junior doctor and in a chaotic, busy emergency department were factors identified by the Commission’s investigation as contributing to his untimely death (Health & Disability Commission, 2008).

The North Shore Hospital Report (Health & Disability Commission, 2009)\(^3\) was a watershed investigation and publication that graphically portrayed acute health care system overload and the consequent death of four elderly patients in the winter of 2007. This was a complex, Commissioner initiated inquiry spurred by the receipt of multiple complaints in regard to North Shore Hospital services (Health & Disability Commission, 2009). The report explains that whilst there were no treatment injuries or lapses in care which caused their immediate deaths, and no individual staff member was responsible, these patients nonetheless suffered delays, indignities and frustrations in care and communication within a context of overwhelmed health services for which Waitemata DHB was held demonstrably accountable (Health & Disability Commission, 2009).

This particular report goes much further than describing the failings of North Shore Hospital, but details the issue of hospital and ED overcrowding both nationally and internationally, which it explains is largely a consequence of hospital access block. The report then acknowledges the

\(^3\) This report was finalised and published by the Health and Disability Commission in 2009, but involved a lengthy investigation into events that occurred at North Shore Hospital throughout 2007.
concerted national action needed to address these issues and refers to the Report (Working Group for Achieving Quality in Emergency Departments, 2008). Stretching well beyond the purview of hospital and DHB failings and well beyond the boundaries of quality of care at Waitemata DHB, the Commissioner also states:

Equally, District Health Boards should not be left to solve intractable funding and delivery problems on their own. They need support from central government. Otherwise, Boards will flounder, management and staff will become demoralised, and failings in care will follow, leading to a loss of community confidence in local hospitals and in the health system (Health & Disability Commission, 2009, p. 6).

2.4.2 Media Reporting

A search of the electronic archives of New Zealand’s largest online and daily print newspaper, the New Zealand Herald, revealed considerable media attention on ED and hospital overcrowding in the decade leading up to the target’s introduction. Some of this was closely associated with Health and Disability Commission reports and Commissioner press releases. I outline some of this media reporting and its content here.

In the earlier articles between 1999 and 2002, one of the main themes is the impact of seasonal illness on escalating ED presentations and, in some cases, resultant cancellation of elective surgery to cope with the demands for acute care beds (Bidois, 1999; Devereux, 2001a, 2001b; Devereux & Johnston, 2001; Johnston, 1999, 2002; Johnston & Wycherley, 2001; Mold, 2000). Articles in the period 2003–2006 begin to feature more closely the experience of patient distress with excessive delays in the ED, along with articles which consider better use of GP services to reduce demand for acute hospital care (Gamble, 2003; Johnston, 2004a, 2004b, 2005, 2006; Rowan & Johnston, 2004). In 2007, eight different articles were identified (Booker, 2007a, 2007b; du Chateau, 2007a, 2007b; Johnston, 2007a, 2007b, 2007c; New Zealand Press Association, 2007), that focus on three important themes: publicising Health and Disability Commission investigations and reports including three of those noted above ((Health & Disability Commission, 2007a, 2007b, 2009); an emphasis on falling quality of care, in particular suboptimal care resulting from ED corridor stays; and strong commentaries on causes and effects of ED problems from ED Clinical Directors. In the last selection in 2008 and 2009, there is again clear emphasis on the politicising of ED quality
problems, particularly the North Shore Hospital report (Health & Disability Commission, 2009). Almost all articles in this group allude to a health policy response both before and after the general election of November 2008 (Borley, 2008; Johnston, 2008a, 2008b, 2008c, 2008d; Johnston & Eames, 2008; Rushworth, 2008; Savage, 2008). There is also a noticeable trend arising from this media reporting, that the preponderance of ED quality problems occurs in New Zealand’s larger urban hospitals and EDs.

Collectively, Health Disability Commission investigations and reports and media reporting undoubtedly contributed to the political pressure on New Zealand’s Ministry of Health to find a policy solution able to address problems of ED overcrowding and delays.

2.5 The Service Solutions and Policy Recommendations

Solutions to the causes of ED quality problems were also introduced in the Report using the I/T/O model. Examples of solutions to the input or demand side for ED care include strengthening primary care service provision through walk in centres and minor injury units, both of which are strategies used in the UK and Spain (Working Group for Achieving Quality in Emergency Departments, 2008). However, the Report cautions that neither strategy has worked to substantially reduce ED attendances and is likewise evident in New Zealand, where the investment in primary care has not reduced ED presentation numbers. A primary care solution that did appear to reduce ED presentations in New Zealand was the Canterbury Community Care Trust (CCCT) (Working Group for Achieving Quality in Emergency Departments, 2008). The Report describes this service as an innovative model which promotes treatment in the community of the patient who might otherwise present or be referred to the ED (Working Group for Achieving Quality in Emergency Departments, 2008).

Solutions such as reduction of ambulatory sensitive hospitalisations, preventative care and better support services for the elderly are considered pertinent areas where primary care strategies may make a difference to the growing demand for ED care (Working Group for Achieving Quality in Emergency Departments, 2008). Referring patients away from ED to primary care, patient education and social marketing are considered by the Report authors as either undesirable or
ineffective solutions (Working Group for Achieving Quality in Emergency Departments, 2008). The practice of ambulance ramping, which involves holding patients outside the ED until they can be accommodated in the facility, is anecdotally reported in the UK and New Zealand (Working Group for Achieving Quality in Emergency Departments, 2008). The Report describes this as a perverse form of demand management and it is not endorsed by members of the group or wider emergency care sector due to clinical risks and delaying of ambulance services.

An acute demand management strategy is considered in the Report, but with acknowledgement that primary care appropriate patients do not constitute the major causes of ED quality problems (Working Group for Achieving Quality in Emergency Departments, 2008). However, since there is increased demand for ED services arising from a fast growing population and indications that some EDs in New Zealand may benefit from improved primary care strategies, a formalised acute demand strategy across the sector is deemed an appropriate aspiration (Working Group for Achieving Quality in Emergency Departments, 2008).

Throughput strategies outlined in the Report include many interventions that had already been implemented in New Zealand. Improvements in the ED workforce included the introduction of Nurse Practitioners (NP) roles (Working Group for Achieving Quality in Emergency Departments, 2008). With an advanced scope of nursing practice, the NP works both independently and in collaboration with ED medical staff to provide more comprehensive patient care than would otherwise be addressed by overly busy ED medical staff (Nursing Council of New Zealand, 2009). However, the impact of ED NPs on reducing delays to treatment in the ED is unknown (Working Group for Achieving Quality in Emergency Departments, 2008). Other workforce strategies identified in UK literature, that are considered in the Report, include increasing the numbers of senior ED clinicians to speed decision making and ensuring availability of staff for unpredicted surges of ED activity (Working Group for Achieving Quality in Emergency Departments, 2008).

The concept and practice of lean thinking is another strategy in place in New Zealand EDs and other health services, such as inpatient wards, designed to improve throughput of patients. The Report outlines the lean thinking process improvement activities of Canterbury and Counties Manukau
DHBs as they have endeavoured to improve patient throughput both within the ED and from the ED into the hospital (Working Group for Achieving Quality in Emergency Departments, 2008). Lean thinking and associated quality improvement activity⁴ is the most prominent and specific process improvement tool that has been applied to improving ED efficiency and quality in New Zealand (Working Group for Achieving Quality in Emergency Departments, 2008).

Other throughput activities noted in the Report include the use of transit lounges and short stay units to reduce access block and overcrowding. Patient streaming, or assigning patients to different minor or moderate groups once in the ED, alongside improved bedside or nurse initiated diagnostics, are also noted as interventions that can aid ED throughput efficiency (Working Group for Achieving Quality in Emergency Departments, 2008). The Report highlights the need to improve processing of GP referrals, particularly patients who are stable. Standard operating procedures and admission and planning units are both active in the ED environment in NZ and reduce double handling of patients (by both ED and inpatient medical teams), as well as contributing to reduction in inpatient length of stay (Working Group for Achieving Quality in Emergency Departments, 2008).

Output solutions described in the Report focus on reducing access block. Three interventions are outlined including: increasing inpatient bed capacity or ensuring occupancy rates are at or below 85 percent; improving bed management processes; and the use of hospital full capacity plans (Working Group for Achieving Quality in Emergency Departments, 2008). In the case of full capacity plans, the Report presents a case study of the Auckland City Hospital Full Capacity Plan which is a technique that involves a coordinated hospital wide process of admitting patients from the ED over the normal census of inpatient wards (Working Group for Achieving Quality in Emergency Departments, 2008). The Report authors explain that full capacity plans do not prevent access block, rather they mitigate its effect through distribution of patient overload as well as redistribution of clinical risk (Working Group for Achieving Quality in Emergency Departments, 2008). The case study highlights the importance of strong leadership from the CEO and a network of supportive Clinical Directors to drive cultural change within the hospital, where wards ‘share the pain’ of ED

⁴ See Brandão de Souza (2009) and Brandão de Souza and Pidd (2011) for review and discussion of trends, approaches and barriers to lean in a number of health care systems and services.
overcrowding and “are therefore incentivised to practice efficient bed management” (Working Group for Achieving Quality in Emergency Departments, 2008, p. 37).

2.5.1 The Report Advice and Recommendations

Advice to the Minister within the Report emphasises that “solutions to ED problems will need to address the underlying causes, and therefore span not only the ED, but the whole of the hospital and indeed the whole acute care system” (Working Group for Achieving Quality in Emergency Departments, 2008, p. 5). Fourteen recommendations are made in the Report that are guided by principles such as patients’ best interests, minimisation and elimination of poor clinical outcomes, whole of hospital and system solutions, DHB executive and management involvement and achieving balance between clinical service and financial requirements (Working Group for Achieving Quality in Emergency Departments, 2008). Four critical recommendations of the Report are:

- An emergency department health target is needed
- Health target relates to ED length of stay
- Corridor stays for ED patients should be eliminated
- An integrated acute care plan for New Zealand is needed.

2.6 The Policy Solution – Health Targets and ED Targets in New Zealand and Beyond

2.6.1 Health Targets in New Zealand

In July 2009, the Ministry of Health in New Zealand introduced a suite of six headline national health targets (Ministry of Health, 2009). One of these targets was the 6 hour ED time target, consistent with the first two recommendations of the Report. Specifically, the target requires that 95% of patients will be admitted, discharged, or transferred from an emergency department within 6 hours (Ministry of Health, 2009). The other health targets introduced to the health sector at this time concerned improved access to elective surgery and reduced cancer treatment waiting times, as well as three targets focused on important public health concerns; child immunisation rates, help for smoking cessation and better diabetes and cardiovascular services (Ministry of Health, 2009). All of
the targets in this suite were to be nationally reported at a DHB level, in contrast to an individual hospital or health service level. None of the health targets introduced at this time were associated with the use of financial incentives, either sanction or reward. The use of incentives, including financial sanctions and rewards, is discussed in the literature review in Chapter 3.

This was not the first time that national health targets had featured in public health policy for New Zealand. In the 1990s, a substantial series of health targets had been pursued in the sector in areas such as obesity in adults and immunisation rates in children (Ministry of Health, 1997). In 2007, the then Director General of Health introduced a revised target regime for the health sector that was based on 10 national health targets. This set of targets again included immunisation rates for children, but also introduced targets aimed at improvement in mental health services, adolescent oral health and the reduction of ambulatory sensitive hospital admissions (Ministry of Health, 2008). Thus, the slimmed down six health target regime of 2009 is the first time that a target had ever been set for addressing the performance and quality of care in ED services.

2.6.2 Health Targets and ED Targets in other Health Systems

There were other health policy antecedents to the introduction of the ED time target in New Zealand, and some of these are featured in the Report. In the introduction to their discussion of the causes of and solutions to ED problems, the Report authors present, in case study form, the radical policy approach taken by the English National Health Service (NHS) to addressing ED quality problems (Working Group for Achieving Quality in Emergency Departments, 2008). The case study outlines the escalating demand for ED services in England (an increase of 3.5 million presentations to EDs from 1999 to 2003/2004) (Alberti, 2004; Working Group for Achieving Quality in Emergency Departments, 2008). A target associated with financial incentives was implemented in the English NHS to ensure that no patient was to spend more than four hours from arrival in ED to admission, transfer or discharge (Alberti, 2004; Working Group for Achieving Quality in Emergency Departments, 2008).

Success of the ED target in England is outlined in the Report, identifying that by 2004/2005, 94.7 percent of all patients presenting to English EDs were managed within the 4 hour time target.
(Working Group for Achieving Quality in Emergency Departments, 2008). The English ED result is then compared to that of Northern Ireland EDs where the target was not introduced and where ED waiting times progressively deteriorated (Northern Ireland Audit Office, 2008; Working Group for Achieving Quality in Emergency Departments, 2008). Northern Ireland NHS has subsequently adopted an ED target where 95 percent of patients should be managed within 4 hours (Northern Ireland Audit Office, 2008; Working Group for Achieving Quality in Emergency Departments, 2008). The time target policy is advocated by the working group as an appropriate whole of system approach to addressing ED quality that promotes senior management accountability and requires ministry facilitation (Working Group for Achieving Quality in Emergency Departments, 2008).

Discussion of the target recommendations in the Report includes the potential for fostering unintended policy impacts and consequences, including gaming of targets (Working Group for Achieving Quality in Emergency Departments, 2008). For example, deterioration of triage rates, ambulance ramping and using full capacity plans to shift patients from ED without good clinical reason are all identified as adverse consequences of an ED time target (Working Group for Achieving Quality in Emergency Departments, 2008). Noting that it is probably not possible to avoid all unintended outcomes arising from the application of targets, the Report describes that a system with no gaming arguably indicates incentives are not working (Working Group for Achieving Quality in Emergency Departments, 2008). However the Report also describes that a wave of gaming and distorted behaviour arising from target implementation without improvement in service quality would represent policy failure. Following this logic therefore, some unintended consequences and gaming behaviours can be anticipated from the implementation of the target in New Zealand, of which some may be considered more tolerable than others.

Health targets were applied to a number of areas of the English health sector in the 2000s, and subsequent literature provides good insight to gaming and other problems that occurred with this target based policy suite in England. In relation to outpatient appointment and elective admission waiting times, evidence suggests that some English NHS Trusts had inappropriately adjusted waiting lists, including deliberate misreporting or misstatement of figures (National Audit Office,
2001; Audit Commission, 2003 cited in Bevan, 2006a; Bevan & Hood, 2006b). In their qualitative study, Mannion, Davies and Marshall (2005) found that targets for elective surgery admissions had indeed caused a cultural shift towards meeting external targets, but to the detriment of service quality in other areas of the organisation not subject to a target. Cancellation of elective ophthalmology surgery, which was not subject to targets, to facilitate outpatient appointments which were targeted, was also found (Public Administration Select Committee, 2003). Corrected ambulance response times were found in a third of ambulance trusts in the NHS, as well as the dangerous and inappropriate practice of the re-categorisation of patient urgency (Bevan & Hamblin, 2009).

Gaming of the English A&E waiting time target included drafting in of extra staff, the cancellation of elective operations, and the queuing of ambulances outside A&Es until there was confidence that the target time could be met (British Medical Association, 2005, cited in Bevan & Hood, 2006b; Bevan & Hamblin, 2009). Re-designation of patients as short stay admissions at or around the target time in order to avoid breaching it and manipulation of data, evidenced by a notable peak in waiting times prior to or at the target time (Locker & Mason, 2006; Mayhew & Smith, 2008), are also indicative of gaming the A&E target.

Contradictory conclusions in regard to the effect of the English A&E target regime were offered by Kelman and Friedman (2009). In contrast to Bevan and Hood (2006b), these researchers distinguish the dysfunctional consequences of performance targets as effort substitution, which involves the reduction of effort in unmeasured performance dimensions, and gaming, which concerns “...making performance on the measured performance dimension appear better, when in fact it is not” (Kelman & Friedman, 2009, p. 917). In their extensive empirical investigation of the A&E target at 155 NHS Trusts, Kelman and Friedman found no evidence for any dysfunctional consequences, including death rates, return A&E visits, mean A&E wait times, elective and trauma surgery wait times and hospital admissions. However, they also acknowledge that during the period of investigation, from 2002 to 2006, a significant increase in NHS budgets and staffing occurred, and that some of the
improved performance in A&Es may well be a product of this increased funding (Kelman & Friedman, 2009).

The Commission for Healthcare Audit and Inspection (2009) investigation and report and then public inquiry and report (Francis, 2013), into the performance of Mid-Staffordshire NHS trust, provides some further indication and substantiation that introduction of the 4 hour ED target in England may have had a bearing on performance elsewhere in that health care organisation. Investigation at this trust was alerted by higher than expected mortality rates in emergency admissions. Some of the broad findings of these investigations include exceedingly poor organisational culture, critical issues with clinical staffing, particularly nurse staffing numbers in the hospital, and an overwhelming management focus on meeting targets, including the ED target (Commission for Healthcare Audit and Inspection, 2009; Francis, 2013).

Notwithstanding the dysfunctional aspects of incentivising improved performance, Bevan’s (2010) comparative analysis of different UK health systems demonstrates that a mixture of policy tools, including targets, sanctions and rewards to improve performance, may be far more effective than quantified measures alone. However, some of the reasons for the exemplary performance results in the English NHS may arise from the phenomenon of gaming, a negative consequence of targets to be discussed further in Chapter 3 review of the literature.

It is worth noting that at around the same period that the ED target was being formulated in New Zealand, a time target for EDs was introduced in the state of Western Australia in 2008 (Geelhoed & de Klerk, 2012). Since then, a National Emergency Access Target (NEAT) has been adopted across all Australian states from 2011 (National Health Performance Authority, 2012). The Australasian influence on the use of time targets in ED is yet another feature and influence on the introduction of the 6 hour ED time target in New Zealand.

2.7 Chapter Summary

Discussion in this chapter attests to the serious issues and consequences of overcrowding in EDs, and delays to treatment for patients. Whilst published research concerning the problems in the New
Zealand health service context at the time of the Report was lacking, and required further effort, what was available to policy formulators painted a disconcerting picture for all stakeholders, particularly for patients. This has been additionally supported by Health and Disability Commission investigation and reporting, and by media commentary. The problems had been manifest in various ways over a significant 15 year time period before receiving attention at a national policy level.

However, there are some important critical comments to make concerning the policy formulation process and the selection of a quantified target to address the service delivery problems. Three key themes to arise from policy formulation activity and from the substance of the Report are:

- the emphasis on emergency and hospital services with regard to the problem characteristics and solutions
- the framing of the issues in terms of ED service quality and its measurement
- the notable influence of ED clinicians, particularly medical, on the promotion and development of a policy response

Whilst there is some discussion in the Report concerning causes of ED overcrowding and delays that are related to wider health system and service issues such as population growth and ageing, chronic care management and aged care residential management, these perspectives are not well represented in policy formulation activity. Primary care service solutions are considered in the Report, but diminished in their importance by the authors. Rather, as I have noted, the policy formulation activity is dominated by ED and hospital personnel, and with an emphasis on the ED and hospital service delivery context.

Secondly, despite explicit knowledge of the issues and concerns associated with the use of targets to effect change in public service delivery, the Ministry of Health elected to institute a performance target framed around ED service delivery. Indeed, the decision was made based on very limited empirical knowledge of the use and impact of ED time targets. Rather, trends in other health systems applying ED time targets seems to have been an important factor influencing the policy
decision, and invariably the ED time target selected. Previous health target policy in the New Zealand system may have also lent weight to the policy decision made.

A final critical comment is in regard to the differing experiences and evidence of problems and solutions at different hospitals in New Zealand. Some EDs had few problems with overcrowding and delays in ED, whilst others, particularly New Zealand’s larger urban hospitals, manifest the bulk of the problems in the country. Strategic efforts to solve the problems in these larger hospitals were identified in the Report, but with limited understanding of success or failure, or of the factors that contributed to that success or failure. Notwithstanding, the target was introduced to all of New Zealand’s hospitals. Perhaps the reasoning was that the new regime of six health targets was to be applied to all DHBs and their health services. Limiting application of the ED time target to only those hospitals with serious problems might have proved difficult to manage. Perhaps also this decision was related to the use of a ratings system and public reporting against the targets, that from a political perspective enabled the New Zealand government of the time to at least demonstrate good performance to its constituency, that might not have actually been a result of the target.

I note a number of implications for review of the literature and research strategy arising from this chapter. The most notable is that not all hospitals in New Zealand have serious problems with ED overcrowding and delays to treatment. There may well be local factors or variables at play that influence this, and which in turn may also influence the implementation and effect of the ED time target. The next implication concerns the unintended and negative consequences associated with targets; namely, that little empirical insight on the effect of time targets in EDs was available to the policy formulators, particularly regarding the phenomenon of gaming. Understanding more about this possible impact is an important area to review in the literature as well as a worthy impetus for research. Focus on the ED and hospital service delivery context in the Report may also have some implications for the target’s implementation and impact; in particular, the absence of key professional and service perspectives from the wider hospital and health system in the policy formulation process. All of these implications inform the review of the literature in Chapter 3, and the research strategy in Chapter 4.
CHAPTER 3
REVIEW OF THE LITERATURE

3.1 Introduction to the Chapter
It is well known in the public policy and management literature that the efforts and intentions of policy makers to advance reform of services for the public good can be a major undertaking that may not work, may only work in part, or in some instances, may work but have other unintended consequences. The quest to understand and address these issues is both perennial and ongoing. It is equally well known that when public policy meets the service delivery organisation, a myriad of factors at this level of government may influence both the effect and outcomes of policy implementation. The primary body of knowledge and literature to which this study aims to contribute is in the broad field of public policy and, in particular, policy implementation knowledge and theory. The secondary body of knowledge for this study is public organisation and management in health care and, within this, the utility of quantified performance measures such as targets to promote reform.

The core bodies of knowledge that underpin this study are thus policy implementation, performance measurement and management, organisation and management, and sociology of health care. The approach taken to review of this literature is to consider and discuss how this knowledge informs understanding of public policy implementation. It is also a relevant task of my review process, throughout the chapter, to identify overlaps or links between these different areas. In the chapter summary, I highlight key features from the literature and provide an outline of a rationale for the study. The chapter closes with comments and directions regarding the research strategy for investigating implementation of the 6 hour ED time target in New Zealand.

3.2 Policy Implementation Literature
Concerns about the gap between policy aspiration and reality motivated an important period of theorising and research, beginning in the mid-1970s with the pioneering and often cited work of Pressman and Wildavsky (1973). Indeed, their case study of the local implementation of a federal
economic programme was subtitled, ‘How great expectations in Washington are dashed in Oakland’, signalling concerns that many governments may have, both then and now, about implementation of their policy directives (Pressman & Wildavsky, 1973). The body of knowledge known as implementation studies was, at least initially, normatively grounded in concern for what makes the achievement of government policy and goals difficult (Hill & Hupe, 2002; Howlett & Ramesh, 2003; Winter, 2003). Problems, barriers and failures in policy implementation, according to this early ‘pessimistic’ theorising, could be attributed to bad implementation practice, lack of attention to diverse groups of policy actors and bad policy instruments (Winter, 2003). All of these broad and initial themes were reiterated and refined in the ensuing implementation scholarship which proceeded until the 1990s.

In order to guide more complex empirical analysis, scholars from the ‘top down’ group of implementation theorists in the 1980s advanced knowledge of policy implementation through the development of theoretical models and frameworks (Hill & Hupe, 2002; Winter, 2003). The work by American scholars Mazmanian and Sabatier (Mazmanian & Sabatier, 1983; Sabatier & Mazmanian, 1979, 1980) and British counterparts Hogwood and Gunn (1984), for example, were allied to a rational and linear model of policy process and the identification of conditions and variables that would help to eliminate or minimise the gap between policy aspiration and reality (Buse, Mays, & Walt, 2005; Hill & Hupe, 2002; Winter, 2003, 2012). Hogwood and Gunn recommended policy makers ensure that adequate time and sufficient resources are available to programmes and that policy be based on a valid theory of cause and effect. Mazmanian and Sabatier reasoned, inter alia, that it was essential to make policy goals clear and to limit the extent of change necessary for policy to be successfully implemented. At a glance, both these perspectives would have practical value in the planning of policy reform to avert implementation problems. Generally however, ‘top down’ perspectives identify a distinction between the processes of policy formulation and implementation (Buse et al., 2005; Hill & Hupe, 2002) and this assumption sits at the heart of tensions between this and other implementation perspectives.
The ‘bottom up’ policy implementation proponents emphasise where the public sector meets the citizen, and the role that front line workers, networks and coalitions of policy actors have in the implementation of policy (Winter, 2003). Michael Lipsky’s (1980) ‘bottom up’ theory of street-level bureaucrats emphasised the substantial discretion that street-level bureaucrats (e.g. police officers, social welfare staff, teachers) have in the conduct of their work and the delivery of social services and benefits (Lipsky, 1980; Meyers & Vorsanger, 2003). This discretion enables front line staff, even in the most rule bound environments, to not only mediate the demands of policy, but also to actively shape policy itself. Lipsky’s theory turns “…the policy process upside-down by claiming that street-level bureaucrats are the real policy makers” (Winter, 2003, p. 214). A major concept arising from the theory is that of coping and coping mechanisms. A universal problem perceived by street-level bureaucrats is that the resources they have to undertake their services are chronically and seriously insufficient to meet the demands of their work, and to combat this tension street-level bureaucrats apply coping mechanisms which may distort their work in relation to policy and organisational goals (Lipsky, 1980; Winter, 2003). For example, coping strategies might include creaming or ‘cherry picking’ easier cases or clients, prioritising or rationing services and modifying programme objectives in such a way as to make objectives easier to attain (Lipsky, 1980; Meyers & Vorsanger, 2003; Winter, 2003).

Two studies, one in health and one in prison reform, help illustrate the relevance of Lipsky’s theory in the analysis of policy implementation. In her research of the introduction of prisoner rehabilitation programs into five prisons in the United States, Lin (2000) undertook interviews with both prison staff and inmates, seeking an understanding of how these programs were being implemented. Two important study conclusions were that prison staff would engage in subverting the policy by undertaking rehabilitation activities that were only weakly related to the policy’s rehabilitations goals, and that these subversion behaviours were to be found in activities that were relatively difficult to identify and control. Another broad finding from this study relates to the policy and organisational fit. Lin proposed that rehabilitation programs must ‘fit’ or ‘match’ the organisational context or environment in order to be successfully implemented. Two themes of
organisational fit include a prison culture where rehabilitation of prisoners is considered ‘legitimate’, and a ‘culture of performance’, including that of performance in prisoner rehabilitation.

Walker and Gilson (2004) were interested in the views of nurses affected by the introduction of a free urban health clinic policy in South Africa, and focused on understanding personal and professional consequences, such as possible negative impacts on the morale and attitudes of nursing staff. The study recognises that a policy of free health care may increase clinical workload and thus have worrying consequences for the nursing workforce involved. Of the several very important findings arising from this study, three have particular relevance to the present research. First, despite overwhelming support for the policy in general, not all nurses in this study believed patients deserved free care; a value-laden judgement that Walker and Gilson explain is a product of the professional, social and institutional character of their nursing work. Second, these value-laden judgements, coupled with speed of implementation, a perceived problem with resources, and a sense of isolation from policy and planning decisions, meant nurses would categorise and, to an extent, blame patients for the frustrations of their work environments. Third, and as a corollary of the former point, there was a risk of negative consequences for patients who were categorised and blamed by nurses for the pressures of the policy on their work.

Other scholars from the bottom-up perspective, such as Hjern and Porter (1981), Barrett and Fudge (1981) and Elmore (1985), broadened the conceptual lens on policy implementation through emphasis on implementation structures, networks of policy actors and the relationship between policy and actions. Barrett and Fudge (1981) conceived implementation as involving a policy-action continuum, where negotiation and interaction between policy and actors is dynamically linked and where policy undergoes modification and interpretation influenced by the differing assumptions of the actors or groups of actors involved. In addition, Barrett and Hill (1984) and Barrett (2006) describe the importance of empirical investigation that moves beyond normative administrative or managerial views of how the process should be, to explore the micro-political context of policy implementation and the complex, dynamic relations and influencing that occurs between organisational actors.
Arguably, the larger point of this and other ‘bottom up’ views on policy implementation is that ‘policy making’ may occur other than in the corridors of central government, and how very difficult it may be for the centre of government to control lower levels of the system, and with this the fate of public policy (Buse et al, 2005). The smaller, and not insignificant point, is that one has to get inside the policy implementation process in these lower levels of government, to discern with greater clarity the influence that lower level public servants, such as teachers, doctors, nurses, prison staff and social workers, for example, may have on public policy and vice-versa.

An important and later cluster of implementation scholarship is termed ‘the synthesisers’, reflecting a well-documented tension between top down and bottom up perspectives (see Hill & Hupe, 2002; Winter, 2003). This tension reflected that each perspective “...tended to ignore the portion of the implementation reality explained by the other” (Goggin, Bowman, Lester, & O'Toole, 1990, p. 12). From the synthesiser standpoint, policy implementation and the problems associated with it can be best understood and studied via greater theoretical and methodological diversity. Elmore (1978) also sits in this ‘synthesisers’ group on the basis of a mixed methods approach to the study of implementation. Elmore’s perspective “contrasts ‘implementation as systems management’, ‘implementation as bureaucratic process’, ‘implementation as organisation development’ and ‘implementation as conflict and bargaining’” (Hill & Hupe, 2002, p. 58).

Another of the synthesiser scholars, Richard E. Matland (1995), emphasised a contextualised contingency based approach to understanding policy implementation. Matland’s model is based on analysis of a policy’s level of ambiguity and conflict, which he proposes are intrinsic features of policy rather than something to avoid or eliminate (Matland, 1995). Policy conflict dimensions in this model concern the importance of the policy goals or processes to stakeholder interests, many of which may be incongruent. Policy ambiguity is related to both the goals and means of policy, for example the roles that various stakeholders may take in the process of implementation. A policy with both low levels of ambiguity and conflict (in Matland’s example, this is small-pox eradication) provides the conditions for a programmed rational decision-making administrative implementation process where, given the necessary resources, the desired outcome is virtually assured. A policy
with low levels of ambiguity but high levels of conflict (an integrated school bus program is the example used by Matland), will result in a political implementation process where implementation outcomes are decided predominantly by the use of power. The third type, high ambiguity and low conflict (Matland’s example is a preschool program for disadvantaged children) will have outcomes that are largely dependent on the resources and actors involved. Matland suggests this experimental implementation process closely parallels a ‘garbage can’ procedure with hard to predict outcomes. The final type, with high levels of both ambiguity and conflict, manifests a symbolic implementation process where the course of policy implementation is determined at the local level contingent upon actors and resources (Matland’s example is a community action program to combat poverty).

Matland’s framework served well in exploring the impact of conflict and ambiguity on the Every Child Matters reforms in the UK (Hudson, 2006), enabling some explanation of variation in the process of implementation. This work also highlights the dynamic nature of Matland’s model where ongoing policy activities may be explained through shifts to different quadrants of the model.

Based on Matland’s contingency model and at least arm’s length assessment of the level of policy ambiguity and conflict, implementation of the 6 hour ED time target may well manifest a symbolic implementation process for a number of reasons. Firstly, there is no precise blueprint to follow in order for service delivery organisations to achieve the target. Secondly, there may be variation in process and impact of policy implementation between different service delivery organisations, contingent on local circumstances and context. Indeed, I noted in the background chapter that some hospitals in New Zealand experienced few problems with ED overcrowding. Lastly, there is potential for conflict between organisational and service delivery stakeholders and their differing priorities. In regard to the symbolic implementation process, Matland further explains:

For policy with only a referential goal, differing perspectives will develop as to how to translate the abstract goal into instrumental actions. The inherent ambiguity leads to a proliferation of interpretations. Competition ensues over the correct “vision.” Actors see their interests tied to a specific policy definition, and therefore similar competing coalitions are likely to form at differing sites. The strength of these actors will vary across the possible sites. Contextual conditions at the local level affect outcomes through their effect on coalition strength...substantial variation is
expected...Professions are likely to play an especially important role...actors with professional training are likely to step in quickly with proposals grounded in their professions (Matland, 1995, p. 169).

This outline of the policy implementation literature highlights a number of points relevant to the present study. Firstly, a key insight of the implementation studies perspective is the importance of the ‘bottom up’ view of ‘policy making’, and the complex and discretionary role of bureaucrats and professionals in the implementation process. It specifically helps to establish where and whom to investigate: public sector professionals who are policy implementers at the service delivery level. Secondly, it recognises, particularly in Matland’s framework, the contingent nature of policy implementation where ambiguity and conflict may be dominant features of an essentially political process. Thirdly, governments are naturally concerned to see that their ‘top down’ policy directives have the desired service delivery effects whilst avoiding or mitigating effects that are not desirable. Yet the choice of a health target as a policy instrument may render the process vulnerable to challenging bureaucratic and professional behaviours and thus substantial risks to policy success. Further understanding of the performance targets is required by way of exploration of the performance measurement and management literature. Lastly, and by way of its absence in this particular body of knowledge, a core weakness of the implementation studies perspectives is lack of conceptual detail and clarity at the organisational and micro-organisational level (Palumbo & Calista, 1990). It is here where policy may be interpreted differently at different levels of government and reflect a confluence of actions “…influenced by the character of those implementing organizations (Palumbo & Calista, 1990a, p. 12). The next three sections of the chapter will explore all these points.

### 3.3 Performance Measurement and Management Literature

The theoretical roots of contemporary performance measurement systems in government reach as far back as the 1890s with Frederick Taylor’s scientific management theory and the analysis of workers’ effort, tasks, work arrangements, processes and outputs in order to design more efficient work systems (Heinrich, 2002; Heinrich & Marschke, 2010). The contribution of another organisational theorist, Chester Barnard (1938, cited in Heinrich, 2002), was the call for greater attention to the role of organisational incentives and the social character of cooperative systems.
According to Barnard, compared with rule-based hierarchical authority, an individual’s social interactions and awareness of a hierarchy of rewards, such as status, money and autonomy, were more powerful motivators of performance (Heinrich, 2002). A third and major theoretical influence on performance measurement is the Management by Objectives (MBO) approach advanced by Drucker (1954, cited in Heinrich, 2002). The basic assumption of MBO is specification of goals that may be explicitly identified in targets and will yield focused and efficient efforts (Van Herten & Gunning-Shepers, 2000a; Van Herten & Gunning-Shepers, 2000b). In contrast to this rational and closed system model, open adaptive system models of performance such as Total Quality Management (TQM) emphasise a multi-level participatory process and rely intensively on public managers’ use of information to link actions with organisational goals and outcomes (Heinrich, 2002).

Quantitative performance indicators, such as targets, rankings and other forms of intelligence, aim to enhance both accountability and transparency in government services as well as the efficient and equitable use of public money (Carter, Klein, & Day, 1992; Hood, 2007; Mannion & Goddard, 2002; Radin, 2006). Quantitative indicators are also proxy measures of organisational effectiveness that in a feedback process can inform ongoing policy development as well as management strategies, decisions and actions (Behn, 2003; Hood, 2007; Mannion & Goddard, 2002; Smith, 1995). Inspired by the MBO approach, targets give policy focus and recognisability and draw attention toward their achievement by stimulating change in the behaviour of individuals and organisations (Bevan & Hood, 2006b; Gooder, 1992; Thompson, Hochwarter, Mathys, & Hochwarter, 1997; Van Herten & Gunning-Shepers, 2000a). Targets may be input, process, output or outcome based, with length of stay targets, such as the emergency department and surgical waiting times, falling into the process category (Carter et al., 1992; Gooder, 1992). There is both indirect (Chun & Rainey 2005) and direct (Boyne & Chen, 2007) empirical support for the view that precise targets lead to higher performing organisations. In fact, Hood (2006) proposed that on the balance of probabilities, the health targets introduced to the English NHS in the early 2000s (targets were established for ED, ambulance service, and elective service waiting times) made a marked difference to reported performance.
The literature on performance measurement in government highlights a range of broad challenges relevant to the use of quantified measures in health care (Bouckaert & Peters, 2002; Carter, 1991; Carter et al., 1992; de Bruijn, 2007; Heinrich, 2002; Hood, 2007; Klein, 1982; Le Grand, 2007; Radin, 2006; Uusikylä & Valovirta, 2007). The first of these challenges relates to organisational complexity. In contrast to other sectors of government such as education and welfare, health care systems and organisations are marked by their complexity in terms of the various health professional, service delivery, organisational and patient groups involved. Complexity of organisational structure, including multiple organisations, and heterogeneity in production of care processes, are also notable features of health systems. Therefore pursuit of accountability for performance and quantitative measurement to judge it, belies this complexity, with many blurred and intersecting lines of service delivery, accountability and management responsibility (Heinrich, 2002; Klein, 1982).

The second challenge is the differing value that service delivery actors may place on performance measures in contrast to policy makers and politicians (Radin, 2006). Consequently, it may not necessarily follow that enthusiasm to measure and manage health service performance will transcend all services affected by particular performance measurement regimes. Furthermore, clinical health professionals (doctors, nurses, midwives etc.) may well be conflicted by the pursuit of efficiency values and standards, over clinical and professional values and standards, which may serve to demean the very organisational actors upon which efforts to improve health service performance invariably relies (Carter, 1991; Grizzle, 2002; Radin, 2006). Risks to the quality of clinical and patient care therefore represent an important challenge to the implementation of quantified measures, in a context where clinical professionals are already well accustomed to the risks of falling clinical quality arising from health reforms.

Next is concern that reliance on one sort of quantitative intelligence to motivate and evaluate performance may ignore multiple organisational perspectives and variables arising from social and political interaction and qualitative impact; thus replacing professional trust and expertise with untrustworthy data, that may further result in loss of innovation, organisational inertia or data
manipulation (de Bruijn, 2007; Harrison & Smith, 2004; Radin, 2006). Quantified measurement may also serve to undermine the intrinsic motivation of public servants, that in health and other social services is considered a key attribute of professional practice (Burgess & Ratto, 2003; Radin, 2006). Finally, measurement of performance may well exert political control, yet the relational distance between the centre of government and the service delivery organisation may also enable politicians to assert that decision making and results were out of their hands, and to a degree, avoid their own accountability for any adverse consequences (Boyle, 2001; Chang, 2009; Heinrich, 2002; Radin, 2006). Health care clinicians may well consider this relational distance a reason to disrupt or dispute reform.

Performance targets are underpinned by linked assumptions that help explain not only challenges and the possibility of dysfunctional consequences of target implementation, but also inherent flaws in their assessment of improved performance. Based on the principle of *synecdoche* - taking a part to stand for a whole - the first assumption regarding performance targets is the establishment of an objective measure that is representative of a particular domain (large or small) of organisational performance, and the second is that what is not measured by the target is either insignificant or unimportant (Bevan & Hood, 2006b).

In regard to the first assumption (the objective measurement of a domain of organisational performance), Carter et al., (1992) and Bevan and Hood (Bevan & Hood, 2006b) explain that some performance indicators provide an inaccurate or incomplete picture of performance since they are ‘tin-openers’ designed to open a ‘can of worms’ and prompt interrogation and inquiry. Alternatively, performance indicators may also be conceived of and function as ‘dials’, “providing a precise measure of inputs, outputs, and outcomes based on a clear understanding of what good and bad performance entails” (Carter et al., 1992, p. 49). A third conception is that of ‘alarm bells’ signalling a normative standard that, when breached, must be attended to (Carter et al., 1992). Whilst the 6 hour ED time target arguably may involve all three of these impacts, it is more likely to be aimed at the ‘tin opening’ effect; that is, a stimulus for change in practices and procedures, in culture and attitudes, and in the systems and operations of hospital service delivery to help improve
performance. Although the target is specific to the ED service, to achieve it also requires change in other service delivery areas of the acute care system, such as hospital bed management and clinical practice behaviours in medical or surgical services across a whole hospital. All of these broad areas for potential impact of the target were signalled in the Report (Working Group for Achieving Quality in Emergency Departments, 2008). Change is therefore required well beyond the walls of the ED, and as noted in earlier parts of this chapter there is no guarantee that the drive to improve performance in one clinical service will naturally transcend these other areas of the acute care system. The ‘tin opening’ and ‘dial’ effects may be threatening for many whose own domains of service and performance are at risk of change that arises from outside their particular area of health service delivery.

In regard to the unmeasured aspects of performance, the assumption of policy formulators is that these do not matter or can be adequately managed through feedback and monitoring mechanisms (Bevan & Hood, 2006b). However, these unmeasured aspects of performance are difficult to detect and manage, unless precise efforts are made to monitor them (Bevan & Hood, 2006b; Bird et al, 2005). Indeed, the very risk of adverse unmeasured consequences may prohibit the change sought by the ‘tin opening’ effect of the target. In their study of the effectiveness of targets on performance in the English education sector for example, Boyne and Chen (2007) note that their findings of a positive correlation between targets and improved exam results and grades must be considered with caution. As these researchers explain, their study did not examine other dimensions of performance, such as equity or value for money, and they question the impact of the target regimen on these non-targeted aspects of performance, including whether better results in one area are bought at the price of lower performance elsewhere in the organisation (Boyne & Chen, 2007).

These problems with targets, ‘tunnel vision’ and ‘myopia’, as Smith (1995) conceives them, can be combated by setting a larger range of performance measures, although it may be impractical or impossible to do so. Therefore, targets and the decision-making and actions they invoke may emphasise improved performance in one area, but cause the omission of considerations in other areas that are ordinarily important (Smith, 1995).
Another concern is that without incentives, targets alone may struggle to be effective in improving performance, and like the targets themselves, incentives may be also be dysfunctional (Bevan, 2010; Mannion, Davies, et al., 2005; Smith, 1995). Common incentives in performance measurement systems are sanctions and rewards. Sanctions at an individual and organisational level include the reputational effect of publication of performance results, for example league tables and balanced scorecards, with their use based on the assumption that negative feedback or the risk of negative feedback motivates change and improved performance (Bevan & Hood, 2006b; C. Davies et al., 2005; Hood, 2002). However, as the study by Mannion et al. (2005) concludes, the publication of performance results in health care, such as star ratings, may also lead to reduced staff morale, bullying, intimidation, and erosion of public trust.

Rewards, such as pay for performance, bonuses or earned autonomy, function by way of their appeal to self or organisational interests (Burgess & Ratto, 2003; Goldsmith, 1992; Le Grand, 2003; Mannion & Goddard, 2002). Yet such rewards for performance may also be deeply problematic in practice (Bate, Goddard, Kuhn & Mannion, 2005; Bevan & Hood, 2006b; Courty & Marschke, 2004; C. Davies et al., 2005; Propper & Wilson, 2003; Smith, 1995). For instance, rewarding high performing organisations (the ‘best to best’ principle) or providing additional resources for the poorest performers (the ‘best to worst’ principle) could well be considered an injustice by those organisations that work hard to improve but only make modest progress, and where both short term or chronic underperformance may be little more than a ploy to manipulate ongoing expectations or to ensure rewards (Bevan, 2010; Bevan & Hood, 2006b; Courty & Marschke, 2004; Hood, 2006; Smith, 1995). Another issue with the use of financial reward is the possible negative effect on intrinsic motivation (Burgess & Ratto, 2003; C. Davies et al., 2005; Weibel, Rost, & Osterloh, 2010), that in health and other social services is considered a key attribute of professional practice (Burgess & Ratto, 2003; McDonald, Harrison, Checkland, Campbell, & Roland, 2007).

Gaming behaviour is also strongly associated with the use of targets as quantified performance measures. Defined as “reactive subversion such as hitting the target and missing the point or reducing performance where targets do not apply” (Bevan & Hood, 2006b, p. 521), gaming
involves deliberate dysfunctional behaviour involving the violation of control system rules and procedures to secure strategic advantage (Jaworski & Young, 1992; Smith, 1995). According to Smith (1995), public servants may use gaming as a way of coping with increased work stresses and contradictions, a conceptualisation already introduced in the theory of street-level bureaucrats. Bevan and Hood (2006b) further explain that governments who use targets should expect gaming to occur, but that there are ways, such as auditing, to limit the occurrence of gaming to an acceptably low level.

At considerable length, Bevan and Hood, who are prolific authors and analysts of public service performance (see for instance Bevan, 2010; Bevan & Hood, 2006a, 2006b; Hood, 1995, 2002, 2007), consider both motives and opportunity for gaming in the public service. These scholars base their discussion around Le Grand’s (2003) dichotomy of public servants as ‘knights’ (altruistic, public spirited, moral and pro-social people) and ‘knaves’ (self-interested, glory and status seeking, rule-bending people). They further refine these descriptions to involve four classifications; saints, honest triers, reactive gamers and rational maniacs. At the heart of their scholarship around motivations and behaviours of public servants, Bevan and Hood emphasise that people may respond quite differently or unexpectedly to demands to achieve public policy, including gaming behaviour in response to targets.

Carter (1991) explains that the notion of performance is invariably full of ambiguity, contestable and highly complex in both theory and practice; much of the literature considered in this section attests so. Whilst it is evident that targets are designed to have an impact on the people, services and organisations to which they are introduced, understanding why and how this occurs and what this involves with conceptual clarity, requires a deeper exploration and understanding of organisations. It is in this deeper exploration of the micro-political context of organisations that greater understanding of performance measures such as targets might be found. The next section engages the organisational literature to identify knowledge that the policy implementation and performance literature may not.
3.4 Organisation and Management Literature

The broad and simplified approach taken here to address organisation and management literature is to select four of Gareth Morgan’s (1997) eight images and metaphors of organisation and highlight particular insights that can inform a far richer understanding of public policy implementation. Morgan explains that all theory is metaphor, and that if we are to accept this understanding then we must also accept that in the study of organisations, metaphors create valuable insights as well as misleading, biased and often incomplete views. To address the paradox, one must recognise that no single theory as metaphor will provide an all-purpose view; each metaphor of the organisation provides a view that the others do not and subsequently the need to seek fresh ways of seeing and understanding (Morgan, 1997).

The metaphor and image of organisation as machines is popular in contemporary theory, but also quite deceptive (Morgan, 1997). Through this image, organisations are, or can be, reliable, predictable, routinised, rational and efficient, and through the operation of bureaucracy and the explicit division of tasks and labour, hierarchy and supervision, rules and regulations, should function effectively (Morgan, 1997). On the basis of this metaphorical view, the implementation of public policy is a straightforward bureaucratic and rational process; although, as already noted, implementation tasks and responsibilities may still have to be determined, in this instance by managers.

Max Weber’s sociological conceptions of organisational bureaucracy were, fortunately, paralleled by his concern that bureaucratic organisations had the potential to erode almost every aspect of human life (see also the discussion by Clegg & Lounsbury, 2009; Morgan, 1997). The ‘iron cage’ of rationality, another metaphor, represents the pessimistic view of bureaucratic organisations that could potentially “…transform human interaction and behaviour into a dreary quasi-mechanisation, bereft of sensuality, spirit and culture” (Clegg & Lounsbury, 2009, p. 119). Bureaucrats are not suspended in space, and as already seen in previous sections of the chapter, have a mind and may take actions of their own making and of the social and cultural worlds in which they live. The key,
although somewhat simplistic, insight from this image is that people and organisations are also social and cultural entities. An unseen aspect of the machine metaphor of organisation is revealed.

Certainly the classical and scientific management theoretical contribution to the machine metaphor (see the discussion provided by Morgan, 1997, pp. 15–26) is manifest in multiple aspects of designing and managing contemporary organisations, for example the MBO approach already considered. As well, ‘lean thinking’ within quality improvement programmes (also briefly noted in Chapter 2), which breaks down and addresses the quality needs of the patient into its component parts, resonates with many features of the organisation-as-machine metaphor (although paralleled by awareness of the social and cultural nature of organisational life). The second insight from this metaphor and image is that absence of an essential component part of the organisation as machine will render its purpose, processes and goals difficult; arguably this point is implicit in Hogwood and Gunn’s (1984) prescriptions for successful policy implementation noted in section 3.2.

The metaphor of organisations as cultures is therefore important, and the second of Morgan’s metaphors to be considered here. Whilst culture is derived from the verb ‘cultivate’, it is also a noun that means to develop or promote and Morgan’s (1997) approach is to conceive of the organisation as a cultural phenomenon which varies according not only to its own stage of social development, but also the stage of development of the society in which it exists, and in this regard culture is not static. Some of Morgan’s preliminary discussion of the metaphor includes the cultural differences that may exist between different countries and societies, and recognition that similar organisations in different countries will manifest particular aspects of these cultural differences. From the perspective of this study, the relevant insight is that a public policy which addresses ostensibly the same or similar problems may have very different results because of these cultural differences, not only in society but also in public organisations.

A key consideration in Morgan’s (1997) discussion of culture is the presence and effect of organisational subcultures.

Organizations are mini-societies that have their own distinctive patterns of culture and subculture. One organization may see itself as a tight-knit team or family that believes in working together. Another
may be permeated by the idea that “we’re the best in the industry and intend to stay that way”. Yet another may be highly fragmented, divided into groups that think about the world in very different ways or that have different aspirations as to what their organization should be. Such patterns of belief or shared meaning, fragmented or integrated, and supported by various operating norms and rituals can exert a decisive influence on the overall ability of the organization to deal with the challenges that it faces (Morgan, 1997, p. 129).

The characteristics and nuances, values and behaviours of an organisation’s subcultures, as well as corporate culture, will clearly be influential in the process of implementing policy, in terms of either fragmented or cohesive intra-organisational culture, such as between different services or departments, or between the differing levels of corporate, management and service hierarchy. Threads of this insight have already been identified in Section 3.2, for example in Lin’s (2000) study of prison reform and the ‘culture of performance’ theme identified in this research. Intra-organisational barriers to the impact of performance measures between different departments or groups in an organisation, as noted in Section 3.2, may also be partly explained by the absence of shared meanings and values between these different parts an organisation.

Morgan (1997) notes that the presence or creation of integrated players or groups with a common purpose and ethos, across organisational divisions, may act as a powerful tool for mediating physical or more abstract subcultural divisions. However this might also include an integrated group whose mission is aimed at quashing or rejecting reform, for example from a group of union representatives (Morgan, 1997). The importance of leadership, particularly corporate leadership in organisational culture, is also acknowledged in this metaphor, since leadership helps establish the values that guide an organisation (Morgan, 1997). However leaders do not individually create or change culture; rather, they may create social processes, images, rituals and symbols that promote or sustain values, beliefs and practices (Morgan, 1997). Other authors have explained that organisational culture and, in particular, organisational leadership in health care are central to any endeavour to improve health services and at every level of the health care system and organisation (Ferlie & Shortell, 2001). This last insight would suggest that themes of leadership and corporate leadership, or the absence of it, may be fundamental to any explanation of public policy reform in health care.
Consideration of how culture is actually created and sustained is addressed succinctly in the organisation as culture metaphor with the central message that shared values, beliefs, meaning, understanding and sensemaking arise from a process of reality construction (Morgan, 1997). Following or enacting rules, such as establishing meeting rules or following extant organisational procedures, is the enactment of culture, although like the breaking of a law, rules can also be challenged (Morgan, 1997).

Morgan describes that sensemaking provides a vital understanding of organisational culture, and refers to the work of organisational psychologist Karl Weick (see also Weick, 1995; Weick & Sutcliffe, 2003; Weick, Sutcliffe & Obstfeld, 2005) to explain the proactive yet sometimes unconscious role that people play in creating their worlds. Sensemaking is an ongoing, subtle, transient and social process undertaken with others that involves the comprehension of circumstances expressed explicitly in words, talk, communication and language, through which meanings materialise and act as a springboard to action (Weick, et al, 2005; Thurlow & Helms Mills, 2009). Sensemaking is retrospective, driven by plausibility in contrast to accuracy and enables people to decide what is relevant and acceptable (Weick, 1995; Weick et al, 2005; Peck & Perri 6, 2006; Dickinson, 2011). Identity of self is central to sensemaking processes and is constructed—who people think they are in context influences how they will interpret and enact events (Dickinson, 2011). Weick et al. (2005) frame the cognition of sensemaking as starting with chaos, moving to notice and bracketing of the chaos, then labelling and categorising, followed by retrospect (or consideration of before and after insights) to make sense of the now.

Peck and Perri 6 (2006) and Dickinson (2011) engage sensemaking principles to understanding the various components of the process of policy implementation within an organisation. According to these scholars, policy implementation as sensemaking provides an alternative account to policy being merely delivered by public sector managers and professionals. The world views of managers and professionals in their local context come to life and shape the repertoire of responses to the analysis of problems and the choice of actions or solutions. Faced with uncertainty or ambiguity, public service managers and professionals must invariably fall back on stock interpretations of
problems that they face, and judge the intentions of people and their organisation’s capabilities. In particular, these authors propose that the repertoire of responses will flow naturally from the biases inherent in their situations and encompass the past, present and future.

The insights provided by the sensemaking literature and the influence of sensemaking on the implementation of public policy can be clarified through links to ideas noted in Section 3.3, for example, on why it is that a bureaucrat or public servant who is otherwise a saint, may become a sinner, or worse still a rational maniac. Why may a seemingly rational and loyal service manager become a gamer of targets, knowingly or otherwise? The answers may rest somewhere in the process of sensemaking that people and organisations experience when confronted with new challenges and the demand for change.

Notably, sensemaking theory, in conjunction with institutional concepts (predominantly historical and social institutions), have been applied to the analysis of health policy implementation in two qualitative multi-site case studies in the UK, and enabled these research teams to identify variance in perceptions and actions occurring at different sites and different levels of government (Coleman, Checkland, Harrison, & Hiroeh, 2010; Pope, Robert, Bate, Le May, & Gabbay, 2006). As well, in both these studies, policy was loosely specified (although in neither case were they performance targets), and thus somewhat ambiguous and uncertain, which enhanced different framings of the policy, meanings and actions for different policy implementers. Another link, this time to Matland’s (1995) contingency model and matrix is apparent (see Section 3.2), in relation to the impact of ambiguity and uncertainty, and to the impact of context at the local level of policy implementation.

Morgan’s political systems metaphor is the third to be considered in this discussion, and adds further depth to conceptualising organisations. According to Morgan, the rational and other portrayals of organisations tend to discourage talk and understanding of political motives: “Politics, in short, is seen as a dirty word” (Morgan, 1997, p. 154). Unfortunately then, limited conceptions of organisational life prevent seeing not only the negative aspects of organisational politics, but also the positive and important (Morgan, 1997). Two points in Morgan’s introduction to this metaphor should be mentioned. First, organisations should be understood as systems of government that are
intrinsically political and manifest diverse and often competing interests and ideologies. And second, that the interplay of competing interests, power and conflict, is a means of creating social order.

‘Interests’ are predispositions toward values, desires, goals and expectations that lead us to act in one way rather than another (Morgan, 1997). Task (the work we do), career and extramural interests all shape our thinking and actions but may do so differently in specific situations, with tensions and contradictions between these interests, rendering people inherently political (Morgan, 1997). A decision to support and/or enact policy reform, by individuals, groups, departments and organisations more broadly, is therefore the outcome of political tensions and provides a good platform for understanding why a medical team, for example, may reject changes to their systems and practices if they do not coincide with their clinical or professional interests. It is also possible that an individual may manage their conflict of interests internally and quite unconsciously, such that they believe in one thing, say another and yet act in a different way again. There is clearly some explanatory potential in identifying how conflict of interests may affect policy implementation, for instance if a manager is induced by monetary reward (an extramural interest) to achieve a target rather than a competing interest in ensuring safe and high quality service provision.

Conflict therefore arises where interests compete or are in tension, for example, individuals or groups exerting their choices, sometimes matter-of-factly, such as a memorandum to reject a proposal for change, or alternatively negotiating the minutiae of detail in such a way as to limit the threats and impact that a change may have. Morgan (1997) additionally explains that many organisational conflicts can become institutionalised, for example in their rituals, stereotypes and attitudes, and in this socialised form may be difficult to identify and break down. A good example of this may be the explicit prescription and control of group membership to avoid people who are likely to challenge thinking, decisions and actions openly. Yet again, a link back to Matland’s contingency model of policy reform, particularly the symbolic implementation process and several other perspectives in Section 3.2 can be made, though with the political metaphor lending a little more substance to the understanding.
“Power is the medium through which conflicts of interest are ultimately resolved. Power influences who gets what, when and how” (Morgan, 1997, p. 170). Several important sources and enactments of power in organisations are formal authority, control of scarce resources, control of knowledge and information, control of boundaries and interpersonal alliances, networks, and control of the ‘informal organisation’ (Morgan, 1997). Based on what has already been discussed throughout this chapter and elsewhere, it is not difficult to comprehend how these sources and enactments of power may impact on policy implementation. But what does stand out about the nature of power is the notion of control; consequently, whichever group or person in an organisation, or for that matter outside of it, has such control, is likely to have substantial influence on policy implementation.

A good example of the interplay of these political metaphor images and ideas can be found in the discussion by Ghobadian, Viney and Redwood (2009), who considered some of the unintended consequences of health reforms in the UK. Applying stakeholder and resource dependency theories to their analysis, these authors propose that public service managers (agents) will invariably favour and pursue the interests of the government (principal) who is the ultimate arbiter and controller of organisational resources, despite the influence of a myriad of other stakeholders involved or influential in organisational decision-making. These authors align the unintended consequences of reform (with reference to Bevan and Hood’s 2006b article, and the Commission for Healthcare Audit and Inspection, 2009), with inevitable dependence on government resources. They propose that because of this dependence, management practice and decisions favouring the interests of government and the pursuit of performance results, overwhelmed the needs of patients for safe and effective care in the Mid-Staffordshire NHS Trust organisation.

It is a natural transition to move from the metaphor of organisations as political systems, with its emphasis on power and conflict, to the final metaphor to be considered— organisations as instruments of domination. This metaphor again highlights some of the concerns of Weber and other sociologists about the bureaucratic organisation and its impact on people and groups; though organisations may be rational and democratic, they may also enable particular “...people and groups to acquire and sustain a commanding influence over others, often through subtle processes of
socialization and belief” (Morgan, 1997, p. 306). An additional feature of this viewpoint is the division of labour in organisations that manifests class and other social distinctions. Quite possibly the key insight is not merely the idea that some people and groups in organisations dominate and exploit others; rather, that the dominated group or individuals may resist.

This metaphor also draws attention to the double-edged nature of rationality. What may be beneficial on one edge of the sword, for example improving the performance of a particular service or department, may also have a sharper edge of unintended consequences on employees or customers. These themes have been clearly introduced in earlier sections of the chapter, with the metaphor enabling a more circumspect view of the organisation.

The third insight from this metaphor is that it emphasises the dominance of particular elite groups in society, such as those who control resources, knowledge and social positions. And, although these types of domination are rarely pure, their reinforcement in the culture of an organisation renders them a potent force in organisational life (Morgan, 1997). The broad implication of this metaphor is the dominance that elite groups in organisations may have over the process of policy implementation. Arguably, the Mid-Staffordshire NHS Trust example explored by Ghobadian et al (2009) might be further analysed through the organisation as systems of domination metaphor; with managers controlling resources and decisions and fulfilling the role of dominant elites, and with performance measurement dominating the affairs of the health care organisation.

The other metaphors and images in Morgan’s framework, organisations as psychic prisons, as brains, as flux and transformation may also be useful conceptual tools that alongside those outlined in this chapter lend a richness and detail to understanding public policy implementation. However, what has been revealed through discussion of the four metaphors outlined in this section, is the need to place further emphasis on understanding the social context of health care organisations; who are the elites and the dominant, and what are the political and cultural barriers and behaviours that may function to complicate, enrich and confound health care organisations and the implementation of public policy. These matters are addressed in the next section.
3.5 The Sociology of Health Care

This final section of the review traverses some well-known and some newer understandings of the sociology of health care. The aim of the section overall is to identify knowledge arising from health care sociology literature that might further inform understanding of policy implementation. I preface the section with a brief consideration of sociology of the professions and public service professionals.

Two respected scholars of professional sociology are Eliot Freidson (1986, 2001) and Andrew Abbott (1988). Both have advanced analyses of professions from early and orthodox ideas about knowledge, traits, power, dominance and structure to more compelling insights that recognise the evolutionary nature of organisations and the ecological system of professions. Abbott argues, in particular, that professions do not exist within a vacuum, but within a system of other professions who are constantly at war over their jurisdictions of knowledge and skill and their place in the market (1988). In his latter text, *Professionalism - the third logic* (2001), Freidson explores the evolution of professions through economic, political and managerial reform, with analysis that identifies different sources of control regarding professional knowledge: free-market, bureaucratic and professional. In addition, Freidson identifies five contingencies necessary for establishing and supporting professionalism: an esoteric and discretionary body of knowledge; division of labour that is occupationally controlled; an occupationally controlled labour market; an occupationally controlled training program; and an ideology serving transcendent value. These conceptual insights on professional sociology may well be pertinent to the way front line health care staff respond to performance targets.

Gleeson and Knights (2006) explain that professionals in public service may be conceptualised as functioning and evolving within a context of social and organisational dualism. The first part of this dualism is that of *structure*, or subjection to external rules and constraints such as audit and inspection, accountability, managerialism and institutional hegemony. The second part of the dualism concerns *agency*, or the way professionals construct meaning and identity within the conditions of their work. A third way is also apparent, *mediation*, where temporary truces allow
movement and space for debate around tensions and conflict that may arise from the dualism and from which creative and entrepreneurial practice may result. Gleeson and Knights describe that the quest for modernity in public organisations means that traditional assumptions of the trusted civic authority of professions have been challenged by both market and managerial discourse, with consequential challenges to professional autonomy and discretion. Implementation of the target may well bring about significant challenge to the professional autonomy of health care clinicians and it would be crucial to explore how this occurs and what the consequences are.

Rudolf Klein (1983) provides an important discussion of political, structural and policy reform in the English NHS that considers the influence of the health professions on the process of reform, and he does so across a lengthy period from 1940 to 1980. Klein continued the examination of reform in a later book to the post 2000s neoliberal era (Klein, 2006). Whilst Klein’s analyses are largely centred on policy and politics, one of the most valuable insights from the work is the sheer resilience and capacity of the medical profession to maintain an authoritative stance and exertion of its interests both in society and in public health organisations. The more recent decades of the NHS, at least from the 1980s onward however, offer no such security for medicine, with public sector reforms encroaching greatly on the social and organisational worlds of the profession (Klein, 2006).

In sum, this literature suggests that not only are public servant professionals and in particular medical professionals vulnerable to struggle for jurisdiction in a wider system of professions, but also that public organisations are in constant modernising flux which demands multidirectional change, accountability and mediation of practice.

Medicine, nursing and many other allied health clinicians, such as social workers, physiotherapists, midwives, occupational therapists and dieticians, comprise the cluster of clinical professional groups in health care. Based on the discussions noted above, struggle for jurisdiction, authority and autonomy plays out both within and between these professions. A range of other occupational groups, some of which have their practice or parts of it regulated through organisational or other controls (primarily technical and clerical staff), is also identifiable in health care. Health service managers, including those who are explicitly clinical managers (for example, nurse managers and
medical directors) and those who do not have their practice regulated by government, are also part of the diverse cluster of professional and occupational groups in public health organisations.

Whilst medicine is a dominant professional group, so too is nursing and the emergent grouping of health managers. Indeed, these three groups have been the subject of a growing body of literature which considers the social and cultural dynamics of health care delivery and reform. This body of literature is complemented by scholarship that has framed the social and professional groups with the purpose and nature of contemporary health service delivery. An outline of these two complementary bodies of literature follows.

Glouberman and Mintzberg (2001a, 2001b) assert that health care is one of the most complex systems known to society. Yet they explain, this complexity falls away through a matrix framework that both differentiates and integrates the four ‘worlds’ of health care: the worlds of cure, care, control and community. The ‘world of cure’ is not unsurprisingly, predominantly the domain of the medical community, and whilst this world is not exclusively the purview of the hospital, it is nonetheless linked to the curative services that hospitals provide and in particular the highly interventionist and intrusive aspects of acute health care services. This curative world conception thus transcends organisational and service boundaries but also characterises the ‘world of cure’ as silos and hierarchies of medical specialisation. The world of cure also grounds the practice of medicine in a social and ethical dimension reinforcing authority and legitimacy in the eyes of society and community. As Glouberman and Mintzberg (2001a) rightly point out, the ‘world of cure’ relies intensively on the work and input of other health professions and occupations, but that medicine largely prescribes curing interventions and activities.

The ‘world of care’, also not unsurprisingly, is the central domain of nursing and as with the transcendent nature of the ‘world of cure’, this world extends across acute and community care divisions. But one of the differences between the former and latter is that nursing professionals easily retrain to function effectively within different service specialities, whereas medical professionals largely train and stay within a particular medical specialty, moving upwards rather than across social and service boundaries. The subordinate socialisation and divisions of caring and
curing, between nursing and medicine, renders a social and organisational battleground that may be deeply dysfunctional without resolution (Glouberman & Mintzberg, 2001a).

The ‘world of control’ in its former life was the purview of administrators but in its current form is largely the purview of managers in their various hierarchical and divisional forms that claim distinction by way of a broad systems view of controlling health care. Managers without professional credentials may suffer socially from the divide between professional structures and status, but this is counteracted by the relative control that they have over the use of resources. Glouberman and Mintzberg (2001a) suggest, however, that weak health care managers may exploit this fiscal power and cocoon themselves within formal resource authority, whilst at the same time giving off an illusion of harmony. Management and leadership practices and characteristics, and cultural attributes that are associated with managerial values and approaches, have been found to be correlated with high economic performance of health care organisations (Lega, Prenestini & Spurgeon, 2013). However, Lega et al (2013) also note that health care organisations run by doctors appear to have better economic performance than others. Whilst the ED time target is not a financial target, it will undoubtedly have resource implications. How managers practice, and how they may lead, utilise resources, and enact the values guiding their behaviours, will be important to identify in the study.

The ‘world of community’ in very broad terms describes an organising principle and structures of governance, such as boards. It also describes a relationship to the ‘world of control’ and in doing so both separates but exerts influence on the ‘worlds of care and cure’. The distance but connectedness of the ‘world of community’ to the other worlds brings with it societal and government influence but one which may render a real absence in understanding the peculiarities of the other worlds.

The main contention of Glouberman and Mintzberg’s matrix is that both the conceptual and practical disconnection of these worlds renders a system spiralling beyond control and no matter how necessary the division of labour may be, “...associated divisions of organization, attitude, and mindset render the system unmanageable” (Glouberman & Mintzberg, 2001a, pg57). The four worlds are thus linked conceptions of one system that requires integration and cohesion which these
scholars also describe through tangible, real world and empirically based descriptions of the mechanisms and management of contemporary health care organisations (Glouberman & Mintzberg, 2001b; Mintzberg, 2002). This scholarship contributes to the present study through providing further verification of the different social and organisational groupings in health care where tensions and conflict in policy implementation may occur. It also pinpoints many other social themes that may emerge in findings and interpretations for this study.

A substantial research contribution to understanding the dynamics and impact of reform in health care has been made by Pieter Degeling and colleagues (Degeling, Hill, Kennedy, Coyle, & Maxwell, 2000; Degeling, Kennedy, & Hill, 2001; Degeling, Kennedy, Hill, Carneige, & Holt, 1998; Degeling et al., 2002; Degeling, Maxwell, Kennedy, & Coyle, 2003; Degeling, Sage, Kennedy, Perkins, & Zhang, 1999). This work in particular has examined perceptions of reform from the viewpoint of medical and nursing clinicians and managers, and general managers. Spanning four countries, England, Wales, Australia and New Zealand, and 26 different hospitals, this research demonstrates that general managers hold strongly systematised conceptions of clinical work, with financial realism and transparent accountability dominating their perspectives. In contrast, medical clinicians have strongly individualised conceptions of their clinical work, whilst demonstrating an equivocal stance on financial realism and transparent accountability. Medical managers, on the other hand, whilst similarly holding individualist conceptions of clinical work, tend also to perceive a need for financial realism and transparent accountability. Nursing clinicians, have both systematised conceptions of clinical work and strongly support opacity, clinical purism and accountability—to self, patients and peers. Lastly, nurse managers hold systemised conceptions of clinical work and are somewhat equivocal about clinical purism and opaque accountability. Accordingly, “...nurse managers, not general managers, are the professional group most supportive of modernization” (Degeling et al., 2003) and can therefore make a significant contribution to reform. These studies broadly support recognition that differences in professional cultures contribute to tensions between medicine and general management. Furthermore, Degeling and colleagues propose that increasing pressure for reform through performance measurement regimes is likely to sow the seeds of rejection by clinical staff, particularly medicine, and exacerbate distrust.
and crises of confidence in health care services. The emphasis, they suggest, should be on responsible autonomy as an organising principle in health care (Degeling et al., 2003).

Health service provision in New Zealand is deeply politicised and reflects resistance to reform by both the health workforce and community (Fitzgerald, 2004; Fougere, 2001). Some of the resistance involves notions of care and perceptions that would suggest health care managers are uncaring or that clinical staff give status-driven care (Fitzgerald, 2004).

With a focus on studies exploring the management and medicine relationship, Numerato, Salvatore, and Fattore (2012) presented a comprehensive review of research addressing the impact of management on professional control in health care,. The review found that managerial hegemony may be interwoven between sociocultural and task-related dimensions of organisation, with the logic of management discourse internalised by doctors, that may manifest in decreased clinical autonomy due to increased requirements for accountability and efficiency. Professional opposition in the sociocultural dimension is underpinned by a history of professional authority, habitus, disposition and imperative. The review identified studies where medical professional norms and ethos were seldom eroded and indeed were "often understood as a source of physician's reluctant attitude toward management" (Numerato et al, pg 631). However this review also identified that negotiation, co-optation and strategic adaptation in the management and medicine relationship is evident, signalling improved collaboration in the organisational context. The centrality of management power may still be exerted, but with such influence moderated by professional control of management tools, communication and clinical surveillance.

More recently scholars have mapped out detailed analyses of the role of health professionals in policy implementation (Dickinson & Mannion, 2012). Tribal behaviours, clinical autonomy, decision making discretion and resistance to change are noted concepts and issues in this body of literature (Debono, Greenfield, Black, & Braithwaite, 2012; Hupe, 2012; Hyde, Granter, McCann, & Hassard, 2012; McDermott, Keating, & Beynon, 2012).
Many of the themes and insights in this section are consistent with earlier parts of the review and may well be evident in this study and in the ways in which health care professionals influence and respond to the target. The more obvious is the importance of different labour force groups in health care, such as management and clinical staff, as well as distinctions within these groups; with each group bringing differing social orientations, values and morals (Section 3.4). Other links include the relationship between coping behaviours of front line bureaucrats (Section 3.2), and with performance measurement activities (Section 3.3) and the ways in which different health professionals may perceive and respond to targets. However, there is also the possibility of some degree of alignment along caring perceptions and shared moral foundations. Yet even these moral and professional alignments are vulnerable to domination by others whose social status and control of resources is more powerful. A final but by no means less important insight is that concerning the medical profession, including how policy reform may encroach upon its professional jurisdictions and social world. Medical staff may mediate or reject the target and such behaviour may be misunderstood by others. The social world of health care is volatile, complex and eminently fascinating in a reforming landscape.

### 3.6 Chapter Summary

#### 3.6.1 Key Features of the Literature

Policy implementation knowledge and literature provides a pivotal but nonetheless limited understanding of what happens when top down policy directives are introduced to service delivery organisations in government. Issues of conflict and ambiguity, of resource constraint and of the divide between the top and bottom of government, are clearly relevant to policy implementation but not necessarily able to help governments and policy formulators understand how things have actually fared within the organisations they want to improve. Whilst knowledge arising from the literature on performance measurement and management is informative, particularly regarding what motivates and changes government actors, it does not provide the conceptual details that help explain the behaviours of organisations and the array of social and cultural influences on the people within them. Importantly, the gaming of quantified measures, particularly targets, is a key concern of this literature. Arguably, the more revealing and with it more complex insights arise from
knowledge of organisations and their management in the public sector and public health care. Culture, leadership, politics and domination are key features of organisational life and in turn may be key factors in the way health care organisations respond to the demand for change. Knowledge of the social world of health care enables further contextualised insights into the types of professional groups, relationships and political behaviours that may shape public policy and the process and outcomes of policy implementation.

The role or relevance of context features in this literature review in a number of different ways. For example, Barrett (2006) refers to the micro-political context inside the implementation “black box”, and Carter (1991) to the context of different government departments. The social and cultural context of health care and organisation also appear pertinent, not only to public organisations but to health care professions. In this regard, Pollitt (2013) describes context as a crucial concept in public policy and management, but omnibus-like in terms of contextual levels, factors and function. Context in the macro, meso and micro levels of government organisation are pertinent, as are local, historical and institutional features (Pollitt, 2013). Thus, study of target implementation should seek to identify what in fact were the most pertinent features of context, and how this functioned to influence process and outcomes.

3.6.2 Rationale for the Research

Review of the literature in this chapter reveals that health care is a highly complex and inherently political context for the implementation of public policy. This suggests that response to the target might be unique not only to the arena of public health care, but to individual health care organisations themselves. Indeed, all these factors prompt several more questions of empirical interest. For example:

- What happened when this target was introduced? What were the strategies involved, and which individuals or groups were behind it? If there was change, was it collaborative and coherent, or was it highly dysfunctional and induced a war zone of competing interests, values and social status?
- If the target was reached, then how? Did the target induce change in health care organisations directed toward improving performance or did the target induce gaming behaviour, and why?

- If the target was not reached, what seemed to prevent this? Did aspects of organisational culture, professional institutions, and leadership practice impact on policy implementation, or was the process dominated primarily by control of resources?

- Was the division of labour important to target implementation? How did health care professionals perceive and make sense of the target?

- Did timing matter? Did the size and location of the health care organisation matter? What are the contextual features or factors of context that influenced the process and outcomes of target implementation?

As noted in the introduction to this chapter, the key issues which motivate this study include that public policy may fail to be effective (in whole or in part) and may also induce unintended consequences of policy reform. A third concern that emerges from the literature involves the problems associated with the use of targets to improve performance—most notably the risk of gaming. Some of these issues can be explained by a more detailed understanding of the front line of the public service organisation, the “black box” of policy implementation. Research of the implementation of the 6 hour ED target in New Zealand's hospitals is therefore an important opportunity to inform theory and practice in public policy implementation. It is also an important opportunity to research the impact of targets and the management of them in health care organisations.

### 3.6.3 Implications for Study Methodology

In order to step inside the “black box” of policy implementation for the target, research needs to engage with front line health care organisations and front line health professionals. It should be noted at this point, that use of the term front line health care organisations, staff and professionals in this thesis, is used to refer to organisations, staff and professionals who are directly involved with
delivery of services to the public, whether clinicians or managers, in contrast to organisations, staff and professionals who may govern delivery of services, such as DHBs, the Government or Ministry.

The research questions that I propose in order to investigate implementation of the ED 6 hour target are:

- **How did front line staff respond to and implement the ED time target and what were the consequences?**
- **How did context influence the process and outcomes of policy implementation?**

These are questions that are clearly not aimed at a normative analysis of what should or should not be done to meet the target (a top down view), nor can they be answered by simply measuring achievement of a target itself. Rather, they are aimed at enquiry that needs to be open to the eyes, ears and voices of people on the service delivery front line, and their perceptions, experiences, opinions, values and actions which give shape to public policy in the service delivery context. Moreover, the people and groups who can inform the enquiry are diverse and include, most importantly, medical, nursing, clinical and management staff both inside the ED and in the wider hospital. The ways in which staff made sense of the target in their organisational context is key to understanding implementation process and effect. Moreover, different health care organisations may have different cultures and subcultures, histories and other local contextual factors which impact implementation. All of this may also be influenced by the magnitude of the various problems and demands related to ED overcrowding and delays to treatment, and to other drivers for improvement in the local organisation. All of these factors guide the research strategy for this study and are outlined in Chapter 4.
CHAPTER 4

RESEARCH STRATEGY

4.1 Introduction

This purpose of this chapter is to set out the research strategy for this study of policy implementation. The specific aim of the study was to explore how organisations responded to the ED time target by investigating the perspectives, experiences and actions of front line clinical and management personnel in the ED and wider hospital. A second and important aim was to identify the variations in organisational responses between hospitals and different informant groups. These aims reflect several strong pre-existing hunches arising from review of the literature regarding the process and effect of policy implementation, the impact of targets and the social world of the health care organisation. The study is thus not without conceptual insight or direction. However, the study does not take for granted which concepts, variables or factors, nor which front line actors, are more important or prevalent in the organisational “black box” than others. Rather, it takes an exploratory approach to the study of policy implementation and asks the research questions:

- How did front line staff respond to and implement the ED time target and what were the consequences?
- How did context influence the process and outcomes of policy implementation?

These questions and aims underpin the research strategy and the methods selected and applied. Following a brief consideration of various philosophical perspectives of the social world that might underpin the study, the choice of an interpretive lens is described and substantiated. Attention in the chapter then turns to describing case study method and multiple-case study design. Qualitative research and associated methods are discussed along with rationale for these choices. Selection and recruitment of case study organisations is then outlined. Recruitment of participants, data collection, the approach to management of the data and finally the procedures of thematic data analysis are outlined in detail. Matters of research rigour and ethical procedure are also described and discussed. The chapter closes with a summary.
4.2 Philosophical Perspectives and the Choice of Interpretivism

Selection of methodology and associated methods for research are guided by the nature of the phenomenon to be studied, the research question and the aims of research, all of which, in turn, are underpinned by broad philosophical perspectives and paradigms. Philosophical perspectives comprise various theories, assumptions and issues about the world, the nature of reality, quality of research and the methods most suited for seeking answers to questions (Neuman, 2011). My task as the researcher is to ensure that my chosen methodology and methods are consistent with the underpinning philosophy. Four broad and frequently referred to perspectives in social research are positivist, post-positivist, critical social science and interpretivist (Crotty, 1998; Denzin & Lincoln, 1998; Neuman, 2011). I touch on the first three of these perspectives only briefly in order to support the grounding of this research in the interpretive perspective.

Positivist social science emphasises the use of empirical observation and discovery of causal laws to produce and substantiate knowledge. From this perspective, reality is real, essential and apprehendable. Positivism asserts an objective and value-free science directed toward explanation, control and prediction (Neuman, 2011). Post-positivist epistemology proposes a modified dualism, where there is separation between the knowing and examined subject, and ontology based on critical realism, where reality is imperfect but may be approximated (Gabrielian, Yang, & Spice, 2008). Explanation, prediction and control are also aims of post-positivist inquiry. In contrast to the positivist perspective however, post-positivism has a greater tolerance for error where findings are probabilities rather than verified laws (Gabrielian et al., 2008). Critical social science, on the other hand, emphasises multiple levels of reality (the empirical, the real and the actual) and the value-based activism of human empowerment (Gabrielian et al., 2008; Neuman, 2011). The purpose of critical social science is not only to study the social world but also to transform or change it through dialogue between the investigator and the investigated. This science combines both observation and understanding of the real world and its structures, with the generation of new insights and explanations through abductive reasoning, praxis and critique (Gabrielian et al., 2008).
Policy scholars, however, reject the notion of the separation of the knowing and examined subject (modified dualism) in the post-positivist description above, based on the assumption that the researcher and the researched should be inherently and intrinsically part of situated meaning-making (Fischer, 1998, 2003; Yanow, 2000, 2003). Thus, post-positivist policy researchers may take an interpretive or critical approach to the study of policy implementation that enables a rather more intrinsic role of the researcher in policy meaning making (Fischer, 2003; Yanow, 2003). Such an approach is aimed at developing a body of knowledge more capable of informing pressing issues in social and economic policy and government (Fischer, 2003). Yanow (2000, 2003), in particular, places emphasis on interpretation of policy at the local level of organisation.

The interpretivist perspective is underpinned by constructionist epistemology and holds the view that all knowledge and meaningful reality “...is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 1998, p. 42). In particular, social constructionism emphasises the social origin and character of meaning making and the embedded nature of social institutions, history and culture (Crotty, 1998). The ontological assumptions of constructionist epistemology concern multiple, socially constructed realities (Crotty, 1998), involving a continuous social process that is freshly created in “...each encounter of everyday life as individuals impose themselves on their world to establish a realm of meaningful definition” (Morgan & Smircich, 1980, p. 494). Such definitions arise symbolically through the medium of language, labels, actions, and routines (Morgan & Smircich, 1980).

Interpretive researchers view the organisation as a social site with unique community characteristics that emphasise social activities, and where researchers bring past and present together through the talk of subjects who are active organisational sensemakers (Deetz, 1996). The interpretive researcher is seeking both a convincing and unifying portrayal of the complexities of organisational life as well as uncovering tensions, contradictions and fragmentations (Deetz, 1996). Miles and Huberman (1994) observe that interpretive researchers are not detached from their objects of study.
Rather, they have their own understandings, convictions and conceptual orientations, since they are also members of particular cultures in particular historical moments.

The interpretive perspective provides an appealing and appropriate philosophical and theoretical foundation for this study, for a number of reasons. Firstly (and in contrast to the other perspectives considered), it encourages an exploratory focus on the social and cultural world of people and organisations, drawing attention to both meaning and context for implementation of policy. It does not seek, therefore, to prove or disprove, but to construct knowledge of the social phenomenon. Secondly, and in particular contrast to positivist science, it recognises the contingent and continuous nature of the social world. Thus, response to the target may be tentative and contentious, with local historical and cultural factors impacting on developing opinions and behaviour, as well as the pace and nature of change. In particular, this perspective embraces the notion of human beings constantly interpreting their world and responding to it in nuanced ways that may indeed change as learning and understanding progress. Next, the interpretive approach acknowledges that the researcher may not be detached, value-free or neutral. Whilst I may be disciplined and methodical, invariably I bring my own understandings and experience as a health professional to the process of investigation and the interpretation of the sensemaking of others. And finally, complexity is central to the social world and organisations. In contrast to notions of clarity regarding “variables”, “factors” or orderly processes, reaching into this complexity through an interpretive research lens is critical to unlocking the “black box” of how a policy like the ED time target is actually implemented.

I acknowledge that interpretivism does not have an exclusive claim to these focal points and concepts in the social sciences (see the discussion by Crotty, 1998, regarding epistemology, theory and methodologies). Nonetheless, I have approached this study broadly from an interpretive perspective that is both compelling and conducive to the aims of the research and its health care setting. I also note the ontological and epistemological distinctions in regard to this perspective; in particular, the role of prior theory to the generation of knowledge and the continuous flux of making sense and meaning of one’s social world. Consequently, a pragmatic choice is made here to account for the aims of the research, whilst negotiating the limits to investigation of the complex social
world of acute health care. Emphasis has consequently been on answering the research question through the application of methods that enable me to engage with, capture and analyse the participants’ views and experiences of their socially constructed worlds, by eliciting their voices, descriptions, metaphors and opinions as close to their lived social worlds as possible.

4.3 Case Study Methodology

In the literature, case study is described as a general methodological framework which enables intensive investigation of a specific instance or a handful of instances of a social phenomenon, and where in-depth understanding can be achieved of complex issues in their real-life, natural context (Crowe et al., 2011; Stake, 2006; Swanborn, 2010). An important characteristic of case studies is that they focus on achieving an holistic understanding of cultural systems of action (Trellis, 1997). The label “holistic” means researchers have accounted for the complexity of causes in human behaviour and social phenomena (Swanborn, 2010), and the term “cultural systems of action” refers to “sets of interrelated activities engaged in by the actors in a social situation” (Trellis, 1997, p. 5).

Thus, case study is suited to situations where it is not possible to isolate the phenomenon from its context and where there is lack of clarity regarding which variables are important (Swanborn, 2010). In addition, the phenomenon of interest is followed over time; such monitoring helps to explain history, changes during the period of study and the complexity of structure of the phenomenon (Baker, 2011; Swanborn, 2010). Case study research therefore emphasises detailed description, understanding and explanation. As Swanborn explains:

The selection of case study as a research strategy is primarily guided by the character of the research question. If it concerns descriptive and/or exploratory broad questions about a social process in a situation in which we have little knowledge of the phenomenon, and specifically if we are interested in the ways several individuals and groups of stakeholders interact with each other and interpret each other’s behaviour, and the ways in which they cope with problems, we need to explore one or more cases to clarify the intricate web of social relations, perceptions, opinions, attitudes and behaviour (Swanborn, 2010, p. 41).

Case studies have a distinctive place in the evaluation of public policy, where they may be applied to generate insight on causal links with policy interventions or programmes that may be too complex for survey or experimental research strategies (Pawson & Tilley, 1997; Yin, 2009). In the
field of health service innovation and quality improvement research, case studies enhance understanding of the relationship between organisational process and context to the failure or success of efforts to improve quality (Baker, 2011). The very same relationship of interest applies to implementation of public policy and the myriad of social processes and outcomes that may emerge at the local level. An issue for this study is to consider what contextual features influence the implementation and impact of health policy.

4.4 Single or Multiple-Case Study Design

There are a numerous designs and types of case study research, including single or multiple cases, and intrinsic (the phenomenon is interesting in its own right), instrumental (the case is of particular interest due to a specific problem being investigated) or collective types (multiple simultaneous or sequential cases) described in the literature (Crowe et al., 2011; Stewart, 2012). Stake (2006) and then subsequently Stewart (2012) define multiple-case study as “being investigation of a particular phenomenon (or group of phenomena) at a number of different sites” (Stewart, 2012, p. 69). I utilise this conception of multiple-case study to guide design and method for this research.

Generally, the choice between a single or multiple-case (sometimes referred to as multi-case) study design is based on different research aims and questions (Yin, 2009). It was conceivable, for example, to have undertaken an informative research project on implementation of the ED target, based on a single case, such as the implementation of the target in one New Zealand hospital, with multiple and mixed methods for data collection and analysis. The aims of this hypothetical single case study might have been to determine the nature and prevalence of specific leadership behaviours or determine the impact of the target on operational outcomes. Such a study would have been instructive about the impact of the target, with many implications for theory and practice. Yet, this strategy might also have missed a great deal more to know and understand about the impact of targets, about political behaviour and a key feature of interest—namely, the relevance, if any, of different organisational contexts to the implementation of the same policy.

There are at least two dimensions of context to be concerned with that Swanborn (2010) describes as the social and the physical, and their impact on the social process. Social context concerns the
“local organisation”, including its culture and history. Physical context concerns factors such as demography, hospital size and urban-provincial-rural setting. As simplistic as these conceptual distinctions appear, these two dimensions may be linked in the thinking and actions of people in their organisational context. Indeed Pawson and Tilley (1997) elaborate that context involves “the spatial and institutional locations of social situations, together, crucially, with the norms, values and interrelationships found in them” (p. 216). Features of context are consequently an important consideration in determining differences in the process and outcomes of policy implementation. This is a key rationale for the choice of multiple-case study design and the ability to make cross-case comparisons. At any rate, and as Swanborn (2010) advises, all research, at some point, boils down to comparison—in this study, I take advantage at the outset from a methodological multiple-case study starting point.

Often the number of cases selected in multiple-case study design is a pragmatic decision (R. Stake, 1995; Swanborn, 2010; Yin, 2009) with a distinction in the literature between replication and sampling logic regarding the number and particular selection of cases (Trellis, 1997; Yin, 2009). By replication logic, Yin (2009) is emphasising the importance of predicting or contrasting results, in comparison to sampling logic that requires operational enumeration of the entire universe of potential respondents. Yin cautions that sampling is a misplaced logic for case studies; rather, that the importance of multiple-case study design is the opportunity for replication to strengthen generalisation to theory. Selection of cases should involve maximising what can be learned in a limited time frame and selecting cases and participants that are willing (Stake, 1995; Trellis, 1997).

The choice of four cases (and four case study sites) for this work is consequently a practical one, influenced by time and financial constraints to conduct the study whilst maximising what can be learned in the period of time available for study. Having four cases still enables replication along with several dimensions of variation between the case study sites, including:

- variation in the size and capacity of the ED and hospital
- variation in the geographic and urban-provincial setting
- variation in reported performance regarding the target.
In regard to the performance variation criteria, the case sites selected for study include two higher performing and two lower performing DHBs, which broadly distinguishes between those DHBs that reported target achievement above 80% but below the 95% measure (higher performing) and those that reported below 80% (lower performing) in the second or third quarters following introduction of the target to the sector (October–December 2009 or January–March 2010). This dimension of variation recognises that the concept of performance and reporting of it publicly, based on a quantified measure, may bring with it very relevant social and cultural experiences for hospitals and staff. It is also an opportunity to identify if higher performance in relation to the target is based on real change or on “gaming” of the target, where processes are manipulated to achieve a target number, without real system change. The limit to four case studies also aids collection of data and tracing the target’s effect over time; more than four case studies would render two rounds of data collection both logistically and financially prohibitive for a single researcher.

4.4.1 What is the Case?

An important aspect of multiple-case design and, for that matter, single case studies too, is to determine at the outset, what is the case? According to Swanborn (2010), a case requires the establishment of clarity between the phenomenon of study and the social unit of study. For this research, the phenomenon of study is the implementation of the ED target and the social unit of study is a public hospital within a DHB setting. Thus, my multiple-case study design is based on researching four different “cases” of implementation of the target in four different public hospitals in four different DHBs. The boundaries of the unit of study also need to be made clear (Swanborn, 2010; Yin, 2009), and in this research, a key social boundary is the staff of the acute hospital, both clinical and managerial staff. Had I expanded the boundary to include the governance structure of the District Health Board and its members, as well as the Ministry of Health and its policy officials, valuable insights might have been gleaned from inter-organisational relationships, processes and outcomes. However, in this study, I elected to circumscribe the social unit to the hospital for practical reasons and for placing emphasis on exploring policy implementation at the service delivery level. The boundaries of the phenomenon, however, cannot be pre-determined as easily, since no public policy and change occurs in a vacuum, and indeed this forms part of the richness
and complexity that is sought to be explored by the research. Thus, whilst collection of data is bounded by time, it does not negate the portrayal and interpretation of past, present and future at each case study site and for each participant.

4.5 Qualitative Research and Associated Methods

Qualitative research crosscuts many disciplines, fields, subject matter and philosophical perspectives (Denzin & Lincoln, 1998). In their generic definition, Denzin and Lincoln (1998) explain that:

Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (p. 3).

Case studies are not always exclusively based on qualitative research and methods; some large studies can include, for example, mixed methods, such as survey and statistical data collection and analysis in addition to interview or focus group data (Yin, 2009). However, this research is based on qualitative methods alone, constructing an understanding of policy implementation based on the qualitative methods exclusively.

Merriam (1998) describes five broad characteristics of qualitative research that link to particular methods. The first characteristic is that qualitative research endeavours to understand the phenomenon of interest—in this study, the implementation of the 6 hour ED time target—from the participants’ perspectives (also known as the emic perspective). The second is that the researcher is the primary instrument of data collection and analysis. The “human researcher”, rather than for example a questionnaire or survey, is the instrument of data collection and analysis. The “human researcher” may adapt and iterate, clarify and summarise and explore responses, insights, context and circumstances. The third is that qualitative research usually (but not always—for example, documentary data collection) involves fieldwork; the researcher must go to the people, site or institution in order to engage in the natural setting. Fourth is the employment of inductive methods that build abstractions, descriptions and concepts, rather than the testing of existing theory. However, qualitative research does not necessarily preclude deductive analysis and the utility of
theoretical frames (see Crotty, 1998; Fischer, 2003). Typical findings from inductive procedures are themes, categories and typologies. Merriam’s final characteristic of qualitative research is the focus on process, meaning and understanding with the production of findings grounded on rich description.

The qualitative methods that I have selected and applied concentrate on the *emic* point of view from the organisational actors (health care clinicians and managers) in their naturalistic social, political, cultural and institutional contexts. Data collection methods which focus on the words, meanings, social worlds and subjective experience of human beings (Liamputtong, 2010a) are thus applied. Methods that might have objectified and aggregated both the social experience and social text would have provided limited opportunity to explore local meaning and sensemaking in an historically and culturally situated process. Accordingly, I have selected and applied personal in-depth interviews with hospital staff and the collection of organisational documents as the means of gathering research data. In addition, two rounds of data collection were conducted to track any changes over time and enable the iteration between developing insights and ongoing change. Doing two rounds of data collection is a research procedure consistent with some key elements of ethnographic and analytic cycles, where the researcher is developing sensitivity to the case study context in order to more fully understand the culture and meanings inherent in that context (Denzin & Lincoln, 1998; Hennick, Hutter, & Bailey, 2011; Spradley, 1979). Two rounds of data collection also enabled identification of changes in the implementation process and outcome over the course of time. These choices rendered the social world of the participants and the organisation accessible without being intrusive or unfeasible in an acute hospital setting. To analyse the data, I have applied thematic analysis techniques and an inductive and then iterative process from these data to theory and back to the data to progress the development of categories and themes. Documents collected are also analysed inductively to enhance and support the developing themes.
4.6 Recruiting of the Case Study Organisations

Four public hospitals in four different DHBs were selected and successfully recruited for this research based on the multiple-case study criteria noted earlier. To facilitate the recruitment of these hospitals, some preliminary steps were required. It could not be assumed that DHBs would welcome scrutiny of the implementation of this target; in my experience as a health professional, I had noted many of the contentions surrounding hospital reform and its effect, as well as the highly political nature of health care organisation in general. Therefore, one of the early steps undertaken for the study was to establish a shortlist of six suitable hospitals and then foster interest in the research. This involved informal introductions to the study by email and phone calls to key personnel at these hospitals, some of whom were managers and some of whom were staff based in the Emergency Department where there was substantial interest in the topic of the ED time target. This preliminary introduction provided the basis for engagement and then recruitment of the staff both in the ED and broader organisation and contributed to the procedures for gaining local research approval in each hospital. Introductions, and building of a research relationship in this way, also built trust and credibility in the study in the particular health organisation and the health sector more broadly.

At one of the six shortlisted hospitals (a low performer), I was unable to gain any interest for the research following informal introduction and it was thus not possible to pursue recruitment of staff at this organisation. Following the completion of hospital recruitment and ethics procedures at the fifth hospital, I was then unable to pursue this hospital as a case study site due to regional events and changes which impacted staff participation. The sixth hospital therefore became a very relevant back-up to ensure four cases could be pursued.

Case study sites (hospital and DHB) are described in some detail in the local findings of Chapter 6. I defer case study site descriptions to that chapter as they help to preface and frame the local stories and themes of implementation for each site.

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5 I make the distinction here regarding four different hospitals at four different DHBs because some of New Zealand's DHBs have more than one hospital within them; consequently, the hospitals in this study sit within four different DHBs.
4.7 Participant Recruitment

Three methods were used to recruit participants to the study interviews: the distribution of invitations by mail to a purposive selection of possible recruits, the posting of an invitation on the DHB intranet for each site, and through email network distribution of the invitation facilitated by research contacts at each site (see the sample invitation at Appendix A). These methods aided wide coverage for recruitment of staff in the whole hospital, but also purposefulness in terms of engaging different professional groups and services. Following the use of these methods, some 52 responses were received across all four sites. Of these responses, 47 staff were successfully recruited to the first round of interviews conducted between February and July 2011. The five respondents who were not interviewed included three staff who withdrew before interview or agreement to interview, one who was not appropriate to interview since I had sufficient informants for that role and area of work, and one who was unable to be interviewed.

To support the voluntary participation and preparation for interview, participants were provided with a participant information sheet (see Appendix B) and the semi-structured interview schedule (see Appendix C for managers and Appendix D for clinicians) following their response to invitations. Both of these documents were designed to give the participants clarity regarding the purpose and procedures of the research and to demonstrate the relationship of the research to the larger national project. Because of my wide range of professional nursing practice in New Zealand in several different health care organisations, this process also ensured that I could be clearly identified by recruits or potential recruits with whom I might have practiced previously and who were then able to make an informed choice, early in the recruitment phase, regarding their participation.

Participants in the study were from the ED and the wider hospital, including both clinical and management staff at all levels of the health care organisation. The goals of recruitment were to achieve 10–12 participants at each hospital, with around half of the recruits working in the wider hospital. I also aimed to have at least four managers at each site and, if possible, at least one executive level manager or clinician. I sought a mixture of medical and nursing personnel as well as
allied health and support service staff. The importance of ensuring that a range of professional and organisational views was captured by the interviews was based on the need to detect any differences, tensions or conflicts in values, agendas and priorities between these participant groups (Glouberman & Mintzberg, 2001a, 2001b). This recruitment strategy also recognises that how people make sense of their world is influenced by the cultural, social and historical features of it (Weick, 1995). I achieved all of these aims across both rounds of interviews with recruitment of a range of staff from the clinical floor through to the executive management level and across different professional groups. Table 4.1, that follows, summarises the participant numbers, professions and locations for each hospital and both rounds of interviews.

Table 4.1: Participant Recruitment Summary

<table>
<thead>
<tr>
<th>Site</th>
<th>Round One Interviews 2011</th>
<th>Round Two Interviews 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NM</td>
<td>NCM</td>
</tr>
<tr>
<td>ED</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>HP</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ED</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HP</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>ED</td>
<td>1</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>HP</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>14</td>
</tr>
</tbody>
</table>

Key:
- Hospital One
- Hospital Two
- Hospital Three
- Hospital Four

Professional Group
- NM: Nurse Manager (includes Nurse & Associate Nurse Managers, Charge & Clinical Charge Nurses)
- NCM: Non Clinical Manager (includes Service, Operations, General & Executive Managers)
- MD: Medical Doctor (includes Medical Leaders, Senior and Junior Medical Officers)
- NU: Nursing (includes Staff Nurses and Nurse Specialists)
- AH: Allied Health (Occupational Therapy, Physiotherapy, Social Work)

Location
- ED: Emergency Department
- HP: Wider Hospital
Whilst the table shows a good spread of participants across the hospital and ED and across managers and clinicians, it is also evident that nurses in the hospital were poor responders to the invitation and opportunity to participate in the research, other than Nurse Managers. This may be a signal of their indifference or disinterest in the research or the target. It may also be a signal of their social experience amongst a hierarchy of organisational and policy actors. However, participation in the research was voluntary and I could only rely on willing participants. The implications of this are noted in Chapter 7.

The second round of recruitment and subsequent interviews was conducted between April and July 2012 and involved selecting a number of the participants from the first round of interviews and phoning or emailing them about participating in a second interview. From this procedure, I aimed to recruit four or five participants, again spread across the ED and hospital. I also aimed to recruit participants who I believed would help me to focus and explore particular issues and areas of interest arising from the analysis of data and the insights and developing themes from the first round. Consequently, I was recruiting iteratively in terms of both participants and my developing understanding. Six new participants were included in the second round to specifically build depth in my developing understandings and help explore specific topics that featured in the first round analysis. From the second round recruitment process, I was able to complete 21 interviews, with the details also noted in Table 4.1 above. Recruitment of hospital nurses remained problematic in this round also.

The decision regarding the number of participants at each hospital was again a pragmatic one related to the time and financial resource to collect the data and then analyse what are very complex and intensive descriptions of social experience. Recruitment numbers were also related to my sense of “saturation” about what was being shared in the interviews. For example, it became apparent after the eighth or ninth interview at each site that very little that was a new insight was being revealed, even though I continued on with pre-arranged interviews. I consider that achieving 16–18 interviews at each site across the course of the study provided me with an ample, rich data set.
4.8 Data Collection

Interviews and documents comprise the data for this project. One type of in-depth interview for research, the semi-structured interview, provides balance between the two extreme approaches of informal conversation, on the one hand, and standardised questions, on the other. Semi-structured interviews are commonly used in health and social science research (Serry & Liamputtong, 2010). Key principles of semi-structured in-depth interviews include open-ended questions, active listening, monitoring of linguistic choice and use of jargon. All of these principles support the goal of hearing the participant’s voice and descriptions. It was equally important to connect with the participant’s voices and descriptions in ways that encouraged trust and understanding in the process and meanings; my professional background and knowledge helped me to make this connection.

Probing for meanings and opinions during interviews was both spontaneous and planned. For example, I utilised the “devil’s advocate” approach (Minichiello, Aroni, Timewell, & Alexander, 1995) to identify participants’ thoughts and reactions if the target went away. Another spontaneous interviewing technique that proved valuable was to identify a particular phrase used by a participant in their response to questions and then invite the participant to explain more, a form of “nudging” probe (Minichiello et al., 1995). Another very planned way of probing that I utilised was to set out a bullet point list of developing themes at a general and local level, which I provided to participants prior to the second round of interviews. I used this list as a way of probing, delving and developing understanding.

Throughout the conduct of interviews, I aimed to ensure coverage of the interview schedule, the judicious probing of responses and topics and as much clarity in responses as possible. In two of the interviews, I was unable to achieve coverage of the schedule that I was aiming for. One of these participants could only allot me a 20 minute interview and the other steered the interview in particular ways. In around four of the interviews, participants were not responsive to probes for clarity or meaning, and this was particularly related to sensitive issues and implementation experiences of the target, and I was thus unable to attain the clarity I sought. These insights contributed to interview memos and the analysis of the data from the interviews.
The semi-structured interview schedule (Appendices C&D), is comprised of questions that help uncover opinions, actions, behaviours, values, tensions, issues, changes and strategies. I noted very early on in the interviews that, without asking, the responses to questions were invariably coloured by both personal and organisational history and culture, along with a wealth of metaphors that frequently transcended particular professional groups, hospital services or case study organisations. I believe the interview schedule was an effective tool for achieving the aims of the interview and the research. I observed that the first question on the interview schedule on its own often resulted in very long and detailed narrative, that frequently provided answers to the other three questions as well. It became necessary for me to use review and clarifying techniques to ensure that the participant did not feel as though they were unnecessarily repeating themselves.

All interviews were conducted at a time and place of convenience for the participant and commenced with brief personal introductions and outline of the interview procedures. At this time, I gained the written informed consent (see Appendix D) of the participant and answered any outstanding questions regarding the interview process, the research and the wider project. The interviews were recorded with digital voice recorders (DVRs) and I utilised two DVRs simultaneously to guard against equipment failure. Throughout the interviews, I used a prepared written guide to aid in the procedures, which also doubled as a form to collect interview notes. These interview notes have contributed to the process of data analysis but have not been included in the analysed data.

Documents regarding implementation of the target were collected from participants at the time of their individual interviews. Like the interview process, the provision of documents to the research was voluntary. To progress the collection of this second type of data, the participants were introduced to the procedure through the participant information sheet, through the communications made to arrange interviews, and at the start and conclusion of interviews. Unfortunately, these multiple reminders failed to provide me with a substantial yield of documents; participants provided only 16 documents, from both rounds of interviews. Additional documents were collected directly from the website for Hospital Three (described in Chapter 6), in order to supplement data for this
site based on the developing local themes. These have been included in the table of documents below.

Table 4.2: Document Collection Summary

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Round One Interviews 2011</th>
<th>Round Two Interviews 2012</th>
<th>Additional Collect</th>
<th>Total Collect</th>
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<tbody>
<tr>
<td>1</td>
<td>9</td>
<td>1</td>
<td></td>
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<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>2</td>
<td>3</td>
<td>19</td>
</tr>
</tbody>
</table>

4.8 Data Analysis

4.8.1 Managing the Data and Process of Analysis

The interviews were transcribed verbatim to text by a contracted professional transcriptionist who completed a confidentiality agreement with me. Transcription was supported by HRC grant funding, as noted in the introduction chapter. These verbatim transcripts I then edited to remove personal or location identifiers and returned to those participants who elected to receive a copy. Two of these participants responded with feedback. One asked for the removal of information that they believed could identify them and the other wished to correct and alter statements in the transcript. With the fourth and final listening to recordings (the immersion process), I took the opportunity to prepare the transcripts for import into MAXQDA11, a computer assisted qualitative data analysis software program. By transcript preparation, I mean that I edited the transcripts further to remove any unnecessary social talk, irrelevancies or repetition (for example ums and ahs that did not add anything to the meanings portrayed or interpreted) which rendered a clearer and cleaner file for coding. The documents that were written were scanned to pdf file for import into the software file for each case study site from which they were collected. Those that were not (a large poster and DVD) were analysed by reading and watching and I completed a simple document with bullet point notation of the features that I believed to be pertinent data for analysis.

To manage the analysis of the data, I made a strategic choice to use computer-assisted qualitative data analysis software (MAXQDA 11.0), in contrast to a manual cut-and-paste paper process. This
choice was primarily based on the volume of data that I was analysing but also due to the multiple-case study design, which required me to give attention to cases sites, professional groupings and to cross-case comparisons. Without the computer software, this would have proved a difficult and overly lengthy process. The use of computer software has also aided trustworthiness of the study as the link between themes, subthemes, codes and raw data is constant and efficient (see the comments regarding rigour by Silverman, 2005).

I took a consecutive and separate site approach to analysing the interview and documentary data. By this, I mean that I undertook the initial coding of transcripts (details of thematic coding technique follows) from the first site where data was collected, and then the second site, and used two different case files in the software for this purpose. I made the choice to keep the coding and thematising of site data separate to ensure that I had generated a body of codes and themes that was pertinent to each site first. Once I had completed the coding, sorting into clusters and development of prospective subthemes and themes phase in the first two sites, I then completed the same procedures on separate files for the remaining two sites. I was able to build on similar codes and developing themes readily due to the high degree of congruence between the sites. Themes that were similar across the sites became the basis for the global findings set out in Chapter 5. Themes and insights that appeared unique for each of the sites were developed within each of the case files, resulting in a set of findings that was common to all sites, and a set of findings that was unique to the particular case study site, with the latter forming the basis of local findings set out in Chapter 6. Comparison of local findings across the case study sites has also aided in my interpretation of similarities and differences at the local level.

4.8.2 Thematic Analysis Procedures

Thematic analysis is one of the most commonly applied methods for the analysis of data in qualitative research (Braun & Clarke, 2006). It is a foundational and flexible method that transcends epistemological positions and theory to provide a detailed and complex account of data (Braun & Clarke, 2006). The procedures for thematic analysis that I have followed have the particular goal of interpreting the social world of policy implementation; its context and processes, its politics and
outcomes, its cultural and historical features. Thus, prior theory and concepts also guide the process of data analysis and the formation of codes, categories and themes. From an ontological and epistemological viewpoint, I come as close as possible to the social world, sense and meaning making of others, whilst at the same time directing my attention to the goals of the research and the desire to create plausible understandings of the key features of policy implementation. My data analysis procedure has been guided by the phases of thematic analysis described by Braun and Clarke (2006). I have also been informed by the general inductive approach to analysing qualitative data (Thomas, 2006).

As noted above, one of the first steps in my analysis process was immersion in the data and familiarisation with it, which I achieved not only through conducting all the interviewing and data-gathering myself, but also through listening to each interview recording multiple times. I acknowledge the lost opportunity to immerse myself in the data by not undertaking my own interview transcription (see comments by Braun & Clarke, 2006; Liamputtong, 2010). However, over an extended period of time, I listened to the digital recordings of each of the interviews at least four times before undertaking any formal transcript analysis. As a consequence of this listening process and reading (and re-reading) the transcriptions, I generated both individual and case site memos, diagrams and themes that helped ensure that I did not, in colloquial terms, miss the “wood for the trees”. I have used these memos to remind me of the bigger picture and early impressions of the interviews and individual sites. Most of these listening generated themes have also been created from transcript analysis.

4.8.3 Generating Initial Codes

Braun and Clarke (2006) recommend that transcripts should be coded systematically, giving full and equal attention to each data item, and identifying repeated patterns of meaning across the data set. My approach to coding the transcripts was to remain both close to the data and endeavour to be comprehensive, an approach consistent with the term “open coding”, which is often associated with a “grounded theory” approach (Bryant & Charmaz, 2007) although this is not my explicit research methodology. This process ensured that I had paid attention to every aspect of the transcript and
possible meanings and generated an initial set of codes inductively. The close reading meant that I took a good deal of the original language of the participants across into the codes. I was also conscious that even during this initial phase of coding, my awareness of key knowledge from literature was guiding some of my coding decisions. Consequently, whilst I coded off the transcripts and what participants said, I was also making some interpretations of their comments based on prior knowledge, as is to be expected in an interpretivist approach.

The first phase of generating codes at the first two sites resulted in over 800 codes at one site and over 900 at the other. To aid managing such a large body of codes, I began to sort them tentatively during the coding process, according to what sort of question regarding the research they would answer. For example, a number of the codes reflected “frames” or interpretations of the target; hence, I was able to group or cluster these as frames of the target in the developing set of codes. Another large group of codes concerned strategic activities, and again I was able to group these confidently into a cluster that concerned strategic actions. At this early stage, therefore, I was sorting the codes tentatively into clusters that related to the same topic or idea or area of research interest. My process of coding was thus inductive, but also heavily guided by the research questions and the literature and therefore also iterative.

4.8.4 Searching for and Developing Themes

Braun and Clarke (2006) outline that themes may be either semantic or latent. A semantic theme describes surface meaning; that is, what is said. A latent theme, in contrast, is one that captures meaning below the surface; it is interpreted and inferred from the text. The themes that I developed in this third phase of analysis were both semantic and latent. To aid the process of developing themes from my body of codes and the initial clusters, I returned to the literature more formally and prepared a list of topics and potential themes that were relevant to the research question and literature, which included conflicts and tensions, negative consequences, gaming, sensemaking, and political behaviours. I entered these topics/themes into the coding set in each of the case files and began a process of exploring the codes and clusters to determine whether they were related or relevant to the literature themes. Memos created throughout the coding were helpful in determining
the relationships between codes and latent themes. To use the “framing” example again, the developing themes and literature support the finding of framing of the target (see Chapters 5 and 6) and is also expressly identified in the sensemaking literature. Another example, the theme of “mixed consequences”, is also supported by the literature concerning policy implementation and targets and thus is a theme which reflects the iteration between the data in development and the literature.

Also at this stage, I recognised the difference between codes which were concerned with some dimension of context, process and outcomes, and I was duly able to create new categories and thus large sets of themes based on these distinctions. Because of the open coding process, there were many more codes and clusters than were needed to answer the research question and, as a consequence, I began to actively select and develop those themes that were central. Residual codes that did not appear to have a category or theme, I placeholders in the data tree as “miscellaneous”. Toward the end of the analytic phase, some of these codes could be more accurately assigned or recoded as their meaning and relevance to the categories and themes became more obvious. Codes that could not be assigned were retained in a coding folder separate to final themes.

4.8.5 Global and Local Theme Development

Global themes (themes common to all case study sites) developed through two key data analysis and data management activities. Throughout the coding of interviews, common terms, words or phrases were readily identified, for example, the words “frame” or “framing”, “buy-in” and “resistance”, and these common words were captured by literal coding. Such semantic or literal codes were clearly identified across interviews and across case study sites and, as a consequence, drew my attention to the shared language and meanings associated with them. Other very common words were “focus” and “quality”. Thus, whilst analysis of data for each of the interviews and sites was managed separately, commonalities appeared quickly and helped me to give early structure to the developing categories and then themes, then through the iteration to the literature were able to be assigned to themes that helped answer various aspects of the research question.
In order to more accurately compare global themes and data across sites, I was able to generate tables through the MAXQDA software for each of the sites and check that there was consistency in my coding and interpretations. At the completion of the development of themes within individual sites within their individual files, I then created copies of each site file before merging all four case study files on to one project file of the software. Consequently, at the completion of data analysis, I had one global file encompassing data and themes from all four case study sites as well as retaining four individual site files. The accurate labelling format of categories and themes meant that this merger of files was simplified.

Local themes were developed with both a literal and semantic, or latent, coding approach as I sought to create local understandings from analysis. Whilst there were terms that were also common at a local level, it was the interpretation of them that helped to create a local story. Good examples of this included the use of the term “provincial” in Hospital One, which had particular relevance to the local story, and in Hospital Two, “success” was a distinctive term associated with particular examples of success, as well as reasons for it. In Hospital Four, failures of the past appeared to be meaningful in some of the interviews and, as I reviewed codes for this site, I was able to identify other types of historical activity which supported this developing theme. At Hospital Three, a distinctive local feature was the struggle to not only achieve the target, but to get the momentum of change needed within the staff of the hospital.

In addition, to support the development of local themes, I addressed the coding of the second round interviews by asking myself what had changed or appeared to have changed since the last round of interviews, then created a cluster of codes I labelled “second round changes” for each site. This cluster helped me to identify commonalities at a local level; for example, the easing of tensions and pressure was described by three participants in Hospital Four. In Hospital Two, what was most noticeable in my analysis of the data from the second round, was that very little strategically had occurred between the first and second rounds, and this contributed to the developing story for that case study site. The various steps and details involved in the management of data and of data analysis are summarised in the following table.
Table 4.3: Summary of Data Management and Data Analysis

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td>Interview transcription</td>
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<td></td>
<td>• Interviews transcribed verbatim by contracted transcriptionist</td>
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<tr>
<td></td>
<td>• Transcripts edited by researcher to remove identifiers and non-essential narrative</td>
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<tr>
<td></td>
<td>and linguistic features (e.g., ums/ahs)</td>
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<tr>
<td>2.</td>
<td>Document preparation</td>
</tr>
<tr>
<td></td>
<td>• Documents scanned to pdf – identifiers removed/blanked</td>
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<tr>
<td></td>
<td>• Documents unable to be scanned (DVD and Poster) were reviewed and codes generated</td>
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<tr>
<td></td>
<td>from this process created on word file for import into MAXQDA file</td>
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<tr>
<td>3.</td>
<td>Managing data</td>
</tr>
<tr>
<td></td>
<td>• Four separate files created on MAXQDA for each case study site</td>
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<td></td>
<td>• Raw data for each hospital site (interviews &amp; transcripts) imported to each separate</td>
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<tr>
<td></td>
<td>file on MAXQDA</td>
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<td></td>
<td>• When data analysis for each site completed, copies for each site made and then</td>
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<td></td>
<td>coding trees from each file merged to single global study file</td>
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<td>4.</td>
<td>Managing data analysis</td>
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<td></td>
<td>• Immersion – listening to first round interviews four times for each interview with</td>
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<td></td>
<td>research notes and memos created from listening</td>
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<td></td>
<td>• Interviews for Hospital One and Two coded</td>
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<td></td>
<td>• Interviews for Hospital Three and Four coded</td>
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<td></td>
<td>• Coding of first round documents for all four hospitals</td>
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<td></td>
<td>• Second round interviews coded following single listening process</td>
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<td></td>
<td>• Second round documents coded</td>
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<td>5.</td>
<td>Managing coding and thematic development</td>
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<td></td>
<td>• First round interviews separately and openly coded for Hospital One and Two; codes</td>
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<tr>
<td></td>
<td>were both literal and latent</td>
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<td></td>
<td>• Sporadic coding memos created</td>
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<td></td>
<td>• Comparisons of codes and data between first two sites with subsequent further coding</td>
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<td></td>
<td>and sorting into clusters; sorting memos created</td>
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<td></td>
<td>• Miscellaneous codes folder utilised as holding process until code able to be</td>
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<td></td>
<td>recoded or excluded</td>
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<tr>
<td></td>
<td>• Review of literature and further generation of codes and then sorting of coding</td>
</tr>
<tr>
<td></td>
<td>clusters related to themes and insights from literature</td>
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<tr>
<td></td>
<td>• Interviews openly coded for Hospital Three and Four</td>
</tr>
<tr>
<td></td>
<td>• Interviews additionally coded for Hospital Three and Four consistent with literature</td>
</tr>
<tr>
<td></td>
<td>themes, coding clusters and developing themes and subthemes</td>
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<td></td>
<td>• Global and local theme tree developed for each hospital site, which involved additional</td>
</tr>
<tr>
<td></td>
<td>coding</td>
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<td></td>
<td>• First round documents coded and sorted according to developing thematic tree for each</td>
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<td>site</td>
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<td></td>
<td>• Second round interviews coded openly and according to developing themes from first</td>
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<td></td>
<td>round</td>
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<td></td>
<td>• Change coding of second round interviews: that is, what appeared to have changed or</td>
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<tr>
<td></td>
<td>happened between first and second round of data collection</td>
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<tr>
<td></td>
<td>• Global and local themes and subthemes developed</td>
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</tbody>
</table>

4.9 **Research Rigour**

An interpretive study is best evaluated in terms of its quality, through various dimensions of research rigour (Liamputtong & Ezzy, 2005). Rather than positivist measurement criteria like reliability or generalisability, qualitative researchers look for rigour in terms of criteria like trustworthiness (comprising credibility, transferability, confirmability and dependability) which are eminently more appropriate and acceptable to qualitative research approaches (Lincoln & Guba,
Davies and Dodd (2002) emphasise qualitative research practice that is visible, accountable and faithful in providing an account of the social world. Dimensions of research rigour that I outline here are procedural and interpretive rigour (Liamputtong & Ezzy, 2005). In addition, I outline the practice of reflexivity in the conduct of this social science research (Alvesson & Sköldberg, 2009; Haynes, 2012). Finally, I review the issue of subjectivity (D. Davies & Dodd, 2002) and my critical role and potential biases in the process of researching and interpreting the experience of policy implementation.

4.9.1 Procedural Rigour

I have addressed concern for procedural rigour in this study in three key ways. Firstly, I do so by ensuring a detailed description of all the research procedures including recruitment of case study sites and participants that ensures transparency in the criteria, purpose and means of recruitment (see sections 4.6 and 4.7). That these selections are anonymous and de-identified, however, is a matter of ethical responsibility assured to participants and case study sites who might otherwise not have contributed to a study that is inherently political. Setting out the details of data collection and analysis, including the creation of categories and themes, is also pertinent to procedural rigour, since to do so provides others with confidence in the procedures and the capacity to follow the steps in this and other studies. Thirdly, I have utilised computer assisted software to manage the data and its analysis, and in doing so retain a persistent link between categories, themes and subthemes to the raw data. This renders the study easily accessible to quality scrutiny.

4.9.2 Interpretive Rigour

Interpretive rigour is central to this interpretive study, and Liamputtong and Ezzy (2005) describe that rigour along this dimension is achieved where the study provides an accurate portrayal of the language and meanings and worldviews of participants. Great attention has been paid to the use of participant language in the development of themes, and this is particularly the case where in vivo (literal) coding ascends analysis to the thematic level. For example, the words frame, resistance, and buy-in were all highly situated, subjective words used by participants and these are but a few examples of the quality of my interpretive processes. Moreover, as the analysis of data proceeded,
the consistency of this language across participant groups and case study sites enabled great confidence in the process of interpretation. I was able to probe and develop the dynamic social construction of the implementation process further through the second round of interviews, as the language and meanings persisted over time.

Arguably, one of the most valuable ways that I have sought interpretive rigour has been the lengthy period of time that was taken to analyse the data, approximately 20 months, including both the first and second round analyses. Moreover, as I engaged in writing up the themes and the associated excerpts, I was aware that I was again checking on and interpreting the work and going back to the data and my codes to check on the meanings that I was emphasising. I have taken the time, in particular, to provide substantial excerpts from the data in this thesis, in order to give substance to the findings and my interpretations. Another valuable and well known method for increasing interpretive rigour has been the use of memos in both the coding and sorting phases of the research (greatly aided by the MAXQDA software program). Frequently, I was unsure of what a code might mean and the coding memos were one way of jotting down the possibilities, so that when I engaged in the code sorting phases I was able to use the memos to refresh and reflect.

4.9.3 Reflexivity Rigour

According to Haynes (2012), reflexivity in qualitative research broadly involves the process of thinking about how our thinking came to be, the awareness that the researcher and the object of study affect one another continuously and mutually, and how “a pre-existing understanding is constantly revised in the light of new understandings and how this in turn affects our research” (p. 73). Reflexivity also recognises the interdependence and interconnectedness of research methods, research data and the researcher (Mauthner & Doucet, 2003). These are matters of epistemology, ontology, method and, invariably, the theoretical influences on the research endeavour, as well as theoretical contributions made by the research work.

The first three matters I have addressed concisely in Sections 4.1–4.4 of this chapter, positioning the study as I do within an interpretive philosophical perspective and social constructionist ontology. Interpretation is an ongoing process oriented to social construction of knowledge within not only
the procedures for gathering and analysing and making sense of data, but also across the thesis journey. My initial notes and scribblings in my doctoral journal included what I thought I might find; they were largely of my wonderings and scepticism about the target at the outset. Some of these have been consistent with the themes and the interpretive findings that I have developed. However, I also recognise that these initial, largely naive scribblings were lacking in depth and bereft of a systematic understanding of the complexities of organisational life in the hospital, of the extraordinary politics of health policy at the service delivery front line, and the constant flow of meaning and sensemaking in society. To this extent, the process of study has changed and developed me as a scholar, as a health policy researcher and social scientist. There is just so much more to it. Themes and findings from this study are capable of telling several different stories about social life in the organisation. However, the story that I direct them toward in this thesis is unequivocally that of understanding policy implementation and my contribution to this body of knowledge and theory generally and, within this, more detailed knowledge of the effect of quantified performance measures. Other developments and contributions from the data, themes and findings wait beyond the scope of this thesis.

Other more practical activities of reflexivity that I have engaged in through the conduct of data analysis and interpretation include doctoral supervision and presentations of various aspects of the findings in semi-formal and formal settings, including research seminars and conferences. All of this activity has fed into the research and thesis development.

**4.9.4 Subjectivity and Bias**

As noted in Section 4.2, the interpretive researcher and approach do not seek to prove or disprove, but to construct knowledge through a convincing portrayal of social phenomenon and organisational life. Moreover, within this process, the interpretive researcher is not objective or detached from the meanings and process of social construction, but an important instrument in the interpretive process (Deetz, 1996). My professional background as a registered nurse who has worked for many years in acute hospitals in New Zealand, including many years in emergency departments, is a key but ultimately subjective strength in my ability to understand where research participants are “coming
from”, what they were “getting at”, what they meant. To an extent, participants may have been relying on awareness of my professional background in order that I did get what they were saying. Indeed on several occasions participants used the term “you will know this” during the interview to describe a behaviour or event, meaning that they believed or perceived that as a health professional I would know. In these instances I concurred where this was appropriate, but probed if it was not clear to me what was meant. This inherent subjectivity aids in constructing knowledge from the *emic* point of view and does not stand as an isolated check on the quality of the research, but is balanced by addressing all of the dimensions of rigour described above.

Bias in relation to my research practice refers to any partiality and favouritism that might distort my interpretation of the social world and experience that I was investigating. Keeping in check what may be bias toward my own profession and my own area of clinical expertise has been addressed in two ways. Firstly, by stepping outside of my normal clinical workplace throughout the conduct of the research, I was thus at arm’s length from the everyday world that I was accustomed to. And secondly, I ensured that I engaged staff from other professions and other parts of the hospital and gave attention to their perspectives, viewpoints and meanings.

Check on interpretive bias during data analysis and writing of themes is also pertinent. One of the fundamental checks that I undertook within the process of data analysis was to consider whether I was seeing only the bad, or only the good. This step was also active in supervision procedures where discussion frequently sent me back to check my steps and my interpretations.

### 4.10 Ethical Procedures

Ethical approval to conduct this research was obtained as part of the larger Shorter Stays in ED National Research Project as introduced in Chapter 1. The approving authority is the New Zealand Multi-region Ethics Committee. To achieve ethical approval, a national application form was submitted jointly on behalf of the investigators for all streams of the Shorter Stays in ED National Research Project, including this qualitative stream. The key documentation for achieving ethics approval for this stream of research included submission of the invitation to participate in research (Appendix A), the participant information sheet (Appendix B), the interview schedule (Appendices
C&D), and the informed consent document (Appendix E). All documents were produced for both electronic and hard copy distribution. To comply with the requirements for ethics approval for this study, a local approval process was completed at each case study hospital. This process required that we (the investigators for the national project) had a local contact at each site, that we had completed any local approval requirements for collection of data, and also required that we had completed all procedures necessary to attain Māori health research approval at each case study site. All of these requirements were achieved by myself and the other Co-Principal Investigator of the national project. Provisional approval was provided to the national project in July 2010 with final approvals for sites received in September 2010 and April 2011. The ethics approval number is: MEC 10/06/060.

4.11 Chapter Summary

This chapter has set out the research strategy for study of implementation of the 6 hour ED time target. Interpretivism, as a philosophical foundation, aligns well with the research aims and questions, and with the public policy context and science. Multiple-case study design enables the research to identify factors or dimensions that may be relevant to process and outcomes at a local level of public service delivery. Methods for collection of data recognise pragmatic as well as philosophical concerns. Methods for data analysis have been open to the meanings, metaphors and frames that emerge from the micro political context of the service delivery front line but have also responded and worked iteratively with extant knowledge from the literature.
Introduction to Findings Chapters

The next two chapters of the thesis aim to achieve three goals. The first is to present thematic findings from analysis of the research data, including both interviews and documents. The second is to provide an interpretation of the themes in relation to the study questions and make an empirical contribution to this field. The final goal is to explore the relevance and impact of local context on the process and effect of policy implementation.

To achieve these goals, the chapters are structured into “global themes” (Chapter 5) and “local themes” (Chapter 6). Global themes are high level abstracted findings that are common to all the study sites and are thus cross-site in nature. Local themes represent findings that based on the data and my analysis appear unique to the individual study site. In the local themes chapter, I identify features of local context, such as local history and social phenomena, target initiatives and impact including change over time. A key concern in this local themes chapter is to identify the impact of local context on the process of implementation.

The pattern of discussion that I follow for all themes is to define the theme, explore the subthemes or dimensions and meanings, and use data excerpts to demonstrate and support the theme. At the completion of each section I provide an interpretive review of the themes presented, and summary for both chapter. Throughout these chapters, excerpts of the interview data, documentary data or codes are featured. The excerpts are referenced in four ways, as in the following example:

*No I don’t think that we’d change much to be perfectly honest. You know it wasn’t easy and we had to have some courageous debate and courageous conversations.* (H2 P-D R2 Senior Manager Hospital)

The reference, *H2*, identifies that this excerpt is from Hospital Two of the study; the hospital references are H1, H2, H3 or H4. The reference, *P-D*, means that this is participant D at that hospital site, with each participant having a single alphabet letter code. The reference, *R2*, identifies that this excerpt arises from round two of the interviews, with only R1 or R2 as choices. The reference, *Senior Manager Hospital*, identifies the role of the participant (Senior Manager) and where they work (Hospital). Participant’s location of work will be either in the ED or the Hospital,
and where a participant’s role specifically involves both ED and the Hospital, then the reference ED/Hospital will be utilised. Reference of document codes will be by hospital site and the interview round only, for example, H1-R2.

In order to promote the anonymity and confidentiality of study participants, hospital sites and DHBs, some words, names and titles in the transcript excerpts and chapter discussion have been de-identified and substituted, for example the term “alpha ward” is substituted for any reference to an acute assessment facility that may have unique identifiable local titles. In Chapter 6, description of the hospital sites and DHBs has been generalised for the same purposes of anonymity and confidentiality.

I have utilised the ellipsis in transcript excerpts to remove unnecessary dialogue, or to aid in sustaining anonymity. I have also added in some words in brackets [ ] in the transcript excerpts where it is necessary to show what the participant is referring to but not stating.
CHAPTER 5
GLOBAL THEMATIC FINDINGS

5.1 Introduction
This chapter and the themes within it represents shared understandings, meaning, thinking, experience and impact of the target that were common to all of the hospital sites. Common patterns of talk and repeated phrases, terms, descriptions, strategies, experiences and so forth, across all the interviews, were readily identifiable as I coded and sorted the data for each of the participants and each hospital site. The global themes were developed separately for each site and then merged into one file where the findings could be readily compared and contrasted. Lower order subthemes for the hospital sites may differ, and where this is so and I believe it to be pivotal to understanding the local implementation process and experience, I make note of this and discuss it in the subsequent relevant sections of Chapter 6.

To present the global themes, I utilise a three-part categorisation framework of sensemaking, context and effect (response and impact): Making Sense of the Target, Layers of the Hospital World, and Response to and Impact of the Target. However, although I have separated these categories out for the purpose of clarity and understanding of the findings, in doing so I also recognise the constant interplay of thinking, context, and effect that is inherent in the descriptions and experiences as well as the interpretive methodology guiding the research. For ease of reference, Table 5.1 sets out the various sections of the chapter including categories and themes.

Section 5.4 introduces a series of complex and highly abstracted themes with several important subthemes, and as a consequence it is the largest and most intensive section of the chapter.
5.2 Global Sensemaking Category – Making Sense of the Target

Making Sense of the Target is a category of themes which represents patterns of thinking and description, perspective, reasoning and explanation of the target. It is a set of themes that represents, quite simply, how the participants made sense of the target during the interviews and in turn how I made sense of their answers through the analytic process.

5.2.1 Framing the Target

_Framing the target is defined as the process of framing and the “frames” themselves. The process of framing is a pattern of talk and description in the interview narrative that describes how participants create a particular view or portrayal of the target. Frames of the target_
encapsulates a variety of metaphors for the target, along with the multiple ways in which participants label, make reference to or describe the target in terms of its meaning or purpose. The emphasis in this theme is on the use and construction of language to frame the target.

The Process of Framing

This subtheme concerns the way in which participants both explicitly and implicitly describe or refer to the target in a particular way, such that they construct a frame of reference or a way of referring to the target. The process of framing the target is also associated with social marketing strategies that were identified in three of the study sites. Explicit use of the terms “frame” and “framed” are noted in the first excerpt, whilst in the second excerpt, the participant describes communicating the patient frame in contrast to the ED frame to their team of ward nurses.

I mean that’s probably what I’d call one of the reasons why - because we frame it in that way - because we framed it very deliberately, that this isn’t about hitting the target, this is about how we value patients. (H2 P-H R1 Senior Manager Hospital)

And they [ward nurses] said well it’s all for the ED, it’s not for us. And I thought that that was actually quite powerful coming from them, because it’s very hard as a manger to try and get a balanced perspective across to my team, saying well actually it’s about the patient and it’s about you guys too. (H1 P-H R1 Nurse Manager Hospital)

Frames of the Target

Four frames identified across all of the hospital sites are the Rule Frame, the Quality Frame, the Patient Frame, and the Organisational Frame. Some of the participants described two or more of the frames in a related fashion. Both the organisational and patient frames are closely linked to the different perspectives on the target that were sought throughout the interviews. In several of these frame excerpts, the process of framing is also identifiable.

There were two other frames that were not common to all sites (the ED Frame and the Punitive Frame) and these will be featured in the next chapter, as I interpreted the construction of these frames as a consequence of local experience of the target.
The Rule Frame

The “rule”, the “six hour rule” and “breaching of the six hour rule” is a particular metaphor, and way of referring to the target and its meaning that was identified in the first round of interviews and further explored in the second round. Through this frame, participants refer to the target as a rule that staff must abide by or that they endeavour not to breach. It denotes the perception and experience of an external motivation or force acting on the person, social group or service to respond to the target. Whilst the rule frame features in all sites, it is most compelling in Hospitals One and Four.

If you’re constrained within the six hour rule as you’ve got to be with that, then the patient has to get admitted essentially, to get them out of the ED system. And so it then becomes a situation where then you’re just forced to get patients moved on so you don’t break the six hour rule. (H4 P-F R1 SMO Hospital)

Because what we, what we found initially when it was - the rule was introduced, - we thought well, you know, well we really do have to toe the line and really try our best to keep the flow going. (H1 P-B R1 SMO ED)

The Quality Frame

Framing the target in terms of quality, such as that it concerned or was about quality, was a very common feature of the interviews; although it was not always the case that the target would or had resulted in the improvement of quality, in the opinion of some of the participants. Differing dimensions of quality are also identifiable, for example, quality of patient care, quality in terms of efficiency of process, or quality in terms of measurable markers.

Okay I think it’s a very useful target. It’s a useful target because first and foremost if it’s delivered it improves quality of patient care. (H4 P-L R2 SMO Hospital)

The Patient Frame

Frequently referred to in conjunction with the quality frame is the patient frame. Whilst talk of “patient” or “patients” naturally permeates the interviews, this subtheme highlights the ways in which participants framed the meaning and purpose of the target as being about the patients and their care. In particular, this frame also reflects descriptions of personal perspectives where
participants take the position of the patient in relation to the target, either through their own experiences as patients or through the deliberate adoption of the patients’ perspective, as in this excerpt:

Our director of quality gave some very clear examples of what it means to lie in a trolley in ED for more than six hours, and trying to personalise that info, if it is your mum or grandma lying there, would you be happy with it? (H2 P-B R1 Senior Manager Hospital)

The Organisational Frame

The organisational frame is multifaceted and refers to a variety of dimensions of the organisation (including hospital and DHB) and then related meanings, labelling or references to the target associated with organisational values, culture, staff, performance, services, systems and process.

The hospital, is the organisation most commonly referred to.

If the Minister’s going to have his 5 or 6 health targets then it’s good that he’s got one that’s for the acute hospital; um, he’s got others that are about immunisation, and chronic diseases and cancer treatments. So it’s important we have one for the acute hospital. (H1 P-G R1 SMO Hospital)

5.2.2 Making Sense of the Problems

Making Sense of the Problems is a theme which encapsulates the ways in which participants describe and link their opinions and experiences of the target to the problems or issues that they believed the target should address. In some instances, sensemaking focused on problems with implementing strategies or actions to achieve the target or problems which participants believed would be encountered in the future.

There are four subthemes in problem sensemaking that are common to all of the study sites; problems with primary health care, resource problems, delay and flow problems and finally problems with staff attitude and behaviour. These subthemes represent various overlapping or closely related problems and issues, for example, medical resource problems were rarely just about available staff, and I have highlighted this in the excerpts to follow. Invariably as participants explored these problems, they were also exploring some of the history that is associated with or underpins the problem.
**Problems with Primary Health Care**

Participants described a number of problems that they perceived were about primary health care service or practice. Much of this was perceived as behavioural, such as problems with GP referral practice, and some related to access to general practice services generally. There was some sympathy for problems in primary health care and general practice in particular, but there was also some criticism, for example of afterhours general practice service. Notably, making sense of the problems in primary health care demonstrates participants thinking beyond the intra-hospital context to the other organisations which interface in acute public health care.

*And you know this hospital is also a place where we are, even though we’re a tertiary level centre we deal with GP level stuff - you know, that we see lots of GP stuff in ED and its completely inappropriate and it’s a multitude of things, some people don’t trust their GP, and some GPs just refer for the most minor things.*

(H3 P-J R1 SMO ED)

**Problems with Resources**

There were various dimensions of resource problems relayed during interviews, for example issues with bed capacity in the hospital, acute operating theatre resource issues or lack of staff to deliver the acute care services needed. The resource problems identified by participants were predominantly in the ED and the hospital, and to a more limited extent in primary care, in the DHB and in the health system generally. Resource issues on both the supply and demand side feature in the narrative. Human resource issues, including both quantity and calibre of staff (for example, the lack of experience and skill of junior medical staff), are another aspect of the subtheme. Frequently, participants linked the resource issues to discussion of strategies to address the target. Local site resource problems if relevant are noted in the local themes of Chapter 6.

*For an SMO working in this organisation and it’s the same to a degree across PPPP DHB, we, we’re the worst, we have the lowest rates of SMOs to patient admissions in this DHB compared with ... other DHBs. We have had a 50% growth in the volume of work relative – over the last 8-10 years, no growth in the teams at all.*

(H2 P-J SMO Hospital)
**Delay and Flow Problems**

There was substantial discussion throughout the interviews that described and explored problems with delays and flow of patients through the hospital and also on occasions, reference to delays in the broader health system. A very common delay described was the long wait to see inpatient specialty doctors in the emergency department, and delays for beds to become available on wards. Other delay and flow problems concerned, for example, flows through acute theatre or delays in discharge from hospital to rest homes or rehabilitation facilities. Many of the delays described were linked to limits of resource and/or behaviour of staff, teams or departments.

*But one of the main reasons was bed blockage, access to beds and one of the things that they identified was you know, discharge planning was a problem...and they looked at days of the week that people were discharged and all kinds of interesting stats came out of it ... they might make a decision on Monday that somebody’s for discharge to the rest home and they might not get there ’til Thursday.* (H1 P-C R2 Senior Nurse ED)

**Problems with Attitude and Behaviour**

During interviews, participants explored problems concerning the attitude and behaviour of medical and nursing staff or teams from the inpatient setting. Problem attitudes and behaviour of ED staff, both medical and nursing, were also identified, for example the cherry picking of patients by ED medical staff (“cherry picking” in this clinical context refers to the practice of choosing easier patients to see or, in some instances, choosing patients the doctor or nurse prefers for professional or personal reasons). In the ward setting, behaviours concerning ward rounding and discharge, hiding of beds and so forth were a common spotlight for problem sensemaking. The attitudes and behaviours of nurse managers on wards also feature here, but other than this, management as a “problematic” professional group is not a major feature of this subtheme.

*There was a lot of behavioural stuff with nurses in this hospital, alright - the hiding of beds - and I mean I can even remember in my early days and in the old ward X, I remember coming on the next morning and the beds would be changed around... they’d have discharges and they wouldn’t tell the bed management office.* (H2 P-L R Nurse Manager Hospital)
5.2.3 Making Comparisons

Making comparisons is a theme which portrays patterns of comparative talk and reflection during the interviews, where participants express their opinions and experiences whilst making comparisons with something else relative or relevant to the participants and their experience of the New Zealand ED time target. Target comparisons across health systems and general comparisons regarding other hospitals, other services, resources and professional practice also feature.

Making Comparisons with the UK Target and Services

Many participants in this study followed a pattern of thinking about the English four hour target and then comparing this with their opinions and experience of the NZ target, or in some cases vice versa. Some of this comparison was from staff with professional experience in the UK, and for others, the comparison was based on professional network knowledge or anecdote or insight from professional literature. Frequently, this particular comparison was the basis for caution about the NZ target and the risk of poor behaviours and outcomes. At other times, it was simply to say that the NZ target was better and a more reasonable or achievable measure. This subtheme was also linked to the different models of emergency medicine practice and emergency services.

I guess when the target first came out the first gut reaction is to put up a wall and run away and hide, mainly I think because there had been quite a lot of anecdotal stories from England where they introduced a 4 hour length of stay in the emergency department, and we have a lot of English staff working here, so they probably influenced us to start with. There were quite a few horror stories from that, so it was kind of a run backwards for, the first thing. (H1 P-C R1 Senior Nurse ED)

Making Comparisons with the Australian Target and Services

Similar to the English target comparisons, several of the participants also narrate comparison with the Australian ED target and acute services that they have opinions, knowledge or experience of. Whilst there were fewer Australian than English target comparisons, what was discussed was primarily concerned with comparing the target measure and different models of medical services between Australia and New Zealand.
It’s been trialled in Australia where it also has not worked, so I don’t see why we haven’t learnt from other parts of the world. (H4 P-G R1 SMO Hospital)

Making Comparisons with other Hospitals or Services

Participants took the opportunity to make comment about how other DHBs and hospitals had addressed the target. Some of this comparison was of a critical nature and some was the basis for learning from other hospital or DHB strategies and then considering its efficacy in their own context. This subtheme also includes comparing resources available to address strategies as well as comparison with hospitals in other countries in which they had worked. Another service comparison concerned the models of alpha wards that were managing acute care.

I think that it’s important to point out ... that the model of care is quite different between Australia and New Zealand, particularly in New South Wales where they have no general medicine teams, and in that situation the ED physicians have a more, ah they have a greater role to play than they do ... The Australians seem to be more empowered there and have a greater role. (H2 P-J R1 SMO Hospital)

5.2.4 Making Sense of the Future

This theme identifies patterns of thinking about the target and then explanation of activities, strategies and potential for the future. The theme is fundamentally concerned with strategic actions, plans, possibilities and opportunities to address the target and other issues of health service delivery. The future may be the immediate or the longer term.

Future Strategy and Change

At all of the sites, strategies and plans were waiting to be implemented, or in some instances the impact of a strategy was waiting to be seen, for example additional medical resources in the ED that had been approved but not yet recruited to. In two of the sites, major planned service development lay ahead from the time of the first round of interviews, and these future changes were anticipated with respect to achieving the target. Participants also thought through an array of possible areas for improvement, for example, in primary health care, hospital discharge management, and triage and nursing practice in ED.
I’ve written a business case for number 7 and number 8 [ED Consultants] and that’s been going now for over six months... we want 16 hours of clinical presence of emergency consultant 7 days a week... The culture changes, the culture shifts, the RMOs who we just so critically depend upon suddenly have the support and expertise working alongside them. The nurses become more confident, everything just rackets up and I think that will be one of the key factors of keeping 95, getting to 97 and staying there. (H1 P-J R2 Manager ED/Hospital)

Future Challenges

Some of the future challenges that participants reflected on concerned planned strategies and interventions, whilst others concerned broad issues in the health sector such as rising demand for services. At times, participants considered challenges and what might be done about them, and a prime example is new alpha ward structures that were implemented in two sites over the period of interviews; the next excerpt features this topic. Some participants reflected on possible challenges if incentives for achieving the target were introduced, as well as possible change to the target measure including that they would be disappointed if it was to be rescinded.

And the most recent thing that’s going to come along and assault us is the advent of the alpha ward and just how that will work... but now I hear, the word on the street so to speak, when you actually talk to the registrars, that the way the person who’s been calling the shots and thinks it’s going to run and the way the rest of his colleagues think it’s going to run, regardless of what they’ve written down, they’re probably going to be two different things. (H3 P-M R1 SMO ED)

5.2.5 Perspectives of the Target

Perspectives of the target explores the particular social views that participants take to consider, evaluate, form judgements about the target and make sense of it. Each perspective offers a differing window through which to view the same phenomenon as well as informing the key features of the perspectives and how these came about.

This theme is consistent with the interview schedule where I asked participants what they thought about the target from a personal, professional and organisational perspective; although these perspectives were also identified in many other parts of the interviews. The three subthemes outlined below capture these perspectives and their various dimensions. I make note here that many of the participants in the study described the difficulty they had with dividing or separating these
perspectives in their minds and explanations, as well as with talking from a particular perspective, for example:

Yeah from a, well it’s a bit hard to separate some of these actually, professional perspective and the perspective of the organisation I work within. (H1 P-F R1 SMO Hospital)

**Making Personal Sense**

There were three key dimensions to the personal sense perspective: the “personal” as derived from their experience as a patient or family member of a patient who had been through ED; the “personal” as from a personal professional perspective; and the “personal” as from adopting the patient’s perspective. Only a handful of the participants in this study describe the personal as being from a patient or family of patient viewpoint. In regard to the third of these dimensions, the adoption of the patient’s view is linked to target narrative that was active in the local context in Hospital Two at the time, and an example of this is the description “...if your grandmother was in hospital having to wait 12 hours in the emergency department, would that be okay for you?” (H2 P-D R1 Senior Manager Hospital). The grandmother metaphor, thus, personalises perspective.

Okay, what do I think about the target from my personal perspective? I’ve had a son who was requiring to come to the emergency department... and, from the perspective of a consumer it was good to have that done and dusted and... it was good not have to wait too long. (H3 P-I R1 Manager Hospital)

So the target from a personal perspective. I think the emergency department, I’ve worked in emergency departments for many years, probably since - I think my first step in the emergency department was in 1983. (H1 P-D R1 Nurse Manager ED)

**Making Professional Sense**

This is a strong perspective identified in the interview transcripts. Professional roles (past and present), experiences, knowledge, authority, responsibility and opinion, are notable reference points for opinion and descriptions. Past professional experience in the UK and Australia featured here for some of the participants. Professional views associated with roles such as being a head of a department, target champion, service manager or nurse manager, for example, are just some of the professional sensemaking perspectives identified. Making sense as part of a professional group, such as from a nursing, medical or surgeon’s point of view, also feature here where, in some
instances, points of disagreement regarding the target and impact may be revealed. Additionally, this perspective captures inter-professional judgements made beyond their own professional purview, for example, how nurses view the impact on doctors or what managers think of the clinicians and vice versa.

And I think the biggest frustration for nursing is that you, you know, one moment you’ve got your patient and you thought you were just up to, just about um, to do something and they’ve gone, and that’s really hard, you know, because you haven’t done that completion of care or whatever. (H2 P-G R1 Nurse Manager ED)

**Making Organisational Sense**

The organisational perspective was the most challenging to identify from the interviews, since largely what was described as an organisational perspective, as with the organisational frame, concerned the intra-organisational, or the view from inside the hospital. Features such as the hospital’s systems and departments, problems, staff, culture and services, characterise this perspective. On only a few occasions, the participants made organisational sense from the extra-organisational view, or through the hospital in its community and health service delivery perspective. I probed for this external hospital perspective of organisation and occasionally the response was in this direction, such as the reputation of the hospital and its target performance. I note here that staff working at more senior levels of the hospital appeared to be able to describe the organisation in a wider context, as in relation to the community served, as portrayed in the following excerpt.

Participant: So I think you know if we take it back fundamentally to why we’re here. And actually making sure that our patients are getting the best deal. I don’t think anybody could argue with it.

LC (interviewer): Are you describing there that it corresponds with community expectations?

Participant: I think it absolutely corresponds with and it should correspond with what the community would expect of modern health care. (H3 P-B R1 Senior Manager Hospital)

5.2.6  **Interpretive Review of Making Sense of the Target**

The development of this particular category has been greatly influenced by the sensemaking literature, along with my consideration of several questions: what did these front line health care
staff think about the target, how did they perceive it, and what contributed to or underpinned that thinking and perception?

These themes reveal a great deal regarding how the front line staff who were interviewed in this study thought about the target. For example, their thinking included consideration of problems which the target was trying to or meant to address, and in this sense, the target enables people to determine or define what those problems actually are. Whether or not that definition of problem prevails and results in strategies to address the problem is another question, since there may be competing definitions and competing influences on the solutions generated and implemented.

Comparative sensemaking is another important how of thinking, and one of the key features identified in the theme concerns the ability of many of the staff to draw on knowledge and experience of ED time targets from other health systems and utilise this as a basis for opinion and judgement. I interpret this as learning that informs implementer thinking, and a means of either refuting or substantiating the target and implementation process.

The dominance of the hospital organisation and intra-hospital view is an important feature of how these participants made sense of the target, whether by the formation of frames or through perspectives, or descriptions of problems. Whilst many participants considered the world outside of the hospital (the extra-hospital view), this was largely in response to my probing for this perspective and also largely related to the problems in primary care and the ED interface. Three of the participants in this study considered aspects of the health of the population which their organisation served, but this was not a major feature of the data and limited in comparison to the intra-hospital view. The vast majority of the participants in this study who are front line implementers thought about the target in terms of their immediate hospital environments.

The theme of framing the target reveals not only the frames but also the process of how particular frames or labels come into being—largely through people’s construction of explicit or, in some cases, implicit narrative or talk. More importantly however, it also reveals two different types of motivation, the intrinsic and the extrinsic. For example, the rule frame locates motivation outside of
the person; the target is a rule, someone else’s rule that we comply with. In contrast, the patient, quality and organisational frames are constructions that I interpret as prompting intrinsic motivation to the personal and professional self.

Another interpretive feature of these themes is the role of history as it informs thinking and the formation of perspectives. For example, making sense of the problems invariably involved reflection on past experiences. Making professional sense invariably involved reflections on past professional work. Making organisational sense was also built on the past of an organisation. How front line implementers make sense of the target involves multiple dimensions of history as they become fluid parts of the implementation experience.

5.3 Global Context Category – Layers of the Hospital World

Layers of the Hospital World is a thematic category that is characterised by five dynamic social layers of the hospital. These “layers” of the hospital create a rich portrait of the political, structural and social complexity which characterises the hospital context and that operates to filter and mediate the perceptions, experience and responses to the target. The layers or themes that I present here are those which I have analysed to be the most crucial to understanding the influence of context on implementation of the target. Whilst all the professional groups that practice, work or interact within or with the hospital feature in these themes, it is the world of medicine that is the most dominant. My exploration of the themes in this category identifies both the contextual features and the mediating processes, and as a consequence, it is a category of themes which reconstructs the social world of the participants through their narrative. As with all of the global categories, this theme of context is common to all of the study sites.

5.3.1 Layers of Hierarchy and Influence

This theme is defined as the multiple layers of social hierarchy that characterise the professional groups and their relationships in the hospital. The three core professional social groups of medicine, management and nursing all comprise a hierarchy of people to which various roles, responsibilities and authority is attached or associated. These layers of social hierarchy act as a filter of influence and responsibility for the everyday functioning of the hospital as well as the implementation of the target.
Analysis of interviews revealed at least five levels of hierarchy in the management group—executive/corporate, general/group, operations, service and line managers. Likewise, in the nursing professional group, hierarchy is also evident in terms such as director(s) of nursing, heads of nursing, nurse managers, charge nurses, nurse specialists, coordinators and, finally, nurses. In medicine, hierarchy within the professional group is characterised by labels such as chief, head, director or leader, SMO or senior medical officer, senior consultants, consultants, senior registrars, training registrars, junior registrars, house surgeons and house officers. This hierarchy within professional groups in the hospital is a strong feature of the language of the participants.

Since much of the interview narrative which portrays social hierarchy concerns two or three words only, I have selected here just one transcript excerpt that features several of the layers in a single passage. Indeed, in this excerpt there is description of hierarchical authority and responsibility associated with the target.

The two target champions, so, are the Chief Operating Officer and then Chief Medical Officer. The champions for the DHB weren’t even ED clinicians and the ED Clinical Director was very comfortable with that. He said this really reflects that it’s a whole-of-hospital, it’s not an ED only issue. And I think that is one of the reasons, one of the reasons that we have had incremental success. The Director of Nursing also accepted that it was a whole-of-hospital problem, it wasn’t just an ED nursing problem, so it involves the clinical nurse managers on the acute inpatient wards and the afterhours duty managers. (H1 P-J R1 Manager ED/ Hospital)

Social hierarchy is a mediating feature of the hospital context that required consideration or negotiation in order to implement the target. In particular, social hierarchy in the management and medical professional groups is associated with influence and authority over those lower in the hierarchy. A very good description of this hierarchical influence is found in the following excerpt where the participant explains the importance of corporate level presence within an explicitly developed target governance group at the case study site. The CEO at the “top”, was driving the target and it was important that the Chief Medical Officer of the organisation was also involved with the governance of the target and at the table.
And I talked about our CEO chairing the governance group - that was a fundamental strategic decision that we made, that the CEO had to drive it. It had to come from the top. If this was the biggest issue that we had to face in our DHB, and our CEO claimed that it was, then he had to be seen to be driving it. The Chief Medical Officer had to be at the table and my take on it is, if they hadn’t been there at the table, it wouldn’t have had the credibility it deserved. (H2 P-D R1 Senior Manager Hospital)

However, despite the presence of medical leaders who are hospital, department or divisional heads with specific hierarchical standing, their ability to influence behaviours within their own group is further mediated by the individual autonomy and authority that is associated with being a senior medical officer. In the following excerpt, threats to that individual power and autonomy of senior medical officers are revealed, as is resistance to influence and threats.

And then even if you’ve got the heads of department agreeing round the table, getting all their individual surgeons on call saying, you know, doesn’t matter what the policy says, they are not coming in you know. That sort of approach doesn’t help. We’re trying to have the philosophy that we’ve got agreed documents of principles. (H1 P-G R2 SMO Hospital)

Nursing hierarchy is less dominant in the data in terms of mediating the implementation of the target. However, nurse managers on the wards, in particular, have the ability to influence the attitudes and behaviours of ward nurses, including behaviours which may impede the flow of patients onto wards (identified in the problem sensemaking theme). Having nurse managers who are supportive of the target and can influence the behaviours of nurses is a mediating factor, although they themselves may have been influenced by a higher part of their professional hierarchy or other professional hierarchies. The influence of senior nurses on the nursing professional hierarchy is also featured in the interviews via social marketing and other influences on day-to-day ward nursing behaviours.

And so I think they [ward nurses] bought into the whole idea of it especially because me, as their leader, was on posters around the hospital, and you know, they knew that it would influence how I look at it as well, if that makes sense, you know, as with your boss involved in a project you always buy into whatever they’re doing to help, help them. Um and I think that they definitely bought into that. (H2 P-F R1 Nurse Manager Hospital)
The key point regarding hierarchy in the hospital context is the power and influence associated with those staff higher up in the hierarchy. Senior managers influence service managers, nurse managers influence staff nurses. For medicine however, and as previously noted, medical hierarchy is less influential on senior medical officers. Senior managers such as CEOs and Group Managers may have authority and influence over management, medicine and nursing, but it is not always the case that such influence is effective, as noted in the following excerpt from a hospital manager and target champion.

The talk about the surgical registrars, they say actually, we are here to learn how to do surgery, we are not here for you to meet your friggin you know, six hour target mate. (H3 P-I Hospital Manager)

5.3.2 Medical Specialisation and Tensions

This theme portrays the existence and development of multiple medical specialties in health care that are in constantly evolving social tension with one another. Specialisation in medicine and the tension between specialties is a mediating factor in target implementation.

A very common way of referring to medical staff in the collective is through use of the term “specialties”, for example, the inpatient specialties, or the surgical specialties and sub-specialties. In the interviews, specialisation is a distinguishing characteristic of the medical profession and, associated with this, are the various evolving domains of specialty practice that divide the practice of medicine horizontally. These domains in medical specialities include expert specialised knowledge and practice, with influence and status that is assigned to that speciality—although the respective assignment may be judged differently between specialties. Specialties and domains also include the existence and influence of medical colleges, for example, the College of Emergency Medicine, College of Surgeons and College of GPs, all of which were mentioned during interviews.

To present the dimensions of this theme, I feature three medical specialties (emergency medicine, medicine and surgery) and selected aspects of specialty tensions that were most dominant in the interviews.

The term “medicine” had a variety of uses and meaning in the interviews; for example, medicine as a general term for all of the medical profession, medicine as in the practice of it, and medicine as a
term to denote a specific medical specialty distinguished from other specialties, such as emergency or surgical medicine. It is this last use and meaning of medicine, a specific medical specialty, that is explored in the analysis of tensions between medical specialties.

The Developing Specialty of Emergency Medicine

Several of the participants in this study described Emergency Medicine as a new and developing speciality of the medical profession with a growing demand for new specialists in the area. Growth of the specialty was recognised by emergency medicine specialists and by others including managers, ED nurses and other medical specialists, with various implications. For example in the following excerpt from an interview with an ED SMO, the narrative portrays how they believe hospital managers perceive and respond to the growth of the specialty:

We’re victims of our success in the last ten years. Cos we’ve gone in ten years in this department, gone from one to eleven specialists, that is fantastic growth. But one was never appropriate, neither was two, three, four, five or six. So we’re growing because we’re a new speciality but they turned round and looked at that and said, we’ve given you all this stuff and you still keep on coming asking for more; and I hear that so frequently, we still keep coming asking for more, when is it going to stop, when is it going to be enough, and so that’s a problem because we’re still a new speciality. (H3 P-H R1 SMO ED)

Emergency medicine addresses “acute and urgent aspects” (H3 P-H R1 SMO ED) of patients’ health care needs, across a wide range of clinical presentations. As one participant described, emergency medicine is “a general speciality” (H4 P-M R2 SMO ED), and the meaning associated with this is that emergency medicine provides care for all patients who come to their departments. As a consequence I interpret that emergency medicine clinical practice may overlap the clinical practice domains of the other specialties.

Defence of the developing specialty of emergency medicine as it has evolved in New Zealand and Australia, including its expanding scope and models of practice, was a point of concern for some of the emergency medicine specialists who were interviewed, and they did so through comparison (a subtheme noted earlier) with other international models. Pride in the New Zealand model of emergency medicine was also evident.
Emergency medicine as a specialty in the UK, it’s about twenty years behind Australasia as a specialty. And really Australasia and America are at the forefront of emergency medicine, whereas the UK is still struggling to catch up and they’re basing their emergency training on the models from Australasia and America, but are still nowhere near catching up. And so therefore my concern is that, you know, we’re - in some ways we’ve already got something in terms of the way we practice emergency medicine in emergency departments which is better and more advanced...I was just worried that we were going to use this rule, or this concept from an outdated model of medicine and then try and apply it here and think that it could be the same. (H1 P-B R1 Senior Medical Officer ED)

A perception of difference in status as between a “specialty” and a “general specialty” was also identified in the interviews, which added to the characteristics of tensions between specialties. Emergency medicine is a general specialty of practitioners who give general care, in contrast to orthopaedic medicine which provides “specialist care” (H3 P-A R1 SMO Hospital). And, emergency medicine specialists are not of the same status as, for example, cardiologists and renal specialists, who are “single organ doctors” (H4 P-M R2 SMO ED).

**Tensions with Medicine**

Medicine comprises a large and complex group of specialties and sub-specialties; to name just a few identified in the data were general medicine, internal medicine, acute medicine, cardiology, respiratory and renal medicine. Tensions between medicine and emergency medicine feature in the data and my analysis identifies some of the overlap of their clinical practice domains. To help explain this, I feature an excerpt where the participant discusses the history of how medicine and emergency medicine were in tension for the same structural space and the same acute medical patients.

When the new ED was built ... a debate emerged regarding whether there should be an alpha ward in association with ED or a medical alpha ward - of course there should have been both. The ED won the argument and the very muddled thinking that existed at this hospital at the time voted out the medicine alpha ward...So the question of whether ED would end up managing more medical patients was never monitored...two thousand more patients self-referred to the ED than would have been predicted from the trends beforehand. All these new patients were medical patients. So the overall effect was that emergency medicine reduced the number of patients admitted to medicine by four hundred, but sixteen hundred new admissions over and above the growth expected were admitted into medicine. (H2 P-J R-1 SMO Hospital)
Another example of the tension between these specialties concerns where the practice of emergency medicine stops and where the practice of medicine starts (horizontal division of labour) and the possibility of repetition. Still another tension between these specialties concerns the development of a new medical subspecialty of acute medicine, a specialty reference noted in at least three sites. This is a tension that signals the possibility of new competition between specialties for a particular cohort of acute patients.

**But then what it appears is they have found is the medical profession [medicine] - I can’t really speak for the medical profession - they had difficulty dealing with this generally so a new specialty of acute medicine appears to have come up out of the Royal College of Physicians and we’ve got a few of those guys who’ve come over here to set up an acute medicine unit at the DHB, which I’m sure that will be a very good thing. But, you see what I mean - this is a model that probably we didn’t need to introduce because we’ve already got an emergency department model which does all of that. (H1 P-B R1 SMO ED)**

### Tensions with Surgical Medicine

The surgical specialties identified in the interviews comprised two key groups, general surgery and orthopaedics, and less commonly discussed were gynaecology, plastics and other surgical specialties and subspecialties that were unique to two of the hospital sites. Similar to the relationship tensions between emergency medicine and medicine, these relationships were also characterised by evolving specialty domain tensions with some additional and important characteristics.

**I guess what’s become more of an issue over time I suppose is the way ED has wanted to develop itself, and wanted to become more in the way of a specialty. When I was growing up ED was essentially run by MOSS’s (Medical Officer Special Scale) and there was no ED specialist programme. And essentially that’s what ED was – was a triage place... over the years ED sort of created themselves as a specialty and turned themselves into a college or whatever they’ve done, and they’ve tried to grab as much of everything else they can. The emergency department suddenly decided they wanted to form their own specialty. And I think they’ve sort of created a bit of a problem for themselves because they’re training all these people, they want to be super specialist emergency physicians who want to do all this exciting stuff...I think the big trouble is that ED has been trying to sort of swallow too much. That’s their big problem. They’ve sort of been trying to develop themselves as a specialty; they’ve tried to swallow all these other things to make their little kingdom. (H4 P-F R1 SMO Hospital)**
Differences in the status of specialties also feature in these relationships, perhaps more so than with medicine, and in particular the tension includes emergency medicine specialists assuming work that had previously been the purview of the orthopaedic specialty as noted in the excerpt above. Emergency medicine specialists, in contrast, perceived aloofness and disinterest of surgeons to the demand for acute surgical service in emergency department.

Another tension in this relationship is the different values and priorities of the surgical specialists including the delivery of elective surgery and the clinical practice of surgery itself. Others perceive that these competing values and priorities result in a disinterest in acute patients, as one ED consultant remarked:

> Well the surgical consultants don’t care. So ultimately the surgical and orthopaedic consultants don’t care... The surgeons still think well ED doesn’t really count you know, not like an operating theatre counts. (H4 P-M R2 SMO ED)

Medical specialisation is an important and dominant feature of the context for implementing the target. Doctors have specialty interests and values and not just medical ones in more general terms. These interests will influence whether or not they will accept or support change to achieve the target and therefore mediate response to the target.

### 5.3.3 Vertical Division of Labour in Medicine

*This theme describes the assignment of specific work and responsibilities to different medical roles and is closely associated with medical hierarchy. The theme centres on the vertical division of medical labour which mediates the ways in which doctors perceive and respond to the requirements or demands of the work they perform and with this, their response to the target.*

Of the many labels for senior doctors that were identified in the data, consultant, specialist, physician and surgeon were the most important since they denote particular professional and social meanings regarding what these doctors do—their work and role is specialised and involves consulting, whether as a physician or as a surgeon. To be or to hold the position of consultant symbolises a position of superior knowledge that others seek (whether they be patients or other members of the health care organisation). There are expectations, norms, boundaries and discretion
related to the work of consultants, including in the private practice work that consultants may undertake outside of their work and roles in public health services.

I guess we’ve been resistant to any suggestion that in order to facilitate the six hour, the consultants would come in and start seeing work that registrars would normally be doing... Well we don’t see it as our role, it would be a significant change in ... our job description; um that’s number 1. Number 2 is that we’re only employed to be on call for emergencies, so if it’s not an emergency, we don’t, we can’t necessarily make ourselves available... well number 3 is that we’re, during hours we’re always doing something, elective, either operating or consulting either in public or private. (H1 P-G R2 SMO Hospital)

Data analysis revealed three dimensions of the junior medical officer role and labour that mediates experience of and responses to the target. The first is that junior medical officers, in particular registrars, perform a substantial volume of acute medical work; as one orthopaedic consultant described it, registrars are the “people on the ground in the emergency department” (H3 P-A R1 SMO Hospital). Both the labour and authority of these junior medical staff are therefore important factors in the context of target implementation, with a deference by registrars, in some instances, to senior medical decision makers (hierarchy). Such deference may be highly individualised to the particular consultants who have immediate authority over them. The deference to more senior doctors to make decisions is also relevant to the role and work of house officers.

We have highlighted that for years you know, you call them [registrars], they can’t come down, you know. Or they send a house officer which is fine, but they’re non-decision makers...We’ve always said you need senior medical people on the floor to make these decisions about the patients. And that’s particularly evident after hours. (H4 P-C R1 Senior Nurse ED)

The second dimension of the registrar workforce and their labour is that they are learning doctors, either formally as a specialist trainee or more generally in terms of gaining registrar experience. Socialisation around being a learning doctor, including their specialist professional training, development and priorities, adds to the social layering and relations of context.

The third dimension of the division of labour in the junior medical staff is regulation of their hours and conditions of work, particularly that of registrars training to be consultants. This regulation, including that specified in employment agreements, extends issues of the management of their
labour up and out of the hospital into the broader context of the medical workforce and within the purview of medical unions and colleges. The impact of regulation means that to address work behaviour and practices of doctors may require political relations and negotiation beyond the hospital.

### 5.3.4 Clinical and Management Distance and Tension

*This theme encapsulates the layer of social distance and tension which characterises the relationship between the roles, responsibilities, values and priorities of health care managers and those of health care clinicians. Social distance includes social, functional and structural distance. These tensions may also be experienced within a single service or embodied within a single role or the work of individual professionals, creating a very interpersonal experience of the tensions between values and priorities. The clinical/management relationship also mediates the target implementation process.*

An important feature of the data was use of the term “clinician” to characterise staff whose purview is concerned with clinical care and hands-on service to patients. Tensions between clinicians and managers or non-clinicians are linked to different agendas, priorities and values and different sets of responsibilities.

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*I think different people have different agendas, so for clinicians ultimately you’re trying to do what’s best for the patient in front of you. For the clinical leaders you’re trying to think of the bigger picture of the whole department and all patients - doing the best for. Some of the managers - it’s more about the target than the patients, sometimes. (H1 P-G R1 SMO Hospital)*

In this next excerpt from an interview with a medical registrar (clinician), the tension is not only with management but also with nursing staff (who are also clinicians but are distinct from medical clinicians) who they refer to as “outside”, and my interpretation of this is that they mean outside the clinical relationship that the doctor has with the patient, and, outside the profession of medicine.

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*And certainly it’s very variable in terms of the pressure from nursing staff and management on clinicians, and that I find quite frustrating to get pressure from outside, on me to see a patient. (H1 P-K R1 JRMO Hospital)*
The next excerpt aids in understanding the intensity of social distance and tension that may exist between clinical and management professionals and also helps to identify historical depth to the relations as well.

I think this DHB has got a lot of potential but it’s completely squandered by the managerial attitude and there is an undercurrent of managerial nastiness in this place that has been here since year dot...and it simmers above the surface and pops up every so often... But it’s always been there and, and it’s a major detriment to us getting things done, because the bottom line is in this place, whether it’s real or not, we all are fairly confident that our managers hate us with a vengeance, and that there’s probably going to be no sorting that. (H3 P-M R1 SMO ED)

Another way in which I identified the distance and tensions in relations between management and clinical staff in the interviews, was when the distance and tensions that might have normally existed between the two had been explicitly reduced through particular events or actions. I highlight in the next excerpt the reference to managers “coming down” and thus narrowing the structural distance.

The hands-on behaviours of the management group, to undertake the work of the clinical staff, also narrowed both the functional and social distance that might routinely have existed between the two groups.

I was on leave and the CEO he got senior managers and all the managers...like talking suits. And he said right, clear your calendars for the next two weeks and he got them all to come into the department every day; they had to come in for eight hours - nothing else - and they had to work alongside everybody, which they did, and um it was incredible... Initially for the first two or three weeks was - you know, some of them would come in at six in the morning and do an eight hour shift. They were pushing patients to the wards, they were helping around the place, they were shadowing - decided to shadow a nurse today, tomorrow they’d decided to shadow an orderly. In some respects he’s [the CEO] earned a bit of mana and so far as it affects our target it’s kind of left it feeling as it’s not totally doomed - you know what I mean? ... And so he still comes down and says you know guys, how we going - how’s this one, and he’ll ring the charge nurse every day at the end of his day, if not pop down, if not the managers will still come down and meet us face to face which is kind of cool. (H4 P-B R-1 Senior Nurse ED)

Again, with reference to the term “clinicians”, one of the senior managers interviewed described their perceptions and relations as a manager largely in terms of influencing clinicians and having expectations of them. The social, structural and functional relationship distance, however, remains intact, as is the tension created by managers’ expectations of clinician accountability.
We struggled to get emergency department physicians focused on it to start off with, and that’s despite that it was actually their target...So I think it was a bit, it was challenging for them to realise they could do some systemic improvement as well. What’s been really hard is to get the rest of specialty input...We, being management, executive and general management, have met with clinicians at various levels and various specialties to see fundamentally and philosophically what’s your problem really...But it is also to be very clear that this is not negotiable, it’s not going away. (H3 P-B R1 Senior Manager Hospital)

Tensions and distance between clinicians and managers may also be within a department or division, and the strongest insight from the interviews concerned the emergency department. As one ED manager described in the interview, “How is it on the shop floor? I don’t feel I can comment on that because I’m not close enough” (H4 P-D R1 ED Manager). Whilst the example here centres around the emergency department, this does not mean that these various tensions do not exist in other departments; rather, there was not sufficient data in the interviews with the hospital participants who were recruited to substantiate this.

Excerpts from a manager and clinician in the emergency department at the same study site demonstrate this intradepartmental dimension of clinician and manager distance and tension. The emergency department manager explained some of the challenges of influencing and controlling the work of medical staff, particularly in relation to achievement of the target, to which the manager had a strong role commitment.

But because there’s inconsistencies with the consultants on the floor... sure there are variables ... around bed block and stuff like that, but it’s so much down to the nurse who is in charge and the consultant. If you get the combination right you’re on a winner. But if you get a consultant that doesn’t - target doesn’t mean anything more to them, and they do not drive and do not monitor the patients and keep on track and stuff, then you might as well not bother. And yet I could tell you off the top of my head who those ones are. (H3 P-C R1 Manager ED)

The same emergency department manager explained the challenges and tensions concerning emergency nursing staff who were more amenable to the manager’s influence, unlike their medical colleagues above, but who nevertheless required explicit persuasive efforts on the part of the manager:
And the nursing staff took a lot of convincing initially too, but they, the nursing staff are a hundred percent on board... and you know we had to have some frank conversations about - you may not agree with the target personally, but actually as, as a department, we, we are going to meet this challenge, and actually you have to get out there and be on the same page about it. (H3 P-C R-1 Manager ED)

In contrast, one of the nurses in the same emergency department described a widening of the social distance between managers and clinicians. Another explicit aspect of the excerpt is the perception of other issues and the influences of “higher powers” on the managers.

I think that the managers, I can’t really say they’ve sold their souls but I can say that they’ve probably been taken over and so their focus is... very different than what it used to be as well. They’re a lot more stressed and a lot more - they’re a lot different because their pressures are, they’re more managed, their focus has changed. They’re now being managed by higher powers...So they have changed huge. I think people always felt they were far more approachable, they are making an effort to be more approachable, but I think that they have their own - they have their own issues that they, you know, have impacted on them as well. (H3 P-E R1 Nurse ED)

A final characteristic of this theme is the intrapersonal tension that may be experienced by target implementers between clinical and management values and priorities. The tension is perceived and experienced as a discord between clinical values which centre around what is perceived by the clinician as best for the patient, and target priority, which may be perceived and experienced as a concern and priority of management. The tension is largely, therefore, concerned with the experiences of clinical professionals inside both the ED and hospital.

So personally I think it’s [the target] a really good thing. I think it is, ah negative ...if in the interests of the target we move someone on in the department or we say they can’t sit here...if the most appropriate place for the patient to be right now is ED and that’s where they should be, and so the patient should never come second to the target. (P3 P-G R1 Nurse Manager ED)

5.3.5 Distance and Tension between the ED and the Hospital

This theme is defined as the social, structural and functional distance and tension which characterise the relationship between the emergency department and other parts of the hospital.
**Social Distance and Tension**

This dimension reflects the way in which the emergency department is perceived and experienced as an entirely different social world to the rest of the hospital and its myriad of wards and departments. There is a social distance between the people who work in ED and the rest of the hospital that one of the participants described as follows:

> I think ED, and I think it’s common knowledge throughout the hospital you know, ED departments work a little differently to other departments within the hospital. You know, the staff are a little different, they just work differently – it’s not always a good thing; you know ED can be a little cliquey. It can be – it’s almost like it’s a complete and utterly separate part of the hospital which it shouldn’t be. So I think that doesn’t work so well – it’s that ED is almost – it can be a law unto themselves. Their own little culture that happens in ED. (H1 P-A R1 Allied Health Staff ED/Hospital)

In this example, the participant is describing how EDs exist in their own social worlds, and a tension arises when others perceive this; it is perceived in a negative social way as being “cliquey”.

**Structural Distance and Tension**

Structural distance and tension was identified through the use of particular language by participants: “down in the ED”, “up in the bowels of the hospital”, “the ED”, “the inpatient wards” and so forth. Other labels and language that characterise structural distance included the contrasting pairs of the “front of the hospital” and “back of the hospital”, the “front door” and “back door”. Some of the participants described this in association with different parts of the patient’s journey and strategic response.

In the following excerpt, the structural distance is associated with a tension regarding the need for more attention to patients who are the shared responsibility of ED and inpatient staff within the ED environment. Thus, the structural distance is about the geography of the hospital.

> I thought it was quite funny that all of a sudden other disciplines had to think about um, ways that they could improve our service you know. It’s their service fundamentally. But there’s a geographical barrier in ED. Even though a patient is, might be a surgical patient waiting for a bed, everyone’s continues to think it’s an ED patient until they actually leave the emergency department. (H1 P-C R1 Senior Nurse ED)
**Functional Distance and Tension**

Two aspects of functional distance and tension include the differences between acute and elective services and patients, and between the controlled and scheduled environments of the hospital and the chaotic, sometimes unpredictable demands of the ED.

_Every other person who works in the hospital is used to scheduling, whether it’s theatre, clinics, even ICUs will schedule their patients, they are used to scheduled whereas we are used to non-scheduled...So there is always a background tension of, what an ED is and what it does and who understands how they work._ (H4 P-M R2 SMO ED)

_So we analyse on a six week cycle that normally on a Friday we would receive, we would get 180 patients through the [emergency] department, so we know that and predict that so if I go to my analyst person and say what do we plan for tomorrow, they’ll be able to say yeah well based on what we have done over the last six weeks we should expect 183 attendances in ED tomorrow. Largely that number is correct you know give or take five say. But there’s days when it might be 20 out or so...so we know that information, however ...the way it’s been termed from the analyst is, ED have given us 65 patients, meaning you know, sort of implying actually that we’re going along doing our own work and bloody ED come along and give us 65 more patients to deal with, you know which is actually not the way...so there is that mind-set that it’s ED’s fault. You know why are they giving us 65 patients, why don’t they give us 60 for God’s sake? How dare they? Then the other thing is ah the specialty view which is almost that the incoming acute patients are the enemy._ (H3 P-I R2 Manager Hospital)

These examples primarily emphasise functional distinctions between acute and elective service, and the tensions between priorities that exist.

**5.3.6 Interpretive Review of Layers of the Hospital Social World**

This category of themes addresses the questions posed by the research concerning the impact or influence of context on the implementation of the target. In particular, these themes respond to questions such as what are the key dimensions of context that influence how the target was implemented and what are the key tensions in the context that have a bearing on process and outcomes.

The most notable dimension of these themes, and thus the label of the category, is the layers of social, functional and structural complexity which characterise the hospital context. It is a feature of context for the implementation of the target, that quite possibly would be found in no other arena or sector of public health care, nor perhaps even the public services more broadly. This complexity
pre-exists the target and mediates the ways in which policy implementers perceive and respond to
the target. It also suggests that endeavours to achieve the target must transcend and negotiate these
complex layers, with a possibility that without cohesion or collaboration, particularly across
structural and social boundaries, efforts may be fragmented.

An additional **dimension** of this complexity is professional, and most importantly the complexity of
medical professionals. Medical specialties and the **tensions** between them represent a dynamic and
evolving social layer for implementation of the target with different values and priorities coming to
the foreground, that are aimed at preserving the integrity, status and development of each medical
specialty and its clinicians. It is a context of heightened medical politics. Introduction of the target
has brought tensions and political behaviours between medical specialties to the foreground of
implementer thinking, as evidenced by the themes and excerpts in this section. This is a situation
that may result in a range of behaviours and strategies for different specialties. These social layers
of the medical profession also offer some insight into the theme of problem sensemaking where
attitudes and behaviours of medical staff featured—what is perceived as a problem, from a non-
medical point of view, may be viewed as very normal from a medical one.

The third key **dimension** of these themes is the distance and tension that exist between clinical and
management staff, their roles, priorities and values. Implementation of the target consequently
exacerbates and highlights the distance and tensions that pre-existed the target, with managers
having an authority and responsibility toward the target that clinicians may not share. This suggests
that the promotion or development of shared values concerning the target would be an important
consideration in target implementation. Yet I noted in the excerpts how clinicians may
fundamentally make choices that aim to preserve what they believe to be quality of care for patients,
regardless of the pressure of the target in their environment. This raises a further question: if that
choice is removed though the re-engineering or erosion of the clinicians’ authority and professional
responsibilities, how might that impact on the patients and, indeed, on the staff themselves?

What appears to be missing from these findings and why? Missing dimensions of context include
the political and economic context of public health care. One of the participants said that the
recession was part of the reason for nursing workforce stability in the ED. However, outside of this, the broader political and economic context did not feature strongly in the interviews, other than in reference to the limited resources of the health system. Whilst there were occasional references during the interviews to the Ministry and Minister of Health, these were largely concerned with the story of formation of the policy and visits to the hospital from the national target champion and policy officials. Another missing dimension of context is that concerning the health of the populations served by these organisations. There were infrequent references to poor and ageing populations, and references to the needs of chronic care patients were limited and paled in comparison to the focus on the hospital’s internal social context.

I believe that the key reason for these absences of context is that these front line implementers identify that their core health service, political and economic interests lie within the hospital. This interpretation is consistent with the dominance of the intra-hospital framing and perspectives in the sensemaking themes.

5.4 Global Effect Category – Response and Impact of the Target

This category of themes presents findings regarding the effect of the target in terms of strategic response (what was specifically planned/pre-planned and implemented), and impact (the way that the target and its strategies have impacted on staff, professional groups or services). Impacts on patients are also described through the participants’ opinions and perceptions and these are explored in the final theme of the category. Some of the subthemes may overlap with other themes and I make note of this during discussion. Whilst these themes are common to all of the hospitals in the study, the timing of some of the strategic responses and activities varies across the hospital sites and where this is due to important circumstances of local context, I will explore this in the subsequent chapters.

5.4.1 Target Focus

This theme is defined as the effect and mechanisms of target focus. The effect of the target is to create a lens that encourages staff or the organisation to focus, to see and pay attention to the problems that the target is, or should be, addressing and to have a focus on the target itself and
its achievement. Two mechanisms of focus are the development of information, feedback and monitoring processes and the mechanism of group work and projects.

The Lens Effect

A very common way of describing the experience of the target by participants, was that it makes people focus, and the metaphor that best describes this is that the target has the effect of a “lens”. The lens metaphor encompasses the many ways in which the target encourages, forces and enables staff to see, to be made aware of and to have clarity about not only the target itself but about the problems and solutions needed to address the achievement of the target; like a new set of glasses placed before one’s eyes. The word “focus” is a powerful and repeated reference in the interviews, and as one participant explained, “I think that the six hour target has also focused our minds” (H3 P-B R1 Senior Manager Hospital).

What was Focused On?

A focus on systems, problems and issues within the hospital, regarding flows of patients, delays, and related behaviours is one broad view highlighted through the target lens; focusing on discharge practice from wards is one such example. Focusing on quality is a further view through the target lens. Another view through the target lens is the focus on particular departments and staff, for example hospital duty managers and their work. Focus on the front of the hospital in the emergency department and alpha ward, is a more obvious structural departmental view through the lens; this focus is discussed in the next theme. Criticism of the front of hospital focus is noted here:

There has been a strong focus on ED itself um you know as I think lots of places have, it’s supposed to be a whole-of-hospital target but the excessive focus is ED. (H1 P-G R2 SMO Hospital)

Focus on the organisation is also a dimension here, as one nurse manager described, “you know you were totally more organisational focused in different departments, focus so that you could, you know, work together to bring those patients where they needed to” (H2 P-F R1 Nurse Manager Hospital).
Who was Focusing?

Senior managers who were interviewed described their focus on the target in a variety of ways, for example, “I have been very focused on the target because I think it was one of the better targets that we were given” (H1 P-L R2 Senior Manager Hospital). Executive and senior managers were frequently described by others as focused on the target or achieving the target.

We also had the CEO who was very focused on enabling us to get to the target. (H1 P-J R2 Manager ED/Hospital)

The organisation, in the collective, was also focused on the target, “I think that it is a huge focus for the entire organisation” (H2 P-F R1 Nurse Manager Hospital); along with the staff of the ED, “and I see that it has focused the attention of ED staff and the wider hospital staff on the target” (H3 P-G R1 Nurse Manager ED).

Information, Feedback and Monitoring Mechanisms

A key component of target focus, is the development of information, feedback and monitoring mechanisms. These three components are linked and cyclical and explain some of how the target focus occurs.

Information/Data

Gathering of information in response to the target was first identified in the interviews when participants described the formal behaviours of recording the circumstances of target breaches in the ED. Nursing coordinators or charge nurses in the ED had primary responsibility for collecting and collating information regarding the patients who had breached, and reasons for this, on a shift, daily and weekly basis, to allow trend analysis. Such information might include that the delay was caused by a slow response to referral from inpatient registrars or, in contrast, be due to a highly complex patient whose clinical needs took longer to manage than the six hours. The gathering of information about ED timeliness was also a developing process.
To begin with it was just about numbers and volumes and those sorts of things. So how many people came in um related to triage, how many people were admitted, how many people were discharged, just basic information. And then it grew further. So then we got a running seven day table on compliance, all those sorts of things, and then we brought in more information around the menus that we had already started collecting about why people were delaying...If there is some suggestion that the delay has occurred due to lack of, specialty delay for example, that we’ve got the information sitting there in front of us. (H1 P-J R1 Manager ED/Hospital)

Another example of this type of data generation concerned timeliness of orderly service, including the gathering of specific data to determine the need for further orderly resource.

A second key form of information generated in response to the target concerned hospital and ward operations, including the length of stay, variations between different clinical teams and, more generally, the timing of patient flow through the hospital.

A third form of information which emerged in response to the target was more formalised research concerning clinical quality in relation to acute care management. This was from both existing published literature and the generation of quality indicator data within hospitals. A formal research project, aimed at developing more in-depth and accurate data concerning specific patient presentations, clinical and operational indicators, is one example of this form of information generation.

Feedback
Four types of feedback in relation to the target were identified from analysis of the interview data: clinical delay escalation, live feedback, informal and formal performance feedback. Each of these types of feedback may have existed in one way or another prior to the target’s introduction, but once the target was introduced, more deliberate and constructed feedback mechanisms emerged, regarding much of the information that has just been outlined.

Escalation of clinical delays refers to the shift-by-shift or daily direct escalation of delays or likely target breaches back to staff involved in the delay. For example, delays to inpatient referral from the ED were escalated to the doctors involved, or delays to admission to wards were escalated, often through the duty manager. Much of this form of feedback was instigated by the senior nursing and
medical staff on shift in the emergency department, with the procedure formalised through policy at some sites.

So I think there’s been a huge improvement in the emergency medicine specialists taking things on and escalating and ringing the surgeons to find out where their team is, and every time we do it there’s emails for Africa from the Clinical Director of Surgery, stop harassing my staff rah rah rah rah...so they’ve finally realised that it’s actually not a good idea to have the surgical registrar on call in clinics. Cause the day we escalated to the specialist he said oh where is my bloody registrar and we say well he is in clinic and he doesn’t know how long he’ll be. Well would you stop harassing him, but next day, the surgical department has decided that we will provide, oh bravo. (H4 P-C R2 Senior Nurse ED)

Live feedback refers to the real-time visibility of the ED information screen both within the ED and across the hospital. Staff in theatre or in operations centres, for example, were able to view the patients in ED, the timing of their stays and pending breaches of the target.

Informal feedback concerns the various types of information sharing processes that feed back to staff or departments about performance, such as when individual staff or team behaviours were problematic.

Formal feedback concerns deliberate processes where target performance (where the organisation is measured at the time), as well as specific issues of delays, is conducted routinely and transparently. Examples of these types of formal feedback include departmental meetings where information regarding specific specialty performance is discussed, or routine operations service meetings with bed and duty management staff. Reporting of events in relation to the target, such as clinical safety concerns, is a formal feedback mechanism identified, although this process pre-existed the introduction of the target. The display of information in the hospital or the routine reporting through email networks are other examples.

Monitoring

The creation of information regarding the target, and the technical systems that support the feedback of that information, enabled staff within the hospitals to watch, analyse and then respond where needed or choose not to. Feedback of the real-time information into various parts of the hospital and within the ED itself (or even beyond the hospital, as noted in the following excerpt), meant that
real-time monitoring of patient flow and the target was available. Participants described active monitoring of the ED information screen by hospital medical staff, emergency nursing and management staff, duty and more senior hospital managers.

They [the ED manager] can access the ED information screen from home as well (laughs). If, assessment area gets into um, overflow or corridors, that we, when I say corridors, cos we don’t have corridor patients anymore even though we do, um you know, they get on the phone to the charge nurse wanting to know what’s happening. (H2 P-M R1 Nurse ED)

Another type of monitoring identified in the interviews was that of trend monitoring from different aggregated data or information sets generated in response to the target, which informed participants of various issues concerning the flow of patients through the ED and hospital. Monitoring of trend information regarding hospital flows also included, for example, ward length of stay and discharge statistics. Again, such monitoring of information facilitated response, though in a delayed fashion.

**Group Work and Projects**

The second key component of target focus was group work and project. Prior to the introduction of the target, many of the participants reflected on past groups or collaborations that had been formed and associated projects that had endeavoured to address issues concerning patient flow or overcrowding in the ED—with varying degrees of success. A notable feature of target implementation was again the formation of new groups or the utility of existing groups within hospitals to address the target. Associated with these groups were projects of various titles, with an array of work activities and work streams.

**Group Work**

A common feature of the groups formed in response to the target is that they were multidisciplinary and comprised senior staff from across the hospital. Patient flow committee or group, target project groups, operational and governance groups are examples of a collective approach to addressing achievement of the target referred to in the interviews. Some of the initial group formation and membership at hospital sites was revised as member conflicts occurred or staff left.
During the second round of interviews, participants described new groups that had been established. One of these groups (born out of a previous collaboration) was largely “hospital operations” in design and function but with an inevitable relationship to sustaining achievement of the target (referred to as the “six hour rule” in this particular site and excerpt).

So to give you an example, myself and the chief financial officer chair something call the HOG which is our hospital operational group which is essentially a weekly meeting about what’s happened in the last week...how did we do? The six hour rule, what are the issues, what’s happening ... six hour rule, what’s happening in elective volumes...and then we talk more broader strategic you know, have we got our winter planning...and we have in that room all the operational relevant people. Now is that related to six hour rule? ...[the]six hour rule is one part of the agenda. (H4 P-L R2 SMO Hospital)

Projects

Projects were frequently associated with the groups formed in response to the target. Goal-directed and time-limited, projects included whole-of-hospital target projects, patient flow projects and hospital discharge projects. At one of the sites, a very specific and large whole-of-hospital target project was undertaken. It is a project that almost every participant interviewed at that site discussed.

A salient example of project work associated with a newly formed multidisciplinary cross-hospital group was identified in Hospital Three, where several projects concerning patient flow, hospital efficiency and clinical indicator development were addressed in order to bring about the changes needed to achieve the target. Associated projects or work through a project that might have pre-existed the target included bed and theatre projects. Project work addressing primary care and issues of ED demand was identified in one of the sites:

With addressing the management of acute pre hospital after hours there’s been a number of projects done, and Dr GGGG who’s a GP completed a huge piece of work. (H1 P-J R2 Manager ED/Hospital)

5.4.2 Focus on the Front of the Hospital

This theme is defined as the strategic focus and impact of the target on the front of hospital structures, services and staff of the emergency department and the alpha ward. Three subthemes of this strategic focus and impact are: Focus on the Emergency Department, Focus on the Alpha Ward and Getting Faster at the Front.
The labelling of this theme as “front of hospital” is a deliberate reflection of the structural strategic emphasis that is evident in the interviews, but also, as noted in the previous category, of the social and functional distinctions that characterise the hospital context. In regard to the timing of the target’s effect, the focus on the front of the hospital (whether by action or plan) preceded or appeared to precede a focus on other areas of the hospital. The “front” is a typical term to capture the sense of the “front door” through which patients arrive, primarily into the emergency department or alpha ward.

**Focus on the Emergency Department**

Implementation of the ED time target involved a powerful and deliberate strategic focus on the structures, services and staff of the emergency department. This focus incorporates changes and development in professional resources, roles and responsibilities for nursing and medical staff in the ED. System, process and quality improvement activities and resources designed to promote the efficient and safe flow of patients through the emergency department are also important characteristics of the strategic focus. The subtheme includes planning, preparation and expectations of a new emergency department.

**Change and Development in Emergency Nursing and Medicine**

Enhanced, changed or additional emergency nursing resources is a notable response to the target. In particular, senior nursing resources were emphasised, with additional FTE allocated for charge nurse and coordinating roles. The role of the nursing coordinator in emergency departments features here, with greater emphasis on the work of managing patient flows, information and communications within the department and into the organisation. At one of the sites, a nursing role was developed and dedicated particularly to managing target achievement in the department. Other nursing roles and allocation changes included those associated with triage, rapid patient assessment practices, and better roster alignment of resources with peak demands throughout the day.

*We brought in, one of our first roles was another charge nurse - patient flow charge nurse, that solely looked at patient flow. (H2 P-G R1 Nurse Manager ED)*
Additional FTE allocations for emergency medical resources are highlighted in the interviews; for example, at two of the hospital sites, more senior emergency medical resources were planned and approved. Changes to scheduling and allocation of emergency medicine resources across the various work areas of the department and across demand times also featured here, with the goal of helping to match resources more effectively with demands and improving the medical staffing during the afterhours periods. Data from one of the hospitals features a new senior medical role aimed at overseeing the flow of patients within the emergency department and across the inpatient teams, as well as supervising emergency medical and nursing staff. At the other sites, these flow and supervision functions were emphasised or re-emphasised within existing senior medical roles.

**System, Process & Quality Improvement**

An important development across all sites, in terms of technical systems, concerns the emergency department information screen, which is both a system and a resource. Whilst some form of this technology pre-existed the introduction of the target, the onset of the target resulted in updating and enhancing its features as well as creating visible and up to date access to the information across many of the hospital’s services and staff. The emergency department information technology also facilitated the collection of real-time data on the flow of patients, although this still required the human resource to do so and was thus related to other themes in this group. Other technical systems to enhance communication amongst staff in the department ranged from simple initiatives like a peg and coloured card system to indicate when a particular activity had occurred for patients, to more elaborate personal communication devices. Such systems reduced the need for face-to-face communication between staff regarding the patient’s progress.
Changes and developments to the orderly resources for the emergency department is a strategic activity designed to enhance the timely flow of patients within and through ED. Improved communication with orderlies, and better alignment of the orderly resource to the needs and demands of the emergency department, were also mentioned in interviews.

Another process improvement identified was the utilisation of the 3-2-1 model to promote efficiency around the key components of the patient’s journey through ED, and I feature this in the next excerpt. This is a particular model that is not new to the introduction of the target, but which two sites used to systematise, manage and benchmark the assessment, diagnostic, treatment, referral and admission flows. It is also a means of assessing the performance of inpatient team response to referral.

An example would be I suppose the 3-2-1 paradigm. So we decided that you know quite early on that actually we needed to have a way of measuring what we were doing and putting that out to the specialties...Okay so let’s look at the six hour journey in the particular ways, and we’ll say let’s allow three hours for ED to do their bit, and if they are referring to a specialty, two hours for the specialty to do their bit and if the patient is going to be admitted, one hour for the patient. (H3 P-H R2 Senior Manager Hospital)

Similarly, triage systems and practice were evaluated and addressed as a consequence of the target, and triage is also linked to the roles and allocation of nursing and medical resources (or lack of them), as well as the new emergency departments that feature in two sites. The emphasis around triage is also linked to the pre-existing performance indicators for triage compliance, with the target and its evolving impact signalling a need to re-evaluate and address the triage component of emergency department service.

Processes concerning admission to hospital feature here with a notable emphasis around the system for booking beds and hospital operations. It is also associated with process improvements to assure patient safety, since rapid admission from the emergency department required more timely patient preparation and readiness for admission. Another process improvement strategy involved direct ward admission rights for ED physicians, a strategy that aimed to address the flow of surgical
patients at the site concerned. It is a strategy that did not gain momentum and I discuss this in the local themes section for the site involved.

At least three of the hospital sites negotiated and instituted formal policies between services and specialists in order to gain agreement and compliance with how to manage certain categories of patients in ED. These policies were designed to reduce uncertainty and problem behaviours between medical specialty staff regarding the process of acceptance and management of referrals. It was a strategic response to the target that met with varying degrees of success.

New Emergency Department

Planning for and anticipating the opening of a new emergency department at one of the hospital sites is included in this theme. At that site, participants’ strategic response to the target was to focus on preparing for the new emergency department and with this the separation of medical specialities afforded by a new alpha ward. The new ED service whilst planned before the target, became part of the response.

Focus on the Alpha Ward

This subtheme incorporates planning, preparation and opening of new alpha ward structures that were active in two of the hospital sites across the data collection period. At another of the sites, focus on the alpha ward involved transition from an existing structure to a brand new one. Developments in the professional resources, roles and models of medical care and service that operate in the alpha ward also featured.

As with the emergency department, the alpha ward is a front of hospital structure and service with a core acute care function. Only two of the case study sites had a pre-existing alpha ward separate from the emergency department prior to the target. In the other two sites, alpha ward functions were present within the designated emergency department structure, with nursing personnel provided from the pool of emergency department staff. Concurrent with the target, changes to the alpha ward structure, functions, staffing, models of care and patient cohorts served by the alpha ward occurred, with the result that, by the end of the interviews, there were four separate alpha wards in all four
sites, but all with some features of service different to the others. Some of these differences I analysed as a consequence of some aspect of local context and I will discuss this in greater depth in the local themes section; here, I concentrate on the general dimensions of change.

**Improved Resources and Roles**

Additional alpha ward resources included, as noted above, the development of entirely new physical structures in two of the case study sites and, with this, additional acute assessment capacity and function that was evident. At a third site, the existing alpha ward utilisation changed and another separate facility was opened. Associated with this structural capacity improvement were human resource improvements, including some additional FTE in nursing and medical staff. Enhancing and defining of medical director or leadership roles within the alpha ward were noted.

**Developments in Medical Service and Models of Care**

At all of the hospital sites, a notable strategic response to the target was emphasis on developing models of medical and nursing service and care through the alpha ward. Attention to who and how particular cohorts of patients would be managed in the alpha ward was a central concern with associated activity. For example, in Hospital One during the first round of interviews, I identified that what had previously been a mixed specialty alpha ward of medical, surgical and emergency patients changed, with the introduction of the target, to medical patients and services only, with a small cluster of beds in the alpha ward still available for observation of emergency department patients. During the second round of interviews at this site, the model had changed back to include capacity to manage surgical patients waiting for surgical registrar review. In Hospital Four, the alpha ward model involved both medical and surgical patients and service, with no emergency department patients at all. In this hospital, aligning the alpha ward nursing models with the medical service models was also noted.
So the other piece that we had to work through was how generic again nursing staff were with that, by getting the different specialties to you know, wanting say surgically orientated nurses versus medical and so forth, who actually had the skills to deal with surgical conditions, now in the end we’ve tried to cohort a little, you know some of those patients within the alpha ward, and so forth but that has been a challenge. (H4 P-L R2 SMO Hospital)

Another aspect of the models of care developed in the alpha wards includes sub-acute pathways in at least three of the sites. These sub-acute pathways included specifically planned clinics in the alpha ward where patients could be followed up by specialty doctors in the days immediately following discharge from the alpha ward. Another clinic-type alpha ward activity involved more rapid access to inpatient specialists for patients directly referred by their general practitioners. In this model, the objective was to reduce the likelihood of an acute presentation to the emergency department and acute admission to the hospital.

**Planning and Preparing for New Alpha Wards**

As with the emergency department, this subtheme also includes planning, preparing and anticipating the opening of new alpha ward facilities. The strategic focus is thus around strategic preparation and expectations for the alpha ward to help achieve the target. In Hospital Three for example, part of the planning included up skilling nurses to practice in the new alpha ward and the plan to implement an internal target for the alpha ward to manage the assessment phase within three hours.

I mean my nurses are currently working down in ED as part of getting skilled in assessment...Well when the patients come through the assessment area they’ll be out of that six hour target...But we’ve made a three hour target. We being Dr XXX basically, he’s the Clinical Director, set a three hour target. (H3 P-L R1 Nurse Manager Hospital)

**Getting Faster at the Front**

Seeing patients quicker, making decisions earlier and acting faster in the management of the patients within the ED and the alpha ward were identified in all of the hospital sites and are important effects of the target at the front of the hospital. Responses to the target that enabled patients to be seen faster included both the professional resource and practice of making rapid assessments and decisions about the patients, and their likelihood of referral and admission. In
Hospitals One and Three for example, the direct transfer of patients following triage or a rapid clinical assessment procedure into the alpha ward and on to the medical teams of that unit reduced the need for more intensive emergency department management.

And now in the daytime we have patients who show up at triage, the triage nurse deems it is more appropriate for medicine - directed right instead of left. Right being towards the alpha ward, left being towards the ED waiting room. So there’s a big more pull from the alpha ward and I think those developments strengthening the senior leadership and resourcing the alpha ward has helped ah, as well as strengthening the resourcing in ED. (H1 P-G R2 SMO Hospital)

As noted previously in the Focus on the Emergency Department theme, one of the process improvements identified was the 3-2-1 model, which endeavours to ensure that the patients’ journey is more timely with, for example, earlier referral to inpatient medical teams. Making clinical decisions earlier is an important feature of the way in which the emergency department specialists and the junior doctors they oversee respond to the target.

I think that it has made us be more um, in - think more about planning for disposition a little bit earlier. I mean, that’s what I would say, um, has been the main change - try to think about what you’re doing with a patient early and that is reflected down...and I think you know, we make people think early, is this patient going to go home or are they going to be here requiring eight hours of short stay management? (H2 P-C R1 SMO ED)

Getting faster at the front door also includes the emphasis on senior medical officers being available to make decisions about the patients in a more timely fashion and this is particularly related to the developing medical and service models of alpha wards.

Participant: In relation to helping in the alpha ward, we now, we now have a consultant or a surgeon associated with the alpha ward, so therefore he’s able to help progress patients either through to being discharged or through onto or being admitted to the ward...

Interviewer LC: I just want to pick up on having the surgeon in the alpha ward. What is it about having the surgeon in the alpha ward?

Participant: He can make the decisions. He’s a senior person that can make decisions. ...with having that happen it just means we have got someone there to make decisions. (H4 PJ R2 Manager Hospital)
Other strategies identified in the data that enabled a faster front of hospital response included improved laboratory processes that help speed up diagnostic work in the ED and alpha ward, and also improved allied health practices, models and resources which facilitate earlier management of patients prior to discharge.

5.4.3 Demands on Emergency Nursing and Medicine

This theme is defined as the demanding impact of the target on emergency nursing and medicine professionals. Some of the demands, such as increased responsibility for patient flows in the ED, are shared across both professional groups and others are unique to each. The theme includes changes to professional practice, professional dilemmas and the professional stresses associated with the target. By “demanding”, I mean that implementation of the target presents challenging and trying experiences for these professionals.

Enhanced Responsibility

A key impact of the target’s implementation has been the emphasis on managing the flows of patients into and out of the ED on a shift-by-shift and daily basis, which has developed into a significant responsibility for senior emergency nurses and doctors. As noted in the prior theme concerning the focus on the emergency department, much of the purpose of additional resources and refined nursing coordinator or charge nurse roles is to provide a consistent means to progress patients through the department in a timely fashion. Whilst some of this responsibility might have existed prior to the target, its introduction has enhanced professional responsibility for target achievement, for senior nurses in particular.

I felt it was very much up to the nurses and the charge nurses in particular and myself when I was on shift, that it was down to us to drive it and to make sure that the patients didn’t breach and you know, if we could prevent it then everything had to be done to prevent it and I felt that it very much landed on the nurses, the charge nurses in particular. (H3 P-C R2 Senior Nurse ED)

Some of those increased or enhanced responsibilities include communicating within and outside of the ED about progress or delays for patients and this brings with it the possibility of tensions amongst ED staff themselves or with other staff in the hospital.
If anything probably, and I’m not saying it fostered negative relationship, but there’s been more ‘angst’ – well it’s just something else to ‘angst’ about, your know what I mean. If there’s an issue it’s – well guys you know this patient’s been waiting three hours to be seen and it only leave us a couple more hours to get things sorted. So in some respects it’s a bit of a catalyst. If you mention that then you can get it back in your face. (H4 P-B R1 Senior Nurse ED)

Other new responsibilities for senior nurses include the management of information regarding the target, such as the details of target breaches and sharing ongoing information regarding the target across shifts with their emergency colleagues, both medical and nursing.

And so, then we became – in clinical practice we became more sort of traffic wardens and you know, just trying to keep flow going, making sure we weren’t going to let patients stay too long in the department. But here, because we’re so busy and we’re split in so many different ways as an emergency consultant, it was just, completely wasn’t doable. And it meant that you’d find your time running round trying to get some stable patient who had very little wrong with them, out of the emergency department rather than focusing on the stat. one who was going to die if you didn’t do something. You know it just seems so wrong. (H1 P-B R1 SMO ED)

For emergency medical staff, there has also been a developing responsibility and change to the senior medical role which involved a shift from work that centred around clinical management of patients, to a role where the oversight of the department and the efficient flow of patients is now central to the practice of emergency medicine specialists. It is not necessarily a change to their role that sat comfortably with the emergency specialists for different reasons.

In the following example, the emergency specialist describes the escalation of delays from the emergency nurse, through them, to inpatient medical staff, and the professional issues they may have with pressuring their medical colleagues.

Occasionally though you have to watch it that you can get used as a big stick, by some nurses. So they’ll get pissed off because the registrar is, ah not taking their call, and when they come to you, they coming expecting you to get the clipboard and beat the registrar about the head until they do take the patient, you know, which often isn’t the solution to the problem and it’s not really a situation that most of us want to find ourselves in. We don’t want to be, you know the enforcer for the ED sort of thing. (H3 P-M R1 SMO ED)
Enhanced Accountability

Alongside responsibility for achieving the target is also being accountable and this is most salient to emergency nurses who were expected to account for the delays in the department to their managers or other managers who might have been monitoring the department – as noted in the earlier target focus theme. At times, this accountability for the target may be more formalised and difficult for staff.

Enhanced Authority

Associated with the responsibility for the target is a new and sometimes heightened sense of authority in their emergency work. The target provides the staff with a form of justification or power to progress patients, make phone calls, escalate problems, and report difficult behaviours. Emergency nurses felt they were more empowered in their interactions with medical staff.

We also encourage them to be more proactive in going to the RMO staff and saying can I help with the decisions, what’s holding you up? What do you need? So actively managing the flow and the decision-making and so it was about empowering them. (H1 P-D- R1 Nurse Manager ED)

Gaming Pressure & Moral Dilemmas

Target pressure is a key thematic finding of this study (see Section 5.4.6), and like all other staff who were interviewed, emergency nurses and doctors also experienced various forms of pressure from target implementation. However, a type of pressure unique to the staff who practice in the emergency department is the pressure to “game”. Many of the staff in this study reflect on the notion of gaming and what they think this involves. Descriptions of gaming behaviours will be further explored in Section 5.4.7, but in essence involves activities which help staff working in the ED to meet the target by stopping the target clock early, but not necessarily indicative of safe practice or real change. Pressure to game is described in the following excerpt:

But there’s possibly one thing that’s changed since the last time we spoke is the little bit more pressure to game, but only on a subtle thing, mainly on use of short stay and observed spaces. Ah but I mean that’s just a manifestation of the pressure that we’re under to achieve it. (H3 P-H R2 SMO ED)
Both the pressure to game and gaming behaviours themselves left staff feeling professionally uncomfortable, and experiencing issues with professional honesty and accountability. In some instances, gaming might result in the policing of the target to prevent fudging and in the excerpt that follows, the fudging behaviour concerns stopping the clock prior to patient discharge from ED.

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<th>So there’s a technical argument around that, there’s just a few, and I have to say there’s only about 5 or 10% of the doctors who insist upon doing that. They get a sharp word from me if they do. Especially when they’re relatives, we say no, they’ve gone home and they’re actually sitting out the back having a plaster is my issue. Because they are not on the system. But no we’re pretty strict about that, about not fudging, cos it’s fudging the number. Cos we want to see that, show that, if there is an issue, we need to highlight it. (H4 P-B R2 Senior Nurse ED)</th>
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**Professional & Personal Stress**

Many of the emergency staff interviewed reflected on the stress that they felt due to the target and its impact on their roles, their working environments and their personal lives. Whilst they might agree with the target, many medical and nursing emergency staff reflected on their experience of stress, some of which moved beyond routine role stress to a more intensive and worrying experience.

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<th>I think if anything just a lot of self-reflection and knowing the pressure that it put me under especially late last year, I needed to make some decisions about, I can’t go anywhere else you know…I was talking to my husband and he said pack the lot in, throw them all out, tell them this, tell them that, as husbands do…This year when we were at the end of the quarter so that’s the January, February, March, April, and we were just under the target, like it was just, we were just on the cusp and the pressure was, honestly it was, just, I was coming to work having to really almost medicate in the car on the way here every day, and drank gallons of gin on the way home, but um, the pressure was huge. (H4 P-B R2 Senior Nurse ED)</th>
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<th>So from a personal perspective, um I hate the target. The target has brought me nothing but pain, it’s ruined, well it’s not quite, ruined is an exaggeration, it has turned a job which I previously enjoyed into one that I don’t enjoy remotely. It’s better now. So I had 18 months of hell in relation to the target…But personally, phone calls on my rostered day off, demands that I fix something on a rostered day off, um I’m at rugby on Saturday morning with the kids and I take a phone call from a senior manager demanding that I fix something. That’s the shit we’ve put up with, well I’ve put up with and I haven’t sort of signed up for that. (H1 P-M R2 ED SMO)</th>
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Some of these experiences are also reflected in the themes which follow concerning the negative consequences of the target (Section 5.3.7).

5.4.4 Dealing with Resistance

The theme is defined as resistance to the target, and the ways that resistance is dealt with through political processes. In order to deal with resistance, implementers sought to get buy-in to the target and strategies to achieve it and they may do so through processes such as pressure, influencing, leveraging and making trade-offs.

Resistance

A common insight and reference from the interviews and data concerned resistance to the target or resistance to the strategies to achieve the target or, indeed, resistance to the impact of the strategies. Without question, the group identified from the interviews and data analysis as the most resistant to the target is medical staff in both the ED and wider hospital. Nursing staff are also noted as being resistant to the target, but this was less common than medicine. I did not detect that managers (non-clinical) were resistant to the target, although some had concerns about aspects of the measure itself and aspects of the process of implementation.

Resistance to the target itself was identified from descriptions of the way that staff responded, such as those who resisted the target due to their experience of the English ED time target or those who used awareness of the English experience and interpreting this to substantiate their resistance. Another type of resistance to the target included the strategies pursued to help achieve it. For example, one of the hospital senior medical officers described a ward-discharge project strategy that they received information about and that they subsequently ignored.

Generally ED SMOs were supportive of some policy or mechanism to change the circumstances that left their departments overcrowded and exhausting to work in. However, three of the emergency medical staff interviewed were resistant to the effect of the target, particularly the impact on their practice and any risks to clinical prioritisation. One of the clinical directors of ED described the following resistance or “push back” in their medical team:
Buy-in

Buy-in to the target signifies support for and commitment to the target or strategies aimed at achieving it. Buy-in was frequently discussed when participants were discussing resistance. Almost all of the staff interviewed in this study discussed the notion or process of buy-in, including buy-in to the target, strategies and impact. Another reference to buy-in is buy-out, such that strategically one had to try to prevent buy-out in deliberate ways.

A notable feature of buy-in, like that of resistance, was that the most problematic hospital group, in terms of gaining buy-in, was medicine, in particular medical staff and teams from the inpatient setting of the hospital. I also noted that at all sites, surgical specialist doctors were frequently cited as not buying in; however, the buy-in from medicine specialties was better. As a consequence, buy-in from medical specialists was inconsistent. There was also inconsistency when there was buy-in to the target but not necessarily to the strategies and impact.

Leverage

A handful of participants used the terms “leverage” or “leveraging” to describe response or impact of the target and at other times, I interpreted what was being described as a process of leveraging. There were three types of leveraging that are relevant to dealing with resistance. The first is the way in which the target leverers stakeholders to the decision-making or hospital leadership table. The second is the way in which the target can lever the position of stakeholders. For example, emergency staff refer to the target as giving them traction in the hospital; the target is a lever that has helped to improve their position of influence and power in comparison to other services and
professions, such as surgical. The third and more common type of leverage in relation to dealing with resistance is resource leverage. A number of hospital services and departments utilised the target to lever resources on the basis that the resource increase or change would enable achievement of the target. Resource leverage for the emergency department was noted in all of the hospital sites. Acute surgical service development, including acute theatre, also leveraged resources. Leveraging of the resources for these stakeholders helped to reduce resistance and improve buy-in.

ED nurses had a tougher time than the ED doctors coming to grips with the idea of what it meant to them and how they had to perhaps modify the way they worked, particularly the senior nurses...and it also became a powerful lever for retaining them when we did a recent nursing restructure. So the target was the main reason that we were able to retain the seniority twenty four seven. (H1 P-J R1 Manager ED/Hospital)

Political Pressure
Political pressure means that people of authority, note or importance, in relation to the target, had some influence over others who might be resistant. Executive clinicians and managers were commonly described as playing a key role in the influence of others, through their formal or informal roles as target champions, by their presence within target groups and activities or through their communications with staff, all of which created political pressure and expectation on staff to respond to the target. Other political influencers that I identified included senior ED medical and nursing staff and there were also some references in the interviews to external political influencers, including the national target champion and other Ministry of Health policy officials.

So I think it’s been such a push from the top at the moment, from the board down and our COO in particular is um pretty straight in the way he feels about the target and that we will meet this target and he expects everybody to be on board with it. (H4 P-C R1 Senior Nurse ED)

Trade-offs
Trade-offs, in relation to dealing with resistance, refer to the acceptance of resource losses for a resource gain elsewhere aimed to help achieve the target. To make a trade-off is therefore to deal with resistance by seeking or offering something comparable and acceptable in return. For example at the clinical service level, in order to better staff the busiest time of the day for medical admissions through the ED, managers and clinicians at Hospital One accepted the trade-off of fewer staff on the
earlier part of the day. Another resource trade-off discussion concerned a new acute surgical unit, but this strategy did not proceed since, for the surgical specialties concerned, it would require the trade-off of existing surgical resource to do so.

We want an acute surgical decant and that would make a huge difference...and the surgeons want one...and I believe there’s enthusiasm amongst them to have one. But I believe they will have to convert some of their existing space and do it within their existing resources and that’s taken away some of their motivation to do it. Motivation or ability to do it I should say... the executive managers say yeah look I think an acute surgical unit will be a good idea but surgeon you have to do it within your footprint. (H3 P-H R2 SMO ED)

5.4.5 Push Through the Hospital

This theme as defined as the strategic response and impact of the target across the wider hospital system. It includes strategic efforts that focus on hospital and ward operations and management to hasten the flow of patients through the various components of their journey through the hospital system. This theme also includes the impact on hospital departments and staff where the more rapid transiting of patients through the hospital shifts both clinical risk and demands from the ED into other hospitals departments and services. The term “push” in this theme means strategic emphasis and actively managing what were previously barriers to the timely flow of patients through the hospital.

Focus on Hospital Operations

Introduction of the target resulted in a strong and deliberate focus, within the case study sites, on the operations of the hospital. It is a theme that moves both structurally and functionally beyond the acute front of hospital structures, and into the breadth of the hospital.

Operations departments and staff and various operations management practices were emphasised in response to the target. Additional bed or duty managers, and new roles and structures for managing hospital operations are important aspects of this. Two different structural examples include a cross-service hospital operations group, and new or redeveloped hospital operations centres. Interviewees also mentioned operation management consultants and inter-hospital transfer management roles. This subtheme also reflects attention on the hospital’s bed capacity and configuration; for example, how many beds does the hospital have, and is it sufficient capacity for demand, and do we have enough medical in contrast to surgical beds? In the first round of interviews at Hospital One for
example, a perceived imbalance of medical to surgical beds is described and responded to with the introduction of the target.

Now part of that is we looked at the inpatient bed allocations, and we had a constant complaint that we have too few medical beds and too many surgical beds, and after a lot of analysis that was agreed with, the difficulty was how you fix them. We’ve done that by shifting wards around and so now we’ve effectively got ten more medical beds, and the surgeons aren’t overflowing into medicine. So their reduced number still is a number that works for them but we’re now much more able to get patients into the right ward which means they also get out quicker. (H1 P-G R1 SMO Hospital)

Hospital operations management practices include planning for real-time response to hospital overload and new or enhanced daily operations meetings. The next excerpt concerns a new layer of on-call manager instituted to support the hospital’s operations after hours.

So there is a call list, so that’s the call list and we all end up on call probably once every two months and to begin with the executives and couple of others were also sort of like the first line call, so we only had first line call, and then it just became too much... So we put in this whole second layer and that has reduced the pressure that the staff were experiencing either direct or indirect. So the first on call absorbs all that, so individually we manage it all differently. (H1 P-J R2 Manager ED/Hospital)

Management of the flows of acute surgical patients through acute theatre also features in this theme. In two of the study sites, acute theatre capacity, personnel and systems were considered problematic and a cause of delays, which in turn resulted in longer ward stays for those patients. Whilst this dimension of the hospital’s operations was detected in only two of the study sites, it does not mean that it was not also relevant to the others.

Attention to the admission procedures from the ED features here, including interactions and behaviours between duty managers and the staff of the ED. For example in Hospital Three, participants described how this relationship is emphasised through the presence of the bed manager in the emergency department, as well as a more defined procedure of patient admission.
Focus on Ward Management

This subtheme focuses on how wards are managed; in particular, the management of staff behaviours, routines and practices that help to push patients through their acute journey in the hospital and is centred around the hospital ward structure.

Ward nursing staff came under scrutiny, explicitly tied to the utilisation of beds in hospital wards, including bed flexibility and flexibility of the hospital’s nursing staff. New roles that oversee the flow of patients onto the wards and involve managing the day-to-day behaviours of ward nursing staff are featured in this subtheme.

Because the other problem in all these DHBs is no-one answers the phones. It’s just so frustrating - no-one answers the phones. So we introduced cell phones. So the three things when I first started that job, that I used to walk in and say is - who’s the coordinator, are you carrying the phone, and is your ward information screen up to date. Because one, the cell phone is the only means of communication, 'cos no-one answers the phone...they don’t make an effort. If they’re in a room they won’t. If they’re standing there they’ll answer it, but they won’t actually make an effort to come out and answer it. So if the coordinator had the phone in their pocket. Now I can still go around and go where’s the phone? Like last night on one of the wards, I’d go is that the phone? - You’d find it in drawers, sitting on desks, in people’s pockets, people took them home. (H2 P-L RI Nurse Manager Hospital)

Further dimensions of the management of ward beds, and of course the staff required, concern the types of patients who go into those beds. For example in Hospital Two, this level of detailed bed and staff resource management involved the creation of cohorts of certain types of patients within the ward. This system made beds more readily available and able to be managed with existing staff resource.

A crucial feature of ward-management strategies is discharge practice and routines. In three of the study sites, strategic focus and activities around discharge from wards was identified. Hospital Two is a very good example, where patients waiting for discharge were routinely moved to the ward lounge to await their discharge papers. Also in this hospital, a staffed ambulatory area had been created where patients waiting for discharge were managed separately from the other rooms and beds of the ward.
New roles which manage the discharge of patients to community rehabilitation or aged care feature here in terms of speeding up the discharge process out of hospital. Another aspect of managing discharge from wards is attention to ward multidisciplinary (MDT) meetings, identified in both Hospital One and Three.

**Sharing Acute Risk & Demand into the Hospital**

An important aspect noted when coding interviews concerned use of the term “push” to characterise the movement of patients from the ED into the hospital and up against what had previously been barriers to that movement. With that push came a sharing of demand for clinical care and its associated risks on to other parts of the hospital, which previously had been housed within an overcrowded ED. There are several complex and overlapping dimensions to this subtheme, including operational push, which potentially placed the patients and clinicians at risk, and chaos on hospital wards, due to intensive demand on services and staff.

“Operational push” refers to the admission of patients onto wards where there may not have been available empty beds or what the ward staff perceived as available clinical staff and resources to care for them. I identified that in at least two of the study sites, with the target’s introduction, patients were admitted into wards where there were not available beds, which caused the normal census of the ward to go over. In the following excerpt, the participant makes an explicit link between operational push, along with associated risks, and the six hour rule.

> We’re just trying to push more through the sausage machine rather than seeing what the problem is ... And so what we tend to get is this - well where can we put patients - we’ll put them in corridor beds. ... Well a corridor bed is when you’ve run out of physical bed spaces in your hospital and you park patients on beds in the middle of a corridor without access to oxygen, suction, call bells, emergency systems, and they’re in fire escapes...so when we get an influx of patients into ED, and we’re starting to breach, as they call it, we’ve gone outside the six hour rule - we’ve got nowhere to put them and so because we’ve used up the traditional surplus capacity ... patients are put in positions of compromise. (*H1 P-E R1 Nurse Hospital*)

In other situations, where a ward bed was available but patients were not ready for admission, some of the participants describe occasions of clinical risk and sub-optimal care.
“Chaos on the wards” relates to the push of patients into the hospital, and is experienced in two ways. Firstly, it concerns the ward staff experiencing ward or work overload and secondly, it concerns the increased and/or speedier admission and churn of patients through the wards.

I had a charge nurse say to me you know, today we admitted 27 patients, and discharged 28. This is in a ward that doesn’t generally have a high, you know usually their length of stay is a bit longer yeah. And I said my god, what was that like? She said it was absolutely ridiculous. She said all we are doing is churning them, this is just you know churning the patients through. (H2 P-N Manager Hospital)

This particular subtheme had begun to develop from the analysis of the first round of interviews and I took the opportunity to explore it with participants in the second round. From this second round of interviews, I interpreted that sharing acute risk and demand into the hospital may not necessarily be an unintended impact of the target, but may well be an acceptable way to engage the hospital staff in responding to the more rapid flow of patients into their areas. In relation to the emergent theme of sharing risk and demand into the hospital, one of the participants described:

My perception of that is...in the old department those patients would have stayed in the emergency department for days and days and days. And I think it’s about time that we shared the clinical risk around the hospital and my personal view is that they have to get on with it. (H4 P-C R2 Senior Nurse ED)

5.4.6 Target Pressure

Target pressure is defined as a strategic response and impact of the implementation of the target with several dimensions including management, clinical and environmental pressure. Implementers of the target both applied pressure to achieve the target and experienced pressure in their working roles and environments.

Management Pressure

Management pressure identified from the interviews involved layers of management pressure that traversed multiple levels of hospital management. It also describes that not only did managers place pressure on their staff, but also the managers themselves were experiencing pressure from their own or other managers. Executive management pressure staff down through the layers of the hospital in all study sites.
This theme developed from analysis of the first round of interviews and I took the opportunity to explore it further in the second round. One of the participant’s responses to the developing theme of pressure was as follows:

"I think it was felt on every level in this department from the operational manager and myself I felt in particular, and the charge nurses on a shift by shift basis they were getting phone calls from general managers who were whiteboard watching from their offices about what was happening." (H4 P-C R2 Senior Nurse ED)

**Pressured Environment**

Pressured environment concerns the immediate demands and expectations for service, arising from the target, which affected hospital operations. It includes the pressure for beds, the pressure to admit and the pressure to discharge. All of these factors create an environment of pressure for the achievement of the target. Pressure to discharge arises from strategic activities and the need to access inpatient beds as swiftly as possible. Pressure to discharge was also evident in the ED.

Pressure on the ED and alpha ward services includes rising rates of patient presentations and thus the pressure of service demand, as well as pressure from public expectations about a shorter stay in the ED.

"I think it’s through the publishing of the results quarterly and the six hour target, and you know the local paper hasn’t been our best friend around it, say that this DHB’s you know, is not doing that well. So I think the public knows what to expect...I think there has been a lot around in the media so their expectation is when I go to the hospital I’m not going to have to wait." (H3 P-C R1 Nurse Manager ED)

**Clinical Pressure**

Clinical pressure involves the behaviours and experience of pressure within the immediate clinical setting. Both medical and nursing staff in the ED and hospital felt pressured in their day-to-day clinical work, from not only trying to meet multiple clinical demands and priorities that are already
part of their role, but also from their immediate clinical or service managers or, indeed executive managers, monitoring the target.

> It’s sort of another thing that we have to do on top of everything else. It can sometimes add to the, if you’re already feeling stressed because of your workload, because of the busyness of the place, because of short staffing, you’ve got this added pressure on top of you, about possible, patients breaching or moving. (H2 P-M R1 Nurse ED)

Pressure on clinical staff in relation to meeting the target has many implications including the perception that a discharge might be unsafe and thus a professional concern. For medical staff, pressure on their clinical decision making and prioritising may involve working through tensions between addressing the needs of the sickest patients first but also recognising that other patients are about to breach the target and there is pressure to prioritise a likely breach. Pressure on clinicians’ practice and prioritising may leave staff feeling conflicted.

> But there is a sense that actually, you know that other patients who are really well... and they have been there for five and half hours, and then somebody else who’s come in who’s not desperately ill but actually requires a little bit more attention and they have only been there for three hours, you sort of feel a bit conflicted...you know sometimes you feel pressure to see the one who has been there longer. (H1 P-K R1 Registrar Hospital)

Other salient dimensions of target pressure include the pressure on particular services such as the ED, on wards and on different professional groups, in particular medicine and surgery. Two other types of pressure, political pressure and pressure to game, noted in other themes, also contribute to this theme. All contribute to the intensive pressure that has resulted from target implementation.

### 5.4.7 Mixed Consequences

This theme is defined as the array of positive and negative opinions and consequences of the target and the process of implementation of the target. It also features cautions and criticisms. The theme is comprised of opinions and also descriptions of impact or outcomes from the participants’ point of view and from their role insights or responsibilities.
Positives

There were multiple positive opinions regarding the target such as it was a valid and reasonable measure and good for the acute hospital. A number of the participants simply describe that the target is good because it has resulted in positive changes. Many of the ED staff interviewed saw the target as a very positive way to deal with the overcrowding of their department since it brought visibility and accountability to the foreground and brought the issues of delays and problematic behaviours out into the open.

Positive opinions and impacts in relation to services overwhelmingly related to the ED, since in the descriptions of some of the participants, the target had reduced the placing of patients in ED corridors, improved department efficiency and enhanced the working environment and relationships of ED staff. In addition, the target had helped ED to get the resources they needed to function more effectively and efficiently.

Positive opinions about the target in relation to patients included giving patients certainty about the length of their stay in ED. Also positive for patients was that their ED and hospital visit was much better and more efficient and that the target had reduced the medical cherry picking of patients. Several of the participants deduced positive impacts for patients from the reduced number of complaints and increased compliments, although the reduced complaints may also be due to brand new emergency departments. As one of the ED managers described:

> The fact that patient satisfaction, we know has improved. They say it’s because we’ve moved into the new department. I think partly we are a lot more visible in that it has some responsibility for that. But I think partly because people aren’t waiting around for hours and hours on end, and how do we measure that, well again it’s because the number of complaints have dropped huge - significantly, massive numbers you know. We were getting 20, 30 complaints a month whereas, and we’d get one or two compliment letters and actually it is almost opposite now. (H4 P-B R2 Senior Nurse ED)

Positive impacts on the organisation included learning and development, better relations between services and professional groups, and improvements in the organisation’s reputation with its

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6 At one site a DVD on a whole of hospital target project featured staff and 3 patients describing the positive impact of the target (H2 R1).
community. Positive learning was relevant to services and individuals who had developed new knowledge and skill in their roles as a consequence of target implementation; for example, nurse managers and senior nurses in the ED and hospital describe how the target had helped them to develop improved communication skills within their nursing teams and with other departments in the hospital. Organisational learning examples included learning due to the focus on developing data and information about the ED and acute care, the hospital, its capacity and its systems and processes. A very good example of organisational learning was that which arose from projects and project methodology that was then applied to other aspects of organisational performance.

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Secondly, what we did develop out of it was a methodology about how to approach this kind of whole system change, which we have reused both in part and in whole since. (H2 P-H R1 Senior Manager Hospital)
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The experience of success is another relevant positive for staff and the organisation. Success was reflected through the successful implementation of strategies and achievement of target gains that were perceived to help boost momentum or, quite simply, the success of just achieving the target itself. Success is also experienced when organisations are acknowledged for their success in the health sector.

**Negatives**

There was an array of negative opinions and descriptions of negative impact as a consequence of the target. I set these out as negatives for patients, negatives for staff and negatives for the organisation, although this framing is largely a telescoping view since what is negative for patients and staff is arguably also negative from an organisational point-of-view.

Many participants reflected on the target negatively; for example, that the target was wrong, that it was wrong because targets in ED had not worked elsewhere, or that it was a blunt instrument to address ED overcrowding. As one ED SMO described, in relation to the decision to introduce the target, “I would have voted no in a heartbeat” (H4 P-1 R1 SMO ED). An important negative for patients that participants described was that the target had increased risk taking, particularly as a
consequence of patients’ more rapid movement through the hospital system or as a consequence of rapid and premature discharge that may result in their having to re-present.

Well, in ED, I don’t know about the organisation, I think the downside of it is that, um, patients perhaps are discharged - some patients are discharged prematurely in order to create beds. And we are seeing - I don’t know what the statistics are - but we are seeing the readmissions coming back through, only discharged two days ago. (H1 P-D R1 Nurse Manager ED)

Of concern for several of the hospital SMOs were the clinical risks, delays and potential for less than appropriate levels of clinical care arising from the more rapid movement of patients on to the wards where the admission process and care in ED was incomplete or lacking.

When the patient hits the ward there is a significant time delay built in...like from a subjective standpoint that patient’s going to take longer for their swelling to allow an operation...When the patient goes directly to the ward after a period of time in the ED without having been seen by the admitting service, that plan isn’t in the notes, so that time on the ward can potentially, you know, the patient’s not making any progress... the nurses potentially don’t know what to be looking out for. (H3 P-A R1 SMO Hospital)

Negatives for staff included frustration, loss of morale and motivation, resignation of nursing and medical staff, assuming increased professional risk and feeling target fatigue where more than one health target may be operating. Other negatives for staff involved feeling professionally threatened by managers, experiencing moral dilemmas over gaming behaviours, carrying an increased workload and struggling with the rapid flow and rapid churn of patients in wards. Several of the impacts noted in the previous theme related to the impact on ED staff are also applicable here, particularly the stress that was felt both professionally and personally. Bullying behaviour was also described or reflected on in all of the hospital sites.

(They) just didn’t take no for an answer, and to the point of ah- to the point of bullying people, you know - they were going to make this change happen and they were going to make it work come hell or high water, move out of the way I’m coming through. (H2 P-I R1 Manager Hospital)

Organisational negatives that I note here include the gaming of the target, micromanagement behaviours, wards in chaos, and risks to the medical teaching activity and responsibilities of the hospital. Gaming behaviours that I detected and interpreted from the interviews centre around the
inappropriate stopping of the target clock, which could occur in three ways. Firstly, the timing of the patient’s visit in the ED may be stopped by removing them from the ED information system when they are still in care in the department. Secondly, it may occur when the patient is moved from one targeted area to another, for example, from the ED to the alpha ward when the time to breach nears. A third type of stopping the clock is when the patient’s visit in the ED is redesignated to that of a patient under observation where the clock no longer operates.

Some patients do move and I am forced into a situation where I have to move a patient, like for instance a patient I know is going to be a hospital admission, to move them to the alpha ward to stop the clock. I don’t like it. But it’s the way it has to be. (H4 P-B R2 Senior Nurse ED)

Cautions and Criticisms

Almost all of the participants reflected on and described both positive and negative opinions and impacts; that is to say that whilst they reflected on and described the positive, they also reflected on and described the negative. It is thus a very mixed and at times conflicted bag of experiences and opinions.

I mean I think there’s two sides to it; there’s definitely, we did look at it as an organisational problem which I think was really good, we did look at is as we need to do lots of quality initiatives to solve the problem and I think that was good because we did change a whole lot … but we also condoned some very bad behaviour at different levels…so there was a bit of an oxymoron there you know, with the one minute we were, doing this No.8 wire stuff…to achieve the goal, but we were behaving really badly in some courts to do it. (H2 P-I R1 Manager Hospital)

What I coded as “in-between” reflects where participants describe or portray a sense of ambivalence, caution, criticism or concern in relation to the target and the impact. For example, some participants criticise the target as not being the right measure or measuring the wrong thing; as being too blunt or too narrow; or that six hours is still a long time to wait. One SMO believed that the target, whilst a reasonable initiative, had simply not addressed the major issues for their organisation, such as chronic care. Others describe a lack of evidence for the target or that it is a double edged sword—to achieve the target, something else must suffer, “it’s like a big duvet, you
know the whole service, you pull it off one place and there’s a gap somewhere else” (H3 P-D R2 SMO Hospital).

5.4.8 Interpretive Review of Response and Impact of the Target

A great deal of strategic focus, including system and process improvements and resource, has been applied to front of hospital services and structures in order to meet the target. The timing and amount of resource, however, appeared to vary greatly between hospital sites and will be considered more closely in the next chapter. Undoubtedly, this strategic focus is a consequence of the importance of ED and alpha ward services to managing acute demand, but it may also be a consequence of the ability of ED services and their staff to leverage resources, service and medical specialty status and authority from the imperative of the target. For ED staff, these are important service and professional gains. Similarly, the target has also been a valuable resource lever for other medical specialties and services in relation to the alpha ward. However, because alpha wards are not measured by the target, focus on their development does not necessarily mean that the flow of patients through them will be any faster than before the target. Rather, they provide an opportunity to manage acute patients, through a structural intervention, whilst enabling hospitals to achieve the target.

Strategic focus on the front of the hospital appears to be a corollary of the social, structural and functional distances and tensions that characterise the intra-hospital context. I also interpret that bringing senior medical decision makers to the front of the hospital contributes to speeding the patient’s journey, whilst at the same time preserving the integrity and authority of senior medical officers’ decision making. Alpha wards also provide a means of separating the practice of medical specialties, which helps to reduce some tensions between medical specialties.

Despite the strategic efforts and resources applied to the front of the hospital, gaming still occurred. Arguably, additional alpha ward capacity and capability is a strategic mechanism for gaming the target if there is no improvement in quality, including the timeliness and quality of clinical care delivered. Stopping the clock prior to disposition or discharge from ED, or by altering the status of the ED admission, are coping behaviours and consequences of pressure that has no other outlet.
As well as the evidence of gaming, getting faster at the front of the hospital has undoubtedly resulted in pushing patients onto areas of the hospital that have, at times, struggled to cope with demand and, in the process, experienced overload, chaos and concerns about maintaining clinical quality; the very quality that was a key feature of the problems that begat the target. Thus, despite the quality framing of the target, quality remains a concern, but now further on in the hospital system. As well, in contrast to the resource investment at the front of the hospital, resources are not a key feature of strategies that push patients through the hospital (although there were some, for example acute theatre resource). Rather, the strategy to push patients through the hospital has been concerned with changing attitudes and behaviour of staff and giving greater attention to the management of hospital operations and wards. The hospital has been asked to carry more of the load of acute care demand and be more efficient, for which there are undoubtedly resource and professional limits.

There are three key target mechanisms in these themes—target focus, target pressure and dealing with resistance—all of which explain how this target, in particular, leads to change. But these mechanisms are not without criticism and the experience of negative consequences described. Dealing with resistance is an important strategic response and impact of the target, and identifies very broadly that resistance should be expected with policy change and that there are various ways to manage it.

Similar to the sensemaking and context themes, strategic effort and impact is very centred on the internal hospital world. Indeed, I noted that little was discussed concerning extra hospital organisation and during the second round of interviews, I endeavoured to explore this area. Whilst some of the participants were able to link activities and liaison with primary care to the target, it was thus not without prompting the participant. Strategic focus and response is consequently hospital-centric and consistent with the immediate environment of these front line implementers.

5.5 Chapter Summary

The three categories of thematic findings in this chapter, demonstrate that the target impacted in a similar very complex fashion in all of the case study sites. The thinking, and patterns of thinking of
staff in response to the target, reveal that this quantified target invited and enabled a flux of meaning making and interpretation that was hospital and professional centred. Staff needed to think through and work out what to do, in order to implement the target, and this was subject greatly to their professional experience and roles. The ED target is a measure and goal that does not define problems or solutions; it is people and organisations of people that do this. As a consequence, these front line target implementers undertook interpretation of the target and made sense of it based on past, present and future professional experiences and related this to their immediate professional concerns, experience and work in the hospital.

Consistent with this refined scope of thinking, subsequent actions and strategies of implementers, including managerial, clinical, political, resource, information and monitoring activity, were also focused on the hospital and on the professional context, and services of the hospital. Key political actors in response to the target were hospital managers, nurse managers and ED staff. According to these themes and my interpretation of them, medical staff in the hospital were notable resisters to the target, and managers notable supporters. Senior medical staff in the hospital protected and promoted their interests and were cautious of the target. Nurse managers, in the ED and hospital, were also supporters of the target, and played an important role in helping to achieve it by influencing the nursing staff that they lead and managed.

The context for implementing the target involves rich social layers of the acute hospital which mediated, constrained and shaped target response in terms of the thinking and actions of staff. A dominant feature of this context is medical specialisation.

The consequences of the target were a balance of the positive and the negative for staff and organisations, and, in the opinion of the participants in this study, for the patients. Pressure from the targets implementation was felt by staff in the ED and hospital, and some of which is linked to more problematic negative consequences including bullying and gaming. The key positive consequences of the target are that there was change and learning and development in response to the target.
However, there was variance and some uniqueness in target impact at each of the case study sites, in terms of local thinking, local context factors and local strategy. Chapter 6 provides a more detailed view of the local experience of the targets implementation.
CHAPTER 6
THE LOCAL TARGET STORIES

6.1 Introduction

A key goal of this chapter is to tell the local stories regarding implementation of the target for each of the four case study sites and, within this interpretive story-telling process, identify what if anything regarding the local hospital site had an impact on the implementation process and outcomes. Identifying similarities and differences across hospital sites and change over time are the second and third goals of the chapter. To achieve these goals I address each of the four hospital sites separately and utilise a three-part framework: introduction to the local story for each hospital and DHB including measured performance; local themes for the site; and interpretive summary of the hospital site. I use a summary table to aid discussion of each hospital site with a simple timeline for impact of the target. The chapter closes with a comprehensive interpretation of the findings and I use a collective summary table to support discussion. I note here that reporting of target performance is by DHB and not individual hospital. Table 6.0 below sets out the sections and local themes by hospital.

Table 6.1: Chapter 6 Outline

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6.2 Introduction to the Local Story for Hospital One & DHB

Table 6.2: Hospital One Timeline of Themes & Performance

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Hospital One is located within a mid-sized DHB serving a population of 150,000–200,000 people. It is provincially located and thus outside of the five major metropolitan cities of New Zealand. It is the only public hospital in this DHB, with over 300 inpatient beds delivering acute, elective, rehabilitation and mental health services. Annual presentations to the ED of this hospital are, in comparison to other EDs in New Zealand, in the mid-range between 30,000 and 50,000 per annum, and it is the smallest ED, hospital and DHB (in terms of population) in this study. The hospital provides a full range of secondary services with some selected tertiary services for its own and
neighbouring DHB populations. This DHB is one of the two higher performing cases in the study with an early target result at the end of 2009 of above 80% but below 95%.

### 6.2.1 The Provincial Establishment

This theme describes the context of a provincial establishment, defined by geographical, historical, political, staff and service phenomena that mediate perceptions and implementation response for Hospital One.

The term “provincial” was used to describe this hospital and DHB by two of the site participants, and several other participants refer to their organisation as “small”, “isolated” and “off the beaten track”. Frequently participants compare elements of their “provinciality” with other larger urban, hospitals and DHBs. Associated with its geography and size, participants described limits of resource (both public funding and staffing), limits of health service delivery, as well as features of the social history of the provincial hospital. For example, this case study site has a history of political, social and community unrest in the two decades prior to the introduction of the target, concerning the experience of hospital closure in the wake of previous health sector reforms.

> And there’s you know- we’ve also got - still got some aftermath of them closing the northern hospital scenario...Well it was closed over 20 years ago. So we had two hospitals. So one town believed - a lot of people in one town believed they lost by not having a hospital...to a proportion of the population it’s still an issue. So every time this hospital doesn’t do something they think - it’s a reason to beat up the place for not having the other hospital. So there’s a bit of jumping on bandwagons about those sorts of things. (H1 P-G R1 SMO Hospital)

A close-knit and longstanding group of clinical professionals (including medical and nursing) is part of the local establishment, described as having a defined power within the hospital; this group was also referred to as the “old guard” or the informal power structure.

Another dimension of the provincial establishment concerns embedded or longstanding services, behaviours and practices. One of the established services involves an afterhours community triage service and on-call GPs, commenced after the closure of the second hospital (as noted above). It is a service that participants describe as expensive to run, with a relatively small patient attendance. It is also described as a bone of contention, which nobody is willing to call an end to. Another
established service is the provision of a minor acute care clinic in the ED, offering an option for patients who do not access the GP after hours due to cost or service limits and barriers. This service is underpinned by competitive tensions between GPs and the hospital.

Within the hospital, leaving patients in the ED or alpha ward overnight, until they could be seen by inpatient consultants in the morning, was a well-established practice that had been routinely accommodated by the ED service. Participants explained that such accommodation of the inpatient services related to the limits of medical resources at the hospital, particularly the ability of surgical specialties to provide 24-hour acute coverage of registrars. As a consequence, delays in the ED for surgical patients were normal at this hospital, underpinned by problematic limits on medical resources typical of a provincial hospital.

6.2.2 Over Focus on the ED

This theme is defined as response to the target which overly focused on the ED through strategic attention and behaviours and through framing as an ED target, and a punitive target.

A key and early strategic initiative in this site was the introduction of ED information gathering, feedback and monitoring mechanisms that left staff feeling overburdened and overly scrutinised by the initiative. I have noted in the previous chapter that all sites engaged in information, monitoring and feedback mechanisms; however, at this hospital site, no less than nine of the 13 participants interviewed (including those in the ED and the wider hospital) discussed, at some length, the ED information screen and the visibility and distribution of information from that system. Indeed, four of them provided me with documents produced by the system. For some hospital staff, the raft of information produced by the system created an additional work responsibility and issue to deal with. For some of the ED staff, the information screen left them feeling micromanaged by the intensive monitoring of their department.

Perhaps understandably, given the intensive focus on ED and the associated generation of information from the ED screen regarding the target, some of the hospital staff perceived that the target was all about the ED; hence the local framing of the target as an ED target. Some of the ED
staff, in contrast, framed the target as punitive; it was being used to punish them. As one ED consultant at this site remarked:

| All of a sudden this target gets turned into something that we’re then going to get beaten with. You know, this is going to become the new stick to beat us with. Why aren’t you working harder, why aren’t you seeing these patients.... you know what I mean - we’re getting beaten with the target. (H1 P-B R1 SMO ED) |

### 6.2.3 Failed Strategy in Surgical Flow

This theme centres on a failed strategy for the flow of acute surgical patients. The theme identifies that, in response to the target, flows of acute surgical patients were displaced from the ED and alpha ward onto an acute surgical unit in the hospital. The change was not universally acceptable and thus this strategic response to the target failed.

Two key strategic initiatives, identified during the first round of interviews, involved a change in the model of service in the alpha ward and, related to this, the formation of an acute surgical unit within existing surgical ward resources. Prior to the introduction of the target, the alpha ward in this hospital managed all specialities including ED patients under observation. This established pattern of service accommodated the limits of afterhours acute surgical service, particularly the availability of surgical staff to assess and make diagnostic, treatment and disposition decisions on patients. After the target’s introduction, the alpha ward service model changed to be principally medical, with a small number of beds allowing for ED observation patients. Consequently, surgical patients awaiting surgical review could no longer be accommodated within the alpha ward, nor the ED, and another strategy of managing acute surgical patients on the wards in a specifically designated area was introduced.

However, the redirection of surgical patient flows and direct admission of surgical patients to the new surgical unit failed for two reasons identified in the interviews. Firstly, it was a strategy which empowered ED medical staff to make decisions regarding which surgical patients were suitable to be admitted to the wards, which was an authority they had previously not held. Neither the ED medical staff nor the surgeons were comfortable with this. Secondly, despite approval of the
strategy at senior management and clinician levels, individual surgeons resisted the strategy, largely on the basis of perceived clinical risk, and it did not embed itself as routine practice.

6.2.4 Target Conflict

This theme is defined as conflict that is a direct result of the implementation of the target. It describes key groups and individuals about which target conflict occurred. It also reflects a key response to the target in the first 18 months of implementation.

During the first round of interviews at this hospital, a notable feature was description of conflict as a result of the target. Such conflict was amongst or between professional groups and between particular individuals. For example, conflict was described between senior managers in the hospital and ED clinicians, and between consultants in ED and the inpatient consultants. Conflict between the CEO and head of the ED is a notable example of conflict between individuals. Other conflicts occurred between ward nurse managers regarding the management of ward patients and beds, and between ED and hospital nursing staff regarding patient management. Conflicts as a result of the target may move beyond the professional to the personal, as described by one nurse manager:

Participant: And it’s become quite, it’s become quite personal amongst my peers.
Interviewer LC: Nurse managers?
Participant: Nurse managers. Clinical nurse managers. And the thing that concerns me there is we’re who role models to the registered nurses...And I don’t believe that they were dealing with this in a respectful manner. And they’re my peers. I’ve lost respect for my peers. (H1 P-H R1 Nurse Manager Hospital)

Whilst I feature conflict as a subtheme for this site, it does not mean that conflict arising from the target did not feature at the other hospital sites. Rather, it is feature of target implementation that was expressly described by several of the participants and I have interpreted it as closely associated with strategic initiatives that had occurred in the first 20 months of the target implementation at this site.

6.2.5 Getting Together and Coming to Agreements

This theme is defined as response to the target where staff and departments of the hospital come together to work more cohesively to generate greater understanding of the problems and solutions needed to achieve the target. Agreements are made to help achieve the target including the allocation of resource.
The first round of interviews for this site was characterised by a theme of target conflict; in the second round this is changed to improved cohesion and partnership between departments and staff in their efforts. A good example is the coming together of hospital nurse managers on the management of beds. Another example is improved relations between duty managers and nursing coordinators in the ED.

I think that the relationship between the duty managers and the clinical nurse coordinators on the floor particularly after hours, was very, was very ah difficult in the beginning, and then just improved as they realised we have to work in partnership, we are in this together, how can we make it work better. And so they, they work more in a partnership which probably enabled, the little steps towards getting to 95%. (H2 P-J R2)

Another type of getting together identified at this site is the coming together of primary and secondary care leaders through an integrated primary and secondary care forum, where issues of acute patient flows are part of the discussion. In the first round of themes for this site, I noted response to the target that had displaced acute surgical patients and changes to their flow onto the wards. In the second round, this failed strategy is set aside and a new strategy is devised to retain these patients after hours in the alpha ward. It is an agreement come to through meetings and conversations between the various stakeholders and then formulation of policy. Whilst coming to agreement does not automatically signal success, there is a sense of conflicted relations easing at the site in the second round.

During the first round of interviews, some of the participants described that they were trying to achieve the target based on zero cost principles. However, during the second round, the participants described agreement regarding the resourcing of additional staff for ED and for the development of acute theatre services.

### 6.2.6 Interpretive Summary Hospital One

The provinciality which characterises this hospital context has played an important role in mediating the way in which these front line implementers thought about and responded to the target, particularly in relation to the resources required and available to deliver acute services that moved patients out of the ED more rapidly. The social construction of provinciality is an implicit means of
making sense of the target—“We are provincial, therefore we respond differently”—whether this is the case or not.

Intensive senior management pressure at the outset of the target that “over focused on the ED” and threatened the clinical authority and autonomy of clinicians resulted in conflicts and resistance, particularly from surgeons and other senior medical officers. At the time of second round interviews and with experience of strategic failure, strategy had changed and conflicts eased, though not without injection of resource and surgeons retaining the established practice of leaving patients in the alpha ward until they were available. This might be considered gaming of the target, given that patients are still acute but not measured by the target. The process of implementation of the target at this hospital site shifted from management-driven to cooperative across managers and clinicians over the course of the study, largely as a result of the conflicts and failure identified, and also the extant power of the medical establishment. Efforts to improve afterhours primary health care had begun to emerge as an area of strategy related to the target toward the end of the study for this site.

### 6.3 Introduction to the Local Story for Hospital Two & DHB

Table 6.3: Hospital Two Timeline of Themes & Performance

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Measured performance</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the outset</td>
<td>End 2009 Above 80% but below 95%</td>
<td>Ready for the target</td>
</tr>
<tr>
<td>Themes of local context or strategies at commencement of study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target in action</td>
<td>Early 2011 95% or above</td>
<td>Focus on organisational culture Target success</td>
</tr>
<tr>
<td>Themes which reflect target response and impact through the implementation process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of study</td>
<td>Mid 2012 95% or above</td>
<td>Target success, but…</td>
</tr>
<tr>
<td>Themes which reflect how things had progressed or were at study completion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hospital Two is located within a large sized DHB serving a population of between 400,000 and 500,000 people who live in an urban setting and relatively small geographic area. The hospital is located in a major metropolitan city of New Zealand. There is more than one public hospital in this DHB providing inpatient beds, with Hospital Two having over 500 beds across a full range of secondary services in acute, elective, rehabilitation and mental health services. Annual presentations
to the ED of this hospital exceed 50,000 per annum. Multiple secondary and tertiary services, to meet the health service needs of its own DHB, as well as neighbouring and more distant and referring DHBs, are also a characteristic of this hospital. This hospital is within a higher performing DHB with a target result from late 2009 above 80% but below 95%.

6.3.1 Ready for the Target

Ready for the target is a theme that characterises the local context of target implementation for Hospital Two. It features social, historical and service dimensions that are unique to the site and mediate the process of target implementation. In particular, organisational culture and quality improvement capabilities, local resource and leadership contribute to the readiness for the target at this hospital site.

The culture in the organisation is described by some participants as a “can do” culture, characterised by committed and motivated staff in the hospital. The “different breed of people” (H2 P-A R1 Manager ED) in the organisation have an important allegiance to it. Another aspect of the culture of the organisation concerns positive working relationships between services and specialties; there are fewer silos and fewer bricks-and-mortar divisions than at some of the other sites. The can-do culture also features a history of successfully meeting difficult challenges with the ability to change and to be innovative.

But I think one of the unique things about this hospital is they have kind of got that, kind of number eight wire thing and you just get on and do it, and people just you know, they just, they’re quite innovative and they kind of do it. (H2 P-E R1 Manager Hospital)

Quality, and the methods to achieve it, was repeatedly referenced in the interviews at this site and linked to historical and leadership phenomena. For example, participants describe quality improvement leaders or managers in the past and present who lead and influence the organisation to engage in quality activities and specialised quality service structures.

Related to the quality theme is the organisation’s ability to learn and change. Participants describe it as a “learning organisation” where the drive to improve quality is evident at different organisational levels, for example from individual nurse managers through to the clinical governance level.
A further dimension of this theme is that the timing was “right” in terms of resources available in the hospital to achieve the target. For example, the resourcing of new staff and newly available ambulatory and inpatient beds coincided with the implementation of the target. A second aspect of timing concerns the arrival of new staff into leadership roles in the hospital; participants consider these people crucial to achievement of the target. In particular, these staff are at the executive level and also in leadership of the emergency department.

A third aspect of timing concerns the readiness of the ED for change. This relates to prior work on patient flow and other quality initiatives. Prior work on the development of the model of medicine and acute medicine was an additional contributing factor to making the timing right, along with agreement amongst staff of the necessity to change.

6.3.2 Focus on Organisational Culture

This theme is defined as the way in which response to the target at Hospital Two has centred on the organisation’s culture. Key dimensions of the theme include a strategic focus on the organisation’s values and challenging and crossing organisational boundaries.

At all case study sites, project work was a notable strategy to address the target. At this hospital site, however, a whole-of-hospital project was implemented very early on, that included a very deliberate social marketing strategy regarding the target, which communicated specific values to staff, including valuing the patient, valuing quality and valuing all the staff of the organisation in achieving the target. Most of the participants discussed the social marketing strategy and two documents arising from it were provided as data. One of the features of the social marketing strategy was the emphasis on front line staff and the importance of their roles in achieving quality and enabling patients to move through the hospital’s services more efficiently.

So when we were mobilising staff behind this, we had a poster campaign, which had pictures of staff from - on all part of the continuum. And what it said was, what they could do and why it was important. What they could and why it was important to them. And why it was important to their patients. (H2 P-H Senior Manager Hospital)

Challenging and crossing organisational boundaries is a dimension that comprises several activities that transcended social, professional and structural boundaries in the hospital to help achieve the
target. For example, a number of new roles were instituted in response to the target that were
designed to pull the patient through the hospital. These included afternoon nursing coordinators on
the wards who would more actively progress admissions from the ED; rehabilitation service
coordinators who would actively plan the earlier transfer of patients into the rehabilitation setting;
and weekend discharge facilitators whose work helped overcome the problems associated with
weekend discharge of patients. All of these roles and their various activities addressed some of the
problematic attitudes and behaviours of clinical staff towards the flow of patients.

6.3.3 Target Success

*This theme is defined as the experience of successful achievement of the target at the time of the first round of interviews. Dimensions of the theme concern the experience of success, target success becoming business as usual for the organisation and the roles of strong communication, leadership and governance in that success.*

Success in the achievement of the target is a dimension that describes the acknowledgement and
recognition of target achievement, as well as some of the rewards of achievement. Success was
specifically celebrated in the organisation and also across the health sector. There is a sense of
satisfaction, motivation, pride and enthusiasm stemming from success that is attributed to the
organisation as a whole.

> I can’t help but think part of the success is, has been, the organisational involvement, you know, because we’ve struggled with this for so many years from ED, real, just ground level, and I think the real success is having an organisation that really embraces it a bit. That I think has been the key to our success and that’s where a lot of other organisations, um, unless they have that, I think, you know, it’s an uphill struggle. (H2 P-G R1 Nurse Manager ED)

Several of the staff interviewed during the first round explained that the target had been achieved
some time previously, so they considered the experience in hindsight. Achievement had become
part of the daily routine of service and for that reason, the target itself was less in their vocabulary.
Change was described as embedded in hospital services, systems and staffing; for example, in ward
nursing staff ratios where nurses might routinely have one or two extra patients when the ward went
into overflow.
In tandem with the whole-of-hospital target project group, another strategy was the oversight of a governance group which was chaired by the CEO and comprised senior management, medical and nursing staff. This group oversaw the target project group, and in doing so gave the target visible senior leadership. Target success is also attributed to communication regarding the target, the project and the values of the organisation, and it is thus part of the social marketing strategy applied at the case study site.

6.3.4 Target Success, but…

Target success, but… is a theme that reflects target impacts and experiences which contrast, explain or contradict the dominant narrative of target success at this hospital site. Dimensions of the “but” were: Target success, but there were financial costs, but there was heavy management control, but there was the accommodating of bad behaviour, but there was a new alpha unit created, but there was some tall poppy syndrome, but there was also defensiveness.

As I have noted in the previous section, successful achievement of the target is a very dominant theme and narrative for this case study site. Associated with this success is strategic emphasis on quality, a can-do organisational culture, focusing on the patients and also emphasis on the important role of all hospital staff. However, in contrast to the value of engaging all of the hospital staff in meeting the target, several behaviours were described that suggest not all the hospital staff were engaged. For instance, the whole-of-hospital target project team comprised, as described by one participant, a hand-picked team that would make the difference. Another participant offered a contrasting view: “They wanted yes people in the group…clearly if you want to um, how shall I put this, if you wanted to be a member of the club you played the game” (H2 P-I R1 Manager Hospital).

The inference is that staff who objected or raised alternate opinions about the target did not get to influence decision making at a target project team level.

Negative experiences such as bullying in response to the target are not exclusive to this site; however, they are in contrast to the focus on staff all working collaboratively together to help achieve the target. Two participants at this hospital site described their perceptions and experience of bullying in direct relation to the target, and for the following participant, it is couched in terms of bad behaviour that was condoned:
I mean I think there’s two sides to it: there’s definitely, we did look at it as an organisational problem, which I think was really good; we did look at it as we need lots of quality initiatives to solve the problem and I think that was good ... but we also condoned some very bad behaviour at different levels just because, um the chief executive had said we’re doing it, and there wasn’t any answer. And I mean the behaviour itself was well known and various complaints were made but nobody would take any action....that kind of - it didn’t sit well with me from a local vision values kind of thing. So there was a bit of an oxymoron there you know, with the one minute we were doing this No 8 wire stuff...to achieve this goal, but we were behaving really badly in some courts to do it. (H2 P- I R1 Manager Hospital)

The term “tall poppy syndrome” was used by one of the participants during closure formalities of an interview in the first round (see the description of tall poppy syndrome in the interpretive summary 6.3.5). During the second round, I explored this term with other participants, three of whom agreed that it was an issue. Perspectives of tall poppy syndrome as a consequence of the target shared by participants include that staff in the hospital blame the target for all of their problems even though it may not be the cause and that other hospitals may marginalise them for their achievement.

Another “but” of target achievement concerned the significant resources that were committed to its achievement, with three participants explaining the relationship between success and having sufficient resources; for example, “...why I think it worked was like um, ED got a lot of money spent on them, they got a lot of money...I think they got millions actually” (H2 P-E R1 Manager Hospital). Available resources put the hospital at an advantage as compared to other organisations.

We did have the advantage of some more beds coming on stream, so that helped us particularly in the second half of the year, of having enough capacity to move the people... So that’s, that’s still probably for those organisations with a shortage of beds, it’s a hard target. (H2 P-B R1 Senior Manager Hospital)

One significant financial commitment concerned the opening of an additional new alpha ward. Introduction of the target resulted in the displacement of acute medical patients from what had been an established alpha ward within the ED service. As a consequence, another unit was created to manage acute medical patients at the front of the hospital.

Another “but” of success includes criticism that target response had failed to address more effective use of ambulatory care services and had created issues of clinical quality. In the following except, a quality facilitator describes what they perceive is a reduction in clinical-incident reporting and
defensive behaviour from ED staff about this. This example explores another “but” of the target success—that whilst the target was achieved, there may have been issues of clinical quality that were being defended problematically.

Well I thought maybe I think the reason for the reporting dropping off this year is that it's been forced underground...yeah and I used to have a really good relationship you know with the charge nurses and some of the staff there [ED]... If I go down to their area now I have to say why I’m down there and then they have to check...I think there’s quite a bit of hostility by their management...so for instance they’ve wanted to do their own little reviews...so normally it’s done externally...by someone that’s not actually involved in their service, yeah they want to do their own review. (H2 P-N R2 Quality Facilitator Hospital)

6.3.5 Interpretive Summary Hospital Two

The readiness of this hospital to respond to the target I believe is a key factor contributing to its experience of early success. Since the target had already been achieved at the time of the first round of interviews, there was very little difference in the strategic initiatives and impact between the two rounds of interviews. These local findings suggest that available resources matter, not only staff and beds, but also leadership and other organisational capabilities such as the ability to learn and engage in quality improvement activities.

Focus on organisational culture is a strategic approach that was aimed at influencing staff attitudes and behaviour. Yet despite readiness for the target and success achieving it, this case study site still exhibits some crucial negative experiences, in particular the experience of bullying and the need to defend its success. The term tall poppy in countries such as Australia and New Zealand, “refers to individuals who represent high ability or admirable qualities” (Mancl & Penington, 2011, p. 79) and tall poppy syndrome is defined as “the seeming pleasure that people derive from witnessing the downfall of highly successful people” (Feather 1994, cited in Baumeister, Smart, & Boden, 1996, p. 11). The “success, but…” theme is a strong signal that there were hidden social experiences and costs for the organisation, not captured by achievement of the target. Success and culture are strong social constructions at this hospital that dominate the narrative of the target, and may help to mitigate the negative and contradictory impacts beneath the surface.
6.4 Introduction to the Local Story for Hospital Three & DHB

Table 6.4: Hospital Three Timeline of Themes & Performance

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Measured performance</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the outset</td>
<td>End 2009</td>
<td>Additional complexity</td>
</tr>
<tr>
<td>Themes of local context or</td>
<td>Below 80%</td>
<td></td>
</tr>
<tr>
<td>strategies at commencement of</td>
<td></td>
<td></td>
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<tr>
<td>study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target in action</td>
<td>Early 2011</td>
<td>ED leading the target</td>
</tr>
<tr>
<td>Themes which reflect target</td>
<td>Above 85% but below 95%</td>
<td>Displacement of surgical flows</td>
</tr>
<tr>
<td>response and impact through the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of study</td>
<td>Mid 2012</td>
<td>Struggle to progress</td>
</tr>
<tr>
<td>Themes which reflect how things</td>
<td>Below 90%</td>
<td></td>
</tr>
<tr>
<td>had progressed or were at study</td>
<td></td>
<td></td>
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<tr>
<td>completion</td>
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</table>

Hospital Three is located within a large sized DHB serving a population of over 300,000 people. There is wide geographic spread of the population in urban, provincial and very rural settings and it is the largest sized DHB, geographically, in this study. Hospital Three is located in a major metropolitan city of New Zealand. There is more than one public hospital in this DHB providing acute and inpatient beds and services, with Hospital Three the largest, having over 500 beds. The hospital provides a full range of secondary and tertiary services in acute, elective, rehabilitation and mental health services. Annual presentations to the ED of Hospital Three exceed 50,000 per annum. The hospital provides care to its own DHB, as well as other neighbouring and more distant referring hospitals and DHBs. It is a low performing hospital with a target result from late 2009 of below 80%.

6.4.1 Additional Complexity

This theme is defined as the additional complexity of structure, service and medical specialisation which characterises the context for target implementation at Hospital Three.

I have noted in the case study site introduction that this hospital is one of several for the DHB which provides service for its own and other neighbouring DHBs (information sourced from H3 SI data). Interviews revealed that the executive leader of the case study hospital, and the person centrally accountable for achievement of the target, is the Chief Operating Officer and not the Chief Executive Officer. In the main, this appears to be a consequence of the multiple hospitals which
comprise the service delivery structures of the DHB (H3 SI data). Such structural complexity brings with it a multitude of tensions and diverse service delivery priorities for the DHB and its senior management personnel.

Consistent with structural complexity is service complexity. The hospital provides secondary and tertiary services across every known clinical health service as well as regional and multiple subspecialty services. Consequently, this hospital’s ED interacts with significantly more internal and external specialties and services than any of the other case study sites in this study.

As with the other sites, efforts to achieve the target are conducted within a context of multiple medical specialties. With so many specialties, a major concern becomes which medical specialty should or could take responsibility for referrals. Staff at this case study site established a formal policy in response to the target (H3 D1) that sets out the criteria and process of medical specialty referral.

> And part of that is because this hospital more and more, as I said I just about fall off my chair if I ring somebody up and they say oh great, I’d love to admit that case... But you know, the more tertiary and quaternary services you get...I mean cellulitis is a classic. I think there are 14 different specialties, you know depending on what part of your body it is - could be maxilla-facial, could be ophthalmology, could be ENT, could be plastics, could be medicine, could be surgery. So I find that very frustrating. (H3 P-H R1 SMO ED)

### 6.4.2 ED Leading the Target

**This theme is defined as the ED leading the target with three core dimensions: framing of the target as an ED target and the punitive frame; focus on the ED service and new ED facility to achieve the target; and ED staff leadership to achieve the target.**

As noted in the global themes, all of the sites in this study placed strategic emphasis on the ED to achieve the target. However at this site in particular, there are additional dimensions that mean the ED is more central and more accountable for change to achieve the target. Participants at this site discussed the problem with the framing of “the six hour ED target”. Staff, including management in the hospital, could quite simply respond that “It’s an ED target,” or “It’s your [ED] target,” and in
doing so, justify their action or resistance. The following transcript excerpt from the ED manager at this site helps to feature this problematic framing:

Because it was called an ED target, I think it’s kind of branded as we own it, and so that has, that has resulted in some of that resistance from the rest of the organisation...I’ve sat here with the clinical director from paediatrics and he said to me it’s your target, you guys made the decision that six hours was the timeframe. (H3 P-C R1 Manager ED)

Associated with the ED frame, and similar to descriptions at Hospital One, some of the staff at the ED in this hospital, in particular medical staff, also perceived that the target was being used to punish them by management of the hospital.

At the time of the first round of interviews, a brand new ED facility had been opened. This was associated with the discussion of the impact of the target by some participants. The new ED provided a purpose-built physical facility that enabled patients to be progressed more efficiently in various ways, such as improved allocation of staff and ability to undertake assessments. One of the managers interviewed saw the resource allocation of the new ED as part of the strategic response to achieving the target, although not necessarily a direct consequence of it.

Interviewer LC: You have talked about a few things that have gone on. Is there any specific thing that you’d like to highlight about what the organisation’s done? Something that you think is fairly important?
Participant: Well I’d like to say that we invested several million dollars in a new emergency department, however that was happening anyway. (H3 P-B R1 Senior Manager Hospital)

In the opinion of many of the ED staff interviewed, it was the ED service and the ED staff who were leading the achievement of the target. In particular, the emergency nurses were considered key drivers of target achievement, and the ED Manager and Clinical Director were key agents in the process of advocating for the importance of the target across the hospital. Not only this, but staff perceived that it was expected of the ED staff to do so and in the following excerpt the participant associates this with the ED frame.
The management approach has almost been...if people are not helping us with the six hour target, then it is our job to bully them into, you know, responding and doing 'the right thing' by the six hour target because it’s our target and we need to be the enforcer of that. (H3 P-M R1 SMO ED)

Associated with the leadership that ED and its staff showed through target implementation, the interviews also revealed that there was much discontinuity in hospital management, particularly those managers who endeavoured to be, or were meant to be, influential in target buy-in and change across the hospital. All of these factors lend to the sense I made of the interviews at this site that for the first two years of the target, ED had been leading the way in trying to achieve the target, particularly through its staff and new service, while wider leadership of efforts in the hospital faltered.

6.4.3 Displacement of Surgical Flows

Displacement of surgical flows is defined as an impact of the target’s introduction where patients have been moved from one part of the acute care service to another. Associated with this displacement are concerns about the possibility of increased ward admission.

As in Hospital One, displacement of surgical flows has been caused by the target and similarly in Hospital Two, where acute medical flows are displaced. Prior to the target and prior to the opening of the new ED, surgical patients were routinely delayed within the ED service awaiting assessment and decision-making by surgical staff, sometimes in an observation facility that had been part of the old ED service. The new ED did not contain such a facility. It was an impact perceived by some participants to encourage a higher and faster rate of admission of surgical patients—with some of these patients not necessarily needing to be admitted.

Well I mean sometimes we’re admitting patients who don’t need to be admitted but we’re admitting them because it’s near the five hour mark...sometimes people who like, again, to give a general surgical viewpoint on it, you know someone’s constipated and they come in and they wait five hours. Now all they need to do is pooh and then go home; that’s it. Ah, we have to admit people you know...and they just need a bit more observation...they actually don’t want to be admitted but now the six hour mark is approaching we need to admit them under general surgery. (H3 P-J R1 Hospital JRMO)
6.4.4 Struggle to Progress

This theme is defined as the struggle to make progress on the target. Progress includes the formation of a whole-of-hospital project group, the opening of a new alpha ward and the allocation of resource for more medical consultants in the ED. Momentum on specialty buy-in and addressing acute surgical flows had not progressed well.

One of the insights from the first round of interviews at this hospital site was that there as a lack of whole hospital process and engagement with the target. Some of this may be attributed to the problems with leadership continuity as already noted. However, during the second round of interviews, a whole-of-hospital project team had been developed, including senior clinicians and managers across the hospital. Their activities involved development of information, data and indicators around acute clinical quality, hospital operations and patient flow, and other strategies that add to efforts to achieve the target.

Participants in the second round of interviews reflected that the opening of a new alpha ward facility was beneficial to the achievement of the target. By managing exclusively acute medical presentations, the facility was able to deal with a proportion of the patients historically delayed in the ED and thus overcrowd it.

A point of contention identified in the first round of interviews was that the target had not leveraged additional medical resources for the ED. However, participants in the second round interviews describe additional resource allocated for emergency medicine consultants which was expected to help achieve the target by providing improved medical coverage, particularly after hours. For the ED medical team, this was progress.

Issues of resistance and buy-in to the target from senior medical specialists in the hospital persisted in the second round. This resistance also influenced junior medical staff attitudes and behaviours. Despite the formation of the whole-of-hospital target group, some medical specialty stakeholders resisted the influence of the group through non-attendance and non-accountability of the group.
Issues of delayed and displaced surgical flows remained a challenge in the second round, and some interviewees discussed possible strategy. Consideration of a separate acute surgical unit had been discussed but had not gained momentum, largely because the resource to establish the unit would have had to come from existing resource and the physical layout of the hospital site would have been unsuitable. In addition, there were doubts about the appropriateness of creating another structure that may not improve the situation.

The idea [acute surgical unit] was floated but the problem with that is it’s a geographic issue of having an acute surgical unit, this hospital here just doesn’t want to go and move patients from ED to another room next door and call them a non-acute patient. …and unless we could prove that there was going to be a benefit for patients, just moving them around the corner and calling it a different name, then it’s not going to happen. (H3 P-D R2 SMO Hospital)

6.4.5 Interpretive Summary Hospital Three

I interpret that complexity of the context at this hospital site creates multiple barriers for implementation of the target. There are so many stakeholders involved in the process that it is difficult to engage them all, with the result that there is an inconsistency in buy-in. This notion of inconsistency also characterises the leadership of the target. It would be inappropriate to speculate that just because the CEO is not a major player in the front line implementation experience that this has been a key factor. Rather, I would suggest that it is a factor that does not help. In addition, the loss of continuity of other senior managers who were assigned responsibilities vis-à-vis the target has also not helped.

The key differences in findings at this site between the first round and second round of interviews is the change from the concentrated effort in ED to broader efforts in the hospital. However in the end, the local findings point to a continued struggle to gain buy-in and momentum on the target contributed to by the multiplicity and complexity of medical specialty service and professional groups, as well as hospital leadership issues.
Additional resourcing of the ED medical consultants may well have been the only option to help achieve the target where further strategies in the hospital were unable to be progressed effectively. At the end of the second round of interviews at this hospital site, the weight of resistance and caution was still greater than the weight of buy-in and change. This hospital is the only site not to have achieved the target at the time of the second round of interviews.

6.5 Introduction to the Local Story for Hospital Four & DHB

Table 6.5: Hospital Four Timeline of Themes & Performance

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Measured performance</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the outset Themes of local context or</td>
<td>End 2009 Below 80%</td>
<td>History of failings</td>
</tr>
<tr>
<td>strategies at commencement of study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target in action Themes which reflect target</td>
<td>Early 2011 Above 80% but</td>
<td>Fighting Fires</td>
</tr>
<tr>
<td>response and impact through the implementation process</td>
<td>below 90%</td>
<td></td>
</tr>
<tr>
<td>End of study Themes which reflect how things</td>
<td>Mid 2012 Above 95%</td>
<td>Practical Leadership</td>
</tr>
<tr>
<td>had progressed or were at study completion</td>
<td></td>
<td>New ED and Alpha Ward - Old Problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Pressure is Off</td>
</tr>
</tbody>
</table>

Hospital Four is located within a large sized DHB serving a population of over 400,000 people who reside in mainly urban areas. The hospital is located in a major metropolitan city of New Zealand. There is more than one public hospital in this DHB with Hospital Four the largest, with over 500 beds. The hospital provides a full range of secondary and tertiary services in acute, elective, rehabilitation and mental health services. Annual presentations to the ED of this hospital exceed 50,000 per annum. It is the second of two low-performing hospitals in the study group, with a target result in late 2009 of below 80%.

6.5.1 History of Failings

This theme is defined as a history of failings in the organisation comprising three dimensions: failings of service and hospital development, reputational failings and failings in leadership.

This hospital is one of two study hospitals which opened a brand new ED and alpha ward during the conduct of this research. The old ED and alpha ward are described as having dysfunctional service models that failed to deliver on the desire for multiple services to work together to provide acute
care, particularly the working together of emergency medicine with general medicine. As one participant described of the old ED and alpha ward, “they basically set it up to fail from the beginning” (H4 P-M R2 ED SMO). Hospital development failings include planning errors for expansion of facilities some years prior and growing difficulties with responding to demand for acute and elective surgery in the DHB.

Reputational failings are identified in the interviews in relation to the outcome of Health & Disability Commission investigations and the poor perception of hospital performance portrayed in the press, noted by several participants, for example:

So that was in the 1990s…and there was a lot of press at that time about some really significant adverse outcomes that had occurred. (H4 P-M R2 ED SMO)

Participants at this site described various issues with leadership which have an historical thread particularly concerning clinical medical leadership as well as general management. For example, poor collaboration, governance and accountability amongst senior medical staff was described and linked to problems associated with delays and overload in ED. Disconnection between clinical and management leaders in the hospital is also described. Some of these failings are explored in the following excerpt.

But the problem, the difficulty and the reason why this hospital has been difficult and I think we – it’s not so much that we’re behaving poorly, you know what I mean, it’s more because there’s no governance. Because there is no – there’s ED, medical, surgical. I mean who’s saying no? ...Well we have an ED clinical director and then there’s the medical clinical director. And then there’s someone for orthopaedics ...but they’ve never agreed on anything. They’ve never sat in a room and said right, every month saying – right these are the issues that have come up in ED – these are the set of rules that we’re going to work by – so when a patient comes in whether you’re orthopaedic or surgical, these things will happen. They just make up their own rules. (H4 P-B R1 ED Senior Nurse)

A legacy of failings at the hospital is part of the local story for this case study site, such that not only did the organisation start well behind in terms of measured achievement on the target, but they also started behind in terms of the social context where clinical and management leadership was
disconnected and where reputation was already poor. For this case study site, there are some additional challenges and barriers to implementation of the target.

We have still got a lot of work to do with the – if the consultant does his ward round at 10.30 on Tuesday and has done for 10 years, is he going to change to you know….so who does anything about that? So until some of that happens the organisation has a long way to go. (H4 P-D R1 ED Manager)

6.5.2 Fighting Fires

Fighting fires is a theme which interprets the early phase of policy implementation for this case study site. It reflects the way in which the day-to-day running of the hospital and planning and preparing for the new ED and alpha Ward occupied implementer attention, and in doing so meant other strategies for meeting the target were not well attended to at the start.

The phrase “fighting fires” was used by two participants at this site with two related meanings. Firstly, it refers to dealing with day-to-day demands of the hospital, and the work of planning and preparing for the opening of the new ED and alpha ward. It is also used to describe response to performing poorly against the target, “...but it was all response to fires, it was all response to gosh this month we are down, why is that you know” (H4 P-B R2 Senior Nurse ED).

I think it was implemented without enough thought going into it and without enough processes put in place. I think it went in place and then we dealt with what fell out from it....but I do think that there was, you had the horse and the cart round the wrong way. (H4 P-J R2 Hospital Manager)

Thus fire-fighting in the beginning phases of the target concerns addressing what is immediately ahead of these front line staff—getting the work done on the new departments and responding in a knee-jerk way to a poor result on the target.

The sense of fire-fighting is developed further with reflections from other participants who felt the hospital had missed the start of the target, for example, “…the hospital missed an opportunity to get everyone on board very early on” (H4 P-C R2 Senior Nurse ED). Focus on a structural intervention (new ED and alpha ward), meant missing the problems of staff behaviour and attitude and strategies needed to deal with them. This insight is also evident in the global theme of problem sensemaking.
6.5.3 Practical Leadership

This theme is defined as responses to the target which involve practical behaviours and changes which address the leadership of the hospital and achievement of the target.

Leadership failings were part of the history at this hospital site, as noted in Section 6.4.1. During the first round of interviews, I noted an event that involved senior managers in the hospital engaging face-to-face with ED staff by working alongside them and helping the day-to-day work effort. It was an event that narrowed the social distance between managers and clinicians as described in Section 5.3.4. Descriptions from the second round of interviews point to several more changes and developments that add to what are practical activities for hospital leaders. For example, change to the executive structure removed a layer of management hierarchy. As well, the participants describe emphasis on learning about hospital operations at a senior manager and clinician level. This also involved a new multidisciplinary group to oversee hospital operations and included senior executive clinicians and managers.

See we no longer have a COO, we used to have a chief operating officer, that layer no longer exists...so to give you an example this has changed things, executive staff chair...our hospital utilisation group which is a weekly meeting...what are the issues, what’s happening in the week coming...what beds are opening...but what has happened is this very senior focus on how the hospital is working in and day out. (H4 P-L R2 Hospital SMO)

In a reciprocal fashion, some of the ED participants reflected that senior managers were more visible and accessible to them since the target had been introduced and that executive focus on the target had been relevant to its achievement. In the following excerpt from second round interviews, the participant describes improved engagement of leaders at “the top” as well as linking this to the process of moving to a new department. The sense that I make of this is that in practical terms, having the new departments was an important signal for leadership of the target across the hospital.

And the other thing I think that’s really made a big contribution is better engagement from the organisation. The organisation at the top...we hadn’t moved [into the new department], so even at that point and the six months prior to that there wasn’t the engagement at the top... but there was so much happening with the move here it was very hard. (H4 P-D R2 Manager ED)
Developments in clinical leadership also feature in the second round, with new leadership roles developed in acute care which helped to improve the flow of patients, particularly related to senior medical roles in the alpha ward and ED. In addition, senior medical leaders were described as influencing the buy-in to the target and strategies in the hospital, as they help to translate and transmit the whole-of-hospital frame within their specialty service. These are behaviours which I did not identify as happening during the first round of interviews.

6.5.4 New ED and Alpha Ward – Old Problems

This theme identifies the opening and utility of the new ED and alpha ward as a key intervention to impact on implementation of the target and, associated with this, the transfer of old problems of acute flow.

More than any other activity at this hospital site during the period of this study, opening of the new acute facilities impacted on the perceptions and experiences of participants with implementing the target. All participants interviewed during the second round considered the facility and its impact from a number of different perspectives. One of these was that the new alpha ward helped to separate emergency medicine from other medical specialties by having separate departments to work in and, associated with this, was the opportunity for emergency medicine to have improved governance of their service.

But to me one of the biggest things was that this was their [ED] department, we had the situation where the emergency medicine department didn’t feel that even the previous iteration was their department, so we had a serious governance, own governance issue that actually, not only the building but also the split of the emergency department into an alpha ward helped solve. (H4 PL R2 SMO Hospital)

Yet such separation may not address the longstanding problem of failings concerning collaboration between medical specialists at the case study site; indeed, it might be argued to promote even greater distance. In addition, the new alpha ward is described as inheriting some of the problems that plagued the previous ED delay to inpatient medical team review. Participants also described the emergent problem of the alpha ward being utilised to receive patients that were about to breach in the ED.
Some patients do move, and I am forced into a situation where I have to move a patient, like for instance a patient I know is going to be a hospital admission, to move them to the alpha ward to stop the clock. (H2 P-B R2 Senior Nurse ED)

Other problems for the alpha ward include issues of its own medical governance, and developing the nursing staff resource and competence for what was a brand new service.

6.5.5 The Pressure is Off

The pressure is off is a second round theme reflecting an easing of pressure on staff, the ED service and the hospital in relation to achievement of the target.

At the time of the second round of interviews at this hospital in 2012, the target had just been achieved for the first time since its introduction in 2009. This achievement is reflected in this theme as well as other events and changes in the hospital, for example, one of the participants described a calmer working environment in the ED and the hospital wards. Clinical teams were more responsive and knew what was happening with their patients, in contrast to the chaotic environment that had prevailed in the past.

Associated with this, participants also describe the alpha ward had helped to improve flow of patients since there was faster clinical decision making and movement of patients on in the system. The alpha ward also enabled ED staff to move patients who were about to breach the target as described in the excerpt above; the facility provided an outlet valve for risk of breach.

Another dimension of this local theme is the relief of pressure associated with the end of the reporting quarter on the target (the target had just been achieved at the site). The easing of pressure on emergency nursing staff was also described because their medical counterparts had begun to take a more significant role in improving the flow of patients through the ED.

Participant: I very much felt that it landed on the nurses, the charge nurses in particular.
Interviewer LC: Has that changed?
Participant: I think it has eased up a bit and it has changed. I think the doctors are much more aware, the flow doctor now on every shift is acutely aware that it’s his job actually to push from a medical perspective. (H4 P-B R2 Senior Nurse ED)
6.5.6 *Interpretive Summary Hospital Four*

The new acute facility, including both the ED and alpha ward, has been a key factor in the local target story of Hospital Four. This facility has drawn the attention and efforts of implementers because of its perceived importance to achievement of the target and also, I interpret, as a consequence of a failed ED and alpha ward previously. However, like Hospital Three, the planning for these new structures preceded the introduction of the target, with the intervention itself part of change already occurring. The relief of pressure afforded by the new facility is important—but it also afforded the opportunity to achieve the target where it was used to move patients who were about to breach the target; arguably, this is gaming behaviour. The insight in terms of the study question is that the implementers at this hospital placed some reliance on the new structures to help achieve the target and in doing so, the pre-existing plan and activity becomes central to the way these implementers and the organisation implement the ED time target policy.

As with the other hospitals, efforts inside the hospital to improve discharge processes in response to the target were identified, as well as activities concerning the generation and distribution of information concerning delays in ED. However, outside of this and preparation for the new ED and alpha ward, very little was addressed early on strategically. There is a link here between fighting fires and waiting for a structural intervention to have an impact. In addition, there is little in the local themes for this hospital to suggest an assertive strategic approach, driven by senior management, at the start of implementation to address issues of resistance. However, toward the end of the study, leadership activities began to emerge at the site, though in more pragmatic rather than overtly political terms.

6.6 *Chapter Summary*

The local story for each of these case study sites has something to reveal concerning local factors that may influence the process and outcomes of target implementation. To support the summary, the themes from each of the hospital sites have been set out in Table 6.6 below, and again I have used a simplified timeline structure. I set out my summary points considering resource, timing, political
and leadership factors and provide some further commentary regarding the similarities and differences between sites with interpretations that also build on the global themes already presented.

Table 6.6: Collective Summary Table

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Hospital One</th>
<th>Hospital Two</th>
<th>Hospital Three</th>
<th>Hospital Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target end of 2009</td>
<td>Above 80%</td>
<td>Above 80%</td>
<td>Below 80%</td>
<td>Below 80%</td>
</tr>
<tr>
<td>Beginning</td>
<td>Provincial establishment</td>
<td>Ready for the target</td>
<td>Additional complexity</td>
<td>History of failings</td>
</tr>
<tr>
<td>Middle</td>
<td>Over focus on ED</td>
<td>Focus on organisational culture</td>
<td>ED leading the target</td>
<td>Fighting fires New ED &amp; alpha ward – old problems Practical leadership</td>
</tr>
<tr>
<td></td>
<td>Target conflict</td>
<td>Target success</td>
<td>Displacement of surgical flows</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Displacement of surgical flows and strategic failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End</td>
<td>Getting together &amp; working it out</td>
<td>Target success, but…</td>
<td>Struggle to progress</td>
<td>The pressure is off</td>
</tr>
<tr>
<td>Target mid 2012</td>
<td>95% or above</td>
<td>95% or above</td>
<td>Below 90%</td>
<td>95% or above</td>
</tr>
</tbody>
</table>

6.6.1 Resource Factors

At the local level, available resources matter. In particular, these findings suggest that where resources are available, the ability to create strategic response is enhanced, alongside achievement of the target. For example, I have interpreted that in Hospital Two, new beds and staff were a key part of the readiness of the site and its early target success. In Hospital Three however, despite a new ED and alpha ward, this case study site was still unable to achieve the target by the conclusion of the study. For Hospital Three therefore, new resource alone was not sufficient to achieve the target, but it did help to make some gains on the measured performance.

At Hospital Four, the new resources afforded by the new acute facility, particularly the alpha ward, coincides with target achievement. Thus, the timing of this resource seemingly contributes to delay in efforts in the wider hospital to achieve the target. I interpret the approach of this site was one of waiting for this resource to be available to determine its impact on the target performance. For Hospital One, resource factors are central to the theme of provinciality, with some valid barriers to target response arising from the limits associated with medical staffing. For this hospital however, by the end of the study, resources were shifted from one part of the organisation to another to boost
achievement of the target though not without an early period of target conflict and efforts that were not resource focused.

The process of applying resources to strategies and changes to help achieve the target thus has a local ingredient, including what was already planned to be spent (new departments in Hospital Three and Four); what becomes agreed on and applied as the target politics and performance evolves (new ED staff Hospital One and Hospital Three); what is available to be applied at the outset (Hospital Two); or what is made available over time (Hospital One, but in contrast not Hospital Three for an acute surgical unit).

6.6.2 Timing Factors

The key finding in terms of timing as a local factor is the timing of resource interventions, such as the new acute structures and the increased staffing of acute areas such as ED and acute theatre. As noted above, the timing of the new alpha ward in Hospital Four coincided with not only achievement of the target, but a reduction in the pressure of the target on organisation. Timing is also relevant in terms of when new resources became available. For example, I noted that new ED consultant resource was made available in Hospital Three toward the end of the study, and this followed failure to achieve the target. Arguably, continued failure at a particular point in time in the process of implementation might be considered a valuable strategy to lever resource.

Another timing factor concerns readiness, a concept that is identified in Hospital Two. Readiness for this site is multidimensional, including the timing of new leaders, new clinical resources and readiness associated with ability to undertake quality improvement. There was readiness also in terms of having tried to address the problems previously with only limited success. There is little in the findings from the other sites which equates to readiness, other than the timing of resource and structural interventions. Arguably, being ready to make change in terms of these abilities is also a factor impacting on implementation and outcomes since Hospital Two is an early success story.
6.6.3 Political Factors

In two of these hospital sites, resistance to the target and its impact was dealt with in quite deliberate ways. In Hospital One, dealing with resistance was by way of a senior management driven approach, with the response being one of further resistance, distressed clinical staff, and then a “meeting of the minds” between senior managers and clinicians. Resistance was only partially dealt with at this site however, since hospital SMOs, particularly surgeons, remained resistant to any change to their working norms and expectations. In Hospital Two in contrast, resistance was managed through efforts to intrinsically motivate staff using social marketing and other strong values symbols, and whilst this did not necessarily mean that there were not issues of intense pressure for some staff, the dominant narrative was one of success. Any fall-out from the change process was managed through constructing success and motivation.

In Hospital Three, activities to address resistance were more subtle, with political persuasion and advocacy being addressed largely by ED staff and then, eventually, through a whole-of-hospital team and project that brought key stakeholders to the table to map out strategies to address the target. But as noted in the Hospital Three story, not all the resisters were at that table, with robust solutions yet to be agreed on and the target yet to be met. Executive management did not take an aggressive approach to address resistance at this hospital, leaving senior clinicians and other managers to work this out amongst themselves.

In Hospital Four, and similar to Hospital Three, I do not interpret deliberate attention to dealing with the resistance of implementers. Whilst information regarding the performance of inpatient teams was generated and shared with hospital medical teams, there was no real pressure to respond in the hospital. To this extent resistance was not dealt with aggressively, and the process was characterised by a “wait and see” approach to what might happen with the new acute facilities. Fresh leadership activity by the end of the study signals a collaborative and practical approach to dealing with resistance.

Arguably, no matter what approach implementers take to achieve the target and deal with resistance, there will be negative impacts (all sites had negative impacts, as noted in the global themes) and the
key may be to take the approach that appears least damaging (Hospital Four) or the approach that appears to best control damage (Hospital Two).

### 6.6.4 Leadership Factors

Executive leadership style and approach has been a relevant factor to impact on the process of implementation in two sites. For Hospital One, the intensive hands-on executive leadership approached has been experienced negatively, for example being interpreted in a punitive frame and as a target conflict experience. In Hospital Two, the intensive political suasion and pressure of executive and senior managers has been experienced in largely positive ways—although it has been helped by social marketing and attention to the attitudes and behaviours of staff.

In the other two sites, executive and senior management style and approach has been somewhat different. Whilst executive and senior managers and clinicians were involved with the target, it was not in a hands-on or overtly political way. For Hospital Three, the complexities of the structural and political environment, particularly arising from the multiplicity of medical specialties, might have made it difficult for the executive leaders to take a deliberate role. Threatening or testing the domains and authority of specialist surgeons and physicians might have carried as many risks for executive leaders as not doing so. In Hospital Four toward the end of the study, executive leaders were engaged with the target and addressing the issues of improving hospital flows, but through pragmatic means, rather than overtly political ones.

### 6.6.5 Framing

Framing of the target as an ED target and as punitive were frames identified at Hospital One and Hospital Three. However, this does not mean that similar framing was not occurring at the other sites. What it does reveal, however, is how both of these frames are linked to quite conflicted and difficult target experiences and the importance of the social narrative in portraying this. It is also linked to the strategic emphasis on ED where staff may begin to experience the weight of expectation and pressure in difficult ways, and it thus contributes to local story-telling. I noted in the chapter 5 that framing of the target as a “rule” was evident in all four hospital sites, but that it was strongest in Hospital One and Hospital Four. In the case of Hospital One, it might be argued
that this is consistent with the management approach that sets rules for others to follow—an extrinsic motivation. In the case of Hospital Four however, I interpret that the language and framing of the target as a rule is part of the social construction of implementers who lacked strong leadership at the outset and other explicit mechanisms of framing the target.

### 6.6.6 Around the Hospitals

Hospital One has met its target through a mixture of executive-driven and then collaborative activity, with a reallocation of resource to the front of hospital for medical staff and to development of acute theatre service. Implementers had negative experiences arising from rapid change, and intense scrutiny of the ED from executive management. Moving of acute surgical flows back to the alpha ward toward the end of the study is a consequence of the inability to change medical staff behaviour and the perceived limits of provincial staffing and demand.

Hospital Two has met its target through changing attitudes and behaviours of staff and through the implementers at this site being far more ready and able to make change. This hospital has also benefited from having resources allocated in time with the target. Whilst there are negative experiences of which staff are critical, the dominance of the success narrative has helped to control any lasting social impacts. Success has had a cost that is managed.

Hospital Three made gains on the target through the opening of new acute facilities and process changes in the ED, but this alone has not helped to achieve the target. Resistance has not been addressed aggressively by management, and the ED has been provided with additional resource toward the end of the study to help achieve the target. Negative experiences for ED staff have been balanced by the positive with a new facility and more medical staff resource allocated.

Hospital Four waited for its new facility to open to help achieve the target. Resistance to the target was also not aggressively managed, with more pragmatic leadership emerging at the end of the study. The new alpha ward helped to ease pressure on services and staff, but also provided a means for staff to game the target and consequently, the resource alone has not been sufficient to achieve improved flow.
CHAPTER 7
DISCUSSION OF FINDINGS - INSIDE THE BLACK BOX OF
ED TIME TARGET IMPLEMENTATION

7.1 Introduction to the Chapter
The implementation of public policy renders many challenges for policy formulators and governments, and for front line service delivery organisations. In addition, targets aimed at improving the performance of government services offer much promise as a policy tool, but also much debate regarding unintended or negative consequences. This study aimed to contribute to theory and practice of public policy, specifically policy implementation, as well as the use of targets to improve performance. Theorists and practitionerers in public service management, particularly health services, are also an important audience.

The research questions posed by this study were:

- *How did front line staff respond to and implement the ED time target and what were the consequences?*
- *How did context influence the process and outcomes of policy implementation?*

These questions were designed to explore what happened when the ED target was introduced to service delivery organisations, and to provide the opportunity to develop plausible explanations of the policy process and outcomes on the health service delivery front line—the “black box” of policy implementation. They were also designed to enable the research to engage with the professional and organisational complexity that characterises health service organisations; an endeavour to interpret and to make sense of policy implementation from the implementer’s view of the world.

This chapter addresses the study findings in light of the research questions and in light of the literature. The chapter also describes methodological and theoretical contributions arising from the study. I summarise implications for policy, practice and research as well as thesis limitations to
close the chapter. An integrated summary of the research findings as they respond to the research questions and issues from the literature is set out below.

7.2 Summary of Research Findings

- Response to the target involved individual and collective thinking of policy implementers that was dominated by health professional and hospital perspectives and experience. As a consequence, front line staff implementing the ED target thought about what they knew from a professional and hospital point of view.

- Implementer thinking was further shaped and constrained by two closely related institutions in the acute hospital context - the institution of medicine and the hospital ward. These institutions were key contextual factors that influenced the process of target implementation.

- Collectively, these findings regarding the thinking and the sensemaking of policy implementers in response to the target, help to explain the scope and focus of implementer actions which, in turn, may account for some of the challenges and negative consequences of policy implementation and targets.

- Key tensions and conflicts in response to the target were between medical specialties and individual medical specialists, and between clinicians and managers in the ED and the wider hospital. Such conflict and tension is a result of the context of implementation in health care and the acute hospital.

- This response was also associated with the formation of political alliances at the hospital sites comprised of hospital managers, nurse managers and ED staff. Political activity in the alliances involved leveraging resources and buy-in, making trade-offs and applying influence and pressure on staff. These alliances also addressed resistance to the target, the gaining of buy-in and the promotion of behaviour change in medical specialists and ward nurses.
- The target stimulated actions aimed at gathering more information to help make sense of the target, which fed back into thinking and strategic actions. Information gathered was also hospital focused, as was the allocation of resources, to the front of hospital services in the ED and Alpha Ward. Whilst these key strategic actions were aimed at achievement of the target, they are also a result of the political influence of the alliances.

- A range of positive and negative consequences arose from target implementation. Gaming behaviour was in response to intensive focus and pressure from managers. Myopic thinking and actions, and target fixation were also evident. Positive consequences, such as a better practicing environment in the ED, and learning and development for individual staff and services, were the product of sensemaking and actions aimed at identifying and implementing solutions. These positive impacts of the target helped implementers to balance and live with the pressure and other negative effects of the target.

- Local context factors that influenced the process and outcomes of target implementation included the leadership approach of senior managers, the timing of major hospital structural interventions, the degree of medical, service and structural complexity, the size and physical location of the DHB and associated demand for acute service and resources available for service delivery. Local history was also a pertinent feature of local response. These factors had an impact on implementer thinking, strategic actions taken and whether the target was achieved. Collectively, these local context factors may account for some of the reasons why policy may be more or less successful in different organisations.

### 7.3 Response and Consequences of the Target and the Influence of Context

In this section, I highlight key components of the target implementation response that were revealed by the study. I also explain the relationships between these components. The discussion highlights several steps in the implementations process, with multiple simultaneous cognitive and behavioural responses and emphases on resource and behavioural change and learning at individual and collective levels across the hospital. The influence of context is addressed in an integrated fashion within the different sections of discussion.
7.3.1 Hospital Thinking, Professional Thinking

The study has found that in response to the target, front line implementer thinking was centred on the hospital and intra-hospital environment. It has also shown that implementer thinking was dominated by professional cognition. Themes to support this finding include Framing the Target, which emphasised, for example, the target in terms of the hospital, and the theme Making Comparisons, which is grounded in the professional experience of staff arising from their work in other hospitals and other health systems. Thinking is therefore also influenced by professional roles past and present. For example, ED doctors and nurses thought about the target in relation to their professional experiences within their service and within their hospitals. Some ED and hospital specialty staff considered aspects of the primary health care and ED service interface that is part of their day-to-day work. Hospital managers likewise reflected through their professional experience and through a broader hospital lens. One of the hospital nurse managers interviewed considered the interface with rest homes and associated discharge practice. Both of the junior doctors interviewed reflected on the target in terms of their professional relationships with their senior consultants. In all of these examples, it might be expected that this should be the case. Indeed, but for a few exceptions, even the patient frame constructed by participants, is dominated by patient experience of the hospital. Thus, in response to the target, these front line staff thought about what they knew about; their professional experience in hospitals and their immediate working environments and service interfaces.

Reflecting on hospital flow problems and solutions, and comparing target or service experiences, was central to the thinking process of these implementers. These are signals of needing to gain some tangible way of achieving a goal that otherwise came with no explicit and detailed set of policy implementation instructions and solutions. In this sense, a performance measure such as a target is amenable to the biases of front line staff thinking, and relatedly, the biases and influence of groups in the hospital who have some form of authority or power to influence the thinking and behaviours of others. Equally, biases and power at the local level in Hospital One helped staff to rationalise their problems and also some of the strategies pursued at that site. Biases and power over thinking is also strongly evident in Hospital Two, with ‘target success’ a feature of the local narrative.
particularly from ED and senior hospital management staff. However, such success narrative occurred amidst an undercurrent of conflict, negativity and cynicism from other implementers in the wider hospital, including managers, senior doctors and nurses.

In summary, thinking (both individual and collective) in response to the target is highly influenced by the hospital and health professional context and is a critical component of target implementation that underpins and shapes actions and consequences.

7.3.2 Gathering More Information and Feeding Back

In response to the target, front line staff gathered further explicit information related to it. Staff also engaged in the formal and informal feedback of information. This finding is evidenced by the sub-theme Developing Information Feedback & Monitoring Mechanisms. In the process of target implementation, this is again testimony of the need to problem-solve how to achieve the target, and some of this was consistent with staff thinking regarding the problems that they face. Thus, staff had certain information from their own experience, certain hunches and intuition, but response to the target required more knowledge. Again, the information gathered was concentrated within the hospital.

Notably, gathering of information in response to the target did not emphasise the target’s impact on patients, for example by conducting research on the clinical impact on patients such as clinical outcomes. Hospital Three was the only exception in this regard, with activity to formulate clinical markers on quality of patient care part of the strategic response. There was certainly caution and criticism from staff regarding the perceived negative impact on patients. Yet such perception did not prompt more detailed investigation. Likewise, staff reflected on negative personal and professional experiences as a result of the target, yet investigation of this experience was also not part of the information that was formally gathered. Whilst this might be explained by the cost and capacity to conduct research, it might also be explained by having other priorities to attend to and a willingness to tolerate negative personal or professional experience at the time—to accommodate it.
Information gathering, for example generating and comparing data regarding the length of stay for patients of different medical consultants (identified at Hospital Three), provides target implementers with more substance and objective, tangible information to work with. It can build on hunches arising from thinking and from experience and prompt other actions. Consequently, information has been very valuable to management and clinical staff to address problems and promote change, since arguably, it is harder to argue against or resist facts than opinion or anecdote; although, even in the case of good hard evidence, some resistance was still evident. Information has therefore served to substantiate and stimulate other planned behaviours in response to the target—a process of learning about what needs to be done. Gathering information and feeding it back is also consistent with the culture of the health care organisation where knowledge and evidence are hallmarks of good professional practice and health care management. The response is thus a norm and expected way of going about things.

7.3.3 **Collective Thinking and Working**

In response to the target, front line staff engaged in collective thinking and work, as is most notably described by the sub-theme *Group Work & Projects*. It is also evident in themes portraying the hospital as organisation frame and perspectives. Working and thinking collectively contributed to focus on the target, and enabled a multitude of other implementation processes to occur. These other collective thinking and working processes included the planning of interventions, the influencing of staff, debate and decision making. Collective work of this kind also gave different professionals and groups of staff from across the hospital the opportunity to come together in ways that they might ordinarily not have. Such collectivity also enhanced political alliances in response to the target.

Collective thinking and working was also evident within individual departments, services or specialty groups. However, if one is not part of the collective, then one may not be directly (face to face) influenced by it. This is salient to findings at Hospital Three where a whole of hospital multidisciplinary working group was eventually formed to specifically address the target, but experienced difficulty in getting some medical clinicians to be involved. This was undoubtedly a way of medical specialists demonstrating or expressing resistance to the target and to changes
needed to meet it, merely by their absence. If several medical clinicians acted in the same way to resist the target, arguably they are also collectively working—in that case to resist the target.

Collective thinking and working therefore aided in giving the target focus and visibility across different parts of the hospital, since group members were carriers of information, language, actions and strategy, able to translate and transmit to others; constructing the target’s implementation through various layers of the hospital and its staff. Therefore, response to the target was not one where a single leader of the target was assumed or appointed, who then made a plan, and then had the plan actioned by followers—a bureaucratic type response. In contrast, the implementation process involved multiple political players actively thinking and working together and through various parts of the hospital.

Collective thinking and working has been a key response to the target that is linked to political alliances formed, and to other strategic actions of policy implementers in order to achieve or resist the target.

7.3.4 Development of Political Alliances
This study has found that in response to the target, hospital managers, nurse managers and ED staff emerged as an important political alliance across all the hospital sites in the process of implementation. Hospital managers were not resisters to the target and were actively involved at the front line, either monitoring the information screens, influencing and encouraging staff, or developing more knowledge and practical skill in front line hospital operations. They were also key members of project groups and leaders in this forum. Whilst not all nurse managers in the hospital had bought in to the target at the outset, the findings show that by the end of the study, nurse managers were playing important roles influencing behaviour change in the ED and the wider hospital. ED staff (managers, doctors and nurses) likewise progressively developed as important political players in the process, influencing other departments, medical staff and managers. Collectively, this alliance has been an active part of Dealing with Resistance to the target and influencing buy-in.
The development of these political alliances is an important insight from the study for a number of reasons. Firstly, the alliances and the members of them transcend social, professional and service boundaries and roles. Managers, particularly senior ones, would not ordinarily work on the clinical shop floor in the ED or elsewhere in the hospital, yet the distance was narrowed through various aspects of target implementation, with managers of all levels, including clinical managers behaving in ways that was not the norm for them. Such actions suggest that managers believed their presence, close monitoring and oversight of the clinical workplace was important to implementation. It helped ED staff feel that responsibility for the target was not just theirs or, conversely, left ED staff feeling overly pressured. Themes from the study around political and management pressure suggest that both hospital and nurse managers were under pressure from more senior managers to prevent breaches and keep a close eye on the target. Consequently, their motives to be so present on the front line may be considered externally influenced. Whilst there were many descriptions provided by clinical staff that this may have been the case, the senior hospital managers interviewed in this study did not portray this themselves.

The political alliances are also relevant because of the accumulating numbers of staff this involved and their influence regarding the target. Jointly, these alliances represent a large group of staff in a hospital. And, as change in attitude and behaviour transfers to nurses on the ward, largely through the influence of nurse managers, then the weight of staff numbers increases. This many staff within a hospital acting in ways to help achieve the target may represent a change ‘tipping point’. In this regard, I believe that the tipping point of numbers was not reached in Hospital Three for two major reasons. In the first instance, I believe this was because the senior managers’ response to the target was not effective or as effective as it could have been and was in other sites; senior managers at this hospital site appeared more ‘hands off’ in relation to the influence of senior doctors, when compared to other study sites. Secondly, I conclude that the tipping point was not reached at this site because of the multi-hospital and multi-specialty local complexity of this case study site, making it more difficult and therefore more important for senior managers to lead and influence across professional, social and functional boundaries of the hospital in order to promote change in
response to the target. The political alliance in Hospital Three had simply not reached the tipping point.

7.3.5 Resource Change

Response to the target resulted in the application of resources in the hospital, with most emphasis identified at the front of the hospital in the acute services of the ED and the alpha ward. It also involved, in relation to two of the hospital sites (Hospitals Three and Four), the process of pre-allocation, where the resource had already been committed to the development of new services prior to the target, and with opening of new departments feeding into the process of target implementation. Accordingly, the target appeared not to alter the planned allocation of resources for these two study sites. To get to the point of opening these new departments and ensuring sufficient staff to run them however, still required, as noted above, implementer thinking and actions that remained focused on how these resources would help achieve the target. I note that the allocation of resources to the front of the hospital is invariably hospital-centric.

The process of implementation was also influenced by availability or timing of resources to respond. Timing of resources appeared to be important at a local level in relation to performance on the target. As noted in Chapter 6, opening of the new front of hospital facilities in Hospital Four directly preceded the achievement of the target at that site. In Hospital Three however, it did not, signalling that more than a new ED and new alpha ward was needed in order to achieve the target in that site.

Whilst it cannot be accurately determined by this study, there appears to be variation in quantum of resource applied in response to the target at different hospital sites. At Hospital Two (the earliest target achiever of the study sites), a multitude of new nursing roles and new service beds (15 Alpha Ward beds) were applied as well as new hospital staff roles, and this was the largest hospital with the greatest number of ED presentations. Only process change and role change characterised resource input at Hospital One, the smallest of the sites in terms of hospital size and ED demand at the time of the first round of interviews. However, at the second round of interviews for this site, agreed use of the alpha ward resource to accommodate surgical patients awaiting review by surgical
doctors had occurred and this may be directly associated with achievement of the target at that time. Front of hospital resource at the other two sites, Hospitals Three and Four, involved brand new services, with some additional staff and bed resource, and they are of a similar size in terms of demand and hospital size. Thus attention to allocation of resources, and the capacity to do so, may be dependent on hospital size. It may also be related to the size of the performance challenge in order to achieve the target; this was particularly so at Hospitals Three and Four who were the lower performing sites from the outset of the study.

7.3.6 Resisting Change
A noted response was the resistance to the target by some staff, both in the wider hospital and ED, which was dealt with in various ways and with various results. The resistance of medical staff is an important finding from the research and can be explained by key factors in the hospital context. Medicine has deeply entrenched authority over the happenings of the day-to-day world of the hospital (ward rounds, admission and discharge decisions, specialty referral practice, diagnostic practice and decisions etc., all described in the data). The hospital has an organisational culture that virtually centres on the role, status and operations of medicine. Hospital wards are structured according to specialties, for example medical and surgical, cardiology and orthopaedics. Nursing specialists in the hospital are also largely structured according to their medical specialty counterparts. Themes of the hospital social world as a context for implementing the target, as noted in Chapter 5.2, feature the domains of multiple medical specialties including the power, status, boundaries and authority of specialties; these help to explain why medical staff responded with resistance. It was inherent in the context, and in the culture of the hospital organisation, that any change in response to the target would impact on medical domains.

I noted that some ED senior medical staff were also resistant to selected aspects of the target, particularly change and pressure on their clinical practice. The ED doctor resistance is consistent with the general notion of medical specialists guarding what they value very carefully. To some extent, individual ED doctors still demonstrated thinking and behaviours indicative of an autonomous medical professional, and it was thus no different to their medical specialist colleagues.
inside the hospital. However, it is to be noted that such resistance to change by ED doctors may have contributed to their ability to lever resources for their specialty and service.

The role of managers in regard to medical resistance to the target has involved influence, pressure and using resource or political levers. To a lesser extent, nurse managers have influenced medical resistance, but largely I believe as a result of their presence in the political alliance with managers and ED staff and their ability to influence nurses who are the largest professional group in the hospital organisation.

7.3.7 Changing Staff Behaviour

Changing the way things were done in the hospital has also been a key response to the target, and it is this response to the target that has brought about much of the resistance identified. Changing behaviours of staff has been augmented through the thinking and information processes of the target, and through political alliances and processes, all noted in previous sections of the chapter. For example, changing the scheduling of medical staff relied on information as to acute demand times and a change that came with few or no costs for the staff involved—it was a fair trade. Changing the way patient admissions were managed was brought about by information on delays at the ED and ward interface and through intensive focus on this aspect of acute care. However, whilst the operational component of this part of acute care has been amenable and able to be changed, the clinical component that involves medical decision making has not been so amenable. In Hospital Two, for example, getting around the medical decision making ownership regarding admission, transfer and discharge of patients appeared to have been more readily achieved than in other hospitals, such as Hospital One, where authorising ED doctors to admit patients to surgical wards without the approval of surgical doctors was rejected (although I note that such enhanced authority for ED doctors was not necessarily comfortable for them either).

Other types of behaviour change identified by this study include how clinicians schedule their work and how managers oversee the hospital and hospital resources, particularly hospital beds and staff. The most controversial behaviour changes identified involved the way medical staff allocate their time and resource individually and within teams and how they conduct their clinical and specialty
practice routines, and a very good example of this involved acute theatre resourcing and scheduling. Nursing behaviours were changed in relation to admission and discharge, for example nurse led discharge procedures, and it appeared from the study that these were more readily achieved than change to medical behaviour.

There was behaviour change in response to the target even though not all staff agreed with the change process and impact. Influence and pressure of managers, and use of particular levers or trade-offs, was associated with this. However, changing the behaviours of patients does not feature in the findings, although there was strategy to redirect patients to acute providers in primary care identified at Hospital Three. Consequently, it is the behaviour of clinicians that is addressed in response to the target, largely influenced by the political alliances of hospital managers, ED staff and nurse managers. Some efforts to change attitudes through social marketing activity and the explicit framing of patient and organisational values in relation to the target is also related to influencing and changing the behaviours of hospital staff.

7.3.8 Living with Consequences

Mixed Consequences is a theme that reflects the positives and negatives of target implementation and in doing so demonstrates that these front line staff and their organisations were able to progress actions and achievement of the target even though there were some important negatives on the way. The negative experiences of change were tolerated, I propose, because there were benefits as well and opportunities; for example, to celebrate success, and to learn and develop at the personal, service and organisational level. Appeal to the values of the greater good may have aided this tolerance of the negative, along with the process of shared responsibility for the target across different groups in the hospital. Managers put in extra effort to work alongside their clinical colleagues on the ‘shop floor’ and be part of the change process and impact, not just clinicians. Another mechanism of tolerance of the mixed consequences may have been the absence of effort to investigate negative experiences for staff and for patients. In this way, implementers were also tolerating the uncertainty of the target and change impact.
The negative behaviours involving stopping of the clock identified in this study can be linked to both motive and opportunity to do so. The findings show that motives to game are largely extrinsic, such as direct pressure on clinicians by managers to move patients in order to avoid a breach. Opportunity arose in two ways: staff ability to use the information system to stop the patient’s visit and staff ability to move patients to another part of the hospital to prevent a breach. For example, the opportunity to stop the clock and, with this, to game the target, for staff in Hospital Four, arose when a new alpha ward opened and patients could be moved there, even though it was not necessarily needed for their care. Intense pressure from hospital managers to achieve the target at this time provided the motive. In Hospital One, moving acute surgical patients to the alpha ward (opportunity) stops the target clock, with a recently failed acute surgical unit strategy providing additional motive and opportunity. Negative consequences, particularly gaming, occurred despite the resource and behaviour changes and despite gains on the achievement of the target. Another plausible explanation of the gaming response is therefore that target implementers had run out of or had no other solutions to help achieve the target.

7.4 The Findings and the Literature

To address the findings in relation to the literature, in this section I consider three broad questions that reflect key issues identified across various dimensions of the literature reviewed in Chapter 3, and discuss links between the findings in relation to the issues and the literature, as well as other relevant literature.

7.4.1 What were the Key Conflicts and Tensions Associated with Target Implementation?

The tensions between medical specialties identified from this research is a key finding that provides an elaborate insight to the political terrain and culture of the acute hospital and medical profession. It is this particular dimension of context that functions to mediate, shape and constrain both the thinking and actions of policy implementers. This finding builds on theory and concepts from the literature on professional sociology, particularly that of Abbott (1988), to show how medical specialties in the acute hospital are in constant developmental tension with each other and not merely with other professions within the hospital. The domains of a multitude of medical specialties
emerged as actively shaping and constraining the ways in which implementers perceived and acted in response to the target.

In addition to these largely horizontal tensions and conflict in medical specialisation, the study findings also uncover features of the *Vertical Division of Labour in Medicine* and how this mediates perceptions and responses to the target. For example, in the subtheme *Getting Faster at the Front*, medical staff have responded in ways that preserve the decision-making authority of the Senior Medical Specialist, by bringing them to the front of the hospital more readily in order for them to “own”, control and make decisions. Preservation of the status of training specialists (registrars on a specialty training programme to qualify as “Specialists”) also features in this theme, such that any encroachment on this status and the privileges that go with it are defended amidst the repertoire of possible solutions. These are just two examples of the way in which the medical institutional context has impacted on the process and outcome of policy implementation and, as noted, was common to all of the case study sites.

The relatively new specialty of Emergency Medicine has leveraged from target implementation in terms of its authority and influence in the hospital, and emergency medical and service resource. Thus, in the process of policy implementation, the specialties of both Medicine (for example, general medicine and cardiology) and Surgery (for example, orthopaedics and general surgery) have experienced intensive inquiry, threat and encroachment into their domains that has been met with notable resistance. The ability for medical specialists within their specialty silos to avoid, deflect or resist pressure to change how they work in order to achieve the target is enhanced by medical autonomy, that in some instances trumps pressure that might descend through the medical and management hierarchy. Medical specialisation was a powerful mediating factor in the implementation of the ED time target.

Professional and medical sociology literature offers some further conceptual and empirical clarity and support for these findings (Noordegraaf, 2011; Zetka Jr, 2011). For example, Drazin (1990) broadly explores intra-professional conflict where segments of a professional group resist change or innovation that is sponsored by competing segments of the same profession. The result of
innovation efforts in this situation are dependent on the power of competing groups and the acceptance of arguments (Drazin, 1990). In the medical sociology literature, the case study featured by Swan, Scarborough and Robertson (2002) highlights medical inter-specialty conflict and tension associated with innovation in prostate cancer treatment. In this study, Surgical Urology Specialists (the more powerful group) responded with initial resistance to encroachment of their traditional control over treatment modalities from Radiotherapists. In another study of the medical profession, Zetka (2011) identifies other concepts and issues relevant to medical specialisation. This research describes that the obstetrics and gynaecology oncology (O&G/O) subspecialty developed out of the ‘virtuoso’ surgeon of the past and then subsequent obstetrics and gynaecology (O&G) specialty. Zetka reasons that the developing O&G/O subspecialty is due to gaps in the market place for specialty service, and to the failure of the core specialty (O&G) to deliver the service promised.

Findings from this ED target implementation study demonstrates much consistency with this professional and medical professional sociology literature. Arguably, surgeons in particular have failed to provide the acute service needed of them for patients within emergency departments. In Hospital One for example, there was an attempt to reduce the failure of surgical service to the ED by the strategy of empowering Emergency Medicine to admit surgical patients. This response was resisted by surgeons and thus became a failed strategy which itself was replaced with one that preserved the decision-making authority and knowledge of the surgeons. Narrative from orthopaedic specialists interviewed in this study (see Chapter 5, Section 5.2.2) demonstrates that they have relinquished some of their practice domain to Emergency Medicine. However, this appears to have largely suited their professional preferences and has timed well with the growing political influence and clinical authority of Emergency Medicine. Medical Physicians/SMOs have equally struggled to provide the required level of acute service in ED and, over time, Emergency Medicine SMOs have developed a knowledge and practice domain that overlaps with that of Medical SMOs (an excellent example of this was identified in Hospital Two, see Chapter 5, Section 5.2.2). These are shifting practice domains in the medical specialties with tensions between them manifest in critical attitudes toward each other, behaviours of indifference and, of course, resistance to target generated strategies.
Kathan-Selck and Offenbeek (2011) investigated the forces that influence the development of the emergency medicine specialty in Dutch hospitals, and the ability of the new specialty to contribute to better performance in hospitals. Their study concludes that socio-political forces between traditional specialties and emergency medicine mediates the contribution of the new specialty to service improvements. This study describes that emergency physicians are not considered on par with the traditional specialists who set the boundaries of their specialty domains. The reaction of emergency medicine specialists is to strive to develop as a recognised specialty. Ironically therefore, emergency medicine becomes an additional layer of the medical hierarchy and loses the value in service improvement that was envisaged (Kathan-Selck & van Offenbeek, 2011). These are research findings that parallel some of the themes of this study, but also highlight that the rise of the emergency medicine specialty in New Zealand may be problematic for improvement in public health service delivery.

Peter Nugus and colleagues have explored issues related to organisational culture and the practical ability of emergency clinicians to meet the needs of vulnerable patients in the ED (Nugus, Sheikh, & Braithwaite, 2012). This study identifies fragmentation of organisation structure and emphasis on organ-specific priorities in hospitals that confound the safe management of complex and vulnerable patients. They conclude that emergency clinicians bargain for their patients’ needs from a structurally and socially unequal position in the hospital hierarchies. This conclusion regarding power differentials in medical specialties is well supported by the present study, but also offers a wider appreciation of the politics of medical specialisation.

Tension between clinicians and managers pre-existed the target, with the process of target implementation serving to heighten this as managers intensified their scrutiny and pressure on the front of the hospital and ED staff, in particular. Bridging social and functional boundaries and distances that might have ordinarily characterised the relationship between clinicians and more senior managers is a change in behaviour, a cultural change that served to place pressure on front line clinicians. In regard to the existing literature, this management response to the target is an example of managers (agents) pursuing the interests of government (the principal). However, in
doing so, and consistent with some of the points raised by Ghobadian, et al. (2009) regarding the impact of the English ED target, managers in this study have placed extensive pressure on clinicians and ED services such that it had prompted gaming responses. Management pressure also raised concerns in these findings regarding the clinical risks for patients and concerns regarding the negative social impact on front line staff (particularly loss of morale).

7.4.2 How did Implementation of the ED Target Promote Change, Learning and Development?

The literature on targets describes that they may enhance policy by giving it focus and recognisability, drawing attention to their achievement, and stimulating change in behaviour of individuals and organisations (Bevan & Hood, 2006a; Gooder, 1992; Stewart, 2012; Thompson et al., 1997; Van Herten & Gunning-Schepers, 2000a). How this occurred with implementation of the ED time target can be found in a number of themes developed from the study, including those that concern thinking and actions of policy implementers, as well as implementation consequences and context.

A critical aspect of these research findings is the importance of sensemaking in response to the target. Weick (1995) describes that two common occasions for sensemaking in organisations are in circumstances of ambiguity and uncertainty (Weick, 1995). By ambiguity, Weick means the shock of confusion related to several different interpretations at the same time, for example the nature of problems, information, interpretations and value orientations. Uncertainty, in contrast, concerns shock due to ignorance, where people lack understanding of change, impact or response. The findings in this study show that both ambiguity and uncertainty are active features of the sensemaking responses for the ED time target. In addition, such ambiguity and uncertainty enabled the implicit and explicit construction of meaning and purpose, for example in the social marketing of target-related values and the implicit reframing of the target amidst staff dialogue regarding it.

Other aspects of sensemaking theory are pertinent to this study as they help explain implementer thinking and actions. Weber and Glynn (2006), for example, combine sensemaking with institutional theory in order to expand understanding of the contextual mechanisms which affect
sensemaking. Beyond internalised cognitive constraint, they propose that institutions also prime, edit and trigger sensemaking such that “taken for granted ways of thinking render alternatives unimaginable or implausible so that action that is in line with institutions follows automatically” (Weber & Glynn, 2006, p. 1640). Priming involves social cues active in situated identity, frames and role expectations (managers and clinicians have primed institutional roles). Editing involves deviance and then the ability for actions to be corrected where role expectation is not met and social policing of action occurs; it is thus an external factor rather than internalised constraint. A good example from the present study is the policing of the target by ED nurses where gaming behaviours have occurred. Institutions trigger sensemaking by providing foci which demand continued attention and creating puzzles of contradictions and ambiguity. An important example of foci that demand attention from the present study is the institution of the hospital ward which involves assumptions and patterns of behaviour concerning how it operates to let patients in (admission) and let them out (discharge)—gatekeeping behaviour. The hospital ward is thus an institutional trigger. Closely associated with this are the assumptions and patterns of behaviour of the institution of medicine which shape and constrain thinking but which also provide a foci for attention in response to the target; problems with medical behaviour and attitude in the themes attest to this.

Along with the construction of shared meanings, locally constructed narratives in organisational sensemaking may also harbour a plurality of perceptions and meanings in contradiction with one another and serve as mechanisms of policy legitimacy and reinforcement of political hegemony (Currie & Brown, 2003). Findings from this study identify shared and contradictory narratives at a local and global level, some of which served to legitimise the target. For example, framing of the target as a rule at the local level implies that there is no choice for staff—they are being controlled and motivated externally and must comply with this in a bureaucratic, top down way. However, such framing did not necessarily result in compliance. Plurality of meaning is evident in these findings with regard to the different problems narrated and the different frames of the target. Quality is a shared and thus a confluent narrative and frame of the managers and clinicians in this ED target study. Quality as a narrative arguably also helps to legitimise the changes made.
The narrative of ‘provinciality’ at Hospital One is another good example of active sensemaking in response to the target, but this time at a local level. Provinciality exemplifies the combination of social and physical context, as described by Swanborn (2010). The provinciality narrative had a bearing on the scope of thinking and actions for the staff at this site. Because this was a provincial hospital, with a troublesome political history associated with its size and location, there was a local institution at work in the implementation process. Thus, some of the answers to questions regarding different impacts of policy and targets may be associated with the social and physical context of provinciality. Whether provinciality manifests and impacts at other provincial hospitals in New Zealand in relation to the ED time target or, for that matter, other government health policy, is a question worthy of future research.

The broad insight from sensemaking and institutional theory is that targets work to promote change and learning by being interpreted and constructed at the street level—the front line implementer level. Ambiguity and uncertainty regarding target purpose or goals lends further to the opportunity for sensemaking. However, the scope and constraint of cognitive processes for front line implementers invariably influences the scope and constraint of strategic actions in response to the target. Institutions in the acute hospital context have functioned to constrain both the cognition and actions of implementers. Such constraint may be further manifest at a local level of sensemaking.

The findings from this study support the ‘tin opening’ effect of quantified performance measures in the management of government services; they function to open a can of worms and prompt interrogation and inquiry (Carter et al., 1992). And, similar to the evaluation of the tin-opening impact of quantified measures in the English NHS, the ED target in New Zealand has functioned not only in a highly contestable way through the implementation process, but has additionally provided an incomplete picture of the performance of organisations, which tolerated both positive and negative unmeasured consequences in the wake of the target achievement. Findings from this study therefore add to and redefine the ‘tin opening’ metaphor at the service delivery level of government. Reflecting on the theme of Making Sense of the Problems, the tin-opening mechanism of the target involved sensemaking that brings to the forefront of implementer thinking key
problems inherent in the culture of service delivery organisations and exposes them for inquiry and for further scrutiny regarding cause. Similarly, the theme of *Target Focus* involves the explicit generation of information about delays in the ED and other information such as the varying length of stays of medical teams on wards. In both of these examples, implementer thinking and the information generated is utilised to underpin feedback to front line staff - a can of worms is opened for which organisations might then need to find solutions in order to achieve the target. The most controversial ‘worm’ or worms identified by this study concern medical staff attitude and behaviour and the tensions associated with medical specialties. Another worm concerns the behaviour of nurses on wards, as well as smaller worms such as the problematic behaviours regarding GP referrals to hospital.

In regard to the other two metaphors from the Carter et al. (1992) typology, these findings suggest that the target may also function locally as an ‘alarm bell’, where target information is being monitored closely on a daily basis, for example by senior hospital managers or by ED managers who then intervene rapidly to prevent a breach of the target. The third metaphor of ‘dial’ is less identifiable from the study themes. Although this does not mean that over time and with continued existence of the target in the New Zealand health sector, that the ‘dial’ function may not feature in the future. Indeed the target may well function as a ‘dial’ for government and the community, which is more consistent with the top down utility described by Carter et al. Overall however, it is the ‘tin opening’ metaphor and change effect that is most evident in these findings, with the can of worms predominantly concerning aspects of organisational culture, medical politics and institutions.

Hogwood and Gunn (1984) emphasised the importance of sufficient resources in order for government policy to be successfully implemented. There is no doubt that the findings from this study attest to the centrality of available resources in order for organisations, and the staff and services within them, to strategically respond and change the way that they do things. However, allocation of resources is a highly political process also. The findings show, for example in Hospital Four, that the opening of a new ED and alpha ward is directly related to achievement of the target, but that such was the expectation of this new structure and resource that little else was successfully
attempted in terms of changing other behaviours of staff in the hospital at the outset. It was a political waiting game for this hospital site; indeed, at the completion of the study, problems with delays to acute assessment had begun to move from the ED to the alpha ward. The findings are similar for Hospital Three in regard to the importance of the new ED and alpha ward resource for this site, although it was not sufficient to achieve the target. In Hospital Three, the resource applied (new ED and medical alpha ward) did not address the problems concerning the flow of acute surgical patients, and for this hospital, the need to find another resource or alternate solution remained looming. Resources alone were not sufficient to meet the target at any of the hospital sites.

Crossan, Lane and White’s (1999) model of organisational learning emphasises a number of concepts that are cogent and highly applicable to this study’s findings, in particular the role of institutions in the process of learning and the powerful relationship between cognition and action. For example, the four I’s of organisational learning in this model, involve the processes of **Intuiting**, **Interpreting**, **Integrating** and **Institutionalizing**, which occur simultaneously at an individual, group and organisational level (Crossan & Berdrow, 2003). **Intuiting** concerns individual experience and images that affect behaviour of the individual and then of others. **Interpretation**, also individual and group, involves the development of language to convey insight and ideas. **Integration** also helps development of shared understanding and adjustment through collective and coordinated action. **Institutionalizing** concerns defining and specifying actions and embedding them within systems, structures, procedures and strategy. These are all ‘feeding forward’ activities in the model which drive learning and change. However, the model also identifies ‘feeding back’ activities, from the institutionalized (organisational) down to the intuitive (individual) and it is in this feeding back process from the organisational to the individual level that learning may be further shaped and constructed and where institutionalized learning processes can easily drive out intuition (Crossan et al., 1999).

This study has found that individual, service and organisational learning and development have resulted from the target’s introduction; staff thinking and actions have been directed toward
problem solving and solution generation in order to achieve the target. However, at the micro-political level of target implementation, feeding forward and feeding back activity may have been central to the ability or inability of implementers to learn and change. Most importantly, extant institutions of the acute hospital have been major constraints on learning and change in response to the target.

7.4.3 What were the Unintended or Negative Consequences of Target Implementation and why did they Occur?

Three unintended consequences of performance measurement and policy impact identified in the literature include myopia, tunnel vision and measure fixation (Smith, 1995) and each of these can be identified in some form in the study findings. Conceptually, these three consequences are very closely aligned since they are all concerned with the vision of organisational members; what they see or do not see. An effect that is myopic is one that has failed to consider the longer term goals of an organisation because of the pursuit of short term objectives. Tunnel vision means that in response to the quantified measure, management personnel emphasise phenomenon that are quantified at the cost of other unquantified aspects of performance. Measure fixation is defined as emphasis on measures of success rather than the underlying objective. The findings from this study demonstrate a hospital/intra-hospital focus regarding strategies to improve flows through and out of the hospital with only limited reference by participants to wider DHB strategy and change; arguably, this is a myopic response to the target. However, this also appears to be an inevitable, if not logical, consequence of the constrained scope of implementer thinking and the limits of strategy available to them. Insights from the Mixed Consequences theme allude to perceived or experienced negative impacts for patients and staff that have not been measured by the target. Arguably, this is a sign of tunnel vision. Themes from this study have identified the intensive management emphasis on achieving the target to such an extent as to create intense pressure on staff that in turn may have provoked gaming behaviour. Arguably, this is a sign of fixation on the target and not the underlying problems of delays in ED and flows through the acute system.

Kelman and Friedman (2009) describe that effort substitution involves response to policy which potentially diverts attention from other areas of organisational performance, and in the case of ED
time targets may involve pressured admission to an already full hospital, and the transferring of resources from one part of the hospital to the ED. However, these researchers claim, as a finding from their research of the 4 hour ED target in the English NHS, that there was little evidence of such impact in that health system. This though was a study without investigation of the front line staff involved, and is therefore limited in terms of identifying the qualitative impact of target response and, associated with this, the types of substitution effect that may have occurred. With reference to this NZ research, undoubtedly new resources have been applied and process changes have occurred which come at a cost from somewhere else in the hospital or DHB or health system; to determine where that resource came from would require further research. Secondly, pushing of patients and clinical risk more rapidly into the hospital system may, as has been identified by the themes of this study, have simply pushed the demand for acute care to another part of the system that may cost in terms of clinical quality or other important aspects of hospital performance, such as elective surgery for example. Conversely, the push of patients on in the hospital may also have had a neutral impact and would be a valuable area of future research.

Arguably, the most contentious unintended or negative consequence of targets and other quantified performance measures (at least in terms of political and organisational behaviour) is that of gaming. There are several features of the literature on gaming that have been highlighted or implicated by this study. First, that gaming involves some kind of behaviour where there is a breach of trust either professionally or organisationally (Mannion & Braithwaite, 2012). Second, is the question of what exactly motivates or triggers gaming behaviour and, associated with this, the intention of the actor (Bevan & Hood, 2006b; Günal & Pidd, 2009; Le Grand, 2003; Lipsky, 1980). A final feature is that gaming responses in performance measurement regimes should be expected and it is the role of management to mitigate or reduce the impact of the behaviour (Bevan & Hood, 2006b). Each of these points is considered in the discussion below.

Breach of trust is most powerfully portrayed in relation to the deliberate misuse of the information screen to stop the target clock. In this event, some staff are conscious that there are implications, such as patient safety, and truth/fidelity (honesty about how the target is being achieved) to
consider. It is this moral deliberation that triggers a counter response described by some participants, to put the patients back on to the ED screen (self-policing), and descriptions of trying to resist gaming of the target.

Shifting patients into the alpha ward to prevent breach was also identified in the English ED target regime and associated with it, in that jurisdiction, were concerns that the quality of patient care may have been compromised (see the Commission for Healthcare Audit and Inspection, 2009; Francis, 2013). If the goals of the target are to improve the quality of patient care in EDs and promote the flow of acute patients through the hospital system, then such behaviour may have missed the point on two counts. The first is if quality is not sustained on hospital or alpha wards, and the second is if patients are delayed as long in the alpha ward as they had been in the ED prior to the target. Whilst the behaviour of pushing the patient on, just before 6 hours, is not of the same calibre of breach of trust as the misuse of the information screen, it is nonetheless behaviour that aids in achieving the target, but is not necessarily reflective of real systematic change. Participants in this study have reflected cautiously on the intention and risks of this behaviour for patient care. Further research is implicated and outlined in Section 7.7.2.

Moving patients onto wards in order to prevent target breach is also described in the operations literature as an understandable ‘coping’ behaviour of staff. For example, with explicit reference to ED length of stay data in the English NHS, Gunal and Pidd (2009) describe “that it is reasonable to suppose that the looming breach point caused the departments to find ways to quickly complete the processing of a small proportion of their patients” (p. 726). Yet such behaviour might have been readily prevented by management, for example by auditing the ED length of stay information and taking responsive actions. However, the gaming behaviours identified in this study are also linked to management pressure to achieve the target, suggesting that any proposed preventative management in this circumstance may itself be problematic. Indeed, whilst the findings did not clearly identify who is changing the patient’s visit on the ED information, it could well have been the managers themselves.
Gaming of the target by stopping the clock, I interpret is also a ‘coping’ strategy as described by Lipsky’s theory of street-level bureaucrats (1980); a means of dealing with a perceived chronic lack of resource to perform their work. Whilst lack of resource was not clearly identified in this study as rationale for the gaming behaviour, this may well be one of the motives or rationale.

The final, broad area of negative consequence of the ED target concerns the excessive pressure on staff, and the experiences of bullying, loss of motivation and morale within the implementation process. These are all important impacts that are not measured by the target, but are inevitably a result of pressure to achieve it. All of these potential impacts of policy implementation have been identified in the literature (Burgess & Ratto, 2003; de Bruijn, 2007; Harrison & Smith, 2004; Radin, 2006). The findings from this study associate these negative consequences with excessive management pressure, but also to the resistance of clinicians that is based largely on protection of their professional interests and priorities. Mitigating or balancing these impacts has already been noted, but the major implications concern management approach, and the astute use of levers and trade-offs to encourage buy-in, meaningful engagement of stakeholders and less damaging change. These negative impacts are also partly explained by the hospital focus of staff thinking and actions. Attention to other areas of the health sector to reduce acute demand and manage acute chronic conditions more effectively could have spread response and impact of the target beyond the staff of the hospital.

7.5 Methodological Contribution

The key methodological contribution arising from this research is the application of multiple case study design to the investigation of public policy implementation. Wider employment of multiple case study design to investigation of government related issues enhances rigour and relevance for the real world of public policy and management (Stewart, 2012). For example, medical specialisation is an important factor that is evident in all these acute hospitals, as is the strong strategic and resource focus on the front of the hospital. These are matters that are enduring despite the different hospital contexts and lend to understanding of the target impact at a Ministry of Health, DHB and hospital level. At the local level of case study sites, different leadership approaches to
managing the target and relations are evident and again the multiple case design affords opportunity to explain the relationship to local process and outcomes. Ability to compare and contrast local process and outcomes is therefore an important product of multiple case study design and the value of the design approach in policy research. In summary, the methodology has facilitated, in this study, policy research that responds to the enduring questions of why and how policy may work in one organisation and not another, why and how positive and negative policy consequences may occur, and empirical insights into the ED target in the New Zealand health sector.

7.6 Theoretical Contribution

The model of sensemaking as policy implementation developed from this study (Figure 7-1) comprises the key contribution to policy implementation knowledge. The model is informed by the theorizing of Peck and Perri 6 (2006) and Dickinson (2011) (noted in Chapter 3) that conceptualises policy implementation as sensemaking. The model identifies the concepts of context, thinking, action and consequences and the relationships between them. Context is depicted at two levels in the model; the general and the local. Contextual factors at both of these levels influence the dynamic cycle of thinking and actions of policy implementers in response to the target and inevitably the consequences of the implementation process. The key contextual factor identified at the general level of context in this study, concerns the institutional and political world of medicine and the way this has constrained and shaped the thinking and actions of policy implementers. A key feature of local context of policy implementation, as identified from this study, is the timing of major resource interventions, which at a local level have constrained the thinking and actions of implementers. Another local factor identified by this study is the leadership approach, which has a relationship to attaining buy-in of staff not only to the target, but to the strategic solutions generated by implementers.
Thinking, Action and Consequences are depicted as a dynamic cycle in the model. As the findings have shown, constrained thinking leads to constrained actions (both also a product of the acute hospital context), and the broad example from the research findings is the focus on the hospital and intra-hospital environment and the behaviours of hospital staff, to help achieve the target. Two of the consequences in this cycle, therefore, are myopia and excessive pressure on hospital staff. More positive examples of the model involve the problem sensemaking and thus thinking of staff regarding delays to admission of patients. In one of the examples at Hospital Three, initial hunches by the ED manager promoted the gathering of more information about delays associated with orderly staff, and feeding information back to activity that increased orderly resource for EDs. Consequently, some improvements to ward admission process was achieved. Another example involved the use of the ED information screen which enhanced the thinking regarding delays to assessment of patients by hospital registrars in the ED. The information screen is an action in response to initial thinking, and further actions such as changing medical rosters ensued. The consequence, in this example, was a reduction in delays, but also some increased pressure on the practice of admitting registrars.

Inside the policy implementation black box of this study are also some of the reasons why public policy such as a target may be successful, or at least appear to be successful, in one organisation and
not another, and why the target may generate negative consequences. For example, the target’s implementation in Hospital Three did not appear to stimulate solutions and change as well as it did in Hospital Two, and there are a number of explanations for this. In Hospital Three, strong and unequivocal executive leadership of the target was not present, whereas in Hospital Two, executive leadership approach was omnipresent. In Hospital Three, the service delivery and medical specialty context was characterised by greater complexity than in other sites, and this is again in notable contrast to Hospital Two, where the local context is characterised by a dynamic readiness for the target. Whilst the target did work to stimulate change in Hospital One, it was a damaging experience for staff that is in some part due to the intensive over focus on the ED service and staff from senior management. For this hospital, the target was achieved by mid-2012, but in the process also generated a series of negatives. However, negative consequences were common to all sites, and arguably the key learning from Hospital One concerns leadership approach. In Hospital Four, achievement of the target is attributable as much to the opening of brand new front of hospital services, as it is to culture change stimulated by the target itself. Achievement of the target may be short-lived at Hospital Four, if demand for emergency and acute care outstrips their enhanced service capacity to deliver it.

The difference between hospitals in apparent success of the target may also be explained by the extent to which gaming behaviours have helped achieve the target. Gaming of the target was strongly identified in three of the sites and slightly less so in the fourth (Hospital One), where, toward the end of the study, staff made strategic changes that helped them to hit the target but arguably missed the point in terms of moving patients on in the hospital system. Gaming is one of the actions generated by the target, but also a consequence of the implementation process.

7.7 Implication for Policy, Practice and Research

7.7.1 Policy

A key insight from this study, with regard to policy formulation, is the use of the ‘ED’ language of the target. Framing this target as an ED target at a government level lent support to narrowly constructed interpretations, or reinterpretations at the local level and with this, the ability of front
line staff to deflect the purpose and impact to the ED. Indeed, this was one of the frames identified in Hospitals One and Three. This local interpretation may have contributed further to limited scope of strategic response. However, the policy was formulated with notable Emergency Medicine specialty influence and promotion, and this arguably has also contributed to focus on the ED where gains in resources have been considerable in response to the target. Framing the target any other way might not have helped such strategic response for emergency services and professions.

An area that was poorly addressed strategically, at least according to these findings, is that of acute demand and acute demand in chronic disease. Whilst there was some effort to improve after hours primary care access and improving referral processes between primary and secondary care, there was not explicit strategic reference to activities that are directly aimed at the reduction of ambulatory sensitive acute presentations particularly for chronic disease sufferers. Another strategic area that was not identified by this study includes health service to Māori population groups. At the very least, a check on the scope of strategic response by Ministry of Health officials and at the DHB governance level may well have extended the strategic impact of the target. Such actions would be needed from a medium to long term perspective of containing the growth in acute care demand, and reducing the overcrowding of EDs. The latter issues in relation to acute demand, primary care, and the management of chronic conditions featured in the Report, as I noted in Chapter 2.

The evidence of gaming in response to the ED target is a salutary finding, from a government point of view. Firstly it is notable that the gaming occurred at only one pressure point (the ED/front of hospital) in the acute system and as such it would not be difficult to monitor and manage this in the future. As Bevan and Hood (2006b) have suggested, auditing of the implementation process would help to reduce the incidence of gaming and its contribution to the measured performance on the target. Next is the insight that both clinicians and managers are implicated in the gaming behaviours—thus external monitoring would be required. Thirdly, is the point that gaming may have prevailed where other strategies were not available or effective. The overall implication for the ED time target policy is that gaming was evident and could be readily managed should the government and DHBs wish to assure the accuracy of target performance results.
The final policy implication is that there were no apparent financial incentives associated with this target in New Zealand, and as such it is in contrast to the English ED target where there were. This comparison shows that the target did by and large work to evoke change without financial incentives, but also did manage to foster negative behaviours, which might have been worse had there been explicit financial rewards or sanctions at stake.

7.7.2 Research

Discussion in this chapter has highlighted the importance of research investigating unmeasured dimensions of performance and impact of the ED target in New Zealand, for example, the impact on quality of care for patients in the ED and hospital, the impact on hospital operations outcomes, and the cost of implementing the target. These dimensions of performance, as well as any impact on mortality rates, are the subject of research in other streams of the Shorter Stays in ED National Research Project (Jones et al., 2012). Such investigation will enable comprehensive examination of the impact of the target in New Zealand, and notably for the hospital sites that were investigated by this study.

Learning, change and development impact highlighted in this study could be investigated in order to map out the features more closely and identify how this can be built on and transferred to other policy implementation activity in health and other sectors of government. An example in Chapter 5, concerned the learning and development of managers as they grew and changed in their roles with the process of implementation. At an organisational level, learning around quality in relation to the target could be investigated, and include what types of quality learning was involved. All of these future opportunities to investigate the positive impacts of the target would help build empirical knowledge of the ED target in particular and target implementation in the hospital context more widely.

Another development as a consequence of the target is that of the clinical practice of emergency doctors and nurses whose roles have been notably impacted by the target. Whether this is positive for both the medical and nursing staff involved is worthy of future research. In addition, future research concerning the experience of living with consequences for staff is also implicated, for
doctors, nurses and managers in the wider hospital and the ED. What is the impact on staff over the longer term, where professional and personal compromise is sustained?

Other explicit areas for further research include the impact of the target on patient satisfaction, patient complaints and clinical incidents. All of these areas have been identified or inferred in this study as being affected by target implementation. Such work would also help to engage with the patients’ experience more closely.

From a health policy implementation perspective, future research which compares implementation of targets or other quantified performance measures across different parts of the health sector would be valuable, since this may enable the refining of contextual factors, and the thinking and sensemaking process. The model of policy implementation arising from this study could provide a valuable framework to guide such research. Future research could investigate implementation of health policy other than targets or quantified measures and again utilise the implementation model as a framework for investigation.

As noted previously in this chapter, the impact of provinciality, in regard to health policy implementation, is a worthy area for future research. In addition, nursing specialisation did not feature significantly in this study as influencing the process and consequences of target implementation. Whilst this may be a consequence of limited recruitment of specialist hospital nurses in the study, whether this would hold true for other health policy or other areas of health service delivery in terms of professional nursing sociology is worthy of investigation.

7.7.3 Practice

Health management practice which intensively pressured front line clinical staff and decision making has been an important finding and criticism by participants in this study, and such pressure is related to negative staff experiences, risk of gaming and also gaming behaviours themselves. Arguably, intensive front line pressure to prevent breaches of the target is a response that is last minute and reactive, in contrast to working through all of the issues associated with overcrowding and delays in ED. In a sense, it is a last ditch and myopic response when other solutions have not
been found or have failed. Is there any value in this type of target response? Clinicians already work under pressure and whether this additional pressure helps improve service delivery and outcomes is questionable.

Arguably, the most important practice implications with regard to the implementation of the ED time target is the management of relations between medical specialty groups. Controlling and directing the behaviours of professionals, in particular health professionals at the service delivery front line, is not a new concern; in fact, it is a perennial one, with quantified performance measures being one such policy tool aimed at addressing this (de Bruijn, 2011; Kirkpatrick, Ackroyd, & Walker, 2005; Mannion & Goddard, 2002). According to Swan et al. (2002), the management challenge in situations where change cuts across intra-professional groups, is to develop and align communities of practice where knowledge is shared openly and where managers coordinate such activity in order to enhance the opportunity for innovation. In a public service context where such intra-professional tension is manifest, and policy change transcends these social groups, it may be predicted that the same intra-professional tensions and issues might occur. Although, as noted in Chapter 5, there may be no other public service delivery context quite like that of the acute hospital, and thus the intra-professional policy implementation issues raised by this study might be considered unique.

Another implication in terms of health service management and the implementation of the target is where to aim the core of target implementation. This study has suggested that this has been at the hospital level, although this may also be a product of the study methodology. Wider scope of strategic response across the primary and aged care sectors may have eventuated, had the target focus occurred at a higher level of DHB organisation. Both of these areas were touched on by the participants in this study, but whether there was broader and deeper strategic response is not known but clearly important to address the flow of acute patients.

7.8 Limitations of the Research

There are a number of limitations regarding the research strategy that should be acknowledged. The first is that this study did not investigate the implementation of the target from a patient perspective,
and as a consequence, cannot substantively represent their experience of policy implementation, either the process or consequences. The second major limitation of the research is the significant focus on target implementation experience in the hospital, and as a consequence, it has not investigated the thinking, actions and consequences of staff at the DHB level, or staff of the Ministry of Health concerning the 6 hour ED target implementation. The limited number of hospital nurses as research participants was noted in Chapter 4. There may well have been some important insights on the target’s impact had this been higher. Nonetheless, Nurse Managers in the hospital who participated have contributed some understanding of the challenges facing ward nurses and the impact on their working environments. Some of these methodological limitations have been considered in the previous sections of this chapter and in recommendations for future research.

At the time of their recruitment, all of the case study sites for this research were measured behind the target—or below 95%. That is to say that they all needed to respond in some way in order to meet it. Other hospitals and DHBs in New Zealand who were at or over the target measure (there were six of these) were not investigated. Whether the findings from this study are relevant to these other organisations represents a limitation of the study. Implementation of the target in these six health care organisations, other than measuring and reporting of the target, remains an important unknown.

The final methodological limit involves the time frame of the study. Whilst there were two rounds of interviews, across a two year period of study, this is still a snapshot in terms of the life of the target, which is still in place at the time of thesis publication in 2014. Further changes and developments may have occurred through ongoing target implementation, including how the organisations sustained their achievement of the target.
CHAPTER 8
CONCLUSIONS

When the 6 hour ED time target was introduced in 2009, and as I observed in the first chapter, one of my initial thoughts as a registered nurse working in an overcrowded ED was to question and wonder whether this target would work. Based on the findings from this study, in these concluding comments to my thesis, I set out several answers to that question.

Findings from this study have shown that the target did indeed work to induce change in EDs and in the wider hospital. Change was fostered by political alliances of staff leading and implementing the target, and by management pressure. Resources such as additional staff and beds were allocated predominantly to EDs and alpha wards that enhanced the capacity to manage demand for acute care. Gathering information regarding patient flow and quality improvement activity have also underpinned change. Process improvements were made in the ED and the hospital, and many of the behaviours of staff and problems with flow of patients through the hospital were addressed with varying levels of success. The target has worked to reduce overcrowding of patients in ED by moving them on much faster to other parts of the acute hospital, or through speedier discharge from the ED. The working environment for ED staff improved as a consequence of the target and many staff across the hospital gained enhanced knowledge and ability in their work.

Yet change in response to the target did not come about without staff resistance, conflict, tensions and cost. Intensive pressure on staff to achieve the target, bullying, and loss of morale were the negative ways in which the target worked. Staff in this study have also observed that quality of patient care may be at risk in other parts of the hospital, where the rapid flow and churn of patients has been heightened. Money has been spent to achieve the target, an important cost that has invariably come from somewhere else in the organisations that were studied.

The target also worked to foster gaming behaviour despite change in the way things were done in the hospital and despite more resources. In addition, efforts to achieve the target have largely
focused on the hospital and the flows of patients through it, and not at the rising demand for ED care. Therefore, the findings from this study show that the target did not work to address key problems in provision of acute primary care services, or chronic care management.

In conclusion, the 6 hour ED time target has worked to unblock the flow of acute patients through the ED and hospital. But it has also worked in ways that may be short-lived without further address of the relationships and behaviours of medical staff in the hospital and without greater attention to the problems and solutions of rising demand for acute care and ED service.
AN INVITATION TO PARTICIPATE IN RESEARCH

Implementing performance improvement in New Zealand Emergency Departments: The six hour time target policy

Dear Colleague

- It is my pleasure to invite you to participate in this qualitative research concerning the implementation of the 6 hour Emergency Department (ED) time target policy in New Zealand. I am Linda Chalmers, a registered nurse and PhD student in health policy with the School of Population Health, University of Auckland. This research project fulfils part of this doctoral degree.
- The research aims to investigate the process of policy implementation in 4 of New Zealand’s EDs and hospitals from the point of view of the clinicians and managers directly affected by the target and involved with its achievement. Knowledge of this policy’s implementation will inform current and future health policy and health service management practice.
- Approximately 10 participants from the ED and wider hospital will be selected at each of four different DHB case study sites, to undertake two rounds of face to face interviews with myself, the first round occurring in early 2011 (in February for this DHB participants) and for some of these participants again in mid 2012.
- This qualitative research is also part of a larger multiple stream national research project investigating the overall impact of the ED time target policy in New Zealand, that is a collaborative undertaking between the University of Auckland and the Adult Emergency Medicine Research Department, Auckland DHB.
- Should you wish to have further information regarding the research, and consider participation in the qualitative interviews, please email the Co-principal Investigator Linda Chalmers - l.chalmers@auckland.ac.nz
- This study has received ethical approval from the Multi-region Ethics Committee on 04/09/10 for 3 years, ethics reference number MEC 10/06/060.
PARTICIPANT INFORMATION SHEET
(CLINICIANS & MANAGERS)

PROJECT TITLE: Implementing performance improvement in New Zealand Emergency Departments: the six hour time target policy

NAME OF RESEARCHER STREAM 3: Linda M Chalmers

Project description and invitation
You are invited to take part in this qualitative research, which aims to investigate the process of policy implementation of the 6 hour ED time target in New Zealand. This research explores how the policy was implemented in 4 of New Zealand’s EDs and hospitals. Knowledge of the impact of the policy on health care clinicians and managers both in the ED and wider hospital is critical to current and future health policy, organization, clinical and management practice. This qualitative research stream is part of a larger multiple stream and multiple case study national research project examining the impact of the ED time target policy in New Zealand. The national research project is a collaborative undertaking between the University of Auckland and the Adult ED Research Department, Auckland DHB. Taking part in this research therefore contributes not only to this particular stream but also to the overall national project and the insights it will provide for our health care system and services in achieving quality in ED and acute health care.

Stream 3 Researcher & Co-Principal Investigator Introduction
I am Linda Chalmers, a full time Doctor of Philosophy student in the School of Population Health (SOPH), University of Auckland. I am also a Graduate Teaching Assistant in post graduate programmes in the SOPH. Prior to commencing my doctoral study in February 2010, I completed nearly 30 years of practice as a registered nurse in clinical, education and management roles. Most recently, this practice was in emergency care settings in Waikato, Otago and Waitemata DHBs, where I was known by my married name of Mrs Linda Koks. My conduct of this research stream and degree is funded for 3 years by a University of Auckland Doctoral Scholarship and post graduate student research funds. I am Co-Principal investigator in the larger national project which is funded by a Health Research Council, Research for NZ Health Delivery grant.

Research Project Procedures
Voluntary participation in this research project is sought from both clinicians and managers in the ED and wider hospital, across all levels of the health care organization, who have relevant experience of acute care service delivery both prior and subsequent to the policy’s implementation.

- Approximately 10 participants will be selected, based on the criterion noted above, to participate in two rounds of face to face interviews with myself, with the first round scheduled for early 2011 and the second in mid 2012.
- Based on a national site visit plan, interviews will be conducted in a place and at a time of convenience deemed appropriate by the individual participant.
Interviews may therefore be conducted either inside or outside of your workplace or work time, and where interviews are outside of your workplace you will be reimbursed for the reasonable cost of travel to and from that outside venue.

Informed consent will be obtained from participants prior to the conduct of interviews (see the informed consent document).

Interviews of approximately 45-60 minutes duration will follow a semi-structured format (see the interview schedule) and will be digitally voice recorded (DVR) and later transcribed to written form.

Interviews will be transcribed by an administrator who has completed a confidentiality agreement with the researcher and national project research group.

Interviews will be supplemented with the collection of relevant policy implementation documents from individual participants, for example, policy, memoranda, plans and guidelines as they directly relate to the implementation of the policy in their health care organization.

Participants will be invited to check their interview transcripts prior to analysis.

**Anonymity/Confidentiality/Right to withdraw**

Whilst the name of your DHB will be anonymised for reports, profiles of the sites in those reports may reduce that anonymity. However, no material that could personally identify individual participants will be used in any reports on this study. You have the right to participate voluntarily, to give informed consent, and to withdraw from the study at any time without explanation. Participants also have the right to withdraw their interview or document data at any time up to two weeks following invitation to review their interview transcripts.

**Data storage/retention/destruction/future use**

DVRs, transcribed interview documents and collected policy documents will be securely stored in a locked cabinet on SOPH premises throughout the conduct of the study. Electronic data will be stored on a password protected computer on SOPH premises. Consent forms will also be securely stored separate to other research data on SOPH premises. Access to the data in any form will be limited to the researcher, transcriptionist and research supervisors for the purposes of the study.

At the completion of the study, research data will be securely stored for 10 years and consent forms for a period of 6 years, after which they will be destroyed.

**DHB and Participant Report Back**

At the completion of the study stream a summary of research findings will be provided to each participant. Other forms of research findings dissemination and feedback into the health sector are anticipated including DHB and national forum and conferences.

**Contact Details and Approval**

Please contact Linda Chalmers directly by email if you wish to take part in this study.

- Stream 3 Researcher & Co-Principal Investigator: Linda Chalmers, PhD Student, Health Systems Section, SOPH, University of Auckland, Private Bag 92019, Auckland 1142. Email l.chalmers@auckland.ac.nz
- Co-principal Investigator National Research Project: Dr Peter Jones, Director of Research, Department of Emergency Medicine, Auckland City Hospital, Park Rd, Grafton, Auckland, 1023. Telephone (09) 3074949 ext 24293. Email peterj@adhb.govt.nz
- Academic Supervisor: Dr Tim Tenbensel, Senior Lecturer, Health Systems Section, SOPH, University of Auckland, Private Bag 92019, Auckland 1142. Telephone (09) 3737599 ext 89001. Email t.tenbensel@auckland.ac.nz

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organization.

This study has received ethical approval from the Multi-region Ethics Committee, 04/09/10 for 3 years, ethics reference number MEC 10/06/060.
Appendix C: Interview Schedule for Managers

INTERVIEW SCHEDULE
(MANAGER)

NATIONAL PROJECT TITLE: Implementing performance improvement in New Zealand Emergency Departments: the six hour time target policy

NAME OF RESEARCHER STREAM 3: Linda M Chalmers

The aim of this research stream is to understand how the ED time target was and is being implemented across New Zealand’s EDs and hospitals. To achieve this aim, front line health staff will be interviewed to identify perspectives, experiences and actions in relation to the target. Participants will be interviewed utilizing a semi-structured method based on the following questions:

1. What do you think about the target?
   - From your personal perspective
   - From your professional perspective
   - From your organisation’s perspective

2. Based on your experience prior to the target’s introduction, what difference, if any, has the target made to your management practice?

3. Based on your experience prior to the target’s introduction, what difference, if any, has the target made to the service(s) you manage?

4. How have you enabled your service(s) to achieve the target?

5. How has/have your service(s) enabled achievement of the target?

APPROVED BY MULTI-REGION ETHICS COMMITTEE 04/09/10 FOR 3 YEARS - ETHICS REFERENCE NUMBER MEC 10/06/060.
Appendix D: Interview Schedule for Clinicians

INTERVIEW SCHEDULE (CLINICIAN)

NATIONAL PROJECT TITLE: Implementing performance improvement in New Zealand Emergency Departments: the six hour time target policy

NAME OF RESEARCHER STREAM 3: Linda M Chalmers

The aim of this research stream is to understand how the ED time target was and is being implemented across New Zealand’s EDs and hospitals. To achieve this aim, front line health staff will be interviewed to identify perspectives, experiences and actions in relation to the target. Participants will be interviewed utilizing a semi-structured method based on the following questions:

1. What do you think about the target?
   - From your personal perspective
   - From your professional perspective
   - From your organisation’s perspective

2. Based on your experience prior to the target’s introduction, what difference, if any, has the target made to your clinical practice?

3. Based on your experience prior to the target’s introduction, what difference, if any, has the target made to the service(s) you practice in?

4. How have you enabled your service(s) to achieve the target?

5. How has/have your service(s) enabled achievement of the target?

APPROVED BY MULTI-REGION ETHICS COMMITTEE 04/09/10 FOR 3 YEARS - ETHICS REFERENCE NUMBER MEC 10/06/060.
CONSENT FORM  
(CLINICIAN & MANAGER)

NATIONAL PROJECT TITLE: Implementing performance improvement in New Zealand Emergency Departments: the six hour time target policy

NAME OF RESEARCHER STREAM 3: Linda M Chalmers

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to take part in this research
- I understand that I am free to withdraw participation at any time, and to withdraw any data traceable to me up to two weeks after receiving an invitation to review my interview transcript
- I agree / do not agree to be digitally recorded
- I wish / do not wish to receive a copy of my transcript
- I wish / do not wish to receive the summary of findings
- I understand that a third party who has signed a confidentiality agreement will transcribe the digital recordings.
- I understand that data will be kept for 10 years, after which they will be destroyed.

Participant Name ____________________________________________
Signature ____________________________ Date ____________________________

Project explained by______________________________
Project Role______________________________
Signature ____________________________ Date ____________________________

APPROVED BY MULTI-REGION ETHICS COMMITTEE 04/09/10 FOR 3 YEARS - ETHICS REFERENCE NUMBER MEC 10/06/060.
REFERENCES


