‘Not one action but many’: Institutional work by commissioners of children's mental health services in the English NHS

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ABSTRACT

This article enhances our understanding of institutional work, through a study of professional health commissioners in the English National Health Service. Using a case study of mental health policy implementation, commissioners are conceptualised as institutional agents involved in shaping the organisational field and its boundary. Health service commissioners face a series of challenges as institutional agents. Commissioning is a relatively new health profession. It lacks a strong professional association and has predominantly been externally professionalised. Commissioners have limited direct organisational strategic management control. In the case study, commissioners were charged with leading implementation of the policy, which required them to address fragmentation in the field. Using existing typologies as an analytical frame, activities by commissioners in the case study are identified and explored as different modes of institutional work. Commissioners created a new normative network and instigated specific processes to embed and routinise cross-organisation working. They undertook boundary-spanning cognitive institutional work, creating new knowledge by commissioning education of school staff in the basics of children’s mental health. Their institutional work involved challenging existing working practices, both in the health field and in the contiguous education field. The article elucidates connections between different modes of institutional work, and attends to boundary work by commissioners in parallel with institutional work in the field. It also outlines how a profession seemingly lacking many of the ingredients of institutional power, might pursue its own professional project through institutional work. Findings have resonance in other geographical and policy areas, and fields.

Keywords: boundary-spanning work, English NHS, health commissioners, institutional work, organisational field, public service reform

INTRODUCTION

Research has revealed important insights into the institutional work of professional groups. Across a range of policy contexts, this literature has revealed how elite health professionals co-opt patients and users to defend the status quo against externally-imposed reforms (Currie et al. 2012), how institutional agents within street-level organisations work to modify policy (Breit et al. 2016), how health care managers adopt and hybridise large-scale policy reforms (Cloutier et al. 2016), how social work managers adapt to hybridisation pressures from the New Public Management or NPM (Breit et al. 2018) and how layered healthcare governance both enables and constrains institutional work (Felder et al. 2018). As well as a focus on managers and hybrid manager-professionals who control organisational resources, this literature has explored the institutional work undertaken by a range of professions. It tends however to be weighted towards those with relatively powerful associations, that is, professions that are able to exert control of professionals by professionals (Noordegraaf 2007). This article enhances our understanding of institutional work, by exploring how a relatively new profession that lacks a strong professional association and which has been predominantly externally professionalised (Evetts 2011), might pursue its own professional project.

The focus in this article is on the commissioning profession in the English National Health Service (NHS), institutionally located in the health field. Using a qualitative case study in the north of England of the implementation of mental health policy (*Future in Mind*), commissioners are conceptualised as institutional agents. The study involved semi-structured interviews with professionals in organisations involved in implementing the policy, as well as observation of cross-organisation meetings. In the case study site, these organisations had reportedly not worked together before in this policy area. Further, some were populated by medical and care professions which, unlike health commissioners, had long-established occupational closure. In contrast, commissioners had been the object of attempts by external actors to professionalise the commissioning profession, in what might be termed professionalism 'from above' (Evetts 2011). Such attempts have involved national top-down programmes to improve the skills of commissioners, and support to commissioning organisations, and are externally-driven. This article explores how, given this combination of policy intent, and organisational and professional factors, health commissioners were able to pursue their own professional project through particular forms of institutional work. It

identifies and explores specific activities undertaken by commissioners, and other actors effectively working on their behalf, which helped commissioners to pursue professionalisation 'from within' (Evetts, 2011). Commissioners leveraged the position of their organisation in the field's institutional hierarchy, and worked as 'diplomats' (Battilana 2011), by aligning their interests with those of notionally more powerful institutional actors. Drawing on the literature, this article responds to the following research question: *How does a profession lacking a strong professional association, which historically has been externally professionalised, and which has limited direct organisational management control, pursue its own professionalism through institutional work?*

The next section briefly outlines links between professionalisation and institutional work, and explores how professionals have been conceptualised and researched as institutional agents in the literature. This forms the basis for conceptualising health service commissioners as institutional agents. The research context is then outlined, followed by a short methodology section. The article's main findings are critically reviewed in the framework of institutional work in the field and at its boundary with a contiguous field. A discussion section explores the wider implications of the findings, before a brief conclusion.

THEORETICAL CONTEXT

The literature on institutional work has established important links between institutional theory, which has tended to emphasise stability, and professionalisation theory that has typically highlighted conflict and instability (Lawrence et al. 2013; Muzio et al. 2013). Professions have been described as 'primary societal institutional agents' in modern society (Scott 2008: 227). Such a perspective posits professions as 'vitally important social actors which develop, maintain, and exert a wide variety of institutional effects' (McCann et al. 2013: 752). Professionalisation and institutionalisation appear inextricably interlinked (Suddaby and Viale 2011), and professionalisation has been characterised as a 'subset of institutionalisation' (Muzio et al. 2013: 705). Institutional work has been defined as the 'the purposive actions of individuals and organizations, aimed at creating, maintaining or destroying institutions' (Lawrence and Suddaby 2006: 215). It emphasises the agency of professionals doing institutional work, who are viewed as 'reflexive, goal oriented and capable' (Lawrence et al. 2013: 1024). A focus on institutional work attends to how professional projects make broad contributions to institutionalisation (Lawrence and Suddaby 2006). In their work to

professionalise, occupational groups interact with other institutional actors 'to establish and maintain positions of hegemony and power' (Suddaby and Viale 2011: 426). This has the potential to institutionalise a 'natural and taken-for-granted character' to particular institutions with, for example, credentialed practice, specialised knowledge and self-regulation coming to be seen as characteristics of organised expertise in professions (Muzio et al. 2013: 706). Professionals have themselves been shown to act as institutional agents in a number of different ways. They might act as cultural-cognitive agents to codify and generate knowledge; they might set standards or impose sanctions as normative agents; or they might act as regulative agents in legal and managerial occupations, and through state-sanctioned self-regulation (Scott 2008). By approaching professionalism as an institution, an institutional work perspective provides an analytical lens on professionalism as a means to organise aspects of modern society (Muzio et al. 2013).

Organisations have been viewed as important contexts for professional projects. They can disrupt professionalism but also be arenas of professional projects (Lawrence et al. 2013). Broadly speaking, more professionals now work in large organisations, which increasingly influence not just the context for, but also the content of, professional work (Evetts 2011). In that shifting environment, professionalism is reportedly orienting from an occupation-based logic towards one driven by organisational factors that have 'hybridised' professionalism (Noordegraaf 2007). Organisations have been shown to influence and shape professionalism and orientate it to organisational ends, for example through work by managers that combines discourses of enterprise with those of quality and care, and by organisations acting on individual practitioners to 're-institutionalise' professional work (Evetts 2009; Muzio et al. 2013). Citing a categorisation developed by McClelland (1990) in a history of professionalisation in Germany, Evetts (2011) argues that occupational groups face having discourses of professionalism imposed on them 'from above', in ways that ultimately serve organisational ends.

Notwithstanding these challenges, professionals have been shown to adapt well to working in large, bureaucratic organisations by conforming to organisational pressures while at the same time using their organisation's power to shape the wider field (Suddaby and Viale 2011: 427). In short, this evolving context provides opportunities for professionals to derive influence from their ability to shape and control organisations, by attending to institutional work as well as occupation-based practice (Muzio et al. 2013). The literature points to three

broad strategies in institutional work, which involve creation, maintenance or disruption of institutions (Lawrence and Suddaby 2006). Subsequent work has used, revised and extended this initial typology. A study of institutional work by elite medical professionals in the English NHS found that they undertook both maintaining and creating institutional work, suggesting some forms of institutional work are closely interconnected (Currie et al. 2012). A study of the activation of professionals in post-NPM policy reform in Norway found that managers pursued different strategies that disrupted and maintained elements in the professionalism of social workers (Breit et al. 2018). This study combined elements in the Lawrence and Suddaby framework with a typology derived in a study of managerial work in policy reform in Canada, which had concluded that managers implementing policy reform engaged in structural, conceptual, operational and relational work (Cloutier et al. 2016). Both these studies note that managerial strategies were context-bound and contingent on the skills and orientations of managers. Other research on institutional work has highlighted the importance of context in respect of the history of policy and governance arrangements in particular geographical spaces and policy areas (Felder et al. 2018).

These studies predominantly focus on institutional work within organisational fields. Institutional work might also have wider impacts at the level of the organisational field itself and at the boundaries with contiguous fields (Zietsma and Lawrence 2010; Suddaby and Viale 2011). A focus on field-level effects deepens links between professionalisation and institutionalisation. It argues that professionals not only adapt to the pressures imposed by organisations but that they use organisational resources to pursue change at the level of the field (Suddaby and Viale 2011). Studies of boundary work have focussed on how boundaries are established in order to protect the autonomy and prestige of different actors, how actors might work to span boundaries to build alliances in different organisational fields, and how actors might seek to breach boundaries in order to influence outside of the organisational field (Zietsma and Lawrence 2010: 194). Boundary work has tended to be explored in isolation from practice work, despite theoretical interconnections between them (Zietsma and Lawrence 2010; Phillips and Lawrence 2012).

The concept of institutional work has itself been the object of criticism in the literature, with concerns being raised that institutional work has been conceptually overstretched (Alvesson and Spicer 2019). This critique argued that the definition proposed by Lawrence and Suddaby (2006) meant that the concept could, in theory, be applied to any purposeful action.

In response, the authors suggested that studies of institutional work clearly distinguish it from what they termed 'plain old work' (Alvesson and Spicer 2019: 207). Later sections of this article return to this. Another critique focussed on the strongly agentic conceptualisation of institutional work. Here, questions have been raised about whether research on institutional work has underplayed structural and contextual constraints on action, and arguments made for a more situated approach to account for institutional work as 'planned action, improvization, coping and responsiveness' (Felder et al. 2018: 91). In this article, institutional work is viewed as contingent and context-bound. Professionals are viewed here as potential agents of change, who can interpret 'institutional pressures' including those emanating from policy makers (Leicht 2016). They do so within a particular organisational field, in specific organisations, and in a specific place and time, in which they give meaning to new arrangements as they negotiate the changing institutional context (Felder et al. 2018).

Taken as a whole, this literature suggests that well-established professions, with relatively powerful associations and state-sanctioned social closure, might be better able to resist encroachments from organisations on their professionalism than professions or occupational groups lacking strong representation or which have only recently emerged as professions. Further, there may be variations in the agency of different professions to pursue institutional work.

RESEARCH CONTEXT

Health service commissioning

Commissioning is a relatively recent health profession, compared with longstanding medical professions active within the organisational field. Commissioning emerged through the introduction into the NHS of a purchaser-provider split in the 1990s. The most recent set of reforms to the NHS (the 2012 Health and Social Care Act), organisationally located local health commissioners in clinical commissioning groups (CCGs). CCGs have been defined as 'clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area'. There were 135 in England in April 2020, each responsible on average for the health of around 250,000 people[1]. They are led by an elected governing body, usually comprising local general practitioners (GPs), other clinicians and lay members,

[1] https://www.nhscc.org/ccgs/

and have been described as 'GP membership organisations' (Storey et al. 2019: 190). Their remit includes secondary services (such as those provided in hospital settings) and increasingly, primary care services (such as community-based GPs). The 2012 Act also moved local public health responsibilities to local authorities, and created a new national lead organisation (now called NHS England), which directly commissions some 'specialised' services such as for rare cancers (Kings Fund 2019). The creation and evolution of CCGs brought together the majority of local healthcare commissioning within a single organisation, and to a degree, shifted power to local clinicians and away from provider organisations. CCG staff include non-clinical 'managers', who tend to operate between the strategic board level and the front-line clinical level of local healthcare systems. These are the professional health commissioners whose institutional work is explored in this article. The limited research on CCGs has reported that these actors play important roles in translating strategic intent into operational change, work that involves 'constructing the mechanisms, procedures and the protocols which helped translate grand conceptual plans into workable solutions' (Storey et al. 2019: 200).

NHS England describes health commissioning as 'not one action but many', comprising 'the continual process of planning, agreeing and monitoring services'[2]. In the context of commissioning by CCGs, this work can be seen as a process, 'starting with a systematic assessment of population needs, followed by the planning of appropriate, cost-effective provision using the purchasing power allocated to the CCGs' (Storey et al. 2019: 189). Although commissioners are located on one side of the purchaser-provider split in the health service, their work requires them to combine front-line service perspectives with those of managers, and to switch regularly between the operational and strategic levels. Their work with other professions requires them 'to relate to other professional groups, which have different vocabularies, techniques and routines' (Noordegraaf 2011: 1363).

Health commissioners have not pursued their own macro-level professional project by, for example, seeking to create their own professional association. Instead, the health commissioning profession in the English NHS is represented by NHS Clinical Commissioners (NHSCC), whose members are CCGs rather than individual professional commissioners themselves. One consequence is that, while individual commissioners might in theory benefit from institutional membership, they appear at a relative disadvantage compared with more

[2] https://www.england.nhs.uk/commissioning/

established medical professions, such as those represented by Royal Colleges in the UK and Ireland. This has potential to limit the ability of commissioners to professionalise 'from within' rather than being the objects of professionalisation 'from above' (Evetts 2011), a risk that appears to have crystallised. For example, external efforts to professionalise commissioning have included the national 'Commissioning Capability Programme', which aims to 'equip commissioners with the skills to deliver on both the challenges of today and the challenges of tomorrow'[3]. Commissioning has also been supported at an organisational level by 'commissioning support units', which provide analytical expertise and data to CCGs and increasingly to healthcare systems (Kings Fund 2019). The presence and actions of these external agencies and programmes suggest that commissioning has been professionalised from above, and is read here as emblematic of the lack of a strong macro-level professionalisation project from within the profession.

Research has revealed how professional groups lacking a professional association might pursue their own professional project at the micro-level through everyday practice (McCann et al. 2013). This is an alternative example of professionalism 'from within' (Evetts 2011) which, unlike efforts to establish formal institutions, involves the pursuit and reproduction of particular everyday professional practices. For example, a study of ambulance staff in the English NHS revealed how they worked to reassert their own model of 'blue-collar professionalism' in what was, in effect, a mode of front-line professionalisation (McCann et al. 2013). This example reveals how professional projects might be pursued through relatively micro-level practices forms of institutional work (as well at the macro-level).

Health service commissioning has not received direct attention in the literature on professions and organisations. While there has been research into the institutional work of health service managers in other contexts (see for example, Breit et al. 2018), the commissioning profession has not been the explicit focus of study. A recent study in the English NHS did focus on CCGs, but was interested in the role and consequences of local clinical leadership by CCGs in the redesign of health services (Storey et al. 2019). Although not a direct focus of the study, the research found that 'non-clinical managers' in CCGs were strongly connected to wider NHS institutional structures, and used their influence to dilute local clinical control over service redesign. These findings point to impacts on local healthcare

[3] https://www.england.nhs.uk/commissioning/

systems from the activity of professional commissioners, and suggest they have potential to play a significant role in shaping local services. Together, these theoretical factors relating to the characteristics of the commissioning profession, the institutional location of CCGs in the English NHS, and the position of professional commissioners within CCGs, point to health commissioners as potentially interesting institutional agents.

The case study

Future in Mind is an NHS-funded, five-year policy programme. It was designed to be implemented locally, with a number of aims: improving young people's access to mental health services; reducing stigma; developing the mental health workforce; and increasing service delivery by schools (Department of Health 2015). In seeking to improve access by shifting services into community rather than clinical settings, it reflected wider changes in the NHS (Ham et al. 2018; Storey et al. 2019). The policy emerged against a backdrop of concerns in the UK, and internationally, about the increased prevalence of mental health issues among young people (WHO 2012; Department of Health 2015). In England, these issues were exacerbated by rising rates of referrals and marked variation in the availability and quality of specialist services (Anderson et al. 2017). Mental health has been relatively underfunded in the English NHS, accounting for 28% of England's 'national disease burden' in 2011/12, but only receiving 13% of total NHS spending that same year (McManus et al. 2016: 27). Recent spending announcements have pledged to grow spending on mental health services. That ambition needs to be seen against a background of low overall funding increases, historic underfunding, cuts to public health spending, and falls of at least 50% since 2010 in funding of local youth services and of children's centres in more disadvantaged communities (National Audit Office 2018: 27). *Future in Mind* emerged against this background of significant cuts to a range of community-based, preventative, health and wellbeing services and increased prevalence of mental health issues among young people.

Local health commissioners were tasked by national policymakers with leading the implementation of *Future in Mind*. Specific features of local implementation were not detailed in national policy, although it required implementation to bring together a range of organisations. Policymakers argued for this to actually happen 'means the NHS, public health, local authorities, social care, schools and youth justice sectors working together' (Department of Health 2015: 14).

The policy was situated in the health field, part of the taxpayer-funded English NHS. Organisationally, constituents of the health field include health service commissioners, secondary and tertiary (highly specialist) service providers, primary care services that can refer patients into other services, and local authority public health services. The field also includes other local authority services (such as those for families and children), counselling services, community-based services, service user groups and networks, and voluntary organisations, which together have extended the field to reflect '[e]mergent health and well-being perspectives' (Storey et al. 2019: 190).

Research was undertaken in Metborough[4], a mixed urban and rural area in northern England with a population in the 250,000-500,000 range. The proportion of its children who live in poverty is just above the national average and, according to the 2019 Index of Multiple Deprivation, it was among the 20% most deprived areas in England. Local actors reported that Metborough had not been immune from the national trend of cuts to children and youth services. Locally, these services had reportedly been focussed on the most vulnerable families, and away from early intervention and prevention services. Local mental health services for children and young people were reportedly under some strain, with a high rate of referrals leading to long waiting lists. The need to relieve some of this pressure on specialist services was an important motivation for local actors in CAMHS and actors in other organisations. As reflected in the national policy design, local implementation involved a cross-organisation partnership. In Metborough, this partnership comprised health service commissioners and service providers, local authority services, counselling services, and ten local voluntary organisations that worked with local children and young people.

METHODOLOGY

Data collection

Participants in the case study included staff in public sector organisations and in non-state organisations. All were directly engaged in implementing the policy and had traits of classical professions, in that they exercised discretion in their work and operated with a degree of autonomy. They were also publicly accountable because of their work in the public-funded implementation programme. On account of these features, they were defined as 'public

[4] This is a pseudonym.

professionals' undertaking 'public tasks on behalf of the common good' (Hupe and Buffat 2014: 551). This definition applied to all actors involved in the study. Given the small number of participants, to maintain anonymity quotes are attributed to one of the five professional/sector groups, rather than to individuals. This still enables commissioner views to be distinguished from those of other actors.

The case study sample was purposive (Creswell and Clark 2017), a non-random design that involved identifying and recruiting individuals whose experience and knowledge were most relevant for the study. Thirty-one semi-structured interviews were undertaken with local actors involved in implementing the policy (see table 1), twenty-seven of which were with actors who identified as female. The commissioners who were interviewed had between less than one year and more than five years NHS commissioning experience, with one having additional prior experience of commissioning work in local government. One commissioner had transferred into commissioning in the year prior to interview from a health service provider organisation, and their interview included reflections on the programme as a mental health practitioner as well as their time as a commissioner. The commissioners' CCG was an organisational member of NHSCC. Ethical approval for the study was granted by the author's host university in July 2017, and fieldwork was conducted between September 2017 and January 2019. Informed consent was sought for all interviews and observations. Participants were interviewed face-to-face in their place of work, with the exception of one interview that was conducted by telephone. Interviews lasted between 43 and 90 minutes, with an average of 57 minutes. Interviewees were asked about their experiences in the programme, its impacts on children and young people and on them professionally, and what public service co-production meant to them. A semi-structured topic guide was used to ensure consistency of coverage, while allowing space for the emergence of new issues. The original study on which this article is based also involved observation of inter-professional meetings. Although participants in these meetings included professionals who were not interviewed for the study, they came from the same organisations as interviewees. Data from the observations have not been drawn upon in this study, which instead solely draws on interview data.

Data analysis

The aim of the analysis was to explicate institutional work undertaken by members of a profession that had been externally professionalised, which lacked a powerful professional association, and whose members had limited direct organisational management control. The

case study was originally undertaken for a wider study of public implementation, for which data had been coded in an iterative process using NVivo software. Analysis of interviews had begun with transcribing, which built familiarity with the data. Initial coding was inductive and open. After several iterations, this stage had generated 23 emic first-order concepts. These related to the parameters of joint working in the partnership and processes that underpinned the partnership, unifying concepts in the partnership, the educating of non-specialist staff, and the sustainability of new ways of working. Although these concepts did not relate specifically to institutional work, they were the basis for coding for this article. Here, the data in these first-order concepts were exposed to theory, in an abductive process of 'theoretical re-description' (Fletcher 2016). The literature deployed at this stage included a range of activities that had been conceptualised as institutional work, and had been empirically explored in a range of settings. These activities encompassed the three broad themes in the literature on institutional work (the creation, maintenance and disruption of institutions), as well as work at the boundary of institutional fields, including boundary spanning (Lawrence and Suddaby 2006; Phillips and Lawrence 2012). These typologies of institutional work, and of related boundary work, were used as an analytical frame.

FINDINGS

This section explores the institutional work commissioners were undertaking as part of their professional project. It is structured theoretically to distinguish between creative institutional work, institutional maintenance, and boundary-spanning epistemic work. Commissioners took forward their professional project in 'everyday' ways that effectively expanded their 'jurisdiction' from below, rather than through macro-level efforts such as seeking to establish their own professional association. Specifically, their professional project involved efforts to demystify the concept of mental health, especially in relation to children with 'low-level' emotional wellbeing issues. This they achieved by opening-up service provision to a wider range of organisations, professional models and perspectives. It enabled them to challenge 'closed' specialised mental health services, which commissioners undertook through creative institutional work (a new normative network) that brought together staff with a range of non-clinical perspectives on children's emotional wellbeing. They also commissioned and funded training of non-specialists in the 'basics' of mental health, in order for them to fully participate in *Future in Mind*. This was cognitive, boundary-spanning institutional work by commissioners, which impacted practice and, to an extent, epistemologies

in the education field. It also enabled commissioners to align additional professional resources to their own professional project. These effects in a contiguous field were however complex and somewhat contradictory for the professional project of health commissioners in Metborough since long-established professions in specialised services were able to influence school staff towards their ways of describing young people's mental health and emotional wellbeing. In sum, the evidence suggests that commissioners took forward their professionalism through 'front-line' institutional work (McCann et al. 2013).

Creating a new 'normative network' in the field

Commissioners created a new normative network, which took the form of an inter-organisation partnership to foster what was described locally as 'system-wide partnership working' [CCG]. It brought together a range of actors for the first time in this particular geographical space and in this policy area, in an example of actor-to-actor institutional work (Lawrence and Suddaby 2006). Commissioners led joint work to develop an initial local plan for governing and delivering the programme, and coordinated joint work to refresh it annually. They also funded aspects of the programme, within the parameters developed and agreed by partners. The intent was for the partnership to enhance and complement existing services. This reflected an important trait in institutional work involving construction of normative networks, which tend to be created alongside pre-existing institutions and organisations (Lawrence and Suddaby 2006).

A core purpose for commissioners was that the new normative network would move on from previous fragmentation, continuation of which would impair efforts at change across organisations in the field. Commissioners spent time building a more integrated approach by emphasising a collectivity:

> 'I think we've been able to help everybody see that actually they are part of this, this family of services that I think we'd forgotten a little bit about before because there was such a big gap … I think it's that sense of belonging, that sense of we are, we know we're a piece of the jigsaw, but now we can see that work, and we can see it practically happening ... so I think it's making that really transparently clear, how that fits and how that looks, and which part of the jigsaw you actually are, and how you fit next to the next piece, has been, I think has been the best way we've able to do that' [CCG].

Commissioners promulgated this notion of a 'family' or 'jigsaw' of services by creating and supporting new inter-organisation processes. These included a new programme board comprising partners from the programme, along with other fora in which partners jointly worked to manage delivery of services. These mechanisms tied-in organisational partners, and brought together two elements of the new normative network, rooted in 'other ways of working, different ways of thinking' [CCG] compared with what had gone on before in the field. They were novel in this policy area in Metborough. Their introduction was a primary means by which commissioners could pursue their professional project through institutional work.

Blurring modes of institutional work

This institutional work blurred the boundaries of creating and maintaining work. New processes were integral to the partnership. They had specific purposes for commissioners. First, by providing oversight and management of services in a set of joint arrangements within the programme, they were a means for commissioners to fulfil their own responsibilities as regulative agents in the field (Scott 2008). Second, they had a more ambitious purpose of fostering new links that would become naturalised and self-sustaining. This suggests that commissioners were involved in a degree of maintenance work by 'embedding and routinising' new practices in the field (Lawrence and Suddaby 2006). The logic of this work was that, while relationships would be initiated and nurtured through formal interactions, the intent was for them to subsequently evolve into self-sustaining, everyday links:

> 'because we'll have enough threads of continuity through that, and enough ways of working, so multi-disciplinary meetings, and the ways of communicating, feeding back and delivering services jointly, so that reinforces and then we can continue the engagement conversation. So, practically and operationally day-to-day we are reminded of how to work together' [CCG].

The processes instituted by commissioners in *Future in Mind* stimulated ongoing, regular interactions that may not have happened beforehand. Positive experiences of these new ways of working were fostering linkages beyond formal processes to changes in the everyday experience:

> '[w]here you've got that relationship there, I think they [partners] feel more able to just run something by you. Whereas before, they may well have just not been not been too sure, maybe sat on it, and then time's wasted and an escalation occurs' [LA/Other].

Work by commissioners to create a new normative network revealed as well interplay between what have been categorised as creating and disrupting modes of institutional work. National policy acknowledged that bringing together a wide range of partners would require 'dismantling artificial barriers between services' (Department of Health 2015: 15). Work by commissioners to create a new normative network necessitated disrupting existing barriers in the field. One focus was CAMHS, which before *Future in Mind* was viewed locally as a relatively closed organisation, including by actors inside of it 'in [Metborough] CAMHS were very much seen as perhaps sitting in their ivory towers a little bit, and quite inaccessible' [Cam] and those in other organisations 'CAMHS are very insular normally … they're always quite difficult to engage' [LA/Other]. Commissioners themselves recognised this challenge 'CAMHS traditionally haven't worked with anyone. I think in [Metborough] we're even worse than most areas in terms of being a very, very traditional, old school type of service' [CCG]. Opening up this organisation was key for commissioners, if they were to instil new cross-organisation working in the field. *Future in Mind* presented them an opportunity to shape the wider field's internal logic away from relatively hierarchical and closed relationships towards a more interlinked and interdependent 'family' of organisations and services. This was intended to impact beyond *Future in Mind*. Investing in new community-based posts in CAMHS would not only deliver the policy itself by enabling more engagement with schools, but also provide a means for commissioners to foster a more outward facing, outreaching mode of practice in the field's dominant provider organisation. Actors within CAMHS were beginning to feel some of these changes, reporting that 'the interface with schools has been really, really positive' [Cam] and that 'I think health and social care has always had a working relationship, but I would hope that *Future in Mind* supported more collaborative working with the third sector and education' [Cam].

Boundary-spanning cognitive work: 'educating' staff in the contiguous education field

Commissioners funded education of non-specialist staff in the basics of children and young people's mental health. Educating actors in knowledge that they need to engage in new practices or with new institutional structures has been described as 'an important form of cognitive work because the creating of new institutions often involves the development of

novel practices' (Lawrence and Suddaby 2006: 227). This kind of institutional work, to build knowledge and skills in non-specialist staff, was important in Metborough … 'the idea of *Future in Mind* is to upskill staff in schools, so that they know what to do' [CCG]. Commissioners undertook this cognitive work indirectly, through the work of other actors in the partnership. Educating took the form of training, designed and delivered by CAMHS, and funded by commissioners. While it was offered to all professionals working day-to-day with children and young people in Metborough, it was aimed especially at school staff in the education field. The objective of commissioners was to increase the 'mental health workforce' outside of CAMHS. Annual local plans stated that the training was well attended, and one of those delivering it reported that 'I'm on about my 8th or 9th cohort running that now, since it started' [Cam]. The training was well-received by school staff, who described it as 'good', 'very interesting', 'people got a lot out of it' [Sch], and who reported that 'we don't want it to stop' [Sch].

Impacts: practice-based changes

Educating institutional work transferred knowledge about children's mental health across the field boundary to school staff. It provided them practical skills, and helped to enrol schools into the programme. Commissioners saw its benefits to implementing the policy:

> 'We've got a lot of good feedback from teachers ... just about they're getting an education on mental health and emotional health and wellbeing, because actually that's something that they, you're sort of thrown into as a teacher, you're made to learn it, you don't go to university to learn how to do that. So, you sort of, you have to adapt. So, I guess we, the biggest feedback we got was that they were finally getting educated on it, and how to deal with children in the classroom, and that distress' [CCG].

Commissioners also clearly saw the value of educating institutional work for their own professional project. It was part of their efforts demystify mental health, at least in respect of 'low-level' emotional wellbeing. As well as diversifying the range of actors involved in service delivery, it also brought in new perspectives on young people's mental health and emotional wellbeing. The intent was to open-up service provision in *Future in Mind* to actors in other fields, and shift school staff away from a focus on specialist services that would go into schools to 'fix young people' towards a 'preventative' model in which school staff would themselves play a larger role [CCG]. Commissioners claimed that a 'genuine benefit' of the training was

that ‘people now realise that actually, unless it's quite clinical and I think quite specialised, it [CAMHS] doesn't need to be there’ [CCG]. For them, the training that they had funded meant ‘no teacher can pretend they don't understand, can pretend that they don't know what they should be doing, even conceptually rather than practically’ [CCG]. They pointed to evidence of change in school staff, who were now ‘holding’ children reporting low-level mental health issues and responding to them in school, rather than immediately referring them:

> ‘I think that's what we've found, that a lot of schools now, a lot of schools now … are more willing to hold young people at that emotional wellbeing level, you know very early stages of children presenting with self-harm, where they would've probably directed straight into CAMHS’ [CCG].

This cognitive work drew school staff into the programme. In effect, commissioners had captured new resources aligned to their professional project, by growing the ‘mental health’ outside of the health field. The field boundary had shifted, not institutionally, but more subtly to manifest a joint responsibility for supporting children and young people presenting with mental health issues. One commissioner claimed that school staff were ‘now a resource that can support working with children and young people’ in *Future in Mind* [CCG].

Impacts: an epistemic shift in the contiguous education field

There was evidence too of a shift in the epistemic boundary between fields and professions as a consequence of educating institutional work instigated by commissioners. This was again subtle, and related to an increase in confidence, and shift in language, among school staff that ran alongside changes in professional practice. Educating was seen to be providing school staff with a new view on issues like self-harm, anxiety and depression, which were beyond their professional pedagogical expertise. As one actor noted of these issues, ‘if you've not a mental health background, you think of [them] in a different way, and understandably so’ [Cam]. Evidence that school staff were beginning to internalise new ways of working and perspectives of specialist services suggested a degree of epistemic shift. The most vivid evidence came in reported changes to their use of language. CAMHS staff reported that their colleagues in schools were ‘starting to understand and kind of gain a broader language’ of mental health [Cam], and that they had:

> ‘started to use different language, use more kind of mental health language, have a better understanding of perhaps what's happening for children, and less fearful I think of using the words “mental health”, you know’ [Cam].

School staff acknowledged this demystification. For example, as one explained, when they contacted specialist services, they:

> ‘know that actually we're not just ringing up and we've got no clue, that “actually there are schools that work quite well with us, that have an understanding, that have training”. So, I think you just, you feel like you're automatically on the same page’ [Sch].

DISCUSSION

This empirical evidence reveals the contours of institutional work by health commissioners in Metborough to take forward their professional project. They leveraged their organisation’s position in the field to shift belief systems in other actors, by creating a new normative network. This comprised an inter-organisation partnership, which commissioners sought to cement by introducing new cross-organisation processes. Here, they were working to shift norms by embedding and routinising new working practices. Work to draw CAMHS into more interactions with others in the field, effectively challenged what had been seen locally as an ‘old school’ approach. Commissioners were also involved in creating institutional work as boundary spanners, through cognitive work in the contiguous education field. This they did by using their financial resources to fund education in the basics of mental health, with the aim of imparting new knowledge and skills to school-based staff. This institutional work had the effect of shifting the boundary between the mental health and education fields by enhancing the ‘mental health workforce’. Such change was evident in new practice in schools, and an epistemic shift in ways that school-based talked about young people’s mental health issues.

This article makes a contribution to our understanding of institutional work. First, it further elucidates and nuances connections between institutional creation and institutional disruption that have been evident in other studies (Lawrence and Suddaby 2006; Breit et al. 2018). Commissioners were dealing with a ‘real-world’ local problem, which was that CAMHS reportedly acted in a closed manner and preferred to work in isolation rather than with other

organisations in the field. The aim was to open up this organisation, which would enable commissioners to pursue their project to break down organisational barriers through creation of a new normative network. CAMHS was an institutionally powerful actor. It held a dominant 'market position' in service provision, and was populated by members of powerful health professions. In theory, it had resources to resist the professional project of commissioners to foster system-wide change and new ways of working in the field. Work by commissioners to create a new normative network necessarily involved some disruption (or at least, challenge), to the established institutional practice of CAMHS. Commissioners did so by, to an extent, aligning with the interests of CAMHS. They sought to establish a local 'family' of services sharing a commitment that the mental health of local children was all of their business, and not just that of specialist services. By drawing in other organisations, commissioners worked to draw out CAMHS from its more closed-off practices.

Second, this article attends to boundary work by commissioners in parallel with their institutional work in the field, thereby responding to a call in the literature (Lawrence et al. 2013). Empirical evidence supported a theoretical view that institutional and boundary work would be closely related (Zietsma and Lawrence 2010; Suddaby and Viale 2011). Institutional work in the field, wherein commissioners funded a new package of education in the basics of children's mental health, was at the same time boundary spanning work to create new skills and knowledge in the contiguous education field, particularly among school staff. Taken as a whole, descriptions by actors of being on the same page with those in other organisations in the new normative network, of having shared responsibility, of there no longer being excuses for misunderstanding between actors, and examples of the use by school-staff of more therapeutic language, suggested a degree at least of modification in the boundary between the health and education fields in Metborough. This was not about a radical redrawing of the boundary between the two fields, but more an incremental step. Evidence suggested some change in the epistemic boundary between the fields, which had potential to help embed and sustain new practices by school staff that were relieving some of the pressure on CAMHS. There was a specific, economic purpose for commissioners here, which was to in effect increase the 'mental health workforce' without incurring the costs and time delays of recruiting into specialist services in the health field. Instead, they were able to lever in new resource, acting as boundary spanners to engage and draw in staff based in the education field.

Evidence in this article also supports a view that work to create and maintain institutions can be interconnected (Currie et al. 2012; Lawrence et al. 2013). Commissioners invested energy and time in creating a multi-organisation partnership that would lead implementation of the policy locally, and which comprised organisations responsible for delivery of services to children and young people. This work involved commissioners creating a new normative network, which brought together these specific organisational partners for the first time in the policy area in Metborough. As part of this creative work, commissioners instigated a set of processes and mechanisms designed to foster, and then to embed and routinise inter-organisation working. This suggests that they were undertaking institutional work associated in the literature with institutional maintenance, alongside their work of institutional creation.

This article contributes as well to our understanding of how a profession seemingly lacking many of the ingredients of institutional power, might pursue its own professional project through institutional work. Commissioners were pursuing their professionalism through front-line institutional work. This is similar to what has been observed in other occupational groups in the health field, such as ambulance workers, for whom institutional work was 'the medium through which occupational closure is sought on the front line' (McCann et al. 2013: 754). Commissioners' professional project involved demystifying the concept of mental health, to open up service delivery and perspectives on young people's mental health to a wider range of organisations. They challenged practices and viewpoints in specialist service providers by creating a new normative network to implement *Future in Mind*. They funded training of school staff, which shaped practice and epistemologies in the contiguous education field and expanded resources aligned to their agenda. The effect was to extend the 'jurisdiction' of commissioners, without a macro-level reshaping of formal professional boundaries, although the findings reveal that these effects in a contiguous field were complex.

In these different ways, commissioners sought to overcome theoretical limits to their profession, stemming from the absence of a powerful association, lack of self-regulation, and a history of professionalisation from outside. Professional health commissioners are organisationally subordinate to local 'clinical leaders' in CCGs. Further, while notionally controlling relatively large financial resources, commissioners remain constrained by large institutional service providers of services, which consume resources and incur costs in ways that commissioners have found difficult to contain (Ham et al. 2018). This reveals a contextual limitation on professional commissioning, in the form of work by powerful service providing

organisations, and the powerful medical professions within them, to maintain their own organisationally and professionally advantageous positions in the healthcare system (Currie et al. 2012; Storey et al. 2019).

Research has suggested that commissioners play a 'key role in resolving a variety of tensions between different perspectives' in the healthcare system (Storey et al. 2019: 200). As such, they might be seen as examples of 'diplomats' in the NHS (Battilana 2011), although they appeared less deferential to other medical professions than previous literature suggests that label would infer. Instead, they used their competences and leveraged the position of their organisation as the local clinical lead in the NHS to influence other notionally more powerful actors, through a variety of institutional and boundary work. They exhibited strong relational skills, working through others and exerting influence beyond their organisation and field, in order to pursue their professional project. This style has been observed in other research on CCGs, where it was described as a model of leadership based in 'persuasion and consultation' (Storey et al. 2019: 199). Commissioners appeared as hybrids of three types of agents conceptualised by Scott (2008). They acted as cultural-cognitive agents by shaping a 'family' of services within the field. By introducing new inter-organisation processes they acted as normative agents in the field. In fulfilling their management functions, they acted as regulative agents. This hybridisation might explain their apparent effectiveness, and appeared an important element of their model of more everyday professionalism 'from within'.

The literature on institutional work has burgeoned over the past two decades, which has led to questions about how well it has been conceptualised. For example, Alvesson and Spicer (2019) provocatively asked if institutional work is more of a phenomenon than a theoretical lens. They argued the need for seeing institutional work as distinct and distinguishable from 'plain old work', and suggested that what might be seen as institutional work included 'creating sets of rules, promoting a new model for an industry or criticising dominant ideas about a particular type of organization' (Alvesson and Spicer 2019: 207). These differences from 'plain old work' might only be subtly distinguishable from institutional work in a profession like commissioning, which is rooted in influencing beyond organisational confines. Notwithstanding that challenge, based on theoretical work in the literature it is argued here that this article relates specifically to institutional work by commissioners. Their activities predominantly entailed institutional creation in the field and across the field boundary, as well as work to maintain new ways of working and to challenge some closed organisational

practices. The partnership created by commissioners to deliver *Future in Mind* was a new normative network, which brought together a set of institutional actors for the first time in this policy area in Metborough. Commissioners actively sought to foster it, and distance it from previous fragmented practice in the field, by instigating and embedding new inter-organisation processes that helped to establish new norms that were becoming naturalised as the partnership became more established, and which went beyond tokenistic linkages. Commissioners undertook boundary-spanning cognitive institutional work, by commissioning training designed to educate school staff in the basics of children's mental health. Institutional work by commissioners not only created new institutions but, to a degree, disrupted existing institutions by challenging insular working practices and by influencing professional practice in schools in the contiguous education field.

CONCLUSION

The approach taken in this paper has been to pursue a form of 'analytic' generalisation from a single case study (Yin 2003: 32). This involved abstracting from the case to generalise about theoretical propositions, rather than seeking to infer from a sample to the population from which it is drawn. Specifically, findings were analytically generalised by drawing upon existing theory to help compare the current case study to the literature. Within acknowledged limits to a single case, this study article adds to the literature on institutional work. It focusses on how a profession without a strong professional association, which historically has been externally professionalised and which has limited direct organisational management control, might pursue its own professionalism. Professional health commissioners occupy an important place in the English NHS, but this is the first attempt to explore their institutional work, both in the field and at its boundary. To an extent, commissioners were effective institutional agents. They did shift working practices, and they enrolled actors from the education field into delivering their professional project. At the same time, they encountered challenges and obstacles, and their institutional work seemed to have somewhat contradictory consequences. Training on the basics of mental health had the effect both of bringing school staff into the purview of commissioners, and of reinforcing some existing institutional dynamics in the health field by extending the reach of specialist knowledge and understandings of children's mental health.

These findings have resonance not just in the English NHS, but also for other geographical contexts. Cross-organisation work in this policy area is evidently an international

issue, given that the World Health Organisation's Mental Health Action Plan called for 'a comprehensive and multisectoral approach, through coordinated services from the health and social sectors' (WHO 2012: 2). This call suggests that the professionalisation and institutional work of actors who commission services is of theoretical and practical relevance in a range of geographical contexts. Recent reforms to the institutional landscape of the English NHS have potential to further influence the health commissioning profession. Service systems are being integrated to meet the needs of local populations, and purchasers and providers of services are being tasked to work more closely in the design, governance, management and delivery of services across entire local health systems (Ham 2018). These shifts have implications for health care professions (McCann and Granter 2019), including commissioning, not least of which is the potential erosion of the existing split between purchasers and providers in the English health service (Ham 2018). It is possible that the particular set of technical and relational skills that commissioning requires, and the work of commissioners at operational and strategic levels, will imbue them with certain advantages as the shift to population-based integrated care gathers momentum. In some degree, they already straddle the divide with providers, by combining front-line sensitivities with more strategic organisational perspectives. The findings in this article study have potential resonance for similar professionals in other health systems and policy areas that are being actively reformed and integrated, and suggest the potential for further research on links between professions, professionalisation, organisations, and institutional work.

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Table 1. Interviews undertaken in the study

Organisational group	Interviews	Label
Service commissioners	4	CCG
CAMHS[5] managers and community-based practitioners	7	Cam
VCS managers and community-based practitioners	9	VCS
Local authority staff / other providers / regional	6	LA/Other
School staff	5	Sch
Total number of interviews	**31**	

[5] Children and Adolescent Mental Health Services

Table 2. Summary of institutional work by commissioners and its consequences

	Mode of institutional work		
Level	Creating mechanisms	Maintaining mechanisms	'Disrupting' (challenging)
Field	Worked to shift belief systems: created 'normative network' ▪ New inter-organisational partnership	Worked to shift norms/beliefs: 'embedded and routinised' new practices ▪ New inter-organisation processes and practices	Challenged provider institution ▪ 'Old school' and relatively closed practices
Boundary spanning	Used financial resources for cognitive work: 'educating' non-specialists ▪ Funded and commissioned training to impart new knowledge and skills to school-based staff in basics of children and young people's mental health		Impacted boundary between health and education fields by enhancing 'mental health workforce' ▪ Practice-based changes ('holding' young people in school and not immediately referring) ▪ Evidence of epistemic shift