HANDBOOK OF CORPORATE COMMUNICATION AND PUBLIC RELATIONS

PURE AND APPLIED

Edited by
Sandra M. Oliver

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 2004
by Routledge
11 New Fetter Lane, London EC4P 4EE

Simultaneously published in the USA and Canada
by Routledge
29 West 35th Street, New York, NY 10001

Routledge is an imprint of the Taylor and Francis Group

Typeset in Chianti and Akzidenz by
Florence Production Ltd, Stoodleigh, Devon
Printed and bound in Great Britain by
Bell & Bain Ltd, Glasgow

British Library Cataloguing in Publication Data
A catalogue record for this book is available from
the British Library

Library of Congress Cataloging in Publication Data
A catalog record for this book has been requested

ISBN 0–415–33419–5

CHAPTER 7

Strategic challenges for corporate communicators in public service

J. Paulo Kuteev-Moreira and Gregor J. Eglin

What is the role of corporate communication professionals at a national level health service and at a local government level? What are the major challenges to decision making faced by executives and politicians?

The chapter puts into context the specific reality of hospital corporate communication within contemporary public service systems and identifies areas of further research and professional development. It also addresses communication change practices in local government through major issues of public policy, such as transport.

A changing healthcare environment

The policy for 'Health for all in the twenty-first century' (HEALTH21) adopted by the world community in May 1998 and promoted by the World Health Organization (WHO) sets out for the first two decades of the twenty-first century global priorities and targets that will create the conditions for people worldwide to achieve and maintain the highest attainable level of health throughout their lives. The regional policy for Europe was a response to its call for regional and national adaptations on the basis of the global one (WHO, 1999).

The ethical foundation of this strategic policy for the healthcare sector is constituted by three basic values (WHO, 1999: 4):

- health as a fundamental *human right*;
- *equity* in health and solidarity in action between countries, between groups of people within countries and between genders;
- *participation* by and *accountability* of individuals, groups, communities, institutions, organizations and all sectors in the health development movement.

Four major strategies for action have been selected to ensure the implementation of HEALTH21:

- *multisectoral* approaches to tackle the determinants of health, taking into account physical, economic, social, cultural and gender perspectives and ensure the use of health impact assessments;

- *health-outcome-driven* programmes for health development and clinical care;
- *integrated* family-and-community oriented healthcare, supported by a flexible and responsive hospital system;
- *participatory* health development process involving relevant partners for health at all levels – home, school, worksite, local community – and promoting joint decision making, implementation and accountability.

This strategic vision has been adapted by all EU member states and it is now incorporated in its national health systems' policies and priorities for action.

However, the implementation of these four major strategies demands change in the shape of new processes of healthcare delivery. This goal runs into difficulties in a number of healthcare sectors whose strategic interests may not coincide with some of the HEALTH21 proposals.

In this context, managing policy implementation requires a range of complex skills. It involves assessing the environment or circumstances in which the policy will operate, not only to identify possible barriers preventing implementation but also to find supporting arguments or actors to facilitate the change process.

In order to understand and influence the environment in favour of the new policy, the technical ability to manage implementation involves the adoption of a set of essential corporate communication tools and corresponding skills. The confirmation of this premise becomes more evident when we consider the principles of the accordion method as developed by Ansoff and McDonnell (1990) and put into the context of European healthcare reforms by Saltman and Figueras (1997). This method suggests two fundamental strategies for change:

1 consensus building (resistance reduction)
2 building implementation.

The strategic process of *consensus building* involves a number of alternative actions amongst which we emphasize, in the corporate context of hospitals, the following:

- *Stakeholders* should be *consulted* to find out how they perceive the changes to affect them; this will help in defining messages to minimize apprehension and anxiety by acknowledging their concerns and preferred options.
- The need for *change* should be felt (perceived as necessary) and complemented by the availability of explanations of the purpose of the change. This should minimize hostility and/or resistance.
- Generating positive *support* for change is possible if the corporate communication professionals are able to make clear to stakeholders the benefits that some particular change will bring to them.
- *Alliances* should be built that support change, if necessary excluding, for some time, those stakeholders who are resistant.
- A clear *plan* of the change process should be disseminated within the stakeholders of the organization and include a clear identification of: tasks, responsibilities, resources required and training and development needs. Expected outcomes and a number of milestones against which to monitor progress should be communicated at an early stage of the process.

The second strategic approach to change in the hospital sector is that of *building*

implementation which implies three major complementary measures to consensus building:

- The change process should be *incremental* over a period of time and begin with the least contentious changes. As trust amongst stakeholders builds up, the more controversial aspects may be introduced. This will demand image management throughout.
- Stakeholders should be *involved* (or perceived as such) from the beginning. Rewards to support can be communicated but those who resist should not be penalized, since entrenching their resistance may prevent the building of implementation.
- Stakeholders should be informed about *progress*. Evaluating the effects of change and communicating them will allow stakeholders to see the promised benefits and maintain their support.

From this conceptual framework this chapter argues that the corporate communication management function is central for the successful implementation of change in European health systems in general and in healthcare organizations (hospitals) in particular (i.e. NHS hospitals).

Thus, whilst considering the application of communication tools and techniques to help the hospital develop and maintain positive relationships with its audiences, we realize that this purpose demands expertise at all levels of corporate communication: interpersonal, groups, operational and strategic (see Oliver, 1997).

Hence, as noted above, consensus building and building implementation are two fundamental strategies to support change as they define clear priorities for the implementation of the changes expected to achieve HEALTH21 and related reforms.

In this context, we are now going to look into some fundamental corporate communication competencies which need to be developed if the corporate communication function is to contribute to that process. The following sections discuss four levels of corporate communication challenges for practice within the hospital environment:

1 professional and personal;
2 communication with internal audiences;
3 communication with external audiences;
4 preparing for critical media reports.

Professional and personal challenges

The hospital corporate communication function implies communicating with a wide array of very different people on a daily basis: board members, medical, nursing, technical, administrative and clerical staff, volunteers, patients and patients' families, representatives of governmental and other health or social organizations, community healthcare-related organizations, professional organizations, suppliers, potential suppliers, local politicians, the media, etc.

As each of these groups has a different purpose to establish at the encounter, it becomes necessary to learn about their expectations. This is the first step to understanding the nature of the hospital corporate culture. One set of skills required here relates to our own (inter)personal communication practice: listening and negotiating skills, assertiveness and one-to-one communication.

Communicating within the hospital organization demands further practice and development of personal skills like those related to

communicating in meetings, making presentations and developing networks within a context of rather volatile and conflicting group expectations and opinions.

In fact, in a corporate environment where the daily pressure, conflicting group and individual attitudes and different professional approaches to problems hamper most prospects of peaceful and stress-free communicational encounters, networking becomes a strategic priority for the development of a corporate communication role. If we are able to develop a network of people who are aiming for a common goal we then have a powerful tool to do our job and help in achieving corporate objectives. Being part of an internal network in the hospital has the following practical advantages:

- provision of relevant comments, suggestions and advice;
- recognition of possible impact and group reactions prior to acting;
- a sounding board for clarifying ideas and strategies;
- extension of support and influence;
- streamlining working relationships;
- improved information flow and knowledge management.

Another fundamental challenge is that of written communication. Contemporary national health systems face a massive multiplication of quantities and formats of written materials published and exchanged via a whole range of channels and technologies: reports, letters, memos, minutes and agendas, briefings, posters and notice boards, patient information leaflets, magazines, bulletins, newspapers, books, faxes, emails, pager messages, web pages, speeches, press releases, backgrounders, etc. In view of all these options for written communication, we need to develop a practical understanding of effective writing for all of them.

Bearing in mind the paramount assumption that *we write to get a response from the reader*, the absence of response to our writings may anticipate a communication breakdown. When a communication breakdown occurs in the hospital corporate environment, its direct effects may become visible through a series of critical problems: ill-informed patients and families, over-worried relatives, increased complaints, dissatisfied staff, bad publicity, suspicious journalists, loss of staff morale or falling productivity.

In this context, a good understanding of our readers (audiences), a clear idea about our messages and a capacity to adapt messages to different audiences (e.g. transform clinical, technical or management information into plain English) and adjust them to different written formats, become fundamental skills for the corporate communication professional in the hospital environment (see also Albert, 1997).

Communicating with internal audiences: the hospital groups

Involvement in the hospital corporate environment is about maximizing the capacity to create and develop functional networks that promote and guarantee positive interpersonal communication between all professionals. By assisting the development of internal networks, the unifying energy arising from people who collude in contributing to achieve the delivery of a complex service through which lives may be saved, we strengthen the role of the corporate communication professional in the hospital environment. This is

one major objective to aim at whilst developing any course of action to communicate with internal audiences.

Most of today's hospital professionals can be described by pointing out their major shared characteristics: they are highly educated, 'territory oriented' and very sceptical about managers (including the corporate communication manager). In fact, within the hospital environment, it is likely that the corporate communication person is one individual amongst a number of strongly self-aware groups of healthcare professionals each possibly comprising hundreds of individuals with their own predefined 'territories' and 'corporate' (group) priorities. The majority of them will be women (especially in healthcare delivery) and increasingly from multicultural backgrounds.

Hence, these professionals are likely to be wary of anybody perceived as representing the board or the administration, as is the case with the corporate communication person. The fact is that healthcare professionals share a very strong group identity and some contemporary proposals for change arising from managers question some of the shared group values and/or priorities (see Harrison *et al.*, 1992). Having said all this, can it become more challenging for the corporate communication practitioner? Yes, it can.

In fact, pressures on the healthcare system include budget strains, litigation and increasing citizen demands. On the other hand, the surge of new technology-related professions demanding similar status to that of physicians and nurses is another communicational challenge as the recognition of that status (or the lack of it) is a potential source of conflict between other hospital professional groups and the board.

Within large and complex organizations such as hospitals, it is natural to find people who are concentrated on the activities and concerns of the particular function or department to which they are assigned rather than on what is happening in other parts of the organization. This corporate reality creates team loyalty but tends to question their individual empathy with the whole organization. This situation adds to the difficulty of creating a shared corporate set of values and behaviours in the hospital environment. In this manner, contributing to effective networking becomes a fundamental purpose for the role of corporate communication as a means to achieving improved shared corporate values by bringing together people from different professional groups and departments.

One could describe the organizational culture of hospitals as 'extremely heavy'. That is to say, it encompasses a diversity of identities and establishes a sense of commitment at two different levels: commitment to the professional healthcare group of origin; and/or commitment to the organization as a whole. The stability of this double identity/commitment will depend on the corporate communication function being able to demonstrate the complementary nature of both (see Harrison *et al.*, 1992). The inability to achieve this purpose will tend to result in conflict and disregard for any effort promoting participation and commitment in activities relevant for the whole but irrelevant to its parts (the professional groups).

Adapted from Huber (1996), who built from several earlier studies, we can identify some major guidelines for the process of building a corporate culture supportive of the need for constant change faced by contemporary hospitals.

- Messages should start from where our internal audiences are in their understanding of the issue.

- Promote the practice (at board and senior management level) of an open style of communication by encouraging discussion.
- Invest time and effort on interpersonal communication: one should meet people in their department and avoid hiding behind email and phone.
- Identify the shared vision of each group, build statements of mission that comply with those 'visions' and then make an effort to 'fit' the values desired for the whole within their 'partial visions'.
- Promote the empowerment of each professional group by valuing and facilitating interaction, co-operation and developing the sense of influence of the group over the whole of the organization.

Further to this, we must also acknowledge a unique group in hospitals: that of the volunteers. Their function may not always be very well defined or known at department level, leaving scope for unhelpful events pertaining to their relationship with the work of other healthcare professionals (especially nurses and ancillary personnel). Our challenge here is to promote their good (group) relations especially with nurses and ancillary personnel. Volunteers need to feel rewarded in other ways than monetary. Thus, group self-esteem uplift tends to be our operational communication theme with this group. Hence, volunteers become a very important network as they can become the extra 'eyes and ears' of the corporate communication professional.

Once we have acknowledged the diversity of internal audiences, we need to consider the purposes of communicating with each one of them. In this sense, we recall the above priorities for consensus building and point out some likely purposes in communicating with hospital internal audiences:

- to establish the perception that 'change for the better' is possible ('it has been achieved elsewhere or even among us');
- to disseminate examples of 'change for better' which occurred in other departments or hospitals (even in other countries);
- to make the need for *change* perceived as necessary and inevitable;
- to disseminate explanations of the purpose of change in order to minimize hostility and/or resistance (adapt this purpose to different groups);
- to generate positive *support* for change by making clear to groups the benefits that some particular change will bring to each one of them;
- to disseminate a *plan* for the change process within all groups of the organization; this *plan* should expose the tasks, responsibilities and resources required;
- to inform all groups about specific outcomes against which the progress of changes can be monitored.

Hence, with regard to specific challenges to do with the hospital internal audiences, we must be aware of the unique complexity of relationships established in a healthcare team (see Figure 7.1). Inevitably the physician is at the heart of the team's propelling energy. In spite of the fundamental contribution of all the other professionals, the number of contacts and requests in the process of patient care directed to the physician is by far higher than any other member of the healthcare team. This fact has three strategic implications for practice: (1) do not send a physician information or request it, if the matter is not important to him/her; (2) until proven wrong, assume that the physician is the most influential member of the healthcare team (for the good and the not-so-good); (3) in spite of the

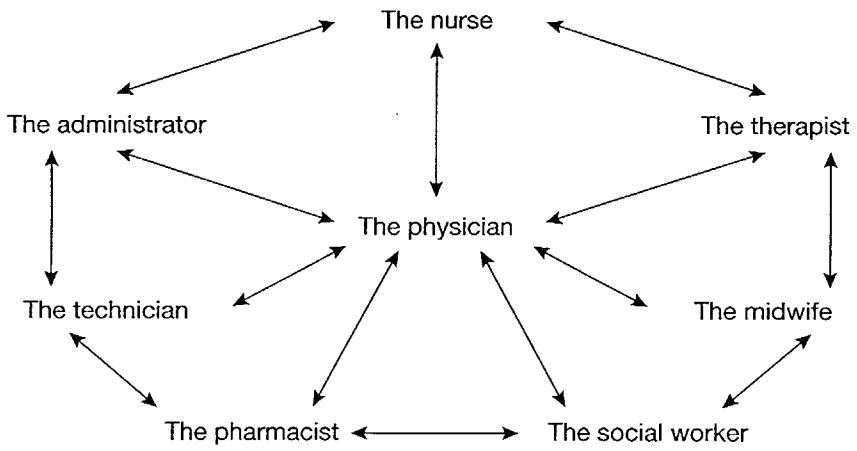

Figure 7.1
Internal audiences – one example of a healthcare team

former being true, never underestimate the influence of other professional groups;

Communicating with external audiences: the hospital stakeholders

Healthcare organizations have a number of stakeholders who confer on these organizations dedicated to caring for people a unique corporate communication environment. The following are the major stakeholders of contemporary hospitals.

Patients and service users are the essence of the hospital's activity. The hospital was created and established to serve them, to satisfy their needs, to guarantee their well-being at all times and to promote harmonious contacts with its premises, technologies and staff. Here we include patients' families and friends (i.e. visitors).

Organizations representing patients and service users are all those non-governmental and voluntary organizations which act as conciliators and negotiators between the specific needs of groups of citizens suffering from a certain clinical condition or socio-demographic characteristic and the hospital's corporate environment within which may sometimes result contradictory service organizational priorities.

Non-care customers are all those entities to which a hospital may provide non-care services such as renting space to shops in its premises (e.g. flower shop, bank, post office, cafeterias, etc.).

Purchasers (or contractors) are also perceived as customers since they pay (or contract) for the services delivered by the hospital. In the European Union these take different names within the variable ministry of health departments, such as health authorities, contracting agencies or authorities, health boards, primary care groups or trusts, social services, as well as health insurance companies or other life and healthcare private contractors. As the trend towards joint private–public investment in healthcare takes over, this type of stakeholder will become increasingly relevant for the corporate communication practice. Even when one works in a public hospital we may have services for private patients, usually purchased by insurers.

Regulators are responsible for evaluating whether the service provision achieves the predefined quality standards. All over Europe we see that forms of professional and service regulation take either a national standards

approach or a more local-based regional regulation, usually oriented towards specific local needs and service delivery.

Partners are all other organizations with which the hospital collaborates in delivering services. Typical partnerships may include sharing technical expertise or co-ordination of service delivery with primary care organizations and diagnosis services (e.g. clinical exams, radiology, etc.). There is increasingly the need to establish partnerships with other service areas like homecare organizations, community health organizations or the social services.

Suppliers are the organizations from which the hospital buys goods and services – from pharmaceuticals and healthcare disposables to high-tech equipment, domestic services and management consultancy.

Competitors/rivals are other organizations providing healthcare services (with public or private ownership). If these services are perceived by *regulators* or *patients and service users* as actual or potential alternatives to services provided by our hospital, they constitute competition. Hospitals which can demonstrate high and increasing numbers of users are more likely to guarantee continuing funding and investment whether from public or private bodies. On the other hand, besides attracting patients and service users, hospitals are increasingly under competitive pressure to attract and retain scarce specialized and highly skilled professionals who may prefer some other hospital or similar healthcare organization.

The *labour market* of the health professions is made up of individuals who actually possess the skills and knowledge needed for the activity of the hospital. Within the healthcare professions the legal and suitable qualifications needed for the clinical and nursing activities are especially scarce. In this context, the hospital's reputation becomes fundamental to assist or damage staff recruitment programmes.

Trade unions and professional associations are stakeholders whom hospitals find themselves dealing with over educational or training matters or over wage or productivity incentives demanded by or offered to staff.

The media must be considered a stakeholder in the sense that they are partners who are always very interested and aware of critical events occurring within the hospital environment. In fact, the media know that every hospital is a prolific 'supplier' of news (good and bad) especially captivating for its audiences (local and national). As in many cases events at the hospital relate to the 'human-feature' kind of stories, sometimes even politically sensitive, we must accept and be prepared for a variable but enduring media interest and thorough scrutiny. Besides, as is the case in numerous proposals for change, the media become the most effective and powerful source of information for hospital stakeholders and internal audiences. Contemporary media not only inform but, most important, also disseminate interpretations, promote opinions and debate about the changes being proposed or implemented. One may have been surprised at how many different groups of stakeholders can be identified as having an interest in the corporate reality of hospitals (Figure 7.2).

The diversity of stakeholders identified in the hospital organizational environment is a major factor contributing to its complex corporate communication challenges. For instance, when the board wants to change one aspect of a service delivered by the hospital, each stakeholder may, from its particular perspective, take a view of the proposed change. The board may see the benefits to be gained from such change, but some of the

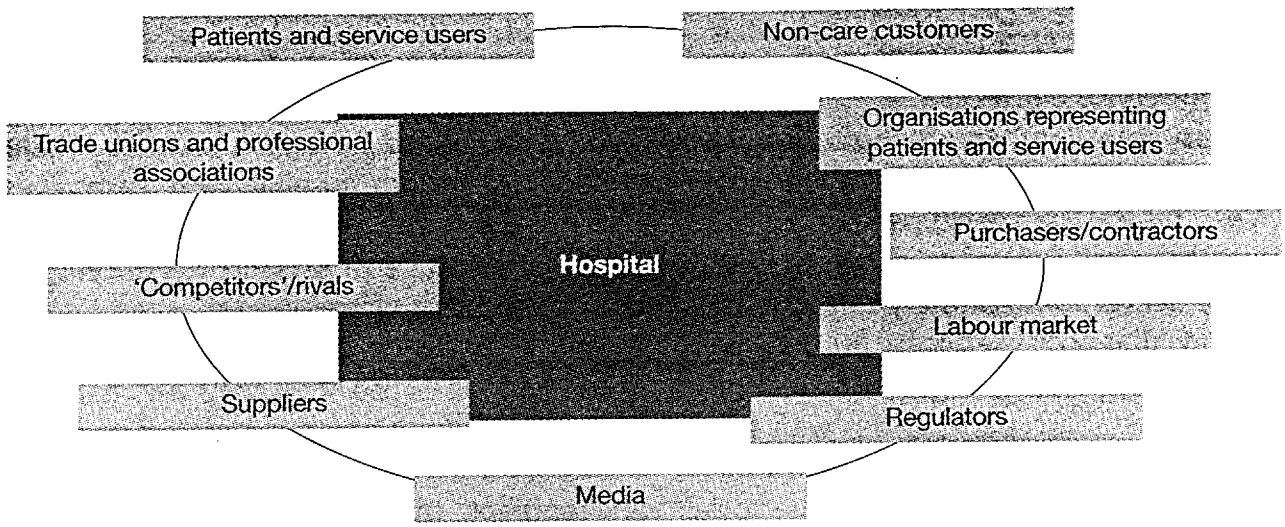

Figure 7.2 A stakeholder environment: the contemporary hospital

stakeholders may emphasize its disadvantages and propose a different way of achieving similar benefits.

As the interests and priorities of stakeholders will vary according to circumstances, we need to take these into account before we communicate a proposed change. Only after considering the nature of the change and its impact from a range of different stakeholders' perspectives is it possible to foresee how each group perceives it and anticipate their attitude and behaviour. This approach is fundamental to facilitating the subsequent decisions on message strategy development.

The awareness of this circumstance leads us further towards the understanding that the contemporary relationships between a hospital and its stakeholders are strongly influenced by the choices and constraints pertaining to the availability of the resources that the organization needs to operate effectively.

Such an analytical approach, as developed by Pfeffer and Salancik (1978), is called the *resource dependence* view. It suggests that no organization is completely independent. In fact, organizations rely on a number of fundamental resources – financial, personnel, information, technology and, not least, that of reputation.

Thus, it is useful to consider what may be the scarcest resource in a particular hospital context. It may be skilled professionals – including staff with the soft skills pertaining to interpersonal communication with patients and families. In other contexts, the scarcest resource may be hospital beds, community services or simply the money to acquire a particular piece of hospital machinery.

Some resource shortages may be resolved by 'simply' making more money available. This is usually one solution demanded by some sectors of contemporary western societies (hospital stakeholders). However, the 'budget cutback' discourse is dominant in the vast majority of western healthcare systems. Yet, few have managed to invert the trend of escalating healthcare budgets and expenses (see Saltman and Figueras, 1997).

The balance between alternative approaches to solve resource scarcity in healthcare (usually associated with two contrasting political views), is sometimes achieved either by finding *alternatives* to the particular scarce resource (e.g. new rules of financing health-

care to overcome money shortage; or hiring foreign nurses to overcome shortage of nursing staff) or by *changing processes* of delivering care (e.g. delivering healthcare at home is less expensive and potentially more positive to the well-being of the patient; carrying minor surgeries in GPs' surgeries to overcome hospital beds shortages). Any of the alternatives is likely to imply conflict with particular stakeholders.

The resource-dependence view also maintains that the attempts to solve resource shortages oblige the organization to change the balance between its dependencies. As suggested by several authors (see Harrison *et al.*, 1992; Pfeffer and Salancik, 1978), this new balance of dependency may be achieved by one or a combination of four strategic alternatives:

- adapt to the conditions (e.g. influence demand of services or its delivery);
- alter its interdependencies (e.g. merger with an organization that controls some of the scarce resources or growth by developing new services/products so that the organization is no longer dependent);
- negotiate environmental conditions (e.g. create partnerships to deliver joint services or share resources, for instance with social services, voluntary NGOs or even the private sector)
- change by political action (e.g. lobbying politicians to obtain subsidies, favourable regulation and contracts).

Clearly the implementation of any of the four possible ways to change organizational dependency in the hospital sector demands good (public) relations with all its stakeholders (see Figure 7.2). This fact emphasizes the strategic role of the corporate communication function in the hospital environment.

In fact, any hospital may adopt one or more of these strategies to ensure access to scarce resources. However, whatever alternative is taken by the board of directors, there will always be varying support from the various stakeholders. There may be those who will support at one end and those who may be fundamentally opposed at the other end.

In this sense, it is crucial that the course of action of the corporate communication professional keeps in mind the strategic essence and principles of consensus building (resistance reduction) and building implementation (see above).

Yet, as conflict with stakeholders occurs, the media become a central stakeholder since they are a major receptacle for reporting problems at the hospital. Many hospital issues reported by the media occur due to some kind of communication breakdown with one or more of its stakeholders or with one of its internal audiences (i.e. professional groups) who use the media as their advocate. That is the subject of the following section.

Preparing critical media reports

As healthcare reforms become more complex and ubiquitous, the purpose of maintaining stakeholders on good terms with the hospital becomes even more challenging. The complexity of corporate communication practice is most evident when we reflect upon the media approaches to events affecting the hospital. What the media typically report and what challenges for practice arise from it, is one contribution to debate intended from this section.

Table 7.1 presents a set of typical categories of press reports pertaining to hospitals. We need to draw a parallel between these categories and particular key stakeholder(s) with

whom a communication breakdown may occur. In other words, we need to understand the nature of typical media reports and relate them to specific communication efforts required to satisfy the needs and expectations of stakeholders affected by any category of media reporting. As media reports alter stakeholders' perceptions, we need to identify the key stakeholders affected by each category so that we can plan preventative measures and procedures. Emerging from empirical data, (Moreira, 2003; Henry, 2002) we identify a number of critical hospital press reports. An introduction to these is presented below.

Management failures

These represent a form of media coverage in which hospitals (especially NHS hospitals) are reported to have failed to achieve one or more of their major social purposes. A hospital may have failed to grant access to healthcare (e.g., being unsuccessful in granting this fundamental *human right* by extensive and long waiting lists), or may have fallen short of its social *accountability* (e.g. unexplained financial mismanagement) or even been accused of wasting resources (thus questioning its contribution to *solidarity*). Keeping

Table 7.1 Categories of press reports

Category	*Categories of critical media reports*	*Key stakeholders (with whom to prevent communication breakdown)*
A	Management failures This includes: waiting time, waiting lists, financial mismanagement and waste	Patients and service users Organizations representing users Purchasers/contractors
B	Clinical errors Including iatrogenesis (clinically induced health problems)	Patients and service users Organizations representing users Purchasers/contractors
C	Professional corporate conflicts	Unions and professional associations Patients and service users
D	Staff shortage	Labour market Professional associations
E	Community relations	Organizations representing patients and service users Purchasers/contractors
F	Corporate events	Organizations representing patients and service users Labour market
G	Human stories (features)	Media Patients and service users
H	Community abnormal accidents	Patients and service users
I	Community violence	Patients and service users
J	Introduction of new hospital technologies, therapies or clinical pathways	Patients and service users Organizations representing users Purchasers/contractors Suppliers
K	Hospital originated pollution	All stakeholders

patients and service users (and their representative organizations) updated on the real capacity of the hospital will help in disseminating realistic expectations. For this purpose, specific corporate media development will be fundamental (e.g. waiting list newsletters) as well as implementing open proactive information flow procedures directed at the media (especially local) so as to disseminate what the evolution of waiting lists/waiting times is in the various hospital departments. The fact that the media may compare one hospital's data with that of other hospitals will demand an argumentative capacity to justify and place progress in the local context (e.g. refer to local epidemiological data). This approach enhances the purpose of accountability. Concerning the scarce resources dilemma, reports may originate from the reaction of some stakeholder to a change in the balance of the hospital dependencies (see previous section). However, the perception of *solidarity* should never be questioned. All resource reallocation must be explained under the patient's best interest and, if the media are to report on it, it needs to be presented from the patients' and service users' point of view. Complex management points of view are very unlikely to be conveyed by media reports.

Clinical errors

These are usually grave reports on events affecting a particular individual. Events may be perceived to have been caused by poor clinical performance undertaken by one (or more) hospital healthcare professional. The role of the corporate communication person in these cases may be to gather specific data on the case (e.g. already published), help clinical staff to prepare a public clinical explanation adding a possible announcement of clinical/legal measures to be taken and/or invite the individuals involved (e.g. patient or family) for a meeting at the hospital so that personalized first-hand information on their case may be provided (rather than inform them through the media). However, a whole set of legal constraints which regulate these cases need to be taken into account.

Professional corporate conflicts

Strikes are the most acute instance of such typical media reports. Often this type of conflict occurs at national level (e.g. the unions versus the health minister) so it may not involve any hospital in particular (except on reports confirming how many professionals adhered to the strike at that hospital). On other occasions, however, conflict may occur at hospital level between a group of professionals and its board of directors. In these situations we face a divided hospital and a complex challenge to practice: whose side are we going to be perceived to be on? From whose point of view are we to pass information to the media? Are there any views likely to ignite conflict and involve other stakeholders?

Staff shortage

This type of media reporting is broad and general. Media usually refer to it as a national issue although sometimes may refer to the situation at one particular hospital as the evidence of one such national problem. Nurses, some medical specialists and specialized technicians are amongst the professionals usually reported to be in shortage. Again the principles presented in the previous section suggest possible strategies the hospital may adopt to overcome this particular resource scarcity. Disseminating an interest in working at our

hospital as advocated by the professionals themselves may be a major contribution expected from a corporate communication professional.

Community relations

Problems pertaining to the level of co-ordination and integration of healthcare within local communities are another major area of reporting. In this context, integrating hospital levels of healthcare management (e.g. secondary, tertiary) with those of primary care (e.g. healthcentres or GPs' practices) in order to grant the best patient flow becomes a major pressure to share resources between social and healthcare organizations. The growing complexity of care and the strained financial system put pressure on hospitals to come to grips with the need to plan and manage integrated care plans. These need to include social care organizations and services (e.g. home care, meals on wheels, social alarm) in co-ordination with recent approaches to healthcare services (e.g. telemedicine, telecare). Any breakdown in these complex caring networks can have dramatic consequences for individuals and are of boundless interest to local (and sometimes national) media.

Corporate events

As in any other area of corporate communication practice, corporate events are a favourite approach for originating positive press reporting for corporations. In the hospital environment, this is not so for the media themselves, unfortunately. In fact, it is not easy to get media to cover hospital corporate events. One needs some imagination and a deep understanding of the nature, essence and culture of contemporary media to be able to create fine-tuned events for the generalist media. However, it is also a fact that clinical, nursing, hospital technology and healthcare management events usually get good coverage from specialized media.

Human stories (features)

Typical reports in this category include the *'miraculous hospital intervention saves baby'* kind of story. One should not try to generate this type of media reporting proactively as medicine is not an exact science. Once the media initiates a story of this kind one can never be sure how it will end. Physicians are usually the 'stars' of these stories. Promoting the fact that these physicians work at the hospital is the most certain benefit the hospital can expect from this category of media reporting.

Community abnormal accidents

Traffic and road accidents involving a large number of people, fires, floods or other types of disasters are the nature of this category of hospital reporting. In these situations it is fundamental that corporate communication professionals gather accurate information and facilitate the flow of data to the media (at any time of the day or night). By preparing a good speaker (clinical or not) to announce numbers and clinical progress of the victims it can become an excellent opportunity to project a positive professional image of the hospital.

Community violence

Victims and offenders of community violence tend to end up at the hospital at some point. Again, in these situations, media reporters are

eager to get up-to-date information and details (e.g. areas of the body wounded, demographic data about the victims). The name of the hospital comes up in the report and it is important that we are able to provide our colleagues, mostly working for tabloid or local newspapers, with the right information. These contacts facilitate the development of good relationships with reporters.

Introduction of new technologies, therapies or clinical pathways

These reports announce some form of innovation at the hospital. These tend to be positive reports although one must beware if any group of stakeholders feels apprehensive or may have misunderstood the change. This kind of media reporting is fundamental for the progress of incremental changes and gaining support amongst both stakeholders and internal audiences.

Hospital originated pollution

This includes pollution resulting from the incinerator combustion as well as hospital toxic waste. Environmental issues can never be underestimated within contemporary societies highly sensitive and aware of its consequences. Corporate arrogance or facts later found to have been concealed may have a dramatically negative impact on the hospital's corporate reputation. In this event, as in others above, we will need to implement a carefully designed crisis communication plan.

In search of a 'balanced resource dependency'

Hospitals are being challenged to balance the widely acknowledged resource scarcity with the values of healthcare and the (sub)culture of the healthcare professions (e.g. physicians, nurses, technicians, health services managers and administrators, ancillary personnel, etc.). As these complex organizations begin to rethink themselves and restructure their dependencies, considering corporate communication phenomena becomes fundamental. The longer hospital managers take to invest resources on this function, the more resistance to change and organizational inertia thrives and paralyses its organizational development. Yet preparing professionals for one such challenging corporate environment is not an easy task.

Indeed, a prominent challenge of HEALTH21 is to strengthen the perception of health as a fundamental human right and the activity of hospitals as contributing to social equity and solidarity between communities, groups and genders by promoting the participation of all its stakeholders in its corporate life as argued by several authors (e.g. Seedhouse *et al.*, 1998; Saltman and Figueras, 1997). However, facing the need to change organizational dependency whilst being under daily scrutiny by media eager to sell hospital issues and gain audiences makes the strategic purposes of consensus building and building implementation highly demanding in terms of professional and personal skills.

In this sense, executive priorities for hospital corporate communication involve a number of challenges related to processes of corporate change management in an environment under the constant scrutiny of the 'public eye'. Now we look at this scrutiny through the concept of public participation in decision making via face-to-face meetings with local government officials and politicians on a separate issue, namely transport policy.

A changing local government environment

The government produced its White Paper, 'Modern Local Government: In Touch with the People', in July 1998. This proposed the most radical reorganization of local government for the best part of a century. The White Paper stated: 'Modern councils should be in touch with the people, provide high quality services and give vision and leadership for local communities . . . The old culture of paternalism and inwardness needs to be swept away. The framework in which councils operate needs to be renewed' (Cm 4014, p. 7 L4).

The first set of changes proposed by government was the creation of new political structures, removing the committee system which had been in place for a century and replacing it with a choice of three models (the status quo not being an option). These were:

- a directly elected executive mayor with a cabinet appointed by her/him from the councillors;
- a cabinet with a leader;
- a directly elected mayor with a council manager.

In the event, most councils opted for the cabinet and leader model with a minority opting for the directly elected mayor.

Other reforms proposed included: improving local financial accountability, a new ethical framework and new procedures for allocating capital finance and setting business rates. Also included were arrangements for the replacement of compulsory competitive tendering (CCT) with the concept of 'best value' in the provision of services to the public.

Perhaps the key to these changes were the sections dealing with 'Promoting the Wellbeing of Communities' and 'Improving Local Democracy'. The White Paper contains some interesting statistics on turnout in local elections in EU countries. It quotes figures by Rallings, Thrasher and Downe (1996) showing that the United Kingdom has the lowest turnout at sub-national elections: 40 per cent compared with, for example, France 68 per cent, Germany 72 per cent, Denmark 80 per cent and Luxembourg 93 per cent. It is these figures that persuaded Britain's central government that local government in the United Kingdom needed 'modernising'. 'New structures alone will not bring about renewal of local democracy which is necessary if councils are to be confident that they are reflecting the priorities and wishes of the people they serve. That can only come about if there is higher participation in elections and close and regular contact between a council and local people between elections' (Cm 4014, p. 38, L3). A close reading of the White Paper makes it clear that what the government is trying to re-establish is communication between the local authority and its citizens. This is implicit throughout the document but, surprisingly, is nowhere made explicit.

The modernization was not without its critics and a heated debate ensued within the political classes in the United Kingdom but seemed to engender little interest from members of the public. Although this debate is important and ongoing, it is not the central concern of this chapter. What is of concern is how communication systems changed within local government as a result of the modernization agenda.

The Local Government Bill was laid before Parliament in 1999 and became law in 2000 following the reform that had already taken place as a result of the White Paper.

Elected in 1998, the author was involved in the modernization process in all its aspects

and led a study using participative observation research criteria and the findings reflected not only the strengths and weaknesses of that methodology but also the importance of face-to-face communication – an area of growing research interest in employee/organizational stakeholder communication management in this era of computer mediated, information overload.

The pace of change was demonstrated by the fact that all the new arrangements were in place in the borough by May of 2000. The borough itself is, in many ways, a typical outer London borough. In the part of the borough nearest to the centre of London there are social problems akin to those found in inner London boroughs while the areas farthest away from the centre of London contain affluent suburbs. Thirty per cent of its quarter of a million inhabitants are from minority ethnic groups, mainly Asian. At the time of the changes, there was no overall political control of the council. In 1998 there was a minority administration formed by the largest party. In 1999 the second-largest party formed the administration with support from the third party. In 2000 the third party withdrew this support and the largest party regained minority administration.

Public participation

The council had set up a modernization committee of elected members paralleled by a task force of senior officers, so that by the time the Local Government Act came into force, the council already had its reorganized structure in place. The council opted for the leader and cabinet model after consultation with the public. This involved the delivery of a leaflet to all households in the borough explaining what was happening and why and outlining the options. The general public were invited to one of three meetings held in different parts of the borough. Advertisements for the meeting were also placed in the local press. The response of the public was underwhelming. In only one of the meetings did the attendance by the ordinary members of the public reach double figures.

Was this symptomatic of the lack of communication that the government had been so concerned about in drafting its White Paper? The poor attendance was the subject of some debate by the councillors and officers. It should be pointed out, however, that the council had been trying to improve its communication links with the general public for some years and had introduced the facility for members of the public to speak at council and committee meetings. A quarterly borough newsletter had been circulated to all households in the borough for some time. Various views were put forward to explain the seeming lack of interest but the lack of participation seemed to support those sceptical of the modernization process.

One of the most controversial proposals of the modernization committee was the setting up of local area committees. Eventually, their establishment was agreed by the council although the shape and size of these committees was debated at length. Finally, five committees of three wards, one of four wards and one of two were set up. The two latter committees were of non-standard sizes because they related to distinct communities. These committees had executive powers to take decisions on highway schemes, parks/leisure issues, monitoring local service delivery, transport matters, local housing management and libraries. They also had the power to determine local planning applications.

Act local

Despite the original misgivings, the committees were a success, although it has to be said the degree of success has varied from area to area. The first meeting of the committee, held in the local library, attracted over a hundred people and attendances since have rarely fallen below that. Initially held six times a year, they now meet ten times a year. The layout of the meeting is important, with the councillors sitting in a line facing the public rather than each other in the traditional confrontational way. The first half hour of the meeting is given over to a 'public forum' where members of the public can speak for up to five minutes on issues they consider to be important. Contributions from the floor are also welcomed in the second part of the meeting which looks at policy issues. For the third part, concerned with planning issues, the committee acts in a quasi-judicial manner and the process here is much more formal. Before this latter part of the proceedings a break is taken and all except those concerned with planning matters tended to leave at this point.

The success of the local area committees took everyone by surprise and stood in sharp contrast to the consultation prior to the modernization. It is clear that the public can relate to a local area in a way that they could not to a large borough. The local area was immediate and accessible. People liked the way that they could put their views across at meetings and could hold their local ward councillors to account. The committee established a symbiotic relationship, with local community groups each helping the other to develop.

Officers from a number of departments were in attendance. Each committee had its own 'lead officer' drawn from the senior ranks of the council's full-time staff. It also had a clerk attached to the newly formed area committee support section.

Best practice

How did these developments affect corporate communication? The council was, and still is, organized into departments each with its own chief officer. Some are involved with service delivery, others have staff functions. Communication flows tended to be within departments with co-ordination organized by the chief executive and meetings of chief officers. While the old committee system existed senior officers of departments would communicate with senior members of the committee responsible for their department. Political co-ordination of information flows tended to be within party caucuses. There were also information flows from individual councillors to officers raising matters on behalf of members of the public. Information also flowed the other way with various departments keeping members informed of developments by a variety of methods including the sending of briefing documents and organizing seminars. Communication between the council and the public generally was, as has been mentioned earlier, by newsletters and other circulars. The council has a communication section responsible for public relations, operating with a communication strategy devised by the council.

The replacement of these committees by the area committees has proved problematic for corporate communication. Local people do not regard things in departmental terms. They do not see why, for example, when a decision has been made to put double yellow lines around a dangerous road junction, a six-month delay is necessary so that the legal

services department can draw up the necessary traffic orders from a collection of areas. They see local problems and opportunities 'holistically'. It is also the case that the local area councillors also began to see the situation in the same way rather than the former situation of being specialists in a particular service area. Hence, information flows began to develop between the area committees and the cabinet and senior officers in quite a different way from the previous service based ones. Furthermore, while the major spending areas of the council are education and social services, these never feature much as a public concern in area committees where the major issue is the environment. Cleansing, recycling, litter, parks and planning, are regular concerns but above all else is traffic.

The use of traffic management

An interesting case study involved a traffic matter. The area has recently had a major road development designed to link two other major roads and take traffic away from local roads. However, as is often the case, the road development attracted more vehicles and local roads continued to be overwhelmed by through traffic. One particular set of roads became a rat run. At one meeting some 200 members of the public turned up at an area committee meeting to demand that something be done. It was agreed to partially close one of the rat run roads. Shortly after the closure another group of people appeared at the meeting to complain about displacement of the rat running problems to their streets. When both groups turned up at the following meeting it took considerable skills of chairpersonship to control the meeting. Eventually the scheme was reversed and another solution sought. The only solution to present itself which did not replace the 'rat run' elsewhere involved closing a road at a particular point. This was duly done for an experimental period. However, a third group of residents appeared complaining that car journeys to work or school were being considerably extended by the closure.

A key communication issue arose at this point. Remarkably, the council's highways section undertook to resurface the main through road in the area at the same time as the experimental road closure. Clearly, the departmental priorities conflicted with the area priorities and the two information flows did not register a possible problem. The matter was resolved at a special area committee meeting held in a school sports hall and attended by over 500 people. Some thirty residents spoke at the meeting. The end result was the removal of the road closure.

More than any of the other reforms introduced by the council as a result of the 2000 Local Government Act, the area committee structure has resulted in more communication between the council and its public. This, in turn, has resulted in problems for corporate communication as information flows from the new structure do not fit well with the old departmentally driven ones. It should also be noted that the area referred to in this chapter already had a strong civil society culture. What is clear is that where local people have the opportunity to meet their local councillors in their local community and hold them to account, sound communication will take place. Giving the community the opportunity to comment on and propose policy bring involvement and improved participation. In this area at least, the reforms have been seen to work.

Summary

Both studies indicate the criticality of face-to-face contact with stakeholders at some point in the strategic communication process. It is not enough to issue communication audits via post or internet. People need the opportunity and space to reflect on issues that directly affect their lives for themselves and with others. Communication is key to sound application of policy and the operational techniques that in the longer term are cost effective. (See also Chapter 4.)

REFERENCES

Health services

Albert, T. (1997) 'Doing the write thing', *Health Service Journal*, 107(5562), 29.

Ansoff, I. and McDonnell, C. (1990) *Implementing Strategic Management*, Hemel Hempstead: Prentice Hall.

Benoit, W. L. (1995) *Accounts, Excuses and Apologies: A Theory of Image Restoration Strategies*, Albany: State University of New York.

Harrison, S., Hunter, D., Marnoch, G. and Pollit, C. (1992) *Just Managing: Power and Culture in the National Health Service*, London: Macmillan.

Henry, R. (2002) *The Complete Guide to Crisis and Risk Communications*, Windsor, CA: Gollywobbler Productions.

Huber, D. (1996) *Leadership and Nursing Care Management*, Philadelphia: W. B. Saunders Publishing.

Martin, V. and Henderson, E. (2001) *Managing in Health and Social Care*, London: Routledge.

Massey, J. E. (2001) 'Managing organisational legitimacy: Communication strategies for organisations in crisis', *Journal of Business Communication*, 38, 153–82.

Moreira, J. P. K. (2003) 'Healthcare stakeholders and the resource shortage dilemma: a contribution to corporate communication theory', Proceedings of the Corporate Communication Annual Conference, Wroxton, UK.

Oliver, S. (1997) *Corporate Communication: Principles, Techniques and Strategies*, London: Kogan Page.

Oliver, S. (2002) *Public Relations Strategy*, London: Kogan Page.

Parsons, P. (2001) *Beyond Persuasion*, Chicago: ACHE.

Pfeffer, J. and Salancik, G. (1978) *The External Control of a Organisation: A Resource Dependence Perspective*, New York: Harper and Row.

Saltman, R. and Figueras, J. (1997) *European Health Care Reform*, Copenhagen: WHO.

Seedhouse, D. (ed.) (1995) *Reforming Healthcare: The Philosophy and Practice of International Health Reform*, Chichester: John Wiley.

Seeger, M., Sellnow, T. and Ulmer, R. (1998) 'Communication, Organisation and Crisis', in M. Roloff (ed.), *Communication Yearbook 21*, Thousand Oaks, CA: Sage, pp. 231–75.

World Health Organization (1999) *Health 21: The Health For All Policy for the WHO European Region*, Copenhagen: WHO Regional Office for Europe.

Local government services

Modern Local Government, In Touch with the People (1998) Cm4014 The Stationery Office.

Rallings, C., Thrasher, M., and Downe, J. (1996) *Enahancing Local Electorate Turnout: A Guide to Current Practice and Future Reform*, London: York/Joseph Rowntree Foundation.