Welfare professions as heroines: Institutional work in Danish elderly care

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Funding

This research was funded by 'Folkesundhed i Midten', Central Denmark Region (Grant number XXX)

Introduction

Welfare states across Europe and their elderly care services have been subject to a variety of public management reforms over the last four decades. Since the 1980s, New Public Management emerged as a response to welfare states, which appeared increasingly bureaucratic and expensive. Marketisation and managerialism promised the provision of the 'best and cheapest' services (Dahl and Rasmussen 2012, Hood 1991). This included disaggregation of public services to their most basic unit as well as evaluation of input and outputs through performance management (Osborne, 2010). In the context of the universalism of Nordic welfare states, disaggregation also lead to standardisation (Dahl and Rasmussen 2012). However, one of the unintended side effects of NPM has been a narrow focus on the internal workings of welfare providers (Torfing and Triantafillou 2013, 2017), which has exacerbated problems of coordination. In the first decade of the new millenium, New Public Governance has emerged as an alternative governance paradigm. It focuses on inter-organisational relationships (Osborne 2006, 2010) and interdisciplinary cooperation for example based on networks (Torfing and Triantafillou 2017). This builds on a state characterised by a range of interdependent actors and multiple processes feeding into the delivery of elderly care.

Importantly, the two governance paradigms exist side-by-side and this creates a range of tensions and dilemmas. The literature on welfare governance/the governance of elderly care has tended to be concerned with mapping out existing governance arrangements, whereas it has been less interested in how welfare organisations address challenges associated with different governance arrangements. This overlooks the potentially important contribution welfare professions can make by virtue of their position as mediators between the welfare state and its citizens (Bertillson 1990, Järvinen and Mik-Meyer 2012). Based on a case study of care pathway in elderly care in Denmark, the aim of the present paper is to analyse how welfare professions like nurses, physiotherapists, occupational

therapists and care assistants through their practice contribute to the making of interprofessional coordination in elderly care.

The case study focuses on the recent introduction of a care pathway in Aarhus, the second largest city in Denmark. The Care Pathway draws on different governance paradigms and includes both standardised rehabilitation packages (NPM) and interprofessional coordination (NPM). It defines specific care services, named contact persons and coordination and milestones relation to three distinct groups of frail elderly, and it requires nurses, physiotherapists, occupational therapists, care assistants and helpers to engage on close collaboration. The case study thus can show how these welfare professions become 'heroines', struggling to make different parts of the Care Pathway fit together. We apply the term 'institutional work' to account for these formal and informal practices of coordination. This type of institutional work is highly gendered as it is primarily done by female, welfare professionals and largely invisible (Doessing 2018a, Strandås et al. 2019: 8).

The next section outlines the theoretical framework of our analysis, which draws on studies of professions and institutional theory. The subsequent section accounts for the methods of our study, whereas the following section presents the results of the analysis. We conclude by summarising our findings and discussing our contribution to the literature.

Theoretical framework

Professions are key to welfare states and the literature has conceptualised the embeddedness of professions in broader societal contexts in different ways (for an overview see Burau 2016). Looking at the systems level, Clarke and Newman (1997) suggest that the welfare states emerging after the Second World War built on 'professional (welfare) bureaucracies'. Subsequent public

management reforms have questioned the centrality of professions and contemporary welfare governance is more hybrid in nature. However, professions continue to play an important role, although under different terms (Newman 2001). Professions are part of relevant networks, but together with public and other non-public agencies; there is also space for new occupational groups at the same time that the boundaries of established professions are becoming softer (Newman 2013). Similarly, Bertilsson (1990) highlights the crucial role professions assume in welfare states, where they emerge as mediators between the state and citizens. As part of their daily work, professions do both, they administer welfare rights on behalf of the state, and they materialise these welfare rights for individual citizens. This can result in conflicting pressures, as professions have to engage in dual advocacy: they at the same time have to legitimise the welfare state and they have to defend the needs of individual citizens.

With New Public Governance, the meso level of organisations is becoming an even more prominent arena for welfare governance, and it is therefore important to conceptualise the societal embeddedness of professions specifically at this level (Denis et al. 2016). This is the focus of a recent body of analyses of professions, which draws on insights from the literature of organisational studies (for an overview see Ackroyed 2016, Denis et al. 2016, Muzio and Kirkpatrick 201, Muzio et al. 2013). Analyses build on a view of organisations as interrelated systems of professions. A classic example is the health division of labour in hospitals, which is shaped by the expert knowledge and associated interests of medical specialists, as well as by the rationales of hospital managers. From this perspective, organisations emerge as the central arena for dual processes of institutionalisation and professionalisation (also see Suddaby and Viale 2011). For example, Noordegraaf (2011, similarly, 2007) coins the notion of 'organized professionalism' to capture the synthesis between institutional and professional logics. Projects of institutional change, for example

concerned with service delivery in interprofessional teams, regulation of quality and safety or improvement practice through use of evidence, offer a lever for projects of professional development broadly understood. At the same time, professions emerge as influential actors in processes of institutional change. This involves constructing, organising and ordering social life in different ways. One example is the co-optation of doctors in healthcare management (Numerato et al. 2012). This requires doctors to employ a complex set of tactics, but which secures managerially defined goals as well as allows reinforcing medical professionalism.

This raises questions about the specific nature of professional agency. What makes professions engage as institutional agents at the meso level of organisations? Following the sociology of professions, studies have typically considered professional projects as the main driver. This goes back to the Neo-Weberian understanding of professions as defined by social closure, whereby professions strive to maximise autonomy (over their practice and entry into the profession) and dominance over other professional groups (for an overview see Ackroyd 2016). An example of self-interested agency is Suddaby and Viale's (2011) discussion of professions and field-level change. The focus is on how processes of professionalisation, pushing the boundaries of professional territory, have repercussions for organisational fields. However, the drivers for professions as institutional agents have become more diverse. Brint (1994) argues that professions have been moving from being social trustees to being professional experts. Professions have traditionally built their legitimacy on possessing expert knowledge and practicing to the greater good of society. This still applies, but only to the extent that knowledge and related credentials match organisational functions and market forces. Muzio and colleagues (2013: 706) therefore make a case for a broader understanding of drivers, following the work by Scott (2008). From this perspective, professions play broader institutional roles drawing on cultural-cognitive, normative and regulative dimensions:

providing categories to frame issues, offering norms to guide action, and engaging with legally sanctionable rules respectively.

Drivers say something about what motivates professions to engage as institutional agents, but not much about the specific roles professions take on. What are the specific roles through which professional agency articulates itself? Building on arguments about the growing importance of organisations as entral sites of (welfare) governance, several authors stress the need to focus on the daily practice of professional work and connect this to the 'institutional work' (Denis et al. 2016, Muzio et al. 2013). The concept captures mundane and everyday activities, designed to create, change and maintain institutions. Such activities involve both reflexivity and agency (Muzio et al. 2013: 708): professions consider how their actions relate to specific contexts and they also able to vary routine action. According to Denis and colleagues (2016: 224f; similarly Muzio et al. 2013) the focus on practice offers a more critical, context sensitive understanding of professional agency: it evolves in specific organisational contexts and can include both acts of contributing to and resisting change. In their study of neighbourhood nurses in the Netherlands, Postma and colleagues (2014) go one step further and argue that institutional work can be an intrinsic part of professional practice, but which receives a new meaning in the face of changes in organisational settings. This challenges the view of professions as embodied in organisations as a novel phenomenon, reflecting broader societal transformations such as New Public Management reforms (Allen 2014, Døssing 2018).

In the present study, institutional work concerns the formal and informal practices of coordinating elderly care across a range of organisational and professional boundaries. Formal coordination is typically tied to structures at macro and meso levels, but which is intertwined with informal

coordination. As Doessing (2018) argues in relation to practices of inter-organisational coordination by nurses in Denmark, informal coordination can be both supplementary and by-passing, and the former can include informal meetings, non-obligatory telephone calls and shared e-mails. From this perspective, the interplay between formal and informal coordination is an indication of the concurrence of institutional and professional ambitions for inter-organisational coordination (Doessing 2018: 700).

Methods

The analysis was based on a qualitative case study of the introduction of an interprofessional care pathway to elderly care in the municipality of Aarhus, Denmark. We used a multiple case-design (Yin 2009) in which a case was defined as a geographical district with nursing homes and home care providers that had implemented the Care Pathway. The multiple case-design was chosen in order to be able to understand and study the introduction of the care pathway as a complex phenomenon and as it allowed us to compare interprofessional coordination both within and across cases (Yin 2009).

Study setting

Our study was based on a given case as it was part of a joint research project on the introduction of the 'Care Pathway' (described below) conducted together with the municipality of Aarhus. The case however represents a current, national trend within Danish elderly care where Danish municipalities introduce various models for everyday rehabilitation for elderly citizens, aiming to develop and strengthen the elder citizens' possibilities of mastering their own lives and remain independent, self-reliant, and active as long as possible (Petersen 2017, Moe & Brataas 2016, Lauritzen 2017).

The municipality of Aarhus introduced the 'Care Pathway' in March 2016. In line with the national trend the Care Pathway was introduced as a systematisation and standardisation of the municipal everyday rehabilitation effort to elder citizens in both nursing homes and home care services. Moreover, the Care Pathway represents a new model for interprofessional coordination of elderly care aiming to enhancing the inter-professional coordination in citizens' rehabilitation and care. The formal implementation of the care pathway ended in January 2018 but systematic work is still put in to sustaining the pathway in daily practice.

The Care Pathway contains three main elements (Sundhed og Omsorg 2018). *First*, all citizens receiving elderly care are assigned to one of three care path types (a simple care path, a combined care path or a permanent care path) based on an assessment of their level of functional ability and the potential for improving the functional ability. The level of care and rehabilitation effort differs between the pathway types as well as the amount of professionals involved and thus the need for inter-professional coordination. *Second*, citizens in all care paths are assigned a contact person and a care coordinator with joint responsibility of the individual care path. Contact persons are the citizens' main care provider and have the responsibility of observing changes in the health and functional abilities of the citizen. The role as contact person is mainly handled by care helpers or care assistants. Care coordinators are the overall managers of the individual care paths and responsible for coordinating the citizens' different care and rehabilitation services. The role of care coordinator is handled by nurses, occupational therapists, physiotherapists or care assistants depending on the care path type. *Third,* all care paths follow the same overall structure. A central element of this structure is regular case conferences held with the contact person, care coordinator, the citizen and relatives, in which the progress of the care path is discussed and care and rehabilitation services are coordinated.

During the implementation of the Care Pathway the municipality of Aarhus also introduced a new electronic care record called CURA and a new catalogue of elderly care services. In the daily provision of elderly care these three initiatives are intertwined and thus the Care Pathway can not meaningfully be understood in isolation from the two other initiatives.

Geographically, the municipality of Aarhus has approximately 340.000 citizens in total, which makes it the second largest municipality in Denmark. The provision of elderly care is organised in seven geographical districts that differs with respect to geographical size and proximity between care providers. This variation makes Aarhus representative of both larger country municipalities and smaller city municipalities. Within each district elderly care is provided by two different types of providers; nursing homes and home care providers, respectively. Organisationally, home care services are further divided into two organisational units; one health care unit and 4-6 home care units, respectively. Both organisational units provide rehabilitation services and day-to-day care but differ in terms of the professionals delivering the services and thus the approach to rehabilitation and care. Where as services in the health care units primarily are delivered by nurses, physiotherapists and occupational therapists, services in the home care units are delivered mainly by care assistants and care helpers.

Case selection

We included as cases two of the seven geographical districts delivering elderly care in the municipality of Aarhus (District Lakeshore and District Hilltop). Case selection aimed to maximise variation in the geographical settings of the districts and thus we included a geographical large and a geographical small district. Moreover we aimed to select best cases in terms of districts where the implementation of the care pathway was in good progress. Within each geographical district we

included as provider organisations the health care unit, one home care unit and two nursing homes (eight provider organisations in total) to maximise variation in the organisational settings. Selection of provider organisations was based on convenience sampling and thus a question of availability and willingness to participate among the providers. The researchers were assisted by collaborators in the municipality in the selection of the geographical districts and provider organisations.

Data collection

Data was collected as a combination of qualitative interviews and observations to enable insight into both the professionals' actual work and coordination practices and the meanings and experiences connected to these.

Observations included participant observations of eight full ordinary working days of different professional groups in different provider organisations (approximately 64 hours) and in eight case conferences. Following professional groups during their work day provided not only opportunities to observe but also opportunities for informal conversations about their work. These informal conversations were an important source of information in the process of understanding the meaning of the care pathway in relation to their professional practice and interprofessional coordination. Moreover, observations during both working days and meetings provided insight into practices and inter-professional interactions as they actually unfolded in practice, and into tacit knowledge that is easy taken for granted (Hammersley & Atkinson 2007, Spradley 1980). The observations were made in April to May 2018 by the authors VB, KC and ANH and were guided by an observation guide. During the observations field notes were made. The notes consisted of both descriptive information (factual data) and reflective information (thoughts, ideas, questions, and concerns) and were refined and anonymised after the observations (Hammersley & Atkinson 2007).

Two types of qualitative interviews were carried out. Individual semi-structured interviews (Kvale & Brinkman, 2015) were conducted with managers of the included provider organisations in each district (home care units, health care units and nursing homes) (6 interviews) and with the overall management of each district (2 interviews). Focus group interviews (Carey & Asbury 2012) were conducted with staff within each type of provider organisation in the two districts (6 interviews). The selection of informants was partly given as there was only one manager of each provider organisation and only one overall manager of each district. Selection of informants among staff aimed to include representatives of all types of professional groups employed in the different provider organisations, including nurses, occupational therapists, physiotherapists, care assistants and care helpers. The researchers were assisted by collaborators in the administrative unit of elder care in the municipality in recruiting management and staff participants. The authors regularly discussed data saturation during data collection. The interviews were conducted in April to June 2018 by authors VB, KC and ANH.

The interviews lasted approximately 30-60 minutes and were guided by a semi-structured interview guide with open-ended questions (Kvale & Brinkmann, 2015). The semi-structured nature of both individual and focus group interviews ensured a certain level of consistency across interviews while simultaneously allowing participants to speak freely and thereby to elicit the participants' specific ideas and opinions. The interview guide was informed by the theoretical framework and the observations made. All interviews were digitally recorded, transcribed verbatim, and rendered anonymous.

Data analyses

The analysis began by constructing and applying a set of codes derived from the operationalisation of the central theoretical concepts and sub concepts of our theoretical framework (See Table XX for overview of our operationalization). All authors independently performed preliminary test-coding of selected interviews and field notes of observations. This was discussed by the authors to refine the codes and settle any differences in coding practice. All interviews and field notes were then coded using NVivo 11 software (QSR International, Melbourne, Australia). Subsequently, the coded material was analysed based on a thematic approach to identify common threads (Braun & Clarke, 2006). The material was discussed between all authors and collated to create preliminary themes, which were subsequently reviewed and refined. We conducted both within-case and cross-case analysis. Additionally, the themes were investigated in relation to the full data set looking for disconfirming evidence and in relation to the operationalization of our theoretical concepts and sub concepts (see Table X) (Maxwell 2013).

Results

Professional agency – between broader institutional roles and more specific professional projects

Across districts and provider organisations, professional agency rested on a combination of broader institutional roles and more specific professional projects. When professionals accounted for what made them engage in the definition, development and maintenance of the Care Pathway, they referred to broader, cultural-cognitive institutional roles. This concerned different ways of how they used the Care Pathway as a frame to flesh out meaning with interprofessional coordination,

including shared understandings and scripts for action. One dimension of professional agency based on cultural-cognitive, institutional roles centred on increased possibilities of ensuring continuity in individual care pathways. Professionals saw the Care Pathway as an opportunity to clarify further the transitions both, between different professional groups and provider organisations. Professionals also connected this to perceived benefits for the elderly.

> *Man kommer også til at kende borgeren bedre [som forløbsansvarlig]. […] Det giver også en sikkerhed for borgeren i og med, at man kender den, der kommer. Det giver også en tryghed for de pårørende, så det er de samme, der kommer. […] Ja [angående kontinuitet], man ved, hvornår borgeren er dårlig, og borgeren skal i bad. [SSA, Fokusgruppe X Plejehjem]*

Another dimension of professional agency based on cultural-cognitive, institutional roles, was related to making the most of better opportunities for interprofessional working, both within and across provider organisations. Working within the same Care Pathway, offered a springboard for developing a joint understanding of the individual citizen across different professional groups and provider organisations. Case conferences were an important lever for doing this.

> *Dorthe (SSA): Jeg vil sige, at som social- og sundhedsassistent der suger jeg til mig, når vi har borgerkonferencerne. Fordi vi ser jo også forskelligt på tingene som fys, ergo, assistenter, hjælpere osv. […] Så det der med at få et fællessyn gennem forløbsmodellen. [SSA, Fokusgruppe Y Plejehjem]*

With the formal nature of the case conferences, professionals developed skills for spotting any new challenges individual elderly were facing and for adopting a more holistic perspective of the individuals concerned. Professionals connected this to seeing the Care Pathway as a means to accelerate and standardise their professional practice, for example through drawing up a care plan and using the common language offered by the Care Pathway.

Professionals also referred to professional agency based on more self-interested, professional projects. This became particularly apparent when professionals described the challenges they faced working with Care Pathway in the context of tight personnel and time resources. In response to greater demands for coordination and documentation especially connected to the new roles of care coordinator, professionals came to articulate more specific professional rationales that made them engage in the definition, development and maintenance of the Care Pathway. Across professional groups, this centered on working with the elderly as the core of professional practice. For example, an occupational therapist felt being care coordinator was first of foremost administrative work, which did not make any difference to her professional practice. Similarly, a nurse referred to coordination work as a 'time bandit' and as essentially 'practical'. From this, the professional project emerged first and foremost as mono-professional. This was underlined, as professionals noted that care coordinators were highly dependent on observations from other professionals in order to be able to secure communication between professionals involved in the specific care pathway. The professional project was also connected to autonomy, and several professionals criticised that the Care Pathway sometimes made professional practice less flexible and less versatile. For example, professionals could be slow in taking action as the Care Pathway rather than the challenge at hand became the primary focus.

Professionals further flashed out the more self-interested, professional projects underpinning their agency when they accounted for the different ways of how individual professional groups contributed to the Care Pathway. Overall, the individual contributions seemed to be located in a hierarchical division of labour, with nurses at the top, physio- and occupational therapists and partly care assistants in the middle and care helpers at the bottom. This particularly applied to nursing homes, where nurses long had had a coordinating role. The hierarchy in home care units and health care units was more complex; in home care units, nurses and therapists primarily had the role of consultants, whereas in the health care units they delivered hands-on specialist care and rehabilitation. This related to different job descriptions of nurses and therapists in the to provider organisations.

Across provider organisations, nurses stressed that they contributed with a health professional perspective, including wound care, care plans, contact to general practitioners and coordination of different tests, as well as with supervision of other professionals. The specific contribution of nurses to some degree varied between provider organisations. Thus, while nurses in nursing homes both delivered care and supervision, it was more clearly separated in home care services. Here nurses employed in health care units delivered hands on care, while nurses in home care units supported care assistants and helpers to ensure the continuity of care trajectories.

> *Jamen, der blev lavet en funktionsbeskrivelse til os dengang vi startede ift. at understøtte hjælper/assistenter, da vi skulle agere som hjælper for dem især – også ift. kontaktpersonen og den forløbsansvarliges nye roller. [Sygeplejerske, Fokusgruppe Y Hjemmeplejen]*

Therapists generally argued that their contribution lay in assessing the elderly, guiding other professionals and training with the elderly. As such, therapists often had more of a supporting role in relation to other professional groups, especially care assistants and helpers, also to ensure continuity in the citizens' care paths.

> *Ergoterapeut: Jeg tager med assistenten ud til borgeren og tænker; "hvad kan vi gøre? Hvad mener du?". Jeg stiller de spørgsmål, der skal til, for at hun måske selv finder løsningen. På den måde bruger man sin faglighed. [Ergoterapeut, Fokusgruppe Y Hjemmeplejen]*

As with nurses the specific contribution of therapists varied between provider organisations. In home care units and health care units the supervision and care delivery were separated, whereas the two responsibilities were in principle more integrated in nursing homes.

Across provider organisations, the contribution of care assistants had a hybrid quality that was located in-between nurses and care helpers. The Care Pathway had given care assistants and helpers new roles as care coordinators and contact persons respectively, and this seemed to sharpen the awareness of self-interested professional rationales underpinning their agency.

> *Vi er både en form for hjælpere, der kan lidt mere og så er vi en form for "mini-sygeplejerske", der kan lidt sår… Jeg har det godt med at sidde i den rolle og kunne have et overblik over, at "der er ikke flere sokker, men der er også et sår på numsen". Overblikket – vil jeg kalde det. […] Det er ikke alle faggrupper, der er ligeså*

opmærksomme på ting, som assistenter er opmærksomme på. [SSA; Fokusgruppe X Plejehjem]

Another important contribution of care assistants and helpers mentioned by other professionals was making 'day-to-day observations'. This particularly applied to care helpers, as care assistants often had the task of being care coordinators for numerous elderly in addition to the many other professional responsibilities they had.

Institutional work – Practices of formal and informal coordination

Across districts the institutional work of professional groups both within nursing homes and in home care services took form as an interplay of different formal and informal coordination practices. As such, when professionals translated the Care Pathway into daily practice and coordinated their delivery of elderly care within the framework of the Care Pathway, they made use of different and intertwining practices of formal and informal coordination. The specific interplay between formal and informal coordination to some degree varied with the contextual /organisational settings of the provider organisations. Thus, there were some differences in coordination practices depending on whether elderly care within the Care Pathway were provided by a single provider organisation (most often by nursing homes) or provided jointly by two providers (most often by the health care units and home care units in the home care services).

Practices of formal coordination

Across organisational settings and districts the formal coordination practices of the professionals mainly related to the formal structure and milestones of the Care Pathway and to coordination and communication platforms already in place in the provider organisations.

The case conferences inherent in the Care Pathway formed one important formal coordination platform in both districts. The formal nature of the case conferences provided space for professionals involved in a specific care path to draw up and follow up on care plans, and to discuss and coordinate their on-going care and rehabilitation activities. Moreover, case conferences served as a safety net to ensure that professionals were not missing out on anything and that any changes in the citizen's pathway were followed up upon. Case conferences acted as coordination platform in both nursing homes and in home care services. However, they were especially valuable in coordination of care paths where elderly care was provided jointly by professionals in health care units and home care units as they provided a formalized space for professionals who otherwise where based at different geographical locations to meet face-to-face and coordinate their rehabilitation and care tasks together with the citizen and their relatives.

> *Borgerkonferencerne er rigtig gode. Det er dér, hvor vi får set hinanden i øjnene og får snakket borgerforløbene rigtig grundigt igennem. Alle relevante personaler deltager, så vi får snakket med de rigtige mennesker.* (…) *Vi kommer hele vejen omkring borgeren og får talt om, hvad det er, som vi gerne vil gøre hos borgeren.* (Sygeplejerske, Sundhedsenhed, X)

Another formal coordination platform used by professionals across districts and organisational settings was the electronic documentation system CURA. In CURA professionals documented citizen information of importance in the individual care paths (e.g. rehabilitation plans, care needs and appointed contact person and care coordinator) and wrote observations and messages to other involved professionals (e.g. tasks to perform or points to pay attention to when visiting the citizens). As such, CURA enabled professionals to keep up to date with the progress of the citizens'

rehabilitation and facilitated coordination and communication among professionals. As with case conference CURA was particularly valuable as coordination platform in care paths provided jointly by health care units and home care units where the geographical context impeded the possibilities of meeting each other and coordinating face-to-face.

An important formal platform for coordination within provider organisations, most profoundly in nursing homes, was weekly staff meetings that where already in place before the implementation of the Care Pathway. Provider organisations in both districts made use of these meetings, which where mainly used as platform for assignment of professionals to the roles as contact person and care coordinator to new care paths and for discussion of acute issues and challenges in present care paths. Joint staff meetings for health care units and home care units were not in place and thus staff meetings did not function as formal coordination platform in care paths provided jointly by health care units and home care units.

As a final formal coordination platform used particularly for coordination within organisation, all provider organisations in both districts had a whiteboard in their lunch room or in a central meeting room with information about their current citizens, including their care path type, assigned contact person and care coordinator and the date for their next case conference. The whiteboards where used by the professionals to create an overview of who was responsible for which residents and care paths and thereby who to contact and coordinate with when needed.

> "*Jeg bruger det* [whiteboardet] *til at få overblik over hvor mange, vi har i enkelt forløb, hvor mange, vi har i moderate forløb, hvordan ligger fordelingen mellem os i forhold til*

opgaver osv.. Er der nogen, der har for mange i varige forløb? Det er for mig et redskab til at skabe et overblik" (Social- og sundhedsassistent, Hjemmeplejen, Y)

Practices of informal coordination

In addition to the formal coordination practices professionals across organisational settings and districts made use of different informal coordination practices. These practices were intertwined with the formal coordination practices, and the ways the professionals activated and made use of the informal practices strongly reflected ability among professionals to vary and adjust routine actions when specific circumstances or contextual factors prescribed it.

One type of informal coordination practice in use across both geographical districts and organisational settings was supplementary informal coordination. Professionals made use of supplementary informal coordination practices to supplement and support the formal coordination practices in use. Supplementary informal coordination was particularly used to support coordination in connection with formal milestones within the Care Pathway and to 'fill in' in between spaces, in terms of supporting the on-going coordination and monitoring of care paths.

Differences in the organisational settings of nursing homes and home care providers to some degree resonated in different practices of supplementary informal coordination. In nursing homes supplementary informal coordination was facilitated by professionals sharing the same work place and thus took form as ad hoc face-to-face communication in the office or in the lunch room, and as spontaneously organised informal meetings. For example informal meetings before and after a formal case conference to prepare, coordinate and evaluate the conference was a highly used practice in nursing homes in both districts.

Contrary to the nursing homes the organisational settings of the home care providers to some extend challenged the possibilities for performing supplementary informal coordination. The location of home care units and health care units at different geographical locations particularly challenged the possibilities of supplemental face-to-face coordination. Consequently, most supplementary informal coordination took place as phone calls and less as face-to-face communication when eventually bombing into each other in the hallway.

> *M (Ergoterapeut): Hos os foregår koordinering rigtig meget uformelt. Det handler om at hive fat i hinanden på de dage, hvor man er der. Vi er der to dage i ugen på det ene sted – X for mit vedkommende og to dage på Frederiksbjerg. Men ellers er det via telefon og ved at ringe – alt efter hvor hurtigt man skal handle.* (Fokusgruppe, Hjemmeplejen, X)

Despite contextual circumstances all professionals gave substantial weight to the supplementary informal coordination practices as a quick and flexible way of coordinating that made possible to inform each other, ask questions and coordinate activities when the need arose. instead of waiting for a formal case conference to take place or a response on an observation made in CURA.

> *RL (Borgerkonsulent): Jamen, der er rigtig mange fordel i at stå ansigt til ansigt med hinanden eller lige ringes ved udover at kommunikere i Cura. Jeg oplever også, at så har assistenterne og hjælperne* [i hjemmeplejen] *lige et eller andet hurtigt spørgsmål, som der faktisk kan hjælpe deres dagligdag rigtig meget. Det kan de så få svar på ved lige at droppe ind på kontoret, hvor jeg sidder. Det gør de faktisk hver dag.* (Fokusgruppe, Sundhedsenheden, X)

Another type of informal coordination practice used across districts and organisational settings was strategic informal coordination, which was used to manage inadequacies and inconveniences in the conditions for using the formal coordination practices related to the formal structure and milestones of the Care Pathway. As with supplementary informal coordination differences existed in the specific strategic informal coordination practices. However, contrary to the practices of supplementary informal coordination these differences were related to situational circumstances and thus the specific inadequacies or inconveniences experienced rather than systematic contextual differences in the organisational settings.

One example of strategic informal coordination was use of informal 'short cuts' to the formal coordination activities prescribed by the Care Pathway as a way of managing the busy reality of everyday life. For example, staff from the home care provider in District Lakeshore described how limited time and resources and a high level of temporary workers sometimes hindered to hold initial case conferences with attendees from both health care units and home care units within 48 hours from initiation of a citizens care path as prescribed by the Care Pathway. As a solution professionals from each organisation separately visited and assessed the citizen, coordinated their assessments by phone and then the case conference was held with just one of the providers.

Similarly, a nurse in a nursing home in District Hilltop explained how she because of inadequate time resources among the employed professionals made short cuts to the formal procedures of the Care Pathway by coordinating all case conferences in the nursing home instead of only for the care paths she was care coordinator for, as described in the procedures of the Care Pathway.

"Dorthe (SSA): De 5-6 beboer jeg er forløbsansvarlig for, det der med at få indkaldt jer, det har jeg ikke gjort

Anette (Sygeplejerske): Det fordi jeg har gjort det. Jeg tænker du har mere end rigeligt at se til, så jeg har gjort det. ..." (Plejehjem, Y)

Although these informal short cuts made the inter-professional coordination deviate from formal guidelines of the Care Pathway they became the best possible practice in the given circumstances, and as such they reflected the professionals' ability and willingness to vary and adjust their routine actions in the effort to provide the best care for the citizens.

Another example of strategic informal coordination used across organisational settings and in both districts was use of additional informal coordination activities to supplement coordination through formal platforms, either because of insufficiency in formal coordination or because of mistrust in the formal coordination platforms. For example, in nursing homes, several professionals working in day-shifts had experienced instances of lacking handling of care tasks by evening- and night-shifts requested by day-shifts in CURA, which was the formal coordination platform in use for coordination of activities between professionals in day- and evening- and night-shifts. Thus, professionals in day-shifts had started using additional informal coordination activities including keeping a physical calendar with information and tasks, and posters with guidelines and things to remember in the office and lunch room.

"Sygeplejersken skriver en besked til nattevagterne i CURA omkring (en beboers) medicin, herudover skriver hun også beskeden i en fysisk kalender som ligger til alles rådighed i kontoret og benyttes til videregivelse af beskeder. Sygeplejersken skriver

beskeden to steder, da hun ikke stoler på, at nattevagterne nødvendigvis orienterer sig i CURA" (Sygeplejerske, Observation, Plejehjem, X)

Another example of strategic informal coordination was use of supplemental phone calls because of mistrust in the formal coordination platforms, especially CURA. Similarly, in home care providers, several professionals, particularly from the health units reported experiences with instances of lost information or lacking feedback on observations and messages made to the home care services in CURA.

*M (Sygeplejerske): I starten skrev jeg simpelthen dobbelt – både det ene og det andet sted – og skrev i deres besøgsplan, og ringede måske, men jeg fik at vide, at det skal de faktisk kunne selv. Det er ikke min opgave. Det kan jeg sagtens se, men jeg er bange for, at informationer går tabt. (*Fokusgruppe, Sundhedsenhed, Y)

As evident from the examples these additional informal practices became as strategic informal way of ensuring the necessary and proper coordination in care paths. As such it reflected the professionals' ability and willingness to vary and adjust their routine actions in the effort to provide the best care for the citizens.with and handling of jobs by professionals working evening- and night-shifts and as such another example of the professionals' ability and willingness to adjust their routine actions in the effort to provide the best care for the citizens.

Discussion / Conclusions

[To be added]

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Tabel X Operationalisation of theoretical framework

Theoretical concept	**Operationalisation**	**Findings**
Professional agency	Drivers that make professionals engage as institutional agents	
Drivers based on broader institutional roles	Related to cultural cognitive, normative and regulative dimensions (Providing categories to frame issues, offering norms to guide actions, engaging with legally sanctionable rules)	Articulate increased possibilities of ensuring continuity in the individual care pathways Articulate better opportunities for interprofessional working
Drivers based on professional projects	Related to social closure (maximizing autonomy and dominance over others)	Articulate core of professional practice in connection to experienced challenges Articulate contribution to pathway in terms that are specific to individual professional groups This particularly applies to care assistants and helpers in connection with their new roles as care coordinators and contact persons
Institutional work	Practices of formal and informal coordination; strongly reflects agency that is ability to vary routine action	Interplay of formal and informal coordination practices. Formal practices relate to structure of the care pathway and existing meetings. Informal practices support formal milestones and 'fill in' in between spaces; and address short comings emerging from the care pathway.
Reflexivity	Adaptation of practices to specific contexts (situations and organisational settings)	Interplay becomes so adaptive that it can include both vertical coordination within organisations and horizontal coordination across organisations