The translational role of hybrid nurse middle managers in implementing clinical guidelines: Effect of, and upon, professional and managerial hierarchy

Abstract

Our study analyses what hybrid nurse middle managers do in their managerial practice, what affects this, and with what effect, focused upon implementing policy-driven guidelines on the clinical frontline. Examining two comparative hospital cases, we conceive their role as one of 'translation'. On the one hand, they exhibit strategic agency. On the other hand, their managerial role not only influences, but is influenced by, professional and managerial hierarchy. In both hospitals, in the short-term, we see how hybrid middle managers are able to mediate professional and managerial hierarchy and implement clinical guidelines through translational work. However, in one case, they less effectively accommodate policy-driven, managerial pressure towards compliance with government regulations and financial parsimony. In this case, the outcome of their translational work is not sustained in the longer term, as professional and managerial hierarchy reasserts itself. Drawing upon the example of their managerial role in healthcare, we highlight that hybrid middle managers enact a strategic translational role and outline situational constraints that impact this more strategic role.

Key Words: hybrid manager, nurse, guidelines, translation, professional hierarchy

Introduction

Globally, health care organisations have been exposed to public policy reforms, moving them towards more 'managerialist' structures (O'Reilly & Reed, 2010). In countries susceptible to Anglo-Saxon influence, these policy reforms are aggregated under the rubric of 'New Public Management' (NPM) (Hood, 1991). NPM reforms involve a number of overlapping concepts, broadly encompassing the need to cut costs and improve quality through managerial, rather than professional, power (Diefenbach, 2009. Despite frequent attempts at organisational change, however, professionals are often seen as resistant to NPM reforms, viewing generalist managerial structures with distrust or suspicion (Ahmad & Broussine, 2003). Such professional resistance to managerialism, and an enduring commitment to professional identities and cultures, has led to an increased focus by policy makers on the

need for hybrid middle managers (HMMs), who combine managerial and professional responsibilities (Llewellyn, 2001), with growing evidence of their pivotal role in managing and organising contemporary healthcare (Dickinson et al., 2013; Kirkpatrick et al., 2009). Policy co-opts professionals into HMMs roles to bridge a policy implementation gap, with the expectation HMMs manage their professional peers (McGivern et al., 2015). Given this continuing focus upon their ranks to bridge a policy implementation gap, the time appears ripe to examine the strategic role of the HMMs, and develop a more grounded analysis of what HMMs actually do in practice.

Extant literature tends to consider HMMs as responding to new role demands through two dichotomous responses -- representative role, buffering their peers from managerial intrusion, or going over to the 'dark side' of management and acting in strategic organisational interest. At best literature may present a mixed response between these extremes (Croft et al., 2015; McGivern et al., 2015). Regarding hybrids as translators allows for fuller consideration of a range of responses that is more nuanced, and highlights not just their response, but what they actually do in practice, around which literature is sorely lacking.

Empirically, to make our contribution, we examine the day-to-day practice of HMMs as they engage in strategic change in the English National Health Service (NHS). Within this context, as well as making a more generic contribution to understanding middle managers' roles, our study responds to a specific call for fine-grained research on the strategic role of middle managers in healthcare organisations through rendering visible the strategic work they undertake in their practice (Walshe & Smith, 2011). We focus upon implementation of nationally produced clinical guidelines as exemplars for study of role of HMMs as translators. We discuss later the notion of HMMs as translators, with a focus upon healthcare. Before that, we detail our theoretical approach to translation.

HMMs and translation

To examine HMMs' managerial practice, we draw upon the notion of 'translation' that focuses on the role of agency and structure in the social construction of meaning and order (Czarniawska & Joerges, 1996). We draw upon the Scandinavian institutionalist notion of translation (Czarniawska & Joerges, 1996; Djelic & Sahlin-Andersson, 2006) that is an alternative to diffusion models developed by American institutionalists. The focus of translation literature is upon the situated nature of institutionalisation (Hasselbladh & Kallinikos, 2000; Kraatz & Block, 2008) and practice variation (Lounsbury, 2008). It signifies a departure from institutional theory's initial focus on isomorphism in organisational fields (Kirkpatrick, Bullinger, Lega, & Dent, 2013). Translation offers a valid 'explanation' for the obvious inconsistency between the perceived trends for organisations to adopt the same dominant set of managerial ideas from their institutional surroundings, but enact them in dissimilar fashion (Boxenbaum & Pedersen, 2009).

Middle managers' translational work during organisational change has received significant study over the years. Studies that invoke a translational role for middle managers investigate how middle managers acquire knowledge (Balogun & Johnson, 2004; Mantere, 2008; Raes et al., 2011), how they actively engage in using editing rules to legitimise their translational role (Balogun & Johnson, 2004; Teulier & Rouleau, 2013); what they do to enrol actors that work on the translation of the new idea (Wooldridge et al., 2008) and sell their own version of how the new idea should be translated in the organisation (Dutton & Ashford, 1993; Currie & Procter, 2005; Rouleau & Balogun, 2011). Studies have also taken a more practice-based view of their translation to consider how middle managers perform editing rules to translate ideas on the ground (Teulier & Rouleau, 2013). Aligned with this, our study examines middle managers' translation of new ideas on the ground to fully understand their translational role with a focus upon middle managers' practices and situational constraints

that frame this. Our study draws particular inspiration from Teulier and Rouleau (2013), who call for more research about the translational role for middle managers in the specific practices through which it is accomplished, with concern for situational constraints. In focusing upon situational constraints, we explore what hybrid nurse middle managers do in practice, what effects this, and with what effects.

HMMs and translation in healthcare organisations

The potential strength of HMMs as translators comes from their ability to view organisational issues through 'two-way windows' (Llewellyn, 2001), reducing resistance to, and encouraging uptake of, managerial reform by professional groups (Ackroyd et al., 2007; Bejerot & Hasselbladh, 2011; O'Reilly & Reed, 2010). By moving between managerial leadership (within the formal management structure of the organisation) and professional leadership (Marnoch et al., 2000), hybrids can theoretically encourage the 'translation' of managerial priorities in professional practice (Ackroyd et al., 2007), redressing professional resistance to organisational reform (O'Reilly & Reed, 2010).

There is a burgeoning literature, which examines HMMs in healthcare. However, commonly this focuses upon medical managers (Degeling et al., 2006; Doolin, 2002; Ham & Dickson, 2008; Iedema et al., 2004; Kirkpatrick et al., 2009; Martin & Learmonth, 2012). Yet there is evidence of a wide range of hybrids enacting middle management roles in healthcare, particularly nurses (Burgess & Currie, 2013). To this end, we offer insights on what hybrid managers with a nursing background actually do in practice, focused upon the implementation of standardised clinical guidelines, in the English NHS, NICE (National Institute of Heal and Clinical Excellence) Guidelines.

This is empirically significant because clinical guidelines are worthy of implementation for the delivery of significant improvements to the quality and cost-efficiency of healthcare, yet

clinical guidelines uptake into practice is low or uneven (Grol, 2001; McGlynn et al., 2003; Sheldon et al., 2004). Clinicians are more likely to adhere to clinical guidelines if developed by their own local professional networks than if developed by others (McDonald et al., 2007; Spyridonidis & Calnan, 2011; Taba et al., 2012), with HMMs expected to increase uptake (Ferlie & McGivern, 2014). Resistance of doctors, who act in ways that maintain or extend their discretion in clinical decision-making (Armstrong, 2002), is likely to impact the managerial practice of our focal actors. Specifically, we examine managerial practice of HMMs (Chronic Heart Failure Nurse Consultants) in the implementation of the NICE Guideline for Chronic Heart Failure (CHF) across two comparative hospital cases.

By positioning ourselves within the translational perspective, this study offers empirical evidence about middle managers' work during policy implementation. We contribute to the HMM literature by asking what HMMs do when implement national policy in the form of clinical guidelines in healthcare. Drawing upon this empirical example, we will describe the strategic practice of middle managers, which we conceive as translation, and the contingencies that frame this.

Translational work in healthcare: The role of HMMs in context

Within healthcare, 'hybrid' refers to middle managers who are skilled in an alternative occupation that implies greater communication between clinical practice and management (Llewellyn, 2001). On the basis there are now both people and organisational tasks that cross the boundary between clinical practice and management, management is no longer about 'oiling the wheels' (Harrison & Pollitt, 1994). Instead, management represents an organisational arena where difficult and contentious clinical management decisions need to be made, a process in which HMMs have a key role, since they are particularly concerned with service improvement, and have a zeal for change (Fitzgerald & Ferlie, 2000). The hybrid

implies greater communication between clinical practice and management, which were previously opaque to each other .

In the English NHS, HMMs may have different professional backgrounds, and may be located at different levels of the organisation, from clinical director and senior nurse manager, to outpatient department manager, diagnostic unit manager, modern matron, and ward manager. Regarding the role of hybrid nurse middle managers, NPM has driven general management roles, structures and processes, to impact the dynamics of professional hierarchy, so that others, such as nurses, in HMM roles can exert some power over doctors, as well as their own profession (Ferlie et al., 1996). Rather than controlling professionals through managers, the policy intent was to convert professionals into managers, reconstituting doctors' and nurses' subjectivities through their co-option into such roles, enabling professional governance from a distance (Martin & Learmonth, 2012).

Yet those taking up HMMs roles, such as nurses, are encompassed within a dynamic system of professions, both within their own profession and related to other professions, particularly doctors (Abbott, 1988). Occupational legitimacy and power are established within situated interactions framed by occupational hierarchy within the workplace (Abbott, 1988). Established professions tend to cede their core work only reluctantly, using an armoury of techniques to defend their territory (Abbott, 1988). By making claims to specialist expertise, dominant professions, such as doctors, are able to set the terms of reference of such territorial battles, so that challengers are immediately weakened by the need to appeal to the discursive norms of the dominant professions (Larson, 1977). Particularly within medicine, monopoly over the techniques and competences needed to practise in a given domain, and carefully guarded entry to a profession, assist the endurance of professional power and doctor-centric care models (Freidson, 1970). The result is that some professionals are positioned as higher status than others. We suggest that the dynamic nature of professional hierarchy may partially

determine which ideas are perceived more attractive for translation into everyday practice as HMMs exhibit agency in making their strategic contributions during the translation process. With regard to the translation of NICE guidelines, we would expect to see a range of outcomes from 'translating' NICE guidelines that are influenced by the power relations associated with professional and organisational hierarchy.

Recent research of HMMs highlight the difficulties faced by role holders at middle levels of the organisation in exerting influence over doctors and other senior clinicians with and through whom they work (Hales et al., 2012; Storey & Holti, 2013). However, in part of a result of policy change, which drives general management roles, nurses taking up managerial responsibilities may now have more influence over doctors (Burgess & Currie, 2013).

In the face of a potential empirical disconnect between policy aspirations for a more strategic role for hybrid nurse middle managers and that this is likely to be stymied by professional hierarchy, we need to examine what hybrid nurse middle managers do in practice, what effects this, and with what effects. In providing a grounded account of middle manager's strategic contribution, we focus upon their role in implementing policy. In particular, we ask what middle managers actually do during the translation of policy aims across time and what are the contingencies around this?

To answer our research question, we induce managerial practice of HMMs managers as 'translation' and link it to a wider literature to engender theoretical generalisation to other empirical settings. In doing so, when discussing data, we explore the perspectives of HMMs through an analysis of their stories organised around five key 'plots' (Czarniawska- Joerges, 1995): *problematisation, interessement, enrolment, mobilisation* and *translational outcomes*, detailed further in our description of how we analysed data. Such an approach allows us to

present insights into what hybrid nurse middle managers do in their managerial practice, what affects this, and with what effect.

Methods

The empirical context of the study

This study examined implementation of standardised guidelines in the English NHS, specifically the implementation of the NICE CHF guideline (or "tracer") in order to gain insights into what middle managers actually do during the translation of policy aims. To familiarise the reader with the NICE CHF guideline, and so they can assess the extent of implementation revealed in our empirical presentation, we summarise key recommendations of the NICE CHF guideline in Table 1 (NICE, 2003). On the one hand, NICE guidelines are directed towards maintaining cost-effectiveness, with the implementation of NICE guidelines subject to managerial rationality around use of evidence-based medicine. On the other hand, they inform clinical practice, aiming to reduce variation and enhance quality of clinical intervention. Pertinent to our research concerns, NICE guidelines impact discretion and autonomy traditionally enjoyed by powerful doctors in clinical decision-making (Dopson & Fitzgerald, 2006).

-- Insert Table 1 here --

Research design

In our examination of implementation of NICE CHF guidelines, we adopted a comparative case-study design, involving two similar sized hospitals. Given the orientation of NICE guidelines towards cost-containment, following scoping interviews with a larger sample of hospital providers, we selected two hospitals whose financial performance differed. Our first case was selected because it had a significant financial deficit over five years, whilst our

second hospital had a slight financial surplus over the same period. As evident in analysis detailed later, selection of comparative cases on this basis, proved significant with respect to the effect of professional and managerial hierarchy. The two hospitals also exhibited organisational structural differences regarding which individuals and groups were assigned which tasks to perform. Hospital1 featured the domination by doctors of key organisational posts like the Medical Director, Head of Clinical Effectiveness; they were responsible for most of the Hospital's clinical governance tasks. By contrast, Hospital 2 featured the domination of such key posts by a group of senior and middle managers and senior nurses – with the sole exception of the Medical Director, who was a doctor.

In our scoping of the research, it became apparent it was a very specific cadre of hybrid nurse middle managers, CHF Nurse Consultants, implemented NICE guidelines across all hospitals that we explored in negotiating access. Consequently, the CHF Nurse Consultant in each hospital provides the focal point for our analysis of the managerial practice, its effects and the effect of professional hierarchy. However, we interviewed others around the CHF Nurse Consultant. Taking account of inter-professional and intra-professional hierarchy, we interviewed doctors (including those in hybrid middle level and executive managerial positions, frontline nurses and those in hybrid managerial positions, and non-clinical managers, across both cases, as set out in our next section of research design.

Data collection

Within our comparative cases, we used a qualitative, interpretive research design drawing on face-to-face interviews with key informants. In both case studies, our access point for research was through the Medical Director, who led the clinical governance directorate responsible for the implementation of NICE Guidelines. They identified key informants, beyond the CHF Nurse Consultant, whom they thought would be involved in the

implementation of NICE guidelines in general and of the CHF NICE guideline in particular. We then used the snowballing technique (identification of further key informants during the fieldwork) to extend our sample of interviewees, from different occupational backgrounds and organisational levels, to further explore diverse and sometimes competing interests in the implementation of NICE guidelines. We stopped interviewing at the point of theoretical saturation, when interviews no longer provided additional insight into our theoretical concerns (Strauss & Corbin, 1990). We conducted 52 interviews in total. 46 semi-structured interviews were conducted with key informants immediately following implementation of local guidelines on the clinical frontline spread out over 12 months (2010-11) (see Table 2).

-- Insert Table 2 here --

Given our focus was upon changing clinical practices, we took the opportunity 9 months later to re-interview 6 key informants to assess whether the local guideline remained. These second phase interviews were carried out with: both CHF Nurse Consultants; 2 hybrid executive managers (one with nursing background, one with medical background) in Hospital 1; 2 hybrid executive managers (one with nursing background, one with medical background) in Hospital 2.

Further background data came from analysis of documentary evidence such as the NICE guideline on CHF, meeting minutes and implementation protocols for NICE guidelines. We triangulated these sources to enhance credibility of our analysis, in particular to counter self-attribution by HMMs for implementation of NICE guidelines. Further, within our interviews, we referred constantly to the implementation protocols for NICE guidelines as basis for assessing the extent of implementation. We note that hybrid nurse middle managers appeared

comfortable in making claims that they diverged from such protocols in their implementation efforts, and their claims regarding their agency were supported by others below and above them in managerial and professional hierarchy.

In interviews, we elicited informant perspectives on: NICE guidelines in general; more specifically on the CHF NICE guideline, how they perceived NICE guidelines in relation to other available evidence of best practice; how plans for guideline implementation were translated into practice; in order to provide a detailed account of the managerial practice of CHF Nurse Consultants. All interviews were transcribed verbatim, transcripts were anonymised, and a code number was assigned for identification purposes.

Data analysis

We used open coding to identify our interviewees' perceptions about implementation of NICE guidelines, who implemented them, and how they operationalised them in practice, with concern for contextual influences (Strauss & Corbin, 1990). Constant comparison of codes was utilised in a systematic way, so that similarities and differences in views were identified, while related key codes were collapsed into more abstract theoretical categories (Gioia et al., 2012) (see Table 3). In the following section, we explore the perspectives of HMMs through an analysis of their stories organised around key plots, which refer to 'schemes used for tying together actions and events through time and space' (Czarniawska-Joerges, 1995:15)

------*Insert Table 3 here*---------

The plots resemble to events associated with the translation of new ideas into practice identified in the literature on the sociology of translation and translation studies: *problematisation* indicates the most important actors and how problems are framed so that

other actors recognize them as their own problems; *interessement* locks those actors into alignment; *enrolment* is the outcome of the previous process, whereby more allies are attached whose roles must be defined and coordinated; *mobilisation* verifies the representativeness of the allies by persuading them that their interests are the same as the translator‘s (Callon, 1986) and *translational outcomes* imply that translations may be placed along a continuum of outcomes ranging from no or almost no change in the spreading construct to comprehensive local transformations (Lamb & Currie, 2012). We used these plots as analytical devices for making sense of the HMMs' translational role. In doing so, in the subsequent stories, we draw attention to what hybrid nurse middle managers do in practice when implementing the NICE CHF guideline, and the effects upon and effect of professional and managerial hierarchy.

Findings

We present our findings structured around five plots. Within the first four plots, we see similarities and differences across both cases in terms of HMMs' translational efforts to translate the national CHF guideline and accommodate professional and managerial hierarchy. Within our final plot we highlight differences between the two comparative cases that might explain the different translational outcomes.

Plot 1, Problematisation: most important actors and framing the implementation problem

Our analysis revealed informants' views that historical national policy developments predominant in the NHS made adherence to NICE guidelines problematic. The institutional demands regulating healthcare were regarded potentially, in conflict with each other.

Informants stressed opposing national policies fashioned organisational barriers for the implementation of NICE guidelines locally (Quotes S1T1 & S2T1, table 4)

These quotes expose an interesting dynamic ensuing from the way that our informants notice rival national policies as barriers to implementation of NICE guidelines. The translational role of CHF Nurse Consultants can be viewed as a response to conflict between rival national policies.

The CHF Nurse Consultants stressed that regulating doctors` practices was challenging. Dominant professional governing bodies, such as the Royal College of Physicians, ensured that doctors maintained a considerable degree of discretion. It was acceptable for doctors to deviate from NICE guidelines (Quotes S3T1 & S4T1, table 4)

Informants contended that NICE guidelines could not easily translate into practice because most clinicians thought that the drivers of change were managerial control from outside, rather than within, the profession. The dominant approach in current policy appeared to be a command and control model of implementation, based upon the policy maker's assumption that, because the CHF NICE guideline was produced by an authoritative body, it would be uncritically accepted by clinicians.

However, informants argued that any command and control implementation of the CHF NICE guideline was inadequate to sustain uptake of best evidence in the treatment of patients with CHF. Informants described early phase implementation across both hospitals, as showing resemblance to a commitment-based model of management (Khatri et al., 2006). In

particular, following publication of the CHF guidelines, the hospitals' executive management decided to strengthen their capacity to comply with national directives for the prevention/treatment of CHF. This led to the recruitment of new staff to give long-term commitment and professional ownership of implementation, displaying a high level of commitment to teamwork, professional values and empowerment (Quotes S5T1 & S6T1, table 4)

Building upon such understandings of policy as problematic and the commitment based approach to NICE guidelines implementation held locally, provided a potential opportunity for CHF Nurse Consultants to use strategic agency to problematise the institutional context for NICE guidelines implementation and articulate the manner in which it affected their organisation. They identified conflict between multiple national policy development and institutional arrangements and established themselves as a strategic resource.

However we also identified differences, which seem to arise not from the way the CHF Nurse Consultant *framed* the implementation problem, but rather to be a consequence of the difference in the professional background between the two CHF Nurse Consultants who make up the problematization. The CHF Nurse Consultant, in Hospital 1, was a specialist in community and preventative care and, in Hospital 2, in specialized treatment (Quotes D1T1 & D2T1, Table 1). We note difference of preference about *what should be translated* from the NICE guideline. The CHF Nurse Consultant in Hospital 1 saw their "translation " as involving a clear, long-term commitment to prevention and early prevention of CHF, whereas, in Hospital 2, the focus of work was in secondary care, involving highly specialised treatment of CHF patients (Quotes D3T1 & D4T1, table 4 to do).This mismatch of preferences led the CHF Nurse Consultants to interact with different stakeholders. We detail this further in the next empirical section.

Plot 2, Interessement: middle managers translational role locks key actors into alignment

In both our hospital cases, we note HMMs' attempts to establish themselves as a strategic resource by trying to convince clinicians and management that the different viewpoints and interests defined by HMMs were consistent with their own interests and viewpoints

Our informants stressed that NICE guidelines had to be adapted to the local context, and to do so, CHF Nurse Consultants had to 'blend' the dual responsibilities of implementing national priorities and catering for the specific needs of their own populations. They allowed for clinicians` discretion without ignoring the 'healthy' operation of their organisation. (Quotes S1T2 &S2T2, table 5)

We note, however, CHF Nurse Consultants interacting with different stakeholders. In case one, the community clinic introduced a service to the local GPs, whereby GPs referral went to the community clinic. The CHF Nurse Consultant made reference to educational and teaching workshops, in which GPs and district nurses were invited to participate (Quote D1T2, table 2). In contrast, the CHF Nurse Consultant in case two worked closely with the hospital consultant cardiologists (Quote D2T2, table 5).

CHF Nurse Consultants had to re-invent the organisation`s implementation strategy. We were able to observe this practice when we analysed and discussed strategic documents, such as NICE guidelines implementation protocols and minutes of meetings, with our informants. When we analysed these documents, we identified statements that were open to multiple

interpretations, such as, HMMs had to: ‘carry out a baseline assessment’ and ‘monitor compliance with NICE guidelines’.

When we discussed these documents with our informants, they suggested these documents were rather symbolic. For example, ‘monitoring of compliance with NICE guidelines’ was a key strategic action for NICE guidelines implementation but other frontline staff and senior managers agreed with CHF Nurse Consultants that it was not cost-effective to do so (Quotes S3T2 &S4T2, table 5).

Finally, CHF Nurse Consultants took on the role of translator, mediating between frontline staff, other HMMs, the CHF senior doctors and middle and executive management. In so doing, they strategically blended together different viewpoints and interests to minimise conflict within their local context, and combine managerial and clinical agendas. Their aim was to improve communication between executive managers and clinicians within their organisations (Quotes S5T2 & S6T2, table 5)

This was not without challenge for CHF Nurse Consultants, who, sometimes can be seen to move uneasily between managerial and clinical perceptions of successful outcomes and interests, thus showing that translating the NICE guidelines was a complex process. We note different interpretations of successful outcomes emerged over the course of the translation process between the two CHF Nurse Consultants (Quotes D3T2 & D4T2, table 5).

Nevertheless, what emerges is not just translation of NICE guidelines to take account of local context, but that HMMs exercise agency towards realising their strategic intent. We further discuss what HMMs actually do in their practice, in the next section, where we discuss how

they aimed to build up agreement among frontline staff, other HMMs, the CHF senior doctors and middle and executive management concerning their strategic role

Plot 3, *Enrolment: translational role framed by professional and managerial norms*

CHF Nurse Consultants highlighted professional norms and values as key to establishing integrity in the eyes of clinicians, undertaking similar clinical work and collectively generating the evidence base to inform their practices (quotes S1T3 &S2T3, table 6).

Their professional discretion is noticeable in accounts presented by CHF Nurse Consultants about managerial practice, as they emphasised that their healthcare organisations should 'not solely rely on NICE guidelines on how to treat patients' (CHF Nurse Consultant, Hospital 1). As HMMs, CHF Nurse Consultants were prepared to modify the CHF NICE guideline to reflect local circumstances. At the same time, CHF Nurse Consultants exercised some control over the development of the local CHF guideline. They argued that, because NICE guidelines were very strategic, their knowledge of context was necessary to accommodate operational issues on the ground (Quotes S3T3 &S4T3, table 6).

Integral to re-introducing the CHF NICE guideline to the local context was the necessity for CHF Nurse Consultants to constantly update their practice with new clinical evidence from the field of medicine. CHF Nurse Consultant (Hospital 1) argued for their translational role on the basis that NICE guidelines were not a 'living' document, so did not accommodate new evidence on CHF treatment. Hence, it was within the remit of the role of CHF Nurse

Consultants to translate guidelines in line with a constant search for the new evidence. The CHF Nurse Consultants recognised the value of the CHF NICE guideline as a means of disseminating best practice, but they stressed the importance of knowing how to search the literature, critically evaluate the various papers, and put their conclusions to clinical use (Quotes S5T3 & S6T3, table 6)

CHF Nurse Consultants also emphasised their managerial practice, employed to enhance improvements in organisational outcomes. In implementing the local guideline, as HMMs, the CHF Nurse Consultants emphasised financial management and performance management practices, which allowed them to exert control and authority over guideline implementation (Quotes S7T3 & S8T3, table 6)

Differences were analysable in terms of the sequence and type of activities that constituted implementation. Hospital 1 was under-performing and had a financial deficit, any organisational change needed to be consistent with a very strong-control based approach (Khatri et al., 2006) to guideline implementation. It was further claimed that the implementation of the CHF did not occur in a fiscal vacuum and thus managerial control was important and inevitable. That meant writing and agreeing a business plan was a long process that required moving back and forth between planning and authorization by different committees and characterised by discontinuity and inconsistency (Quote D1T3, table 6). In contrast, in the second case study, and as a consequence of the better financial position that Hospital 2 faced, the CHF Nurse Consultant getting agreement fro the development of the new community service was more straightforward (Quote D2T3, table 6)

HMMs thus worked to re-introduce the CHF NICE guideline and embed the local guideline into their local context. In so doing, HMMs aim to hold together their strategic role by mobilising efforts by doctors and their managers to support their translational work.

Plot 4, Mobilisation: holding together their strategic role

Within both hospital cases we found that, following construction of the local guideline, existing CHF care pathways were subject to change in accordance with the local guideline. A new nurse-led community service, managed by the CHF Nurse Consultant, for the treatment of CHF patients was introduced. The CHF senior doctors from the local hospital (in case two) and doctors from the community ('General Practitioners' or 'GPs') (in case one) changed their referral patterns and used the community CHF service. In this respect, the CHF Nurse Consultants` translational role in relation to the CHF service remit was recognised. In translating NICE guidelines CHF Nurse Consultants engaged in developing initiatives that support the interests of more senior professionals.

We note doctors commented upon the CHF Nurse Consultants` professional integrity – something not always possible where hospital consultants are not involved (Quotes S1T4 &S2T4, table 7)

Executive managers also supported the managerial practice undertaken by CHF Nurse Consultants, because they saw benefits coming from the ability of HMM to control the implementation process. Local guidelines took into account the local financial circumstances,

which shaped the ability of their organisations to implement best practices (Quotes S3T4, S4T4, table 7)

Central to the implementation of local guidelines was money. When additional funding was refused by their organizations for improving compliance rate with the local guideline, financial support was sought by the CHF Nurse Consultants, in their role as hybrid middle managers, from external providers, such as the British Heart Foundation (BHF) (Quote S5T4 & S6T4). However we note different ability to secure funding. In case one, the CHF Nurse Consultant was not able to secure funding. This was attribute to the fact the community clinic had a strong focus on prevention, which the BHF did not like (Quote D1T4, table 7).

In case 2 in contrast, through their interaction with BHF the CHF Nurse Consultant was able to attract the extra funding and expertise that proved crucial to improving the capacity of the CHF team to implement the guideline (Quote D2T4, table 7)

As evident in the next empirical section of the paper, whether the translation role of the CHF Nurse Consultant was sustained was determined by ongoing support of doctors and their managers. In short, as apparent below, hybrid nurse middle managers are unlikely to enjoy unfettered translation agency.

Plot 5, Translational outcomes: contingencies that frame translational activities

Apparent in interviews with key informants nine months following the implementation of local guidelines, local guidelines were sustained in Hospital 2 but not sustained in Hospital 1. CHF Nurse Consultant's translational work in Hospital 2 led to the emergence of new models

and innovations where the 'original' NICE was no longer be recognisable (Røvik, 2011). In large part, this was a consequence of the antecedents of performance and financial pressures faced by executive managers and professional hierarchy in both Hospitals. We detail this further with the following sub-themes.

Performance and financial pressures

Hospital 1 had been unsuccessful in the recent past in delivering key fiscal targets within the available resources, due to poor financial management skills (Quote TO2, CS1 table 8)

A financial deficit over five years together with poor leadership represented major obstacles for the CHF Nurse Consultant`s managerial practice in Hospital 1. It was emphasised, because the organisation was under-performing and had a financial deficit, any organisational change needed to be consistent with a very strong-control based approach (Khatri et al., 2006) to guideline implementation(Quote TO2,CS1, table 8).

The CHF Nurse Consultant emphasised executive managers` priorities changed once the organisation satisfied national policy, and successfully passed a national audit on CHF NICE guideline compliance (TO3, CS1, table 8)

Further evidence of the effect of the control-based model of management was the provision of financial incentives for GPs, which underpinned local implementation of the CHF guideline. Nurse Consultants requested extra financial resource to incentivise GPs. In the face of financially challenging circumstances, however, control was invoked

by executive managers, who now did not support their request. GPs meanwhile, refused to undertake extra work to support the new service (TO4, CS1, table 8)

Khatri et al., (2006) shows that the control-based approach can lead to low morale and a climate of mistrust. Employees can experience feelings of helplessness and frustration. Reflecting this, the CHF Nurse Consultant claimed changes in her status as a leader in community cardiology diminished her satisfaction with being involved in the implementation of the CHF guidelines. It appeared the implementation of the CHF guidelines was not sustained over the long haul (Quotes TO5,CS1 &TO6, CS1 table 8)

In contrast, in the second case study, the implementation of the CHF guideline was sustained over the long term. Having hitherto preserved a healthy fiscal balance, Hospital 2 allocated enough funding to the introduction of nurse-led specialised services, which was championed by the CEO long before the publication of the NICE (QuoteTO1,CS2, table 8)

In Hospital 2, late phase implementation maintained the characteristics of a commitment-based model (Khatri et al., 2006). Informants involved in the implementation of the CHF guidelines asserted executives decided to strengthen the organisation's capacity to comply with national directives for the prevention/treatment of CHF. This led to the recruitment of new staff to give long-term commitment and support. Increasing staffing levels, training and competence through deployment of widespread quality training was funded (Quote TO2,CS2, table 8)

Professional hierarchy 'bites back'

The CHF Nurse Consultant in Hospital 1 enjoyed some early success in the re-organisation of the community CHF clinics through building consensus among key decision-makers and offering alternative options for more cost-effective provision of CHF services, which was predicated upon a community-led nurse service. However, later, it was not just that she could not develop service, but the community service that she managed, was discontinued. At the same time, CHF senior doctors clawed back the service (Quotes PS1,CS1 &PS2,CS1, table 8)

In contrast, in the second case study, the sustainable uptake of the CHF guideline was not just a consequence of the better financial position that Hospital 2 faced, but reflected acceptance of the new service the CHF Nurse Consultant managed, by higher status professionals. The Medical Director from the hospital supported the nurse-led community CHF service. He continued to transfer most of the CHF patients to the community CHF team because this represented an opportunity to develop further the hospital cardiac department (Quote PS1, CS2, table 8)

Thus, we see the interests of the CHF Nurse Consultant and more powerful medical colleagues in the hospital are aligned. Indeed, the latter were prepared to manage their GP colleagues, whom we note are of lower status intra-professionally within the medical profession (Currie et al., 2009) in support of the community led CHF service, without a need to resort to financial incentives, so that the service was sustained (Quote PS2,CS2, table 8)

Aligning the diverse interest of key stakeholders was a crucial aspect of the CHF Nurse Consultants` managerial practice in Hospital 2, which reinforced and sustained their

translational role. CHF Nurse Consultants were trusted to ensure best clinical practice in CHF and so produce the best outcomes for their patients. We note the new service endures. On revisiting the site informally, one year later, following the end of our study, the CHF Nurse Consultant described a new model of care where the 'original' NICE was no longer be recognisable (Quote PS3, CS2, table 8).

Discussion

We explore what HMMs do in their managerial practice, what affects this, and with what effect Specifically, we consider two comparative cases of hospitals in the English NHS, where an emerging hybrid managerial cadre, CHF Nurse Consultants, implement standardized guidelines into frontline clinical practice. Drawing on their stories, our analysis is organised around five key story plots around problematisation, interessement, enrolment, mobilization and translational outcomes. We note similarities and differences in HMMs' story plots and we shed light on how variation in the dynamics within the stages shape translational outcomes. For instance, we see, in both hospitals, HMMs' stories about the institutional context around policy and professional organisation provides impetus for their managerial practice in translating NICE CHF guidelines. We note HMMs' problematise policy as inconsistent and recognise that those subject to change perceive professional autonomy as sacrosanct, so that managerial intrusion is unwelcome. However HMMs' problematization is framed differently. We see difference of preference about what should be translated from the NICE guideline. This mismatch of preferences led the CHF Nurse Consultants to interact with different stakeholders (*Plot 2*). We also note differences in terms of the sequence and type of activities that constituted implementation across both cases (*Plot 3*). For instance, Hospital 1 was under-performing and guideline implementation needed to be

consistent with a very strong-control based approach (Khatri et al., 2006). Consequently, guideline implementation was a long process that required back and forth movements between planning and authorization. In contrast, getting agreement from the development of the new community service in the second case was more straightforward. Finally, we also see differences in the CHF Nurse Consultants' ability to sustain and enhance their strategic role (*Plot 4*). So, while in the short-term, the CHF Nurse Consultants' were able to mediate professional and managerial hierarchy and implement clinical guidelines through translational work, in one case, they less effectively accommodate policy-driven, managerial pressure towards compliance with government regulations and financial parsimony. In this case, the outcome of their translational work is not sustained in the longer term, as professional and managerial hierarchy reasserts itself. Drawing upon the example of their managerial role in healthcare, we highlight that hybrid middle managers enact a strategic translational role and outline situational constraints that impact this more strategic role.

Bringing empirical analysis together theoretically, within our study, the stories support existing work that explores middle managers' role as translators of strategic change (Fauré & Rouleau, 2011; Rouleau, 2005). In particular our study reinvigorates Fauré and Rouleau (2011, p. 180) finding that, 'the strategic role of middle managers as translators between heterogeneous stakeholders is becoming more and more important in many industries and has so far been underexplored'. By describing the HMMs' translational role related to the fluid negotiation of professional jurisdictions and managerial tasks, our study contributes to the recent research on middle managers' micro-practices that affect strategic change (Rouleau & Balogun, 2011).

The second striking element to emerge from our study was the interdependency of actors and situational constraints that impact translation in professionalised contexts, where middle

managers' translational role and outcomes may vary (Reay et al., 2006; Teulier & Rouleau, 2013). By focusing upon the translational role of middle managers at the micro-level, our study renders visible the effects of, and upon, HR management practices, professional and managerial hierarchy and the influence of NPM (with its emphasis upon performance management). Our study supports many current understandings about the interplay between professions and other actors, such as policy makers and administrators. However, our study draws attention to key dynamics of the relationship between antecedents of professional hierarchy and exogenous pressures that determine middle managers' power to embed change. Our findings extend literature about HMMs -- we show HMMs seem crucial to embedding change, rather than just one off implementers or of being a passive recipient (Balogun, 2003).

Extending extant literature that shows not all HMMs are equally able to embed strategic change (Ahearne et al., 2013), our study contrasts the effect of control-based and commitment-based approaches to management of employees (Khatri et al., 2006). Specifically, our study shows commitment-based management approaches provide opportunities for middle managers to exercise initiative, ingenuity, and self-direction in realising strategic change.

We note the effects of inter-professional and intra-professional differences, or about how the dynamic nature of professional hierarchy might affect middle managers' strategic role. Our study considers how middle managers' roles are framed by differential power and status, so that some HMMs enjoy more legitimacy to accommodate policy-driven, managerial pressures and professional hierarchy and embed strategic change on the ground. Other recent academic studies confirm effects of inter-professional and intra-professional hierarchy. (Currie & White, 2012). In their study of modern matrons that enact HMM roles, Currie et al. (2010) highlight their limited influence within their own nursing ranks, as well as their sub-ordination to doctors. Meanwhile Croft et al. (2015) characterise the role of hybrid nurse

middle managers as one existing in a liminal space, within, and between, professional hierarchies, a position from which they struggle to exert influence over others within, and outside, their own ranks. In essence, the effect of hybrid nurse middle managers is one considered to be limited by inter-professional and intra-professional hierarchy.

Extant literature tends to present variation in response as something to do with individual characteristics of hybrid managers (Korica & Molloy, 2010; Llewellyn, 2001; Spyridonidis et al., 2014), whereas our study highlights situational constraints as key. In this light, our study warns that possibilities for strategic contributions by middle managers are only realised, when middle managers' practice aligns with interests of higher status actors, otherwise the latter are likely to enact power in a way that 'bites back' at interests of the former. Translating this to the organisational level, we highlight situational constraints: in our empirical study, different modes of HR, financial deficit and performance pressures, influence whether middle managers' strategic activity can be integrated in an organisation. Thus, we cannot assume an enhanced role for middle managers easily materialises, as strategic change emerges.

The figure below (Figure 1) demonstrates the key themes discussed so far and most importantly it reveals their dynamic relationship. It represents CHF Nurse Consultants' managerial practice of translation in their role as a HMM, with a focus upon their mediation of professional and managerial hierarchy that influenced the implementation of the NICE CHF guideline. This figure highlights that translational practice of CHF Nurse Consultants was similar across both case studies, at least until its final phase.

-- Insert Figure 1 here --

Conclusion

We offer new insights on what HMMs do in their managerial practice, what affects this, and with what effect through considering their translation role (Czarniawska & Joerges, 1996; Røvik, 2007). We show that HMMs are capable of mediating professional and managerial hierarchy via practices of translation. We show difference regarding the degree to which HMMs translate policy intent for others and how context impacts translation (Boxenbaum, 2006; Frenkel, 2005), highlighting significance of professional hierarchy (Abbott, 1988), managerialist policy pressures (Meier & Hill, 2005), and approaches to management of human resources (Khatri et al., 2006). Our study shows that hybrid nurse middle managers understand and interpret policy intent for others. We show that agency of HMMs and professional and managerial hierarchy 'enjoy' a recursive relationship, the latter never being far away from 'biting back', even as HMMs try to accommodate potentially competing agendas and interests. Finally, we show that the HMMs are capable of connecting divergent ideas generated from within the organisation with strategic issues (Floyd & Wooldridge, 2000), but this is part of a fluid negotiation of professional jurisdictions, in response to the call for such studies by Wooldridge et al., (2008).

In practical terms, those policymakers and senior managers keen to implement NICE guidelines and other policy intervention, need to consider the interaction of translation with professional and managerial hierarchy and different modes of HR. Specifically, they need to consider to whom they allocate a translation role, and how they support translating actors. Our study confirms that HMMs are uniquely capable of working through and translating sets of ideas belonging to management and sets of ideas belonging to clinical practice (Llewellyn, 2001). However, to do so requires that their translational ability is enhanced through mediating professional hierarchy, and through buffering them from financial pressures (Burgess & Currie, 2013).

Finally, linked to the above, we encourage further research to assess the transferability of our model, set out in Figure 1, but with concern for translation carried out by other actors in healthcare organisations and settings, from different positions in the hierarchy, so as to examine the interaction of translation with professional and managerial hierarchy. Professionals are increasingly moving into hybrid management roles across public sector organisations globally, not just in healthcare, but in local government (Morgan et al., 1996); secondary schools (Busher & Harris, 1999) further education (Gleeson & Shain, 1991), higher education (Clegg & McAuley, 2005), social work (Jones, 1999), civil service (Thomas & Dunkerley, 1999). The strategic role of hybrid actors as translators may also extend beyond the public sector, an example being accountants, expected in this case to combine technical and customer-orientated roles where they act as translators across their professional peers and executive managers (Granlund & Lukka, 1998).

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Apendixes

Figure 1: HMMs' practice of translation

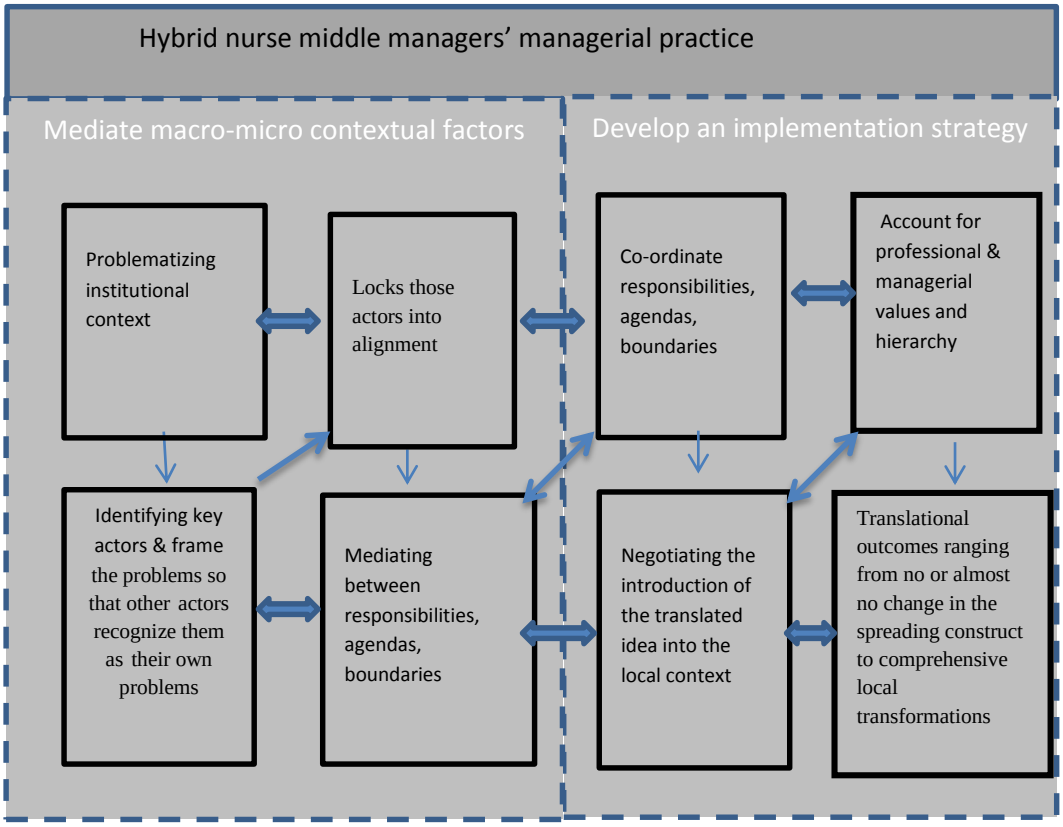

Table 1: NICE CHF guideline, key recommendations

- Streamline the CHF treatment pathway between primary and secondary care
- Introduce community clinics led by experts who should take the lead in the treatment of CHF patients
- Ensure that CHF patients are on β-blockers
- Ensure that echocardiographic examination for assessing CHF patients is available
- Introduce and improve palliative care
- Decrease hospitals' length of stay

Table 2: Type and number of informants interviewed

Organisation role	Hospital one	Hospital two
CHF nurse consultants	1	1
Frontline nurses delivering CHF	5	7
Hybrid executive managers with a nursing background	7	9
HMMs with a medical background	3	2
CHF doctors	1	2
Non-clinical executive and middle managers	4	4
Total	21	25

Table 3: The following figure depicts the data analysis process and the progression from simple coding to more aggregate theoretical categories

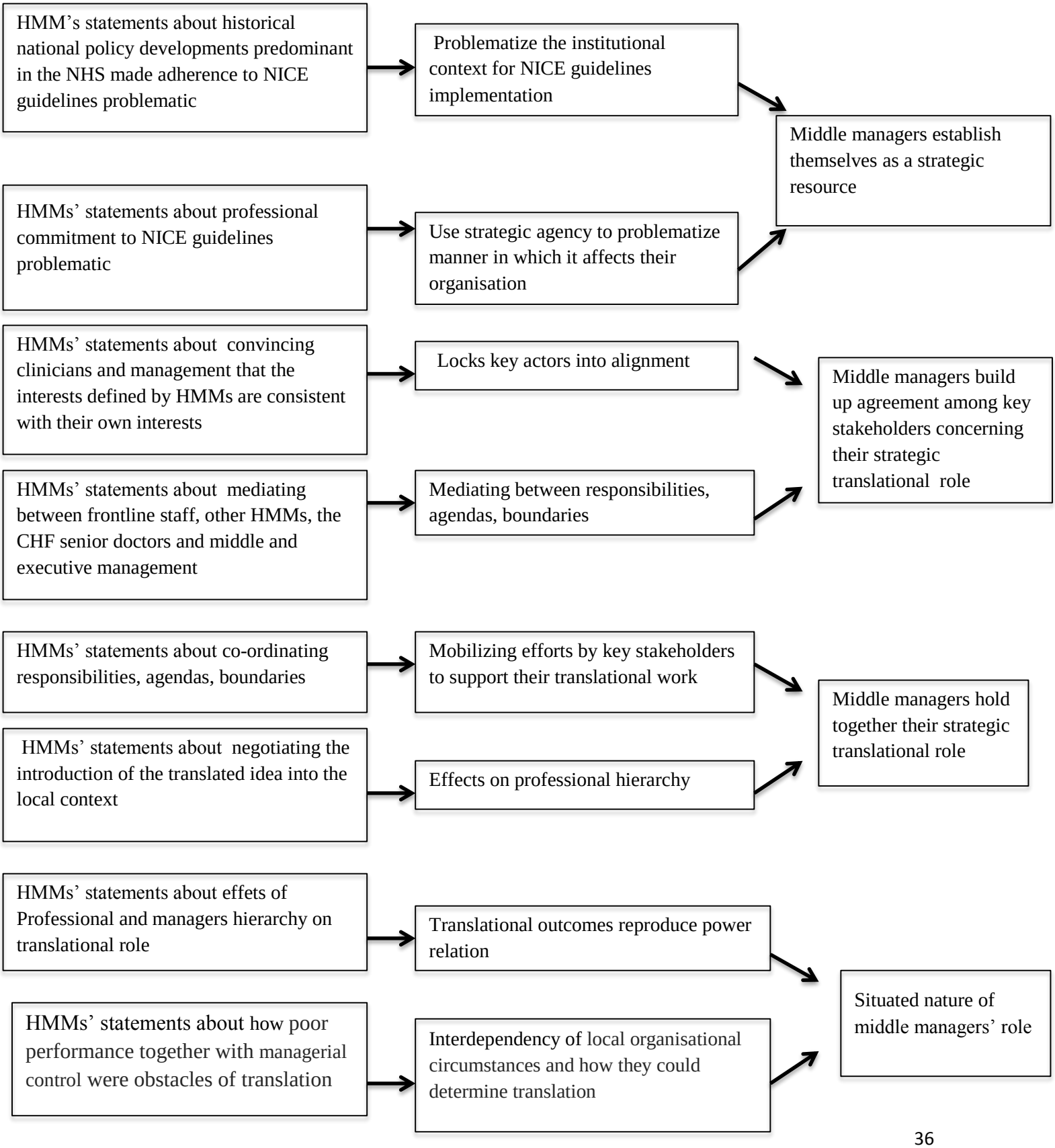

Table 4, Problematisation: most important actors and framing the implementation problem

Similarities	
Competing national policies	Health policy of having alternative providers and choice has built up organizational barriers, rather than knocking them and I think this would impact upon the implementation of things like NICE guidelines (Executive Lead Nurse, Hospital 1) (Quote S1T1) Policies that come down from the Department of Health sometimes conflict with each other. A policy that has come down one day may be in direct contrast to policy that comes down another (Head of Clinical Governance, Hospital 2) (Quote S2T1)
Doctors` professional autonomy	Doctors have the right to prescribe differently in many ways, influenced by their knowledge and interest. You can't enforce clinicians to implement guidance, because you need to allow that freedom to act in the best interest of patients (Director of Nursing, Hospital 1 (Quote S3T1) It is all about developing professional expertise that hinders NICE guidelines implementation. Doctors are difficult to persuade to comply with NICE. They often will say, 'this is how I do it' (CHF Nurse Consultant, Hospital 2) (Quote S4T1)
Commitment-based model of management	We have much more intelligent approach to implementation. No one could deny that the NHS needs to monitor its activity and have mechanisms of doing that, but, I think our approach is more professionally oriented with more professional discretion about the kind of intensity around which implementation is monitored (Chair of NICE Guideline Implementation, Hospital 1) (Quote S5T1) In terms of that commitment and professional discretion I think it's really good that it's growing over the last year. So, that's been been really reassuring actually that there is this continual buy-in (CHF Nurse Consultant, Hospital 2) (Quote S6T1)
Differences	
Job characteristics and responsibilities	I have been nursing approximately for 14 years and always being in community cardiology since qualifying, which is a heart failure specialist job, but it is a community job rather than a hospital job (CHF Nurse Consultant, Hospital 1) (D1T1)

	I had developed this special interest in the treatment of CHF and managed the clinical cardiology team and know I am head of integrated governance leading the community service (CHF Nurse Consultant, Hospital 2) (D2T1) Obviously I had to develop and maintain strong links with the local hospital and ensure that CHF patients received the right level of treatment. I have been looking at putting together a needs assessment for the prevention and early diagnosis of CHF in the area and planning how to do that and allocating for myself a number of jobs and thinking of the kind of information I need to collate and put together (CHF Nurse Consultant, Hospital 1) (D3T1) I lead the CHF community service. My role is partly as Head of the clinic. I have a small clinic looking into specialized treatment in the community and also she provides strategic CHF advice to a whole variety of people within the hospital (CHF Nurse Consultant, Hospital 2)(Quote D4T1)

Table 5, Interessement: middle managers translational role locks key actors into alignment

	Similarities
Clinicians` discretion and 'healthy' operation of their organisation	It is important for me to facilitate clinical change without ignoring cost-effectiveness that is implicit in the job of being clinical lead (CHF Nurse Consultant, Hospital 1) (S1T2) I think there is an increasing level of regulation and performance management right across the NHS, which places great demands upon all of us. We have to focus on our local needs without ignoring national priorities. It is the conflict between the local and national needs. And you have to be able to say that we have to take into account our clinicians experience as well (Senior Nurse Manager, Hospital 2) (S2T2)
re-invent the organisation`s implementation strategy	We don't always know how we could monitor compliance with NICE guidelines. To do that we have to spend too much time and effort, and I can't see the cost-effectiveness of that (CHF Nurse Consultant, Hospital 2) (S3T2) Our local strategy just gives prompts to consider when implementing. In a way the process is left under the discretion of the leading person; it is not explicitly said to do things […] I think that my role is to drive it (CHF Nurse Consultant, Hospital 2) (S4T2)
Strategically blended	Sometime clinicians are really like 'ok what does it [senior

together different viewpoints	management`s vision] mean for me?' What we are doing is trying really to translate information in order for it to go out as simply as possible to people (CHF Nurse Consultant, Hospital 1) (S5T2) So as the clinical lead some of the things I try to do is to translate government policy into conversation with our managers, our clinical staff about the benefits that the patients get and where that is easy to do we just get on and do it (CHF Nurse Consultant, Hospital 2, Hospital 2) (S6T2)
	Differences
Interacting with different stakeholders	We developed a proposal based on NICE guidelines and we went round all the GPs introducing the service in order to use them and also the community as well (CHF Nurse Consultant, Hospital 1) (D1T2) *We introduced a community care clinic to get all the CHF referrals from the hospital and the community. We introduced a service for echocardiographic examination for assessing CHF patients here*, we had the cardiology team from the acute hospital and the consultant cardiologists were very influential because most GPs did respect them; (CHF Nurse Consultant, Hospital 2) (D2T2)
Successful outcomes	For me, a successful outcome is to improve prevention, which require time to assess though. The implementation of the NICE guideline is also important for me (Frontline CHF Nurse, Hospital 1) (D3T2) Fewer admissions to hospital for CHF, that was the bottom line for us. I m not sure whether the death rate has gone down but I hope it has but I do not know. However, we do not see quite as many CHF patients; they are dealt with well in the community (D4T2)

Table 6, *Enrolment: translational role framed by professional and managerial norms*

	Similarities
Professional norms	I am influenced by good quality studies and not commercially biased that have to be validated. Meeting other people with similar interests, you get new information, what is happening and what is going on. (CHF Nurse Consultant, Hospital 1) (S1T3) It is difficult. In some cases you have conflicting studies, especially about drugs. You have to take this into account. It is very difficult to get the balance right, so you have to appraise the literature, but the literature is not really going to touch that, it is more about developing professional expertise (CHF Nurse Consultant, Hospital 2) (S2T3)
NICE guidelines as strategic resources	NICE guidelines are not so good at looking at practicalities of our local context, which local guidelines will do. We developed our local protocol guidelines, because the [NICE] does not provide the how-to-do. (CHF Nurse Consultant, Hospital 1) (S3T3) The NICE guideline was are more of a framework of what should actually happen but what you actually need are the resources or initiatives that make it work in your areas. NICE guidelines don't give the resources , they give you the framework to follow, but the doing of it is coming from other resources CHF Nurse Consultant, Hospital 2) (S4T3)
NICE guideline not the only resource	You could practice evidence-based medicine not necessarily grounded in clinical guidelines, there are things that you are doing them in a certain way because of experience in searching and appraising the literature (CHF Nurse Consultant, Hospital 1) (S5T3) Personally what is important for me and what makes sense is that I provide high quality clinical care, if NICE helps me doing it then great (CHF Nurse Consultant, Hospital 2) (S6T3)
Exert control and authority over guideline implementation	We developed the financial planning for the year, as well as deadlines to be devoted to implementation. These practices are about audit, as well as trying to understand what influences implementation of NICE (CHF Nurse Consultant, Hospital 1) (S7T3) We have devolved responsibility for the NICE guideline implementation into the clinical division and make [name of the CHF Nurse Consultant] responsible for delivering the updates that are relevant (Chair of Clinical Division, Hospital 2) (S8T3)
	Differences
Approach to	Writing a business plan is a long process, It is the bureaucracy. It is not so

management	much form filling, but it is procedure. For example, I put in a bid for funding from the hospital budget for the forthcoming year and spent a couple of days doing that, and yet in order to release the money I have to do another business case, a completely different format (CHF Nurse Consultant, Hospital 1) (D1T3) A business proposal was put together by us[clinicians] with a bit of support from management. It went to the board and I think it took two months until the funding was available. This allowed long-term planning (CHF Nurse Consultant, Hospital 2) (D2T3)

Table 7, Mobilisation: holding together their strategic role

CHF Nurse Consultants` professional integrity	The CHF Nurse Consultant is working in the best interest of my patients and I trust the way she is going about her work, from an integrity point of view (CHF Doctor, Hospital 1) (S1T4). There is this attitude that you have to have the right amount of knowledge, experience and professionally training to be able to support people actually. And a good example of that is the use of [name of the CHF Nurse Consultant] to develop the CHF community clinic (GP, community clinic) (S2T4)
Managers supporting Nurse Consultants' managerial practice	I am not clinically trained, so I take my guidance from our CHF Nurse Consultants. I would not dream of saying I know better than them, because the NICE guidelines say something different. (Executive Manager, Hospital 1) (S3T4) I trust she can show evidence of what we do, I can see her energy auditing ourselves and showing figures to people so they know what we do and justify the patients need and support (Head of clinical governance, Hospital 2) (S4T4)
Interaction with external agencies	We did put some bids in at the British Heart Foundation to try to get some nurses in (CHF Nurse 3, Hospital 1) (S5T4) I had a lot of support and funding from the British Heart Foundation (BHF). I have a good relationship with them CHF Nurse Consultant, Hospital 2) (S6T4)
	Differences
Securing successful	I was hoping that we can actually move things forward because some funding has been promised to try to provide the support out side there in

funding	the community but we didn't manage to get it. I suspect this was because our service has a strong focus on prevention and the British Heart Foundation in more interested in prevention (CHF Nurse Consultant, Hospital 1) (D1T4) We have very strong links with them [BHF], in fact two of our nurses have always been employed by them (CHF Nurse Consultant, Hospital 2) (D2T4)

Table 8, Translational outcomes: contingencies that frame translational activities

Case 1	
Performance and financial pressures	We have been through some nasty financial deficits in the past, although we are well out of that now and in a good financial position. (Director of Operations, Hospital 1) (TO1CS1) We have developed vertical structures that do not support the implementation of guidelines, which I see very much as a horizontal linkage. Issues that have to do with clinical effectiveness have been neglected. And this structure is chosen in order to deliver [on] the external pressures. (Medical Director, Hospital 1) (TO2,CS1) We passed a national audit of CHF and the hospital sees our service is complying with NICE and this is enough for them, but not for me. (CHF Nurse Consultant, Hospital 1) (TO3,CS1) I still get some referrals from GPs, but much less. If the hospital board allowed us to provide some financial incentives I think we would be in a better place (CHF Nurse Consultant,

	Hospital 1) (TO4,CS1) I still get some referrals from GPs, but much less. If the hospital board allowed us to provide some financial incentives I think we would be in a better place (CHF Nurse Consultant, Hospital 1) (TO5,CS1) Our community CHF service conforms to the national directives. We could develop this service but we have to be careful with our investment plans. We got in the habit of becoming parsimonious with our resources because we have seen some nasty financial deficits (Director of Commissioning, Hospital 1) (TO6,CS1) Money was well managed within the organisation, so the CEO championed the CHF specialised services. We have a lot of specialist teams that are lead by nurses. (CHF Nurse Consultant, Hospital 2) TO1, CS2) Four special CHF nurses were taken on and worked with the cardiologist for a six-month period. All these were about increasing commitment and expertise to meet the patients' needs. (CHF Nurse Consultant, Hospital 2), (TO2, CS2)
Professional hierarchy 'bites back'	When the CHF Nurse Consultant came into post this was a huge priority. She instituted and led a local CHF group. There was a huge amount of work done (CHF Nurse 1, Hospital 1) (PH1,CS1) The cardiac rehabilitation is likely to go the same way, back to a medical consultant led service in the hospital. We agreed to move it to the community. However, the hospital currently has it and it might stay there (CHF Nurse Consultant, Hospital 1) (PH2,CS1) The idea was that if the cardiologists

	could offload the heart-failure patients to the community, it would increase their scope to develop their particular area and need as well. (CHF Nurse 3, Hospital 2) (PH1,CS2) We had the right support from the medical director. We used to write to non-compliant GPs and we were also copying the letter to the medical director, which is another thing that made them think about their practice. (CHF Nurse 2, Hospital 2) (PH2,CS2) Our service has been running for a long time now. We already do most of the things that NICE says and many more. The NICE guideline was a good place for us to start, but we have developed our own guideline. We are amongst the very few hospitals (nine in England) that are doing the incredible complicated vascular stents. That's not in the NICE guideline. It is about having the leading edge locally and investing in good practices. (CHF Nurse 2, Hospital 2) (PH3,CS2)