

# A realistic review of clinico-managerial relationships in the NHS: 1991-2010

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## Glossary of terms/abbreviations

A&E – Accident and Emergency Department.

AHRC – Arts and Humanities Research Council. Research and training agency.

BMA – British Medical Association. Professional medical association and trade union for doctors and medical students.

CEO – Chief Executive (Officer).

CHC – Community Health Council. Public representative body put in place in the 1974 reforms and abolished by Labour in 2003.

CHI – Commission for Health Improvement. A government agency set up by the Health Care Act 1999 to improve the quality of patient care and assess NHS Hospitals' performance. It was abolished in 2004 when its responsibilities were subsumed by the Healthcare Commission.

COPD – Chronic Obstructive Pulmonary Disease.

CPPIH – Commission for Patient and Public Involvement in Health. An independent, non-departmental public body established in 2003 to set up and support Patients' Forums. It was abolished in 2008 when Patients' Forums were replaced by Local Involvement Networks (LINKs).

CQC – Care Quality Commission. A non-departmental public body established in 2009 to regulate and inspect health and social care services in England both within and outside the NHS.

DHA – District Health Authority. Administrative units of the NHS in England and Wales from 1982 to 1996 when District and Regional Health Authorities were replaced by single-tier Health Authorities.

DoH – Department of Health.

EBM – Evidence Based Medicine. Idea that clinical practice should be based on sound biomedical research that first came to prominence in the 1990s.

ESRC – Economic and Social Research Council. Research and training agency.

FCE – Finished Consultant Episode. A completed period of care of a patient using a NHS hospital bed, under one consultant within one healthcare provider.

FCEs are used to calculate health care costs.

- FHSA – Family Health Services Authority. Administrative unit of the NHS (replacing Family Practitioner Committees) from 1991 to 1996. Abolished in 1996 when their responsibilities were taken on by Health Authorities.
- FPC – Family Practitioner Committee. Autonomous authorities for GP practices set up in 1985 and replaced by FHSAs in 1991.
- GDP – Gross Domestic Product. A measure of a country's overall official economic output.
- GNP – Gross National Product. A measure of a country's overall official economic output.
- GM – General Manager. Managers introduced into the NHS in 1984 following the Griffiths report in 1983.
- GMC – General Medical Council. An independent regulator for doctors in the UK that controls entry to the medical register of doctors and sets standards for medical schools and postgraduate education and training.
- GMS contract – General Medical Services contract. The new GMS contract came into being in 2004 and was a new contract between GPs and primary care organisations.
- GPSI – General Practitioner with Special Interests. GPSIs were introduced under the NHS Plan 2000. The role of a GPSI involves the acquisition of knowledge and skills that enable GPs to dedicate a portion of their time to perform the role of consultants within general practice.
- HA – Health Authority. Administrative units of the NHS in England and Wales from 1996 to 2002 when Strategic Health Authorities replaced them.
- HAZ – Health Action Zones. The HAZ initiative was launched in 1997 as a seven years pilot to explore working across organisational boundaries to tackle inequalities and deliver better services.
- HISS – Hospital Information Support System. Hospital IT system.
- ICT – Information and Communication Technology.
- IVF – In vitro fertilisation.
- JCR – Journal Citation Reports.
- LINKs – Local Involvement Networks. Public participation body established in 2008 to replace Patient and Public Involvement forums.
- LPSA – Local Public Service Agreement. Initiated in 2000 these agreements were between Local Authorities and the government to deliver key national and local priorities.

- LSP – Local Strategic Partnership. Partnerships set up in 2000 between representatives from the local statutory, voluntary, community and private sectors to address local problems, allocate funding, discuss strategies and initiatives, mainly based around regeneration.
- MRSA - Methicillin-resistant *Staphylococcus aureus*. A bacterium responsible for several difficult-to-treat infections in humans.
- NICE – National Institute for Clinical Excellence. Set up under the NHS Plan in 2000 to ensure high quality care in the NHS, and developed a series of clinical guidelines.
- NIHR – National Institute for Health Research.
- NPM – New Public Management. Type of management style in the 1990s characterised by having hands-on professional management, explicit standards and measures of performance, greater emphasis on output controls, a shift to disaggregation of units, greater competition, and stress on private sector styles of management, stress on greater discipline.
- NPSA – National Patient Safety Agency. An arms-length body of the Department of Health set up in 2005 to establish a single national system of reporting and the analysis of adverse medical events and near misses.
- NSF – National Service Framework. Policies set by the National Health Service (NHS) in the United Kingdom to define standards of care.
- NUPE – National Union of Public Employees. Trade Union.
- OSC – Local government Overview and Scrutiny Committee. Overview and Scrutiny is a function of local authorities in England and Wales introduced by the Local Government Act 2001.
- PALS – Patient Advice and Liaison Service. Set up under the NHS Plan 2000, this service replaced the Community Health Council in supporting complainants and helping to safeguard patients within hospitals.
- PBC – Practice Based Commissioning. A Department of Health initiative begun in 2006 designed to target financial drivers towards primary care.
- PCG – Primary Care Group. Set up in 1999 to include GPs, other health professionals, social services representatives and lay members to develop primary and community care services and commission hospital services. They were gradually replaced by Primary Care Trusts starting in 2000.
- PCT – Primary Care Trust. Organisation set up under the NHS Plan 2000 with responsibility for delivering health care services and health improvements to their local areas.

PEC – Professional Executive Committee. Set up in 2007 in Primary Care Trusts to set the overarching framework, direction and environment for Practice Based Commissioning and link its development to the commissioning strategy.

PFI - Private Finance Initiative. A way of creating public-private partnerships by funding public infrastructure projects with private capital. Launched in 1992 in the UK.

PI – Performance Indicator. First introduced into the NHS in 1990s.

PPIf – Patient and Public Involvement forum. Public representative body established in 2003 to replace Community Health Councils.

PSBR – Public Sector Borrowing Requirement. National budget deficit – public sector net case requirement.

QALY – Quality Adjusted Life Year. A measure of the quality and the quantity of life used in assessing the costs and benefits of a medical intervention.

QOF – Quality and Outcomes Framework. Introduced as part of the new GMS contract in 2004 replacing other fee arrangements to reward best practice and improved quality of services.

RCGP – Royal College of General Practitioners. Professional body for General Practitioners.

RCT – Randomised Controlled Trial. Type of scientific research experiment commonly used to assess the efficacy and effectiveness of health care services.

RHA – Regional Health Authority. Administrative units of the NHS in England and Wales from 1982 to 1996 when District and Regional Health Authorities were replaced by single-tier Health Authorities.

Strategic Health Authority – NHS administrative body. Established in 2002 and reorganised in 2006.

TGWU – Transport and General Workers' Union. Trade Union.

TU – Trade Union.

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# Executive Summary

## ***Background***

At the end of the 1980s a great deal of work was done summarising and synthesising what we knew about NHS management, and specifically clinico-managerial relationships, at that time. Research during the 1990s tended to focus on the emergent internal market, with performance management and the increasing pace of reform strongly represented during the 2000s.

## ***Aims***

This report aims to synthesise research published in the 1990s and 2000s into a form that will be useful to managers, clinicians, academics and other stakeholders, to show how clinico-managerial relationships have changed over the last twenty years, and to consider which forms of development and training programmes might best support their improvement.

## ***Methods***

The project makes use of realistic synthesis, examining the evidence in the light of the context in which it was generated to try and establish links between contexts, mechanisms (the means by which change or reform were attempted) and the outcomes that were achieved. We searched research databases and grey reports over the last twenty years to try and develop a synthesis that represents, as best as we can, the findings of published work between 1990 and 2010.

## ***Results and conclusions***

In hospitals, research finds the educational background of staff to be a key determinant of how they view reforms, with medical clinicians still broadly characterised as generally opposing managerialist reforms, medical managers offering some support for them, nurse managers showing broad support, but nurse clinicians generally opposed to them. These differences in perception, and an associated opposition to attempts to introduce multidisciplinary team working, mean that considerable 'tribal' behaviour still seems to predominate.

Full-time managers often regard doctor-managers with suspicion, and doctor-managers regard the managerial aspects of their role as part-time, temporary, and having little authority over their peers who often do not regard doctor-manager roles with respect. Nurses have often regarded new managerial roles as offering them the opportunities to take greater

responsibilities, and so consider them in a more positive light than doctors. Roles such as modern matrons, however, have been frustrated by often being located outside of hospital management structures, and by being given responsibilities for areas such as hygiene that are the result of contracts with external contractors. New nursing clinical roles have been partially successful, but nurses often find it difficult to balance the care-based model of their profession with an increased biomedical and curative focus.

In contrast to the hostility and gaming towards targets and performance management in hospitals, in GP practices there has been little opposition to Quality and Outcome Framework (QOF) reforms from either doctors or nurses. GPs regard QOF as being based on best practice, and as allowing them to pursue more specialist cases, while nurses regard it as providing them with new opportunities to extend their roles and even to run primary care entirely through nursing staff.

The extent to which the pay-for-performance element of QOF has led to its success is open to question, with GPs often using additional resources to employ more staff or purchase IT rather than raising their own salaries. QOF does appear, however, to have led to GPs taking a more biomedical view of patients and to increased standardisation of care. There is little evidence, outside of changing appointment systems to manipulate two-day targets to see patients, of QOF gaming.

Nurses express some concerns about their ability to deal with the challenges that their extended roles offer, of the lack of training available to support them, and about becoming 'absorbing groups' for jobs that GPs don't want to do, but are generally positive about QOF. In particular, where it creates an environment where greater teamworking between GPs and nurses, the changes are particularly positively regarded, although relationships with practice managers are still sometimes problematic.

Recommendation:

- There is much secondary care has to learn from QOF: it suggests that provided targets are linked to everyday practices that clinicians see as being evidence-led, service quality improvement can be achieved. Putting in place an outcomes-driven framework in secondary care requires central targets be translated into everyday practices (suggesting a key role of clinical managers), and also that clinical specialities be given more autonomy in hospitals in how they meet their targets. This will require imagination and perseverance from managers of all kinds, but the achievements of QOF suggest that service quality can be driven through such a method.

In addition to attempts to reform clinico-managerial relationships, policy during the 2000s has also attempted greater patient and public involvement through patient choice and public involvement reforms that have considerable potential to change the dynamics of healthcare.

Policies to increase patient choice have struggled to achieve their goals. 'Choose and Book', the computer system upon which choice is based, has often not worked smoothly enough to allow choice to take place within a GP consultation, and GP consultations often struggle to produce patient-led decisions, with patients being offered little scope to make meaningful choices. Despite suggestions that patients will become empowered through the use of the internet, the idea of a well-informed health consumer appears to be the exception rather than the rule - and doctor-patient relationships have been remarkably stable.

Patients appear to want choice within services rather than between services - they want to be consulted about possible alternative courses where they receive on-going programmes of treatment. They would also like more choice about the date and time of treatment. Present choice policies neither empowering patients in relationships with clinicians to become better informed about their health or care, nor offer them the kinds of choices that they actually want.

Reforms to achieve greater public participation in healthcare have created considerable confusion because, in trying to put in place new structures by which the public might become more involved in healthcare decision-making, they have resulted in a raft of new organisations that have been abolished, changed role, and been reformed with remarkable rapidity.

There is a great deal of confusion as to whether public participants are meant to be representing wider communities, and whether the diverse public can even be represented through committee-led processes. There appear to be different views of what constitutes participation from policymakers and the public, with the latter wanting a far more open and dialogic form of involvement than health services have been able to provide.

There have been considerable problems in establishing boundaries between different bodies such as Local Authority Scrutiny Committees and public representative groupings such as Patient and Public Involvement Forums, and later LINKs (Local Involvement Networks) and PALS (Patient Advice and Liaison Service), as well as difficulties with sustaining involvement as participatory mechanisms undergo considerable change.

In short, bottom-up reform has struggled to involve the public as either individual choosers of their care through patient choice policies, or to involve them in health services through public participation mechanisms. If a key reform goal of the 2000s was to drive bottom-up reform through the empowerment of patients through choice policies, and the public more generally through participatory mechanisms, current mechanisms have not achieved these goals.

#### Recommendations

- Patient choice can be a mechanism for driving service improvement, but it needs to focus on the kinds of choices patients want to make



(date and time of treatment), and on putting in place more dialogical means between patients and doctors of informing choices. This has the potential to change relationships between doctors and patients to a more participative framework, and to increase service quality as a result.

- Public participation also needs to be more dialogic to allow the public to engage at the deeper level they wish to, and for managers and clinicians to be trained to facilitate such an approach. The public need to be informed about what difference their participation makes to decision-making for it to work.

## **Training, development and education**

How can training and development best support relationships within the NHS? A number of key points have emerged.

Training needs to be contextual in providing managers and clinicians with a background of history and policy in the NHS, and to be based on inter-professional problems solving to encourage a greater appreciation of the differing perspectives differently trained staff can bring. There should be a greater use of tools such as case studies for training so that training addresses real-life problems rather than being based on competency-led approaches that does not take adequate account of the NHS context. It is also crucial that training allows critical interaction between participants and tutors to assess the robustness of the evidence and frameworks being considered.

Training should therefore follow the pattern of understanding the specific NHS context, and of active and collaborative problem-solving within it. Competencies can be taught, but in an applied setting where critical engagement and collaborative working across clinical and managerial boundaries are put at a premium.

In addition, doctors still seem to require additional training on how they can interact with patients in a more collaborative form, especially if patients are to make choices and services be commissioned through GP surgeries, with patients often still struggling to make themselves heard. As present reform proposals move commissioning to the local level it will also be crucial that GPs and those working Local Authorities to scrutinise them, are adequately trained to take on their new roles. For improved public participation, managers, clinicians and the public need to be trained and better prepared to understand the rationale and principles of their involvement, and for decision-making to be more closely linked to participative mechanisms for the public to find it meaningful.

---

# 1 Introduction

This project aims to summarise and synthesise the published research on clinico-managerial relationships between 1990 and 2010, and to explore the ways in which training programmes might better support such relationships.

The format of the report is a little unusual, and so requires some explanation. What we have aimed to achieve is to present the material in a format that will be of use to a diverse range of stakeholders, and yet remain academically rigorous. At the same time as this, it would make little sense for a synthesis to be so long that readers might as well go to the original sources, so we have tried to be as brief as possible whilst still meeting the brief set. The report is structured in the following way to try and achieve these goals.

First, three summaries are presented. These are derived from the research examining the 2000s, which is likely to be most relevant to stakeholders because it presents the most recent evidence. The three summaries are structured around the headings of top-down reform, bottom-up reform, and management development. The top-down summary presents the results of reform programmes such as performance management and clinical governance on clinico-managerial relationships, and addresses the central question of why it is that, given the widespread negative reactions and problematic relationships that top-down reforms have caused in hospitals, reforms such as QOF been, relatively speaking, so positively received in GP surgeries? We believe that the lessons that can be learned from this comparison offer important insights into the management role in hospitals, and the ways in which clinico-managerial relationships might be eased as a result.

The second summary is concerned with bottom-up reforms, primarily those based around patient choice and public participation. On reviewing the literature from the 2000s, it seemed to us that these reforms had considerable potential to change the relationships within clinical groupings and between clinical groupings, managers and the public, and so that they should be a part of the final report even though they involve extending the original brief. This summary suggests that bottom-up reforms have not been particularly successful in the NHS during the 2000s, a finding that is extremely important given the new coalition government's emphasis on GP-led commissioning and patient choice in their 2010 White Paper.

The third summary addresses management development and training, exploring what kinds of training programmes appear to have met with some success, according to the published research, and which have struggled to meet their goals. It suggests that generic competency training of the type that uncritically presents management frameworks is unlikely to

be well received in a health care setting. Training instead needs to be contextual, engaging with the specific healthcare setting by exploring its history and dynamics, getting both clinicians and managers to explore problem-solving from different perspectives, and allowing participants to critically engage with evidence and the training frameworks used. This points to a greater use of case study-based problem-solving, with cases based on real NHS examples, and competencies taught in an applied and cross-disciplinary fashion, to present a valuable way forward. This section, in line with the extension of the brief to consider relationships with health services and the public, also briefly considers the implications of that analysis for involving and training both clinicians and the public to achieve greater involvement.

The three summaries are followed by the report's methods section, which we present after the summaries because, although important, the results sections will probably be of greater interest to readers, and then the conclusion, which answers the research question the project proposed, and which emphasises again its key findings.

The summaries in main body of the report are dependent upon full-length analyses of the periods of reform from 1990 to 1997, and 1997 to 2010. We have included both a method section and two full-length analyses, based around the Context-Mechanism-Outcomes framework for each period, in appendices.

In structuring the report in this way, we have attempted to present three levels of synthesis. The first is the Executive Summary, which gives an overview of the project. The second is the three summaries, which present an additional level of detail and the key citations upon which the findings are based. The third is the full Context-Mechanism-Outcomes framework for both periods upon which the main body of the report is based, and which is included in the appendices. We hope by presenting the report in this way readers can find the synthesis that best suits their needs, rather than assuming a one-size-fits all approach will work.

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## 2 Top-down reform and clinico-managerial relationships

### 2.1 *Introduction*

In both 1997 (1) and 2000 (2) the Labour government suggested that the NHS had been characterised in the past by a 'command-and-control' system that was in place until the end of the 1980s, and market fragmentation after then. Despite acknowledging in the NHS Plan that 'clinicians and managers want the freedom to run local services' (2) (S. 2.32), the introduction of what Harrison (3) calls 'scientific-bureaucratic medicine', with its combination of medical knowledge based on randomised controlled trials, evidence-based medicine, systematic reviews, and Labour policy involving the National Institute for Health and Clinical Excellence (and its predecessors), and the Care Quality Commission (and its predecessors), resulted in medical labour processes becoming subject to far greater standardisation.

Medical process standardisation was further institutionalised through 'clinical governance', where managers of health services were given responsibility for clinical as well as managerial outcomes (4, 5), and the introduction of a national performance assessment framework which published annual ratings of trusts (6, 7).

As such, it is hard to avoid the conclusion that policy during the 2000s put in place a considerable range of techniques for greater top-down control of health services. The NHS, in contrast to other areas of the welfare provision where service provision has gone in the direction of becoming more differentiated and less standardised (or post-Fordist) (8), has become more standardised and centralised (or Fordist) (3).

The effect of the extent of this standardisation on clinico-managerial relationships varies considerably depending on the care context in which it has occurred. The following sections explore the changes primarily through research in hospitals and general practice, where the majority of research has been conducted, with research from other settings, where it exists, being presented to show how it compares. This section does not consider Primary Care Trusts for two main reasons; first, because, compared to hospitals and GP practices, there is very little research on clinico-managerial relationships with them and so it is harder to present a clear picture; second, because their proposed abolition in the coalition government's 2010 White Paper means that hospitals and GP practices have become the main focus of future policy, and so are arguably more important in terms of this synthesis.

### 2.1.1 The effects of top-down reform in hospitals on clinico-managerial relations

Clinical governance and performance management have been experienced by clinicians in hospitals as a generalist policy of 'undifferentiated aggregation'(9), not dealing with performance or compliance at the level of the individual doctor(10), and instead perceived to be the result of externally-driven targets about which clinicians had not been consulted(11), and which are not related to their everyday practices(7).

Research has tended to concentrate on the 'gaming' that performance management in hospitals has often led to (12-15). Managers came to refer to some targets as 'P45', which if not met, meant they risked losing their jobs (12), leading to a risk of care being distorted to achieve targets in areas that carried such a risk, or of focusing on 'quick wins' rather than dealing with the underlying determinants of health (16). The use of targets has led to improvements in maximum waiting times for both hospitals and ambulance trusts(17), but has had less affect on health inequalities (16, 18) and at the price of widespread gaming. How have these changes affected clinico-managerial relationships?

A major research finding of the 2000s shows how the educational background of both managers and clinicians affects their perception of both their everyday duties and health reforms(19-21). This work can be summarised through the use of a table showing attitudes to a range of healthcare modernisation issues from a range of perspectives.

**Table 1. Differing perspectives on aspects of health reforms**

| Healthcare professionals' stances on the key elements of health service modernisation |                    |                  |                  |                |                  |
|---|--------------------|------------------|------------------|----------------|------------------|
|   | Medical clinicians | Medical managers | General managers | Nurse managers | Nurse clinicians |
| Recognise connections between clinical decisions and resources                        | Oppose             | Support          | Equivocal        | Support        | Oppose           |
| Transparent accountability  | Oppose             | Support          | Support          | Support        | Oppose           |
| Systematisation   | Oppose             | Oppose           | Support          | Support        | Equivocal        |
| Multidisciplinary teams   | Oppose             | Oppose           | Equivocal        | Support        | Support          |

*Source: Degeling et al, 2003, p. 651*

This work suggests that the background of managers and clinicians can lead to almost entirely different perspectives on a range of important organisational issues (compare medical clinicians with general managers or nurse managers above), which have profound implications for attempts to get them to work together. The same authors do make suggestions for overcoming these considerable differences in perspective, which we will revisit in the summary on management development (see below).

### 2.1.2 Hybrid roles

The creation of hybrid managerial/clinical roles, such as clinical directors, should be a means of overcoming differences between managerial and clinical goals and perspectives. Postholders, however, often receive little

respect from their medical peers for taking them on (22), and doctors struggle to balance the 'part-time' aspects of the managerial role with their clinical practice(23). There is a lack of clarity over exactly what hybrid roles demand (24) and full-time managers often deliberately attempt to exclude medical directors from strategic discussions (25), even organising meetings to minimise medical manager input(26-28). Research from Australia suggests that managers regard clinicians as unstrategic because of their focus on individual patient outcomes rather than large-scale decision-making (29).

Medical managers often also perceive their managerial roles to be temporary, believing they will return full-time to their clinical work (25) once they have completed their managerial responsibilities, giving them a strong incentive not to alienate their colleagues. It also seems that medics regard discussions with their managerial colleagues in an overtly political way rather than as a means to improve decision-making (30). Attempts at creating the open sharing of information between doctors and managers are regarded with suspicion by doctors because of the specialist and paternalistic culture that still dominates their outlook (31).

A more positive portrayal of the doctor-manager is given by research, again from Australia, where a lack of formal authority requires the occupants of such roles to navigate organisational fields that are complex, multi-faceted and heavily contested. Doctor-managers are portrayed as pulling off delicate navigations through roles that cast them as colleagues, managers, first among equals and medical club directors, with a strong need for well-developed and an ability to deal with competing arguments through 'conversation'(32).

Despite attempts to get doctors to take on Chief Executive roles, doctor-managers are still the exception at the top levels of hospital Trusts(33), but examinations of board-level discussions between senior managers, both clinical and non-clinical, suggest more complex patterns of discussion and decision-making taking place. Here, clinicians are increasingly able to draw upon managerial discourses to challenge decisions they perceive as being against clinical interests (34). The new managerial vocabularies doctors draw upon also seem to adjust the world view of doctors so that they become more resource aware in their decision-making (35), but allow them to opt-in to managerial discourse where they find it appropriate (36). By adopting managerial language, clinicians become more acceptable to managers who are more likely to accept their reasoning as a result (34).

As such, despite the almost overwhelmingly negative way that relationships between doctors and managers are portrayed in research, and the extraordinary difficulties that hybrid clinical-managers are often found to be having, there is room for compromise, but it tends to begin with clinicians learning to adopt managerial language and techniques first (30), with the incentive that it can be a means of retaining their power and control (37).

### 2.1.3 Nursing

Within nursing, the 2000s has been a period where new roles have become more established and issues of professional identity have come to the fore. Nursing appears to have been perceived as a profession more compliant with reform than medicine (38) and research does seem to indicate that many nurses have embraced the opportunities that clinical governance has offered in order to take on new professional and managerial roles (39).

New nursing roles such as nurse practitioner and nurse consultant allow nurses to take on more technical elements of care work such as prescribing (40) or the administration of intra-venous drugs(41). These new responsibilities highlight tensions between the more traditional 'caring' aspects of their role and the more biomedical focus on 'cure' (42). Nurses report that the additional technical tasks that they have taken on lead to them being 'rushed off their feet' to the extent that these new tasks crowd out their ability to provide more personal aspects of caring (41).

Role redesign has also led to a greater reliance on Health Care Assistants to provide the routine care that more specialist nurses are no longer able to provide, and leading to suspicion of the government attempting to create efficiency savings by moving nursing care to the least expensive level(43). However, other research appears to indicate that there are few economies to be gained from reallocating nursing tasks in this way, even when there is a shortage of trained nurses(44). It is possible to interpret the changes within a managerialist logic of greater nursing expertise allowing doctors to specialise in higher level tasks, and so increasing efficiency(45), but at the same time allowing scope for groups within each profession to pursue more fulfilling work and creating the potential for increased team-working (19).

Nurses taking on new roles such as the Modern Matron or Nurse Consultant often report considerable confusion as to what these new roles entail, a viewed shared by other professional groupings. The enactment of the Modern Matron's role occurs within a dynamic system of professionalism in which the new role is interpreted in terms of a range of factors in connection with the new role and its previous versions, as well as with wider professional differentials and how they impact on operational management. (46). This creates an uncertain dynamic which creates space for professional and managerial boundaries to be challenged, but also a genuine confusion as to what the new roles are meant to be accomplishing. Modern matrons have also struggled to deal with issues around infection rates because of their lack of ability to manage problems in domestic services, which are often seen to be outside of their control, and requiring managers from other backgrounds to intervene(47).

Nurse Consultants report that their job roles have been the source of some political debate (because of the use of the word 'consultant') and of the time it takes for other professionals to adapt to their new roles as they become established(48).

Nurse managers report that they interpret managerial roles, where they take them on, through the lens of their professional identity, and that they can be successful as managers so long as they are not forced to divest their professional identity(49). Their professional interpretation of managerial directives leads to them often communicating them in a dismissive manner(50). However, there is also a literature presenting the opportunities for nurses to become 'leaders' in a very positive light(51).

#### **2.1.4 Summary of outcomes of top-down reforms**

The analysis above suggests a number of important points, as follows.

First, there seems to be widespread 'gaming' of performance management systems in hospitals, with both doctors and nurses experiencing the reforms as the imposition of externally-imposed managerialist systems that have nothing to do with their everyday work.

Second, that the differences in perspective between doctors, nurses, managers and hybrid clinical-managerial roles often appear to be rooted in the training each group initially received, and are remarkably difficult to overcome.

Third, that hybrid clinical-managerial role holders receive little respect from their clinical peers for taking on managerial roles, and often regard the managerial aspects of their roles as part-time and temporary. Full-time managers, in turn, often seek to exclude clinical managers from strategic discussions, and where they are included, to minimise their input. There is an element of fear here - if clinicians move into senior management positions this could be at the expense of managers presently occupying those roles. More positive portrayals show hybrid role holders as performing complex role-juggling through persuasion and the use of strong inter-personal skills, and of being able to challenge managers by developing expertise in managerial areas such as finance. Nurse managers particularly often seem to display the ability to work across clinical and managerial roles without losing their professional identity.

Fourth, that the experiences of nursing in hospitals as the result of clinical governance is ambiguous, with opportunities to take on enhanced tasks, but with the workload coming from new tasks leading to considerable workload problems and potential isolation from more traditional caring roles. New nursing roles have often resulted in considerable confusion as to how they are to be understood by both the nurses themselves and other professional groupings understand them. There are often concerns about the lack of authority that Modern Matrons have to deal with issues such as infection control that are under their remit because of fragmented lines of authority.



## **2.2      *The effect of top-down reform in general practice on clinico-managerial relationships***

The context of general practice is different in many significant ways to that of the hospital - practices are smaller, doctors tend to run them largely independent of formal management roles, and the clinical work is at once more general, but at the same time has greater for potential standardisation(52).

### **2.2.1      QOF**

The main mechanism by which clinical governance has been implemented in general practice is the Quality and Outcomes Framework (QOF). QOF has been characterised as a performance management system based on 'pay for performance' (53), but this perhaps conceals its most important characteristic of being based, not on highly abstracted performance targets that clinicians regard as being separate from clinical practice (as in hospitals, see above), but based on 'best practice' (54), and being related to everyday work(55).

QOF is not perceived to be a sudden change, but the result of an incremental process going back to the limited list prescribing in the 1980s, and the GP contract of the 1990s that increased practice nurse involvement and led to the introduction of targets into primary care(56). This perception of continuity is also shown in pre-QOF research that indicated GP care was already emphasising a greater outcomes focus and apparent acceptance of loss of some autonomy as a result of the introduction of performance measures(57).

### **2.2.2      The effects of QOF on GPs**

GPs initially seemed to welcome the opportunity their new contract offered them to opt-out of out-of-hours work, but were generally sceptical about whether the improvements specified by QOF could be achieved (58). QOF, however, has been a remarkable success in getting GPs to conform to its goals(59, 60). This leads to a key research question - how and why has QOF been so successful in getting clinicians to both internalise its processes and achieve its targets?

In contrast to clinical attitudes in hospitals, there has been little opposition to the introduction of QOF from either GPs or practice nurses(61). Research suggests that the success of implementation is due to GPs believing that QOF is a credible tool for improving care, especially in relation to chronic disease management(53), and that patients seem to be generally happy to cooperate with the increased monitoring that QOF introduces including screening, testing and practice-initiated appointments(60).

GPs argue that the new contract has allowed them to engage more often with more complex cases(62) giving them a greater scope to become

specialist practitioners themselves, even if this can lead to them becoming isolated from 'rank and file' GPs(63). GPs have often taken on the extra work associated with QOF in addition to their care workloads, in contrast to their approach to fundholding in the previous decade(64). QOF is not entirely without its problems with there being ambiguity about whether GPs are more satisfied with their jobs as a result of the changes, and some studies suggesting dissatisfaction with the heavy-handed surveillance associated with QOF (64) or with the extra workload(60). However, other studies show GPs expressing broad satisfaction with the new contract's results(62). Equally, it does seem that QOF has only led to improvements in chronic disease management in areas which have explicit targets in the framework, and these improvements have come from an increased investment in new staff(54), rather than existing staff changing their behaviours.

The extent to which the pay-for-performance aspect of QOF has influenced doctor behaviour is also subject to contradictory findings. Some studies make the claim that this has been a central part of QOF's success(60), whereas others suggest that much of the additional money earned by practices has not gone on extra GP pay but instead on new IT systems or appointing new staff (62), and that GPs are not motivated by QOF in itself(65). Perhaps more remarkably, QOF has led to doctors challenging the performance of their peers where they are perceived not to be engaging with it(52, 64), effectively turning them into managers of the system.

Research suggests that the routinisation of QOF leads to a privileging of standardised biomedical information in GP practices(62) in line with Harrison's claims about 'scientific-bureaucratic' medicine becoming predominant in the NHS(3). Within such a view, patients become viewed not as individuals, but instead as data points or diagnostic groups, challenging the personal relationships that are meant to predominate in general practice, and the close GP knowledge of patients that the reforms privileging their position in the NHS are based upon(66). Standardisation also creates space for the challenging of doctor-nurses boundaries as increasing amounts of care can be provided through nurse-led clinics(52), leading to a questioning of which, if any, aspects of care can be better provided by doctors in primary care(67). QOF has created its own bureaucracy, leading to a potential reduction in clinical autonomy and flexibility(64) as care becomes more rule and guideline-bound. New IT systems put in place have embedded new patterns of working into practice life to an extent that has the potential makes the changes permanent(55), often introducing new control mechanisms in the process (68), again emphasising their managerial potential.

There appears to be little research suggesting that widespread 'gaming' occurred as a result of the introduction of QOF, but concerns were expressed by GPs on the extent to which their practice was becoming 'checklist' or 'tickbox' driven(61, 65). Evidence does point to at least one

clear incidence of GP gaming though - in relation to the 48 hours maximum patient wait for appointment times, and involving surgeries putting in place convoluted booking systems to be seen to be hitting the target(12). This appears to suggest that GPs and practice managers are not immune from gaming where they believe targets imposed upon them are unworkable. Equally, where GPs believe they have not been consulted about changes to QOF, or are unaware of the research that underpins amendments to the system, they also suggest they are less willing to comply(54). It would seem that if QOF is changed too frequently, or becomes based on principles that GPs do not regard as being best practice, the targets associated with it might be more difficult to achieve, again a lesson for reforms based heavily on GPs taking on new commissioning roles (66).

### **2.2.3 The effects of QOF on nursing**

A substantial amount of the screening and everyday care work associated with QOF has been delegated to nurses and health care assistants(69). This has raised concerns about nursing staff receiving the appropriate amounts of training to carry out their new roles, especially because training needs have become practice-specific depending upon the particular pattern of delegation that has occurred(70).

Nurses tend to regard QOF in a more positive light than doctors, embracing the new ways of working and the potentially greater autonomy that comes from it (52). There are, however, concerns about potential losses in autonomy coming from its highly-specified targets (58) and acknowledgements that the new tasks and roles put them under increased work pressure(70). Other work suggests the risk of nurses becoming 'absorbing groups'(71), taking on new roles that GPs don't want to carry out, such as health promotion, with nursing becoming just a combination of such tasks as a result. However, these findings have been challenged by more recent studies that suggest nurses have become the effective leaders of care provision in areas such as chronic disease management(70) and are more than capable of taking over the entire function of GP practices in their own right(67). Equally, there is research that suggests that QOF has led to practices engaging in increased levels of greater teamworking between doctors, practice managers and nurses and aided by improved IT (60).

### **2.2.4 Practice management under QOF**

Practice management appears to be an area where there is very little dedicated research. Work does, however, suggest that there have been considerable tensions between doctors and practice-managers over decision-making, and that QOF sometimes has the potential to concentrate decision-making in a small clinical elite (59) to the exclusion of practice managers(72).

### **2.2.5 The consequences of QOF in general practice**

In summary, QOF, the main mechanism by which top-down reform has been implemented in general practice, is perceived to be part of an incremental, longer-term process of reform which clinicians believe is based on best practice, and with which they are fully engaged.

GPs have gained from the contract that introduced QOF by opting out of providing out-of-hours care, and reorganised their surgeries so that practice nurses have taken on a large number of additional tasks. Success in meeting targets has led to new staff being brought in, and new IT systems been introduced to manage the administrative processes required.

There is little explicit 'gaming' within QOF, although there are concerns that it is leading to a 'tick box' culture, and research suggests that it is leading to a more biomedical model of care, in contrast to the more personal, family doctor-led holistic view often associated with general practice. However, this more biomedical model may be under challenge from nurse-led versions of general practice that are emerging.

### **2.2.6 What explains the differences between hospitals and general practice?**

A number of contrasts emerge from the synthesis above.

In hospitals top-down reform has become associated with being part of an externally-driven performance management process externalised by clinicians because the targets put in place are at a level of abstraction which are not a part of the day-to-day practices of either doctors or nurses. Hybrid clinician-manager roles are still struggling to become established, and role holders do not appear to receive respect from their peers for engaging with managerial roles. There appear to be substantial differences in perspective between clinicians and managers, the roots of which go back to their initial training. Research suggests that clinical governance has not improved inter-professional relationships, with widespread gaming of performance measures, and clinicians often struggling to engage with managerial roles and balance them with their professional practices.

In general practice, in contrast, top-down reform has occurred through QOF, the targets for which operate at a more everyday level, and doctors and nurses have reorganised their activities to achieve considerable success in meeting them. GPs understand QOF targets as representing best practice, and despite their concerns about the increased 'tick box' approach required of them, accept them as being legitimate. QOF has led to increased tensions around practice management, but also to increased team-working in practices between professional groupings and the adoption of new patterns of working to achieve its targets. QOF is perceived to offer both doctors and nurses opportunities to develop new professional roles.

In hospitals central targets exist at a level which clinicians regard as abstracted from their practice, and which have little to do with their practice, but this is not the case with QOF, the targets for which are instead regarded as part of achieving quality care and best practice. Because performance targets have not been internalised by clinicians in hospitals, this had to managers and doctors gaming them, something which only seems to occur in general practice around the two day appointment target. Managers in hospitals do not appear to be successful in persuading clinicians that targets should be their concern, whereas in general practice, GPs and nurses have internalised the targets for themselves, effectively becoming self-managing in the process. It remains an open question the extent to which the acceptance of targets in general practice is due to the pay-for-performance system, but research does seem to indicate that the targets being embedded in best practice is more important than GPs being rewarded for meeting them.

There are tensions between practice managers and clinicians in general practice, but these are probably small compared to the very significant differences that still appear between clinicians and managers in hospitals, where clinical-managers find their roles not respected by either their colleagues or from full-time managers.

### **2.3      *The implications of the analysis for hospitals***

Degeling and his co-writers, whose research shows the very different perspectives that managers and clinicians hold on many organisational issues, suggest that the only way to break through the impasses that result from this, and the additional problem of consultants often being unwilling to accept the leadership of doctors from other specialties (73), is for clinical governance to be devolved to specialty level where clinical teams can develop integrated care pathways, bringing together both clinical and managerial identities into a responsible, collaborative form of autonomy (20). This approach, in common with other attempts at achieving more team-based working in hospitals such as Total Quality Management(74) and the use of clinical microsystems (75), stresses the importance of getting professionals and managers to work together to achieve mutually agreed targets, as well as an improved way of tackling complex issues such as improving patient safety (76).

There is a key translational role for hospital managers in linking together general, externally-imposed targets with everyday clinical practices. There is nothing particularly new in this - it is central to the idea of Management By Objectives in all of its forms. However, what is different in the context of the NHS is that managers in hospitals have to find ways of making these targets relevant and important, despite clinicians presently not regarding them as being part of their clinical activity which is still very largely focused toward their professional identity rather than their hospital role. However, this is possible – as a result of QOF targets being linked with quality

improvement and best practice, they have been accepted in general practice. Hospital managers, and especially hybrid clinical managers, now have a key role in linking together the centrally set, abstracted targets with what is required from clinicians in local Trust settings.

What is required to deal with the barriers to successful clinico-managerial relationships in hospitals then, is a combination of abstract and general, unit-wide targets being translated into a meaningful form at speciality level, and, for cross-disciplinary teams to be given the autonomy to work together to meet those targets. This would result in the holy grail of meeting performance targets through autonomous clinical teams. Section four considers the kind of management development programmes that could assist such a change in focus, but in the meantime the report turns to considering the impact of 'bottom-up' reforms such as those attempting to increase patient choice and patient and public participation in the NHS, and how these might have affected relationships within healthcare.

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## **3 Bottom-up reform in the NHS: patient choice and public and patient involvement**

### **3.1 *Introduction***

The 2000s, as well as instigating a range of means for attempting greater top-down control over the NHS, also put in place a range of reforms designed to change clinical and even managerial relationships with patients and the public. This 'bottom-up' reform occurred through two main mechanisms; efforts to increase patient choice; and changes to the means by which the general public and individual patients can participate in decision-making in health services. This section will review each in turn, examining the effects particularly on relationships between either doctors and patients or NHS organisations and the public as appropriate to track the changes that occurred as a result.

### **3.2 *Patient choice***

Patient choice has become a central part of policy during the 2000s, and is at the centre of the new coalition government's proposals for the NHS (66). The main means by which patient choice is meant to work is through patients choosing GPs and secondary, community and specialist services. Health services will be made more responsive provided that money can be made to follow their choices. Patient choice policies demonstrate a great deal of continuity between the Labour and coalition governments, with the former arguing that choice was a better way of driving improvement in public services more generally (77), and the latter basing plans for NHS reform around GP commissioning and patients making choices within that framework (66).

Patient choice policies are nothing new - as far back as the 1980s governments were suggesting that health services needed to take greater account of them in order to become more focused on the needs of individual service users rather than professionals (78). What have we learned about patient choice since then?

#### **3.2.1 *Evidence on patient choice***

The first problem in interpreting the evidence on patient choice is that there has been less of it than we might expect. This is because between 1990 and 1997 health care decisions were driven by fundholding practices rather than individual patients (79, 80), with very little scope for patients (or even other purchasers) to make much in the way of provider choices (81), and most referrals being made within areas local to patients only (82), limiting the scope for competition or a market for care to develop. As such, the

evidence on patient choice in the 1990s tended to come not from the UK, but usually from the US (83).

### **3.2.2 Evidence from patient choice research in the 2000s**

Patient choice policies gained momentum in the UK again from 2001 onwards (84). There was a pilot project in London, the implementation of which was considerably different to the way the choice policy was rolled out in the rest of the country. Patient choice in the London pilot was designed to offer patients who had waited over six months the opportunity to go to a different care provider, with their choices supported by advisors and transport. Such an approach appears staff-intensive in terms of its organisation around frequent telephone calls and organising transport for those wishing to move provider because of waiting. It also, significantly, was not geared to challenge clinicians and managers, because it tried to move long-waiting patients to providers who could treat them more quickly rather than trying to address clinical quality or actively reduce waiting times. Choice, in contrast, in the rest of the country, was explicitly designed to try and drive up service responsiveness on market principles of funding following the best provision, and was offered to all patients, not just long-waiters. However, it was also offered without specialist advisor support (despite the government itself acknowledging how important this was for the policy (85)), and without extra transport. These differences limited the potential for learning from the pilot in the rest of the country (86).

One of the big problems we have in evaluating patient choice as a means of changing relationships within the NHS is that there has been no large-scale evaluation of it even though it has become the common-sense approach to reform for both Labour and coalition governments. We can, however, pick out a number of studies that have offered important contributions over the last decade.

A first series of studies suggest that GP practices might not be the best place for patients to be making choices about their care. The short span of consultations make including a process for patients needing to make choices extremely difficult, especially for more vulnerable patients, often not helped by difficulties in getting Choose and Book to work well (87). It also appears that many GPs don't allow much scope in their consultations for patients to make choices (88), that patients believe their views are taken into account in consultations more than they probably are (89) and perhaps most worryingly, that they may be treating patients differently based on perceived attractiveness (90). Despite expectations about growing health consumerism and anecdotes (and research) showing patients using the internet to challenge doctors over healthcare decisions (91), research suggests that in GP practices it is overwhelmingly doctors that make the healthcare choices, not patients.



Patients are, however, extremely loyal to GPs, only changing them in extreme circumstances (92). This is heartening in the sense that it shows the continuing emphasis on personal relationships in general practice (or perhaps that patients find the prospect of changing practice daunting), but it does present difficulties with the idea of patients driving reform not only through their choice of secondary care, but also their choice of GP, as both the previous Labour government and the coalition White Paper suggest are key drivers for changing relationships and improving health services.

The assumption underlying patient choice is that it has the potential to change doctor-patient relationships, and in present reforms, to put in place mechanisms through which patients can drive improvements in services. However, the research above challenges whether increasing patient choice has the ability to achieve these goals, suggesting that patients often struggle to make their preferences known in GP surgeries.

If GP surgeries have problems as a possible site where patients can make choices, however, then they are almost certainly better than the systems by which choice has been contracted out to telephone-based systems where any kind of informed choice becomes nearly impossible. The lack of support patients receive through telephone-based choice systems makes it hard to see how they can make them in an informed way (93). One lesson that can be learned from the London Patient Choice pilot was how much support patients require when making choices (94), showing how hard it is to get patients to challenge doctor referral decisions, and how difficult it will be using this mechanism as a driver of service improvement.

### **3.2.3 Additional problems**

There appear to be additional structural problems making informed patient choice of secondary care difficult in GP surgeries. The QOF system has been a remarkable success in getting GP practices to provide care in line with its targets, but guideline-driven care more generally often conflicts with offering patients choice about their treatment (95). It also remains an open question as to whether GPs have the critical skills to help patients make choices (89) - a considerable concern given its importance in the new coalition government White Paper.

It is also the case that patient choice might work directly against the trend for GPs to acquire special interests. Research indicates that patients prefer to be seen by consultants for specialist treatment, and are far more tolerant of poor treatment from consultants than they are from GP with Special Interests (GPSIs) performing the same care (96). It may well be that GPSIs are at least as capable of providing that treatment as consultants, but this highlights the tension between the NHS providing evidence-based treatment, and the treatment that patients say that they want. Patients who experience GPSI care are often happy to receive it again - but it would probably not have been their first choice as they expect and prefer to be seen by consultants. This highlights the problem that

evidence-based care may not be at least initially what patients want; given the growth in popularity of complementary and alternative medicine during the last two decades. The treatment that patients might choose (given free choice) could be very different to that which has the strongest evidence-base.

This finding – of the tension between what patients might want to choose and the research evidence-base, takes us to the heart of another tension of using patient choice as a mechanism to change doctor-patient relationships. If patient choice is a key mechanism for driving service improvement, then it is not clear where these choices go against what is, in the clinicians' view, the best evidence currently available.

In addition, studies of secondary care have suggested that patient choice policies have limited potential to change local care referral patterns which are based more on historical precedent rather than evidence, and because patients prefer not to be referred to providers they do not know. Even in the face of widely-reported adverse clinical events, GPs continue to refer to the same hospitals (80), suggesting that GP referral decisions are not always based on the best available evidence, and further complicating the view of how referrals from GP practices can drive improvements in services as a whole.

Research and analysis has historically characterised GPs in a 'gatekeeper' role in the NHS (97), controlling access to prescriptions and secondary referrals and limiting treatment to keep care within affordable limits. The research above suggests that this element remains a central part of the GP role, and that if the aims of patient choice reforms were to significantly change relationships between doctors and patients, then they have some way still to go.

### **3.2.4 Conceptual issues with choice**

Many studies of choice suggest that, in order to choose the best provision and to act as a means of increasing the responsiveness of health services, patients will need high quality information (77). However, this may be a misunderstanding of the process involved in patient choice. This is because there is evidence that tools designed to support patients in making choices do not have any effect in reducing patient anxiety or improving their satisfaction with decision-making (98). More information does not necessarily help with choice - if patients don't have the time, resources or support to understand it, it may make things worse. In these circumstances, patients will refer the decision back to their GP so that choice is no longer driven by them.

It also seems to be the case that patients prospectively value the idea of choice more than they do at the time they have to make it. In the US in studies of cancer care, patients state they would like choices far more when well than when they are actually ill, when they prefer doctors to make

choices on their behalf (99). More generally, experimental studies suggest that there are many situations where patients simply do not want to make choices because of the potentially adverse consequences associated with them (100). In such circumstances, asking patients to make choices they would prefer not to make holds the potential for significant long-term adverse consequences for their psychological well-being.

Finally, evidence from the SDO-funded synthesis of research on patient choice, suggests that it may well be the case that very few patients actually want choice - what they would prefer instead are good local services (101). Evidence from Europe suggests that where choice does take place, it tends to be the young, healthy, affluent and well-educated that exercise it, and then their decisions are based not on strong evidence but instead on patients' prior knowledge of services, their convenience and their price (102) – which again points away from the commissioning of high quality services envisaged by either Labour or the coalition government. It also suggests that some patient groups are much more likely to be challenging clinicians than others, which has considerable implications when attempting to change relationships with patients.

### **3.2.5 What kind of choices do patients want?**

Despite all these misgivings however, patients do like some kinds of choice. They value not choice *between* services, but choices *within* services. They want to enter a collaborative relationship with clinicians to decide their care (103), and this works best when patients are entering a relationship where care is going to take place over a longer period (chronic disease and maternity services, for example). It also makes obvious sense that patients would like greater say about *when* they are seen - with Choose and Book often unable to provide this level of flexibility.

It therefore seems that the structures put in place by the NHS to facilitate patient choice seem too often to give patients the wrong kinds of choices, and so do not empower them in their relationships with health services. It also seems that the information government sponsored web-sites provided to assist them in their choices (such as NHS Choices, [www.nhs.uk](http://www.nhs.uk)) are poorly-used and do not meet their needs (104).

In summary, if the goals of patient choice reforms were to empower patients to increase the responsiveness of health services, and especially to recast relationships between patients and GPs to allow that to happen, it would seem that the present means for achieving these goals are not being met.

## **3.3 Patient and public participation in the NHS**

A second key area of bottom-up reform in the NHS have come through attempts by which patients and the public can utilise 'voice' mechanisms to

improve the quality of services through increased patient and public participation in the NHS.

Increasing patient and public involvement in the NHS was a clear goal of the Labour government's policy from 1999 onwards (105) with the NHS Plan (2) extending this approach and a year later, *Shifting the Balance of Power* (106) aiming to give local communities more influence over the development of services through greater Primary Care Trust (PCT) engagement with them.

The structures through which patient and public involvement were to be achieved have been an area of considerable change. The Health and Social Care Act 2001 required NHS bodies to involve and consult the public in the planning of the provision of services and the development of proposals for changes in the way those services were provided, and in decisions affecting the operation of those services (107). The National Health Service and Health Care Professions Act 2002 abolished Community Health Councils and replaced them with Patient and Public Involvement Forums (PPIFs) for each PCT and NHS Trust in England, managed by the Commission for Patient and Public Involvement in Health (CPPIH). The PPIFs could also be referred to local government Overview and Scrutiny Committees (OSCs)(107). The Health and Social Care (Community Health and Standards) Act 2003 set up the Healthcare Commission (formally the Commission for Healthcare Audit and Inspection) whose responsibilities included conducting patient surveys and involving patient groups in service user consultation. Finally, an additional wave of legislation (the Local Government and Public Involvement in Health Act 2007) abolished PPIFs and replaced them with Local Involvement Networks (LINKs). LINKs were established in April 2008.

### **3.3.1 What have we learned about patient and public involvement in the NHS?**

A series of findings from research in this area suggests a considerable degree of confusion both over the means by which the public are meant to participate in health services, but also the roles they are asked to occupy when doing so. All of these are barriers to the greater involvement of the public in health service decision-making.

### **3.3.2 Public and participation in general terms**

Research suggests that public and patient involvement has adopted an undifferentiated approach to constituencies within the public, and not taken sufficient account of the different motivations of different public groups to be involved in health services (108). In addition, the consumerist language of patient choice policies often appear to create contradictory tensions with attempts to involve the public as citizens (109). This tension appears to have been strongest in the area of mental health where service users have actively resisted being labelled as 'consumers' and through self-organised

groups campaigned to be heard through dialogic mechanisms and for service improvement through these means (110, 111). Research has criticised participation mechanisms by claiming that they are not designed to make health services more democratic (108), but were instead based on a more limited, smaller-scale view of service improvement, and even as 'a means of manipulating patients and the public rather than empowering them' (16). New public and patient participation organisations are regarded by researchers as lacking independence and legitimacy (109).

The abolition of Community Health Councils resulted in a loss of public participation capacity (108), especially as staff were not allowed to transfer across from the old institutions to new ones such as PALS (Patient Advice and Liaison Service) (112, 113). These new institutions have often appeared to be initially poorly formulated, being enacted without clear guidelines as to their roles or how they are meant to work within the NHS (especially in relation to the new performance management systems), and without the resources to do the jobs asked of them (109). This resulted in very different models of participation appearing from one locality to the next, some based on bureaucratic models which tended to favour expert opinion above public contribution, and others based on a more dialogic form that allowed deeper consultation to take place (114, 115).

In primary care GPs still saw themselves as patients' advocates and had little time or resources to increase patient involvement in the running of their practices (22). They maintained a gate-keeping role and had little knowledge about the way patients could become more involved. There is no evidence to suggest that patients' views are systematically gathered and acted upon to improve service quality.

### **3.3.3 Different expectations of involvement**

Research from both the UK and overseas points to the different expectations that the public and health service managers and clinicians often have of participation mechanisms. This work is most clearly formulated in a Canadian study (116), but the findings are confirmed by UK-based examinations of participation as well. These differences are summarised in Table 2.

This research suggests that the public, when asked to participate in health services, need to understand the context of the decision they are being asked to become involved with, as well as the link between the consultation and the outcome of the participation. The public expect careful recruitment of an appropriate mix of people, power-sharing between participants and decision-makers, and a great deal of open information-sharing between health services and themselves, which they take to be a sign of trust in the process. They want the information presented to them to come through neutral facilitators, time to build confidence with the topic, and for lay views and experiential expertise to be listened to during the participative process. This list of expectations and requirements is rather more expansive and

wide-ranging than is offered through the vast majority of public participation forums (synthesised in the left column in Table 2).

**Table 2. Abelson et al.'s comparison of public consultation design principles**

| Table Comparison of public consultation design principles with citizens' views about public involvement  |   |
|--|---|
| Public consultation design principles (from previous synthesis work)   | Citizens' views about public involvement (from focus groups results)  |
| <p>Clearly communicate:</p> <ul style="list-style-type: none"> <li>the purpose of the consultation</li> <li>its procedural rules</li> <li>the relationship between the consultation and the decisions taken</li> </ul> <p>Represent views, interests and constituencies:</p> <ul style="list-style-type: none"> <li>by carefully considering whose input should be considered</li> <li>by providing opportunities for all participants to contribute fairly</li> </ul> <p>Develop procedural rules:</p> <ul style="list-style-type: none"> <li>that promote power-sharing and mutual respect among participants and between participants and decision-makers</li> <li>that allow for adequate time for questions, clarification, listening and understanding</li> <li>that promote trust, credibility and legitimacy</li> </ul> <p>Provide information:</p> <ul style="list-style-type: none"> <li>that is accessible (e.g. understandable, appropriate amount)</li> <li>presented in a way that informs discussion</li> <li>that can be discussed and interpreted</li> <li>from credible and trusted sources</li> </ul> | <p>Communication</p> <ul style="list-style-type: none"> <li>clear communication about the purpose of the consultation, and its relationship to the larger decision-making process</li> <li>identifiable links between the consultation and the decision outcome (through the presence of someone in a decision-making role)</li> </ul> <p>People</p> <ul style="list-style-type: none"> <li>careful recruitment of the appropriate mix of people for the issue being discussed</li> </ul> <p>Process</p> <ul style="list-style-type: none"> <li>promote power-sharing and mutual respect among participants and between participants and decision-makers through neutral, impartial facilitation</li> <li>use a flexible structure to allow for meaningful contributions</li> </ul> <p>Information exchange</p> <ul style="list-style-type: none"> <li>information sharing in a context of trust</li> <li>information to be presented clearly, honestly and with integrity (by neutral facilitators)</li> <li>needs to ensure participants' comfort with the topic and to build the confidence for meaningful participation</li> <li>lay views and experiential expertise should be listened to and considered</li> </ul> |

*Source: Abelson et al., p. 211*

UK-based research examining citizen's juries has shown the difficulty of getting public participatory decision-making to work but, even more importantly, that where the public are asked to participate in a decision with no power or authority it is a disempowering event for them (117). In his study of public involvement in cancer-genetics services, Martin (118) found that whilst clinical staff were prepared to listen to the public, the public found their roles too restrictive, with professionals wanting and expecting them to act as deferential consumers, but the public participants instead wanting to be actively engaged with decisions and becoming stakeholders in the way the service was developed.

The issue of which members of the public are chosen to participate is also shown to be important for the process to be legitimate (108), and whether those chosen are meant to be representative of a wider group or not (109, 119). Whereas health services often want the public to be representative of their local communities, those that want to participate seem to reject this, instead wanting to stress their individual experience and background (120).

It is unclear the extent to which Local Authority Overview and Scrutiny Committees were designed to make the NHS more democratic, as any accountability to local people achieved would be indirect. The evidence suggests there is enthusiasm within Local Government for the Committees as a means of achieving greater public involvement, but huge challenges in establishing the roles, support and local links that would make them effective (121). In addition, there were difficulties in establishing appropriate boundaries between the Committees and the work of first,

Patient and Public Involvement Forums (109) and later LINKs, with the latter being established to counter criticisms about the inability of either the Committees or the Forums to represent local communities (122), but further confusing the means by which local accountability was meant to work (123).

Patient complaints about health services are an area which have potential to form a bridge between individual experiences and collective service improvement. However, it seems that the NHS is still struggling to deal with complaints, with concerns that Trusts are becoming more secretive in their dealing with them, and that the complaints process remains lengthy and onerous, paper-based, with little opportunity to challenge findings with few opportunities for personal interaction to achieve resolutions through the process (124).

### **3.3.4 What are the lessons from public participation policies?**

Public participation has been an area of almost continual reform and change over the last ten years, with little opportunity for institutions to become embedded in NHS structures and for relationships to become established between NHS organisations, participation institutions and the public.

A key finding is that the public want far deeper participation than the NHS is presently offering - they want to become partners in decision-making rather than token representatives or groups that are occasionally consulted, and they want the NHS to make clear the links between consultation and decision-making in ways that it often presently struggles to achieve (116, 120). This findings has resonance with work examining the reinvigoration of local democracy more generally, with Stoker (125) advocating a 'politics for amateurs' that achieves many of these goals, but which also counsels that the public need to be educated to have reasonable expectations about the extent to which their views can be taken into account during complex decisions.

At present, it would seem that the bottom-up mechanisms introduced by the NHS are inconsistent from one area to the next, fragmented because of boundary confusions between various representative bodies (most visible in the introduction of PALS (112, 126), an area of some confusion because of continual reform, and often not giving the public the opportunity to participate in partnership with clinicians and managers. The NHS, in short, has not put in place mechanisms that have allowed the public to challenge the often passive role they assume in relation to driving health service improvement.

## **3.4 Bottom-up mechanisms compared**

The two main bottom-up mechanisms compared here, patient choice and public participation, share the aspiration of making health services more

responsive and changing relationships between public professionals, managers and the public as a result. Both, however, have struggled to achieve these goals.

Patient choice policies do not deal with power and information imbalances between GPs and patients, and often seem to offer patients the wrong kinds of choices - instead of asking patients to choose between providers, they often appear to want instead the guarantee of good local services and the choice of when they access them. Where patients want choice over their services, they are part of a longer-term process of care such that where a patient has a long-term condition or has a care pathway that allows informed choices to be made - such as during pregnancy.

Public participation mechanisms seem often limit the means of participation to one that can be more rightly labelled as consultation, in which members of the public are allowed to contribute to decision-making in health services, but often in a highly proscribed manner, with limited opportunity to become more active stakeholders or participants. The results of consultations are often not well communicated, with the public not seeing links between the consultation and the final decision. This has elements in common with the problems of patient choice policies - as with patient choice, the particular kind of engagement that is being offered is not the kind the public appear to want. The public appear to want (and expect) a deeper process of participation where they work in partnership with clinicians and manager rather than being occasionally consulted about particular decisions. It certainly has not helped that public participation mechanisms have been changed so often in the last ten years that some commentators regard them as being in 'disarray' (127).

In both choice and participation, the public and patients appear to want a process that is more dialogic - for their views to be actively sought and recognised by health professionals and managers, and for them to have clear evidence that they have been taken in account. In patient choice, the choices offered through Choose and Book processes often give little room for discussion or information provision, with patient choice advisors not being a part of the process despite the clear recommendations of the Office of Public Service Reform to the contrary (85). In public participation, opportunities for the public to be involved are often too limited in scope and offer little opportunity for dialogue, discussion or for the public to be adequately informed about the discussion through adequate, independent briefing. The research indicates all of these are necessary, but the NHS falls short in achieving them.

There were hopes that greater patient involvement would result in changing traditional power relations between professionals and patients (35). The variety of methods of participation, coupled with unclear guidelines as to how the public and patients should be involved, left gaps where managers and professionals could set agendas and fix boundaries on what could be discussed or decided upon, with the former particularly often leading the



forum in which participation occurs, and with it becoming tokenistic in process. There is evidence of clinicians, managers and the public working together more inclusively, but most research points towards a more constricted, dictatorial way of working with patients, and with some managers using the new involvement processes to legitimate their own ends.

As such, neither of the bottom-up mechanisms put in place seem able to allow the patient and public to achieve the greater responsiveness of health services through the present mechanisms provided. Patients and the public want more dialogic, and less transactional means of interacting with clinicians and managers to improve services. The next section considers what might be done in terms of development activity, both in terms of supporting managers and doctors to work together, but also to support greater patient and public participation in the NHS.

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## **4 Management development: what do we need to do to support doctors and managers in the NHS?**

### **4.1 *Support through management development programmes***

From the analysis in the sections above on top-down and bottom-up reform, a number of important factors arise considering how best to support doctors and managers through management development programmes.

Perhaps most importantly, the professional training of clinicians and managers is a crucial factor in understanding their different perspectives on organisational problem-solving(20). We know that nurse-managers tend to have a different view of the world to doctor-managers(39, 49), and that managers without a clinical background are often suspicious of clinicians in hybrid managerial roles (25), even going as far as organising meetings to avoid or minimise clinical input (27). Doctors also appear to be less willing to work with clinical managers from specialties other than their own (73). Problems arising from the differences in perspective between clinical-managers and non-clinical managers appear to be worse in hospitals than in GP surgeries, although there are problems in relationships between clinicians and practice managers in the latter as well (72).

What these findings suggest is that management development programmes must take account of, and understand, clinical as well as managerial perspectives, and to help facilitate clinicians and managers in understanding what each can contribute to improving services. What is possible in terms of management (and leadership) in healthcare organisations is limited by the context within which clinicians and managers work, with managers having to work in environments where the changes required of them through policy are often under-specified (128).

### **4.2 *Evidence from research on management development programmes***

A first point arising from research is that clinicians often regard effective leadership to be embedded in their specific work context (129). So generic, competency-based management training is likely to be perceived as being separate from their practice, and of little use. Where training programmes have not taken account of the NHS context, introducing management competencies without the scope for participants to critique them, clinicians often mobilise against the programmes (130, 131), leading to participants

dropping out (130) and the courses becoming a source of conflict. Clinical participants, trained in critical evidence formulation, often found the lack of critical engagement on generic management programmes frustrating, rejecting them as a result. Generic management courses appear to be poorly received and 'The message here is that sensitivity to context is important.' (131) (P. 58). The Management Charter Initiative, similarly, was criticised as being private-sector based and so unable to take account of the specific health service context and too abstracted from practice (132, 133).

Training courses that respondents evaluate as successful tend to have particular characteristics. Courses that give clinicians a background in managerial ideas allow them to engage with managers across a wider range of organisational issues, and so can be useful in helping with this provided they are not rooted in uncritical, acontextual understandings of management. Courses run in the North West (134), and particularly the North East (135), have made progress towards these goals, with the latter's success being put down to allowing individuals time to reflect on their practice and because of its flexibility and responsiveness to participant feedback. In Trent early career doctors and managers were brought together to consider live issues in their organisation as well as using simulation and role play that was linked explicitly to practice (136). This appears to have worked well in facilitating mutual understanding between clinicians and managers. In Dorset, general practices have been successfully supported through half-day courses away from practice to study management but, more importantly, through programmes that emphasised practical problem solving and which utilised inter-professional collaboration (137).

Courses that ignore or do not adequately deal with the different perspectives clinicians and non-clinical managers bring to their roles, often struggle to succeed. There is a danger of professional identities clashing with the managerial perspective that development courses tend to present, with one particular NHS-led management development programme being singled out for failing to deal with this conflict (138). Equally, mutual suspicion between clinicians and managers on training courses often seems to be based on the differing education backgrounds of the groups, with clinicians being required to engage with continuing education throughout their careers and the latter not having the same demands (139). Development programmes need to take care to set up their programmes in such a way not to alienate either grouping by presuming the two are equally familiar with training processes.

Management education, then, needs to be contextual in dealing with the different backgrounds of clinicians and managers, to allow inter-professional problem solving that has relevant to day-to-day practice, and allow critical interaction, especially around the understanding of evidence, where the different backgrounds of clinicians and managers offers scope for

conflict, but also far greater mutual understanding, if differences in perspective can be explored (139).

There are differences of opinion as to whether training should take place with work colleagues, even at a speciality level, to work through the specific problem they are encountering (75), or whether training with those from other organisations works best so that present work problems are not allowed to dominate (135). In both cases, however, the emphasis on developing practice-led models of training, addressing problems inter-professionally, and a strong awareness of the NHS organisational context, appear to be the main factors to the courses being successful. These factors have a great deal in common with the approach to management training recommended through 'deliberate practice' understanding (140) which similarly place on a premium on understanding organisational contexts and training that emphasises practical problem-solving within those specific domains (141). Management knowledge is based more on practical problem solving, often facilitated through in-depth case studies (142), than on the teaching of generic competencies.

However, a significant problem is the lack of research and evaluation examining whether management development programmes, of the type described above, but also more generally, can be shown to have impact upon NHS organisations. There is remarkably little work exploring the effects of management development programmes on actual practice when clinicians and managers have returned to their everyday jobs. This is clearly an area where a great deal of further research is required.

### **4.3 *Other forms of training***

The summary of 'bottom-up' reform suggests that other forms of training are also required in the NHS.

Reforms based around patient choice are still the source of considerable confusion. This is because the approach refers to such a range of contexts, in such a range of situations, that it is often not clear what kinds of choices particularly professionals are meant to be offering, and which patients actually want.

What is almost universal is that patients want to discuss their treatment with their doctor, and to be given choices within a programme of treatment when they occur (103). This may sound like common sense, but the research suggests that many patients are still not receiving care that meets these criteria (88) (89). It is therefore important that doctors, especially those who might have qualified before patient-centred models of care were prevalent, are made aware of the importance that patients attach to being consulted about decisions that affect their health, and that they are encouraged, through their continuing professional development, not only to keep up to date with new treatments, but also to make sure they are developing the inter-personal side of caring patients attach importance too.

It is also important that the public have the opportunity to engage collectively with their local health services. There has been a great deal of policy reform over the last ten years attempting to achieve local participation, but mechanisms have changed so often, and reforms appeared so contradictory at times (109), that developing 'citizen'-type roles within health services still requires a great deal more work. The means by which the public participate in health services needs to take account of the research that suggests that far deeper and more meaningful participation is wanted. This will require a great deal of training for members of the public, but also for clinicians and managers engaging in participation processes, so that expectations between the different groups can become more aligned and greater success achieved in such forums as a result.

As many writers in the discipline of politics write, there is an urgent need to reinvigorate local democracy, and for local people to understand that they not only 'consume' health services, but also pay the taxes that fund them, and that decisions about how services should develop have the potential to affect communities in a profound way (125). Local health organisations are likely to be very large local employers, and so have strong links with the economy. Equally, the development of health services raises decisions about which services should receive additional funding, and which perhaps less. Much of the debate about health services is often at the level of individual patients who believe they should be receiving treatment using new drugs or improved procedures, and find that the NHS is unable or unwilling to fund them. Such debates take place in a vacuum separate from collective decision-making within a fixed budget, and without regard for the consequences on other services should new drugs or treatments be funded instead. There are, at present, few mechanisms or few forums within which such debates can be held, and so a gap exists between the individual decisions patients receive about their own care, and the collective decisions about service development in local areas.

Managers need to be routinely able to engage with local people concerning decisions about local health services, or the democratic accountability of healthcare will remain very much at arm's length though periodic national elections. The means by which the public are consulted in PCTs and Foundation Trusts is often tokenistic (109), and if GPs are to be given stronger commissioning roles under the coalition government's plans, then they too will have to find ways of engaging with local communities to a far greater extent to ensure some kind of democratic accountability.

A great deal of work needs to take place, on both the side of the patient and of decisions makers in local health services, to link decision-making together. In a time when budgets are likely to be frozen or cut, educating the public about the nature of health service choices, and making public managers accountable for them, assumes an additional level of importance, if those difficult choices are to be seen to have legitimacy. Coalition government proposals for local commissioning through GPs and for local

government to take greater responsibility for the NHS, social care and public health, will mean that ensuring local authority accountability will become more important than ever. Supporting public participation through appropriate training and by providing forums to allow explanation and debate will be an important part, if decisions to reduce to limit the growth of services are to be regarded as legitimate.

#### **4.4      *Training recommendations***

Given the discussion above, a number of propositions can be put forward as to the best means of supporting health managers and clinicians in managerial roles.

1. Hybrid clinical roles need much stronger support from both clinicians and non-clinical managers in order to work as intended. The problem-based, collaborative training advocated here and above is one way of such support being provided, but individual organisational design needs to ensure that both doctor-manager and nurse-manager roles are given the authority and status they deserve in NHS management.
2. NHS management training needs to be organised on a problem-based, multi-professional collaborative basis to ensure that clinicians are not isolated by being taught generic management theory, and that all participants are able to contribute their professional expertise to practical, problem-solving tasks that will inform their team-working in real life situations.
3. Case-based material represents a pedagogical tool that is likely to facilitate greater collaboration and closer team-working through the use of practical problem solving it can achieve. The SDO now has an extensive library of such material that might form the basis of training packages, as well as increasing the take-up of its funded research. This represents an excellent opportunity for it.
4. Changing relationships between patients, the public and clinicians requires an investment to train doctors to make them more sensitive to patient need, to facilitate choices in a new environment where GP commissioning is going to form the centre-piece of attempts to make health services more responsive, as well as to offer greater opportunities and training for the public to be more involved in the running of NHS organisations.

#### **4.5      *Realistic evaluation***

The synthesis of research in the project was conducted using realistic review methods (143-151). The realistic method aims to explore the relationship between the context, mechanisms and outcome of particular interventions, and to improve understanding of the dynamics between these elements. It is an approach to research synthesis recognised as

having strong relevance to health organisational research (152), and was chosen in order to isolate the effects of both institutional and policy contexts on reform, and to explore the dynamics of relationships in producing particular outcomes. The importance of understanding the relevance of context in health organisational research has been long-understood (153, 154), but is often still not incorporated into reviews and empirical work. The danger of carrying out reviews without adequate consideration of context is that research loses any sense of its specificity, and findings lose any sense of where they may or may not be successfully applied. The realistic review method builds on the ideas of realistic evaluation pioneered by Pawson and Tilley (155), but applies predominantly to the synthesis of pre-existing (secondary) research rather than to evaluating interventions which the participants are engaged to examine first-hand.

Examining how particular initiatives (in this case treated as the 'mechanisms' in the realistic methodology) have impacted upon reported outcomes, and how these inter-relate, in turn, with the differing contexts of health organisations, has the potential to produce actionable knowledge that is context-sensitive (131). In as distinctive an area as healthcare, it is critical for research that links between contexts, mechanisms and outcomes are carefully explored.

The realistic approach grounds the research firmly by avoiding claims that 'magic bullet' answers exist for how to better support both nurse and doctor manager. Instead, it aims to produce contextually-sensitive understandings of how relationships can be more successfully managed, and to answer in what circumstances, how and why, engaging clinicians in management appears to work (156). It aims to answer the key question of 'what works' (105, 157) in a rigorous, yet pragmatic manner.

The project used realistic review methods to examine the literature on health management since 1990, the period covered by it. The initial bibliographical search for the project was conducted using Web of Science, Business Source Premier, and Science Direct in order to identify both relevant pieces and journals where articles of relevance to the project were published. Grey reports and findings were initially compiled by examining funded research projects from organisations such as the NIHR (National Institute for Health Research), ESRC (Economic and Social Research Council), and AHRC (Arts and Humanities Research Council). Research was then screened for its relevance to the present study and its aims. In contrast to a systematic review, research was included for its ability to generate and add to our understanding of professional/managerial dynamics rather than for reasons of sample sizes or reported methodology robustness (148). Findings were then examined in terms of their patterns between institutional and policy contexts, dynamics between the groups and their underlying mechanisms, and the success or otherwise of the combinations in the research.

The aims of this work were to produce contextually sensitive understandings of what appears to work, when, and how, that managers and clinicians and other stakeholders will be able to learn from, informed by rigorous academic practice.

#### **4.6     *Identifying the journals and literature***

The project began by revisiting research syntheses on the dynamics of health politics in the late 1980s and early 1990s (158-160), as well as classic studies of the dynamics of clinico-managerial relationships (161-163). These provided an initial context within which the research could begin.

To supplement journal database searches (see above) academic journals were also initially identified using the ISI Journal Citation Reports database via the JCR (Journal Citation Reports) Social Sciences Edition (2007). The webpage for this was accessed on 1 April 2009. (<http://admin-apps.isiknowledge.com/JCR/JCR?SID=W1kfIId6L2FHIdEHCpa> )

The following subject categories were searched:

1. Health Policy and Services
2. Public Administration
3. Social Issues
4. Sociology

A list of journals was drawn up, determined by likely coverage of clinical-managerial relations in terms of management, policy, and theory. The British Medical Journal provided another starting point because of its extensive coverage of this issue.

Each of the journals were then examined, article by article, for research published between 1990 and 2010 likely to be relevant to the research, and compilations of the abstracts made. The range of abstracts included the subject areas of Health Care Management, Health Care Policy, and Public Management and encompassed both empirical and theoretical papers. The initial number of hits per Journal is reproduced in Table 3. The abstracts were then read by another researcher to verify inclusion.

These journals represented the starting point of the project, which then branched iteratively outwards into the literature by compiling lists of research cited within the pieces first examined in the project, and following up journals and authors whose work appeared relevant. This was supplemented in turn by further searches made using google scholar, which were designed to make sure the review included pieces most-cited in the literature, cross referenced against the research already included.



**Table 3. Initial journals searched**

| <b>Title</b>   | <b>Number of abstracts<br/>1990-2000</b> | <b>Number of abstracts<br/>2001-2010</b> |
|--|--|--|
| Administration and Society                           | 6  | 10                                       |
| BMC Health Services Research (starts 2001)           |  | 9  |
| British Medical Journal                              | 121                                      | 348                                      |
| Critical Social Policy                               | 4  | 20                                       |
| Environment and Planning C-<br>Government and Policy | 2  | 2  |
| Governance   | 3  | 4  |
| Health Affairs                                       | 8  | 15                                       |
| Health Policy  | 8  | 32                                       |
| Health Services Research                             | 0  | 1  |
| International Journal of Health Services             | 5  | 10                                       |
| International Review of Administrative<br>Sciences   | 9  | 2  |
| Journal of European Public Policy (1997-<br>2000)    | 0  | 0  |
| Journal of Health Politics, Policy and Law           | 9  | 6  |
| Journal of Social Policy                             | 1  | 12                                       |
| Milbank Quarterly                                    | 5  | 4  |
| Policy and Politics                                  | 19                                       | 21                                       |
| Policy Sciences                                      | 0  | 0  |
| Policy Studies (1998-2000)                           | 0  | 0  |
| Public Administration                                | 26                                       | 24                                       |
| Public Administration Review                         | 11                                       | 5  |
| Public Management Review (1999-2000)                 | 3  | 28                                       |
| Public Money & Management                            | 49                                       | 61                                       |
| Social Policy & Administration                       | 9  | 22                                       |
| Social Science and Medicine                          | 33                                       | 27                                       |
| Sociology of Health & Illness                        | 11                                       | 21                                       |
| <b>Total</b>   | <b>342</b>                               | <b>684</b>                               |

Reports, White Papers, and Government Documents were accessed following searches of various websites as follows:

- National Institute of Health Research – Service Delivery and Organisation Programme <http://www.sdo.nihr.ac.uk/>

- National Audit Office  
<http://www.nao.org.uk/publications.aspx?psl=1&y=4496&s=433&c=All&t=All>
- Select Committee on Health  
<http://www.publications.parliament.uk/pa/cm/cmhealth.htm>
- Department of Health  
<http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm>
- King's Fund <http://www.kingsfund.org.uk/publications/>

The bibliographic databases used by the project were then searched for articles on key emergent mechanisms identified as being important within the project (e.g. performance management, management education in the NHS, management development in the NHS, Patient and Public Participation), and these key terms searched for in google scholar to make sure that important papers (measured in terms of citations) were not omitted from the study. This boosted the range of journals already searched to include specialist medical, health services, and management development literature, and to ensure important research had not been missed in the initial search. This yielded a further 478 items.

Again, the emphasis in the review was placed upon finding pieces that added to, or differed from, the understandings generated from our emergent understanding of research already examined on the project. In contrast to a systematic review, we were not attempting to assess research based upon the reported methodology, but instead to assess its potential theoretical and empirical contribution to the project. Two researchers (Harrington and Greener) assessed research to be included in the project on this criterion, with findings from the emergent synthesis being assessed by the rest of the project team, all leaders in research in the field.

## 4.7 *Thematic structure*

The period under investigation was divided into 1990-1997, with the Conservative government in power, and 1997-2010, under Labour. This provided an initial framing for examining the literature and developing contextual understandings of reform in each period.

The context of policy at the beginning of the 1990s was written up first to establish a firm base from which to work, followed by an outline of the context, mechanism, outcome framework for 1990-1997. This produced theories for how clinico-managerial relations would develop. Articles were then assigned to thematic groups around mechanisms based around these contextual theories. Policy at the end of the 1990s was used as a basis for compiling a list of themes (e.g. professionalism, or purchaser/provider split) and articles were grouped around themes (each article could have more than one theme) and the relevant group(s) of people.

The groups identified were:

- Managers
- Professionals (consultants)
- Patients
- GPs and primary care workers
- Nurses
- Politicians
- Management Consultants

Papers could and did refer to different combinations of these groups of people and this was reflected in deciding which articles could be grouped together.

The mechanisms were as follows:

- The introduction of the purchaser/provider split – including internal markets
- Changing management – including
  - Delegation of responsibility to local level
  - Involvement of professionals in management
  - RHA/DHA reorganisations
  - Split between policy and operation
  - Business ideas and management – e.g. Business Process Re-engineering
- Total Quality Management – including all quality initiatives
- GP contracts and fundholding
- Consultant Contracts
- Nurses – changes to duties and professionalization
- Performance information and performance management
- Audit/Inspection – including financial and medical audit
- Increased privatisation – including working with the independent and private health sectors, competitive tendering

In addition, four conceptual mechanisms were identified:

- Professionalism – included position of consultants, nurses and patients as professionals in relation to the changes, challenges to professional standing, changes to the professional role.
- Managerialism – included position of managers in relation to the changes and in relation to professionals, changing developments in the role of managers.
- Consumerism – included changing position of patients, and changing role of patients as customers and then consumers of health care.
- Efficiency – including cost-containment, accounting, resource management.

Articles/reports etc. were thus grouped as an evidence tree. Individual items were then explored to see how far they proved or disproved the contextual theories or how they contributed to the creation of new theories.

The literature for this period was reviewed to identify outcomes from the mechanisms for the 1990s, paying particular attention to the contexts of these outcomes.

Methodology was similar for the 2000s. Here the context was what had happened to clinico-managerial relationships at the end of the 1990s. Mechanisms were derived largely from the NHS Plan 2000(2) (with some additions from later policy documents that built directly on the NHS Plan policies). There were a number of mechanisms for the 2000s derived from the plan which had a bearing on clinico-managerial relations as follows:

1. Funding from Direct taxation
2. Investment in NHS facilities and equipment
3. Investment in NHS staff
4. Abandoning the market – the Third Way
5. Partnerships with private and voluntary services
6. Primary Care Trusts reform
7. Strategic Health Authorities reform
8. Regional Directors reform
9. NHS Appointments Commission
10. Strengthening the role of Public Health
11. Performance Management (including Local Authority Scrutiny, Audit Commission)
12. Organisations/policies to improve standards in the NHS (including National Care Standards Commission, National Institute for Clinical Excellence (NICE) , Commission for Health Improvement (CHI) National Patient Safety Agency (NPSA), Council for the Quality of Health Care, Clinical Governance)
13. Doctors' contracts (GPs and Consultants) (including Medical Education Standards Board, UK Council of Health, National Clinical Assessment Authority)
14. Changes for nurses, midwives, therapist and other NHS staff (including Modern Matrons, University of NHS, NHSplus)
15. Patient Choice (including PALS, NHS Charter, Patients Survey, NHS Direct, Electronic Booking for Operations).

In terms of health service relationships in the 2000s there were three main overarching mechanisms that became the programme theory:

1. Performance Management - including no additional resources without reform, the Policy-implementation gap – deliverology, target-driven government to drive up standards and reduce waiting lists, 'Earned autonomy' for good performers – Quality and Outcomes Framework, Clinical Governance, Foundation Trust status.
  - Sub-mechanisms – including Local Authority Scrutiny, National Care Standards Commission, National Institute for Clinical Excellence (NICE), Commission for Health Improvement (CHI), Audit Commission, National Patient Safety Agency (NPSA), Council for the Quality of Health Care.
2. Patient Choice – including increasing the range of provider choice, money following the patient.
  - Sub-mechanisms – including Choose and Book, Payment by Case, Payment by Results, PCT reform.
3. Changing Relationships with the Patients and Public – Doctors should be able to focus on what they are good at, Nurses will increase

professional status, Nurses in charge of infection monitoring should improve infection rates.

- Sub-mechanisms – Nurse prescribing, Modern Matrons.

The literature was then reviewed to find the outcomes from the programme theory and the impact the mechanisms had on clinico-managerial relations.

#### **4.7.1 Organising the structure of the report**

Once the review's major findings were compiled, the structure of the report was decided upon. We split the main research of the report into decades in line with the searches, to reflect the different approaches of the Conservative and Labour governments, and decided to present the research under the 'top-down', 'bottom-up', and 'management development' headings. We chose the split between 'top-down' and 'bottom-up' reforms because they appeared to form a major part of government reasoning over attempts to reform health services during the 2000s especially. This was based on the research, but also on first-hand accounts of health reform during the 2000s appearing from former Prime Minister Tony Blair in his autobiography, but most explicitly from the former head of the Prime Minister's Delivery Unit Michael Barber who wrote in his book 'Instruction to Deliver'

*2002/3 would be a transitional year, in which we undertook 'the shift from top-down driving of public services to sustainable improvement driven by the pressure of customers'.*

(p. 143)

and

*'...the next phase for professionals would involve going forwards to a time dominated by consumer pressure, extensively publicly available data, choice and innovation. 'It will be more demanding [for them], not less, than the era of centrally drive reform,' I concluded in bold type.*

This view of attempts to reform relationships both 'top-down' and 'bottom-up' in the 2000s comes through strongly in the academic literature, as well as from insiders in the policy process, so seemed to have strong validity.

#### **4.8 Dissemination event**

On the 21 June 2010 a dissemination event was held at the Wolfson Research Institute, Durham University, advertised locally to local health professionals and academics, and nationally through the research institute's mailing list and website. Around thirty attendees heard the project's provisional findings, which were discussed and scrutinised in a series of workshops. All attendees were given the opportunity to feed back to the project team separate from the workshop.

A brochure of provisional findings from the project was produced for attendees to examine during the event, and a series of workshops run to assess attendees' understanding of them, as well as giving an opportunity

for them to both challenge the research, and to suggest areas where additional work needed to be done. This allowed the emergent structure of the report (especially the division into top-down and bottom-up reforms) to be checked to make sure it made sense to the NHS community, as well as to get feedback on which areas of the findings were of particular interest. This resulted in the work of Degeling, which delegates wished to receive greater coverage, being placed more prominently in the report, particularly due to the feedback from Professor Andrew Grey, for which the research team are especially grateful.

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## 5 Conclusion

### 5.1 *Revisiting the research questions*

The research set out to answer two main questions:

- 1 What does existing research tell us about the dynamics of doctor, nurse and manager relationships, particularly at middle-management levels? What difference does it make when clinicians also occupy management roles? How have these relationships changed in various waves of health reforms, particularly from the 1970s onwards?
- 2 What means of supporting managers, both clinical and non-clinical, are in place within the NHS, and how do these vary in terms of both the type of health organisation (for example, Hospital Trust, PCT, Mental Health Trust) they have been deployed in, and their perceived outcomes?

In our review it has been noticeable that the dynamics of doctor, nurse and manager relationships in secondary care have remained remarkably unchanged through all the reforms in the NHS during the last 20 years. In hospitals, research has found the educational background of staff to be a key determinant of how they view the reforms that have taken place since the 1990s, with medical clinicians still broadly characterised as generally opposing managerialist reforms, medical managers offering some support, nurse managers showing broad support, but nurse clinicians general opposition to reforms. These differences of perception, and opposition to attempts to introduce multidisciplinary team working, mean that considerable 'tribal' behaviour still seems to predominate.

Full-time managers often regard doctor-managers with suspicion, and as being unstrategic. Clinicians tend to view managers as driven by political and financial imperatives. There seems to be widespread 'gaming' of performance management systems, with both doctors and nurses experiencing the reforms as the imposition of externally-imposed managerialist systems that have nothing to do with their everyday work. Doctor-managers regard the managerial aspects of their role as part-time and temporary and having little authority over their peers who often do not regard doctor-manager roles with respect.

Nurses have more often regarded new managerial roles as offering them the opportunities to take greater responsibilities, and to increase their professional standing. So they regard them in a more positive light than doctors. Roles such as modern matrons, however, have been frustrated by being outside of hospital management structures, and by being given responsibilities for areas such as hygiene that are the result of contracts with external contractors. New nursing clinical roles have been partially

successful, but nurses often struggle to balance the care model of their profession with its increased biomedicalisation coming from taking on new technical tasks.

New nursing roles have allowed nurses to take on more technical elements of care work but such reforms have taken place within a managerialist logic of greater nursing expertise allowing doctors to specialise in higher level tasks, increasing efficiency, but at the same time allowing scope for groups within each profession to pursue more fulfilling work. The new managerial roles occur within a dynamic system of professionalism which creates space for professional and managerial boundaries to be challenged but have also led to confusion about what the new roles are meant to accomplish.

In contrast to the hostility towards targets and the gaming that has occurred as a result, in GP practices there has been little opposition to QOF reforms from either doctors or nurses. GPs regard QOF as being based on best practice, and as allowing them to pursue more specialist cases, while nurses regard it as providing them with new opportunities to extend their roles and even to run primary care entirely through nursing staff.

The extent to which the pay-for-performance element of QOF has led to its success is open to question, with GPs often using additional resources to employ more staff or purchase IT rather than raising their own salaries. QOF does appear, however, to have led to GPs taking a more biomedical and less personal view of patients and to increased standardisation of care. There is little evidence, outside of changing appointment systems to manipulate two-day targets to see patients, of QOF gaming.

Nurses express some concerns about their ability to deal with the challenges that their extended roles in primary care offer, of the lack of training available to support them, and about becoming 'absorbing groups' for jobs that GPs don't want to do, but are generally positive about QOF. In particular, where it creates an environment where greater team-working takes place between GPs and nurses, the changes are particularly positively regarded, although relationships with practice managers are still sometimes problematic.

Practice management appears to be an area where there is very little dedicated research. What work there is suggests that there have been tensions between doctors and practice-managers (although less than tensions between managers and clinicians in hospitals) over decision-making, and that QOF sometimes has the potential to concentrate decision-making in a small clinical elite, often to their exclusion.

## **5.2 *Attempts at reforming relationships between managers, clinicians, patients and the public***

On reviewing the literature from the 2000s, a central part of policymaking has been to attempt to change relationships in healthcare through the use



of user or patient-led means, primarily those based around increased patient choice and public participation, and so they have been included though they involve extending the original brief to address public-clinical and public-manager roles as well as those between clinicians and managers.

Policies to use patient choice to change relationships between doctors and patients, and GPs and consultants, have struggled to achieve this goal. 'Choose and Book', the computer system upon which choice is based, has often not worked smoothly enough to allow choice to take place within a GP consultation, and so for choice to be made in a participative way between GP and patient. In addition, GP consultations often struggle to produce patient-led decisions, with patients being offered little scope to make meaningful choices. Despite discussions about patients becoming empowered through the use of the internet, the idea of a well-informed and consumerist patient appears to be the exception rather than the rule - and doctor-patient relationships have been remarkably stable in form in general practice.

Patients appear to want choice within services rather than between services - they want to be consulted about possible alternative courses where they receive on-going programmes of treatment. They would also like more choice about the date and time of treatment. Present choice policies neither empower them in relationships with clinicians to become better informed about their health or care, nor offer them the kinds of choices that they actually want.

Reforms to achieve greater public participation in healthcare have created considerable confusion because, in trying to put in place new structures by which the public might become more involved in healthcare decision-making, they have resulted in a raft of new organisations that have been abolished, changed their roles and reformed with remarkable rapidity.

The abolition of Community Health Councils led to a gap in public participation mechanisms, and to a loss of expertise. The new institutions designed to replace them often appeared initially to have no national framework to work within, and to be inadequately resourced. Some organisations developed dialogic forms of public participation within the new framework, others more tokenistic, bureaucratic processes.

There is a great deal of confusion as to whether public representatives are meant to be representing wider communities or themselves, and whether the diverse public can even be represented through committee-led processes. There appear to be different views of what constitutes participation from policymakers and the public, with the latter wanting a far more open and dialogic form of involvement than health services have been able to provide.

There have been considerable problems in establishing boundaries between different bodies such as Local Authority Scrutiny Committees and public

representative groupings such as Public and Patient Forums, and later LINKs and PALS, as well as with sustaining involvement as participatory mechanisms undergo considerable change.

In short, bottom-up reform has struggled to involve the public as either individual choosers of their care through patient choice policies, or to involve them in health services through public participation mechanisms. If a key reform goal of the 2000s was to drive bottom-up reform through the empowerment of patients through choice policies, and the public more generally through participatory mechanisms, the NHS has not managed to achieve either goal, and relationships between and within clinicians and the public have not significantly changed.

There were hopes that reforms to increase patient and public involvement would result in unsettling traditional power relations between professionals and patients. There were a few examples of patient and public involvement improving services in this way, but most of the evidence points towards a more constricted, dictatorial way of working with patients, and some managers using the new involvement processes to legitimate their own ends.

### **5.3      *Training, development and education***

How can training and development best support relationships within the NHS? A number of key points have emerged.

Our findings suggest that management development programmes must take account of, and understand, clinical as well as managerial perspectives, and help to facilitate clinicians and managers in understanding what each can contribute to improving services, particularly through shared problem-solving approaches that look at case-based material and get professionals to work together to come up with solutions to the kinds of problems they are likely to face at work.

Where training programmes have not taken account of the NHS context, particularly by introducing management competencies as generic and without the scope for participants to critique them, clinicians often mobilise against the programmes, leading to participants dropping out and the courses becoming a source of conflict. Generic management courses appear to be poorly received, as are initiatives that present private-sector-based ideas without any attempt to translate them into the NHS context.

In contrast, successful training courses are those that are located in the specific NHS context, allowing space for critical reflection, and which both teach management ideas by getting multi-professional groups to work through case-based material in active problem-solving. Training needs to be contextual in providing managers and clinicians with a background of history and policy in the NHS, and to be based on inter-professional problem-solving to encourage a greater appreciation of the differing perspectives differently-trained staff can bring. There should be a greater

use of tools such as case studies for training to be regarded as addressing real problems rather than competency-based training that ignores the detailed NHS context. It is also crucial that training allows critical interaction between participants and tutors to assess the robustness of the evidence and frameworks being considered.

Training should therefore follow the pattern of understanding the specific NHS context, and of active and collaborative problem-solving within it. Competencies can be taught, but in an applied setting where critical engagement and collaborative working across clinical and managerial boundaries, are put at a premium.

In addition, doctors still seem to require additional training on how they can interact with patients more collaboratively and consultatively, especially if patients are to make choices and services be commissioned through GP surgeries, where patients often struggle to make themselves heard.

For improved public participation, the forums in which such participation occurs need to be examined to ensure they are allowing the public to be involved at the deeper level they suggest they want, and managers and clinicians trained to take greater account of public views in their decision-making. The public especially want decisions to be more closely linked to the result of participation for the public to find such processes meaningful. As present reform proposals move commissioning to the local level it will also be crucial that GPs and those working Local Authorities to scrutinise them are adequately trained to take on their new roles.

## **5.4      *Limitations of the research***

The realistic framework has been useful in the report, especially in terms of the comparison between hospitals and general practice in the top-down section of the report. Separating the context of the research from the mechanisms in that instance allowed a comparison which does not appear in the literature so far, and so is, to our knowledge, an original contribution.

In other cases, however, the framework has been more difficult to utilise. A first reason for this is that health service research is often conducted in anonymous settings, with contextual details missed out so that sites are not easily identifiable. This makes contextual analysis more difficult as contexts often have to be inferred through a close reading of the research rather than them being made explicit. It is a shame that research to synthesise the findings of previous work is being compromised by a need to anonymise findings in this way.

A second problem is that the reforms of the 2000s particularly have come at such a pace that identifying particular changes as being linked to particular outcomes of policy is often extremely difficult or even impossible. The government's 'continual revolution' in healthcare has means that high quality evaluation is often extraordinarily difficult to achieve. Sadly, the

pace of reform does not appear to be slowing under the new coalition government, and so the same problems can be expected to continue into the future.

A third limitation has come through, compared to hospitals and GP surgeries, the lack of organisational research in Primary Care Trusts. Work does exist, and we have included it in the appendices to the report, but the mergers and continual changes in PCGs and PCTs over the last decade appear to have limited the amount of primary research we have in those settings. That PCTs are scheduled to be abolished in the present coalition plans for reform means that this gap is not as urgent as it might have been, but it is a concern that after ten years of PCTs we still know, compared to hospitals and general practice, so little about how they are run, and of the relationships between clinicians and managers within them.

## **5.5 Further research**

A number of suggestions for further research come from the work above. First, there is still a real lack of evaluation of NHS training and development programmes that considers the effects of such programmes after those involved have returned to their workplaces. Bearing in mind the considerable cost of such programmes, this is a worrying omission, and one that needs to be addressed.

Second, Degeling's surveys of how different managerial and clinical staff view reform have been a crucial part of the argument above in understanding how managers, nurses and doctors understand both their roles and the changes going on in the NHS. We would argue that this work needs to be repeated and a comparison made with Degeling's earlier results to see if the differences he found have decreased, remained the same, or even grown more deep. This work would provide a valuable and timely research project.

Third, there is little work examining the public's opportunity to become members of Foundation Trusts, and what difference this has made to the way that FTs operate. The synthesis above would suggest that the potential for this is likely to be limited, but we have found little work examining whether membership has led to increased public involvement or not, and what good practice can be learned where increased participation has occurred. This seems to us to hold the potential to be valuable research.

Fourth, the work on patient choice above does not include studies of whether and how patients are using NHS-sponsored information websites such as NHS Choices. Understanding how the public interact with these new resources, and whether they have the potential to overcome the problems associated with choice at present, especially in asserting a stronger presence for patient choice in general practice, seems to represent a promising project.

Finally, given the conclusions above about management development and management research, there is a need for the SDO to look at the wide range of case studies it has commissioned, and to investigate how these might be used as training aids. Key organisational initiatives could be extracted from existing work and training materials put together that utilise them to provide a basis for managers and clinicians to discuss potential solutions to the often very difficult solutions that they raise. If the conclusion of the report above, that training through collective problem solving, is correct, then the SDO already has access to a range of high quality resources that, with some work, could be of huge benefit to NHS training programmes.

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# Appendix 1: Healthcare during the 1990s - the Context Mechanism Outcome framework applied to the NHS 1990-1997

## ***Introduction***

This section of the report considers the period 1990 to 1997. At the beginning of the 1990s Harrison, Hunter and Pollitt (and their co-writers) published a range of syntheses (158, 159, 164, 165) of research that provide a valuable resource for exploring the state of health organisation, politics and policy at the end of the 1980s. One of the devices they use is the 'shared version' of health politics that appears at the end of this section, and which is used in the 1990s and 2000s summaries in this appendix as a basis for comparing how the reforms covered within it had affected relationships within the NHS.

The appendix proceeds as follows. First, it investigates the context of health policy at the beginning of the 1990s to provide a starting point for the research. It then examines the key mechanisms of change that were introduced between 1990 and 1997, before going on to explore the outcomes that research indicates occurred as a result of those changes, setting in turn the context for health policy in the 2000s - the next section of the report. It concludes by considering which of the changes that occurred during the 1990s appeared to be the most significant – answering the question of what worked during that period, how and for whom that is at the centre of realist synthesis.

## ***The context of health policy in the 1990s***

### **Background**

The creation of the NHS created a situation of mutual dependency between the state and the medical profession (166). The medical profession were dependent on the state as a monopoly employer, and the state dependent on the medical profession to run the NHS and ration scarce resources. Klein argued that this dependency and the accommodation of frustrations on both sides continued to characterize relations within the NHS.

The introduction of general managers at the beginning of the 1980s marked the beginnings of attempts to shift clinico-managerial relations within the NHS. The period 1948-81 was a period of relative stability in the health service and the various governments showed no serious aspirations for the control of the medical profession by NHS managers (164). Clinical freedom remained as a central premise in the organisation of health care (166).

Harrison and Pollitt (167) have identified that between 1966 and 1982 the shape of total service provided by NHS was the aggregate outcome of individual doctor's decisions to choose which patients to accept, how to investigate and treat, whether to admit and for how long.

The concordat between the state and the doctors was based upon an accommodation allowing the medical profession clinical freedom and letting them ration limited health care resources under the guise of clinical decisions, as long as overall budgetary decisions remained with the government (168). This gave the consultants a great deal of power, as they could decide whom they wished to admit to hospital and 'ran their hospital department like fiefdoms' (169) (p.358). This behaviour led to growing criticisms about the slow uptake of new knowledge and practices, inter-professional rivalries and a preoccupation with professional rights and remuneration. Health services often seemed to be organised around the needs of professionals rather than the patients they were meant to be serving (170).

In addition, there was little oversight by NHS managers or their peers. The government perceived the professional groups within the NHS engaged in the pursuit of self interest at the expense of public good, and to have created institutional stagnation as result. In this way the political consensus that had previously protected the NHS from radical reform 'became the enemy instead of the objective' (166) (p.701). At the beginning of the 1980s the Conservatives had 'unprecedented government resistance to medical domination of the NHS' (164).

The subsequent reforms on the 1980s can be seen as attempts to change relationships in healthcare, driven by the pressures of cost containment and the desire to increase the NHS's efficiency (169). This inevitably brought conflict with the medical profession as doctors viewed such reforms as a challenge to their authority and autonomy.

## **Reform in the 1980s**

The 1980s were marked by two major reforms to the NHS – the 'Griffiths' managerial reforms of the early eighties and the 'Working for Patients' reforms at the end of the decade.

In 1983, the NHS Management Inquiry or 'Griffiths report' (171) claimed to address the problems of:

1. Lack of individual management accountability (pluralism)
2. The machinery of implementation was weak. Managerial emphasis on reacting to problems (reactiveness)
3. There was lack of performance orientation in the service, little objective setting and almost no evaluation of services (incrementalism)
4. Managers lacked concern for consumers' views of the service (introversion)

As a result it produced a number of recommendations:

1. The Creation of Health Services Supervisory Board under the Secretary for State. This would take on all responsibilities for NHS management and will include people outside NHS on the Board.
2. The Creation of general managers for Regional Health Authorities (RHA), District Health Authorities (DHA) and units. These managers had responsibility for achieving objectives but with the freedom to design local organisational structures. General Managers were appointed on fixed term contracts for five years.
3. Reviews were extended to unit level. The aim of the reviews was to reduce costs without impairing services
4. Clinical doctors were to be more involved in local management. So consultants were allocated workload related budgets.
5. More attention was to be paid to patients and community opinion through Community Health Councils (CHCs) with more market research establishing patient views.

Other interventions followed. In 1983 laundry, domestic and catering services were put out to competitive tendering. In 1984 restrictions on the right to prescribe were introduced.

A second 'more oblique approach'(167) to managing professionals occurred under changes to resource management. Interventions included having doctors as managers, clinical management structures, and development of professionally run audit and quality mechanisms. These emerged throughout the 1980s and pre-date *Working for Patients*.

Implementing Resource Management occurred in three stages – clinical budgets, management budgets, and Resource Management (post 1986). In the 1970s managers/administrators could calculate average cost per patient, but there was little or no participation from clinicians and little control over expenditure. In the early 1980s the Clinical and Evaluation Research Unit tried out clinical budgets in three Health Authorities (HAs). This required clinicians to take responsibility for clinical budgets and responsibility for managing clinical care. These first pilots led on to what were termed 'demonstrations' of Management Budgets in four HAs in 1984-5.

During the 1980s there were growing curbs on Trade Unions and national pay agreements. In the 1970s the NHS traditional unions were NUPE (National Union of Public Employees) and TGWU (Transport and General Workers' Union) and agreements on pay were reached via the national Whitley agreements of 1971 and 1976. Other health professionals in the Royal College of Nursing and other allied professional associations (e.g. for midwifery and pharmacy) also had collective bargaining and possessed seats on the staff side of the Whitley Councils. When in 1982 cooperation between TUs (Trade Unions) and professional groups in a pay dispute threatened the government, the government set up a Pay Review Body for nurses, midwives and other health professions. This was a replacement of pay negotiations by an independent organisation which began to disrupt

union solidarity. It was selective so that participation in the Pay Review was confined to groups who did not take industrial action.

The period (pre 1990s) ends with a second wave of reforms following the White Paper *Working for Patients* (1989) which was the result of a Ministerial Review carried out in 1988. *Working for Patients* created the purchaser/provider split in the NHS and NHS trusts. This was followed by the new contract for GPs in 1990.

## **Clinico-managerial relations following the Griffiths Report**

The Griffiths managerial reforms changed the the role of managers in that they became positioned more explicitly as agents of government rather as the medical facilitators they had often been in the past (165). The attempt to cast managers in the role of agents of the government represented a move away from the predominant consensus management style prevalent pre-Griffiths to a need for managers to become more proactive in their decision-making and behaviour.

There were two crucial breaks with past practice. Firstly, there was a clear change from the expectation that the roles of health service managers were based around diplomacy and administration. Professional influence in management teams was reduced, and managers encouraged to learn from their private sector counterparts and become more dynamic and strategic. Secondly, there was a shift away from the philosophy that better management would result from putting in place appropriate career structures for managers along which they could gradually progress as they gained in experience. Instead, managerial and organisational performance should be measured and sanctions and rewards allocated to those responsible for delivering them.

However, in terms of policy implementation, the overriding concern of central government in the 1980s was on fiscal matters.

*'Management agendas comprised a number of inputs of varying significance. Local priorities jostled with national priorities for attention and looming over them was the centrality of finance.'*

(165) (p.59)

Newly-appointed General Managers spent much of their time reacting to short-term political imperatives driven by financial concerns. Unit General Managers were unsure whether their primary loyalty lay with the Districts or the Board. Added to this Unit General Managers were not supported by those at other levels. The Regional Health Authorities (RHAs) were perceived as being over-bearing, high handed, and undermining the authority of the District Health Authorities (DHAs). Day and Klein(172) saw attempts to introduce managerialism into the NHS as threatening threatening the bargain between the state and the doctors implicit in the creation of the service (see above). The concentration on financial matters

also meant that the new general managers were associated with cuts which did not improve relations with clinicians.

There was little evidence of general managers consciously attempting to manage the NHS's culture. Old NHS 'tribalism' still prevailed with each professional group displaying its own particular attitudes and priorities. Managers were still behaving as diplomats and had not succeeded in convincing most consultants that they should defer to the new management-led culture (165).

As time went on there was increasing strain between the centralist government drive for accountability from General Managers and the desire to make management less reactive. The large number of national priorities (47) made the agenda for General Managers unmanageable. Changes made to encourage consumer responsiveness were seen as superficial and rhetorical 'frills', which provided an increased tension because of claims that patients' behaviour was moving away from the deference, gratitude and respect for clinicians of previous decades (172).

The new indicators for performance assessment also had little impact on medical autonomy. There were some shifts in the 'frontier of control' between doctors and managers, but the professionals' structural monopoly remained largely intact(165) and attempts to intervene with or assess clinical performance were 'off-limits'. Attempts to attain greater management authority was handicapped by lack of a resource management system and reliable measures of quality. Clinicians were still not accountable for resources and resource management was developed in a state of 'organisational isolation'(167) (p.90). The result was that performance assessment did not have a systematic impact on professionals.

In a similar way the impact of Resource Management resulted in increases in efficiency and improvements in resource allocation, but were not ultimately a means of controlling doctors. The dissemination of Resource Management was slow and doctors had a major say in information systems (in order to get them to use the information) which resulted in the systems often being more useful to clinicians than managers (167).

The success of the 'Griffiths' reforms were therefore limited in achieving their goals. Clinicians retained their autonomy and power by being able to set the standards of performance against which they could be measured, as well as the means by which they were held to account for them. Managers were unable to become more proactive and strategic because of their lack of control over clinicians, but also because the goals set for them by government were primarily financial rather than involving organisational change. The NHS remained a largely introverted organisation, dominated by clinicians, with patient and public views being sidelined and marginalised (165). Audit and quality initiatives were professionally controlled, and doctors' training and career patterns remained intact (173).



## **The impact of the Griffiths reforms on nurses and patients**

Two other groups that reforms might have had an impact on were nurses and patients. Nurses were not particularly successful in gaining management posts in the Griffiths reforms, and there was initial resistance from nurses particularly about the idea of nursing budgets being held by non-nurses. The government made some concessions and allowed the Chief Nursing Officer onto the Management Board and districts were required to have a senior officer to give nursing advice. Nurses turned to Quality Management as a way of taking advantage of the new emphasis on patient care, but, as noted above, found their work increasingly monitored and measured through resource management with no parallel attempt to control medical staffing.

There were attempts by nurses to gain more professional credibility throughout the 1980s. However, the recruiting shortage and introduction of NVQs (under a national accreditation scheme) in 1985 led to a further loss of power by the Royal College of Nursing. There was a lack of distinction between professionally qualified nurses and others and no powerful Trade Unions to back them, in contrast to consultants and GPs who maintained strong political representation and control over their professional accreditation through the Royal Colleges. Towards the end of the decade nurses were beginning to redefine their roles as independent clinical practitioners undertaking health promotion, screening and counselling. There was also a major reform to nursing education through Project 2000. These moves can be seen as a professionalising strategy linked to attempting to boost the profession's flagging status (174).

The Griffiths reforms were meant to lead to more attention being paid to patients and community groups. In practice, however, little seemed to happen. Gabe et al. (173) identified future challenges coming from the increasing willingness of lay people to question the position of the medical profession, with the Women's movement especially prevalent in challenging the producers of health care. The extent and significance of these challenges, however, remained constrained by the continuing power of the medical profession in the NHS.

## **Working for Patients**

*Working for Patients* was the result of the persistence of the NHS's financial problems and the difficulties of engaging clinicians in having responsibility for management. During the 1980s the reduction in Public Sector Borrowing Requirement (PSBR), plus the proportion of GDP (Gross Domestic Product) occupied by public expenditure fell from 47% in 1982 to 39.5% in 1990 (167). Other factors included demographic changes including the increase in elderly over 75 years rising from 4.2% in 1961 to 6.9% in 1990 and technical developments including increases in drug costs.

Challenges were economic, but also ideological (173) with the Conservative government wanting to 'liberalise' (p. xiv) the economy, abolish dependency culture, and encourage business values and market mechanisms. From such a perspective the crisis in the NHS in 1980s was seen as a consequence of restrictive practices of the medical profession.

The *Working for Patients* White Paper arose out of the Ministerial Review into the NHS established by Thatcher in 1988. Secretary of State Kenneth Clarke had been involved in overseeing the introduction of the General Management reforms and this had been important in shaping his thinking. Clarke quickly concluded that moving away from funding the NHS on a tax-funded basis risked greater expense (175), focusing his attention instead on how it could be reorganised. The separation into purchaser and provider was based on a number of sources including ideas from US economist and policy entrepreneur Enthoven (176). For Enthoven the NHS 'was riddled with 'perverse incentives' that resulted in extensive inefficiencies and punish anyone who tries to reduce them' (177). The purchaser/provider split and the introduction of general practitioner fundholding were not part of Enthoven's model, and the purchaser/provider split was essentially a more pragmatic and less ideologically driven model (178). Ham (179) suggests that the choice of the internal market more a case of an idea being at the right place at the right time than of ideology, but it certainly helped that the idea of using market mechanisms in the public sector fitted with the government's prejudices about the world (180).

*Working for Patients* resulted out of what was the government called a 'massive expansion of the NHS' and was characterised as a drive towards increased efficiency (78). Reform was presented as necessary because of rising demand and ever-widening range of treatments due to new technology. There were wide variations in the cost of treatment, waiting times, prescription and referral. The way of dealing with this was to raise performance, improve management and delegate responsibility:

*'It [the government] is convinced that it can be done only by delegating responsibility as closely as possible to where health care is delivered to the patient – predominantly to the GP and the local hospital.'*

(78) (p.102)

There were 2 primary objectives:

1. To give patients, wherever they live in the UK, better health care and greater choice of the services available; and
2. Greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.

There were seven key measures intended to achieve these objectives:

1. To make the Health service more responsive to the needs of patients, as much power and responsibility as possible would be delegated to local level.

2. To stimulate a better service to the patient, hospitals would be able to apply for a new self-governing status as NHS Hospital Trusts.
3. To enable hospitals which best meet the needs and wishes of patients to get the money to do so, the money required to treat patients would be able to cross administrative boundaries.
4. To reduce waiting times and improve the quality of service, to help give individual patients appointment times they could rely on, and to help cut the long hours worked by some junior doctors, 100 new consultant posts would be created over the next three years.
5. To help the family doctor improve his service to patients, large GP practices would be able to apply for their own budgets to obtain a defined range of services direct from hospitals.
6. To improve the effectiveness of NHS management, regional, district and family practitioner management bodies would be reduced in size and reformed on business lines, with executive and non-executive directors.
7. To ensure that all concerned with delivering services to the patient made the best use of the resources available to them, quality of service and value for money would be more rigorously audited.

The emphasis was very much on changing management which was reflected in the following aims:

1. To make a distinction between policy (minister) and operation (Chief Executive and top Management)
2. To improve information to local managers for budgeting and monitoring
3. To ensure consultants were involved in management
4. To extend the use of the contracting out of non-core services
5. To keep drug prescribing within reasonable limits.

The creation of what were described as self-governing trusts was an attempt to delegate decision-making to the local level. One of the criteria for hospitals becoming self-governing was that senior professional staff, especially consultants, must be involved in the management of the hospital. The intention was to give consultants more responsibility for resource management. It was intended that funds would flow to the providers of care in line with the contracts for care, rewarding those that were able to attract the most patients. There was meant to be a dual system of accountability with General Managers accountable for the spending of Health Authorities, but consultants determining how resources were actually used.

A large part of Working for Patients was devoted to the means by which consultants might be integrated more into NHS management. Consultants were particularly to be made accountable for the financial consequences of their decision, which had to strike:

*‘a proper balance between two legitimate pressures, both of which are focused on patients’ interests: the professional responsibilities and rewards of the individual consultant; and the responsibility of managers to ensure that the money available for hospitals buys the best possible service for patients.’*

(78) (section 5.2)

At the same time as this, there was a greater emphasis on the managerial control of hospital doctors, with consultants to have fuller job descriptions agreed with the DHA, and distinction awards that were linked to their commitment to management and in reward for the development of services. The panel for agreeing these awards was to be chaired by RHA Chair and include managers, rather than being medic-only affairs as in the past. Such measures were an attempt to remove some of the profession's autonomy in determining workloads and rewards, and to link consultants into management.

*Working for Patients* split strategy, which was then the responsibility of the NHS Policy Board chaired by Secretary of State for Health, and operational matters which went to the NHS Management Executive chaired by the NHS Chief Executive. The Management Executive was to be made accountable to the Policy Board, and which was to draw on expertise both inside and outside the NHS. Family practitioners became the responsibility of the NHS Management Executive in an attempt to integrate primary and secondary care better.

There was also the desire to create a chain of management:

*'the overall effect will be to introduce for the first time a clear and effective chain of management command running from the Districts through Regions to the Chief Executive and from there to the Secretary of State.'*

(78)(Section 2.6)

Working for Patients also expressed the view that it was difficult to 'exercise authority' over the 190 DHAs. So RHAs were given that responsibility by carrying out the 'essential tasks' of setting performance criteria, monitoring activity, and evaluating effectiveness. Service providers were then meant to be responsible for day-to-day decisions about operational matters leaving the DHAs to concentrate on ensuring the health needs of their population were met. HAs were to become 'more business-like in their approach'.

The Resource Management Initiative was seen as developing as a tool to:

- link diagnosis to cost,
- provide activity data for medical audit, and
- support both clinical and operation functions.

As noted above, *Working for Patients* introduced (firstly, on a voluntary basis) GP practice budgets for those with lists of at least 11,000 patients. These practices received a budget for outpatients, inpatients, and diagnostic tests. The intention was to increase choice and to regulate hospital referrals and waiting lists. A reduction in prescribing costs cost to be incentivised through the use of indicative drug budgets. Patient choice was to be improved by increasing capitation fees from 46% to 60% of GP income, providing better information to patients, and making it easier to change their GPs. Medical audit was to build on the Royal College of General Practitioners' (RCGP's) Quality Initiative working locally in each

Family Practitioner Committee (FPC) on a professionally-led basis, and incorporated into the new GP contracts which were put in place in 1990.

The management role of the Family Practitioner Service was to be strengthened and FPCs made accountable to the RHA, again reinforcing the chain of management. HA membership did not escape this desire to manage in 'a business-like way' (78) (section 8.5). The Secretary of State appointed five non-executives, five executives and one non-executive chair. Executive members included the general manager and finance director who were appointed by non-executives.

At the end of *Working for Patients* there are some strategies to encourage work with the private sector such as working with the independent health sector, increasing private medical cover for retired people, extending competitive tendering for treatment, and increased joint working with the private sector in terms of finance and property development. However, the main thrust of the document is about strengthening management.

The reforms took place over three years as shown in Table 4.

**Table 4. Three phases of implementation of *Working for Patients***

|      |   |
|------|---|
| 1989 | <p>New NHS Policy Board</p> <p>Reconstitution of the NHS Management Board as a Management Executive</p> <p>Health Departments and RHAs identified the first hospitals to become self-governing NHS Hospital Trusts and devolved operation responsibility to Districts and hospitals, and prepared for GP practice budgets</p> <p>Regulations to make it easier for patients to change their GPs</p> <p>Creation of first additional consultant posts, agreed job descriptions, and new framework for medical audit</p> <p>Resource Management Initiative was extended - extra costs were expected to be offset by improved efficiency.</p> <p>Indicative drug budgets for GPs</p> <p>Audit Commission set up.</p> |
| 1990 | <p>Continued devolution of operational responsibility</p> <p>New GP contracts</p> <p>Changing management of consultants' contracts</p> <p>Extension medical audit</p> <p>Setting up shadow boards of NHS hospital trusts</p> <p>RHAs, DHAs, and FPCs were reconstituted, and FPCs became accountable to RHAs.</p>   |

|      |   |
|------|---|
|      | Regions began paying directly for work they did for each other.   |
| 1991 | <p>First NHS hospital trusts were established.</p> <p>The first GP practice budget-holders bought services for their patients.</p> <p>Indicative drug budget scheme was implemented</p> <p>DHAs began paying directly for work they did for each other.</p> |

## Other contextual factors

At the end of the 1980s there are two other contextual factors which had an impact. The first is the rise of managerialism in the Public Sector which Hood was to characterize in 1991 as *new public management*(181). The distinctive features were:

- Explicit standards and measures of performance
- Greater emphasis on outputs and results
- Disaggregation of public bureaucracies into agencies operating on a user-pay basis
- Greater competition through use of quasi-markets and contracting
- Stress on private sector styles of management practice
- Stress on performance incentives for managers
- Stress on discipline in resource use and cost improvements
- Emphasis on the public as customer

The second contextual factor is what Harrison and Pollitt refer to as a 'bubbling stew of quality initiatives' used as a lever for change (167) (p.109). In the late 1980s – early 1990s Quality became a widely used term in the NHS through quality studies, quality circles, quality charters and other initiatives. Health professionals had always regarded themselves as always having a high regard for quality, and so it became contested terrain and a 'highly political process'(167)(p.95).

In the early 1990s Medical Audit was happening at local and national level but this was voluntary until *Working for Patients*. It then became a requirement for every consultant and GP to practise audit and this was agreed between managers and clinicians, with peer review retained and so protecting medical interests.

In 1989-90 the Department of Health provided funding to support HAs introducing Total Quality Management. However, there were no fixed quality benchmarks and regular and wholehearted participation of medical profession was the exception. Equally, there was uncertainty about how it related to other systems like medical audit, Resource Management, and

contracting, and the funding attached was regarded as insufficient to introduce the required systems properly (167).

### The 'shared version' of the dynamics of health politics

In their 1990 book, Harrison, Hunter and Pollitt (158) present what they call the 'shared version' of UK health politics synthesised from their review of literature up to that point. They go on to critique its account of the dynamics of health policy on the grounds of its lack of ability to deal with power in all its forms, but it does provide a benchmark for considering reform from 1990 onwards.

The 'shared version' has nine dimensions; that health politics is incrementalist; that partisan mutual adjustment dominates as no one actor or institution is able to dominate; that within partisan mutual adjustment the medical profession tends to dominate because of its ability to veto decisions relating to it that it does not like; that lay health authority members are in a weak position compared to both clinicians and senior managers; that 'consumer' organisations are in a weak bargaining position in relation to the NHS; that the 'centre' (or central government) provides little operational guidance over the implementation of most of its policies, but does exert influence over both the level and distribution of resources for healthcare; that health authority managers are largely reactive and their role is about dealing with disputes rather than shaping the direction of their organisations; that the complexity of NHS organisation adds to the inertia coming from partisan mutual adjustment making change extremely difficult; and that the 'whole, complex and slow-moving edifice has been underpinned by an extremely durable political consensus' (p. 8).

The nine elements of the shared version are summarised in Table 5.

**Table 5. The 'shared version' of health politics**

|   |  |
|---|--|
| Incrementalism  | Changes tend to be slow, and narrow in scope   |
| Partisan mutual adjustment  | No one actor or institution is able to dominate  |
| Medical profession have veto power  | Doctor representative bodies are able to prevent policy changes that might adversely affect doctors in the NHS |
| Lay health authority members in a weak position compared to doctors or managers | Health services are run with little reference to external pressures or controls- 'introversion'                |
| Health consumer groups are weak   | Health consumer groups have become more concentrated, but still exert relatively little power over             |

|  |  |
|--|--|
|  | decision-making processes  |
| The 'centre' has little operational control over implementation, but does have control over resource allocation and distribution | Central government has little control and little information about how health services are run, but does control the overall budget and how it is distributed regionally             |
| Health authority managers are largely 'reactive'   | Managerial roles tend to be about fire-fighting, diplomacy, conflict-avoidance and consensus-seeking   |
| Complexity of system contributes to inertia  | The vast size and complexity of health services combined with entrenched interest groups makes change very difficult   |
| Durable political consensus  | No government has challenged the 'double bed' relationship between the state and the medical profession (see above), and the NHS continues to be popular and supported by the public |

The shared version provides us with a benchmark against which to measure change which we will revisit at the end of this section, and again at the end of the section on policy in the 00s, to explore the extent of change that research appears to indicate.

## ***Mechanisms for change during the 1990s***

The 1990s introduced a range of mechanisms for attempting to introduce significant change into the NHS. This section will consider the purchaser/provider split (following on from '*Working for Patients*' above), managerialism (following the Griffiths reforms and the NHS's version of the new public management), performance measurement, audit and medical audit, the GP contract, reforms designed to change relationships with patients, and the Private Finance Initiative (PFI).

### **Purchaser/provider split (includes the internal market)**

The purchaser/provider split was meant to encourage efficiency by making it necessary to have information about services, and by rewarding more efficient providers. The split would give an incentive to increase productivity because increased revenue would come from achieving greater activity, which would in turn, be the result of attracting care contracts (172). The market was intended to incentivise purchasers to buy the best, and best value, care from providers for their local people (182). Hunter (183) has described this as a 'faith' in market principles and competition to improve performance and raise efficiency, but instead risked market failure because



of it being 'unattainable in practice' (183). Advocates of the use of markets in the public sector, however, were of the opinion that the traditional public sector bureaucracies 'wasted resources on excessive administration'(184) which could be resolved by introducing competition-based incentives.

Central to the success of the proposed market was the need for good information systems that made clear the costs of services(185). It was thought that purchasers would make 'well informed and unrestricted choices' (186). The aim was to provide increased choice and that the market would therefore be flexible enough to respond to clients needs and wants (184), also increasing the accountability of services (185).

Another improvement coming from the purchaser-provider split was that purchasers would be able to concentrate on planning for health needs without having to deal with operations management (185). Planning was to be based on patient need rather than being provider driven. The market was intended to encourage entrepreneurship and business-like activity (and mindset), and the process of gaining Trust status was to encourage local flexibility in delivering services and generating income (185). The market would enable the NHS to develop free of bureaucratic top-down intervention (187).

Bennett and Ferlie argue that it is important to distinguish between the economist ideal of a perfect market, and the 'quasi markets' being created within the public sector. The differences were that quasi-markets had imperfect competition and less from perfect information. The most important strategic process within quasi markets was management by contract (186). Contracts were an important way of codifying agreements made by the purchasers and providers and so were an essential management tool. In the NHS, contracts were crucial in getting money to follow patient referrals, providing an incentive for providers to respond to the needs of patients (188).

Day and Klein saw the reforms as a combination of the NHS model, based on financial parsimony and social equity, with a market system that would bring responsiveness to consumer demands (172). This was seen as ambitious, even if it was 'largely stumbled into' rather than being ideologically driven. They saw the aims of the reforms were to improve management, remove perverse incentives, and deal with organizational rigidities.

In 1994 a framework for market management was published to regulate competition further as an attempt to balance incentives through competition and the stability of planning and regulation (188). This established rules for handling purchaser and provider mergers, collusion and anti-competitive behaviour. GP fundholding was extended with health authorities gradually having less responsibility for purchasing. Coordination for the purchasing function was included in an accountability framework. This then became a more managed market and a further move away from the ideas of a completely free or classic market.

In summary the internal market was meant to encourage efficiency and discourage waste, as well as give managers increased legitimacy to challenge clinicians in the name of market discipline (179). For market incentives to work there was a need for improved information and competition so that purchasers of care could make genuine choices. It was expected that the market would improve accountability, and improve planning for health care.

## Managers and managerialism

The Management Board set up under Griffiths had attempted to bring new technical skills and managerial drive into the NHS. However, it had not quite lived up to these expectations, not establishing itself as an independent corporation, and instead remaining embedded in the Department of Health (189).

The Policy Board proposed in *Working for Patients* was to be responsible for strategy with an NHS Management Executive to deal with operational matters. The aim was to introduce a clear and effective chain of command. The executive did not have new administrative machinery but had a new mission, responsible for implementing the various policy innovations including trusts and GP fundholding. Thus Klein detected 'a subtle shift of style' of management moving from being administrators to becoming shapers of the future NHS (189). Hunter agreed that the government had identified managers as the key agents of change(190).

The streamlining of the NHS management executive to eight regional officers was designed to reduce management costs. This was seen as an attempt to simplify and clarify management responsibilities (187). The mergers of the existing DHAs and FHSAs (Family Health Services Authority) was intended to produce savings in management costs and ensure better coordination of secondary and primary care. Management would be located in 8 regional offices and Ham(187) saw this as an important part of the government's plans because the contact point for purchasers and providers would be at regional level rather than the centre. This meant that regional offices would be able to manage the market in a way the centre had not been able to. The reduction to two levels of management represented the achievement of the single chain of command as specified in *Working for Patients*. The regional offices were meant to operate with a light touch and thus establish an equilibrium between competition and management (187).

For Klein the NHS reforms represented a deliberate challenge to the medical status quo (191). The shift of power between consultants and managers, and between hospitals and general practice was part of this deliberate challenge to free the NHS from rigidity. Hunter similarly sees the changes in 1990 being a shift in the frontier of control 'clearly and explicitly in favour of managers'(190) (p.443). This was to be done through greater control by managers over doctors' contracts, the introduction of medical audit, and the resource management initiative. Such changes implied

‘victory for management over medicine’ and further that the interests of each group were different and separate (192)(p.558).

Resource management was the successor to Management Budgeting, and was introduced after the latter had failed to win support and commitment from key personnel, having no clear management structures to support its developments (190). Consultants, however, remained unenthusiastic about priority setting and what they saw as managerial interference, and few doctors applied to become General Managers or later Chief Executives. This has been ascribed to a lack of training and management ability among doctors, their limited interest in becoming managers, the lack of positive incentives of pursuing a management career.

There were experiments in clinicians taking on greater resource management but with no clear management structures to support decentralised budgets, these often struggled because such roles had ‘neither management authority nor explicit reporting relationships with colleagues’ (190). There were also experiments with clinical directorates and in the early stages of the reforms. These appeared to bring gains but the self governing status of trusts resulted in ‘severe rifts’ between clinicians and managers.

Introducing a more pro-active and performance-led approach to management was to be key to achieving increased efficiency and accountability (183). The NHS was believed to have suffered from ‘being over-administered and under-managed’ (183) (p. 801). The ideas of making the NHS more ‘businesslike’ came to the fore and the internal market was meant to reward flexibility and entrepreneurialism (185). There was an increase in the importance of management not only in the UK and not only in the NHS, and a new wave of writing on management and achieving excellence (192).

The concepts later identified as those of the New Public Management (NPM) found favour, although there was criticism of the importing of industrial models of management into the public service (185). The rise of NPM was linked to the slowing down of expenditure on public services growth and staffing, a shift towards privatization and quasi-privatization, the development of automation, and the development of a more international agenda (181). NPM was seen as a way of correcting for the failures of old public management, or as a way of destroying the traditional public service ethos and culture. It was characterised by having hands-on professional management, explicit standards and measures of performance, greater emphasis on output controls, a shift to disaggregation of units, greater competition, and stress on private sector styles of management, stress on greater discipline.

The rise in NPM was accompanied by the growth in use of Management Consultants in health care. This was part of the radical reconstruction of public sector under the Conservative Governments (193), compounded by the introduction of Trusts which could no longer draw on expertise from

NHS regional offices, and by 1998 consultancy for NHS was worth an estimated £25 million. Among consultants paramount importance was given to the 'Three Es' – economy, efficiency and effectiveness, and little thought given to costs or limitations of this view.

In summary, changes in management were meant to produce clear and effective chains of management command, and represent a shift away from central to regional control. Managers were to have a new role as shapers of the NHS rather than reactive and conciliatory administrators. Management changes were also concerned with reducing costs (by reducing layers of bureaucracy), and challenging the power base of consultants. There had been attempts to bring consultants into management but these had not been effective. The changes in management were meant to increase efficiency and accountability, and there was an increase in the use of management consultants.

## **Performance measurement**

Performance indicators and performance management were introduced as tools in the NHS in the 1970s, but during the 1980s, aided by improvements in information technology, were regarded as having the potential to become key tools in achieving increases in accountability and managerial control in healthcare. The government wanted to know what medical staff did, the quality of what was done, how variations in services occurred, and how cost-effective services were (177). All of this information was also crucial to the functioning of the new internal market, and was to lead to improvements in quality or providers risk losing contracts (185).

Information and Communication Technologies (ICTs) were expected to bring greater efficiency. This was connected to the government's belief that the NHS problems could be solved through the introduction of economic thinking which again required more information about performance and services. Laughlin acknowledged the large amount of investment in the information systems for the NHS internal market (194) despite the absence of specific evidence of such an approach having previously worked in the NHS (195). In other public sector organisations ICTs had been useful in freeing up professionals to concentrate on professional work (e.g. in the Police force), but these gains mostly occurred in the management of physical resources. In some cases this has resulted in a challenge to middle managers, with 'signs' that the traditional command and control form of bureaucracy was changing towards more information-based network forms of organization (196).

Finally, quality initiatives became part of what were called 'total management processes' during the 1980s. Towards the end of that period, Duncan Nichol's letter to General Managers (GMs) gave initial areas for quality improvement. After this, quality then became one of four main themes of the Citizen's Charter in 1991 (the others being Choice, Standards, and Value or Value for Money (197), and quality became a

means of improving services to patients (198) through the use of published standards of service the NHS was meant to meet, and managers were to be held responsible for delivering.

## **Audit and medical audit and other quality initiatives**

Davies and Nutley(199) pointed out the importance of special knowledge for physicians and other health workers in providing legitimacy for their practice. The aims of the reforms of *Working for Patients* included the use of medical audit to attempt to get the NHS to assess the efficiency or cost-effectiveness of its services. Davies and Nutley argue that although health care workers had successfully grappled with assessing what worked in healthcare, they had been less clear about assessing efficiency (199). Part of the difficulty was a 'lack of consensus on an accepted paradigm' as well as a lack of methodological tools to determine efficiency. It was not simple to apply cost-effective measures to all cases since effectiveness can be context dependent, especially in health care where the doctor patient relationship can affect outcomes. The movement to introduce guidelines for the correct care management of specific disease groups or clinical problems did not produce much change because the guidelines were not enforced.

*Working for Patients* sharpened the focus on who was responsible for clinical effectiveness. Identifying health needs and purchasing services meant that purchasers had to use research evidence on service effectiveness making medical audit became part of the professional obligation of all doctors. This was later extended to all staff groups and renamed clinical audit (199).

Medical audit and subsequent quality initiatives were meant to improve care and in addition improve effectiveness and efficiency. However, there was a lack of consensus over assessing what worked, and how effective (or cost-effective) interventions were.

Pollitt has identified that Quality in NHS was divided along tribal lines (200). In 1980s Directors of Quality Assurance mostly had a nursing background, but with medics demanding that they be assessed by peers only, this resulted in oddities such as 17 pilot Total Quality Management schemes which could not include medics in their assessment to lead to a 'a hollow-centre totality' (P. 162).

## **GP contract**

The government sought to reduce primary care health spending as a result of the reforms (172) on the assumption that fundholding could reduce costs by making GPs more conscious of their prescribing and referral decisions. Equally, the new GP contract, essentially imposed on the profession in 1990 by Kenneth Clarke (172) (p.49), attempted to focus on getting GPs to provide better care through a range of measures. In line with market thinking, the Government believed that by making GPs derive a higher

proportion of their income from capitation fees, this would give GPs the incentive to compete for patients (172). In addition, there would be payments for childhood immunisation and cervical cytology, as well as regular health checks for children under five years, and people over 75 years, plus other health checks for newly registered patients, at risk groups, and patients with chronic conditions.

GP practices would in return have to produce an annual report, and prescribing costs would be scrutinized. Larger practices could apply for their own NHS budgets for a range of hospital services (172). This then was part of the original objective of *Working for Patients* which was to 'develop a system in which money would follow the patient' (201)(p.288). It was also a way of making sure money flowed to those GPs who were practicing best medicine (i.e. preventive and target achieving activities) (172).

The changes to the GP relations were intended to produce better health care, more patient choice, whilst rewarding those producing quality health care at a local level. The new contract with GPs increased government control over GPs. GPs gained more power in relation to hospital colleagues which again suited the government who wanted to weaken the influence of consultants.

## **Patient choice and consumerism**

*Working for Patients* claimed that the NHS had not served patients well and was not sufficiently responsive to patient need. Budgets had been based on historical patterns of service rather than the needs of the population and consultants were in control of specialties(177). The intention was that the reforms would make services more responsive to patients. So money would follow patients to provide an incentive for this (188). Arguments from the political right were in favour of increased patient choice with the assumption that patients would prefer more choice and free market approaches to service provision (202). However, it was not entirely clear how this could work in practice as the reforms did not allow consumer demand to drive the service and DHAs determine patient needs for their areas (172) rather than patients themselves.

## **PFI and capital expenditure**

The launch of Private Finance Initiative (PFI) in 1992 proposed private finance not only became the preferred method for funding capital projects but was also extended to cover the provision of services (203). PFI was designed to attract private finance to enable NHS trusts to undertake capital projects they might not otherwise be able to fund (203), reducing public spending on capital projects, and bringing in private sector construction expertise to avoid the budget over-runs and delays associated with capital expenditure in the past (204, 205). NHS trusts were required to show they had considered private finance before they could apply for

government funding. In this way PFI was starting to effect mainstream NHS provision.

PFI was also intended to transfer risk to the private sector with a concomitant transfer of some control to the private sector. The realisation of profits, however, depended on the security of income of NHS trusts. This was far from certain and Ham (206) commented that there were uncertainties on a range of issues; the attitude of GPs and their commitment to local trusts; a possible change in government, public opinion which was against privatising the NHS, and the long term costs to the government for its capital and transaction costs.

It was not until after 1997 that research could begin to assess the results of PFI, and so the outcomes of this approach to reform will be covered in the appendix covering policy during the 2000s.

## **Outcomes**

Having described the context of policy at the beginning of the 1990s, and the means by which change was occurred, this section goes on to explore the resulting outcomes.

### **Purchaser/provider split (the internal market)**

The internal market was meant to encourage efficiency and discourage waste. Improved information was necessary to ensure the effective working of the market. It was expected that the market would improve accountability as well and result in better planning for health care. It was also meant to increase patient choice and health service responsiveness.

One of the main aims of imposing the internal market was to make the NHS more efficient but efficiency was defined very narrowly by the government. According to government's efficiency index for NHS there was improvement of between 2-3% per annum since the internal market began but this has been seen as a crude performance measure (185). Söderlund et al.'s study (207) found that there had been real productivity gains for NHS hospitals, with trust status particularly linked to increases in productivity. Productivity in this case meant average cost per patient episode and was not related to quality of care in not taking account of health outcomes, and so limiting their use as an index of improvement.

In retrospect, it was also appearing that the 1980s had demonstrated remarkable increases in efficiency without the costs of the internal market (see below). During the decade the average length of stay for all acute cases fell by 28%; throughput of cases per bed per year increased by 46.8%; acute care beds fell by 17%; and the occupancy rate was kept at a near optimal 85%. All this was done whilst decreasing average cost per acute inpatient case by 10%, decreasing average cost of geriatric cases by 25%, and increasing the number of GPs by 18%. In addition, the UK spent

half the GNP and third of the dollars per capita that US spent on health care (177). NHS activity increased during the 1980s when there were no incentives to improve performance. Hospitals treated 16% more inpatients, took care of 19% more emergencies and carried out 73% more outpatient surgery in 1989 than in 1980 (182).

The costs of the internal market were substantial with £2 billion in start up costs and a further £.05 billion per year in running costs (208). The marginal rise in productivity needed to be set against higher transaction costs (178). The official implementation figures were substantial (£79m 1989-90; £306m 1990-1; and £383m 1991-2) and were well in excess of initial estimates (182) (page 316). Plus there were additional start-up costs for fundholding and capital asset registers. The NHS Consultants' Association estimated increases of 11.6% on administration for 1992-3, up from 5-6% of total health service expenditure pre-reform. Petchey (208) estimated fundholding operating costs 1993-4 were £66.6m or 3.5% of total fundholding budget. Between 1990-95 £165m was paid for managerial support. It was estimated managing fundholding cost £60,000 to £80,000, about 6% of budget. This was not distributed equally as suburban and rural practices enhanced their purchasing power.

Administrative and management costs grew. The contract system was more expensive to administer and more managers had to be employed to negotiate and monitor contracts (188). Between 1988-93 the number of general and senior managers rose from 1,240 to 20,010, and between 1989 and 1994 the number of all managers increased fourfold, albeit with number of other administrative staff falling by 10%, but also in the same period the number of nurses and midwives also falling by 12.4% (185). At the end of the decade Iliffe and Munro (182) declared the attempt to reduce bureaucracy had been a 'spectacular failure' (p. 318).

There were problems of providers not being efficient because of a lack of knowledge among purchasers about the kind of services required; reluctance to refer patients on the grounds of cost, the lack of a fair pricing system which penalized efficient providers, and resources not matching increased workloads (185).

There was an implicit belief from government that competition was cost-effective but there was little evaluation of this (209) (210). GP fundholders formed coalitions to cover over 200,000 patients to get more leverage and negotiating power over hospitals, but in doing so reduced the potential choice of purchasers. Most contracts were negotiated on a 'block' basis with little detail of quality and audit, and with little scope to be moved to alternative providers.

Block contracts meant that instead of money following patients, purchasers and providers agreed contracts based on traditional service patterns. Block contracts came about partly because there was initially little cost and volume information but even later when there was greater information, there was little progress towards cost and volume and cost per case



contracting (186) (211). Purchasers and providers moved towards three or five year service agreements, and there was a tendency for purchasers to initiate cartels to provide seamless services and get the co-operation of all local providers rather than introducing competition. In addition, GPs were reluctant to refer to consultants whose work they did not know, and patients tended to remain with local GPs and want to attend local hospitals (212).

There was a lack of cost effectiveness data and information flows that were restricted to processes not outcomes. Overall there was a lack of evidence about what worked and an emphasis on cost:

*'The pricing of contracts has been constrained by lack of expertise and accounting practices orientated to meet cash limits rather than reflect cost structures.'*

(p.1439).

This resulted in managers being motivated by wanting to stay within budgets rather than contract for more efficient health care. An early study of the purchaser/provider split found it had not led to a radical change in the pattern of services (213). Another study in Birmingham (214) reported that the RHA was intending to move towards cost and volume contracts. However, although contracts seemed to be more sophisticated and addressed need and quality rather than just finance, as time passed purchasing organisations downsized and contract periods were extended reducing competition (186). Contracting was relational with purchasers seeming to prefer to encourage co-operation rather than competition, leading to a reduction in the detail and frequency of contract negotiations, diminishing medical involvement, and the reluctance to invest resources in monitoring and information which made purchasing less competitive and 'reduced the contracting process to a mere device for moving money around the system' (186) (p.64).

Because HAs (Health Authorities) were not allowed to destabilize Trusts, and Trusts perceived themselves as unable to reduce costs in response to loss of business because of the fixed costs involved in having to maintain wards, to support A&E (Accident and Emergency) services, and to have sufficient patient volumes as defined by the Royal Colleges where they had teaching programmes, HAs purchased from local suppliers to maintain trusts. This meant that money was not following patients but patients following money where the HA had contracted (215). If managers were meant to be using the legitimacy of the market to drive change in their organisations, they were finding there was not much of market out there to provide authority for their claim (81).

Ham (216) at the end of the decade concluded that competition had had little measurable impact and any impact was felt at the margins. For example, GP fundholding produced some changes in areas such as prescribing but this was only in some practices and did not change performance. Reductions in prescribing and referrals tended to result in one-off improvements that were not sustained (217). Some GPs had been

able to innovate and use resources differently, providing additional primary care services, changing prescribing patterns and even offering minor surgery, but this was limited to a small number of well-managed practices (218).

Maynard (209) suggested that NHS labour market remained unaffected by the market. Consultants still had jobs for life. Contracts and pay remained centrally determined and few trusts have sought to change this, despite having some scope for local pay bargaining, and this resulted in there being few mechanisms to change employment structures to incentivise staff.

In the period before PFI became established there was little change to the NHS capital market. Trusts were not permitted to make and hold surpluses and had no reserves. Capital stock was increasingly antiquated and in poor repair and there was limited access to private capital.

There was a sense of managers wrestling, not wholly successfully, with the demands of new financial arrangements. The requirement to make 6% return on capital was seen as arbitrary and was not treated as particularly important by trusts. Financial returns and league table performance did not provide good information for managers to run their organisations better. Managers thought there was no correspondence between financial performance and patient care. The role of the board was also not under pressure because there were no shareholders and therefore the board could not be removed because of a poor Annual Report (219).

Fundholding appeared to have produced a two tier system of health care with patients of fundholders better able to get secondary care services than non-fundholders (in terms of follow-up treatment and shorter waiting times) (214) (185). Changes to GPs are discussed in greater depth below.

Patients still had very little direct say in the pattern of service delivery (185). The level of patient involvement in the choice of hospital and consultant was low and changed little in the first two years of the reforms. The exception was GP fundholders where patients had more choice but fundholders only served a minority of the population. There was therefore only a marginal effect on increasing patient choice, and patients tended to follow contracts rather than being the driving force behind contract formation.

Although the market was meant to devolve responsibility, the centralist tendencies of government had continued through the abolition of RHAs (220). However, the NHS at a local level retained considerable autonomy as the number of central directives and initiatives led to organisations making choices over what to implement and what to ignore (185).

The extension of the business ethos, complexity of contacts, and secrecy of the NHS made financial conduct more difficult to police, but the growth of audit led to the revelations of a number of cases of fraud and waste of tax payers' money (for example, The Wessex Computer Integration Scheme,

and unauthorized payments made by senior managers at the Yorkshire Regional Health Authority) (185).

In sum, the reforms had cost a great deal to implement and there was an increase in both administration and management in terms of costs and increasing bureaucracy. The (in retrospect) less radical reforms of the 1980s were revealed to show considerable improvements in productivity at a much lower cost. There was some evidence that GP fundholding had improved services for some patients, but concerns about it creating a two-tier health service and the cost-effectiveness of fundholding being open to question. Patient choice had not widened, limited by the lack of a competitive marketplace, a lack of information about services, GPs and DHAs being primarily responsible for the contracting of services, and patients preferring local treatment for both primary and secondary care. Competition had been curtailed by the use of block contracts, and increasing purchasing cartels. There was little evidence of better planning with GPs referring on the basis of personal recommendations rather than being involved in needs assessment. The reforms had not strengthened accountability. In all, research suggests there had been remarkably little effect on clinico-managerial relationships attributable to the creation of the internal market.

## **Managers and managerialism**

Reforms to the NHS were meant to produce clear and effective chains of management command, and a shift away from central to regional control. Managers were to have a new role as shapers of the NHS rather than administrators, and to mount a challenge to the power base of consultants especially, who had, through the doctrine of clinical autonomy, often decided how services should be run.

Managing in the NHS was complex and political (221) resulting three unique and often conflicting pressures in NHS trusts:

1. The push for entrepreneurship and innovation, backed by the greater control of finance resulting from trust status
2. Controls from the Department of Health made trusts highly regulated and politically controlled
3. Medical professionals participated in high level decision-making – able to unite as a professional group to exert control over decisions.

Trusts were organized on the basis of medical practices, standards and procedures but also with bureaucratic rules and procedures. Medical professionals influenced the communication and styles of behaviour throughout the organisation and their work patterns and professional standards influenced the CEO (Chief Executive Officer). The dominant culture of trusts was clinical (192, 222). There was a tension between clinical autonomy which acted as a decentralizing force and the development of trusts as businesses with corporate objectives and board structure which were centralizing forces.

The lack of real management authority created constraints for managers. In Trusts managers and consultants were meant to work together to win contracts. However, managers were ill equipped because there was no information on local health needs, and because competitive forces did not develop in the internal market. Central government continued to dictate the agenda and the objectives remained finance-led. Managers were worried about their lack of legitimacy with no structures for local accountability (223).

Boyett and Finlay's (222) survey of NHS business managers 1993 in trusts in Trent RHA found the culture to be predominantly clinical. Most managers had worked previously in the NHS for an average of 13 years. Managers were knowledgeable of what entrepreneurial activity was but felt constrained because they were not involved in the strategy-making process and because prices in the internal market were outside of their control. Although managers recognised the importance of patients, patient choice was regarded as secondary to the needs of purchasers (p. 403). Many managers felt isolated with innovation restricted to small areas of influence and income generation playing a minor role. Managers were keen to be seen as risk takers and innovators but were constrained by resource allocation, the short-termism of NHS, policy makers' requirements and emotiveness of NHS values. There was overt antagonism towards the medical profession and doubts about medics' ability to manage, whilst managers felt their own role was undervalued.

There were examples of managers trying to behave in a tougher, more confrontational manner to challenge medics (224, 225) but in general, they found themselves one of many players in their Trusts negotiating in a number of power-bargaining relationships (226). Senior managers had difficulty of finding the balance between strategic and operational concerns and Chief Executives spent much of their time negotiating with powerful stakeholders about the direction that should be taken.

Hunter (183) found that medics tended to behave in a tribal manner toward one another, creating a key role for managers in bringing the different tribes together. Instead what was being offered was a hybrid of the command and control model on the one hand, and the neoclassical market on the other which led to a clash of cultures rather than integration. The types of organizational relationships that developed over the previous decade were low trust and unlikely to lead to the NHS being run in the public interest. In 1996 the BMA (British Medical Association) reported low recruitment of GPs due to dissatisfaction with career, low morale and high levels of stress and increased bureaucracy. The erosion of public service values and replacement by market-based values were anathema to many who wanted a career in public service.

Managers within a hierarchy could also differ (227). Currie's study found that executive managers did not want middle managers developing a marketing orientation and liaising with purchasers outside the

organisational boundaries. They thought middle managers should stick to implementation and internal concerns. However, purchasers were more inclined to value the opinion of consultants about the service than middle managers. Executive directors were concerned that marketing activity emerging from middle managers was inconsistent and that middle managers were taking on boundary-spanning roles. The extent of possible marketing activity was prescribed by internal market regulations and by nationally prescribed performance indicators, but there was some freedom to take up an enhanced role.

Ranade (228) carried out four case studies looking at General Managers (GMs). She found that GMs at District and Unit levels were generally supportive of reforms and aimed to make NHS more business-like. One district was optimistic about expansion. This organisation had considerable experience in contracting and felt it had a head start on clinical management, costing and rationalization of facilities. However, in general, managers aimed not to increase share of market but to make modest service improvements. Competition remained a marginal concern, and there was more enthusiasm for developing public health and delivering better services for patients. By the second year attitudes had changed as people adapted to the purchasing role and became more detached, and hard-nosed. Managers were willing to challenge clinicians and not be as complacent about competition from other trusts, illustrating a concern for the market dynamic that does not appear often in research.

There were problems with gathering information about service cost and quality. The bulk of contracts were simple, speciality block contracts (access to defined service by defined population for an agreed fee) or block contracts with ceilings and floors on activity. Risk management clauses were crude because there was asymmetry of information, quality was contentious (either too prescriptive or did not change clinical behaviour), and there were large transaction costs. The trusts were keen to become champions of the people but this was still largely rhetoric.

Towards the end of the decade the Patient's Charter had some influence in reducing waiting times but at the expense of an increase in the number of patients waiting for relatively short periods of time (188). There was pressure applied by health ministers to managers and Chairs of Health Authorities who were told their jobs were at risk. It is claimed that there was an increase in productivity – official figures show number of patients treated rose by 21% between 1991-4 – but this could be due to improvements in recording arrangements, and more generous funding settlements.

Few doctors made the transition into management roles. Barnes (229) reported on an example where Clinical Directors had been appointed and the organisation had adjusted well, but those in post still felt a conflict of loyalty to individual patients and the organisation as a whole. Their successes with efficiency savings had not benefitted their own services and

they were due to lose out under the new allocation rules. The unit was heading for a major overspend and the two clinical directors had led a campaign against closure of the hospital.

Another study of clinical directorates in hospitals in Wales(230) found that there was a great deal of initial inertia from management because of waiting for the outcome of the 1992 general election, highlighting the political aspect of health reform. After 1992, though, commercial language was increasingly used on wards and in clinical meetings, and the establishment of medical cost centres led to an increased use of competition language. However, doctors remained uninterested in resource and cost issues in audit, remaining focused on the technical aspects of medical care.

Consultants more generally, rather than engaging with new opportunities to become involved in management, often appeared to be 'not remotely interested in management issues at all'. (231) (P. 222), refusing particularly to engage in contentious issues such as cuts in funding or ward closures.

By 1994, after government enthusiasm for the reforms had waned, it seemed as if there was no coherent strategy guiding the NHS(232). NHS managers were confused by Treasury demands to increase workload in the acute sector on the one hand and seeking the reallocation of resources into community care under Health of the Nation (233). Important questions such as the balance between competition, co-operation and management, the relationship between fundholding and HA commissioning, and the number and configuration of NHS trusts, appeared to be going unanswered. The Treasury refused to acknowledge funding shortages within the NHS and so managers had to meet the often contradictory goals of meeting targets, remaining within budget but at the same time not making staff redundant or closing facilities (234).

One study looking at an attempt to apply new management ideas was Harrison et al.'s (235) case study investigating applying Peters' 'Thriving on Chaos' to an NHS trust. The CEO had seen this as an opportunity to further both the interests of his hospitals and his own role. There was enthusiastic commitment to the project which disappeared during implementation because relationships with DHA remained problematic and the Trust could not enhance revenue due to national policy of restricting patient flows. The fast-paced innovation the change attempted also required purchasers to embrace innovation quickly. Senior managers had enthused front-line staff about the changes but commitment to change in the Trust was not matched by senior managers in the Trusts, or within the DHA. The research concluded that the problems of trying to achieve significant change within the NHS were still present, and that attempting to introduce reform programmes designed in the private sector highlighted the fundamental differences between the public and private sectors.

## Management consultants

The 1990s saw an enormous growth in the number of management consultants used by the NHS. Trusts could no longer draw on expertise from NHS regional offices since all the regional management had been disbanded. Trusts and HAs come instead to rely on management consultants.

Initially the consultants came from HAs but when hospitals converted into self-managing trusts they were required to employ consultants with a business background. Between 1985-95 consultancy doubled, and by 1998 consultancy for NHS was worth an estimated £25 million (193). However, consultants needed repeat business and so seldom gave unwelcome advice and tended to further the current financial strategy of the organisation rather than suggesting different ones. Reports were confidential to clients and were rarely validated externally. They tended to be hostile to doctors and rarely included them in their teams. This was particularly true of public health doctors who had the expertise to challenge them (193). Paramount importance was given to the 'Three Es' – economy, efficiency and effectiveness.

Leys (193) refers to evaluations that showed management consultants had frequently been rationalising centrally-driven projects for cutting back the acute care sector, which was seen as expensive and clinician-dominated, and promoting primary-level facilities with no evidence that they would be cheaper or meet demand. This has been legitimised by rejecting needs assessment since need was seen as incompatible with the effective discharge of financial duties (236). Froud and Shaoul (237) found that Trusts cited varying improvements resulting from using management consultants such as reduction of junior doctors' hours; accreditation for consultant training; poor quality of existing building; dysfunctional location of service; changes in technology leading to new forms of treatment with more out-patient and day surgery and shorter length of stay, greater emphasis on regional specialisms and centres of excellence. However, these claims were rarely quantified or supported by empirical evidence.

Trusts were encouraged to downsize on the basis of crude index of beds per thousand FCEs (finished consultant episodes). Leys (193) concluded that management consultants' chief concern was meeting the needs of the client organisations rather than patients. Consultants became embedded in the NHS however, to the extent that they became influential actors in the process of administrative reform (238). Management consultants provided external judgements based mainly on quantitative, financial, commercial, information and communications expertise (239), giving credibility to NPM approaches because that came from the private sector, and so were perceived as being endorsed by policy-makers.

## Summary of the effects of managerial changes

In summary, the managerial changes of the 1990s had not produced clear and effective chains of management command; instead managers had to negotiate with a number of different clinical tribes which appeared to have largely retained their power, and towards which managers sometimes expressed antagonism. Few consultants wished to occupy new management roles, or even to engage in managerial processes, and those that did often found them dispiriting experiences. The quality of management information was often low, and policy direct diminished after the government appeared to lose enthusiasm for its reforms as the decade went on. Ideas from management consultants were increasingly used within the NHS, but with little evidence of improvement as a result.

## The effects of reforms on clinicians in hospitals

The introduction of the internal market, along with its associated consultant contract changes and the increased emphasis on managerialism, were intended to improve services for the patient and improve cost containment and efficiency. Along with the introduction of new constraints on clinical freedom through audit, and clinicians being given increased responsibility for budgets, the changes were in many ways a direct challenge to the consultant authority.

The first indication of the reduced importance of professions in deciding NHS policy was their exclusion from the review that led up to Working for Patients. Klein (166) warned that the profession might have to adapt and recognise their accountability in order to be seen as future partners in the policy process. Consultants had been used to running their hospital departments 'like fiefdoms' and able to make decisions about who to admit and treat (169). The Working for Patients review was secretive and the profession reacted angrily to the publication of the White Paper. The BMA reacted with 'a lurid media campaign, warning of impending disaster for the health of the nation' (169) (p. 363).

Southon and Braithwaite (170) suggested that conflict was the most likely result of the reforms, which would in turn reduce the coherence and performance of the NHS. They also thought the reforms would not work because patients wanted 'a unique, confidential service with the full scope of medicine's capabilities applied in their particular case'. This would not happen if the system concentrated on low average cost per case. They suggested that the differences between doctors, politicians and managers was illustrated by research that suggested that the clinical professions had different characteristics to managers, because of their high level of expertise, autonomy, and commitment, their identification with peers rather than their organisations, and their professionally-driven systems of ethics and maintaining standards (170).



Change was, however, constrained because of the more conciliatory approach to the reforms by the government after the initial furore and conflict. Clarke being removed from the health portfolio, was taken as a sign that the reforms would be less radical than they first appeared to be. The language of the reforms changed from competition to contestability (240), and the medical profession regained their control over their own parts of the NHS (194). There was notionally a challenge to the dominant position of consultants since medical staff now had to engage in cost-effective practice to ensure their hospital wins contracts, but the limitations of the marketplace meant that these challenges were somewhat emasculated in practice.

The reforms were still considered by many researchers as a direct attempt to control professionals and make them more accountable (241). The Audit Commission report in 1995 (242) showed there was still a lack of clarity about what was expected in terms doctors' roles. Under 60% of doctors in training grades had a job description. Junior doctors had work rates that depended on set numbers of tiers of cover than actual amount of work required, and were often supervised poorly. Consultants were criticised for doing private work, with only 54% of them attending all their fixed sessions. The Commission recommended that consultants should have job plans which should be monitored. However, this was not going to be easy because consultants had other NHS duties like committee meetings (243). The fact that the Audit Commission was writing of this five years after the reforms suggests that, although there was still desire to bring clinicians to account, this was not happening. Jackson (244) suggested that managers could use the report as a means of demanding job description clarifications from consultants, and to make them accountable for the private work they were doing. Managers could also put pressure on consultants to adhere to job plans and work more efficiently. This would have undoubtedly been a source of conflict and ill will.

Mechanic (245) thought there had been some erosion of physician autonomy, but that 'while the autonomy of physicians as individuals has been constrained, medicine as a cultural force and as a social paradigm is more powerful than ever' (P 486). Salter (246) also found change in power relationships, with GP fundholders gaining ground over their consultant colleagues as a result of the reforms. Further change was constrained, however, because both the state and local managers needed the medical profession to provide its crucial role in rationing the scarce resource of care, and so could not antagonise them further.

Changes to the consultant contracts did not succeed in making doctors more accountable, even in the face of series of high profile medical scandals. The contract did not provide a means of rewarding consultants based on an accurate measure of the quantity and quality of their work, and their commitment to NHS, as the Working for Patients reforms had suggested it should (247).

Doctors challenged managerial attempts to bring them under greater managerial control. McGucken (248) claimed that senior managers of Trusts needed to be medically qualified in order to be credible to consultants, echoing the view of many doctors that non-medical managers should not be in charge of the NHS. Similarly Ross (249) insisted that Royal colleges should maintain standards and not let trusts circumvent the traditional ways of appointing consultants by appointing locums to non-existent posts or by using temporary consultant appointments. Brearley (250) argued that cases of medical malpractice through the GMC (General Medical Council) should be made by peer review only, and would only succeed with the support of medical profession.

However, doctors also faced criticisms about their ability to run their own affairs in the NHS, to self regulate, with claims that existing procedures were inadequate to deal with serious problems of doctors' behaviours and attitudes (251). Peer tolerance had led to in some cases a lack of commitment to duties, poor skills, dishonesty, and disorganised practice (252). The GMC had responded by proposing a new performance review, but one in which the doctors were seeking to retain the right to determine their own standards and to monitor those standards. Lupton(253) commented on the increase in questioning medical authority since the 1980s, including increases in malpractice litigation, complaints, and media coverage. However, there was still a high level of professional autonomy and most people still had great faith in their own doctors, and the NHS remained the most popular institution in the UK (254).

Despite the continued dominant of medics in hospitals and GP surgeries, towards the end of the decade Richards (255) wrote of the growing disillusionment among doctors. The exodus of young doctors from NHS had been exaggerated but 'disillusionment and discontent among doctors seems widespread' (p.1705). The number of doctors taking early retirement had increased, especially amongst those without merit awards. Long hours on-call remained a major problem. Consultant morale was low with increasing frustration and despair at the increasing numbers in A&E, emergency admission squeezing out elective referrals, elderly patients blocking acute beds because of inadequate community provision, and the supervision of trainees in theatre and outpatients reducing number of operating sessions. In general there was a feeling that increased resources were needed rather than more reform. If there was discontent on the side of the government and from managers unable to secure greater change in the NHS, doctors too seemed to be unhappy with the state of affairs.

As noted above in the section on management, few consultants were prepared to enter management roles. A study in Medway (246) found that a clinical directorate was seen by Medway's clinicians as a way of buttressing power against full-time managers rather than as collaborative arrangement to improve services. Within the clinical directorate there was a clinical director, senior nurse manager and business manager but no clear idea of distribution and responsibilities between them. Only a third of

Medway's clinical directors were proactive which meant that senior nurse managers took on the main burden of operational and staff management and were then unable to influence the management board of their unit. This group was regarded by other managers as another pair of hands or just another administrator to carry out whatever new project came along. Within the clinical directorates there was also 'managerial schizophrenia' with the absence of any generally accepted definition or guidelines. Only a minority of clinical directors were actively committed to their role partly because they worked on it for two to three sessions per week and because the post would not lead to a senior management position (see also (256)). Becoming a clinical manager was seen as a chore rather than as having intrinsic merits or as a stepping stone on the career ladder.

Marnoch and McKee (257) concluded that clinical directors had not been fully absorbed into traditional NHS line management. Clinical directors rarely dominated devolved budgets or created new strategic arena and remained wary of activities which would either distance them from their clinical colleagues or challenge clinical autonomy.

Throughout this period nurses were attempting to gain professional status and welcomed any opportunity to do so. So for example Lempp's (258) experience of moving to primary care as a specialist in HIV gave her equal status with medics as well as providing more holistic care for patients. Practice nurses found increased interest and autonomy by embracing health promotion (71), and GPs were keen for practice nurses to take on this role because this offered them the opportunity to specialise. In hospitals, and as noted above, nurses were often the biggest advocates of quality initiatives, but found them a means by which managers and clinicians could monitor nurse workloads instead.

## **Summary of the effects of reform on the medical profession**

In summary, the medical profession reacted angrily to the reforms and sought throughout this period to retain their professional power and autonomy. There is no evidence that they were any more accountable to the NHS, and management were still unclear about job descriptions and workload in the middle of the decade. Professionals became involved in medical audit and so retained professional autonomy to be arbiters of what quality medical care consisted, and retained the right to police and monitor professional standards. Very few professionals became clinical directors largely because of lack of career progression, training, and clear guidelines. Nurses sought to increase professional standing and seemed to achieve that more in primary care. Nurses embraced quality initiatives but this contributed to being able to be managed in terms of workloads.

## **Performance measurement and performance management**

Performance measurement and performance management were put in place to achieve the goals of increasing control and accountability. The

government wanted to know what medical staff did, the quality of what was done, how variations in services occurred, and how cost-effective services were (177). Information and Communication Technologies (ICTs) were expected to bring greater efficiency. Quality initiatives came to prominence in the last 3-4 years of the 1980s and were intended to improve services to patients (198).

There is very little written in the literature about performance information (PI) and performance management directly. Authors seem to have concentrated on audit, Quality initiatives and Evidence Based Medicine. Performance information was improving in that some purchasers and providers were moving towards contracts that involved detailed costs and volume information. However, medics, although good at assessing what worked through RCTs (Randomised Controlled Trials), were not as good on assessing a treatment's cost-effectiveness (199). There were wide variations in resource management and audit (259).

Performance Information was rarely used for strategic decision making. It was used more to provide a limited form of information to the public (260). Indicators were therefore a means of periodic external control (through the media reporting of high and low performers on the league tables that were constructed from performance data) rather than as programmes for improvement for managers or clinicians. Indicators were accepted as indicators of quality by government 'despite concern about what they are actually measuring' (260).

Likierman's (261) three year research project with 500 middle and senior grade managers about performance information found that there were difficulties measuring quality, and that as a consequence agendas become dominated by what it was possible to measure. Performance Information was used for political ends to secure agreement often concerned with the RHA working with DHAs and FHSAs.

There were concerns about what targets were for and doubts that they served the needs of patients or commissioners. Vaughan and Higgs and Russell (262, 263) found performance indicators of limited use particularly if care of patients were the prime concern. Performance information did not value or capture the richness and variety of activity. Propper (264) identified that it was likely that performance monitoring was simply generating inefficiencies. (P. 1686).

The increased use of technology was meant to improve information flows. Currie and Brown's (265) study of IT implementation in a Trust highlighted problems between clinicians and management, and the gap between government policy and organisational practice. The Hospital Information Support System (HISS) was championed by the CEO but not supported by senior consultants except in haematology. So haematology became part of a pilot study for implementation – showing that implementation of change continued to depend upon clinician support. However, there were different understandings from the ward, unit, laboratory and implementation team

about the system. Haematology clinicians were initially keen because they thought the system would be quicker and laboratory staff wanted to be part of the initial design to perpetuate their own, perceived to be efficient, work systems. The senior clinician was keen to have a number of tests in order to test the system, but the head of laboratory did not want changes to the system. The implementation team did not appreciate how busy the laboratory was, how quickly tests needed to be done, and importance of accuracy. Junior staff were removed from the process of implementing leaving senior managers to go to meetings whilst not understanding the system in detail. The software group eventually ran out of time whilst trying to accommodate the different groups and so put in own system rather than tailored to needs. The HISS project team lost control of the project and so the general implementation was rejected by clinicians. The project, in sum, failed because the implementers did not take account of different meanings attached to the project and clinicians were able to constrain action. The study provided an exemplar of everything that could (and did) go wrong in the implementation of IT systems in the NHS.

Information about costs and services was meant to be readily available to aid planning for health needs of local populations. However, the provision of such information was largely left up to the market and purchasing functions. Although there were some efforts to make planning more sensitive to local needs, and the mergers between FHSAs and DHAs created the potential for facilitating planning across a wide range of health services, there were also obstacles to planning and co-ordination (185). There was a lack of communication and antagonism sometimes about sharing information between the purchasers and providers. In addition GP fundholders lay outside the conventional planning process of the DHAs, and so incorporating their purchasing decisions into such plans was difficult. The government had to intervene to rationalize the provision of care, both in the case of the London hospitals and later for the national plan for cancer services in 1995 (185).

There were therefore doubts about whether what PIs (Performance Indicators) measured what was important in terms of improving health care, and they remained irrelevant to many managers, being used largely by DHAs as a means of reporting on progress towards government targets. IT was meant to improve information but there were significant difficulties over implementation.

## **Medical audit and quality initiatives**

Medical audit and quality initiatives were meant to improve care and in addition improve effectiveness and efficiency. However, there was a lack of consensus over assessing what worked, and how effective (or cost-effective) interventions were.

An interview study with doctors at district hospitals in 1991 found that the need for audit was accepted but there was criticism of the way it was being

introduced (266). The main obstacles to implementation were suspicions over the motives of the government, and regarding audit as something that was mainly about cost-containment or disciplining doctors. Doctors felt that they routinely assured the quality of their work, and so such initiatives were a waste of time. There were also fears that audit has the potential to turn medical practice into an unthinking, unsubtle art because it was unable to capture its contingencies and complexities. This was borne out in other work suggesting that audit and the use of guidelines (linked to Evidence Based Practice) would result in a 'cookbook approach' to health care, stifling individual contributions, de-professionalizing medicine, and ignoring the patient as an individual (267-269). Audit was also regarded as imposing more work, and creating a culture in which junior doctors felt in vulnerable position and unable to challenge seniors, and peers were reluctant to criticise one other (266). Research concluded that doctors were not convinced of the value of audit, and did not know how to implement it correctly.

Lawton and Parker's (270, 271) research on doctors, nurses and midwives on the implementation of protocols showed there needed to be a balance between standardising protocols and allowing professionals to use clinical judgement. Compliance could not be assumed. Protocols were seen as embodying best practice but also seen as a means to make care more accountable to managers, and to reduce costs. Medics were less likely to comply than nurses or other health workers, and they treated protocols as decision-making tools rather than specific rules they should strictly adhere to. Lawton and Parker's work concluded that producing guidelines was costly and should only be used if needed seen as avoiding costly litigation because of these difficulties with compliance.

When Medical Audit became mandatory little further change resulted (200). Professionals took the lead and leading medical institutions rushed to print guidelines creating a medical model of medical audit. There were six main features:

1. Only doctors should conduct audit
2. Main purpose should be educational and developmental, not regulatory or judgemental
3. Participation should be voluntary and non-attendance should not be penalized
4. Standards should be set locally – by participating doctors
5. Absolute confidentiality should prevail
6. Where doctors regularly fell short of locally-determined standards this should be dealt with by medical peers, not as a management problem

The Department of Health did not put up much opposition to these proposals, allowing medics to dominate audit processes (200, 269). Community Health Councils had asked to be involved in medical audit but the Department of Health rejected their request, emphasising it was to be a professional exercise. There was also resistance to letting managers use information from audit and there were several instances in Pollitt's study

where managers had been met with 'prevarication and resistance' (200)(p. 164). Data was not being used to compare different providers and in most districts audit was treated as professional development or educational activity (p. 165).

Packwood et al.'s (269) study had similar findings. This looked at four case studies of the implementation of medical audit in acute hospitals post 1989 in four acute hospital units 1990-92. They found that during this early stage of implementation medical audit had not resulted in stronger management of medical activities but rather in locally determined medical audit activity, focused on technical process and medical management. Recognition of consumer interests in audit had been slight and generally indirect.

In the later years of the decade Evidence Based Medicine (EBM) came to the fore. Although there was by no means consensus amongst clinicians about the movement, (272), the idea was that clinical practice ought to be based upon sound biomedical research had a strong appeal, and had the potential to provide quantifiable answers to the providers of health care rationing and accountability (272). However, once again implementation was to be left to the busy clinician, there were not enough resources, and there was no authority for making clinicians implement the guidelines, and it could be criticised as rejecting other criteria for rationing such as the rescue principle (to help those who are acutely ill or threatened), cost utility such as the QALY (Quality Adjusted Life Years), and equity. Davies and Nutley (199) noted EBM's rapid rise to prominence but also there was dissent about it among practitioners because of the narrow range of evidence, emphasis on effectiveness demonstrated in quantitative experimental methods, neglect of cost-effectiveness, and loss of the art of practising medicine and clinical freedom. Once again the implementation depended on the individual doctor.

At the end of the decade there were a series of medical scandals (268, 273, 274) such as the paediatric cardiac surgery in Bristol and failings of cervical screening programme in Kent 1996. Medical audit, quality initiatives, and EBM had not prevented these and once again the quality and accountability of medics was again called into question (275).

The need for medical audit was accepted but there was great suspicion from medics about how it would be used, especially the effect on clinical autonomy. Compliance was patchy and doctors were quick to gain control of audit and then Evidence Based Medicine and use them as educational and advisory tools rather than a set of rules that must be followed. Neither movement appears to make the medical profession more accountable in the series of scandals that emerged at the end of the decade.

Moving on to explore quality initiatives, a blizzard of initiatives were introduced during the decade including the implementation of systems including Kaizen (Continuous improvement), Quality Councils, Task Groups, Improvement Teams and Quality Circles; Quality Co-ordinators, Champions

and Facilitators; Quality News; and Quality Awards, Total Quality Management (TQM) as well as Quality standards such as BS5750 and Value for Money (197, 200, 276, 277).

There was also a proliferation of papers and books written to instruct about implementing quality initiatives. Davies (197) reporting on the pilot study in Spring 1992 in North West England and North Wales on a range of LAs and HAs found there was in general good awareness of quality management. The NHS was keen in particular on Donabedian's work on the structure, process, and outcome model. There were variations in approach ranging from a central, corporate approach, to departments or sections acting on their own initiative. The majority of organisations relied for advice on external consultants who were using material from a range of sources. There were no separate budgets for quality and it was financed through training budgets or special funding from NHS pilot programmes. Where there was a systematic approach then there was an emphasis on formal training – e.g. senior managers attending a 2 day course on quality awareness led by external consultants, followed by seminars for section heads and unit managers to disseminate.

However, these initiatives were being used individually rather than as a coherent pattern of quality management instruments (260). As Pollitt wrote 'the NHS is currently bubbling with a mixed stew of 'quality' initiatives.' (200) (P. 168), and they were not integrated with resource management structures and processes (260). Nor was there any attempt to relate costs of quality programme to the savings produced, although this was recognized as being a yardstick of performance (197).

There were recommendations about improving quality initiatives which mainly focussed on commitment from senior managers, sufficient resources, the employment of outside consultants, communication, devolution of responsibility for quality initiatives, and some form of TQM (197, 278). There were deeper concerns, however. Pollitt wrote of Quality as being a kind of religious cult invented in Japan (200). Taylor (277) in an attempt to demystify the 'chimera' of quality reduced quality initiatives down to three key elements:

1. techniques for understanding the requirements and expectations of service customers/users/patients--in the customers' order of importance;
2. techniques for overcoming barriers to cooperation between groups within organisations, for sharing information and skills, for facilitating individual and organisational learning, and for releasing individual energy and enthusiasm into efforts aimed at meeting or exceeding customers' expectations; and
3. empirical techniques for measuring performance and attaining agreed standards and for analysing and improving the processes of producing and delivering goods and services.

Taylor saw the quality initiatives as a way of challenging professional authority, but patients (and some staff) were mistrustful of managers



making decisions about their health care because they suspected their motivations might be more concerned with cost than quality improvement. (277, 279). Bain (280) in his study of GP practices found that GPs wanted to build performance review from within, seeing quality initiatives imposed by the FHSA as being about number crunching rather than providing better care. Pollitt (279) thought there was a need for explicit and public indicators of standards that stressed the needs of the patient. Managers were unlikely to know more about quality than service deliverers whereas professionals could argue that they monitored their own quality and that managers could be short-term and follow their political masters. In TQM programmes quality was largely determined by service providers rather than patients (200).

Another source of scepticism was the applicability of quality initiatives designed in commercial environments to a public service organisation (277). A standard like the BS5750 focused on services with high product content (278) with quality controls often being quantitative based and not applicable to the practice of medicine which involved subtle interactional skills (279), and dependent for success on personal relationships especially with the recipients of services (281) that were not a part of private sector, product-based production systems. Quality initiatives therefore occurred within 'the prevailing contours of power, authority and autonomy' (200).

The cost-effectiveness of quality initiatives was questionable (277). Walshe (281) called for more sophisticated approaches to quality specification and that this would involve value choices because it was about public service:

*'The question of quality in public services is not one of meeting service specifications, but of dealing with the shifting value structure of society.'*

(pp. 513-14).

Quality initiatives could be and was used by management for the workload allocation of nurses. TQM was meant to be geared to patients but there were no fixed quality benchmarks, the medical profession did not take part regularly or wholeheartedly (a few exceptions), and did not really happen because it did not cross departmental boundaries. Pollitt concluded that the predominant conceptualisations of quality remained professional at this time (200).

An enormous amount of time and resources were spent on quality initiatives but there remained deep scepticism about the applicability of quality initiatives borrowed from business to a public service. It was doubtful whether quality initiatives were effective and, like medical audit, initiatives tended to be local and fragmented. The medical profession retained their right to determine what was considered to be high or low quality. Only information on nursing quality was used by management for workload allocation and costing.

## The effects of the reforms on GPs

Reforms relating to GPs were intended to produce better health care, more patient choice, and reward those producing quality health care at a local level.

Although NHS activity increased during this period there was no evidence of increased choice for patients (275). Competition in the market was limited. GPs who became fundholders had an incentive to build up larger practices and form buyer cooperatives with other local practices which resulted in limiting competition and choice (172). The workload for contracting had led purchasers and providers to move towards longer-term agreements and competition was limited by having monopoly, or near monopoly, of providers (188) (p.207). Ferlie (282) , however concluded that there were signs that the expansion of fundholding in the 1990s was bringing changes, making the NHS more outward looking and shifting to contracts based on cost and volume rather than the block contracts commonly used by DHAs (188). At the start of the 1990s block contracts were the norm and although by the end of the decade there were more cost-and-volume and cost-per-case contracts, these represented increased sophistication rather than changes to providers or more money going to non-local providers (212).

Bain's (283) study of five practices throughout UK in the early days of the reforms showed that different types of practices all suffered increased workload and stress. A rural practice visited could see few opportunities in the new contract. Health promotion clinics were not a viable option with a highly dispersed population, there were concerns that personal care was not acknowledged in the new contract, and that it would to increased expenditure on administration. A city centre practice experienced increased workload alongside administrative upheaval. The practice served an area with high deprivation and there was little response from patients to attend for health checks. A city centre sole practitioner thought that health promotion clinics were unlikely to improve overall health, and there was no proper balance between personal care and population based care. The final practice, in Hythe, had experienced increased workload and stress, and the erosion of protected time for education. The final practice (in a post industrial hinterland) was still recovering from new regulations, having difficulty working out priorities, and had limited space so they could not benefit from practice development.

Calnan and Williams(284) study of rank and file GPs found that the new contract was seen a major threat by GPs. It was regarded as constraining GPs' freedom to organize their work and as increasing administrative loads that they were 'drowning in paper'. The reforms were perceived as a threat to their professional identity that emphasised pecuniary gain rather than altruism and patient welfare. There was disagreement about the benefits of the increased emphasis of health promotion in the new GP contract. Some GPs welcomed it because they thought it might initiate change, but others

thought the three yearly check up and targets were a complete waste of time and money. Job satisfaction had increased for some but most said it had declined because of increase in workload resulting from new contract and outside interference.

Concerns abounded that the split between fundholding and non-fundholding GPs was leading to a two-tier system with fundholders better able to reduce waiting times for their patients (285). Financially it was not cost-effective for individual fundholders to act on their own which led to the growth of consortia (283). Farrell and Morris(286) in an interview study found that few GPs felt that fundholding had promoted competition either between practices or in relation to hospital providers. Most patients persisted in registering with their local practice and preferred going to local hospitals(286, 287), a preference described by Exworthy (212) as the innate localism of the NHS.

A key way of improving services was to have health checks for over 75s to be carried out by GPs as part of their new contract. However, Glendinning et al.'s study (288) showed there was a lack of consensus about the benefits of such screening. Doctors did not take kindly to being told what to do (p.322) and so nursing staff did most of the screening. There was a high impact on those practices with large numbers of elderly patients. Although some of the FHSA thought GPs would be reluctant to do screening unless they were forced to, despite it being regarded as good practice, the major stumbling block appears to have been the ambivalence about the usefulness of such assessments. It was difficult to evaluate the effectiveness of such assessments because there was no stated purpose for the assessments. With both the FHSA and GPs having very little justification for having the assessments, the assessments were often carried out at basic contractual requirement level.

The Audit Commission Report into GP fundholding in 1996 (289) found that there had been some successes in terms of reducing waiting times and outpatient follow-up visits, better communication with hospital based services, and development of practice based services. However, none of the FHSAs or DHAs visited by the Audit Commission had developed systems for judging how wisely fundholders were purchasing, and none of the practices involved in the study claimed that improving health for their patients was a reason for them becoming fundholders (290). Few fundholders had involved patients in purchasing plans or done any form of needs assessment.

Bain's (285) study in Nottingham found that GP fundholders were happy about the changes and being in control of their own destiny. GPs saw themselves as agents for change of services for patients. There was some ambivalence towards the changes because GPs potentially had to make difficult decisions such as delaying patient treatment or not allowing patient treatment because of resources (286). Nevertheless the £30,000 for becoming a fundholder was 'hard to turn down' and represented a considerable reward (286) (p.33). In addition, fundholders could use

savings to improve buildings which many did during the early years. Writing at the end of the decade Hausman and Le Grand (291) reported that there was anecdotal evidence of abuse but concluded that surpluses were in fact small, limited the scope for abuses while at the same time limiting the potential financial incentives for being a fundholder. Nevertheless with 60% of savings invested in practice premises (290), the Audit Commission (292) was concerned about public money being used in this way because of the clear possibility of financial gain to GPs who could subsequently sell this equity for their own profit (188, 290).

Some researchers found GPs dissatisfied with the increased administrative burden associated with the reforms (285). Farrell and Morris, in interviews with senior managers and professionals in education, social services and the NHS, including GPs (286) found that bureaucracy had increased, workload had increased, and there were more tiers of management. GPs were reluctant to be fundholders because of the time commitment, and were concerned that giving more tasks to practice nurses could make their work less interesting and reduce their personal contact with patients (291).

There were also concerns about the set-up and on-going costs of fundholding, including the need to employ practice managers and an increased bureaucratic workload (293), along with evidence of declines in patient satisfaction, perhaps as a result of lower levels of referrals and prescribing (79) in fundholding practices.

Income gained from extra clinics was welcomed but deprivation payments and targets for immunisation and cervical cytology were hard to achieve (280), but practice nurses appeared to welcome many of the changes because of their gains in autonomy and responsibility. Practice Managers were also benefitting, gaining new skills and responsibilities. Teasdale's (294) article in praise of practice managers suggests they had the potential to take on serious management roles:

*'to respond positively to a changing environment and who can define and agree objectives, analyse problems, establish priorities, negotiate between conflicting demands, devise a strategy, implement the plan, monitor its progress and review its effectiveness'.*

(p 454)

Whether practice managers had the skills, influence or power to expand their role to this extent is debatable, however – GPs were used to being autonomous and self-governing (295), and the extent to which they would have allowed practice managers to expand their managerial roles to this extent is doubtful.

The ability of fundholders to influence hospitals was ambiguous. There was concern that the quality of general practice would be lost because GPs would be chasing budgets, finances and balancing books. Some GPs also felt threatened by perceived need to have financial management skills. There was a great deal of resistance to using price as a bargaining tool with many GPs seeing this as being beyond the pale (296). Enthoven (275)

found that there had been a shift in power between primary and secondary/tertiary care, with GP fundholders more successful than HAs buying services because HAs could not afford to destabilize local hospitals, and because GPs did not have to worry about costs to the provider.

By 1996, the medical profession appeared broadly in favour of fundholding, despite its initial concerns. Some commentators from the BMA were even able to see the new contract as a vote of confidence in primary care (297).

## **Summary of the effects of reform on GPs**

In summary, the reforms led to some evidence of improved services for patients, mainly from fundholders, in terms of reduced waiting times for hospital appointments, more timely testing and diagnoses, and more practice based services. However, there was little increase in choice for patients because of the persistence of localism in the health service. Competition was blunted as GPs became part of buyer co-operatives, but did contribute to an increase in cost and volume contracting in contrast to the block contracts that prevailed from DHAs. GPs received some rewards for becoming fundholders but these were often offset by the increased administrative burden involved. There were some indications that power was shifting to primary care and that fundholders were having some impact on secondary care, but this was limited by the size of fundholder budgets and the continuing professional power of consultants in hospitals. GPs did not, nevertheless, become fully committed to being managers and wanted to retain professional autonomy and relate to patients as individuals rather than being restricted by financial concerns. Practice managers were given responsibilities for dealing with the additional financial and administrative burdens that come from fundholding, but had little scope for imposing managerial change or reform upon GPs.

## **Patients and consumerism**

The reforms were intended to make the health system more responsive to patients who through money following their choices, would lever improved services.

Previous sections have shown how patients were mainly 'conspicuously absent' (172) from decisions about health care and how block contracts, and lack of competition restricted patient choice. Patients still had very little direct say in the pattern of service delivery and the level of patient involvement in the choice of hospital and consultant was low and changed little in the years of the reforms (185).

There was little evidence that providing patients with a more responsive service had become any more of a priority for the NHS. One revealing study by Allsop and Mulcahy (298) of three case studies on how doctors responded to complaints about medical care found that negative comments were seen as a challenge to doctors' competence and their expertise as

professionals. Complaints were seen as a personal attack and most doctors felt the complaints were unjustified and were caused by the patient being ignorant of medicine. Doctors also did not think managers had the right to handle complaints because they were a clinical rather than service matter (p. 818).

Harrison and Wistow's study (213) showed that when the NHS sought public opinion it was unsure what to do with the information when it conflicted with DHA strategy. When the DHA sent a questionnaire to public it found the response threatening to the main provider unit because people wanted more community based care for elderly people. Not all authorities were proactive in seeking public's views because of the risk of creating too high expectations. None had found it easy to work with the CHC seeing them as too political or obsessed with provider issues.

There were concerns about how the customer-driven services could be reconciled with the managerialist reforms put in place in hospitals, and the fundholding reforms in GP surgeries (299). Empowerment seemed 'to consist of little more than improved information brochures and the occasional survey of customer satisfaction' (299) (p. 83). Patient and public involvement had a focus on individuals rather than as publicly concerned citizens and 'arrangements for any collective participation or representation for citizens are not discussed.' (299) (p.83).

Walshe (202) questioned the representation of patients as consumers. To treat patients as customers was inaccurate and confusing since the service relationships was not like shopping for goods and services. The GPs in Farrell et al.'s study (286) remained strongly committed to patients and had a strong, individually focussed public service ethos despite policies which sought to undermine their professional role. They did not think of their patients as customers.

The public had become more critical and questioning of what health care professionals did and how they did it (300). With more articulate and better informed public, the medical profession had to move from being bureaucratic, paternalistic and unresponsive. Medics did come under greater scrutiny and professional autonomy had to some extent been eroded by corporatization, proletarianization and de-professionalization (301). Nevertheless the unresponsiveness was still there. At a micro level there were studies still showing surgeons structuring ward rounds around their concerns such as physiology, wound condition and recovery/discharge rather than relating to patients' concerns (302).

The reforms had not succeeded in making the health system more responsive to patients or the public. Patients had not experienced an increase in choice, and decisions about health care were made without public consultation.

## Conclusion

The reforms of the 1990s marked a radical change at the political level with some commentators regarding them as a radical break with the 'corporatist political bargain' of the 1980s (169, 172). In 1989 for the first time the medical profession and health care interest groups were excluded from the decision making process leading up to the review (168). The government relied more on markets and managers to implement policy rather than working with doctors to carry out reforms. The introduction of the market was a challenge to the dominant role of consultants, and designed to make medical staff engage in cost-effective practice in order to ensure hospitals won contracts.

However, despite all of the change and reform, clinico-managerial relationships appeared remarkably untouched. The internal market did not impinge directly on consultants and left their relationships with managers in hospitals remarkably untouched, largely because of the lack of real competitive pressures in the marketplace, but also because doctors for the most part were not engaged with managerial processes as Griffiths had hoped they would. Nurses, however, regarded the reforms in a more positive light and as an opportunity for increased professional opportunities. Despite attempts to introduce performance indicators, significant doubts about their efficacy or relevance to NHS decision-making remained. GP Fundholders may have experienced a small increase in power in relation to consultants as a result of being given budgets, but the fundholding reforms also resulted in accusations of the introduction of a two-tier service where some patients were favoured above others. The public, however, did not understand the differences between GPs, and suggestions about increased health consumerism were not being supported by the research evidence. PFI offered a means by which gaps in health capital expenditure might be addressed, but the effects of its implementation were to largely occur in the next period covered in the report, even if there were concerns about how private firms might profit from it were present even as far back as 1995 (206).

## Revisiting the 'shared version'

Harrison, Hunter and Pollitt's 'shared version' gives us an index to measure the changes of the 1990s again. Where does the research indicate change had taken place, and through which mechanisms?

The government's more confrontational approach to health politics, beginning at the end of the 1980s, was a direct challenge to incrementalism, partisan mutual adjustment, and the medical profession's veto power over policy. The government did not allow the doctors' representative bodies to participate in the review leading up to *Working for Patients* and largely ignored their protests and representations after its publication and up to legislation. This is important in understanding changes in clinico-managerial relations because it suggested that policy was

deliberately challenging the position of the medics in the NHS, and that managers could be expected to gain as a result of the introduction of the internal market because of the increased legitimacy it would give them in challenging clinical practice. This was certainly the rationalisation Kenneth Clarke was to subsequently give for the reforms (179). If there was one thing that 'worked' in the 1990s it was the government's challenge to the medical profession at the policy level – with the benefit of hindsight we can see that the doctors were never again to have the levels of influence and veto-power they had over policy, that they had in the 1970s, for example (303).

However, the radicalism of the government's proposals appeared to ebb when it came to their implementation. The language of the market quickly gave way to one of requirements for 'smooth take offs' and for contestability rather than competition (240). Medical representative bodies such as the BMA (British Medical Association) had lost face as a result of their failed challenge to the government's proposals (304), but hospital consultants appear to have gone on much as before as the market dynamic never took off due to a lack of competition (81), the substantial technical problems in getting resource flows to follow individual patients, and because patients simply preferred going to their local healthcare providers, limiting the scope for any kind of market to develop (82). It is certainly true that the government did not follow through the radicalism of their proposals, allowing healthcare to 'becalm' (305) during the 1990s, but it is not clear how, even if they had decided to implement their market to its maximum extent, it could have made much impact outside of large, urban areas where competition could exist and there was scope for winning and losing contracts to seriously affect the running of hospitals. There is some evidence to suggest a small rebalancing of power between GPs and consultants resulting from fundholders receiving budgets, and so being able to seek better deals for their patients by reducing waiting times, but the small budgets most fundholders had in relation to the total activities of hospitals reduced their ability to create real change (144).

The reforms of the 1990s, despite being initially framed as offering patients more choices, did not achieve this goal. There are arguments that patients of GP fundholders were able to achieve gains in terms of reduced waiting times (306), but this was hardly-bottom up reform driven by informed and empowered consumers of care, and it is questionable whether patients even understood the differences between fundholding and non-fundholding practices. Patients certainly remained reluctant to change GP practices, suggesting that they did not understand the benefits that fundholding might bring.

It seems reasonable to conclude then, at the end of the 1990s, most of the 'shared version' remained remarkably intact despite ten years of concerted reform. The consultants remained largely autonomous in their hospitals, able to opt out of management initiatives based around issues such as quality improvement, and unwilling to take on management roles that they



felt might compromise their ability to practice medicine. Managers struggled in an environment where consultants often showed little interest, or even open disdain, towards their work, with poor management information and with little support or guidance from the government, which appeared to be losing interest in its reform programme. Little wonder that many managers brought in management consultants to try and provide some help and legitimacy in performing their roles. GPs, where they were fundholders, had small gains where they were able to change the recipients of their contracts for care, but these were limited in scope by the small size of practice budgets and the secure employment tenure of consultants losing work as a result of contract changes. Nurses in both hospitals and GP surgeries took on new roles, often with great success, but did not appear to see a significant increase in their professional standing and any gains were often perceived to be at the 'gift' of doctors giving up responsibilities they no longer wished to hold (71).

The Conservative government's last White Paper, issued in 1996, is a remarkably conciliatory document celebrating the NHS's success rather than promising a radical future for it (307). There had been a loss of motivation to radically change the NHS at the policy level, but the medical profession had shown itself to be unable to prevent a government with a radical programme of change from putting in place new structures and systems it did not like – a key contextual factor for the next decade.

There is little evidence of managers becoming more strategic and pro-active during the 1990s. Instead, the research still paints a picture of managers having to work around senior medics in their organisations. If the medics had lost face and power in arguments over health policy, they still held autonomy at the level of their own NHS organisation, believing themselves to be more accountable to their professional body than to the managers in their hospital trusts. Early experiments in hybrid clinical/managerial roles did not appear to be working well as clinicians worked as part-time managers to retain their clinical practice, and returned to full-time clinical practice after they had finished their management role, so having an incentive not to upset their colleagues too much. They also found managerial roles available to them to be poorly defined and without the authority over their clinical peers to create much change. This resulted in exactly the conflict-avoidance, consensus-seeking and diplomacy that health service management more generally was characterised by in the 'shared version'.

The 1990s saw little change in terms of patient and public involvement, and as we noted above, little room for health consumerism in the internal market.

Finally, the NHS political consensus appear to have undergone serious challenge at the beginning of the decade by the state overtly challenging the doctors at the national policy level, even if the subsequent reforms made little different for most medics in their everyday work. The 'internal'

political consensus (between the medical profession and the state) had been successfully challenged by the government. Even if it subsequently did not implement its proposals in a radical way, the government had shown it could change the NHS's organisation in the face of opposition from the doctors (180). However, the NHS 'external' consensus remained intact – it remained popular with the public and this made it difficult for government to implement radical policy for fear of being accused of 'privatising' or 'dismantling' the NHS, especially for a Conservative government.

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## Appendix 2: Healthcare during the 2000s - the context mechanism outcome framework applied to the NHS 1997-2010

### ***Introduction***

This section of the report provides the source documents for two of the three summary documents presented in the main body of the report, the 'top-down' and 'bottom-up sections'. It applies the Context-Mechanism-Outcome framework to policy between 1997 and 2010, with the context section derived from the section of the report section outcomes from 1990 and 1997 (see above).

### ***The context of reform in the 2000s***

The outcomes section of the report for the period 1990 to 1997 (see above) suggests the following conclusions:

First, the reforms of the early 1990s had not produced change on the scale that was originally intended. The two key primary objectives of *Working for Patients* (78) were:

*'To give patients, wherever they live in the UK, better health care and greater choice of the services available; and*

*Greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.'*

(p.102)

Research synthesised in our 1990s summary suggested, however, that the costs associated with the reforms were large, that there was a rise in administration and management costs, and increased bureaucracy. The reforms did not appear to have produced efficiency gains greater than those of the 1980s, which were the result of less costly reforms. There was evidence that GP fundholding had improved services for some patients but again its cost-effectiveness in achieving this was questionable.

Management was a process of continual negotiation with different clinical groups (sometimes characterised in tribal terms), with doctors often opting out of quality-driven initiatives, and with few consultants wished to enter managerial roles. Managers lacked good quality information to challenge differences in clinical outcomes, and the government's ebbing enthusiasm toward reforms as the decade progressed reduced the urgency for change.

The medical profession had reacted angrily to internal market reforms and sought throughout this period to retain their professional power and autonomy. Doctors still regarded themselves as primarily accountable to

their profession rather than to the NHS, and even by the middle of the decade consultants often had unclear job descriptions and difficult to establish workloads. Consultants insisted on being reviewed by their peers only in audit processes, retaining professional autonomy from managers, and being instrumental in defining quality medical care, as well as retaining the right to police and monitor professional standards. Very few consultants became clinical directors (managers) largely because of lack of career progression, training, and clear guidelines. Nurses regarded the reforms as offering opportunities for career progression, and to increase their professional standing, especially in primary care. Nurses embraced quality initiatives, but often found that this created mechanisms for their workload to be more closely managed.

There was some evidence of improved services for patients, mainly for patients of fundholders, in terms of reduced waiting times for hospital appointments, more timely testing and diagnoses, and more practice based services. However, there was little increased choice for patients because of the persistence of localism in the health service (212) and because GPs moved towards longer contracts and became part of buyer co-operatives. GPs referrals remained largely unchanged, and patients remained local to their local GPs. There were some indications that power was shifting to primary care and GP fundholders were having some impact on secondary care.

Performance management remained weak during the 1990s. There were doubts about whether the existing performance indicators being used measured what was important in terms of improving health care. The first performance league tables appeared in 1995 but appeared more as an exercise in public relations than a tool for management (308) and they were not widely used by managers, being regarded instead as something used largely by DHAs to meet government targets. An enormous amount of time and resources were spent on quality initiatives but there remained deep scepticism about the applicability of quality initiatives borrowed from business to a public service. It was uncertain whether quality initiatives had been effective and, like medical audit, they tended to be local and to be implemented outside of other relevant initiatives, such as resource management.

Medical audit was at least initially regarded with great suspicion from medics, especially with regard to its possible effects on clinical autonomy. Compliance was regarded as optional for doctors, and they were quick to gain control of audit and it as an educational and advisory tool rather than as a means of managerial control.

The reforms had not succeeded in making the health system more responsive to patients or citizens. Attempts to achieve greater patient voice through initiatives such as a Citizen's Charter (309) appeared to make little difference because of the lack of guarantees attached to them. Patients were unlikely to complain, and if they did so, little happened in response.

There were some attempts to involve the public in healthcare decision-making but these were fairly marginal and the purchasers and providers determined health care with limited input from them. Community Health Councils were largely appointed rather than elected bodies and, whereas they had the ability to block changes through the use of public campaigns, especially in the local media, were not democratic bodies designed to achieve greater accountability (310) .

The Conservative's last NHS White Paper *The National Health Service: A service with ambitions* (1996) (307) reiterated a commitment to the founding principles of the NHS; universal population coverage; high quality care; and availability of care on the basis of clinical need rather than ability to pay. Its objectives were to create a well informed public, a seamless service, evidence based practice, a highly trained and skilled workforce and a service that responded to patient needs (311). There was little time, however, for any change to be implemented because of the election of the new Labour government in 1997.

## ***Labour in power***

The election of the Labour government in 1997 saw reforms to the market model to, in terms of the government's rhetoric, bridge the gap between centralised control and market mechanisms – finding a 'third way' (216). Other mechanisms including new forms of inspection and regulation were to be introduced. Labour's plans appeared to be a reaction against the reforms of the 1990s because the model of managed competition was now regarded as 'deeply flawed' (312). The intention of the new reforms was to 'heal those wounds, reduce inequalities, and install a cooperative model of commissioning for health gain' (312).

Later in 1997 the Labour government published its plans for the reform of the NHS in England (1). The Labour plans introduced national standards of care to try and ensure fair access to services and uniform quality (313), but appeared to some commentators to introduce a command and control model of central management in contrast to the Conservative reforms of 1991 which had been designed instead 'to diffuse blame to the market' (314). The reforms were intended to ensure patients would 'get greater consistency in the availability and quality of services' (1). It was intended to achieve this through national service frameworks and the Commission for Health Improvement which would be a new tool for monitoring and control. Primary Care Groups were being set up (500 in April 1999 to replace 4000 existing commissioning organisations – including GP fundholders) but there were doubts about how budgets would be fixed since there were considerable local variations in population, and concerns that the control of resources in primary care groups might then be seen as a way of 'devolving responsibility and blame for unpopular rationing decisions' (315). Fundholding was abolished because it was regarded as creating a two-tier service – the criticism we encountered on the review of

literature in the 1990s. Budgets for Primary Care Groups would be cash-limited, but with the ability to move money between different services to balance their books. Estimating needs, and providing care was to be undertaken within a tight managerial budget.

The proposals in *The New NHS* were intended to improve clinical effectiveness and reduce bureaucracy by aligning clinical and financial responsibility, empowering doctors and other health care professionals to improve services from the patient's perspective (315). The move to longer term service agreements, ending of extra-contractual referrals, and reductions in management costs were meant to deliver savings of £250m per year. Trust mergers would also bring high spending health authorities and trusts closer to average. The view of the government was that rationing or charging for treatment would not be necessary.

There were considerable continuities with Conservative policies (316) but also some differences. Long-term collaborative relationships were now to be encouraged, and whilst the government claimed it had abolished the internal market, the underlying purchaser/provider split remained (182). Health Authorities and Local Authorities would agree a local Health Improvement Programmes, and the National Institute for Clinical Excellence was established to monitor and evaluate the introduction of new drugs and technologies (182), with the latter change offering a challenge to The Royal Colleges and General Medical Council as it suggested that treatment had to be cost-effective as well as clinically-effective. If one reason for the government not completing its challenge to the medical profession during the 1990s was its acknowledgement that the profession performed a crucial role in rationing care through its prescribing and treatment decisions, this role was now being reduced through the creation of NICE, perhaps suggesting more space for tackling the doctors during the 2000s. New models of accessing the NHS were encouraged by the setting up of NHS Direct and the creation of NHS walk-in centres.

In sum, New Labour's initial aims for reform were similar to those of the preceding Conservative government; improving clinical effectiveness, reducing unnecessary bureaucracy and providing a service that was more responsive to the needs of patients. Labour presented their reforms as being more inclusive than their predecessors, although some commentators suggested quickly that they had the potential to be more radical than Conservative attempts to reform the NHS during the 1990s had been (317). Although initially the New Labour party advocated a return to basic principles of the NHS, policy between 1997 and 2000 was not intended to dismantle the Conservative government's reforms (316). Elements of competition were retained, including the purchaser/provider split, and PFI. The reforms did though represent an increase in command and control policies by the creation of new, centralising institutions (318), an increase in regulation and monitoring, and further attempts to increase information for patients and patient involvement. Despite the conciliatory rhetoric in the White Paper about leaving the delivery of front-line service to health service

staff, the reforms did not, however, assume that NHS staff would be motivated to improve services with just training, development and support. Staff instead found themselves increasingly being regarded by the government as part of the 'forces of conservatism' likely to block improvements (216).

Table 6 shows the legislation and documentation from the New Labour government from 1997-1999.

**Table 6. Timeline for Labour policy 1997-1999<sup>1</sup>**

| Year        | Events   | Legislation and documentation   |
|-------------|--|---|
| <b>1997</b> | March – NHS (Primary Care) Bill receives Royal Assent.<br><br>May – General election, in which Labour gains majority and forms a new Government under Tony Blair.  | The new NHS – Modern, Dependable<br><br>NHS (Primary Care) Act<br><br>National Health Service (Private Finance) Act<br><br><b>Designed to Care.<br/>Renewing the National Health Service in Scotland</b>                            |
| <b>1998</b> | Abolition of GP fundholding  | Scotland Act<br>Government of Wales Act<br>Information for Health. An Information Strategy for the Modern NHS. 1998- 2005<br><br><b>A First Class Service:<br/>Quality in the New NHS</b><br><br><b>Modernising Social Services</b> |
| <b>1999</b> | Primary Care Groups (481)<br>Clinical Standards Board for Scotland<br>National Institute for Clinical Excellence<br>Commission for Health Improvement<br>Walk-in NHS Centres<br>National framework for mental health services<br>Devolution of power to Scotland and Wales | <u>Health Act</u><br>Saving Lives: Our Healthier Nation   |
| <b>2000</b> | Abolition of the NHS Executive<br>Primary Care Trusts (first wave) -<br>National Service Frameworks<br>Food Standards Agency   | <u>The NHS Plan</u>   |

<sup>1</sup> Timeline compiled from:- Ham, C. (2000). The Politics of NHS Reform 1988-97: Metaphor or Reality. London, Kings Fund, and NHS Reform [www.sochealth.co.uk/news/NHSreform.htm](http://www.sochealth.co.uk/news/NHSreform.htm)

## ***The NHS Plan***

The direction of health policy changed with the publication of the *NHS Plan* in 2000 (2), with it providing the framework and starting point for Labour's approach to health reform during the decade.

The purpose and vision of the NHS Plan was 'to give the people of Britain a health service fit for the 21<sup>st</sup> century: a health service designed around the patient' (p. 1 Executive Summary). These twin concerns, to modernise the service and to centre the NHS around the patient, run throughout the document.

Unlike the previous decade where the NHS was meant to function within existing resources and improvements were to come through efficiency, New Labour stated that the NHS was failing to deliver partly because of underfunding and having too few staff.

The NHS was seen as a '1940s system operating in a 21<sup>st</sup> century world' (2) (p.2 Executive Summary) and this gave rise to underlying, systematic problems including:

- Underfunding
- A lack of national standards
- Demarcations between staff
- A lack of clear incentives
- Barriers between services
- A lack of support and intervention
- Disempowered patients
- Over centralisation
- Underinvestment

Many of these problems are remarkably similar to those outlined by Griffiths in the 1980s, in particular the lack of individual management accountability (pluralism), lack of performance orientation (incrementalism), and lack of concern for patients' views of the service (introversion). There are also considerable continuities with the issues *Working for Patients* attempted to address such as the focus on improving services for patients and giving greater choice, having more consistently good services, and rewarding staff who provided the best local services.

The plan set out a series of major reforms (p.15):–

- a system of inspection and accountability for all parts of the NHS. The principle would be national standards combined with far greater local autonomy, with new money to reward good performance.
- a consultant contract that gave most money to the doctors working hardest in the NHS.
- nurses and other health professionals would be given the bigger roles that their qualifications and expertise deserved.
- local health services and local social services would be brought closer together in one organisation.



- the NHS and the private sector would work more closely together not just to build new hospitals but to provide NHS patients with the operations they needed.
- patients would have an advocate in every hospital, so that a system designed around patients was a system with more power for patients.

The reform programme suggested there would be both top-down reform through new systems of inspection and accountability, new contracts, new roles, organisational reform, and an increased role of the private sector and bottom-up change based on reforming systems derived around the needs of patients who were to receive more power, and later (see below), new means for participating in decision-making in the NHS.

The period 1997-2010 as a whole represents the most sustained period of continuous reform in the history of the NHS (319). Because of the sheer volume of policy change, we have divided them into two main processes of reform - top-down reform being based upon mechanisms such as performance management and clinical governance, and attempts to achieve greater bottom-up reforms through increasing patient choice and public participation. The sections will cover policy change from 2000 onwards through the context-mechanism-outcomes framework under these headings and explore what the research evidence suggested about each as research attempted to catch up with Labour's reforms over the full period, 1997-2010.

## ***Top-down reform***

### **Context**

To recap, performance indicators were not regarded by managers as an information tool during the 1990s. Indicators were used for external control through league tables rather than by programmes for improvement(262, 263). There were difficulties measuring quality and, as often is the case, what was able to be measured and was measured, was what got done (261). Medical audit had not resulted in stronger management of medical activities but rather in locally determined medical audit activity, focused on technical process and medical management. Recognition of patients' interests in audit had been slight and generally indirect(269). The implementation of evidence-based medicine and quality initiatives were left clinicians, there were not enough resources, and there was no authority for making clinicians implement the guidelines.

Patients (and some staff) were mistrustful of managers making decisions about their health care because they suspected that the prime consideration of managers would be financial (277, 279). Bain (280) in his study of GP practices found that GPs wanted to build performance review from the bottom-up, with standards imposed by the FHSA as being about 'number crunching' rather than improved care. Pollitt (279) thought there was a need for explicit and public indicators of standards that stressed the

need of the patient. Managers were unlikely to know more about quality than service deliverers whereas professionals could argue that they monitored their own quality and that managers could be short-term and follow their political masters. In Total Quality Management (TQM) programmes quality was largely determined by service providers rather than patients (200).

There were, then doubts about whether Performance Indicators (PIs) measured what was important in terms of improving health care. An enormous amount of time and resources were spent on quality initiatives but there remained deep scepticism about the applicability of quality initiatives borrowed from business to a public service. There were doubts about whether quality initiatives were effective and, like medical audit, initiatives tended to be local and fragmented. The medical profession retained their right to determine what was considered to be high or low quality. Only information on nursing quality was used by management for workload allocation and costing, so accountability and cost effectiveness could not be attributed to the reforms.

## **Policies/policy documents**

The NHS Plan brought performance management to the fore as a key means of improving the quality of services. Following the scandal of children's heart surgery at the Bristol Royal Infirmary (180), public opinion was demanding improvements in quality and high standards in health care, the government set up systems of performance management, standard setting and monitoring to ensure the quality of health care. The government could not longer claim that improvement would come through the workings of the internal market, as it had claimed to dismantle it. Instead, it required every hospital, primary and community care services and nursing homes to have an annual prospectus setting out standards, their performance, and the views of patients on standards. There were to be national standards for all major health conditions and standards for both health and social care (see Appendix 2). Five National Standard Frameworks had been developed for Mental Health, Coronary Heart Disease, Cancer, Older People and Diabetes. More were to be developed using guidance from NICE (National Institute of Clinical Excellence). Doctors and nurses were to work more to standard protocols. In addition, there was to be monitoring and inspection of NHS organisations.

Under the new delivery model (2) the centre (i.e. the Department of Health) would:

- Set standards
- Monitor performance
- Put in place proper systems of inspecting
- Support modernisation
- Correct failures

This then was regulation through setting standards and monitoring performance. Standards were to be reached by working with patients and professionals to develop national standards of care. It was expected that by 2004 patients would be able to see a primary care professional within 24 hours, and a GP within 48 hours, and that consultants would be giving 4 million outpatient consultations in primary care and there would be 1,000 specialist GPs (see below).

Foundation Trusts were established as independent, not-for-profit, public benefit corporations with accountability to their local communities rather than being under central government control. Foundation Trusts were set up under the Health and Social Care (Community Health and Standards) Act in 2003 (320). They were providers of care within the NHS but were to be given a greater range of freedoms and flexibilities than NHS Trusts in the way they could manage their affairs including freedom from central control and performance management by SHAs (Strategic Health Authorities), the ability to access capital on the basis of affordability and to invest surpluses in developing new services, and the ability to tailor new governance arrangements to the circumstances of their community. They were inspected by the newly created Healthcare Commission to ensure compliance with healthcare standards and targets, and overseen by a new independent regulator called Monitor. Monitor could intervene in the event of significant non-compliance with statutory obligations.

Clinical governance became a statutory duty of quality on all NHS organisations, rather than the uncoordinated and unaccountable quality initiatives that had preceded the NHS Plan, and meant that board members of health organisations were given responsibilities for both the clinical and managerial aspects of care (321). This was meant to be a means of integrating responsibilities and encouraging greater cross-working between clinicians and managers.

The *NHS Plan* also introduced new ways of flexible working that were designed to break down barriers and demarcation between groups of workers and empower nurses and therapists. Nurses, midwives and therapists were to become empowered to undertake a wider range of clinical tasks including 'the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs.' (2) (p. 83). The Chief Nursing Officer identified several key roles for nurses:

1. To order diagnostic investigations such as pathology tests and X-rays
2. To make and receive referrals direct to specialists such as therapists or pain consultants
3. To admit and discharge patients within specified conditions and within agreed protocols
4. To manage patient caseloads in areas such as diabetes and rheumatology
5. To run clinics in areas such as ophthalmology or dermatology
6. To prescribe medicines and treatments

7. To carry out a wide range of resuscitation procedures including defibrillation
8. To perform minor surgery and outpatient procedures
9. To triage patients using the latest IT to the most appropriate health professional
10. To take a lead in the way local health services were organised and in the way that they are run (2)(pp.83-84)

In primary care a wider range of primary care professionals would help with some aspects of care, with pharmaceutical services helping with repeat prescriptions, more dental access centres being funded, and midwives were to develop their role, working with local doctors and nurses to develop services for maternity and child health. Therapists, scientists and health visitors would also develop their professional roles.

The Quality and Outcomes Framework (QOF) for GP practices was intended to provide incentives to improve quality standards and as a way of recognising practices' achievements (56). GPs submitted information on outcomes and processes based on the QOF. Other benefits deriving from the information were that practices could identify and prioritise practice developments; Health and Social Services Boards could consider practice developments and identify areas of health inequalities at a local level; and the Department of Health could better plan health services.

QOF was designed to remunerate GPs for providing good quality care and to fund work to improve the quality of health care being delivered. It was a fundamental part of the General Medical Services (GMS) contract, introduced in 2004. Achievement was measured against a range of evidence-based indicators, with points and payments awarded according to level of achievement. The four QOF domains were the clinical domain (80 indicators in 19 clinical areas); organisational domain (36 indicators in the areas of records, information for and about patients, clinical and practice management and medicines management); patient experience domain (5 indicators in length of consultation, patient surveys, and patient experience of access); and additional domain (eight indicators in the areas of Cervical Screening; Child Health Surveillance; Maternity Services and Contraceptive Services). This was a voluntary part of the GMS contract, and GPs could choose whether to aspire to achieve all, part or none of the available QOF points. There was also to be a bigger role for GPs in shaping local services. More would become GPs with special interests (GPSIs), able to perform minor surgery within general practice (as some enterprising GP fundholders had done in the 1990s).

Nurses, midwives and health visitors were to provide 3 core functions under the new framework for nursing in primary care (322):

- First contact/acute assessment, diagnosis, care, treatment and referral
- Continuing care, rehabilitation, chronic disease management and delivering NHFs
- Public health/health protection and promotion programmes that improve health and reduce inequalities. (P.8)

A new generation of graduate primary care mental health workers were envisaged as taking work pressure off GPs, as well as allowing GPs to engage in more specialist interests toward the goal of being GPSIs.

By 2004 there were to be around 1,000 nurse consultants. These would 'work with senior hospital doctors, nurses and midwives in drawing up local clinical and referral protocols alongside primary care colleagues' (p.86). Modern Matrons were to be introduced to work in hospital wards with special responsibilities for the politically-sensitive area of infection control, tackling public concerns about the spread of viruses such as MRSA (Methicillin Resistant Staphylococcus Aureus). These posts would be supported by the NHS Modernisation Agency through the new Leadership Centre for Health, and there would be management support for the training of clinical and medical directors. There was to be continued investment in training and professional qualifications for nurses and doctors. In addition, better leadership was to be encouraged at all levels throughout the NHS.

### **Programme theories – what were the top-down reforms meant to achieve?**

The performance management regime was a means of addressing concerns about the lack of challenge to medical dominance that seemed to have occurred during the 1990s, and were further necessary because of Labour's claims to have abolished the internal market for care, so removing the main internal mechanism in the NHS for improving it. Under the new delivery model (2) the centre (i.e. the Department of Health) would:

- Set standards
- Monitor performance
- Put in place proper systems of inspecting
- Support modernisation
- Correct failures

The purpose was not only to set standards and monitor performance but also to provide a means of judging when organisations were not working well and to provide correction. Performance management became a tool to identify failing organisations and help justify making changes in those organisations. Within this new framework there was the idea of 'earned autonomy' (p. 59) which meant that intervention by central government would be in inverse proportion to the success of NHS organisations (as measured by standards of performance). There would be progressively less intervention as organisations improved. If, however, the proper standards of care were not delivered, the government would intervene (on behalf of patients) to deal with those 'failing' organisations.

Trusts had to comply with Performance Assessment Frameworks designed by government, and there was a policy of making performance information public and so 'naming and shaming' those organisations which had not meet the requisite standards. Initially organisations were rated on a traffic light system (which later became a star rating system in 2001(17), and

later still a system based on evaluative statements). Performance assessment was seen by the government as essential to:

- Focus on delivery of critical targets
- Provide clear linkages between priorities, targets and traffic lights
- Assess of clinical quality
- Test staff satisfaction and patient experience

This was target-driven government designed to improve standards and reduce waiting lists, and a way of bridging the policy-implementation gap.

Those organisations which scored highly were to be rewarded by extra funding and also increased autonomy and would benefit from (323):

- Less frequent monitoring from the centre
- Fewer inspections by the Commission for Health Improvement
- An ability to develop investment programmes without prior approval
- The retention of more proceeds from local land sales for investment in local services
- The possibility of being used as pilot sites for initiatives such as team bonuses
- Being given resources for taking over and turning around persistently failing trusts
- Getting an accelerated funding uplift, if they were receiving less than their fair share of resources.

This was to be a 'robust management and support framework to deliver standards' (2) (p. 59) based on both inducements to adhere to standards and sanctions if standards were not met. Any additional resources were only given if there were reforms. Earned autonomy (p. 59) was meant to mean that intervention by central government would be in inverse proportion to the success of NHS organisations (as measured by standards of performance). There would be progressively less intervention as organisations improved. If, however, the proper standards of care were not delivered, the government would intervene (on behalf of patients) to deal with those 'failing' organisations. Under the new system organisations support, or 'special measures' would initially be provided to provide strong incentives to comply with the new performance framework (2), in contrast to the way that the publication of performance indicators carried few consequences in the 1990s.

It was also intended that Foundation Trusts would have closer links with their communities and so develop services tailored to the particular needs of their patients and local communities(320). This was a way too of rewarding those trusts who were financially viable, sustainable, and well governed, all criteria for becoming a Foundation Trust.

The aim of clinical governance was to improve and ensure the quality of care provided to patients. It was part of quality improvement in the NHS which had three main strands:

- clear national standards for services and treatments. through National Service Frameworks and a new National Institute for Clinical Excellence
- local delivery of high quality health care, through clinical governance underpinned by modernised professional self-regulation and extended lifelong learning
- effective monitoring of progress through a new Commission for Health Improvement. a Framework for Assessing Performance in the NHS and a new national survey of patient and user experience (324).

NHS Trusts were to choose clinicians to lead clinical governance and set up action plans to deliver high quality care but the guidance was not prescriptive as to the exact methods to be used. The intention was to create 'a systematic set of mechanisms that will support staff and develop all health organisations to deliver a new approach to quality' (324). Clinical governance was to apply to all Health Authorities, Primary Care Groups, Primary Care Trusts, and to NHS Trusts. The focus on quality was meant to lead to clinical governance changing the culture of the NHS away from a culture of blame to one of learning. These changes were intended to encourage flexibility and can be seen as wanting to modernise nurses and other health professionals as well as take pressure off the medical profession.

There was an explicit desire to encourage professional development of nurses, midwives, pharmacists, therapists and health visitors. Nurses and other health professionals were given the opportunity to increase their professional standing. Demarcation between professional groups was to be eroded, with more flexibility for nurses and other allied professionals to do some of the work doctors had done previously. Public Health consultants were the exceptions in that their role was strengthened. Clinicians were meant to make decisions (with managers and patients) about how local services should be run.

Changing professional relationships in these ways would enable doctors to focus on what they were good at, whilst nurses and other allied health professionals would increase their professional status by taking on new roles such as prescribing. GPs would be freed up to take on advanced and specialist roles (322). The reforms would also provide increased flexibility 'between services and between staff to cut across outdated organisational and professional barriers' (p.5) leading to better care for patients, and more choice for patients.

Having more leaders within the nursing profession was seen as desirable: 'There are simply too few of them' (2)(p.90). This perhaps reflected a belief that nurses needed leaders in order to change practice. This was also a consequence of public demand which wanted to see matrons back in hospital. Modern matrons were to be strong, clinical leaders with clear authority at ward level. They would be given the authority to resolve clinical issues such as discharge delays and environmental problems such as poor cleanliness.

Leadership was seen as more important by the government following the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995 (180) where it was acknowledged that the development of leadership and management skills had been patchy. The Leadership Centre began rolling out development programmes for clinical and medical directors. Non-Executive members were also targeted because many had no clear understanding of their role. It was thought that leadership at all levels needed to be improved and that clinicians should be encouraged into management.

## **New agencies, and modifications to old agencies**

A number of agencies were set up to set standards, monitor performance and support the reforms outline above:

Local Authority Overview and Scrutiny Committees – Local Authorities were given powers to scrutinise the work of local NHS organisations through a local all-party committee. They could refer major changes in local services to the new independent Reconfiguration Panel which would rule on contested changes. The intention was to engage a democratically elected tier of government to reflect local views. This was to replace the scrutiny role of the Community Health Councils.

National Care Standards Commission – The intention was to target services for older people specifically to reduce the burden on acute care and provide more appropriate services. This organisation was set up to raise standards in domiciliary and residential care. The organisations would establish a National Services Framework setting out standards for care of older people

National Institute for Clinical Excellence (NICE) – As noted above, this organisation was set up to ensure high quality care. Previously this had been left largely to the market and competition but that had produced variable standards of care. NICE would provide clear guidance on the best treatments and interventions. The intention was that this would provide a 'faster, more uniform uptake of treatment which work best for patients'(2) (p. 58).

Commission for Health Improvement (CHI) – The Commission would make regular inspections of health bodies. CHI was set up to ensure the quality of care in NHS hospitals (including clinical governance), community and primary care services. Annual publication of the results of the Performance Assessment Framework was now the responsibility of CHI. CHI also could make inspections for hospital cleanliness.<sup>2</sup>

Every NHS organisation was to be inspected by CHI every 4 years, and any organisations who were rated 'red' under the traffic light system could be inspected every 2 years. CHI could also be sent into organisations where

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<sup>2</sup> CHI have since undergone a number of name changes with the nearest present body being the Care Quality Commission



there was concern over poor health care or patient safety. CHI and the Audit Commission were expected to carry out national inspections and reports as well. This meant that CHI was to be increased in size to cope with all the new work.

CHI was an independent inspectorate and this was an important layer of the monitoring process. The commission worked closely with the Audit Commission and Social Services Inspectorate, especially on joint inspections. The aim of these inspections was to reduce delayed discharge of older patients, reduce preventable emergency admissions and readmissions, and to speed up the assessment of older people's needs.

Following the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995 (180) the inspection role for CHI was strengthened. This was to give the public independent assurance that each provider of NHS services had proper quality assurance and quality improvement mechanisms in place. A statutory duty was placed on Chief Executives and service managers to be accountable for quality. CHI could impose special measures on organisations with poor care or where patient safety was a concern.

**Audit Commission** – The Audit Commission was to help develop measures for the Performance Assessment Framework to improve health care. The Audit Commission would support CHI on developing measures for performance assessment, inspections, producing national studies and inspections, and annual reports on NHS organisations.

**National Patient Safety Agency (NPSA)** - The NPSA was set up in response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995 (180) to establish a single national system of reporting and the analysis of adverse medical events and near misses.

**Council for the Quality of Health Care** – This was a new organisation set up in response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995 (180). The Council would co-ordinate the work of the new Council for the Regulation of Health Care Professionals, Patients Forums, and Commission for Patient and Public Involvement in Health to set standards for health care and provide training for greater community involvement.

The NHS Modernisation Agency was to take a lead on bringing protocol based care into the NHS. It was to work with NICE, patients, clinicians and managers to draw up clear protocols for treatment and care. Care and treatment were to be more flexible to patients needs and part of the Modernisation Agency's work was to break down old demarcations between professions. The Agency would help local managers and clinicians redesign local services in service modernisation sessions.

The government introduced a new Leadership Centre for Health which operated through the Modernisation Agency. The intention was to improve

leadership within the NHS. The Agency would provide tailored training and support to managers and clinicians at different stages in their careers. This included those who wanted to work on the front-line as well as those who wanted to develop management careers, and non-executives and Chairs.

The University of NHS was intended to support the development of front-line staff and services (323).

## **Outcomes**

### **Performance management**

A first goal of publication of comparative performance measures was to allow patients to choose better health care, and to incentivise health organisations to improve with greater freedoms available to high-performers, and for fear of being 'named and shamed' for low performers.

There were a range of problems however. The public had difficulty making sense of the quality information published about hospitals' performance, and weighing up the different measures of performance (325), and did not fully comprehend the star rating system (113), despite its simplicity. Commentators like McKee (326) thought the systems only captured a tiny amount of the overall work of a healthcare provider. In addition, 'hard' (qualitative, easily measured) information was often used to identify organisations that were not performing well rather than being part of a management regime to encourage good performance or identify best practice (327). Goddard, Mannion and Smith advocated using a mixture of 'hard' and 'soft' information to improve performance (327), with the latter often providing intelligence about their organisations that the former could not provide because of its limited scope and lack of timeliness.

Boyne and Law (328) examined Local Public Service Agreements (LPSAs) designed to focus on outcomes of service delivery. These were, as so often with performance indicators in the health service, based on input and output measures rather than focusing on outcome. They acknowledged that PIs were complex to develop, and their research on Local Strategic Partnership (LSPs) found that 88% had well defined indicators, but also that they tended to lead to indicator rather than outcomes focus. 29% of the LSPs' indicators had poor statistical validity because often they were based on a small number of cases. In addition, the indicators often depended on factors outside the organisation's control.

By the second half of the decade there were widespread criticisms of the target culture and performance management. Hood (12) referred to the element of fear that had begun to accompany targets. CEOs referred to some targets (especially those around waiting times) as 'p45 issues' where failure to meet a target would mean them losing their jobs, and appeared to be at odds with the policy aim of giving greater autonomy to local organisations and front-line managers. The Prime Minister's Delivery Unit in

the first few years of the decade closely monitored performance giving an 'unprecedented level of prime ministerial attention to public performance data' (17)(p. 15).

Hood acknowledged (17, 329) that there were some improvements from the performance management. There was a decrease in the number of patients waiting 12 months or more for surgical operations (from 40,000 in 2001 to fewer than 10,000 in 2003). There were increases of number of patients seen within the 4-hour target by Accident and Emergency departments and Ambulance trusts showed an increase in the percentage of category A calls (for immediately life-threatening emergencies) that were seen within eight minutes between 1999-2000 and 2002-2003. Maximum waiting times were dramatically reduced in England after the introduction of the star rating system. This was a marked difference to other countries in the UK who had not applied the 'targets-and-terror' (17)(p.527) and suggested that increased spending on health care was not solely responsible for the improvements in figures.

However there also seemed to a 'substantial disparity between reported and actual performance data' (17) (P.517). Throughout the 2000s there was evidence of managers employing gaming strategies when reporting performance. There was little outright cheating and falsification of data but other forms of gaming were seen as acceptable, for example, shifting some ambulances to the rural list of ambulances which had less stringent response time targets. Hood (12) compared the target system to that used by Stalinist Russia and identified 3 types of gaming; ratchet effects effect where undemanding targets were put in place with the sole of aim of those being measured easily exceeding them, and so providing little incentive for improvement; threshold effects where targets gave no incentives to exceed them, and evident, for example, when there were no incentives to have patients wait less than 4 hours in A&E; an output distortion or manipulation of expected results. Hood found increasing evidence of gaming of all types.

Hood's research was not the only work to uncover gaming. CHI uncovered the problem of patients having to wait in ambulances before being seen in A&E departments, and beds being created by removing wheels from gurneys to meet A&E waiting times targets (330, 331). A study (332) of ambulance trusts and performance management found that indicators were seen as ends in themselves and the unmeasurable aspects of the work were neglected, with different trusts recording time and categorising emergencies differently, and concerns that paramedics were becoming overly concerned with response times rather than other aspects of their job, and resulting in practices such as sending out ambulances without fully trained staff.

Organisational data returns were largely accepted by central government without verification or checking, and when patient survey data contradicted organisational data the discrepancies were not investigated. In 2006 Bevan and Hood (17) were unsure how long the performance regime would last.

Towards the end of the decade the numbers of performance indicators were being reduced as organisations struggled to have the time and resources to comply with the performance regime.

A study on health inequalities and performance management (16, 18) found little connection between targets and implementation of health programmes. The study interviewed Chief Executives and other top level managers in health organisations, local authorities, and partnership organisations between 2006-08. Targets were found to have provided a focus and made tackling health inequalities a priority. However, other priorities such as waiting times or achieving financial balance were seen as much more important. These were referred to as the 'p45 issues'. In Wales chronic disease management and the provision of local services were more immediate priorities, and in Scotland health inequalities moved into social exclusion. Although there was focus in England there was little actual modelling of how to achieve the targets. As the 2010 deadline for health inequality targets moved nearer, Harrington et al. and Blackman et al. found (16, 18) there was a shift in emphasis towards lifestyle and clinical solutions in England to score 'quick wins'. Rather than trying to tackle the underlying determinants of health, the focus was on increasing the prescribing of statins, anti-hypertensives and smoking cessation aids in order to have some chance of reaching the 2010 targets.

Performance management had led to improvements in waiting times but there were a number of flaws to the system. There remained doubts about whether what was being measured mattered. In addition, there was evidence of 'gaming' with managers manipulating figures. Finally, the research literature showed that there were a number of perverse outcomes which had led managers away from improving health care to 'feeding the beast'.

## Foundation Trusts

If performance management was the stick to control secondary care, Foundation Trust status can be seen as the carrot, a way of rewarding those trusts who had complied with the government's policy aims. Foundation Trusts were meant to be freed from central control and make health services more accountable and responsive to patients and local communities (333). Klein (334) identified that rather than having freedom, there was a danger that Foundation Trusts would suffer from an 'excess of accountability' through being scrutinised by the independent regulator Monitor, the Commission for Health audit and Inspection, Overview and Scrutiny Committees and PCTs. Hunter et al. (335) thought the setting up of Foundation Trusts showed an 'unhealthy pre-occupation with acute care' (p. 213) which went against the government's avowed aims of developing primary care, reducing the health and inequalities gap between rich and poor, and promoting a whole system perspective around the patient.

Early indications were that Foundation Trusts were not performing any better than acute trusts. Lewis reporting on the Healthcare Commission's Review of Foundations Trusts (336) pointed out that Foundation Trusts had reduced waiting times but no more so than acute trusts, there was little evidence of major improvements in quality, and the way clinical care was provided had not changed, with clinical relationships remaining largely unchanged.

A later report from Monitor for the House of Commons Health Committee in 2008 (337) found that Foundation Trusts were performing well financially, and only one was rated poor for quality. However, Monitor had to intervene in 5 Foundation Trusts for poor performance over MRSA. Governors were clearer about roles but a sizeable minority (16%) were still not satisfied with their boards of directors. However, there was a lack of evidence that Foundation Trusts had promoted innovation and greater public and patient involvement. Overall though, Monitor found that the annual health checks (self-certified by Foundation Trusts) were excellent and the trusts showed strong financial performance with surpluses.

However, in 2009 the problems at Mid Staffordshire Foundation Trust emerged after a report by the Healthcare Commission triggered by high mortality reports (338). The report showed failings at virtually every stage of the pathway of emergency care including poor systems, poor training, poor supervision, poor relationships (between professionals and between professionals and managers), complaints not reaching the trust's board, and poor reporting systems. Clinicians thought that the trust was driven by financial considerations and that the clinicians and nurses were marginalised. It did not have an open culture and complaints were hidden from the board within general statistics. Monitor had granted the Mid Staffordshire Acute Trust foundation status following a quality review (self-certified) and recommendation from the Healthcare Commission.

The problems with Mid Staffordshire showed flaws in the way Foundation Trust status had been granted to an organisation which was subsequently found to have poor standards of care. The implication was that financial considerations had overridden good care with departments understaffed, and staff poorly trained. The expected safeguards did not work. Klein (339) points out that all the bodies who were meant to sound the alarm about the Trust failing did not do so; no routine reporting from Monitor, the Healthcare Commission, the SHA, PCTs, PPI forums, the Local Government Scrutiny Committee, or the governors led to the problems being disclosed. Klein advised the need for a more precise focus on the information that mattered, and for a culture of professional responsibility.

The Mid-Staffordshire case shows how problems between clinicians and managers continue to get in the way of the effective running of health services, and the importance of getting such relationships right. In particular it shows how neither top-down nor bottom-up mechanisms managed to drive up standards in an organisation found to have poor

standards of care, emphasising that there are no magic solutions to service improvement.

## **Clinical governance**

The effects of clinical governance are remarkably difficult to assess in and of themselves as the policy overlaps with so many other initiatives. In secondary care it is often associated with patient safety, performance management and the use of clinical guidelines, and in GP surgeries with QOF, and again, guidelines. Clinical governance was introduced by the Labour government in the 1990s, but despite its relative longevity as a means of governing healthcare, it remains much misunderstood and appears to suffer from both definitional and conceptual confusion (340).

Rather than treating clinical governance as separate from the other mechanisms examined above, the report therefore incorporates research in the area under its other headings to avoid excessive repetition of results.

## **General practice and QOF**

In GP surgeries there were explorations of substituting the first point of clinical contact away from GPs to other occupational groups such as nurse practitioners, case managers, physician assistants and nurse triagers. Nurses and allied health professionals were given limited prescribing rights but many of the innovations transferred the less complex elements of primary care work to non-doctors, and under supervision of GPs (341). GPs' work became more medicalised and they retaining the more complex elements of care.

GPs took on the extra work associated with QOF in addition to their care workloads, in contrast to their approach to fundholding in the previous decade(64), but there is ambiguity about whether they are more satisfied with their jobs as a result of the changes, with some studies suggesting dissatisfaction with the heavy-handed surveillance associated with QOF (64) or with the extra workload(60), but others expressing broad satisfaction with the results of the new contract (62).

There has been little opposition to the introduction of QOF from either GPs or practice nurses(61) but there were concerns about increasing workload which affects the time able to be spent on clinical duties (64). Research suggests that the success of implementation was due to GPs believing that QOF is a credible tool for improving care, especially in relation to chronic disease management(53), and that patients seemed to be generally happy to cooperate with the increased monitoring that QOF introduced including screening, testing and practice-initiated appointments(60).

There was a concern that QOF has only led to improvements in chronic disease management in areas which have explicit targets in the framework, and these improvements had come from an increased investment in staff (54). In addition, doctors were challenging the performance of their peers

where they are perceived not to be engaging with QOF (52, 64), effectively turning GPs into self-managing groups.

There appears to be little research suggesting that, in line with the implementation of clinical governance in hospitals, 'gaming' occurs as a result of the introduction of QOF, but concerns were expressed by GPs on the extent to which their practice was becoming 'checklist' or 'tickbox' driven(61, 65). There was one clear incidence of GP gaming though - in relation to the 48 hours maximum patient wait for appointment times, and involving surgeries putting in place convoluted booking systems to be seen to be hitting the target(12).

Evidence-based medicine and QOF led to GPs recording increasing amounts of data for management use. GPs had a greatly increased income but at the price of their work becoming 'more intense, specialised, closely monitored, prolonged and routinised.' (341) (P643). Payment for performance through QOF had been found to lead to improvements in quality indicators for diabetes (342). However, it was difficult to disentangle the effects of QOF from other quality initiatives and inequalities in age, sex, and ethnic groups persisted at practice level (342).

QOF, however, has been successful in getting GPs to conform to its goals(59, 60) and GPs had accepted the need to discharge 'bureaucratic accountability' particularly in recording clinical decisions(343). This was a clear reduction in GPs' autonomy because they were providing data which meant that others could judge their work.

The new GP contract allowed GPs to engage more often with more complex cases(62) and to have greater scope to become specialist practitioners. However, this could lead to GPs becoming isolated from 'rank and file' doctors (63).

## **Hybrid clinical/manager roles**

A key mechanism through which clinicians and managers were meant to work more closely together during the 1990s and 2000s was the creation of 'hybrid' roles which involved clinicians taking on greater managerial responsibilities through the creation of roles such as clinical or medical directors, or in middle-management, clinical leads.

The research indicates that postholders of these hybrid roles often received little respect from their medical peers (22), and struggled to balance the 'part-time' aspects of the managerial role with their clinical practice (23). Doctors often perceived managerial roles to be temporary, that they would one day return to their clinical work(25), and that hybrid posts had a lack of clarity as to what the roles required (24).

There were a number of medical manager hybrid roles in secondary care. Medical directors were members of trust boards and below them each directorate was led by a clinical director. However, although physicians

became bureaucratized and accepted increased commercial and managerial responsibility, they did not become de-professionalised (36). Clinicians and hybrid managers maintained high levels of clinical autonomy and resisted attempts to enhance managerial control of medical practice. Medical and clinical directors were never line managers so although they could be held accountable for budgets they actually had no authority over colleagues or colleagues' use of resources. Kitchener's study (1991-95) (36) of these hybrid managers showed that clinical directors were not enjoying the increase in administration and that they needed to maintain clinical time in order to remain on the register of specialists and be able to practice in the future. Hybrid managers were uncomfortable with their boundary-spanning role and retreated to their home profession when conflict arose (27). Clinical tasks were not taken over by other groups and peer review was still seen as the primary method of quality assurance(36).

Research from Australia suggested that managers regard clinicians as unstrategic because of their focus on individual patient outcomes rather than large-scale decision-making(29). Medics in the UK regarded discussions with their managerial colleagues in an overtly political way rather than as a means to improve decision-making (30). Attempts at creating the open sharing of information between doctors and managers was regarded with suspicion by doctors because of the specialist and paternalistic culture that still dominates their outlook(31). Full-time managers often deliberately attempted to exclude medical directors from strategic discussions (25) and organised meetings to minimise medical manager input(26-28).

A detailed portrayal of the doctor-manager was given by another Australian research study where such roles required their occupants to navigate organisational fields that are complex, multi-faceted and heavily contested. Doctor-managers acknowledged their lack of formal authority over their peers, but compensated for this by moving between a number of relationship roles including colleague, manager, first among equals and medical club director. There was a strong emphasis on inter-personal skills being required and an ability to deal with competing arguments through 'conversations'(32) that could never quite be closed off for fear of it leading to conflict.

An attempt to bring clinicians into management was their inclusion in Professional Executive Committees (PECs) (344). The committee was never seen as a powerful or effective decision-making body, and GPs in particular were viewed with suspicion and seen as self-interested, and clinician attendance in general tended to be erratic signifying it was not a priority amongst that group, or a lack of interest in the initiative. There were also problems of representation; GPs were keen to claim they represented the views of patients but this was not accepted by other members. The NHS Alliance's review of PECS(344) similarly found that there was weak clinical leadership, the PECS tended to get bogged down in detail, there was



rubber-stamping of decisions made elsewhere, and lack of role clarity with fragmentation of professional groups and managers.

Despite attempts to get doctors to take on Chief Executive roles, doctor-managers were still the exception at the top levels of hospital Trusts(33). However, examinations of board-level discussions between senior managers, both clinical and non-clinical, suggested more complex patterns of discussion and decision-making were taking place. Here, clinicians were increasingly able to draw from managerial discourses to challenge decisions they perceive as being against clinical interests(34), but at the same time the new managerial vocabularies they drew upon adjusted the world of view of doctors so that they become more resource aware (35). The new vocabularies medical managers were learning allowed them to opt-in to managerial discourse where they find it appropriate(36), as well as making their reasoning more acceptable to managers who become, in turn, more likely to accept professional contributions as a result(34). Where clinicians were able to adopt managerial language and reasoning then, it led to increased acceptance of their views by managers.

## Nursing

Within nursing, the 2000s has been a period where new roles have become more established and issues of professional identity have come to the fore. Nursing appears to have been perceived by the government as a profession more compliant with reform than the doctors(38) and research seems to indicate that many nurses have embraced the opportunities that clinical governance has offered in order to take on new professional roles (39).

New nursing roles such as nurse practitioner and nurse consultant allowed nurses to take on more technical elements care work such as prescribing(40) or the administration of intra-venous drugs(41). This appears to have had ambiguous effects, with it being possible to interpret such reform within a managerialist logic of greater nursing expertise allowing doctors to specialise in higher level tasks, and so increasing efficiency(45), but at the same time allowing scope for groups within each profession to pursue more fulfilling work. A more pragmatic view is that the implementation of the Working Time Directive led to nurses having to take on new roles to fill the gaps left by the lack of availability of junior doctors, but at least some research indicates that this did not lead to widespread change (345).

Nurses have been keen to show they could do clinical work and there were a number of papers published by the British Medical Journal showing studies and randomised controlled trials (RCTs) of nurse led improvements. Some of these had positive outcomes. A study of nurse-led clinics for the secondary prevention of coronary heart disease in primary care seemed to be cost effective compared with most interventions in health care, with the main gains in life years saved (QALYs) (346). Currie et al. (347) found that Elective Direct Current cardioversion under general anaesthesia can be

safely done by an appropriately trained nurse in a day surgery unit remote from an acute general hospital. This model of care is effective and can reduce waiting times and relieve pressure on acute beds and junior doctors. Coulthard et al. (348) found that a nurse led intervention improved the management of urinary tract infections in children (visiting GP surgery) was valued by doctors and parents, and may have prevented some renal scarring.

Other findings about nurse led interventions were more negative. For example Richards et al. (349) found that nurse triage reduced the number of same day appointments with general practitioners but this resulted in busier routine surgeries, increased nursing time, and a small but significant increase in out of hours and accident and emergency attendance. Consequently, triage had not reduce overall costs per patient for managing same day appointments. Taylor et al (350), using evidence from 9 RCTs found little evidence to support the widespread implementation of nurse led management interventions for COPD (chronic obstructive pulmonary disease). Walsh et al. (351) found that acute hospitals may not be cost effective settings for nurse led intermediate care. Inpatient and total costs were significantly higher for nurse led care than standard care of post-acute medical patients.

New nursing roles produced tensions between the more traditional 'caring' aspects of their role and the more biomedical focus on 'cure' (42), and with a focus more on team-working than the individualism associated with medicine(19). Nurses in hospitals also reported that the additional technical tasks that they take on lead to them being 'rushed off their feet' to the extent that these new tasks crowded out their ability to provide more personal aspects of caring(41). Role redesign led to a greater reliance on Health Care Assistants to provide the routine care that more specialist nurses are no longer able to provide, and leading to suspicion of the government attempting to create efficiency savings by moving nursing care to the least expensive level (43). However, other research appears to indicate that there are few economies to be gained from reallocating nursing tasks in this way, even when there was a shortage of trained nurses (44).

Nurses taking on new roles such as the Modern Matron or Nurse Consultant often reported considerable confusion as to what these new roles entailed, with other professional groupings sharing the lack of clarity (48). The enactment of the Modern Matrons role occurred within a dynamic system of professionalism in which the new role is interpreted in terms of the existing role most closely associated with the new role, the changing role of those within the profession and its relationship with the new role, the relationship between professionals and power differentials that impact on the new role, and relationship between the new role and organisational management(46). Results were therefore highly contextual and far from predictable. Modern Matrons were meant to enjoy authoritative freedom, command cleanliness and good patient care, and be free from bureaucratic constraint (46).

However, more senior nurses were situated alongside or above Modern Matrons in the hierarchy, and this could be a cause of uncomfortable relationships. Modern matrons were accountable to many different stakeholders, were able to exert little influence over doctors, and also lacked influence over their own ranks. They worked alongside nurse managers rather than within existing nurse management hierarchies.

In general practice, a substantial amount of the screening and everyday care work associated with QOF was delegated to nurses and health care assistants(69). However, there were concerns about nursing staff receiving the appropriate amounts of training to carry out their new roles (70). Both nurses and doctors expressed concerns about the potential loss of autonomy coming from the highly-specified nature of QOF(58), but with nurses tending to regard the changes more favourably, embracing the new ways of working that come from them, whilst at the same time acknowledging the new tasks and roles put them under increased work pressure(70). Nurses also appeared to relish the greater autonomy in general practice where it occurs(52), reporting fewer of the problems that existed in hospitals as a result of role changes.

An ethnographic study of QOF implementation (68)found that decision-making was made largely by GPs although they delegated much of the work to others in the practice. A GP executive partner would send a message to the relevant nurse (each had responsibility for a disease area) who would then be expected to take action. 'In this way, hierarchical relationships between the nurses and the executive partner were maintained.' (P.236) Nurses could, however, challenge GPs, if they were responsible for a particular patient and had missed the target. QOF teams usually had a powerful GP who acted as the QOF lead, with nurses given the more routine, task-based work and so both nurses and GPs 'appear to have accommodated QOF-driven changes to clinical work by recreating well-worn professional boundaries and clinical hierarchies.' (P.240)

Some research general practice also suggests that greater teamworking between doctors, practice managers and nurses has occurred, aided by improved IT (60). Early work, however, foregrounded the risk of nurses becoming 'absorbing groups'(71), taking on new roles that GPs don't want to implement, such as health promotion, and that nursing roles become a combination of tasks delegated to them by doctors, although later work challenged these findings (70), and recent studies suggest nurses they have become the effective leaders of care provision in areas such as chronic disease management(70) and are more than capable of taking over the entire function of GP practices in their own right(67).

## ***Summary - the impact of top-down reforms on clinic-managerial relationships***

The focus on targets and gaming can be seen as reducing managerial legitimacy. Rather than concentrating on patient needs, targets seemed to have often resulted in managers focusing on how they can best present activity on statistical returns (352, 353). The reduction in waiting times can be regarded as evidence of the success of top-down reforms, but at a time when additional resources were granted to healthcare, it is difficult to attribute the waiting times to either improved management or to the additional service capacity generated from the rising NHS budget and the entry of new providers of care into the health marketplace.

Performance management systems were concerned with processes rather than addressing health outcomes, but have served a purpose in offering a means by which clinicians can begin to be held to account for differences in treatment outcomes and waiting times, even if there has been surprisingly little progress in this area (354). Clinicians in secondary care have continued to treat clinical guidelines as educational tools rather than protocols which should be followed.

Performance management was meant to identify failing organisations and provide the means of changing management teams or even closing down low-performing providers. In practice takeovers of failing organisations were rare, and poorly performing managers were not removed from their posts. Instead, there is a perception, especially in media coverage, that the NHS has often 'paid off' its poorly performing managers rather than confronting them with dismissal.

In secondary care relationships between managers and clinicians showed more continuity than change. As in the previous decade, clinicians continued to guard their clinical autonomy and resisted attempts to come under further management control. NHS managers still had only limited control over the deployment of medical expertise in hospitals, especially in relation to inequalities in service provision(355). Clinicians in the NHS often felt little need to engage with managerial practices, and there was outright hostility in some cases. Managers were positive about change but clinical directors were dissatisfied 'with limited resources, declining autonomy, and the growing emphasis on financial (over clinical) goals.' (356)(P. 20).

Health professional values and work practices remained entrenched (355). Guren-Uslu's and Conrad's study (357) is an example of how cost of treatments remained a hotly contested issue. The study of benchmarking in 3 large acute trusts revealed there was a lack of integration of cost and quality with managers tending to stress the importance of cost efficiency whilst clinicians thought quality improvement was more important. Managers emphasised cost and clinicians persisted in emphasising patient care, and clinicians also maintained that management concerns were secondary to doing what was best for the patient(358). Service managers

were keen to engage clinicians in benchmarking but needed a non-threatening way of doing it. Executive managers thought that EBM would help, having noted that clinicians were able to work fast at innovation through their own clinical networks. However, in this case clinical and managerial conflict effectively stopped improvements.

A major research finding of the 2000s shows how the educational background of both managers and clinicians affects their perception of both their everyday duties and health reforms(19-21). This work can be summarised through the use of a table showing attitudes to a range of healthcare modernisation issues from a range of perspectives.

**Table 7. Differing perspectives on aspects of health reforms**

| Healthcare professionals' stances on the key elements of health service modernisation |                    |                  |                  |                |                  |
|---|--------------------|------------------|------------------|----------------|------------------|
|   | Medical clinicians | Medical managers | General managers | Nurse managers | Nurse clinicians |
| Recognise connections between clinical decisions and resources                        | Oppose             | Support          | Equivocal        | Support        | Oppose           |
| Transparent accountability  | Oppose             | Support          | Support          | Support        | Oppose           |
| Systematisation   | Oppose             | Oppose           | Support          | Support        | Equivocal        |
| Multidisciplinary teams   | Oppose             | Oppose           | Equivocal        | Support        | Support          |

*Source - Degeling et al, 2003, p. 651*

This work suggests that the background of managers and clinicians can lead to almost entirely different perspectives on a range of important organisational issues (compare medical clinicians with general managers or nurse managers above), which has profound implications for attempts to get them to work together. Hybrid clinical-managerial role holders received little respect from their clinical peers for taking on managerial roles, and often regard the managerial aspects of their roles as part-time and temporary. Full-time managers, in turn, often sought to exclude clinical managers from strategic discussions, and where they were included, to minimise their input. Some hybrid role holders were capable of performing complex role-juggling through persuasion and the use of strong inter-personal skills, and were able to challenge managers by developing expertise in managerial areas such as finance. Nurse managers particularly often seem to display the ability to work across clinical and managerial roles without losing their professional identity.

The experience of role changes for nursing in hospitals was ambiguous, with opportunities to take on enhanced tasks, but with the extra workload coming from new tasks leading to nurses reporting that they were 'rushed off their feet' and experiencing isolation from more traditional caring roles. New nursing roles have often resulted in considerable confusion as to how other professional groupings understand them, and to concerns about the lack of authority that some of these new roles, such as Matrons, have because of fragmented lines of authority. Nurses were keen to prove their competence but there was still evidence of the traditional medical hierarchies persisting in secondary care. This created an uncertain dynamic which creates space for professional and managerial boundaries to be

challenged, but also a genuine confusion as to what the new roles are meant to be accomplishing. Modern matrons have struggled to deal with issues around infection rates because they were unable to manage problems in domestic services, which are often seen to be outside of their control, and requiring managers from other backgrounds to intervene(47). Nurse Consultants reported that their job roles have been the source of some political debate (because of the use of the word 'consultant') and of the time it takes for other professionals to adapt to their new roles as they become established(48).

Nurse managers reported that they interpreted managerial roles, where they take them on, through the lens of their professional identity, and that they can be successful as managers so long as they are not forced to divest their professional identity(49). Their professional interpretation of managerial directives leads to them often communicating with them in a dismissive manner(50). However, there is also a literature presenting the opportunities for nurses to become 'leaders' in a very positive light(51).

Certainly in the first half of the decade barriers between professions (particularly between GPs and hospital doctors) continued (359). One study found there were also barriers between hospital and primary care, and between doctors and other health professionals (31). Knowledge was not always freely shared within organisations, especially by managers who did not share information about funding or offer help to clinicians on developing business cases. The study found that the old medical hierarchies persisted with both managers and nurses feeling silenced by clinicians. Consultants were also seen as looking down on nurses and GPs.

Clinicians also sought to maintain their control over regulation. Salter (10) traced how the GMC seized the initiative over revalidation and got the Royal Colleges involved rather than allowing the various mechanisms the government had put in place to take charge. National agencies were created on an ad hoc and unsystematic way which meant there was room to contest the regulatory territory. For example, NICE was set up to monitor and advise on clinical excellence, but the with the medical profession holding expertise in that area, it needed to work closely with the Royal Colleges, who then had scope to influence the way it worked.

Although managers were meant to have more freedom to make changes they were in fact hampered by firstly the sheer pace of changes in government policies (360) and secondly, because of the difficulty of reallocating funding to new areas with the the vast majority of resources effectively pre-committed (28). Managers only had room to change things at the margins, and so relatively small amounts of resource became the source of dispute and debate. Managers were likely to commit resources where the organisation was in danger of failing, whilst not committing more resources to those activities which were in the comfortable middle range of thresholds. There was no incentive to improve performance where the organisation was doing acceptably well.

There was little evidence that Foundation Trusts had led to changes in the way clinical care was delivered. Foundation Trusts did show improved financial status but it was difficult to link this specifically to foundation trust status. There were grave concerns with the Mid Staffordshire Foundation Trust status that the additional autonomy and freedom might in fact have hidden a culture where financial gains became more important than quality.

Clinical Governance in secondary care became an area of conflict between clinicians and management (356). Clinicians often reported that they regarded clinical governance to be a management rather than a clinical problem (361). Degeling et al (19) suggested that unless clinical governance can be re-made into a specialist-led quality improvement system, it has little chance of achieving its goals - it has become not a quality-enhancement process but instead a fairly crude tool for quality-assurance.

In primary care, with QOF, clinical governance seemed to be internalised by clinical staff in primary care, with the policy not regarded as the imposition of a set of targets over which professionals have had no say, but instead as an integral part of everyday practice.

Research suggests that the routinisation of QOF led to a privileging of standardised biomedical information in GP practices(62), in line with Harrison's claims about 'scientific-bureaucratic' medicine becoming predominant in the NHS(3). Within such a view, patients become viewed not as individuals, but instead as data points or diagnostic groups, and so offer a significant challenge to the personal relationships that are meant to predominate in general practice, and the close GP knowledge of patients that reforms privileging their position in the NHS are based upon (66). Standardisation created the space for the challenge of doctor-nurse boundaries as increasing amounts of care can be provided through nurse-led clinics(52), leading to a questioning of which, if any, aspects of care can be better provided by doctors in primary care(67). As well as this, QOF has created its own bureaucracy, leading to a potential reduction in clinical autonomy and flexibility(64) as care becomes more rule and guideline-bound.

Sheaff (341) detected a slight shift in the balance of power between managers and clinicians in primary care. Managers had difficulty dealing with performance issues from GPs because the supply of GPs was small and their work could not easily be substituted by technology. Much of the screening and everyday care work associated with QOF was delegated to nurses and health care assistants(69). There was concern about training for new roles(70). Both nurses and doctors expressed concerns about the potential loss of autonomy coming from the highly-specified nature of QOF(58), but with nurses tending to regard the changes more favourably, embracing the new ways of working that come from them, whilst at the same time acknowledging the new tasks and roles put them under

increased work pressure(70). Nurses also appear to relish the greater autonomy in general practice where it occurs(52).

Some research suggests that QOF has led to improved teamworking between doctors, practice managers and nurses, aided by improved IT (60). There is very little research examining practice management, but there are signs of considerable tensions between doctors and practice-managers over decision-making, and that QOF sometimes has the potential to concentrate decision-making in a small clinical elite (59), often to the exclusion of practice managers (72).

In primary care there were more challenges to doctor-nurses boundaries as increasing amounts of care could be provided through nurse-led clinics(52), leading to a questioning of which, if any, aspects of care can be better provided by doctors in primary care(67). QOF has created its own bureaucracy, leading to a potential reduction in clinical autonomy and flexibility(64) as care became more rule and guideline-bound.

### ***Bottom-up reform***

Having summarised the effects on clinico-managerial relationships that came about as result of top-down reforms, the report now moves on to explore the second main theme of research and change in the 2000s, bottom-up reform.

### **Patient choice – context**

In the 1990s the internal market and the purchaser/provider split had been set up in order to encourage efficiency, improve accountability, increase choice and the responsiveness of the NHS to patient choice. The intention was that through providing patients with information about services, their choice would result in providers competing for patients. Money would follow patients, resulting in those who provided better services being more successful. It was envisaged initially that the market would benefit by freeing up the old bureaucracy but by the middle of the 1990s competition had been curtailed by the use of block contracts, purchasing cartels, and government regulation creating a quasi-market. By the end of the decade the internal market had been wound down as a less confrontational approach to health organisation prevailed.

The lack of dynamism and change resulting from the quasi-market of the 1990s was seen as arising from an inadequate understanding of professional and managerial motivations (182). The NHS executive regulated and monitored the emergent market tightly, and little competition emerged. The government intervened to impose or refuse mergers between providers, prevent Health Authorities removing contracts from under-performing hospitals. Market change was constricted by regulation and ambiguity (209). District Health Authorities were unsure whether they could close, merge or sell trusts which were owned by the



government. The government was keen not to see the closure of any hospitals due to an aggressively competitive approach because they were afraid of losing votes at the impending election. The situation of the London hospitals became a problem early on since, had the market dynamic been allowed to run its course, several hospitals could have closed (362). However, these hospitals had a high degree of emotional support from patients and public at large and were seen by professionals as exemplars of the tradition of medical teaching and research. Following protests from clinicians at the hospital and the public, the government commissioned a report from the King's Fund and in 1993 set up the London implementation group and essentially became the market regulator.

In economic terms, if excess capacity was removed this could cause a local monopoly and remove competition. Maynard concluded that purchasers had few financial incentives to behave efficiently:

*'Competition is constrained, distorted by explicit and implicit rules whose existence is a reflection of the ignorance and fears of politicians and policy makers and is a product of reforms introduced rapidly with little regard to the need to time a programme of integrated changes over an inevitably lengthy transition period.'*

(209)(p.1441).

Prices were regulated by the government because they were afraid local monopolies would use their market power to make excess profits. Prices were set so as to equal average costs in order that trusts would break even. The reforms therefore created a 'quasi-centralized bureaucratic confusion dressed up in the rhetoric of market competition.' (209)(p.1437).

A major barrier to competition was the emergence of block contracts. Rather than money following patients, purchasers and providers agreed contracts based on traditional service patterns. Partly this was because initially there was little cost and volume information but even later when there was greater information, there was little progress towards cost and volume and cost per case contracting (186, 211, 212, 214). The workload for contracting had led purchasers and providers to move towards longer-term agreements and competition was limited by having monopoly, or near monopoly, providers (188) (p.207). Purchasers and providers moved towards 3 or 5 years service agreements. There was a tendency for purchasers to initiate cartels to provide seamless services and get the co-operation of all local providers rather than introducing competition. In addition, GPs were reluctant to refer to consultants whose work they did not know, and most patients persisted in registering with their local practice and preferred going to local hospitals(212, 286, 287) (275). The purchaser/provider split had not led to a radical change in the pattern of services (213).

The overall picture was confusing with the market being regulated by the government and the professions. Contracting was relational with purchasers seeming to prefer to encourage co-operation. The reduction in detail and frequency of contract negotiations, diminishing medical

involvement, and the reluctance to invest resources in monitoring and information made purchasing less competitive 'and reduced the contracting process to a mere device for moving money around the system' (186) (p.64).

There was some evidence of improved services for patients, mainly for patients of fundholders, in terms of reduced waiting times for hospital appointment, more timely testing and diagnoses, better communication with hospital based services, and more practice based services(363). However, none of the Family Health Services Authorities (FHSAs) or District Health Authorities (DHAs) visited by the Audit Commission had developed systems for judging how wisely fundholders were purchasing, and none of the practices gave improving health for their patients as a reason for becoming fundholders (290). Few fundholders had involved patients in purchasing plans or done any form of needs assessment.

Although NHS activity increased during the 1990s there was no evidence of increased choice for patients, and there was a perception that primary care had become a two tier system with fundholders better able to secure services and reduced waiting times for their patients (285).

When Labour came to power in 1997, they initially rejected the use of competition in the NHS and instead stressed the importance of effective planning and the need for greater openness (364). The purchaser-provider split was retained but fundholding abolished and general practitioners told to 'end differential access to care' (182).

## **Policies/policy documents**

The twin concerns of the NHS Plan, to modernise the service and to centre the NHS around the patient, run throughout the document, with a central theme being to be 'to give the people of Britain a health service fit for the 21<sup>st</sup> century: a health service designed around the patient' (p. 1 Executive Summary).

In 2001 a consultative document 'Extending choice for patients' (84) was published which began to articulate the government's new emphasis on bottom-up, patient-led reform. This followed by a pilot on giving patients who had waited long periods for care in London the option to choose to go to a new provider (86), and commitments to offer all patients a choice of secondary referral providers by the end of the decade. Choice was to be put in place through a new computer system called 'Choose and Book' that aimed to provide a personalised care booking system to reduce treatment non-attendance, and allow patients to have a stronger say in where and when they would be treated.

*Practice Based Commissioning: Engaging Practices in Commissioning*, October 2004, (365) outlined how GP practices were to be given commissioning responsibilities with PCTs becoming their agents to procure

services. Practices took responsibility for making commissioning decisions and allocating resources between competing priorities.

NHS Direct – NHS Direct was an advice service for patients to contact by phone or on-line. It was intended to be a one-stop gateway to health care and to give patients more choice about accessing NHS services. Patients would be able to access a range of services including emergency care, social care, pharmaceutical treatments and dentistry. The intention was to improve information to patients and reduce unnecessary waits for treatment in Accident and Emergency departments. By 2004 NHS Direct was meant to be accessible through digital TV and there would be over 500 NHS Direct information points providing touch-screen information and advice.

### **Programme theory – how was choice meant to work?**

One of the principles underlying *The NHS Plan* was that the NHS would shape its services around the needs and preferences of individual patients, their families and their carers. Through subsequent changes, patients were to be able to choose GPs, and to book hospital appointments at a convenient date and time for patients using the 'Choose and Book' computer system, with Payment by Results leading to funds following patient choices. Patients were to get more information about services and performance of NHS organisations to inform their choices.

The reformed financial system of Payment by Results was meant to incentivise and reward good performance and reduce waiting times. This was to address the problems of block contracts in the 1990s which had offered no incentive for providers to increase throughput and improve services for patients. Money would now follow patients and in theory make service providers more responsive to patients' needs.

PCTs were to commission and deliver health services. PCTs were to become the lead organisation in assessing need, planning and securing all health services for a locality, and improving health. PCTs would engage with local people, devolve more power to front-line staff, and provide and commission services to meet needs and build partnerships. The tensions between individual patients choosing their provider, and PCTs purchasing care on their behalf, appeared to make the dynamics of how local health economies were meant to work a little less clear. This lack of clarity was added to under Practice Based Commissioning(365) in 2005. The intention was that practices would be able to secure a wider range of services, more responsive to patient needs and from which patients could choose. In conjunction with Payment by Results, this meant that where practices were able to provide or commission services locally following patients' choices, and funding would follow. The intention was that patients would benefit from a greater variety of services, greater number of providers, and in settings that were more convenient for them. In addition, the public would

benefit from a more efficient use of services and greater involvement of front line doctors and nurses in commissioning decisions (365).

Thus, by increasing range of provider choice and linking this to a system whereby the money was following the patient, it was hoped to drive up the responsiveness of the NHS to patients. The information provided to patients was to be improved through patient-friendly guidelines, and patients were to receive copies of letters sent by consultants. There were plans to have smart cards to allow patients access to health records, and later in the decade, the creation of the 'NHS Choices' website ([www.nhs.uk](http://www.nhs.uk)) was structured to allow patients to see all their local healthcare providers to facilitate easier choice between them.

Patient choice was therefore a key mechanism to increase the responsiveness of providers of care (366), and so to achieve bottom-up, sustainable reform in healthcare (367). There was more emphasis on providing information so that patients could choose not only secondary providers, but also between local GPs. Government policy suggested that choice had considerable potential to modify health service relationships, challenging health professionals and managers to become more patient-focused and responsive to patient need.

## **Outcomes on patient choice**

There was no large scale evaluation of the extension of patient choice in the 2000s but there were a number of studies that offered important contributions to our understanding of the development of the policy.

## **Evidence from patient choice research in the 2000s**

Although there was a desire to bring in evidence based information into GP consultations, in practice there were constraints as regards to time in consultation, limited time for doctors to keep up with evidence and lack of technical resources and training so that doctors could use this type of approach (88, 368). There were difficulties in getting Choose and Book to work well in GP surgeries (87) because of consultation time limits and because incorporating choice processes into consultations required them to become more computer-oriented, challenging the personal nature of care delivered there.

There is also evidence that patients were still not being consulted about courses of treatment and referral options in general practice. Research suggested that patient views were taken into account in consultations less than an independent observer found they were (89), and that there was evidence that GPs treated patients differently based on their perceived attractiveness (90). Increasing patient choice also raises the real issue of what GPs, with their focus on guideline-driven care (95) should do where patient wanted care the GP believed did not correspond with the best available medical evidence. There were studies that found that, in these

circumstances and where GPs felt patients were uninformed about the choices they were making, they overrode patients' wishes (88, 113, 369-372).

The evaluation of the London Patient Choice pilot showed that patients needed considerable support when making choices (373) which they were not receiving in GP practices, and that telephone booking systems did not provide adequate support for patients (93). The exact location where patients were meant to make their choices was unclear - it would be inconvenient and time-consuming for patients to speak to both their GP and a patient choice adviser in a GP practice (144), and even more so if upon receiving a referral from a GP they were required to make another appointment to actually make their choice. There were doubts too GPs had the information technology and critical assessment skills necessary to help patients make choices (89) – a remarkable finding suggesting that patients needed effectively to be better at choosing care than their own GPs to make the most appropriate care choice.

Work on choice often suggests that, in order for it to work, patients need high quality information (374). However, tools designed to support patients in making choices were found to have no effect in reducing patient anxiety or improving patient satisfaction with decision-making (98). There is evidence that patients prefer their doctors to make choices on their behalf when very ill (99) or when there could be adverse consequences, such as in the case of the birth of a severely disabled child (100). A study looking at the application of a decision analytic model for prenatal testing, for example, found that some women in practice made choices that were 'discordant' with the choices they had arrived at using a decision analysis model (375).

Patients also did not always want to make choices about their care (113, 376-379). Many studies showed that patients continued to rely on clinical judgement or did not use information to make choices (376, 377, 380-383). This was also true when choosing a particular hospital (379, 381, 384) where patients were more inclined to rely on their GP to make the decision for them. Patients sometimes found it difficult to make a judgement based on the confusing, different assessment criteria (325). Younger people and those with greater educational experience were more likely to use information from the internet to make choices but most still relied on personal experience of services (376). Patients were not aware how star ratings were derived and the discretion used in some of the judgements to assign star ratings (113).

Patients also preferred to be seen by consultants and were more tolerant of poor treatment from them than when receiving care from GPs with Special Interests (96), care which may have been able to offer them treatment more quickly and effectively. There was moreover the question of who should determine the right choice and who then is accountable for the outcome. For example, one study showed how the favoured decision to

undergo scheduled caesarean delivery could negatively impact immediate neonatal outcomes (385), and another that clinicians might comply with patient choice to have caesarean births even though they knew the outcomes from vaginal births were more likely to be better (386).

Somewhat paradoxically, there were many studies showing that patients wanted choices. Studies found that it was difficult for clinicians and nurses to always prejudge correctly what those choices might be (369, 380, 382, 387-418), but these choices were often the type made within a programme of treatment rather being choices between treatments. So within a pregnancy, a woman might want to make choices about the preparation and type of birth she has, but be less concerned, so long as her wishes can be met, about where the birth takes place. In chronic disease, relationships can be built up between health care providers and patients where potential treatments can be discussed and explored and with patients having choices in those areas, choices which again are based on discussion and dialogue and collaboration, rather than being driven by market-based ideas of choosing between competing providers (419).

Practice Based Commissioning (PBC) was meant to increase the variety of services available to patients, enhancing choice, and help to aid demand management through devolved budgets (144). However, in practice GPs had little time to develop new services (420) and were unlikely to be able to commission care on a large enough scale to influence PCTs and Trusts to improve the quality of care. There was tension between PBC and patient choice policies since PBC practices would be likely to set up new services or contract for care, whilst individual patients might prefer being referred for a treatment or provider other than that for which PBC practices had contracted. If individual patients started to make their own choices for care, there was a danger that this would fragment the influence of primary care over secondary care even further.

Consultants were very much opposed to Choose and Book because they saw it as taking away their discretion to manage clinics as they wished. In practice GP referral patterns remained based on historical precedent and hospital referrals continued largely unchanged (80). Outside of London most people had access to at least 2 trusts within 60 minutes by car but this hardly represented a competitive marketplace, especially as patients preferred to choose whichever provider was nearest, particularly if they had a serious illness (421). Provider competition was unevenly distributed since long-term and complex treatments such as cancer care and treatment for chronic conditions tended to be publicly-provided only since private organisations, needing to make more guaranteed returns, concentrated on shorter term health problems(421).

Greener and Mannion's (80) study of staff groups at all levels within an NHS hospital trust between 2006-2008 showed that patient flows were well-established and based on 'historical GP referral patterns' (p.97) and not the result of conscious patient choices. Choose and Book was seen, not

as part of a system of competition by the trust but as a way of managing demand. Patients again did not want to travel too far and had loyalty towards the local hospital, and any choices they did make were on the basis of availability of car-parking spaces and quality of food as on the basis of care. Independent providers were not seen as significant competition. Patient choice was not succeeding in changing relationship between NHS staff and the public for three reasons:

1. Patients were not making choice decisions and were not active and sophisticated in their choices.
2. Competition between providers were limited
3. PCTs and SHAs were not taking responsibility for ensuring the provision of local health care was of a high standard.

## **Impact of choice on relationships in health services**

The new market for care can be seen as a way of fundamentally changing relationships in healthcare in favour of patients, with clinicians responsive to their needs being rewarded, at the same time giving greater legitimacy to managers who want to reform NHS organisations to become more patient-responsive. However, choice did not greatly affect the delivery of services as most patients were often not allowed to make choices by GPs who were content to over-rule care decisions they made, because patients did not want choice, or because where they were offered choice they persisted in choosing local GPs and trusts rather than choosing on the basis of reported care quality or performance.

There were some changes in that health consumerism was increasingly recognised and acted upon by some clinicians and nurses, with the later greater particularly having to provide their service 'with a smile' (422) and doctors having to deal with patients who had increased access to medical information via the internet (91). However, choice was not the transforming mechanism that initially had been hoped for. There were structural difficulties around patient choice including difficulties in getting Choose and Book to work, the persistence of local and longstanding relationships between primary and secondary care, practice based commissioning not extending healthcare choices, and the difficulty of squaring policies around medical guidelines with the choice agenda. Choice did not require clinicians in secondary care to change their practices to attract patients, and the lack of perceived market threat meant that managers regarded choice systems more as care booking systems than as a market threat. There is little evidence that choice had made the NHS more responsive to patients in the significant way it had been intended. Patient choice-led reforms did not appear to have significantly changed clinician-patient, or manager-clinician relationships in a fundamental way.

## Public and patient involvement - context

The second main range of mechanisms for achieving bottom-up reform were those attempting to achieve greater public and patient involvement. Throughout the 1990s patients were mainly 'conspicuously absent' (172) from decisions about health care. Patients still had very little direct say in the pattern of service delivery and the level of patient involvement in the choice of hospital and consultant was low and changed little during the 1990s (185).

Community Health Councils (CHCs) remained marginalised (423, 424). Public consultation was usually initiated by Health Authorities or other NHS organisations. CHCs did run health panels which were representative in that they were drawn from a random sample matched to community profiles. However, difficult topics such as health rationing were not put to panels because it would have been expensive and difficult to obtain a coherent view from so many people. Difficult decisions about care of the dying, and reducing waiting lists were instead put to citizen's juries or face-to-face panels. In most cases commissioners set the agenda and Harrison and Mort concluded in 1998 that health panels had not significantly changed, shaped or determined policy(425).

Public and participation reforms during the 1990s had not succeeded in making the health system more responsive to patients. There were some attempts to involve patients but decision-making was still made by senior clinicians and managers with little or no input from the public.

## Policies/policy documents

In 1999 the policy document *Patient and Public Involvement in the New NHS* (105) set out policies to involve patients and public more in the policy making process for the NHS (109). The aim was to make Patient and Public Involvement (PPI) a central value underpinning provision of health services. This was both at a collective level involving service users in strategy and planning services, and at an individual level in relations between patients and GPs and other health professionals. The NHS Plan (2) a year later included this drive for more public involvement at all levels of decision making within all NHS organisations and set up a number of agencies to facilitate this. In 2001 *Shifting the Balance of Power within the NHS: Securing Delivery*(106) outlined the policies supporting a shift in the balance of power towards frontline staff who would understand patients' needs and concerns. The intention was that local communities would have more influence over the development of services through PCTs engaging with local people.

The Health and Social Care Act 2001 required NHS bodies to involve and consult the public in planning and developing services, and making decisions affecting the operation of those services(107). The National Health Service and Health Care Professions Act 2002 abolished Community



Health Councils and replaced them with Patient and Public Involvement Forums (PPIFs) for each Primary Care Trust (PCT) and NHS Trust in England, managed by the Commission for Patient and Public Involvement in Health (CPPIH). The PPIFs could also be referred to local government Overview and Scrutiny Committees (OSCs)(107) through which Local Authorities were given powers of scrutiny, thus linking elected members into monitoring.

The Health and Social Care (Community Health and Standards) Act 2003 set up the Healthcare Commission (formally the Commission for Healthcare Audit and Inspection) whose responsibilities included conducting patient surveys and involving patient groups in service user consultation. Within hospitals the Patients Advice and Liaison Service replaced the Community Health Council (CHC) in supporting complainants and helping to safeguard patients. Patients were to have redress over cancelled operations as a way of improving services and helping to encourage services that revolved around the patient's convenience rather than the service provider's convenience. The information from annual patient surveys was to be published by health organisations and actions taken as a result. Financial rewards (as incentives) were linked to the results of the National Patients Survey.

More lay members were to be on professional bodies like the GMC, NHS Modernisation Board, the Independent Reconfiguration panel, the Commission for Health Improvement and the Citizen's Panel for NICE. A final wave of legislation (the Local Government and Public Involvement in Health Act 2007) abolished PPIFs and replaced them with local involvement networks (LINKs). LINKs were established in April 2008, replacing Patient and Public Involvement Forums. LINKs were not attached to an NHS organisation but were area and network based. LINKs were open to individuals and groups, and were responsible for(122):

- Finding out people's views of local health and care services.
- Providing suggestions about improving services.
- Looking into specific issues of concern to the community.
- Making recommendations to the people who plan and run services and ensuring a response is received from those people within a specified time period.
- Asking for information about services and ensuring information is received within a specified time period.
- Carrying out visits, when necessary, to see whether services are working well.
- Referring issues to the local council's health overview and scrutiny committee if it seemed that action was not being taken.

## **Programme theory – how was patient and public participation meant to work?**

Patient and public involvement was intended to increase the responsiveness of the NHS at all levels of decision making within all NHS organisations.

Some of the agencies set up were to provide safeguards for patients. PALS (the Patient Advice and Liaison Service) had a role in protecting patients from poor standards and Patient Forums could inspect NHS premises and services. The Local Authority Scrutiny Committees linked local members (and thus the public) into monitoring health care services. Many of the new bodies were attempts to engage the patient voice in decisions about health services as well. The intention was that NHS organisations would take note of, respect, and act upon the patients' voice rather than local managers and health professionals making decisions based on their own views.

## **Outcomes for patient and public involvement**

Although there were several different ways of involving patients and public in health care, by the end of the decade it was clear that public input had predominantly been sought on an informal or ad hoc basis. The government had often not given clear guidelines how user involvement should be implemented (426-428). The lack of guidelines meant that user involvement could be (and was) interpreted differently within different organisations (112, 114, 115, 425, 428-431).

Tritter et al. (431) in their study of user involvement in cancer services found variations in definitions, aims, usefulness and mechanisms between organisations in the South West. There was no common definition of user involvement between users, professionals and managers which led to limited trust between participants. Patients and staff were unclear about, and had no shared understanding of, the purpose of public involvement (432). Bower (429) reported on clashes in general practice. Because there were no clear guidelines and patients were being asked for what they wanted, there were difficulties when patients voiced expectations that were in excess of government targets and in excess of what GPs could offer. Patients had influenced changes to care through public demands for reduced waiting times. However, although patient views were sought in patient surveys, in practice there were conflicts between patients who wanted both improved access and continuity of care and professionals who were unable to supply both. In addition, at this point (2003) information from patients came from a number of different patient surveys or sources that used different information, or were based on different questions. There was little uniformity of data which was another reason for patient views being a contested area.

New organisations such as Patient and Public Involvement forums (PPI) and Patient Advice and Liaison Service (PALS) were criticised for their complexity and incoherence (112, 113). CHC staff (with their expertise and experience) were not allowed to transfer across to the new bodies, creating gaps in service and expertise. Strategic Health Authorities managed PALS performance whilst PPI forums had a monitoring role but were not given the promised powers to take over failing PALS. The PPI forums had a less powerful role than the Community Health Councils (CHCs) they replaced,

and both PALS and PPI forums were criticised for being too narrowly focussed on health care. Health Action Zones (HAZs) and Local Strategic Partnerships (LSPs) were increasingly taking over cross-sector working but PPI forums did not have the resources and skills necessary to oversee such complex arrangements. Both PALS and PPI forums were not adequately resourced and funding was not ring-fenced for them (112, 432). Neither were they integrated into performance management and service improvement mechanisms in Trusts, limiting their ability to influence service development or represent patients. A CHI report in 2004 (112, 433) found there were few successful examples of where PPI forums had been embedded in everyday practice.

PALS were too small and too detached from clinical governance to cause meaningful change. The lack of democratic accountability meant they could be seen 'as a means of manipulating patients and the public rather than empowering them' (112) (p. 546). Baggott suggested that PPI forums had not succeeded because their structures did not recognise the different perspectives, roles and motivation of the various actors, and lacked independence and legitimacy (112). PPI forums did not have democratic legitimacy which meant that others (clinicians and managers) could equally claim legitimacy. There was no clear idea of the relationship between PPI and the choice agenda, but with the Labour government expressing a clear preference for 'choice' above 'voice' mechanisms (85, 434),

Throughout the 2000s there was continued uncertainty about how the role of the public's collective voice should be incorporated into health services, and whether the public were acting (or ought to be treated as) citizens or consumers (115, 426, 435, 436). The voice of the public in health services was rarely integrated with other governance institutions or processes (436). Part of the difficulty came from New Labour's conception of citizens and their voices not being embodied in local democracy but acting as individuals with rights and (under the Third Way) responsibilities. (435) This led to an 'indeterminacy of participation' (436) (p.450), and 'contradictory manifestations' (426) (p.5) of service users. This tension appears to have been strongest in the area of mental health where service users have actively resisted being labelled as 'consumers' and through self-organised groups campaigned to be heard through dialogic mechanisms and for service improvement through these means (110, 111).

Research from both the UK and overseas points to the different expectations that the public and health service managers and clinicians often have of participation mechanisms. This work is most clearly formulated in a Canadian study (116), but the findings are confirmed by UK-based examinations of participation as well. These differences are summarised in Table 8.

**Table 8. Abelson et al.'s comparison of public consultation design principles**

| Table Comparison of public consultation design principles with citizens' views about public involvement  |   |
|--|---|
| Public consultation design principles (from previous synthesis work)   | Citizens' views about public involvement (from focus groups results)  |
| <p>Clearly communicate:</p> <ul style="list-style-type: none"> <li>the purpose of the consultation</li> <li>its procedural rules</li> <li>the relationship between the consultation and the decisions taken</li> </ul> <p>Represent views, interests and constituencies:</p> <ul style="list-style-type: none"> <li>by carefully considering whose input should be considered</li> <li>by providing opportunities for all participants to contribute fairly</li> </ul> <p>Develop procedural rules:</p> <ul style="list-style-type: none"> <li>that promote power-sharing and mutual respect among participants and between participants and decision-makers</li> <li>that allow for adequate time for questions, clarification, listening and understanding</li> <li>that promote trust, credibility and legitimacy</li> </ul> <p>Provide information:</p> <ul style="list-style-type: none"> <li>that is accessible (e.g. understandable, appropriate amount)</li> <li>presented in a way that informs discussion</li> <li>that can be discussed and interpreted</li> <li>from credible and trusted sources</li> </ul> | <p>Communication</p> <ul style="list-style-type: none"> <li>clear communication about the purpose of the consultation, and its relationship to the larger decision-making process</li> <li>identifiable links between the consultation and the decision outcome (through the presence of someone in a decision-making role)</li> </ul> <p>People</p> <ul style="list-style-type: none"> <li>careful recruitment of the appropriate mix of people for the issue being discussed</li> </ul> <p>Process</p> <ul style="list-style-type: none"> <li>promote power-sharing and mutual respect among participants and between participants and decision-makers through neutral, impartial facilitation</li> <li>use a flexible structure to allow for meaningful contributions</li> </ul> <p>Information exchange</p> <ul style="list-style-type: none"> <li>information sharing in a context of trust</li> <li>information to be presented clearly, honestly and with integrity (by neutral facilitators)</li> <li>needs to ensure participants' comfort with the topic and to build the confidence for meaningful participation</li> <li>lay views and experiential expertise should be listened to and considered</li> </ul> |

*Source: Abelson et al., p. 211*

This research suggests that the public, when asked to participate in health services, need to understand the context of the decision they are being asked to become involved with, as well as the link between the consultation and the outcome of the participation. The public expect careful recruitment of appropriate mix of people, power-sharing between participants and decision-makers, and a great deal of open information-sharing between health services and themselves, which they take to be a sign of trust in the process. They want the information presented to them to come through neutral facilitators, time to build confidence with the topic, and for lay views and experiential expertise to be listened to during the participative process. This list of expectations and requirements is rather more expansive and wide-ranging than is offered through the vast majority of public participation forums (synthesised in the left column in Table 8).

In cancer-genetics services, Martin (118) found that whilst clinical staff were prepared to listen to the public, the public found their roles too restrictive. Professionals wanted patients to act as deferential consumers, but patients instead wanted to be actively engaged with decisions and become stakeholders in the way the service was developed. Sometimes, though health services often wanted participants to be representative of a wider public group but participants seem to reject this, instead wanting to stress their individual experience and background (120).

Forster and Gabe (109) point out the lack of clarity and coherence for PPI from the beginning which included vagueness about how the public were to be involved, what questions would be selected, whose interests would be represented at the different modes of participation, and for whom the feedback from the participation was intended. Hughes (122) drew attention

to PPI forums' ' failure to represent local communities, their inability to encompass the patient's journey through health and social care services due to their attachment to particular NHS bodies and the confused relationship between the internal PPI activity of Trusts, the role of PPIFs and the role of Overview and Scrutiny Committees.'(p.242)

With the lack of guidelines, variety of ways of involving public and patients, and lack of clarity over the public's role (citizen, patient, or consumer), professionals and managers were left free to determine the terms and boundaries of public involvement, and were possibly encouraged to do so by these circumstances. One example was Fudge et al.'s (428) study of a multi-agency modernisation programme to improve stroke services in London that found user involvement was initiated and led by professionals who determined the areas of service improvement to be discussed. The concept of user involvement remained vague and there were variations in the understanding and commitment to the programme by users and professionals. Staff suggested what the users should focus on and did not allow discussion, for example, of transport issues although users had initially wanted them to be discussed. Nevertheless, some users found it a constructive experience and made personal gains in that they felt their ideas were listened to, would be acted upon and would help others. Some professionals viewed it as constructive and as a way of democratizing the service but others saw it only in terms of complying with government directives.

Another example of the variation in approaches is Callaghan and Wistow's (114, 115) study of the implementation of PPI in two different localities. One locality conceived of public involvement as a largely consultative process, gathering information from users on services. Here the public voice was very much subordinate to the managerial voice, with managers setting the terms of the debate and the public being reactive, there to choose between alternatives supplied by management. In contrast another area used networks of sub-locality organisations. The emphasis here was on developing processes of communication using pre-existing network structures. Relationships were 'multiple, dynamic and developing'(114) with the aim of achieving shared understanding.

Milewa (437) found that managers and clinicians within PCTs and PCGs (Primary Care Groups) were retaining ownership of how public and patients' involvement developed. Commissioners of health services set the agenda, and officials were free to challenge or defend the opinions of the user group according to their goals. In primary care GPs already saw themselves as patient advocates and had little time or resources to seek patient involvement (438). They maintained a gate-keeping role and had little knowledge about the way patients could become more involved in practice decisions.

Similarly Hodge's (439) study of user involvement in a forum for Mental Health Service users found that power was exercised through the

discourses used in meetings to retain normative boundaries and reinforce the 'existing, institutionally defined power relations'. The forum was split equally between agencies, service user organisations and service users. Voices of the public were heard but did not contest norms. So for example, the issue of ECT (Electroconvulsive Therapy), which was of great concern to some users, was not discussed because it was seen as something that professionals would not be able to change. The people servicing the forum, and the nature of reports back to the forum, meant that members of the forum were informed about policies and could to some extent debate the issues they were presented with but they were there essentially to give 'authority and legitimacy' to a course already agreed upon. Agencies and service user organisations were keen to get actions agreed rather than debating underlying issues of policy.

It was unclear how far the public were involved in priority setting and resource allocation. Mitton (120) reported on a review of the research which showed that there had been little evaluation of the effectiveness of public participation and there was an absence of studies identifying what role the public played in performance measures, monitoring, evaluation and design. Mitton suggested this might well be because the public were not involved in these areas. In 2007, Daykin et al.'s systematic review (432) of public involvement found only nine papers to review. There had been little impact on changed services. There were some improvements in better understanding by staff about the patient's point of view, better communication with professionals about care, and social benefits for the patients. However, there were no clear relationships between intervention and outcomes. Health care staff tended to see patient involvement as a source of stress because they needed structures and resources to facilitate public involvement.

By the end of the decade there had been little published evaluative research linking public and patient participation with improved health services (109, 440). A report from CHI in 2004 concluded that patient and public involvement was 'rarely central to the activities of NHS organizations' (433) (p.11). In 2008 Forster and Gabe (109) wrote that the framework for collective involvement was in turmoil. The Commission for Patient and Public Involvement only lasted 18 months as an organisation before being dissolved. The government had shifted its attention to increasing patient choice, with local forums suffering from poor retention of members, and unclear roles, and there was inconsistent support for Overview and Scrutiny Committees. Similarly Bradshaw (127) claimed participation mechanisms were in disarray, citing a meta-analysis of patient surveys by Richards and Coulter in 2007 (441) which found that the NHS was far from patient centred, and that clinical staff did not provide support for patient involvement. A King's Fund Report in 2010 (440) found that patients had not been involved as much as they wanted to be in decision-making for primary care, with few reliable and robust studies of patient involvement in developing primary care services.

Local Involvement Networks (LINKs) were introduced in 2008 and replaced PPI Forums as another incarnation of patient and public involvement organisations. LINKs were attached to local areas rather than NHS organisations partly because of the reduction in numbers of PCTs and partly because of the government's dissatisfaction with the performance of PPI forums and Oversight and Scrutiny Committees. However, some of the problems that had dogged the previous PPI organisations were also present at the inception of LINKs. Plans for the internal organisation of LINKs lacked sufficient detail (122, 442). This was partly due to the government's attempt to avoid top-down control and allow LINKs set up their own ways of working. Learmonth et al. (119) argued that LINKs needed space and time to pursue their own agendas, if they were not to become tokenistic, unthreatening and homogenous. However, the history had been of 'volatility in the official structures for patient involvement' (p.107) and as LINKs were meant to be representative of 'ordinary people', they had a duty to seek out the views of local populations, but recruited people on the basis of individual knowledge and experience of health or health care.

The accountability of LINKs was unclear (442, 443). Hogg (442) suggested that the organisations could link to local democracy, and could even provide a way of determining local priorities but this was not explicit in government policy. Bradshaw (127), however, claimed that it was unlikely that LINKs would actually bring about organisational responsiveness. There had been little evidence of the improvement of standards by including participants in health care planning. Most challenges from the public to major local service reconfiguration had been ignored and Bradshaw saw no reason for this to change with LINKs (127). LINKs had few powers to demand specific information and no sanctioning powers (123). Dixon et al.'s study (123) mapping the accountability of NHS trusts based. Foundation Trusts continued to look up to government (and even SHAs) rather than down to the public. Dixon et al. concluded that there was a confusing maze of accountability relationships.

The role of the Local Authority Overview and Scrutiny Committees in widening democracy in the NHS was unclear. There were huge challenges in establishing the roles, support and local links that would make them effective (121). In addition, there were difficulties in establishing appropriate boundaries between Committees and the work of first, Public and Patient Forums (109) and later LINKs.

Complaints about health services are an area which has potential to form a bridge between individual experiences and collective service improvement. However, it seems that the NHS is still struggling to deal with complaints, with concerns that Trusts are becoming more secretive in their dealing with them, and that the complaints process remains lengthy and onerous, paper-based with little opportunity to challenge findings, and with few opportunities for personal interaction to achieve resolutions through the process (124, 338, 339).

## **The impact of patient and public involvement on health service relationships**

There were hopes that patient involvement would result in unsettling traditional power relations between professionals and patients (444). There were a few examples of patient and public involvement improving services but this was in an ad hoc way. There was certainly no great revolution where patients and public were deciding how most of the NHS should be run, or where they were making a major contribution to policy decisions. The variety of methods of participation, coupled with unclear guidelines as to how the public and patients should be involved, left a gap where managers and professionals could dictate the agenda and fix boundaries on what could be discussed or decided on. In secondary care managers took the lead in patient and public participation. Sometimes they worked towards an inclusive way of working with patients sometimes by developing networks, but most of the evidence points towards a more constricted, tokenistic way of working with patients.

In primary care, GPs had too few resources in terms of time to fully engage with patient and public involvement and regarded themselves as patient advocates already, not seeing the purpose of further patient engagement. GP patient surveys were found to be of limited use. Patients were not as involved as they wanted to be in decision-making, and there were few reliable and robust studies of patient involvement in developing primary care services (440).

By the end of the decade New Labour were more focussed on Choice as a mechanism for change. Although LINKs represented another attempt to include patient voice, and although it is too early for a body of evaluative evidence as to its effect, the signs are that this latest attempt will suffer from the same lack of clarity of its roles and accountability as previous attempts and is likely to be sidelined in the same way.

### ***Top-down, bottom-up reforms and the 'shared version' – what had changed during the 2000s, and how?***

In the section on clinico-managerial relations in the 1990s (see above) the 'shared version' of health politics presented by Harrison, Hunter and Pollitt (158) was used to both contextualise and measure the outcomes of change during that decade. How had things changed during the 2000s, and as a result of which the reforms above?

The first elements of the shared version are those of incrementalism, partisan mutual adjustment and the medical profession holding veto-power over changes they do not like. In the 1990s, the government had challenged the medical profession's veto power over policy at the national level, legislating for the internal market in the face of concerted opposition, especially from the BMA. However, the effect of the internal market on the



day-to-day activities of most clinicians was marginal – as market pressures did not evolve.

The 2000s demonstrate a government passing reform after reform with very little organised medical opposition, even when proposals challenged the doctor's right to self-regulate (445). If the Conservatives had challenged the medical profession's right of veto over policy at the national level during the 1990s, Labour demonstrated during the 2000s that they could create new policy and legislation with little or no regard to the profession's views.

If Labour were able to make policy without medical consultation, to what extent did their reforms affect the day-to-day practice of doctors? It seems fair to say that most doctors, most of the time, have not been significantly affected by policy changes during the 2000s. However, there are areas where managers have gained greater power and authority, and there are a range of new challenges to the authority of doctors to practice autonomously.

The changes associated with clinical governance gave hospital boards greater responsibilities for both clinical and managerial activities, and there is evidence that this has resulted in more assertive management practices appearing in which medical practices are more openly challenged and even, in some cases, management action for perceived low performance leading to doctors being sacked (446). Doctors appear to be more accepting of the need for management in their organisations than in the past. It may well be that, as new generations of consultants qualify, attitudes towards managers will change as they will cease to be regarded by doctors as interlopers and part of the status quo.

Nurses, on the other hand, appear to embrace roles far more readily, both in hospitals and GP practices, but bring a different perspective to these roles than either non-clinical managers or doctors, filtering management through their nursing training. In hospitals, nurses have taken on new roles that challenge the boundaries between nurses and medicine, but often at the price of having to formulate a new professional identity that embraces both care and cure in equal measure as their role becomes more biomedical and less about everyday personal care. It also seems that in hospitals nurses have taken the brunt of patients demanding higher standards of service (422). Roles such as Modern Matrons have struggled to make an impact because they often appear to be positioned outside of the administrative hierarchy within hospitals, and so have little real authority, and because they are given responsibilities for areas such as infection control which are often largely in the hands of outside-contracted services.

It is a reasonable summary to say that in hospitals clinico-managerial relationships, in general, still do not work as well as they should, with mutual suspicion on all sides being the norm, born of the different training backgrounds of doctors, nurses and managers and the difference in perspectives this brings.

The creation of hybrid doctor-manager roles goes back to the 1980s and 1990s, but there still appears little evidence that clinical-director and other similar roles are respected amongst medics. There are always exceptions to that generalisation, but for the most part senior hybrid roles appear difficult to fill, and because doctors know they will tend to return to full-time medical practice afterwards, and because of the lack of authority over medical peers that the roles carry. Hybrid roles require high levels of interpersonal skills based around persuasion and consensus-building to make them work.

The rise of information technology in the 1990s and 2000s has led to a transformation in the way that health services are run. From a situation where the Department of Health had very little idea what went on in the NHS most of the time, with any information being hard to assess and arriving too late to act upon, the growth in IT has meant that the 'centre' has been able to take an increased interest in monitoring and measuring the performance of the NHS. The use of performance management in hospitals has been perhaps the defining organisational change of the 2000s, but has led to widespread gaming and cynicism from managers and clinicians. Waiting lists have fallen, but it is hard to say whether this was due to the increased resources granted to the NHS during the decade or the increased capacity coming from the incorporation of not-for-profit and private entrants into the mixed economy of care.

Performance management in primary care, in contrast, has been a considerable success. QOF has been perhaps the most successful implementation of policy, in meeting its own goals, in the history of the National Health Service. It has opened up new professional roles for GPs and nurses that they appear to embrace, and the QOF targets have been met and exceeded. There may be downsides to the success of QOF, with patients becoming more biomedicalised and dangers of a 'tick-box' culture developing, but there is evidence that GPs and nurses have worked together successfully and cohesively to reach and exceed targets. Some nurses now want to extend their roles further and argue in favour of general practice becoming entirely nurse-led, demonstrating the increasing confidence and assertiveness of the profession in this area.

QOF raises some profound questions about performance management. It is easy to argue that its implementation (in terms of attaining its goals) has been so successful because of the resources attached to its targets, but research seems to suggest that GPs have been less interested in personal enrichment and more focused on getting in place IT systems and new staff as a result of reaching QOF goals. It also seems that GPs regard QOF as being about genuinely achieving high quality service and that QOF itself is based on best-practice rather than being the set of seemingly arbitrary targets set for secondary care.

If we are to see a shift to the NHS's services becoming entirely commissioned through GP practices, and QOF being used as an instrument

toward that goal, then this raises real risks that GPs will cease to regard QOF as being about best practice and instead come to think of it as a managerial tool instead. Under these circumstances, we might suggest a fall in compliance – GPs were prepared to ‘game’ the two-day appointment target they perceived as imposed upon them, and may be prepared to treat QOF changes not based on clinical-led measures in the same way.

It is hard not to conclude that the voice of the patient is still weak in making decisions about care, and the voice of the public is still weak in terms of its involvement in local NHS decision-making, making it difficult for patient and the public to act as a driver to change relationships within the NHS. Again, there are exceptions to these claims, with evidence of Trusts engaging with local people in a more dialogic and participative way, but the lack of clear national requirements seems to mean that there is still a great deal of tokenistic public involvement occurring. Patient choice policies, equally, have not strengthened the voice of the ‘consumer’ in healthcare, often giving patients the wrong kinds of choices – requiring them to choose between providers when what they would really like are choices within local services (where they occur, as in pregnancy where the type of birth might be chosen) and choices about the time they are seen, neither of which are a central part of approaches to patient choice as presently constituted. These different choices have much potential to challenge the way services are delivered, and to change the way that clinicians interact with one another and the public, but are not being addressed through the mechanisms currently in place to change health service relationships.

In summary then, after two decades of reform, the ‘shared version’ still has a great deal of power in describing the dynamics of healthcare. The medical profession have lost a great deal of power in policymaking, but are still remarkably dominant in local healthcare organisations, even if there is evidence of more assertive management practices appearing. Nurses have found new managerial and clinical roles available to them, and have often embraced them, especially in primary care. Central government has become far more active in the day-to-day running of healthcare, but top-down performance management has often led to gaming and cynicism in hospitals. QOF, in contrast, has been hugely successful in achieving its goals in GP practices, and key lesson can be learned about successful policy implementation from it.

The NHS, during the 2000s, found itself on the most concerted period of reform in its history, and many aspects of the delivery of healthcare have been transformed. Many of the most obvious of these are associated with information technology and the use of computerised systems and the performance management they have made possible. But were we to take doctors from the beginning of the decade and transplant them into their equivalent healthcare setting at the end of it, it is questionable how much difference they would notice. Managers might seem to be a little more assertive, nurses might occupy a wider range of roles, and computers

would be more widespread, but they would hardly find the NHS transformed. Clinico-managerial relationships have changed, as have relationships between clinicians and patients, but continuity remains the norm.

## **Addendum**

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact [sdo@southampton.ac.uk](mailto:sdo@southampton.ac.uk).