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The Discursive Institutionalism of Continuity and Change: The Case of Patient Safety in Wales (2009-2010).

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The Discursive Institutionalism of Continuity and Change: The Case of Patient Safety in Wales (2009-2010).

TITLE: The Discursive Institutionalism of Continuity and Change: The Case of Patient Safety in Wales (2009-2010).

SUMMARY: Although public actors bring about institutional change through public action, the related ideas and discourse that seek to promote change may equally have little or no effect on existing institutions. Patient Safety provides a large scale (ie. world-wide) example of just such a paradox. On the one hand Patient Safety has become a readily definable institution within its own right in the field of healthcare. But on the other hand the promised benefits of improved quality of care (improved performance), as measured by reduced 'avoidable harm' (a reified construct that lacks an agreed empirical base but is heavily weighted with meaning and emotion), have failed to materialise and pre-existing institutional practices are largely unchanged. Drawing on Discursive Institutionalism (DI) this paper uses the case of Patient Safety in Wales (2009-2010) to show empirically how, when, where, and why ideas and discourse matter for institutional change, and when they do not.

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INTRODUCTION

Institutions constrain agency driven change. The 'institutional rules', and the legitimised beliefs and values, limit perceived choices and possible courses of action. The actions of agents, and the subsequent organizing, are expected to conform to the norm. Actors, in turn, reinforce institutional inertia by abiding by these same rules, beliefs and values, and by ensuring they are upheld. This ensures the continuity of the institution and related institutional behaviours and perceived outcomes. The benefit accrued is one of continuity and thereby a degree of certainty and assumed predictability (a sense of 'knowing' about doing as opposed to not knowing what 'we' are doing). For change to occur at an institutional level the legitimised rules, including the beliefs and values, the accepted practices, and so on, must change. This sort of change can occur in two simple forms: either the existing institution must change, or a new institution must emerge and challenge existing institutionalised behaviour.

Schmidt (2008; 2010) comprehensively articulates Discursive Institutionalism (DI) and provides a dynamic view of institutional change. The focus is on the interactive processes involved in discourse and the role of ideas (cognitive and normative) in a 'meaning context'. That is, ideas and meanings are important parts of discourse as is the way in which these ideas and meanings are communicated. Discourse, here, is considered as both text (what is said) and context (where, when, how, and why it was said), structure (what is said, or where and how) and agency (who said what to whom). DI considers institutions to be both as context (within which agents speak, think, and act) and as contingent (a result of agents' thoughts, words, and actions). Thus institutions are both actors' internalised structures and constraints and constructs created and changed by the same actors. Agents create and maintain institutions by making sense in meaning context. That is, agents abide by the ideational rules or assumed norms of the setting. However, agents are able to think, speak and act outside of their institutions while they are inside them. They can deliberate about institutional rules while they are using them, and persuade one another to change or maintain the institutions. Thus actors can effect institutional change from within the constraints of the institution by holding a duality of location and utilizing a duality of discourse through the use of ideas and meanings. Actors can hereby create a situation where the institution is in a state of dramatic flux which appears very much like inertia. Institutional change – ie. a break from inertia that results in either an observable change to the institution or a new institution - occurs when the flux escapes the constraints and 'new' ideas and meanings take root.

One of the difficulties with using discourse is the variety of meanings, interpretations, philosophical groundings, and ontological and epistemological standpoints (e.g. see Halkier, 2003). Schmidts' approach owes much to Critical Realism and has similarities with Fairclough's (1992; 1997; 2005) treatise on Critical Discourse Analysis. A distinction is that Fairclough was considering discourse at the organizational level, and noted a distinction between organizational structures and agents rather than a co-creation of the paradox of simultaneous institutional continuity and change. However, both approaches, that of Schmidt and Fairclough, have similar questions albeit at different levels. Fairclough pays attention to the structure of language, the linguistic attributes, and includes this as important in the analyses. Schmidt, on the other hand, is more concerned with words, ideas, meanings and context, which is more suited to analyses on a larger scale across organizations and of institutions. Halkier (2003), contrasted different theoretical frameworks of discourse analysis and provided a model methodology for discourse analysis in relation to institutionalism and public policy. This methodology is arguably closer to that of Schmidt than Fairclough. What

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all three of these authors have in common is an acceptance of Critical Realism as a guiding philosophy and the use of discourse analysis to explicate the generative mechanisms as represented by the discourse (including language as a generative mechanism in its own right (see Thomas, Sargent, and Hardy, 2011 for example)).

Discourse analysis, and Discursive Institutionalism, provides us with a way of exploring and explaining: the generative mechanisms that built, continue to build, and maintain the institution; the changes that have occurred as a result of the institutionalization of Patient Safety; and the continuity of pre-existing practice as well as the development of new practice even though there is no strong, concrete, evidence of the intended level of improvement in performance.

This paper considers an example of institutional change that resulted in the creation of a novel institution within the field of Healthcare; Patient Safety. However, despite the creation of an institution, there is a continuing discourse within healthcare that laments the lack of progress in terms of achieving better quality of care and in reducing the reified construct of avoidable harm. Avoidable harm is seen as a concrete measure of quality of care, with the actual measure constructed as 'errors' or 'incidents' reported to governmental agencies, which is effectively a form of regulation. This lack of progress is also recognised by the continuing 'catastrophic failures' in healthcare as reported by the media (For example, the recent failings of Mid Staffordshire in the UK). In addition, new organizations, such as the error reporting agencies, have emerged, and other organizations have been strengthened (e.g. the Institution for Healthcare Improvement), that serve as bastions of the institution (they are organizational agents), and promote and reinforce the core understandings and practices. Thus we see organizational carriers of the institutional discourse as well as individual agents.

The focus of this paper is a national case study (of Patient Safety in Wales for 2009-2010) that allows for inter-organizational comparisons of discourse in the context of a larger Wales-wide, and ultimately world-wide, discourse promulgated by a new institution which emerged from a pre-existing discourse. There is an attempt to address the problems of emergence, hegemony, and recontextualization, at the organizational level with reference to the institution.

The contribution made by this paper is: a) theoretical; the extension of DI to a new setting with an expanded understanding of the construct; and b) methodological; the use of discourse analysis to identify contextualised ideas and meanings that reflect institutional hegemony.

METHODOLOGY

This paper utilises two data sets both set in the context of the institution of Patient Safety and a data set of non-participant observations. The first set is the public quarterly reports of organizations' error reporting. These are the National Patients Safety Agency (NPSA) quarterly reports for Wales. These reports show the number of errors reported, the type of error according to a small number of predetermined categories, and the amount of time it took to report the error/s. This data shows the pattern of reporting over time for each organization in relation to the median pattern for all similar organizations. The second set of data is the board papers for each organization (NHS Trusts in Wales) as made available in the public domain. These papers represent a very particular discourse in that they are a public

record of the business of the organization and are available for public scrutiny. While on the one hand we can therefore expect them to be heavily 'censored' on the other hand they provide an ongoing public account that the organization must live up to. Given that the minutes of the board meetings require approval in the following board meeting we have a documented instance of 'cultural persistence' (Zucker, 1977). Within these texts we are concerned with the discourses of Patient Safety. In addition there is a set of data based on non-participant observation and informal interviews relating to the 1000 Lives Campaign (which represents a particular organizational-agent driven discourse).

In addition, the NHS in Wales went through a period of substantial reconfiguration with 38 NHS Trusts reconfigured into seven over 2009/10. This provides a setting of considerable flux and organizational change exogenous to Patient Safety. Yet the institution was maintained.

DATA ANALYSIS

The NPSA reports provide the opportunity for simple descriptive quantitative Board papers will be analysed using key search terms with a focus on the minutes of meetings. A random selection of additional papers will be searched using the key terms and any documents with the relevant key terms will be identified and searched throughout the corpus. A thematic analysis will be used to develop and link the emergence, hegemony, and recontextualization of Patient Safety. The data from the NPSA reports, the board papers, and the non-participant observations of 1000 Lives will be triangulated to support the findings and conclusions.

EARLY FINDINGS

Early findings from a descriptive analysis of the NPSA reports indicates that in 2008/9 the number of trust reporting below the median number of errors decreased – more Trusts reported more errors and more Trusts reported closer to the median number of errors - the relative number of trusts taking longer than the median to report errors increased. That is, Trusts reported more errors but took longer to report them relative to other organizations of similar size and complexity in the UK. However, post-reconfiguration the new Welsh Trusts are compared against other Welsh Trusts only (that is, against six other Trusts in Wales). Within this reporting framework the variation in reporting is at least similar to the variation when Welsh Trusts were benchmarked against UK-wide matched Trusts. There is one exception – one of the Welsh Trusts retained autonomy of identity and function and continues to be compared to other UK-wide organizations. This Trust's reporting has retained a level of consistency.

DEVELOPMENT

Development will focus on data analysis and presentation of results as follows:

- Additional analysis of the NPSA data to include: clarification of patterns of reporting; which NHS trusts were amalgamated and what are the pre- post-reconfiguration patterns of reporting; patterns emerging in the categories of reported errors both pre- and post-reconfiguration.

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- Further description and discussion of the 1000 Lives Campaign including: non-participant observer data; and the substantive claims made by the Campaign compared to the NPSA data and the absence of supportive data in the public domain. (For example, Wales data is no longer available on the Dr. Foster's database.)

- Analysis of the Board papers to highlight the development of ideas and meanings and their role in the creation and maintenance of the institution (Patient Safety). This is set in the context of Wales as it develops a distinct identity from England in relation to Healthcare policy and the development of 'world class' Healthcare system.

- The emerging argument will focus on explaining this example of Discursive Institutionalism in relation to considerable and conflicting and varied endogenous and exogenous forces.

Note: the argument will be made for the importance of public domain documentation as exemplars of Discoursive Institutionalism and as carriers of formal – extrinsic - institutionalism and the implications of this for an agentic perspective of institutionalism.

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