Organizational learning and project identity in a health and social care partnership

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Abstract

This developmental paper explores the idea that organizational learning in public sector settings is facilitated by localised project identities and inhibited by interventionist bureaucratic reforms. Drawing on a 7-year longitudinal study, the paper shows the organizational integration of previously separate health and social care services was predicated on the ability to cross previously rigid and impermeable institutional, professional and organizational divides. Whilst our findings suggest that organizational learning was predicated on close interaction between key personnel from two provider organizations, we also found that organizational learning was adversely affected by shifting policy priorities and by the power asymmetries that inhered in the broader institutional ecosystem of the NHS.

Introduction

The question of public sector governance has been of pressing concern to policy makers, practitioners civil society at large in recent years. Whilst the 1980s and 1990s saw a perceived decline of the welfare state, disenchantment with heavily bureaucratised public sector organizations and the rise of the new public management (Pollitt and Bourkhart 2011, 2017; Clegg et al 2011) collective experience of the 2020 pandemic has seen a revalidation of the bureau-professionalised 'expert state' (Phan and Wood 2020; Reed 1996). Those responsible for the governance of public sector organizations have not, however, seen a return to 'business as usual'. To the contrary, a renewed emphasis on collaborative partnerships, project working (Sjöblom et al.2013) and joint ventures between private and public sector bodies has frequently given rise to complex hybrids and/or unstable dualisms (Skelcher and Smith 2015; 2017). Whilst there is some evidence that collaborative projects offer fertile seedbeds for learning and knowledge exchange, some studies have found that this learning is rarely diffused in a 'systems-wide' manner across the organization as a whole (Scarbrough et al. 2004a; 2004b). These aspects are of particular relevance for the UK health and social care system. Here, innovation and learning has been heavily constrained by the broader policy or institutional environment of the NHS (Currie and Suhomlinova 2006; Paton 2016). Whilst some studies have identified middle management as a pivotal group that can mediate between senior managers and front line staff (see for example Burgess et al. 2015), there is a general lack of high quality evidence on how disparate actors (for example middle managers, senior managers supervisory grade managers or care commissioners) might collaborate in health or social care settings, and even less evidence on how relations between different participant groups might develop over time. It is with these research gaps in mind that the current paper presents findings from a seven-year longitudinal study that shows how project-based collaboration and created the preconditions for a 'systems wide' changes and a

joint venture whose purpose was first to exchange useful knowledge between partner organizations, and then to institutionalise this in the form of shared knowledge assets.

Methodology

All the interviewees organizations cited in this paper have been anonymised. A total of 70 interviews conducted with selected personnel from 'CareCom' (a local Community Care Provider), and 'Mid-County Adult Social Care services'. In April 2013 senior executives from both of these organizations participated in a project steering committee whose purpose was to improve services for vulnerable patient groups, particularly those who had been identified by risk assessments conducted by the local NHS Clinical Commissioning Group (CCG) as 'frail' and/or 'elderly'.

Case study analysis

The initial impetus for the mid-County 'frailty project' came from health care commissioners who responded to an *NHS England* initiative that sought to develop more integrated health and social care 'pathways' for the most vulnerable patient groups. The qualitative data gathered by the original study corroborates the idea that public sector innovation projects are strongly influenced of antecedent context (Crossan and Berdrow 2003; Neilsen et al 2018 Engwall 2003; Lindgren and Packendorff 2009; Brunet et al. 2021). The protracted timescales involved in developing fully integrated care services contrasts strongly with the assumption that the integration of historically segmented care services can simply be realised through sudden and discontinuous organizational change programmes (du Gay 2003). In phase I of the project (lasting approximately 18 months from early 2013 until mid-2014), managerial attention was focused on highly formalised commissioning procedures and risk assessment measures and not on exploring the specific ways in which localised knowledge exchanges might provide broader 'systems level' benefits. The learning we observed in this phase was highly compartmentalised and limited to the exchange of formalised knowledge. However a second phase of the project (lasting from mid-2014 to late 2015) provided a more reflective context that allowed the importation of external expertise. This period saw a significant shift in managerial attention away from formal commissioning frameworks towards a much more devolved approach that encouraged the active participation of staff who were working at, or close to the front line. While Phase II was characterised by a shift to more responsive, patient-centred mulitdisciplinary team working, the project lacked a 'social infrastructure' (Adler and Borys 1996) that would provide the requisite steering, monitoring and evaluation mechanisms that would allow 'systems wide' benefits arising from particular experiments in service innovation to be identified and replicated. The project thus incurred many of the costs associated with the exploration of new knowledge but few of the benefits associated with the exploitation of shared knowledge assets. Learning was at this point constrained by poor project coordination and by the presence of medical status hierarchies. Here our evidence corroborates the view that such hierarchies inhibit the diffusion of cross disciplinary learning at the front line (c.f. Burgess et al 2015; Dopson and Fitzgerald 2005; Ferlie et al 2005).

A third phase of the project saw a significant political reversal in 2016/17. This reversal derived from shifting policy priorities and from the highly centralised culture of compliance that pervades the UK NHS. Localised learning on new forms of best practice was halted by top down control imperatives that emanated from NHS England**.** Many of our interview respondents stated that a shift to centralised 'strategic transformation' planning halted experimentation and knowledge- sharing within the project. These respondents also cited turnover of key personnel, lack of consistency in the commissioning regime and lack of senior management support as key factors that inhibited learning and knowledge exchange. These aspects are compatible with the argument that organizational discontinuities create premature closure in in project-based learning (Scarbrough et al 2004; Engstrom et al 2007). The longitudinal data also suggests that the reassertion of top down controls provided a contextual referent point for renewed collaborative efforts in 2018 and the establishment of a joint venture in 2019. Intensified collaboration between CareCom and Mid County Social Services was instantiated not by contracting out, or by formal bureaucratic procedures but by a memorandum of understanding that formed the basis for the sharing of project-related knowledge and resources. Organizational learning and a shared project identity was creatively realized by knowledgeable individuals, but it was also 'collectively realised in that it evolved from distributed social practices' Berends and Lammers (2010:1047). The cumulative learning that we observed in the fourth phase of the project was supported by a social infrastructure that was in turn rooted in collaborative 'learning by reflection' on the part of both senior management and middle managers (c.f. Sun and Anderson 2012). Whilst the work of the new project management organization was socially constructed and assembled by a heterogenous range of actors, it was also imbued with key elements of formalisation as manifested in i) the adoption of rigorous project steering, monitoring and evaluation techniques; ii) the repeatability of tasks and iii) the continuous involvement of supervisory managers in reconfiguring key service interfaces. These attributes helped to facilitate the uptake of newly redesigned care services and their assimilation into the routines and practices of front line units.

Discussion/conclusion

Our case study findings support the proposition that organizational learning was in our case study example inhibited by highly interventionist bureaucratic reforms and facilitated by localised project identities that emerged from collaborative working in a 'temporary' project management organization. The project management organization we observed created a dialogic space that facilitated horizontal working and capacity for generating shared knowledge assets. The evidence presented sheds particular light on the long-standing question of how localised project learning may be diffused to broader organizational, institutional or sectoral contexts (Engstrom et al 2007; Berends and Lammers 2010). The project management organization that emerged in phase 4 was also underwritten by the joint actions of senior management (from both community health and social services) who claimed and demarcated a new operating jurisdiction in the local care economy. The formal measures that emerged in the final phase of the project were aimed at systemising routinizing new practices that had been instantiated on a highly localised basis (c.f. Scarbrough et al. 2004).

Whilst formalisation is often directly counterposed with deformalized local action, a more meaningful divide in our chosen empirical setting was the distinction between the 'coercive' forms bureaucracy observed in project phase 3 and the 'enabling' bureaucratic forms observed in phase 4 (Adler and Borys 1996; Lusiani and Langley 2019).

Limitations and implications for future research

Studies based on single case study research designs cannot be generalised to larger populations. Such studies can, however provide the basis for theory building and analytic generalisation (Eisenhardt 1989; Eisenhardt and Graebner 2007; Yin 2017). The rejection of formal commissioning mechanisms we observed in the second phase of the project involved senior executives in the pursuit of what Demir and Knights (2021) have termed unsanctioned practice innovations. Whilst these unsanctioned practices have to date been understood as the exclusive preserve of lower order employees, our findings show the ways in which senior executives working at unit level contested both commissioning frameworks and the top-down directives that emanated from the broader institutional ecosystem of the NHS. This suggests a broader view of service innovation in the UK health and social care system, and a more nuanced account of how senior managers may collaborate with other organizational participants as *bona fide* agents of resistance and creative organizational change.

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