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STAKEHOLDER PERSPECTIVES ON NEW WAYS OF DELIVERING UNSCHEDULED

HEALTH CARE: THE ROLE OF OWNERSHIP AND ORGANISATIONAL IDENTITY.

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Abstract

Rationale, aims and objectives: To explore stakeholder perspectives of the implementation of a new, national integrated nurse-led telephone advice and consultation service (NHS 24), comparing the views of stakeholders from different health care organisations.

Methods: Semi-structured interviews with 26 stakeholders including partner organisations located in primary and secondary unscheduled care settings (general practitioner (GP) out-of-hours co-operative; accident and emergency department; national ambulance service), members of NHS 24 and national policymakers. Attendance at key meetings, documentary review and email implementation diaries provided a contextual history of events with which interview data could be compared.

Results: The contextual history of events highlighted a fast-paced implementation process, with little time for reflection. Key areas of partner concern were increasing workload, the clinical safety of nurse triage and the lack of communication across the organisations. Concerns were most apparent within the GP out-of-hours co-operative, leading to calls for the dissolution of the partnership. Accident and emergency and ambulance service responses were more conciliatory, suggesting that such problems were to be expected within the developmental phase of a new organisation. Further exploration of these responses highlighted the sense of ownership within the GP co-operative, with GPs having both financial and philosophical ownership of the co-operative. This was not apparent within the other two partner organisations, in particular the ambulance service, which operated on a regional model very similar to that of NHS 24.

Conclusions: As the delivery of unscheduled primary health care crosses professional boundaries and locations, different organisations and professional groups must develop new ways of partnership working, developing trust and confidence in each other. The results of this study highlight, for the first time, the key importance of understanding the professional ownership and identity of individual organisations, in order to facilitate the most effective mechanisms to enable that partnership working.

Introduction

Increasing patient access to unscheduled primary health care is a recurrent theme of the UK Government's health policies (Department of Health 1997; Department of Health 2000; Scottish Executive 2000). Service developments have included walk-in centres, 48-hour access to an appropriate health care professional and 24-hour nurse-led telephone consultation, advice and health information services. These developments have necessitated new ways of working within the NHS, with nurses adopting a greater role in triage, treatment and referral decisions (Rosen & Mountford 2002; Sibbald *et al.* 2004). The establishment of nurse-led telephone consultation services has particular implications for health care delivery, as this model of care cuts across established boundaries of organisations, blurring the traditional demarcations between health care professionals and changing the nature of the patient-professional interaction (Pettinari & Jessop 2001). Thus, a greater understanding of these new organisational arrangements is required (Davies 2003).

The devolved nature of UK health care (Hunter 1979; Pollock 1999; Smith *et al.* 2004; Hopton & Heaney 1999) has led to increasing variation in service developments between the four countries of the UK. Nurse-led telephone services are no exception to this trend. In 1997, NHS Direct was established in England with the aim of providing callers with health information, advice on self-care or on the most appropriate service to contact themselves to meet their clinical need (Department of Health 1997). It was also hoped that it could reduce unnecessary demands on other NHS unscheduled care services, in particular GP out-of-hours co-operatives, accident and emergency departments and the ambulance service (NHS Executive 1998). Evaluation of NHS Direct demonstrated that its impact on these other services was minimal, with only GP co-operative activity showing a small but significant reduction in activity (Munro *et al.* 2000). This was attributed to the stand-alone nature of the NHS Direct sites, with an inadequate transfer of patient

information between the services and the superimposing of NHS Direct on existing structures of immediate care (Shekelle and Roland 1999). In other part of the UK, NHS Direct Wales was established at the same time as NHS Direct and with a broadly similar remit; no equivalent service was established in Northern Ireland. Scottish health policy chose to learn from the English experience, delaying the establishment of a nurse-led service (NHS 24) until 2002.

NHS 24 has similar aims to NHS Direct, including nurse-led consultation, advice and information and the alleviation of pressure on other NHS services (Scottish Executive 2000). However, in an attempt to avoid the stand-alone approach of NHS Direct, NHS 24 was designed to integrate with other partner organisations, namely GP out-of-hours co-operatives, accident and emergency departments and the ambulance service. By developing innovative information management and technology (IM&T) links, patient information and triage decisions elicited by the nurse could be passed from NHS 24 to the partner organisations by electronic or faxed messages. However, the success of this integrated service depended on the reliability of the IM&T links, the confidence of nurse advisors to make an appropriate triage decision without seeing the patient and the confidence of the partner organisations to accept those decisions. This partner confidence would be key to the establishment of successful working relationships.

Shared understanding of professional ethos and identity is a pre-requisite for mutual confidence between two organisations. This is particularly important if one professional body dominates an organisation. Hunter refers to this as "tribalism", reminding us that tribes have different goals and perceptions regarding effective care (Hunter 1996). New ways of delivering health care thus requires professional groups to acknowledge and respond both to their own organisational identity and to those of others. Failure to do so may lead to conflict and misunderstanding between the organisations trying to work

5

together to deliver effective health care. Again, this will be particularly relevant where different professional groups are no longer working within the same physical environment or location and where the responsibility for care is being shifted from one organisation to another. This shifting of responsibility can impact on those providing care. Several studies have shown that an unintended consequence of the movement of health care work from one professional group to another is the creation of uncertainty with regard to professional identity and a fear of losing power and autonomy to other professions (Williams & Sibbald 1999; Elston & Holloway 2001; Degeling *et al.* 2001).

With the development of nurse-led telephone triage and consultation services, health care delivery is shifting from one set of professional boundaries and organisations to another. In the nurse-led telephone services, nurses are the only providers of care whereas general practitioners are the predominant professional group in out-of-hours co-operatives. In accident and emergency departments doctors and nurses work together; in the ambulance service, there are few doctors, calls are taken by trained call handlers, then passed onto paramedics. These different structures may impact on the way in which the organisations are able to work together to achieve successful implementation.

This paper aims to explore stakeholder perspectives on the implementation of NHS 24 in its first site, comparing the views of different health care organisations, to ascertain obstacles to successful integration with partners, and to offer more general comment on why the partners shared common concerns yet responded differently. We suggest that shifting organisational identities and ownership may have had some bearing on partner responses to key concerns about workload, nurse triage and communication. This has implications for future policy and service developments.

Methods

The findings reported in this paper are part of a larger, national evaluation of the implementation of NHS 24. This work has adopted the theoretical approach of realistic evaluation (Pawson & Tilley 1997) in order to understand how the social contexts in which the service was being implemented may impact on its success or otherwise. This approach has allowed the integration of both quantitative and qualitative methodologies in order to test and explain the phenomena identified at both a national and local level.

A contextual history of the process of implementation was obtained by attending key meetings, both in the first site and at the organisation's Executive Team and Board. Key informants completed a weekly electronic diary highlighting notable events, both positive and negative. Key papers, including Board papers were reviewed to identify pertinent issues at the time and to review the response of NHS 24 to those issues. Field notes and documentation were used to monitor developments in the implementation of the organisation. Interview data could then be compared to this contextual history.

During 2002-2003, we conducted semi-structured interviews with twenty-six respondents, to understand stakeholder views on the development and implementation of NHS 24 in the first site. The interviewees were purposively selected to cover each of the partner organisations, NHS 24 itself and key area and government organisations. Respondents included five from the integrated out-of-hours co-operative (out-of-hours co-op), two from the Scottish Ambulance Service (SAS), two from the local Accident and Emergency department (A&E), ten interviews with NHS 24 employees from various levels, and seven from "interested" organisations such as the Primary Care Trusts[1], Scottish Executive Health Department and management consultants involved in the implementation and

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[1] Primary care trusts in Scotland were statutory organisations broadly equivalent to primary care groups and trusts in England, but with no power of commissioning.

development of NHS 24. Interviews were usually conducted face-to-face, lasting between forty and ninety minutes. A generic interview schedule was designed from a review of NHS Direct evaluation studies (Pearce & Rosen 2000; Mark & Shepherd 2001), issues raised during the non-participant observation of meetings and the return of e-mail implementation diaries. The interview schedule was piloted on two respondents and reviewed: the pilots were not included as part of the formal analysis. Interviews began after the service was introduced in northeast Scotland (May 2002) and continued over one year. Assurances of confidentiality were given and anonymity maintained throughout by pseudonym use.

Ethical approval was obtained from the Scottish multi-site research ethics committee and ratified by the local research ethics committee.

Analysis

Interviews were tape-recorded, with permission, transcribed verbatim and inputted into a qualitative data analysis software package (QSR NU*DIST 6). Interview transcripts were read intensively by GH and by other members of the team and emerging themes and sub-themes discussed. Analysis was iterative and informed the on-going process of interviewing. General thematic codes were identified first (e.g. employment, communication relationships, integration with partners, implementation, experience and expectations of NHS 24, organisational structure and culture). These were then broken down further into smaller sub-themes (e.g. employment was broken down into current, length, nature, and previous; experience into positive, negative and key messages) (Miles & Huberman 1994). A constant comparative approach was used whereby the codes and the transcripts were continually re-assessed and re-interpreted (Glaser & Strauss 1968). These major themes and sub-themes were then used by GH to construct a coding framework and verified by other members of the research team, who re-coded a selection

of interview transcripts. These were compared with the original coding undertaken by GH and areas of different interpretation resolved during team meetings.

Results

Data from attendance at key meetings involving the partner organisations (GP out-of-hours co-operatives, A&E and the ambulance service), return of email diaries and review of documentation allowed the construction of a contextual history of the process of implementation. This history, along with the interviews, highlighted three areas of concern: increasing workload; nurse triage; and communication difficulties. These are discussed in turn before considering the impact of organisational identity on these views.

Contextual history.

NHS 24 was rolled out across Scotland in a phased introduction, starting with one area in the northeast of Scotland in May 2002. There were three integrated partners. The first was an established GP out-of-hours co-operative with approximately 200 GP members, a population base of 350,000 and covering a mixed urban/rural setting (Thomson *et al.* 2003). This co-operative had previously undertaken its own telephone triage using GPs and offered patients home visits, centre consultations or telephone advice, depending on clinical need. In common with other out-of-hours co-operatives, it had been set up as a limited company, with all GPs sharing in its the financial ownership. The second partner was a large accident and emergency department located in an acute hospital setting; the third was the Scottish Ambulance Service, which operated from several regional call centres.

The headquarters of NHS 24 was located in the west of Scotland, approximately 150 miles from the first site, so the organisation's Executive Team was not locally based. Instead, a Service Integration Team (SIT) consisting of local NHS 24 staff and members of the

partner organisations was established. Calls to NHS 24 initially went to one call centre, located in the northeast. In November 2002, NHS 24 began operating in the west of Scotland and a second call centre, located in the west, was opened. At busy times, one call centre could handle calls on behalf of the other centre, a process known as "virtualisation". Neither of these call centres were co-located with the existing GP out-of-hours co-operatives in their area.

Over the first six months of operation, increasing tensions and difficulties between NHS 24 and the GP co-operative partnership were identified; these were less apparent in the partnerships with A&E and the ambulance service. Tensions centred on a perception of unsustainable increases in workload, inappropriate triage decisions made by NHS 24 nurses and unreliable IM&T links. This culminated at the end of the six-month period, with co-operative members voting on whether to remain in partnership with NHS 24. NHS 24 responded to this with the instigation of a Quality Improvement Plan, a document that explicitly identified and sought to address communication, information technology and clinical quality issues. Meetings with other partners indicated similar issues, with initial increases in workload, communication lapses that might have led to inappropriate admission procedures and concerns about the clinical safety of telephone triage. However, at no time did they suggest leaving the partnership with NHS 24. It is against this background that the interviews took place.

Increasing Workload

Respondents from the GP out-of-hours co-operative repeatedly highlighted concerns about initial increases in clinical activity, the time taken for patients to access and go through the NHS 24 triage process and the number of patients prioritised by NHS 24 as requiring to be seen by a GP within thirty minutes. These factors were all said to contribute to a sense of increasing workload. Some respondents did suggest that GPs now spent

less time on telephone triage, but with no concomitant decrease in shift work. This perception of increased activity immediately post-launch contributed to widespread membership dissatisfaction:

…but the membership of [out-of-hours co-operative] *became very vehement in terms of the activity levels that we were seeing as soon as the integration process started, and indeed to date (Co-op 3)*

Both the ambulance service and A&E also suffered from an initial workload increase although at the time of interview (< 7 months after implementation) this was reported to be tailing off. They accepted this as part of the organisational development of NHS 24. Opinion from the ambulance service was that NHS 24 had quickly resolved the increase in it's activity and that the service was dealing with fewer trivia calls from the public. In A&E, one respondent was "impressed" by the rapid response of the NHS 24 organisation to increasing admissions:

I was impressed by the relationship the partners built up during those first few weeks. It was a case of, the guys from NHS 24 and me initially on at least a weekly basis to start off with and then when the integrated partners, that was on a weekly basis and then luckily we've reduced down to appropriate levels considering the crisis we had at the beginning (A&E 1)

Nurse triage

The nurse-algorithm interface and respondents perceived lack of confidence in telephone triage were held partly responsible for the reported workload increase. Interviewees from all of the partner organisations viewed the computerised decision support software algorithms as rigid and mentioned the experiential component of triage. A secondary care

respondent outlined why clinicians required convincing about the robustness of the algorithms by suggesting that:

An assessment by definition is done by people who see, talk and communicate with the victim and you need to feel them, so to speak, and that is why clinicians will have a very intuitive distrust of a telephonic assessment (A&E 2).

He went on to elaborate that assessment is a "people thing" that can be facilitated by IT but not led by it. In contrast, the ambulance service respondents were sympathetic and understanding of the difficulties that nurse advisors faced in the initial move from face-to-face contact to telephone diagnosis:

There was an increase in [patient] *calls and if the nurses had seen that patient face-to-face they might not have been so ready to get an ambulance … They were over-cautious and erring on the safe side. We had to have dialogue every day. We came down every day and said this can't go on we're suffering (SAS 1).*

However, A&E consultants and ambulance service staff are more likely to have one-off contacts with patients, with previous knowledge of the patient unnecessary in dealing with that contact. This contrasted with the long-term knowledge that GPs felt they had of their patients, which clearly spilled over into the out-of-hours setting. GPs pointed to their experience of triage in the out-of-hours co-operative and suggested that knowledge of the patient aided them during the telephone consultation, especially if they felt that the patient was trying to "work" the triage to their favour.

I know when a patient phones me I set off with a certain amount of information and know a fair amount about that patient. Without that information I'm really then stuck. Some

patients can emphasise various components of their problem to make it important that you see them. (Other Co-op 3).

GPs also shared the view of the ambulance service respondent that the nurses lacked experience in dealing with the undifferentiated problems that present in primary care, leading to over cautious triage.

NHS 24 put local measures in place in an attempt to resolve these difficulties. A reciprocal arrangement was established where out-of-hours co-operative GPs began "walking the floors" in the nurse NHS 24 centre and nurse advisors spent time in the out-of-hours centre. This had important relationship gains, training benefits and increased understanding of the others organisation. Subsequently, nurses rotated into the primary care emergency centre, and triaged calls from there. However, this measure met with limited success and was stopped within several months.

Communication

Communication impacted on the organisations in two ways: day-to-day communication between organisations and call virtualisation. Both of these depended on the reliability and status of the information technology (IM&T), which at the time of the interviews, was subject to periods of downtime. This downtime impacted on the electronic transfer of patient information between the organisations, in particular the out-of-hours co-operative and was felt by GPs to impact on clinical safety. In such situations, communication reverted back to the use of fax machines and telephone calls.

Most respondents also commented on the lack of communication between NHS 24 and its partners. NHS 24 headquarters was geographically distant from the first site, leading to a perception of a stand-alone or independent service - a *"fortress mentality"* suggested one

13

out-of-hours co-operative respondent (Co-op 1). Other stakeholders suggested that communication had not been two-way and claimed *"that NHS 24 should listen a bit more and do a little less of the Power-point"* (Primary Care Trust 1). In defence, one NHS 24 executive team respondent brought attention to the time scale involved in the implementation of the service suggesting that, *"if you have to get everyone to agree to everything, then frankly you can only go at 1mph"* (ETM 2). However, this speed of change exacerbated existing tensions in communication and inhibited the building of relationships.

Call virtualisation, the ability of one contact centre to be able to take calls from another usually, but not always, at time of high demand, was another area where communication was an issue. Here, respondents from the ambulance service were the most positive compared to other partner organisation interviewees. The "fail-safe" aspect to virtualisation, i.e. the ability to ensure that the service remained available during periods of peak demand was highlighted. However, the pay-off for being able to build in this fundamental component to the system was a perceived loss of local sensitivity or knowledge, which according to some, had developed via historical or geographical necessity and was synonymous with the GP co-operative.

The ambulance service respondents were comfortable with the management of this "local" and "national" dichotomy given that this is an inherent part of the service they offer and one that they have experience of. For them, the issue of local knowledge and sensitivity was much less important:

That isn't to say something will go wrong one day, but if you think we're handling over 1000 calls a day right on that basis. [SAS 2]

However, for those in the North centre overcoming the hurdle of "local knowledge" was often compounded by the aforementioned I&MT difficulties:

…nurses are struggling with the geography up here [North] *and they belong to this area and the customisation that's required from the North is considerable, … And often because of a technology difficulty, we might not get information that we need or who is on call that night. [SIT 1].*

Organisational identity

In general, the GP out-of-hours co-operative was the most negative in its response to NHS 24. This was noted by other partner organisations and by NHS 24 itself. One explanation put forward for this scepticism was that NHS 24 was seen to be politically driven.

How do you establish partnership in something that's seen to be politically driven, actually driven by politicians? That's been very hard, you know, the old adage of "if you'd given the money to us [GP Co-op] *we'd have delivered, we'd have been able to develop and deliver the service locally". They may well have been, I'm not trying to argue that that wouldn't have been a model of delivery, but they'd never have had the investment in technology or indeed continued ability to invest in that technology "if we'd split that money 15 ways". (NHS 24 ETM 4).*

The argument against creating a franchised service around existing GP co-operatives was that NHS 24 was a national standardised service, cross-cutting different areas and services. The desire of GPs for a more franchise-based service reflected the tradition of GP ownership of co-operatives, which had been established as limited companies. GPs felt that NHS 24 did not recognise the benefits of this nor recognised the multi-faceted and

individualised nature of the co-operative membership and the organisational style in which the co-operative Board was not in control but <u>represented</u> the opinions of all its members:

…, the Board of Directors, don't run a company with employees. All that we are, are the instruments of 252 members. A voice… (Co-op 1).

An additional factor at play was the deep sense of pride that GPs had in the development of the out-of-hours co-operative as a model of care. The view was often expressed that the level of care delivered had been of a high quality and was less expensive.

I think on the whole they [NHS 24] are now doing it not too badly but I overall feel that after a huge amount of effort spent in the integration exercise and the post-integration exercise we now have got a system [that] *because of the huge investment is only marginally worse than that which existed before (Co-op 6)*

Having the locus of out-of-hours care removed from the co-operative impacted on GPs, as they perceived their control and autonomy over clinical decisions to be diluted. This was suggested by several respondents to be at the route of GPs' hostility towards NHS 24, which was causing them to lose *"their identity, they were losing their local focus. They were losing their doctor triage"* (NHS 24, SIT 1). One ambulance service respondent suggested that NHS 24 was perceived as a threat by GPs to their primary care domain:

So the whole campaign [NHS 24] was about being a softer organisation, it's a listening line, an advice line, unthreatening, help yourself and all the rest of it, and also the strap line was very much about "in addition to other services". That was the bit you could never get across to the GPs, they always thought it was taking over and it's a new service (SAS 2).

One way in which NHS 24 tried to counter such negative responses was through the use of "champions" or "charismatic leaders" (Mark & Shepherd 2001), who aided recovery work on this and other clinical aspects of the service. Medically qualified, previously GPs and now employed within NHS 24, these individuals were noted for their capacity to champion the service in clinician circles and to enhance clinician-clinician communication through a shared understanding of primary health care delivery.

Discussion

This paper is part of a larger study evaluating the implementation of a national, integrated nurse-led telephone consultation service, providing unscheduled care and integrated with GP out-of-hours co-operatives and accident and emergency departments across Scotland and with the national ambulance service. This integration of organisations is a key difference from other nurse-led telephone services, such as NHS Direct, and affords the first opportunity to explore the way in which these organisations respond to each other. The work here represents qualitative findings from a detailed case study undertaken in the first site. Interviews were conducted with a range of key informants, selected on the basis of being to provide an organisational perspective to the process of implementation, rather than a purely personal perspective. For example, one of the interviewees was the clinical director for A&E services at the first site. The issues and concerns raised during the interviews were also apparent during observation of key meetings, reading of NHS 24 Executive Team minutes and Board meetings and were raised in the electronic diary returns. Findings are also consistent with work exploring the implementation of NHS Direct, in which GPs saw the out-of-hours co-operatives which they were instrumental in setting up become part of a wider nurse-led telephone consultation service (Pearce & Rosen 2000; Mark & Shepherd 2001).

Each of the integrated partners identified increasing workload, the clinical safety of nurse triage and a lack of communication between the organisations as key concerns. These were clearly genuine concerns and, in the first weeks of service implementation, the perception of increasing workload and inappropriate triage was supported by analyses of NHS 24 and integrated partners activity data (unpublished data). However, this appeared to be reducing by the time that most of the interviews were being conducted. What was also clear from the contextual history of the organisation was the rapid pace of implementation across Scotland, with other sites integrating with NHS 24 within a few months of the first site's implementation.

Both GP and non-GP respondents attributed the negative response of the out-of-hours co-operative to a loss of GP autonomy. This can only partly explain the negativity. Changing roles and the re-configuration of health care work, such as found when nurses take on telephone triage previously conducted by GPs, has been shown to create uncertainty and a sense of lost autonomy (Williams & Sibbald 1999; Elston & Holloway 2001; Degeling *et al.* 2001). However an additional factor, overlooked by most respondents, was the very real sense of ownership both in terms of service development but also in terms of company ownership that GPs had in the out-of-hours co-operative. GP out-of-hours co-operatives had been set up as limited companies contracted to provide out-of-hours care and, as such, were not directly part of the NHS. Ignoring this factor had clearly led to an under-estimation of the complexity of the organisation, in which each GP member felt that their view was equally important to all the others and in which the co-operative Board could only act in a representative way rather than in a bureaucratic way. This enhanced sense of an organisational identity or culture within general practice has also been identified as contributing to the success or otherwise of the implementation of clinical governance within primary care (Marshall *et al.* 2002).

In contrast, although there were similar tensions and difficulties with both the accident and emergency department and with the ambulance service, these were less likely to develop into open hostility and were also resolved more readily. These services were already part of the wider NHS, unlike the independent contractor status of GPs and their co-operatives, and their staff had no financial ownership in the organisations. We suggest that this, coupled to the transient nature of many of the medical staff in A&E (Allen 1997), may have contributed to this. This was even more apparent with the ambulance service, which shared a similar identity and ethos to NHS 24, i.e. a national service delivered through locally placed call centres and with no strong medical presence dominating the organisation. Finally, both A&E and the ambulance service were already used to receiving patients from other organisations and the overall contribution of NHS 24 to their workload was small (unpublished data). In contrast, the GP out-of-hours co-operative had previously been the first point of contact for patients, with NHS 24 now assuming initial responsibility for all their patients. Therefore, understanding and trust appeared more readily available between the organisations that shared similar identities and ethos to one another, in particular the ambulance service and NHS 24.

These organisational identities also impacted on attempts to resolve tensions. Medical leaders located within NHS 24 were able to work with both A&E and with the ambulance service at an organisational level, where regular meetings helped to ease tensions and resolve difficulties. However, with the GP co-operative, it's Board could again only act as a representative of the membership, with all GPs having an equal say in the success or otherwise of the implementation.

These tensions were undoubtedly added to by the virtual nature of the system, with care being conducted across several organisations. This has implications for current and future policy developments, where care may be delivered across organisations using innovative

means of communication, for example using paramedics to deliver unscheduled care out-of-hours.

Out-of-hours care has shown that GPs can readily embrace change and new ways of working when it is in their professional interest and is driven from the ground up. Examples include the establishment of GP out-of-hours co-operatives in the 1990s (Hallam & Henthorne 1999; O'Donnell *et al.* 1999) and the opt-out from 24-hour responsibility since the implementation of the new GMS contract (BMA General Practitioners Committee 2003). However, new models of service delivery which aim to develop seamless care across the whole system (NHS Scotland 2005) will require inter-professional working which crosses traditional boundaries. The complex ownerships and identities that exist within different parts of the health service need to be recognised and acknowledged before change processes can be effective.

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