

A Qualitative Study of Organisational Response to National Quality Standards for 7-Day Services in English Hospitals

Elizabeth Sutton

University of Leicester

Julian Bion (✉ j.f.bion@bham.ac.uk)

University of Birmingham College of Medical and Dental Sciences <https://orcid.org/0000-0003-0344-5403>

Russell Mannion

University of Birmingham

Janet Willars

University of Leicester Department of Health Sciences

Elizabeth Shaw

University of Leicester Department of Health Sciences

Carolyn Tarrant

University of Leicester Department of Health Sciences

Research article

Keywords: Organisational culture, Healthcare quality improvement, Qualitative research

Posted Date: September 23rd, 2020

DOI: <https://doi.org/10.21203/rs.3.rs-63964/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

Version of Record: A version of this preprint was published on March 6th, 2021. See the published version at <https://doi.org/10.1186/s12913-021-06213-w>.

Abstract

Background National standards are commonly used as an improvement strategy in healthcare, but organisations may respond in diverse and sometimes negative ways to external quality demands. This paper describes how a sample of NHS hospital trusts in England responded to the introduction of national standards for 7-day service (7DS), from an organisational behaviour perspective.

Methods We conducted 43 semi-structured interviews with executive/director level and clinical staff, in eight NHS trusts that varied in size, location, and levels of specialist staffing at weekends. We explored approaches to implementing standards locally, and the impact of organisational culture and local context on organisational response.

Results Senior staff in the majority of trusts described a focus on hitting targets and achieving compliance with the standards. Compliance-based responses were associated with a hierarchical organisational culture and focus on external performance. In a minority of Trusts senior staff described mobilising commitment-based strategies. In these trusts senior staff reframed the external standards in terms of organisational values, and used co-operative strategies for achieving change. Trusts that took a commitment-based approach tended to be described as having a developmental organisational culture and a history of higher performance across the board. Audit data on 7DS showed improvement against standards for most trusts, but commitment-focused trusts were less likely to demonstrate improvements on the 7DS audit. The ability of trusts to respond to external standards was limited when they were under pressure due to a history of overall poor performance or resource limitations.

Conclusions National standards and audit for service-level improvement generate different types of response in different local settings. Approaches to driving improvement nationally need to be accompanied by tailored support for improvement that takes into account local context and organisational culture.

Background

As in many countries, the National Health Service (NHS) in England has a strong history of driving change through centralised national standards and guidelines, regulation, targets, and performance management. This approach is recognised as having some benefits, but has also been criticised for increased risk of tunnel vision and gaming in response to performance management,(1) precipitating unintended and undesirable consequences for staff and patients. Reliance on national standard setting, performance management and targets, financial incentives, and inspection has been argued to increase bureaucracy and result in a tendency towards compliance rather than commitment to change.(2, 3) Commitment has been argued to be key for achieving genuine improvements in quality within organisations:(4) commitment-based strategies for improvement are those which are based on shared values, goals and a sense of purpose, and collaborative working. In contrast, compliance-based strategies

are focused on achieving targets, depend on hierarchies, systems and standardised procedures for co-ordinating and controlling change, and are less likely to result in sustainable improvement.

Research has identified that external demands for quality can result in acquiescence or compliance-based responses, but may also generate more negative responses including avoidance, defiance and manipulation.(5) Burnett et al(6) described factors that influenced organisational response to external demands to demonstrate improvement in finance and quality measures in hospitals in Europe. Organisational responses were mainly shaped by perceived external coherence of the demands, managerial competence to align demands with an overall quality improvement strategy, and managerial stability. When these factors were in place organisations tended to work to integrate and respond to external demands in a positive way; when absent, organisations were more likely to respond with habitual or symbolic compliance decoupled from improvement efforts.

The ways in which organisations respond to external pressures for improvement is likely to be influenced by their organisational culture(7). Organisation culture is an anthropological metaphor, one of many metaphors used to inform research, consultancy and management in organisations (8). The study of organisations in cultural terms focuses on that which is shared between people within organisations, for example:

- beliefs, values, attitudes and norms of behaviour;
- routines, traditions, ceremonies and rewards;
- meanings, narratives and sense-making.

Such shared ways of thinking and behaving help define what is legitimate and acceptable within any given organisation; they are the normative glue that holds an organisation together, and in colloquial terms 'the way things are done around here'. What distinguishes one organisation from another is their shared cognitive and symbolic context and their varying pools of tacit knowledge - which organisational members understand, but are not necessarily conscious of knowing. Evidence suggests that high-performing organisations have distinct cultural features: positive norms and values, strong feelings of belonging, trust and cohesion; an 'outward facing' orientation, and flexibility to embrace change.(9, 10) In contrast, organisations that struggle to improve quality are more likely to exhibit a non-collaborative, hierarchical culture and a lack of cohesive mission and vision, and dysfunctional external relationships; but they are also more likely to be experiencing problems with resources and inadequate infrastructure, and system shocks such as senior leadership turnover, or financial failure.(10) Making change happen is particularly difficult when healthcare organisations lack organisational 'slack' – the time and resources to enable learning and creativity. The ability of organisations to improve quality is likely to be shaped by an interplay between leadership(11), organisational culture and the extent of strain on the organisation.

In this study we investigate the organisational responses of a sample of NHS hospital trusts in England (organisations that manage and deliver hospital services) to the introduction of national quality standards (7-day service standards, 7DS), which were accompanied by external monitoring. The

implementation of 7DS within the English NHS arose from concern about increased patient mortality following weekend hospital admission(12). Political pressure resulted in the development of ten clinical standards, with four identified as priorities for improving patient outcomes: time to first consultant review; access to consultant-directed testing; access to consultant directed interventions; and ongoing consultant review of patients high dependency needs(13, 14). Implementing 7DS requires significant structural changes that carry with them resource implications. These include, for example, altering staffing patterns, extending services and ultimately making changes to established ways of working. The extent to which trusts are meeting 7DS is currently measured by self-report against a standardised framework(13).

The implementation of national 7DS in the NHS in England provides a valuable case study through which to study organisational responses to external demands for quality implemented through national standards and monitoring. We aim to explore how organisations responded to standards and targets specifically from an organisation behaviour perspective.

Methods

The study is part of the High-intensity Specialist Led Acute Care (HiSLAC) project, which evaluated weekend care for acute medical patients, with a particular focus on care quality and specialist (consultant) staffing (15). We selected eight NHS hospital Trusts in England for an in-depth study of the factors influencing the response to 7DS standards. Trusts were sampled for diversity in weekend specialist intensity(16), size and location.

To assess trust achievement against the four prioritised national standards for 7DS we reviewed trust level data from the national audits of 7DS,(17) (Table 1).

[Table 1 here]

To study organisational response, and characterise local context and organisational culture, we conducted semi-structured interviews with members of the senior management team, and frontline staff in each trust. We also accessed national reports on care quality and financial performance for each trust (Care Quality Commission reports), to provide contextual information.

We purposively sampled five to six members of staff in each trust to participate in semi-structured interviews. Staff were sampled to cover a range of roles including board members, and frontline clinical and non-clinical staff involved in implementation of 7DS. The interview topic guide (Additional file 1) used the Competing Values Framework (CVF), a validated model of organisational culture, (18, 19) to stimulate discussion and reflection. The CVF uses two main dimensions; the first describes how internal processes are structured within the organisation and the second describes the orientation of the organisation to the outside world. This gives rise to four distinct cultural 'types': Clan, Developmental, Hierarchical and Rational. Organisations are not simply categorised as one or other of these four types, but may have values reflective of more than one type, or may have a stronger pull to one particular quadrant. Interviewees were asked to identify the cultural type(s) from the CVF that best described the

overall culture in their organisation in relation to implementing change. They were asked to discuss their organisational culture and local context, how they had approached implementing the priority standards, and the factors impacting on their response.

Interviews were conducted between November 2017 and March 2018, face-to-face, or by telephone for the convenience of the interviewee. Interviews lasted between 30 minutes and an hour and were audio-recorded. Recordings were transcribed, anonymised, and imported into Nvivo 11 software. ES and ESh coded and analysed the data in collaboration with CT. A selection of transcripts were open-coded, then a full coding frame was developed, incorporating open codes and themes related to the CVF, and was used to code the full data set. Themes and codes were reviewed and discussed within the team. We used case summaries and cross-case narratives to interpret findings, drawing on the distinction between compliance and commitment-based responses.

Results

We conducted a total of 43 semi-structured interviews, including board level staff (medical directors, financial directors and chief medical officers), acute medical consultants, acute consultant rota co-ordinators, and senior nurses.

We distinguished between two types of organisational response to the national 7DS: a compliance-focused response which centred on accountability and demonstrating compliance with the external standards, and a commitment-focused response that involved aligning external standards with organisational goals and values to achieve change. We describe how these orientations were expressed in approaches to implementation, and identify key features of the local context that shaped the way organisations responded to the standards. Trusts' features and approaches are summarised in Table 2.

[Table 2 here]

Compliance or commitment?

Compliance oriented response

The majority of Trusts responded as might be expected, with senior leaders focused on hitting the targets laid out in the 7-day framework. We categorised five of the eight trusts as taking a predominately compliance-based approach (trusts 3, 7, 10, 12, and 17) (Table 2). Staff in these trusts described an emphasis on complying with meeting the standards.

There was a big piece of work about where everyone was against the standards as a baseline, and then, what do you need to do to get yourself up to complying with standards [...] what we've been monitoring since then [...] is compliance with that seven day standard (Trust 03, Board member).

Senior staff in these trusts were concerned to ensure that they performed against the standards in terms of how they would be perceived externally, and had concerns about the potential consequences of failing

to perform against these national standards.

Senior leaders tended to describe using command and control approaches to deliver against the standards, with little flexibility in how changes were to happen. In practice this meant a more top-down approach to implementing change, for example central coordination of changes to consultant rotas or the introduction of new roles for staff.

Board members in several of the trusts (notably 3, 10 and 12) regarded themselves as being innovative and open to bottom-up improvement where possible, but also argued that central control and direction was crucial in managing and implementing large scale change. In trust 10, for example, board members described being keen to support empowering staff to make improvements, but this was limited to addressing the 'low hanging fruit' of quality improvement rather than dealing with national directives.

So we want to empower people to, to develop their, what they are doing, improve [...] you know not the big systematic problems but the things that just need [fixing] (Trust 10, board member).

Top-down approaches, with formal rules and procedures, were seen as enabling control over the process of large scale change, and particularly important when the stakes were high – as in the case of 7DS where the Trust was under scrutiny.

You've got to have some control in place to be able to see how you're doing against [standards] [...] (Trust 3, board member)

There was evidence that top down approaches could drive changes forward, and the majority of trusts that leaned towards a compliance-based approach showed an improvement on the priority 7DS in terms of the national 7DS audit (Table 1). When changes were imposed, however, there was evidence that consensus and commitment among frontline staff was lacking, with the legitimacy of the standards being questioned.

I'm not sure that all these patients do need the reviews that are being asked for [...] That's the argument I'm getting from [staff] (Trust 7, board member).

There was also seen to be a lack of a sense of collective responsibility among the workforce around weekend working. In Trust 10, for example, there was concern expressed that senior clinical staff, being directed to take undesirable shifts, were simply passing these on to more junior consultants who found it difficult to refuse.

It is a frequent occurrence for senior consultants to ring junior consultants to say 'can you do my [...] on call for me I've got x or y, or I just can't do it'. [...] So it's not 'you scratch my back and I'll scratch yours', it's 'you're junior you'll do it'. So that is not good for morale. (Trust 10, Consultant).

There was little sense in these trusts, at board or frontline level, of engagement with the standards as a lever to make genuine improvements to the quality of service delivery. As a result the implementation of

the standards was arguably disconnected from longer term goals around improving quality.

And at the moment, unfortunately because of the way the pressures that we are all under collectively [...] we end up in a system which is more controlling. [...] It means that actually we spend our time thinking about the next month or two rather than planning for 5 years. It is not sustainable (Trust 10, board member).

Commitment oriented response

Despite the standards being mandatory, three Trusts in our sample avoided a predominantly compliance-based response (trusts 11, 16 & 18). While senior leaders recognised the need to account for their performance, their concern was not primarily about outward displays of compliance and accountability. In these organisations, senior leaders were able to find ways to align external demands with the values of their organisation and frame them in terms of their overall goals of providing high quality patient care; this helped reconcile any issues about perceived legitimacy of the standards.

So if you look at our values as an organisation so we did a piece of work on our values and expected behaviours. [...] Our values as an organisation which we've all signed up to are patient centred and safe, friendly, professional and responsive, and [...] you can definitely link wanting to improve services for patients at weekends to all of those values (Trust 11, board member)

Commitment-focused trusts were more likely to use collaborative and flexible approaches to implementation as opposed to imposing change. They were creative in their approaches to solving the problem of staffing the extended weekend service, reflecting their commitment to the spirit of the standards – providing better quality of care for patients at weekends – as opposed to demonstrating compliance with the letter of the standards. There was a concerted effort to engage frontline staff in the enterprise of improvement, and to involve them in decision-making, encouraging a perception of unity and willingness to work together to achieve weekend working.

You just need to be mindful of the way you're doing it, when you try and change the system to allow specialists to work at the weekends. So you need to sit down with the specialists and engage with them. [...] While it might take time, as I say, when you're doing it, you'll get a more positive outcome (Trust 18, Consultant).

Trust 16 also described using social strategies such as peer pressure to encourage recalcitrant staff to take on new ways of working, rather than imposing diktats from above.

We had a meeting of all the medical specialties where we got the [clinical directors] to talk about their 7 day service implementation. [...] The way it was presented was a very proud [clinical director] saying 'look what we've done'. [...] And within the space of about an hour those that had any ambivalence about it had actually changed their mind about it (Trust 16, board member)

Of fundamental importance to progressing change was a show of investment and reciprocal commitment from the Trust board towards consultants who were being asked to change the way they worked. In Trust 16, part of the implementation of 7DS was a trust-wide commitment to guaranteeing staff time off in lieu in the week to compensate for weekend working.

The scoring of these three trusts on the national audit was varied (Table 1). Trust 11 demonstrated improvements against the standards over the time period; for trusts 16 and 18 there was clear evidence from the qualitative research that they had engaged positively and creatively with the standards and were working to achieve genuine improvements, but this was not reflected in their data on the national audit. Trust 18's performance against the standard of time to first consultant review remained low.

Commitment or compliance orientation: the impact of organisational culture, context and performance

How trusts approached responding to the 7DS was shaped by organisational culture and local context (Table 2).

Staff described how both the orientation towards external standards, and the approach taken in implementing them, reflected the prevailing organisational culture. In trusts that took a compliance-based approach, interviewees identified the organisational culture as primarily hierarchical (characterised by top-down leadership approaches and structured around policies and rules), in some cases with features of clan culture (bonded by loyalty and emphasising tradition). Staff were used to responding to directives 'from the top', and felt they had little involvement or empowerment to shape organisational change.

You're just waiting, so some person in a [senior] position to then say 'OK, we want to do that' and then you work towards that. So obviously that is a consequence of having this kind of culture. (Trust 12, Consultant).

In trust 7, organisational instability played into the approach to implementing standards, and was argued to have necessitated a strongly 'top-down' approach to change in order to ensure compliance with the standards. There had been a recent merger between two different hospitals, and there was strong resistance to changing ways of working in one of these hospitals which was considered more 'clan' like and community-focused than the other. The resistance to changing their ways of working was such that it required a senior executive to mandate that the change should occur.

In one of the areas [...] they all said 'No, we're not doing it that way and we want to do it our way'. It required me to go in and say to them why they couldn't do what they wanted to do. (Trust 7, board member).

In contrast, in two of the trusts which took a commitment-based approach (16 & 18), organisational culture was identified by senior leaders and frontline staff predominantly as developmental. In these trusts, leaders characterised their organisations as innovative, creative, and adaptive. They described how their prevailing culture enabled them to reframe the standards in relation to their own priorities, and to resist being tied to external judgements of quality.

I think the way that we approached it was to completely ignore the political rhetoric [...] I think there is something about a kind of culture in people taking on what they see to be a good thing, participating in that (Trust 16, Board member).

One commitment-focused trust appeared to be an exception in terms of how they described their organisational culture and its relationship to implementing 7DS. Trust 11 senior leaders described a predominantly commitment leadership style, emphasising their shared vision of improving patient care and their organisational values. However, unlike the other Trusts with a commitment orientation, frontline staff in this organisation identified the organisational culture as hierarchical and clan-like (Table 2). This discrepancy can be explained in relation to the Trust's location, size and nature of its workforce. Trust 11 was a small district hospital with long-serving, loyal staff. Shared, cohesive values of frontline staff, along with a stable senior leadership team, meant it was easier for senior leaders to obtain endorsement from front line staff in order to implement the required changes.

Response to 7DS was also strongly shaped by the trusts' overall history of performance against quality standards, their financial position, and the resource limitations within their local context. Notably, trusts 16 and 18, which described resisting a compliance-based approach, were operating at a surplus and were rated as 'Good' in the most recent Care Quality Commission inspection (Table 2). As such the senior leaders in these trusts did not feel under scrutiny or pressure to demonstrate compliance with external targets.

The questions we ask ourselves [...] would the patient have got better care if they were seen over the weekend or out of hours, or whatever you want to define as seven day service. [...] We fill the framework [for 7DS reporting] when we have to, and ignore it if we can get away with ignoring it (Trust 18, board member).

In contrast, in those Trusts that were already dealing with a legacy of poor performance, senior leaders felt pressure to deliver against 7DS standards, but struggled to engage meaningfully in efforts to improve weekend working as they were already under strain from being placed in special measures. This drove a compliance-based approach to meeting targets, but some leaders acknowledged that directing resources towards the 7-day services agenda was not a priority in the face of other more pressing quality issues.

We, tend to be focussed on results, delivering these results [...] But seven day working [...] t's been subsumed, whilst - you're under more immediate actions to resolve those issues that you're addressing [being in special measures]. (Trust 17, Board member).

For Trust 17, the difficulties faced by being in special measures were compounded by their isolation from other providers, which made it difficult to collaborate with others to deliver improved weekend services, alongside their longstanding difficulties in recruiting and retaining staff.

Discussion

Our study highlights that a national, service-level, improvement initiative delivered through standards, targets and performance management, generated differential responses across organisations. Commitment-focused trusts aligned standards with organisational goals, and focused on producing consensus to drive change, along with using creative and flexible solutions. Trusts that orientated towards a commitment-based approach were more likely to be described by staff as having a predominantly developmental organisational culture. Senior leaders in these trusts facilitated a shared sense of purpose in improving the quality of care for patients around the clock, and resisted focusing on external accountability. Notably, trusts exhibiting a commitment-based response were more likely to have a history of higher performance, greater organisational capacity, fewer infrastructure challenges, and favourable financial circumstances, which allowed them greater flexibility. These trusts did not, however, consistently show improvement against 7DS national audit data, perhaps reflecting their prioritisation of values-based change over external displays of compliance.

A more common response to these externally imposed standards was a compliance-based response. This response was displayed by trusts which were seen as having a hierarchical organisational culture, in which top-down directives were used to drive changes to service organisation and delivery. Organisations that displayed compliance-based strategies were generally able to demonstrate improvements against the standards for 7DS, but this approach prioritised meeting the standards over improving quality of care, and could result in dissatisfied and disenfranchised staff. For a minority of these trusts, a severe lack of resources, and a pressing need to improve basic service quality were barriers to engaging with delivering against the 7DS agenda. These organisations at best, tried to demonstrate a level of compliance, and at worst, felt unable to respond to these additional demands given the other pressing challenges they were dealing with.

The link between organisational culture and improvement approach is not unexpected – the labels applied to cultural types relate to the ‘usual way of doing things round here’. The two trusts that were described as having a developmental culture, were also described by staff as having ways of doing things that were creative and flexible, and as working around common values and goals. This was seen as enabling them to resist the potential negative consequences of external performance management approaches to service-level improvement. Perhaps more importantly though, these two trusts had a history of high performance and a financial surplus, meaning that senior leaders were less concerned about having to demonstrate improvement. Previous success meant they felt they would be under less scrutiny and had more leeway to do things their own way. As Burnett et al observe, leaders are most concerned with delivering the quality demands that affect the reputation or the funding of the hospital. When these targets are met, organisations can procure additional funds for quality improvement thus creating a virtuous circle leaving those without the ability to draw on these funds at an even greater disadvantage.(6)

This study makes a novel contribution by taking an organisational behaviour perspective to understand responses at organisational level, to nationally imposed standards and targets. Regulatory and performance management approaches are likely to remain part of the strategy for improving healthcare

in the future, particularly in centralised systems like the NHS in England. These approaches are likely to continue to be important in relation to the implementation of new policy, or to reduce unwanted variation and inconsistencies in the quality and delivery of services. Our study suggests that some organisations, particularly those that are innovative, forward-looking, and well-resourced, may respond well to externally-imposed standards by using them as a springboard for commitment-based change. Perversely this may not be reflected in external audit data. For the majority of organisations, the imposition of standards and monitoring is likely to generate compliance-based approaches which may result in the desired changes on indicator measures, but may be limited in terms of embedding sustainable improvement. For struggling organisations, additional requirements to meet performance standards may be unrealistic and introduce additional strain.

The NHS 7DS agenda was rolled out primarily through a national programme of standards and monitoring, employed with the aim of improving the delivery of weekend care to a standard level of performance across all local NHS trusts. This blanket approach had variable impact in the trusts we studied. Our findings suggest that efforts to implement large-scale change across organisations should be supported by a balance of different methods, including more attention on proactive support for change.(18) Our findings underline the importance of contextually-sensitive approaches to driving improvement that reflect the extent to which organisations are under strain, and the resources available to them. For example, stretch targets might motivate high performing and well-funded organisations to innovate, while approaches such as reciprocal peer review(19), and targeted funding (e.g. for additional staff in new roles to enable change), might be more effective in helping struggling organisations improve. Our findings also suggest the need for external verification of improvement in response to standards, to provide a more nuanced assessment of levels of engagement with genuine improvement.

This study has limitations. The study was conducted in NHS trusts in England; research in other types of healthcare systems may identify different dynamics. We interviewed a small sample of staff in each trust; perceptions of organisational culture were summarised to give an overall assessment, and we did not aim to capture subcultures within the organisation(20). The assessment of how well trusts were meeting the 7DS was based on published self-reported data on adherence to standards gathered as part of the national audit. We used the 7DS as a case study to investigate response of English NHS trusts to national standards, but acknowledge that evidence is lacking about whether in fact implementation of these standards can reduce mortality for patients admitted at weekends.(21) Our sample included only eight trusts, but these were selected to reflect a range with different specialist intensity at weekends, location and size. We were also able to recruit staff with different roles to provide a variety of perspectives within each organisation. This relatively small qualitative study has generated hypothesis about the relationship between culture, local context, and organisational response to performance-management approaches to driving improvements in service delivery. More research is needed to explore the relationships between these factors: a larger quantitative study of response to 7DS including assessments of organisational culture and local context, and independent assessments of improvement, would be of value.

Conclusion

Our findings show how national standards for service level improvement and audit can generate different types of response in different local settings. Externally-driven standards can be integrated into value-led organisational change strategies when organisations have a supportive culture and capacity for change; but may generate a tokenistic, compliance-based response when organisational culture and local context are less facilitative. Approaches to driving improvement nationally need to be accompanied by tailored support for improvement that takes into account organisational differences.

List Of Abbreviations

7DS: 7-day service standards

CVF: Competing Values Framework

HiSLAC High intensity specialist led care

NHS: National Health Service

Declarations

Ethics approval and consent to participate

The project received ethics approval from the South West Wales Research Ethics Committee: Reference 13/WA/0372. Written informed consent was obtained from each participant prior to interview.

Consent for publication

All participants provided written consent to anonymised quotations being used in reports and publications for the study.

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The study was funded by the NIHR's HS&DR Programme, grant no 12/128/17. This article presents independent research funded by the National Institute for Health Research (NIHR). CT is supported by the

NIHR Applied Research Collaboration East Midlands (ARC EM). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care. The NIHR did not have any involvement in the design of the study, in collection, analysis, interpretation of data, or in writing the manuscript.

Authors' contributions

CT devised and led on the qualitative research design, analysis and writing of the article. JB was the Principal Investigator for the overall project and contributed to drafting the article. RM was involved in analysis and drafting of the article. JW and ESu conducted interviews, JW, ESu and ESh contributed to analysis. All authors read and approved the final manuscript.

Acknowledgements

We thank participating NHS organisations and staff, and the wider HiSLAC study collaborators group.

References

1. Mannion R, Braithwaite J. Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service. *Internal Medicine Journal*. 2012;42(5):569–74.
2. From compliance to commitment: should the NHS look to the Danish on how to accelerate change and improvement? [Internet]. The Health Foundation. [cited 2019 Jul 15]. Available from: <https://www.health.org.uk/blogs/from-compliance-to-commitment-should-the-nhs-look-to-the-danish-on-how-to-accelerate-change-and-improvement>
3. Brewster L, Tarrant C, Dixon-Woods M. Qualitative study of views and experiences of performance management for healthcare-associated infections. *Journal of Hospital Infection*. 2016 Sep 1;94(1):41–7.
4. Bevan H. NHS targets: from compliance to commitment. *Health Service Journal* [Internet]. 2010 [cited 2019 Sep 17]; Available from: <https://www.hsj.co.uk/the-nhs-change-agent/nhs-targets-from-compliance-to-commitment/5015859.article>
5. Oliver C. Strategic responses to institutional processes. *AMR*. 1991 Jan 1;16(1):145–79.
6. Burnett S, Mendel P, Nunes F, Wiig S, van den Bovenkamp H, Karlun A, et al. Using institutional theory to analyse hospital responses to external demands for finance and quality in five European countries. *J Health Serv Res Policy*. 2016 Apr 1;21(2):109–17.
7. Mannion R, Davies H, Marshall M. *Cultures For Performance In Health Care*. McGraw-Hill Education (UK); 2004. 319 p.
8. Dickinson H, Mannion R. *The Reform of Health Care: Shaping, Adapting and Resisting Policy Developments*. Springer; 2011. 256 p.

9. Braithwaite J, Herkes J, Ludlow K, Testa L, Lamprell G. Association between organisational and workplace cultures, and patient outcomes: systematic review. *BMJ Open*. 2017 Nov 1;7(11):e017708.
10. Vaughn VM, Saint S, Krein SL, Forman JH, Meddings J, Ameling J, et al. Characteristics of healthcare organisations struggling to improve quality: results from a systematic review of qualitative studies. *BMJ Qual Saf*. 2019 Jan 1;28(1):74–84.
11. Fulop NJ, Ramsay AIG. How organisations contribute to improving the quality of healthcare. *BMJ* [Internet]. 2019 May 2 [cited 2020 Aug 5];365. Available from: <https://www.bmj.com/content/365/bmj.l1773>
12. Freemantle N, Ray D, McNulty D, Rosser D, Bennett S, Keogh BE, et al. Increased mortality associated with weekend hospital admission: a case for expanded seven day services? *BMJ*. 2015 Sep 5;351:h4596.
13. NHS England. NHS England » Seven Day Services Clinical Standards [Internet]. 2017 Sep [cited 2019 Apr 2]. Report No.: 06408. Available from: <https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/>
14. Seven Day Consultant Present Care [Internet]. Academy of Medical Royal Colleges. 2012 [cited 2019 Nov 6]. Available from: <https://www.aomrc.org.uk/reports-guidance/seven-day-consultant-present-care-1212/>
15. University of Birmingham, Academy of Medical Royal Colleges. HiSLAC [Internet]. 2019 [cited 2019 May 2]. Available from: <https://www.hislac.org/>
16. Aldridge C, Bion J, Boyal A, Chen Y-F, Clancy M, Evans T, et al. Weekend specialist intensity and admission mortality in acute hospital trusts in England: a cross-sectional study. *The Lancet*. 2016 Jul 9;388(10040):178–86.
17. NHS England. NHS England » Survey results for individual trust performance for 7 day hospital services [Internet]. [cited 2019 Feb 4]. Available from: <https://www.england.nhs.uk/publication/survey-results-for-individual-trust-performance-for-7-day-hospital-services/>
18. Allcock C, Dormon F, Taunt R, Dixon J. Constructive comfort: accelerating change in the NHS. The Health Foundation. 2015;40.
19. Reciprocal peer review for quality improvement: an ethnographic case study of the Improving Lung Cancer Outcomes Project | *BMJ Quality & Safety* [Internet]. [cited 2020 Aug 5]. Available from: <https://qualitysafety.bmj.com/content/21/12/1034.short>
20. Mannion R, Davies H. Understanding organisational culture for healthcare quality improvement. *BMJ*. 2018 Nov 28;363:k4907.
21. Underwood C, Sutton M, Meacock R. Association between elevated weekend mortality and the seven-day hospital services programme in England: A retrospective longitudinal study. *Health Policy*. 2019 Nov 1;123(11):1042–8.

Tables

Due to technical limitations, table 1 is only available as a download in the Supplemental Files section.

Table 2: Trust context and culture

TRUST	NOTABLE FEATURES	ORGANISATIONAL CULTURE	FINANCIAL POSITION 2017-18	CQC QUALITY 2017-18	ORGANISATIONAL STRATEGY
03	District general hospital in an urban location. 50% shortfall in consultant staffing in A&E and reliance on bank/agency staffing in AMU in particular. Well networked to other services in the locality.	Hierarchical	Reduced financial deficit but still had large deficit of over £20 million	Requires Improvement	This organisation focused on complying with the standards. Policies, processes and protocols were important in this hospital. They had implemented some changes by the introduction of more acute care physicians but there was the sense that more consultants were needed in order to deliver.
07	Teaching hospital in an urban location in a deprived area. History of organisational turbulence as two separate organisations merged into one Trust a few years prior to fieldwork. Staff recruitment an issue in this Trust.	Hierarchical / clan	Agreed to deliver a deficit of no more than £35 million in 2018/19	Requires Improvement	Focus on compliance with standards. A merger between two different hospitals had led to a more hierarchical approach in order to effect change. Over the past few years they had focused on recruiting new staff for the emergency pathway but were still exploring how staff could work differently.
10	One hospital in a group of 3 in a relatively affluent urban area. Good links with other services in the locality. Recent change of board leadership; consultant body described as 'the old	Hierarchical / clan	Had met their control total	Good	Focus on compliance with standards, use of audit to monitor. The hospital was reported to be hierarchical and reactive in implementing new policies and structures. The consultant body was reported to be 'clannish'. Management were

	fashioned firm structure’.				still working out where the gaps were in 7 day service targets. Changes to the consultant contract meant consultants were asked to conduct ward rounds at the weekend.
11	District hospital. Staff recruitment difficult. The location was felt to be a deterrent as it was an expensive area to live in. Trust was in financial special measures at the start of the fieldwork.	Hierarchical / clan	£12 million deficit against a planned deficit of £7 million	Requires improvement	Commitment-based strategies. Organisation with a community feel, with stability and loyalty. Focus was on best interests of patients. Delivery was through incremental change and collaboration.
12	Large teaching hospital and major trauma centre. Difficulties in recruiting to acute general medicine but not to specialist branches.	Hierarchical / clan	Deficit of over £8 million	Good	Focus on compliance with standards. There was seen to be a need for policies and procedures to maintain standards, and that innovations could be slow to implement and the organisation could suffer from micromanagement. New doctors were being told they would undertake acute medicine for 50% of the time and take part in the weekend rota, and contracts were short term.
16	One of three hospitals supplying acute and maternity services located in a	Developmental	In surplus by over £7 million	Good	Commitment-based strategies. The focus was seen as being on the best interests of patients. This site used

	deprived area. Good links and access to the services supplied by the other Trusts.				cooperative and collaborative strategies including peer pressure to achieve change. Management was heavily invested in achieving consensual change.
17	Hospital in a rural location. Significant problems with staffing at all levels and a high number of locum consultants; great difficulties recruiting staff. A&E in nearby location closed in the evenings adding to pressure on acute services. Isolated from other services.	Hierarchical / clan	Financial special measures	Requires Improvement	Focus was on compliance with standards. The organisation was dealing with a legacy of poor performance and trying to instil good practice. There was a tension between encouraging innovation and controlling policies and procedures. The management did not have a specific plan or programme to meet the 7 day standards but were trying to use resources efficiently and centralise. They were working hard to recruit internationally, and improve the workforce with leadership programmes and centralise job plans. Yet there was a sense of great strain in this organisation.
18	Large teaching hospital. Interviewees state that they have been meeting 7 day standards for some time. The hospital is well staffed.	Developmental / rational	In surplus by over £20 million	Good	Commitment-based strategies. This site framed changes in terms of best interests of patients. Change was being achieved through collaborative strategies including gaining consensus through

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [Table1.JPG](#)
- [AdditionalfileInterviewTopicGuide.pdf](#)