

City Research Online

City St George's, University of London

Citation: Cornish, Y.G. (2001). Involving clinicians in commissioning: a case study of policy and process. (Unpublished Doctoral thesis, City University London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version. To cite this item please consult the publisher's version.

Permanent repository link: https://city-ref-test.eprints-hosting.org/id/eprint/11879/

Copyright and Reuse: Copyright and Moral Rights remain with the author(s) and/or copyright holders. Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge, unless otherwise indicated, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way. For full details of reuse please refer to City Research Online policy.

City Research Online: http://openaccess.city.ac.uk/ publications@citystgeorges.ac.uk

INVOLVING CLINICIANS IN COMMISSIONING: A CASE STUDY OF POLICY AND PROCESS

Yvonne Gail Cornish

A thesis submitted in fulfillment of the regulations for the Degree of Doctor of Philosophy

City University
Health Management Group

March 2001

CONTENTS

List of Tables		**7**
Acknowledgement		**8**
Declaration		**9**
Abstract		**10**
Abbreviations		**11**
Chapter 1	**INTRODUCTION**	**12**
1.1	**The research topic**	**12**
1.2	**The research context**	**12**
1.3	**The research client - the South East Thames Commissioning Network**	**15**
1.4	**Background to the research specification**	**16**
	1.4.1 National influences	**16**
	1.4.2 Local influences	**20**
1.5	**The project brief**	**21**
1.6	**Definitions and scope**	**23**
1.7	**Methodological issues in policy analysis**	**24**
	1.7.1 Analysis *for* policy	**25**
	1.7.2 Analysis *of* policy	**25**
1.8	**Structure of dissertation**	**26**
Chapter 2	**CONTEXT**	**28**
2.1	**Introduction**	**28**
	2.1.1 The evidence-base	**29**
	2.1.2 Scope and limitations	**31**
2.2	**Policy and organisational context**	**32**
	2.2.1 Politics and pupose - the background to the NHS reforms	**33**
	2.2.2 Analytic frameworks	**38**
	2.2.3 Opposition to *Working for Patients*	**41**
	2.2.4 Theorising the dissent	**44**
2.3	**Implementing the internal market**	**49**
	2.3.1 The pace of change	**49**
	2.3.2 Managing the market	**51**
2.4	**The role of commissioning in the internal market**	**51**
	2.4.1 What is purchasing?	**52**
	2.4.2 Who is the 'customer'?	**54**
	2.4.3 Who were the purchasers?	**56**
	2.4.4 Developing purchasing	**58**
	2.4.5 The language of purchasing	**59**
2.5	**Theoretical context**	**61**
	2.5.1 Distinction between theory and concepts	**61**

2.5.2 The role of theory in health service research 63
2.5.3 The search for theory 66
2.5.4 Theorising the policy process 70

Chapter 3 LITERATURE REVIEW 74

3.1 Purpose of the review 74
3.1.1 Search Strategies
3.2 Clinical involvement in commissioning and contracting - 76
a reviewof the 'grey' literature
3.2.1 The Health Services Journal editorial 77
3.2.2 The management consultants' survey 80
3.2.3 The Ministerial Task Group's draft report 81
3.2.4 the Conference of Royal Colleges/IHSM Conference 85
3.2.5 Challenging assumptions and explanations 87
3.3 Clinicians, managers and clinical directors: from conflict to incorporation? 89
3.3.1 'Tribalism' in the NHS 90
3.3.2 The impact of general management on professional power in the NHS 93
3.3.3 Involving clinicians in management: before and after Griffiths 95
3.3.4 Theorising the debate 101
3.3.5 The micro-politics of medical power 105
3.4 Professional advice in the NHS 106
3.4.1 The Regional Medical Advisory mechanism 106
3.4.2 Professional advice for purchasers 108
3.5 Conclusion 112

Chapter 4 RESEARCH DESIGN 114

4.1 An unfolding research brief 114
4.2 The focus of the research 116
4.3 Framing the question 117
4.4 Developing a project plan 121
4.5 Turning a management problem into a research question 122
4.6 The philosophy of management research 123
4.7 The politics of management research 128
4.8 Pragmatic considerations 131
4.9 Back to the drawing board 132
4.10 From methodology to method 133
4.11 Review of the methodology 134
4.11.1 Surveys in sociological research 135
4.11.2 Addressing the critics 136
4.11.3 Qualitative methods in health services research 141
4.11.4 Methodological rigour in qualitative research 143

Chapter 5 RESEARCH METHOD 144

5.1 Research timetable 144
5.2 Particpating organisations 145
5.2.1 Health Authorities 145
5.2.2 Participating Trusts 148
5.3 Indentifying the clinicians 150
5.4 The survey popluation 151
5.5 Data collection: Phase I - Interviews with Commissioners 152
5.5.1 Purpose 152
5.5.2 Gaining access 155
5.5.3 Structuring the interview 156
5.5.4 Recording the interview data 158
5.6 Data collection: Phase II - Survey of Provider Clinicians 160
5.6.1 Purpose 160
5.6.2 Developing and piloting the questionaire 161
5.6.3 The survey questionnaire 162
5.6.4 Administering the survey questionnaire 163
5.6.5 Response rate 163
5.7 Data analysis: Phase I - Interview data 164
5.8 Data analysis: Phase II - Survey data 166
5.8.1 Checking and coding the questionnaires 166
5.8.2 Statistical analysis 167

Chapter 6 EXPLORING THE ISSUES WITH COMMISSIONERS 168

6.1 Introduction to first stage of the fieldwork 168
6.1.1 Purpose of the interviews 168
6.1.2 The interview process 170
6.1.3 Interview topics 171
6.1.4 Themes, issues and concepts 173
6.2 Contextualising the research problem 173
6.2.1 Policy and organisational change 174
6.2.2 The complexity of the commissioning process 177
6.2.3 Capacity within commissioning organisations 178
6.3 Reasons for involving clinicians in commissioning 180
6.3.1 A broad consensus 180
6.3.2 Access to the knowledge-base 181
6.3.3 Accountability for the delivery of services 183
6.3.4 Management of change 187
6.4 Which clinicians should be involved, and at what stage of the process? 189
6.4.1 Clinical Directors 189
6.4.2 Nursing and allied professions 191
6.4.3 Wider involvement 192
6.4.4 Which aspects of commissioning? 193

6.5	Accessing independent professional advice	194
6.6	Current purchaser-provider relationships	196
6.7	Conclusion	199
Chapter 7	THE SURVEY OF PROVIDER CLINICIANS	201
7.1	Introduction	201
7.2	Survey response	202
7.2.1	Response rate	202
7.2.2	Non-respondents	203
7.3	Characteristics of respondents	203
7.3.1	Individual characteristics	204
7.3.2	Current role and responsiblities	206
7.3.3	Workload in relation to this role	206
7.3.4	Characteristics of employing organisation	209
7.4	Working relationship with commissioners	211
7.4.1	Direct contact with commissioners	211
7.4.2	Understanding each other's agendas	213
7.4.3	Can the relationship be improved?	216
7.5	Current clinical involvement in commissioning and contracting	219
7.5.1	The wider commissioning process	219
7.5.2	The contracting cycle	221
7.6	Future involvement in the commissioning process	225
7.6.1	Which aspects of commissioning did the clinician want to become involved in?	225
7.6.2	Perceived benefits to increasing clinical involvement	227
7.6.3	Perceived barriers to change	228
7.7	How did these clinicians feel about contracting?	230
7.7.1	Sub-group differences in feelings about contracting	231
7.7.2	Respondent's own reasons for their reported feelings	232
7.7.3	A tentative hypothesis	236
7.8	Summary and conclusions	238
7.8.1	Summary	238
7.8.2	Conclusion	239
Chapter 8	DISCUSSION AND CONCLUSIONS	241
8.1	Introduction	241
8.2	Summarising the research findings	244
8.2.1	The final project report	244
8.2.2	Relating the research findings to the client's questions	245
8.2.3	Wider dissemination of the research findings	248
8.2.4	Setting the research findings in context	249
8.3	Discussion	252
8.3.1	Revisiting the internal market	254

8.3.2 A relational market? 256
8.3.3 The development of commissioning 259
8.3.4 The knowledge base to support commissioning 262
8.4 Conclusion: a case study of policy and process 266
8.4.1 Setting the agenda: the Ministerial directive 267
8.4.2 The policy process in the NHS internal market 273
8.4.3 Regaining the agenda: clinical knowledge and power 278
8.4.4 Rethinking power in the policy process 280

References 284

Appendices 291

A Interview schedule 291
B Survey Questionnaire 293

LIST OF TABLES

3.1	Typology of professional management (adapted from Causer and Exworthy, 1999)	102
5.1	Research Timetable	147
5.2	Participating Trusts	149
7.1	Survey respondents by age	204
7.2	Respondent by sex and professional group	205
7.3	Number of sessions allocated for management duties	207
7.4	Number of sessions actually spent on this work	207
7.5	Clinical workload of respondents	208
7.6	Organisational location of respondent (employing trust)	209
7.7	Respondents by length of time Trust established	210
7.8	Frequency of direct contact with commissioners by usefulness of contact	212
7.9	Who should take responsibility for improving this relationship?	217
7.10	Areas of commissioning cycle identified as important for clinical involvement	226
7.11	Barriers to increasing involvement, in order of importance	229
7.12	Clinicians' feelings about the contracting process	231
7.13	Feelings about contracting by sex of respondent	231
7.14	Feelings about contracting by professional group	232
7.15	Feelings about contracting, by reported frequency of direct contact	237

ACKNOWLEDGEMENTS

Many people have helped and supported me throughout this research, and I would like to thank them all. Some have contributed directly by participating in the research process. Others have offered me advice and guidance, answered my questions, listened to my ideas or read and commented on drafts of chapters. Whilst it is not possible to thank everyone individually, there are three groups of people who deserve a special mention. Firstly, thanks are due to the South Thames (East) Commissioning Network, who commissioned the applied research on which this thesis is based. I would particularly like to thank John Vesley, who chaired the Project Steering Group and was my main source of support and advice during the period of fieldwork. His commitment to the project, and his continued interest in its progress, were invaluable. The second is Rick Stern, who was responsible for all the projects in the Commissioning Development Programme in the South East Thames region. Rick not only provided the necessary funding for the work, but also ensured that research findings were widely disseminated across the region. I would also like to thank colleagues within the South East Institute of Public Health (now CHSS at Tunbridge Wells), for providing me with the time and space to develop my research skills, and to complete the writing of this thesis. Special thanks must go to Dr Sheila Adam and Dr June Crown for encouraging me to undertake this work. I would also like to thank those colleagues whose support took a more practical form. This includes Linda Jenkins for checking my statistical data, Jonathan Pennick for providing IT support, and Mandy Stevens for secretarial assistance. Particular thanks are, of course, due to my colleagues at City University, where I have worked and studied for the last six years. I would especially like to thank Professor Geoff Meads and Dr Roland Petchey for their continuing support and encouragement. Finally, I would of course like to say a very special thank you to my supervisor, Professor Derek Cramp, for his calm patience and reassurance, and to my partner, David Dudt, for listening to me, feeding me, and being the perfect proof-reader.

DECLARATION

I grant the powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

ABSTRACT

This thesis examines the issue of clinical involvment in the commissioning process within the NHS internal market. It is based on an applied research project undertaken across the purchaser-provider divide in one NHS region, during the 1994 - 95 annual commissioning cycle. Six District Health Authorities and thirty NHS Trusts in South East Thames took part in the research, which was commissioned by the South East Commissioning Development Network.

The purpose of the research was to support the development of the NHS commissioning function across the region. Specific research objectives included assessing the levels of clinical involvement in commissioning at a local level and exploring how the provider clinicians experienced the commissioning and contracting process. The reasons why health authority Chief Executives and Directors of Public Health wished to address this issue were also explored.

The research used both qualitative and quantitative approaches to data-collection and analysis. In-depth, fact-to-face interviews with 10 health authority Chief Executives and Directors of Public Health were followed by a postal survey of 325 clinical directors and similar lead clinicians. The postal survey achieved a 75% response rate.

Interviews with health authority Chief Executives and Directors of Public Health found overwhelming support for involving local clinicians in the commissioning process, but a wide diversity in the reasons for this. However, on analysis of the data, a number of common themes emerged. These included the need to access clinical advice, to influence clincial behaviour, to ensure contracts are deliverable and to achieve shared ownership of change. Interviews also highlighted the complexity of the commissioning process, the lack of clarity over the purpose of commissioning, and the shortage of appropriate skills within commissioning authorities. These issues were being made more difficult by a fragmentation of relationships resulting from the introduction of the internal market, and constant organisational changes.

The survey of provider clinicians revealed that less than a quarter of respondents had frequent contact with their main commissioners, and only one third felt they had a shared vision for the future of their services. Clinicians were particularly concened that their commissioners did not understand what they were purchasing, especially in terms of clinical issues, patient need and resource contstraints. Where respondents had been involved, it was mostly at the contracting stage of the annual commissioning cycle, and most felt this was inadequate. They felt their input into more strategic areas, such as agreeing service changes and developments, were more important than contract setting, negotiating and monitoring. Clinicians had mixed feelings about the process, with those who reported more frequent direct contact with their main commissioners appearing more positive. Overall, there was strong support for increasing levels of clinical involvement in commissioning, and evidence of considerable scope for improving the relationship between health authority commissioning teams and lead clinicians in the service providers.

Health authority purchasing during this period is an under-researched area, and this study contributes a detailed analysis of one aspect of the workings of the internal market in one NHS region during the mid 1990s. As a case study in policy analysis, this thesis offers insights into the policy process within the UK health care system, and the ways in which this operated within the changing policy arena created by the introduction of the internal market following the Government White Paper, *Working for Patients.*

ABBREVIATIONS

BAMM	British Association of Medical Managers
BMA	British Medical Association
CEx.	Chief Executive
CME	Continuing Medical Education (Continuing Professional Development)
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
DHA	District Health Authority
DMU	Directly managed unit
DoH	Department of Health
DPH	Director of Public Health
EBM	Evidence-based medicine
EL	Executive letter (from the NHSME or NHSE)
ECR	Extra-contractual referral
FHSA	Family Health Services Authority
GPFH	General Practice Fundholder
GPs	General Practioners
HC	Health circular (from the Department of Health)
IHSM	Institute of Health Services Management
JCC	Joint Consultants' Committee
M(H)	Minister of Health
MOH	Medical Officer of Health (now DPH)
NAFP	National Association of Fundholding Practices
NAHAT	National Association of Health Authorities and Trusts
NHS	National Health Service
NHSE	National Health Service Executive
NHSME	National Health Service Management Executive (now the NHSE)
R&D	Research and development
RAWP	Resource Allocation Working Party
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCT	Randomised Controlled Trial
RHA	Regional Health Authority
RMAC	Regional Medical Advisory Committee
RMI	Resource Management Initiative
SEIPH	South East Institute of Public Health
SETRHA	South East Thames Regional Health Authority
SoS	Secretary of State for Health
SSC	Speciality sub-commitee (of the RMAC)
ToR	Terms of reference

CHAPTER 1 INTRODUCTION

1.1 The research topic

This thesis examines the issue of clinical involvement in the commissioning process in one region of the UK National Health Service, during the 1994-95 commissioning cycle. Clinical involvement in the commissioning of health care began to emerge as a health policy issue during the 1993-94 commissioning round, two years after the establishment of NHS internal market. It moved rapidly up the national political agenda during the early months of 1994, precipitating a Ministerial letter to Chairs of all District Health Authorities during January 1994. Shortly afterwards, a Ministerial Task Force was established, with a specific remit to review the clinical input and advice which was informing current contract negotiations, and to make recommendations for promoting this in 1994-5 and beyond.

In response to this initiative, the South East Thames Commissioning Network, a group of Chief Executives, Finance Directors and Directors of Public Health based in the former South East Thames Region, agreed to commission a research project to explore the level of clinical involvement in commissioning at a local level, across their own region. This research was one of five projects funded that year by South East Thames Regional Health Authority, from money provided by the NHS Executive to support the development of the commissioning function. The research therefore needs to be located within the context of the development of the commissioning function within and beyond South East Thames and the wider policy framework that supported this development. This context is touched on briefly below. It will be further developed in Chapter 2 and Chapter 3. An overview of the structure of the thesis is given at the end of this chapter.

1.2 The research context

In 1991, *Working for Patients* set in motion what many observers have subsequently argued were were the most far reaching reforms the NHS had experienced since its

inception in 1945. In separating purchasers from providers and making the latter into self-governing NHS Trusts, *Working for Patients* created an internal market within the NHS, in which the District Health Authority had responsibility for purchasing health care on behalf of its resident population, through a process of annual contracts with service providers. These reforms were not simply about changing the organisational structure, but were aimed at "challenging some of the professional, managerial and organisational procedures which have persisted over the years", including shifting the power relations between the principle actors, doctors and managers (Hunter, in Popay and Williams, 1994).

This theme of shifting power relations between professionals and managers runs through many of the commentaries on the recent history of the NHS, and is worth further exploration, particularly in the light of the development of a new hybrid, the clinical director. Clinical directors evolved from initiatives to increase the involvement of clinicians in management, particularly in resource management, following the NHS management inquiry, or 'Griffiths report' (1983). The changing role of clinicians in management is discussed in Chapter 3.

Further exploration is also needed into the issue of the knowledge-base which supported the purchasing process. The early message from the Department of Health (and other commentators, for example, Kirkup and Donaldson, 1994) was that this was a relatively simple process, with Directors of Public Health using their epidemiological skills to assess the health needs of their local populations, and health authorities contracting with local hospital and community health services for treatment and care to meet these needs, to agreed service levels and quality. It was described at the time as "a deceptively simple model" with "...the radical agenda of changing the NHS from a provider-driven, to a purchaser-led system and freeing it from the shackles of professional interest." (Salter, 1993) No more would resources be allocated on historical patterns of service delivery, but instead "purchasers will consciously use a range of new, non-medical skills to structure the supply of health care so it fits the identified needs of the population." (Salter, 1993)

However, these 'new, non-medical skills' took time to identify and develop. The Department of Health assisted in this process, with the 'Project 26' initiative, in which a number of Health Authorities 'fast-tracked' various approaches, and a series of epidemiologically based needs assessment reviews were commissioned from academic departments (Stevens and Raftery, 1994). However, until the trilogy of speeches by the then Minister for Health, Dr Brian Mawhinney (1993) there was little mention of involving clinicians in the contracting process, apart from taking their views into account as part of the 'corporate' approach to health needs assessment, although this changed a year later (after my fieldwork was complete) with the publication of *Clinical Involvement in Contracting - a Handbook of Good Practice* (1995) by the NHS Executive.

This change in emphasis, from the earlier rhetoric of separation between the purchaser and provider roles, to the importance of collaboration is every bit as interesting as the more specific questions being asked by the research sponsors about the level of involvement of clinicians within South East Thames and how they felt about the contracting process locally. My thesis is that the themes of the shifting power base between clinicians and managers in response to the development of the internal market and the development of the knowledge base to support purchasing, are inextricably linked. Furthermore, they cannot be separated from issues around resource allocation, as the internal market fundamentally changed the way in which resources moved through they system. Money did not, in fact, follow patients as intended, at least, it did not do so for the population covered by health authority contracts (GP fundholders were able to be more flexible, as they often contracted, at least initially, on an individual basis) but it certainly followed contracts. The setting of these contracts was therefore, crucial in determining the pattern and level of health service provision. Decisions about who placed contracts for what and where, are therefore policy decisions, albeit at the 'micro' rather than the 'macro' level of policy making.

However, as Gill Walt (1997) argues, it is at the 'micro' level that the various players in the policy arena can be most effective, and it could be perhaps be argued that the introduction of the internal market shifted not only the balance of power between the key

players in the policy arena, but also the location of the policy arena itself. In this sense, the issue of clinical involvement in commissioning, and the drive by the NHS Executive to ensure that clinical staff are part of the contracting process, could be interpreted in a two ways - both of which I will explore in the discussion of my findings.

The first interpretation would be that this desire to move from contracts being informed solely by the public health perspective of purchaser to the desire to involve provider clinicians in the process, was a further attempt by the NHS Executive to make clinicians more accountable for the allocation of devolved resources (where initiatives such as Resource Allocation and Management Budgeting had previously failed). Alternatively, it could be viewed as a response to pressure by the medical Royal Colleges to shift the balance of power from managers back to the medical professions at a local level, as the Regional Medical Advisory mechanisms were being dismantled or bypassed. Both of these themes will be explored in more detail in the following chapters. Meanwhile, it would be useful to have some further information on the background to the project undertaken for South East Thames Commissioning Network, which forms the main part of the research on which this thesis is based.

1.3 The research client - the South East Thames Commissioning Network

The South East Thames Commissioning Network was established by the Regional Health Authority to support the development of commissioning across the former South East Thames region. It aimed to achieve this by bringing together Directors of the different commissioning functions to promote a shared approach to commissioning for health. (The term 'commissioning for health' was by this time beginning to replace the term 'purchasing for health' in many areas, though the difference in meaning was not always clear, to either participants or observers, and the terms were often being used interchangeably.) The Network was made up of senior representatives from the six health authorities in South East Thames, including Chief Executives, Finance Directors and Directors of Public Health. It met regularly, and had a budget, which arose from

money earmarked by the NHS Executive to support the development of commissioning, following Brian Mawhinney's trilogy of speeches.

During the Spring of 1994, the Network met to agree a number of priority areas for developing the commissioning function across the region. Once it had identified these priorities, subgroups were set up for each, and were responsible for agreeing how to take their work forward. This included agreeing a work programme, and commissioning any work the group did not feel equipped to undertake itself. As a result of this process, seven project teams were initially established, and five projects were eventually commissioned. One of these projects was the research into levels of clinical involvement in commissioning in South East Thames, which forms the basis of this thesis. This was one of three projects which were to be undertaken within the South East Institute of Public Health, which is how I became involved in this work.

1.4 Background to the research specification

1.4.1 National influences

At the time the project was commissioned, the issue of clinical involvement in contracting was moving up the political and policy agenda. The trilogy of speeches delivered by health minister Brian Mawhinney during 1993 had recently been published by the NHS Executive, outlining a framework for purchasing for the first time since the separation of the purchasing and providing roles. In these speeches, clinical involvement in contracting was described as an essential component in effective purchasing, central to the development of the "mature relationship" between purchasers and providers. Moreover, it was to be part of the 'knowledge-base' to inform commissioning, alongside epidemiological approaches and information on effectiveness and outcomes.

This message was further reinforced in January 1994, when Dr Mawhinney wrote to all Chairs of District Health Authorities "to stress the importance of ensuring that doctors and nurses in provider units are participating in the current contract negotiations" and

requesting information on the steps being taken to ensure this was happening. In June, 1994, a ministerial task force was established to review clinical involvement in contracting. Their brief was

> "to review the clinical input and advice which has informed the current contracting round and assess the influence this input has had on the contracts negotiated for 1994 - 95, with the aim of promoting clinical involvement during 1994 - 95 and beyond." (NHSE, unpublished)

Although this task group reported to ministers during the autumn of 1994, a full report was never published. Instead, a set of 'good practice' guidelines' (NHSE, 1995) was circulated the following summer, by which time the project being undertaken on behalf of the South Thames (East)[1] commissioning group was almost complete.

However, these guidelines dealt only with the contracting process itself, not the whole commissioning cycle, and, because they did not appear until shortly after the project was completed, they did not influence the questions the project asked, or the form it took. However, the task force recommendations make interesting reading alongside the findings of this research, and will therefore be picked up again in the discussion (Chapter 8) It is however interesting to question at this point on why clinical involvement in contracting, rather than the whole process of commissioning, was the ministerial brief, especially as previous guidance such as *Managing Activity and Change* (EL(93)10)

> "placed a clear requirement on purchasers and providers to ensure that clinicians and other professionals were involved in drawing up purchasing plans, discussing purchasing changes and the process of managing change." (NHSE unpublished).

---

[1] During the period in which this research was undertaken, there was a reduction in the number of Regional Health Authorities in England, (from fourteen to eight), as part of the Functions and Manpower Review. South East Thames and South West Thames were merged, though for sometime continued to work separately, with the east of the region becoming know as South Thames (East).

Perhaps this suggests that ministers were more concerned that clinicians should be held to account for delivering the contracts that their Trusts were signing up to, especially in terms of resource use (by agreeing levels of activity), rather than feeling they should continue to have a (dominant) voice in the wider policy agenda, especially around the configuration and development of service provision? Nevertheless, there is clear evidence that clinicians had strong feelings about their exclusion from the wider policy agenda, and that they were putting pressure on government to redress the shifting power base that the market had initiated.

For example, the task group report, outlining the background to its work continues,

> "despite the clear messages coming from the centre there was a strong feeling amongst clinicians, voiced particularly at the JCC, that they were not being fully involved in the commissioning process" (NHSE, unpublished)

A further example of the pressure being exerted by the medical establishment took the form of a major national conference, held in London during November 1994, on 'The Involvement of Clinicians in Commissioning and Purchasing Care'. Although organised jointly by the Conference of Medical Royal Colleges and the Institute of Health Services Management, this conference was held at the Royal College of Physicians, and delegates were drawn overwhelmingly from the medical profession. The main theme of the day, as outlined in the conference brochure, was

> "to explore how hospital consultants who have first hand knowledge of how clinical services operate, and of the effectiveness of different health care interventions can get this information across to purchasers in order that the best possible care can be commissioned." (Conference flyer)

A further 'policy driver' in the sense of implementing the specific policy of increasing clinical involvement in contracting was the media, albeit the health management media. A survey undertaken by a firm of management consultants (McClean Jones McCarthy,

April 1994) found that clinical directors were very unhappy with their levels of involvement in the commissioning/contracting process, with "73% of clinical directors" reporting that they were not a formal part of the contract setting team. (Press Release, 7 April 1994) Although neither the press release nor the full survey report gave any details of the methods used (in terms of sampling frame, sample size or response rate), so there was no detail by which to judge the methodological quality of the work undertaken, the findings nevertheless received considerable publicity (See Chapter 3). The Press Release was widely circulated, and the issue was picked up the Health Services Journal Editorial, under the headline 'Smile at a Doctor Today'. This claimed that:

> "Three-quarters of the senior clinicians who took part complained that they were excluded from contract negotiations with the health authorities and GP fundholders. Clinical issues were given low priority when contracts were drawn up, they claimed, and financial considerations were 'always paramount'." (HSJ, April 1994)

The editorial continued, "it would be easy to dismiss these gripes as old-fashioned tribalism and whingeing", and pointed out, perhaps rather unnecessarily in a journal designed for health service managers, that, "after wielding unchallenged power in the NHS for generations, consultants have taken unkindly to the rise of the health service manager." Not only, the HSJ argued, were hospital consultants feeling "suddenly subordinate", but they were also "having [their] most dearly cherished and long-held assumptions" overturned - an allusion, presumably, to the fact that managers by this point in the development of the NHS internal market, were beginning to flex their managerial muscle and challenge the notion of clinical autonomy.

Nevertheless, there was a real concern being expressed, by managers, about the breakdown in communication and working relationships between themselves and their clinical colleagues, with the editorial suggesting that "mutual distrust between managers and clinicians...[is] reaching epic proportions." The language used was highly emotive:

"While many managers are quick to assume clinicians always act out of professional self-interest, most clinicians believe managers will invariably pursue the cheapest cost-cutting option regardless of effects on service levels and quality. Managers see clinicians as involved in a bad-tempered, last-ditch attempt to preserve their privileges; clinicians see managers as the ruthless agents of a government bent of curtailing NHS costs come what may." (HSJ, April 1994, p.13)

There was little evidence in the survey to support the above position, but clearly, by this point in the development of the internal market, relationships between clinicians and managers were popularly perceived to be near breaking point, to the extent that (even) managers were beginning to become concerned about the potential for damage.

> "The dangers if this trend is allowed to continue unchecked are plain: not only mass disaffection and confrontation, but ineffective and poor quality services. Consultants are best placed to propose service developments and modifications, and theirs is the major contribution to defining and monitoring quality. If that is not recognised and fostered, innovation will be stifled. If doctors are forced to take responsibility for decisions they cannot influence, destructive passions will soon be unleashed." (HSJ, April 1994)

1.4.2 Local influences

It was against this background that the Commissioning Development Network in South East Thames decided to prioritise this area for further work. Most members of the group had seen the Health Services Journal Editorial, and the chair of the subgroup had circulated the survey report. This served to reinforce local worries about a growing perception that there was an increasing communication gap between the members of the Commissioning Network and 'their' clinicians, ie those working in the Trusts with which they had major contracts.

At around the same time, the Audit Commission published a report (1994) which raised further questions about clinical involvement, but this was in relation to their involvement in Trust management: both in day-to-day management within hospitals, and also in managing change. There was concern expressed about the uneven development of clinical directorates and business units, and the tension for professionals between clinical freedom and organisational accountability. One solution suggested by the Audit Commission was that purchasers and Trusts should work more closely together "to develop a shared understanding of future trends and options for the delivery of health care". Whilst this report had only a brief mention in the *Health Services Journal* (which referred to "plentiful evidence" to support the view that "the great project to involve doctors more in management...is rapidly ailing"), it was picked up by Commissioning Network subgroup, as some of the group members were worried about what was happening in their local Trusts. (Many Trusts were at this time flexing their muscle, and refusing to let purchasers know very much about their internal arrangements)

There was, therefore, considerable local concern over the potential for fragmentation of clinical/professional influence. Taken together, these factors were felt to be increasing the concerns among commissioners about how they could continue to access appropriate clinical input into their policies and strategies.

1.5 The project brief

This project brief was in the early stages of development when I took on responsibility for undertaking the research. The Chair of the sub-group had written an outline project proposal, and the South East Institute had agreed to undertake the work. Three main elements had been identified to the work programme agreed by the group. These were outlined in a letter from the Chair to the Institute, dated 14 June, 1994, as follows

> "1. a survey of clinicians (clinical directors?) in South Thames (East) to see what level of involvement they have had in commissioning processes and their views on how it has felt to them .

2. a survey of all NHS Trusts in South Thames (East) to ascertain the precise structure of their clinical directorates and the resources and functions attributed to those directorates

3. a scrutiny of good practice in this area with a view to combining all three work programme elements to produce a report suggesting ways forward in South Thames (East)...."

Furthermore, notes from an earlier meeting suggested the group wished to address a number of questions, including

"1. what are the expected tangible benefits in involving clinicians more fully in commissioning?

2. what areas of commissioning stand to gain from increased participation by clinicians? Is their influence desirable in

(i) the formulation of Health Strategy?

(ii) the establishment of successful Resource Allocation and Purchasing Strategies?

(iii) the effective operation of the negotiating/contracting processes

(iv) the creation and management by commissioners of .

- clinical audit
- quality
- research and development programmes etc

3. what is the current level of participation of clinicians in appropriate areas?

4. whose responsibility/influence is it to bring about any perceived changes that are necessary?

5. how should such changes be effected? ”

(Source: notes of the project team meeting, 15 April 1994)

By the time I first met with the group in July, they had, in addition to the above, identified a number of objectives and issues. Their four objectives were to

1. discuss how it feels to clinicians
2. identify opportunities for greater involvement
3. propose mechanisms for securing greater involvement
4. discover whether some clinical directorate structures are preferable to others

The issues they had identified to discuss for that meeting included how they would define the terms 'clinician' and 'commissioning'; how they would secure ownership of the project by providers and the co-operation of those who would need to take part; how to operationalise the research questions they had already identified; and to agree the structure, scope and timescale of the project.

1.6 Definitions and scope

As the ways in which the issues outlined in the last paragraph were resolved are fundamental to the conduct of the research, these will be described and fully discussed in the following chapters. However, for the purpose of clarity, and in recognition of the rapidly-changing health policy agenda, it is important to note that, at this stage of the development of the 'internal market,' commissioning for health was predominantly about the purchasing of health services, which was still mainly conducted by health authorities. Whilst GP fundholding had been in existence for some time, and a number of 'locality commissioning' arrangements were in place within South East Thames to 'capture' the views of non-fundholding GPs on the purchasing of health services, concepts such as 'primary care led purchasing' were still at an early stage of development. The 'clinicians' referred to throughout this research are, therefore, those clinicians (doctors, nurses and professions allied to medicine) who provide health care in the hospital and community

health services, otherwise known as the secondary and tertiary care sector. The involvement of GPs or other members of the primary care team in commissioning was seen by the clients as beyond the scope of this project.

There was also, at this time, an 'opening up' of the space between the terms 'purchasing' and 'commissioning.' These two terms were sometimes still being used interchangeably, but a shift in meaning was clearly occurring - hence the need for the project steering group to clarify its own definition. This change of terminology is discussed more fully in Chapter 2, but throughout the research, the term 'commissioning' has been used to include the broad range of activities carried out by health authorities throughout the annual 'purchasing cycle,'and the processes that inform these activities. It is therefore much broader than the annual negotiation of contracts.

1.7 Methodological issues in policy analysis

One final issue which needs to be introduced here is the role of research in policy making and implementation. In many ways, it would be quite accurate to describe the research I was commissioned to undertake for my clients as a piece of applied management research. I had, after all, been asked to find out what local managers were doing about a particular issue and what managerial action needed to be taken to improve their performance in this area. However, as the project specification was re-negotiated with the Steering Group, and the literature review began, it became evident that a number of broader research questions underpinned the more immediate questions my clients wanted to answer. (See Chapter 4) These questions, together with the questions which the Steering Group had already identified, shifted the location of the research from applied management research towards policy analysis.

Policy analysis, as Ham and Hill (1993) observe, is the preferred term to describe both the analysis *of* policy, and studies undertaken to inform policy (analysis *for* policy). This distinction requires further explanation, as both aspects come into play throughout this thesis. For Ham and Hill, policy analysis is both an academic activity concerned primarily

with advancing understanding and an applied activity concerned with contributing to the solution of problems. (Ham and Hill, 1993) Researching the issue of clinical involvment in commissioning could potentially fall into either of these categories. However, I would like to argue that the design of this particular piece of research (Chapter 4) and the context in which it is set (Chapters 2 and 3) enable it to fall into both. This is illustrated below.

1.7.1 Analysis *for* policy

My clients, the South Thames Commissioning Network, had a problem, for which they sought an evidence-based solution, based on some original research. They needed information to inform local policy making (decisions) and implementation (managerial action). They wished to establish the base-line of current levels of clinical involvement in commissioning, both to inform their own practice, and to feed back to central government (who had already made a policy decision that clinicians should be involved in commissioning, and issued a directive to that effect) details of how effectively, or otherwise, they were in achieving this. They also wished to know how they could improve levels of clinical involvment in commissioning locally, ie what factors would help them to implement the Ministerial directive within their own, and their local provider, organisations? What managerial action was required, and how could this best be facilitated? This part of the research was, therefore, an applied activity, and can clearly be located within the category of analysis *for* policy.

1.7.2 Analysis *of* policy

Yet even this does not fully describe the work, as it leaves aside the context in which the research was undertaken, and the broader questions which it will attempt to address, especially the questions in which I have a particular interest, ie why was this an issue, at this time, for this group of people? Why was it so important to them that they agreed to commission work in this area, as opposed to, say, the role of the public in influencing commissioning (also high on the policy agenda at that time - the Ministerial letter did, in

fact, request information on this topic also, but the Commissioning Network did not prioritise this for further work). Extending the research to include a broader range of questions, which both underpinned the applied research I was commissioned to undertake and set it in a broader context, has subsequently embedded the empirical work (the fieldwork undertaken for my clients) in an analysis *of* policy, which I hope will contribute to a greater understanding of the policy process itself, particularly in relation to the way in which this was affected by the introduction of an internal market into existing NHS structures and processes.

1.8 Structure of dissertation

This chapter has provided a brief overview of the background to the research in relation to the immediate policy and management issues which influenced the topic becoming an issue for the client. It has described why the research was undertaken, and what it was expected to achieve. Chapter 2 extends this analysis, through further exploration of the policy and organisational background to the research, and sets this in a broader theoretical framework. Chapter 3 continues to establish the research context, through a critical review of the literature relevant to the research questions.

Chapter 4 covers the research design in some detail, describing the way in which the research questions and project plans were developed through working with the steering group and other key actors who had an interest in (and therefore a potential influence on) the outcome of the research. It takes a reflexive approach to the research process, turning the "critical methods of social enquiry upon the practice of social enquiry itself." (Hoggett, Jeffers and Harrison, 1994). The methods used for data collection and analysis are described in detail in Chapter 5. These two chapters together cover what is usually combined in one chapter headed 'methodology'.

Chapters 6 and 7 describe the research findings from fieldwork undertaken for the client. Again, these will be separated into two chapters for reasons of clarity. In Chapter 6, the findings from qualitative research undertaken in the six purchasing authorities who took

part in the project are presented in some detail. Chapter 7 covers the findings from the survey of clinical directors, which is broadly quantitative, though the questionnaire included a number of open-ended questions to allow for some qualitative analysis. Together these two chapters form a 'case study' of a particular policy issue, at a particular moment in time.

Chapter 8 discusses the ways in which the research findings can be interpreted, and locates the findings in the wider context of the policy-making and implementation process in general, and the role of clinical professionals in this process in particular. It picks up on some of the theoretical issues around policy analysis, and explores the ways in which the case study in South Thames expands some of the current academic debates on power and the policy process.

CHAPTER 2 CONTEXT

2.1 Introduction

This chapter sets the research project in the wider context of the 1991 NHS reforms within which the issue of clinical involvement in commissioning is embedded. The Government White Paper, *Working for Patients* (Secretaries of State for Health, 1989) set in motion what many observers subsequently argued were the most far-reaching reforms the NHS had experienced since its inception in 1948. These reforms, which established an internal market within the UK health care system by separating the purchasing and provision of services and creating a contractual relationship between the two, were not simply about changing the organisational structure of the NHS. They were linked to a wider ideological commitment to the inherent efficiency of markets as a means of allocating resources and providing services (Glaser, 1993); and, it has been argued, aimed to challenge some of the professional, managerial and organisational procedures which had persisted over many years, including shifting the power relations between the principle actors, doctors and managers. (Hunter, in Popay and Williams, 1994)

The extent to which the internal market was a success or failure, the criteria for assessing this, and the lessons which can be learned, remain the subject of debate (Le Grande, Mays and Mulligan, 1998) and are beyond the scope of this research. However, the type of market which was introduced into the NHS in 1991 and the way this market subsequently evolved, the development of purchasing (commissioning) as a function and the knowledge-base needed to support this, and the shifting power relations between clinicians and managers as the market unfolded, are all key themes which the research will address, and therefore require further discussion. The first two of these themes - the introduction and subsequent development of the internal market, and the role of commissioning and the knowledge-base which underpins this, will be examined in this chapter. The theme of the shifting power relations between clinicians and managers, which runs through many of the commentaries on the recent history of the NHS, in fact

pre-dated the 1991 reforms. It nevertheless continued to be an issue following the introduction of the internal market, and was a major concern of the South Thames Commissioning Network at the time the research was undertaken. It is therefore also important in terms of understanding the research into clinical involvement in commissioning, particularly in the light of the development of the new clinical-managerial hybrid, the clinical directors - who were the subjects of the South Thames survey. This theme will be further explored in Chapter 3.

In addition to identifying and exploring a number of key themes and issues which the empirical research into clinical involvement sought to address, this chapter also attempts to locate the South Thames study within a broader field of enquiry, to establish a theoretical framework for interpreting the research findings. As Klein (1995) has argued, NHS structures and processes do not exist in a political vacuum. They are linked to a set of values and beliefs about the nature of society, the role of the State, and the relationship between professionals and those who need their services. But the NHS is also (as is any health care system) a political system in its own right - in that the distribution of resources is largely determined by the balance of power within the system. (Klein, 1995)

The issue of clinical involvement in commissioning can, therefore, be firmly located within the theoretical frameworks available to health policy analysis. These frameworks will be referred to throughout this chapter, wherever they can shed light on analysis of the events which form the context of the research, and discussed in more detail in the final section of this chapter (see section 2.5). Theoretical issues will be revisited and further discussed in the light of the research findings, in Chapter 8 of this thesis.

2.1.1. The evidence-base

At the time the research field work was undertaken, the amount of published research on the development of the NHS market, the role of commissioning, and the involvement of clinicians in commissioning and contracting was very limited. As Chapter 3 demonstrates, an initial literature review revealed little on the immediate questions under investigation in South Thames. One of the reasons for this was undoubtedly that the

particular issue the Commissioning Development Network wished to address, ie the provider clinicians' involvement in the commissioning process was a very recent concern. This was linked to another factor affecting the availability (or otherwise) of a body of work in which to locate the research: that is, that the changes brought about by the 1990 NHS reforms were so extensive that they took a number of years to complete. This not only meant that new issues continued to arise throughout this period, but that commentary on these took time to appear in the journals. Furthermore, although publication of *Working for Patients* (Secretaries of State, 1989) five years earlier had generated considerable academic and popular debate (which continued throughout the period of implementation) much of this was highly speculative, and uninformed by academic research - a fact which also requires explanation.

As a number of analysts have reminded us (Hunter, 1994; Le Grand, 1994; Dixon, 1998) the 1991 NHS reforms were implemented without any preliminary pilots to test the proposals or any plans for research to evaluate the impact of the proposed changes. Indeed, the Government of the day made a clear decision to press ahead with the NHS reforms, without making any official provision for testing, monitoring or evaluating their impact. (Robinson, 1994) This was not simply an oversight. That the political climate of the time was very much against working with academic advice, is amply illustrated by the evidence given to the House of Commons Select Committee, by the then Secretary of State for Health, Kenneth Clarke, who denied the need for formal monitoring and evaluation and expressed the view that calling on the advice of academics in this way was a sign of weakness. It is this lack of research evidence that led Le Grand (1994) to the early conclusion that, "In the debate over the NHS reforms, anecdote and prejudice have generally substituted for systematic evaluation."

Since my research fieldwork was completed, rather more academic commentary on this period has become available. Nevertheless, whilst much has been written about the prevailing political and economic environment of the 1980s which preceded the 1991 NHS reforms, the highly politicised nature of their introduction combined with the lack of any established mechanisms for undertaking independent research and evaluation, has

meant that sound investigation of their impact has been somewhat patchy (Dixon, 1998). Furthermore, the published evidence is scattered across several disciplines, and some areas of the reforms (notably GP Fundholding) have received considerably more attention from researchers than others. There are therefore major gaps and limitations in the research evidence, particularly in the area of health authority purchasing (Le Grand, Mays and Dixon, 1998). Indeed, even the King's Fund initiative established to remedy this early evaluative deficit failed to include any studies which would look specifically at the purchasing role of health authorities - apparently on the basis that the activities of health authorities were neither as interesting, nor as 'research friendly' (sic) as the introduction of GP Fundholding. (Mulligan, 1998)

In spite of this initial lack of research into health authority purchasing, the King's Fund review of the evidence (Le Grand, Mays and Mulligan, 1998) lists 38 examples of studies on health authority purchasing published between 1991 and 1997. Whilst few of these were available prior to my research being undertaken, publication did reach a peak during 1995. This was at the same time as my own data was undergoing analysis, and initial findings from the South Thames study were being reported back to the Commissioning Network and to research participants. Where appropriate, these studies have been used as a basis for comparison with my research findings, and are therefore drawn on in later chapters.

2.1.2 Scope and limitations

As this Chapter draws on a diverse and extensive range of literature, it is, of necessity, selective. Whilst much has been included, a great deal has also been discarded. The criterion for inclusion has been relevance to the focus of the research - and within this criterion, every attempt has been made to ensure a balanced approach to the evidence. For the purpose of clarity, the literature in this chapter is reviewed thematically, rather than chronologically. It will explore the background to the 1990 NHS reforms, the introduction of the internal market, and the development of the commissioning function

within this, and will locate these changes within the context of debates about the health policy process.

The following chapter, (Chapter 3) will take a different starting point, by examining a number of health service management issues, including the debates around the changing power relationships between clinicians and managers resulting from the introduction of general management (prior to the purchaser/provider separation), and the limited success of subsequent attempts to draw clinicians into this role, through initiatives such as resource management and devolved budgeting. The development of clinical directorates will be covered in some detail, along with the role of clinical directors, as these clinicians with a management role were the main focus of my research (see Chapters 4 and 5).

Throughout these two chapters, the various theoretical approaches to understanding the health policy process will be examined, with particular reference to the role of health professionals in general, and the medical profession in particular, in the making and implementing of health policy. This poses a number of questions around the impact that the various organisational and management changes might (or might not) have had on these processes, and it is these questions, and the research methods that would be needed to answer them, that will be returned to in the final discussion and interpretation of the research findings (Chapter 8) which will in turn highlight some of the theoretical and methodological issues which I will argue need to be addressed in relation to health policy analysis and research if these questions are to be answered satisfactorily.

2.2 Policy and organisational context

At the time of the research into clinical involvement in commissioning in the South East of England, the introduction of the NHS 'internal market,' with its separation of purchasers and providers, was in effect complete. The fourth (and final) wave of hospital and community health service applications for Trust status had just been approved by the Secretary of State. This meant that over 95% of NHS services were being provided in self-managed NHS Trusts, who funded this activity through contractual arrangements

with district health authorities and fund-holding General Practitioners. Further organisational change was anticipated, as the role and function of the Regional Health Authorities was being reviewed, and legislation to enable the mergers of district health authorities (DHAs) and family health service authorities (FHSAs) was being prepared.

However, the summer and early autumn of 1994 was in many senses a pivotal point - as the first phase of implementing the internal market reached completion, and the future development, with its emphasis on the shift towards primary-care led purchasing, had yet to begin in earnest. How had this situation come about? What was the purpose of the 'internal market,' and what was its implementation expected to achieve? To answer these questions, we need to go back to the 1980s, and examine the political and ideological agenda of the conservative government of the time, and the impact this had on public sector organisations, including (but not only) the National Health Service.

2.2.1 Politics and purpose - the background to the NHS reforms

The NHS internal market, with the separation of the purchasing of health care from the provision of services, did not occur in a political vacuum. As Appleby and colleagues remind us, "a consistent theme of Government policy during the 1980s was a belief in the superior efficiency of the private sector." (Appleby, 1994 p23) The ideology of the 'new right' argued that free markets were inherently more efficient than managed markets, that private funding was preferable to public funding, and that competition was preferable to professional monopoly or state bureaucracy (Glaser, 1993). Yet throughout the 1980s, this set of beliefs and values had only limited influence on the NHS. There were a number of initiatives to improve management effectiveness (these are discussed extensively in Chapter 3), and the introduction of competitive tendering for ancillary services. Apart from these relatively marginal changes, however, the principles on which the NHS had been founded, ie that it should be a national, public service, funded out of taxation and free at the point of use continued to remain largely unchallenged.

Yet the NHS had not been without its critics. In addition to the critique of the welfare state and ideas about the inherent superiority of markets as a mechanism for service delivery which were emerging from the right wing 'think tanks' such as the Institute for Economic Affairs and the Centre for Policy Studies, there were a number of critiques of medicine and the medical profession arising from quite different philosophical, epistemological and political perspectives, such as community medicine, medical sociology, health economics, feminist theory and practice (including the women's health movement) and from classical and neo-classical Marxism. These critiques raised a number of questions around the persisting inequalities in health status (by social class, by gender and by ethnic group), inequity in the provisions and outcomes of health treatment and care (which were not accounted for by the inequalities in health status), professional domination and paternalism; inefficiencies and perverse incentives within the health care system; an overemphasis on treatment at the expense of health promotion and disease prevention; and a failure to meet the needs of patients and their carers. Indeed, the NHS was felt by many to be in urgent need of radical reform, in spite of its ongoing political popularity as an institution.

Nevertheless, it was a funding crisis, rather than pressure from these radical critiques, that led the Prime Minister Thatcher to announce her fundamental review of the structure and funding of the NHS on the BBC's current affairs weekly programme, 'Panorama' one evening in January 1988, and it was this review that finally led to the introduction of what later became known as the 'internal market': As Klein (1995) reminds us,

> "The proximate cause for the decision to set up the Review can...be seen as the Prime Minister's resolve to escape from what was becoming an ever more embarrassing political situation. But what created the situation was the failure...to resolve the tensions between constrained budgets and expanding demands. (Klein, 1995, p. 178)

This tension was not only a problem for the UK health care system, but was influencing health care reform across Northern America and much of Europe (see, for example, Ham,

ed. 1997). Nevertheless, each country's approach to resolving this tension has been different, reflecting its own existing circumstances. Within the UK, there had been no specific mention of proposed major changes to the NHS in the Government's election manifesto in 1987, apart from a commitment to improve efficiency and to strengthen management (Butler, 1992). The NHS was (and still is) regarded as a very politically sensitive area, with strong public and professional commitment, in spite of the critiques cited above. If a market in health care had been under consideration, this was not evident at the time the Conservatives began their third term of office. Nevertheless, the Thatcher review began by looking at the issue of funding health care, and it appears that a number of alternative approaches to a system funded by general taxation had initially came under consideration (Butler, 1992; Klein, 1995; Webster, 1998).

However, as the review progressed, a combination of caution about the political consequences of changing the financing of the NHS and a growing awareness that, for all its limitations, a tax-funded service is a very good way of controlling expenditure, meant there was ultimately little enthusiasm for changing the way the health service was financed (Ham, 1992) and the review appeared to reach a stalemate (Butler, 1992). A number of factors seem to have then come into play which both moved the review forward, and changed its focus. Firstly, Margaret Thatcher decided to separate the Department of Health from the Department of Social Security, and she appointed Kenneth Clarke (seen then, as now, as being towards the 'left' of the Conservative Party) as Secretary of State. This resulted in a change of emphasis within the review, which moved away from discussions about the sources and volume of NHS funding, and on to discussion about increasing the efficient use of available resources, through changing the way health services were to be delivered. It was here that the work of Enthoven became a major influence.

Enthoven, a health economist from the USA, had identified a number of structural problems and perverse economic incentives within the UK health care system. He talked of 'institutional sclerosis' and 'gridlock' in the system, and criticised the impact of government spending limits, long-term consultant contracts, GP autonomy, unionisation

of the workforce, and national wage agreements, all of which, he argued, combined with the politicisation of the NHS to frustrate change. Furthermore, he added, the combination of over-centralisation and provider domination (where each District Health Authority was a monopoly supplier of services to its population) contributed to a system whereby inefficient units experienced a reduced workload but received no less money. (Enthoven, 1991). In addition, capital was a 'free good' where property already existed, but difficult for others to obtain; management information systems wholly inadequate; and 'customer service' was perceived to be poor. Finally, he claimed, any incentives to encourage innovation were noticeably absent. (Enthoven 1991)

In his now-famous monograph, *Reflections on the Management of the National Health Service* Enthoven (1985) outlined an alternative structure in which health authorities would receive funding from the government to provide (and pay for) health services for its own resident population, but would be reimbursed for providing treatment or care to non-residents, through a process of contracting. This 'internal market' as Enthoven termed it, would he argued, effectively deal with the issue of cross-boundary flows (where patients resident in one health authority were treated by a service located in another), whilst leaving the service free to users and funded out of taxation. To achieve this, Enthoven declared, it would be necessary to create a 'demand side' or purchasing agency, which would be funded on a per capita basis, and a 'supply side' of service providers, who would receive payment for work undertaken under contract. Enthoven believed that such a market would de-centralise much decision-making and financial control. He himself referred to this arrangement as 'market socialism,' as neither the ownership, the employees, nor the customers would change, with health services remaining funded out of public funds raised through general taxation.

Enthoven's model was based on three insights - that quality and economy go hand in hand; that improving these will be controversial, therefore powerful incentives would be required; and that management and organisational change should encourage the prime motivation of most NHS staff, which is patient welfare. He also identified a number of pre-conditions, which he felt would be important for the system to be feasible - for

example, that general practitioners should only be able to refer to hospitals where health authorities had contracts, consultants should be contracted on local terms and conditions, and an adequate management information system would need to be in place to drive the market. Enthoven's views had a considerable influence on the outcome of the NHS Review, reinforcing work being undertaken by a group of health economists working in the UK (mainly within the University of York), and his influence was clearly visible in the White Paper which finally emerged. However, neither his influential monograph, nor the White Paper, fully addressed the detailed operation of the market that was to be introduced, nor the pace at which it was to be implemented, though Enthoven (1985) had argued that "the nature of politics, medicine and British culture make it overwhelmingly likely that whatever change does take place will be incremental." Some time later, he sounded a further note of caution, suggesting that successful implementation of such a model was by no means guaranteed, and recommending that government, politicians and the public should concentrate on broader strategic aims, rather than the operational details. (Enthoven 1991)

When *Working for Patients* (Secretaries of State, 1989) was finally published in January 1989, it included a programme of reform which is described in the document as "formidable." It also contained two major changes which had not been considered by Enthoven. One of these was the establishment of 'self-governing hospitals' or NHS Trusts. The other was the introduction of practice budgets for some general practitioners (soon to become known as GP Fundholders), to enable a limited range of elective procedures to be purchased directly by the primary care sector. Both of these changes will be discussed later. What is more important in terms of understanding the research context, I believe, is that most of these accounts of the background to the NHS reforms, whilst recognising the rich mixture of influences on the policy process at the time, fail to analyse the changing power dynamics within which these various influences are set. To do this, more theoretical insights are required.

2.2.2 Analytic frameworks

Rudolf Klein (1995) argues that there are a number of different ways of telling the story of how and why the internal market came about, and goes on to identify at least six. The first, he refers to as the "Cleopatra's nose" version. In this, the combination of Margaret Thatcher's short temper and the severe barrage of criticism focussed on the NHS reached a critical mass, provoking her decision to announce a review. Next, he suggests, there is the economic determinism version. This basically argues that the difficulty of reconciling escalating demands and escalating costs within the NHS with the economic need to reduce public spending (in order to fulfill the election pledge to reduce taxation) made the need to find alternative sources of funding appear to be the only possible solution to the perceived crisis in the NHS. Then there is what Klein calls the "ideological 'outing' version". In this scenario, he argues, the Government of the day finally felt sufficiently secure electorally to pursue their ideological commitment to free market provision of welfare services, up to and including the NHS. Two further explanatory frameworks cited by Klein (1995) include the 'policy-learning' and 'policy soup' versions. In the first of these, he suggests that the Government had learnt, by its experience in other sectors, how to overcome what had previously been thought to be insurmountable obstacles to change. An alternative to this was simply that the range of ideas available to government allowed it to chose from a wider "policy menu" than had been available when it first came into office. Finally, Klein argues, there was the "predestination version", which locates change within the NHS in the context of changes in theory and practice that were occurring in large organisations everywhere, largely as a result of changes in information technology. When taken together, Klein argues, these explanations combine to enhance our understanding of the policy-making process. (Klein, 1995).

This sense of multiple narratives and competing (or complementary) explanations has, however, both strengths and weaknesses. For example, it now seems obvious that the political and economic background to the NHS reforms of the late 1980s are tightly interwoven, and together set the context in which the organisational and management changes within the NHS following the purchaser/provider separation need to be analysed.

To argue that a single influence (such as the economy, or a political ideology) could determine the outcome of events would be regarded by most observers as an over-simplification. Whilst many of the analytic frameworks within which policy analysts worked in the recent past were essentially reductionist in their approach, recent developments in policy analysis tend to be much more eclectic, borrowing freely from different social science disciplines (such as economics, sociology and political science) in order to "create an over-arching framework for analysis that takes the kernel from each theory and uses it to develop an understanding of the complex world of health policy." (Walt, 1994) In this sense, it is argued that taking multiple versions of events, and subjecting them to an eclectic range of analytical frameworks, can increase our understanding of events.

However, on closer investigation, even Klein's multiple explanations have a number of potential shortcomings. Firstly, they are often underpinned by what is often describes as a 'top-down' model of policy-making, which has been challenged elsewhere in the policy literature. "In a top-down view of health policy, governments propose (or enact) and managers, in their capacity as agents of the centre, dispose (or react)" (Harrison et al. 1992, p. 106) This is a common approach. Indeed, as Allsop (1994) has pointed out, "the term 'health policy' has mainly been limited to the policies of governments." Nevertheless, many policy theorists, including Harrison and colleagues (1992) would now challenge this - even going as far as to suggest that it is "naive and simplistic":

> "A limitation - one of many - of an orthodox 'top down' view of policy formation and implementation is its inability to appreciate or even comprehend the power of those on the periphery to shape policy and its implementation." (Harrison et al, 1992. P. 98)

Top down approaches to policy analysis, it is argued, fail to address the iterative relationship between policy-making and policy implementation. This alternative view, articulated by Allsop (1994) suggests that "policy, far from being encapsulated in statements of intent, is the consequence of the actions taken in the process of

implementation." Implementation can, in effect, translate policy into something quite different from that which was intended by the policy-makers.

Secondly, these 'top-down' approaches fail to analyse the power relationships that exist within policy communities. Policy communities can be defined as "networks of individuals from various institutions, disciplines, or professions" that "provide a number of different fora in which the early stages of opinion formation and consensus building amongst experts takes place" (Walt, 1994, p.110) Within the arena of health policy, the policy community might include health care professionals, managers, academic researchers, journalists, and many others - but these are by no means always in agreement with each other, and will have different sources of power and spheres of influence. This adds a further level of complexity, as the power dynamics within the community, and the way these impact upon both the development and the implementation of policy, also need to be taken into account in policy analysis.

Finally, the conceptualisation of power within the policy process is itself frequently problematic. Whilst many accounts of the NHS reforms document the way in which a 'new right' Government developed and implemented, (in what appears to have been a very autocratic way) a set of policies aimed at introducing market liberalism into a core institution of the welfare state, they are nevertheless largely descriptive accounts. There is little analysis or critique of the policy-making process during this period from a more theoretical perspective. There is simply a sense in which new political ideologies and a diverse range of radical critiques came together with economic necessity reinforced by pressure from doctors, nurses, the media, and the general public, and resulted in a major change in health policy. Yet a closer analysis reveals that these accounts are in fact underpinned by broadly pluralist assumptions about the policy-making process, assumptions in which "power is a shifting attribute, which depends on the current combinations and coalitions of interests" (Barker, 1996, p. 81) The adequacy of pluralist assumptions about the distribution of power in the health policy process will be examined in more detail in Chapter 8. Meanwhile, I look briefly at one particular interest group, and its response to the proposed policy changes resulting from the NHS review.

2.2.3 Opposition to *Working for Patients*

There was considerable opposition to the reforms proposed in the White Paper, from politicians, health professionals and the general public. Its publication

> "...sparked off a battle of propaganda a counter-propaganda that was remarkable for its scale and cost, for the furious intensity and acrimony of its conduct, and for the levels of personal vilification to which it sometimes descended." (Butler, 1992, -. 58)

The BMA ran a particularly powerful advertising campaign, that more than matched the Government's own expenditure on publicity, and included a series of posters on roadside hoardings across the country, full page advertisements in the national press, and 11 million leaflets which were distributed through GP surgeries. (Klein, 1995)

> "Nothing like it had been seen in the NHS policy arena since the opposition provoked by Nye Bevan 40-odd years before. Nor was the degree of conflict the only similarity. In both cases, the degree of hostility appears - in retrospect, at least - disproportionate to the cause." (Klein, 1995, p.193)

In addition to their high-profile media campaign, the BMA also lobbied its membership. In April 1989, four months after publication of *Working for Patients* (Secretaries of State, 1989), and two months after eight of the working papers which outlined various aspects of the reforms in some detail had become available, it produced its own written response. A message from the Chairman of BMA Council displayed on the cover of this document reads:

> "I urge you to read this report, and, if possible, to attend the meeting of your BMA division which will be considering it. There you can influence the policy decisions which are to be made at the Special Representative Meeting which in

> turn could well influence the future of the NHS. The Council will ensure that the Representative Body's decisions are forwarded to the Government, and that the public are told of them." (BMA 1989)

Throughout the report, the BMA argues for the need for greater consultation with those working within the NHS, for the piloting of specific aspects of the reforms, and for appropriate evaluation of such pilots. In the report's recommendations, the Association states that it is convinced that many of the proposals outlined in WFP and its associated working papers " would cause serious damage to the NHS by leading to fragmentation and destruction of the comprehensive nature" of the health service, and concludes:

> "That having regard to the determination of the Secretary of State to introduce the proposals contained in the white paper without adequate time for consultation and without any pilot studies or evaluation, the Association will continue to devote resources to inform the public and Members of Parliament of the damage which will be done to the National Health Service and of the consequences for patients." (BMA, 1989, p.19)

Yet by this time, the Government had already announced its intention to complete, by May 1989, discussion on those aspects of the White Paper which would required primary legislation. It is therefore difficult to see how discussion of this document by BMA membership divisions could ever have hoped to influence policy-making at this late stage in the process. The policy had already been made, and the timescale for implementation had been set. Yet opposition continued unabated up to and beyond April 1991, the day the internal market was due to 'go live', and much of this opposition was clearly orchestrated by the BMA, even though it had begun to realise as early as January 1990, that, "while the propaganda battle was being won, the war itself was being lost." (Butler, 1992, p. 63)

This begs a number of questions. Why, for example, was the medical profession's opposition to the changes so strong? Why did it take place in such a public way? And

why was it so persistent? Surely, by this stage in the policy process, the best the profession could have hoped to have achieved was an opportunity to influence the implementation process in some way - perhaps by delaying the pace of change, or by making minor modifications locally, or to the operational details. Furthermore, it had been the medical profession, in the shape of the Presidents of the Royal Colleges, who had been a major voice in demanding the review. (Klein, 1995)

Clearly, there were concerns about the specific recommendations within the White Paper itself. The BMA response (see above) had dealt with each of the recommendations in turn, and found most of them wanting. In fairness, their response did welcome the proposed extension of medical audit, subject, of course, to "substantial additional resources both of medical time and money" (BMA, 1989, p. 5) but it was clearly deeply critical of the proposed internal market. Butler argues that "the anger and bitterness of the doctors...can be understood in part as a natural response to the perception of threat" (Butler, 1992) - implying that implementation of the White Paper could be expected to profoundly affect the circumstances in which health care professionals worked. Whether this perception of threat was an accurate assessment of the likely changes the White Paper was expected to bring about, was not discussed. But was this perceived threat sufficient to account for the strength of the professional opposition?

Butler himself appears to have thought not, as he suggests that, in addition to opposing what the White Paper included, there were strong grounds for opposition on the basis of what it left out. The main omission was obviously the failure to address the issue of the perceived under funding of the NHS, which many argued had been the reason for undertaking the review in the first place. Butler also suggests that the "absolute silence" on community care was a source of opposition - but this seems less plausible, as the related White Paper, *Care in the Community*, was published at the same time (its timescale for implementation was considerably longer, as the proposed changes to funding mechanisms came into contact with the thorny issue of local government finance, but that is beyond the scope of this account). Another reason suggested by Butler was the scant attention given in the White Paper to the issue of medical teaching and research.

This was indeed one of the criticisms raised by the BMA; nevertheless, even taking all of these explanations together does not seem to me to be quite adequate to account for the extent and ferocity of the opposition.

Klein (1995) attempts to explain the degree of hostility by looking beneath the surface, and suggest that "the ostensible pretexts for the conflict concealed other motives." Disentangling the reasons for the extreme reaction to the White Paper reforms is complex, he argues, but suggests that many of these reasons extended beyond the NHS, and were informed by a generalised hostility to Mrs Thatcher, "who by 1989 was widely seen as a domineering autocrat intent on imposing her own vision on the world" (Klein, 1995, p. 193). This certainly provides a broader context for the opposition, but even this seems to me to fall into the 'necessary but not sufficient' category of explanation. After all, not long after this barrage of opposition, on the 9th April 1992, the electorate returned a Conservative Government for a fourth term of office. Admittedly, this was with a reduced majority, and Margaret Thatcher had been replaced as Prime Minister by John Major, but nevertheless, implementation of the internal market within the NHS remained central to Government health policy throughout this period. I find it hard, therefore, to believe that disillusionment with the Government *per se* was the whole story. Other factors must surely have contributed to this dissent in some way, and it here that a closer look at the policy process - particularly in relation to the way this changed during the years of the Thatcher government - may offer some illumination.

2.2.4 Theorising the dissent

What appears to need adding into the above explanations, is a discussion of the medical profession's power and influence within the health policy arena - not simply in terms of their ability to 'win the battle but lose the war' over the introduction of the NHS internal market, but in the broader sense of their role as actors in the policy community. Barker (1996) has summarised this neatly, arguing that

> "The monopoly of medical care which the medical profession has tended to enjoy, at least in the Western world, combined with its autonomy, has tended to create a situation in which the medical profession has a great deal to say in relation to health policy." (Barker, 1996, p.89)

As the above description of the BMA campaign illustrates, the medical profession clearly did have a great deal to say in response to *Working for Patients* - but this is not in itself necessarily surprising. What was surprising, as discussed above, was the particular way in which these views were expressed, that is, in a high-profile, public campaign in opposition to the policies of a conservative government. History of the NHS shows that this was unprecedented, as:

> "Although the medical profession had been given to violent outbursts against Labour, as witnessed, for instance, by the events of 1946 or 1975, it had never before confronted a Conservative government with such ferocity, or allied itself with Labour in defence of the Bevanite conception of the health service." (Webster, 1998)

To explore how and why this situation might have come about, we need to look briefly at the origins and deployment of medical power.

Health policy analysts argue that the power of medical profession is rooted in their contract with the State (Klein, 1995), though the form which this contract takes has varied over time. In the 19th Century, the newly-emerging medical profession secured its monopoly professional status in return for a commitment to maintain standards, to control its members, "and in other ways to relieve the state of the burden of regulating the rapidly-growing field of organised medicine," (Harrison et al, 1992, p.17) Medical power, in this analysis, has its origins in the achievement of professional status *per se* and is synonymous with freedom from external control in terms of clinical practice (clinical autonomy). With the introduction of the NHS, Klein argues, there was an "implicit bargain" between the State and the medical profession, in which central government

controlled the overall NHS budget, whilst doctors controlled what happened within that budget - in other words, "the price of preserving clinical autonomy...was accepting the constraints of working within fixed budgetary limits." (Klein, 1995, p. 75) Whilst this has created recurring tensions within the health care system, it has nevertheless ensured a mutual interdependence between government and the medical profession. One of the consequences of this mutual interdependence is that the medical profession has "permeated the decision-making machinery of the NHS at every level and achieved an effective right of veto over the policy agenda." (Klein, 1995, p. 49) It was this 'right of veto' that the medical profession was exercising in opposing the NHS reforms, but this does not explain why it needed to exercise this veto in such a public way. To explore this aspect, we need to examine the location of policy-making a little more closely.

Harrison and colleagues (1992) make a distinction between two main components of medical power, which, they argue, operate at different levels of the policy arena. At a 'macro' level (ie the level of the state), they argue that the medical profession "operates as a highly persuasive and powerful pressure group" (Harrison et al, 1992, p.138). Its power derives from its professional expertise (over which the profession itself has control); its ability to threaten to withdraw its cooperation or even its labour (as it did in the late 1970s); and its social status (the general public and other health care professionals, such as nurses, have historically been more deferential to doctors than to other professional groups). Furthermore, they continue, its various professional associations (such as the BMA and the Royal Colleges), are well resourced and highly organised. As a result, the medical profession, through its representative bodies, "long ago secured the right to be consulted about all manner of proposed changes to the NHS." (Harrison et al, 1992).

This view of the medical profession as a pressure group (or interest group) operating alongside other groups within the health policy arena is a view shared by analysts such as Walt (1994). It is inherently pluralistic in its assumptions, although Walt argues for a notion of 'bounded pluralism'. This notion broadly accepts the pluralist premise that sources of power (such as information, expertise and finance) are distributed "non-

cumulatively" (ie no one group ever controls them all), but "does allow that major economic decisions are made by a small ruling elite." (Walt, 1994, p.97) Walt goes on to argue that health professionals are a particularly interesting sectional group within the health policy process, and that the medical profession in particular "was perceived as having high status by the great majority of government policy-makers". This legitimacy, she contends, was supported by the considerable consensus about the central role of the state in the provision of health care. (Walt, 1994, p. 102)

This is not to suggest that the medical profession can never be defeated. Indeed, some analysts would argue that it is at this 'macro' level that the medical profession is most vulnerable to challenge. One reason for this is that the medical profession is by no means united. As Klein has suggested, "intra-medical politics...would require a study in their own right to them anything like justice." (Klein, 1995, p.22). There are, for example, clear divisions between hospital consultants (who are NHS employees) and general practitioners (who are independent contractors), a division governments have frequently used to their advantage, often driving a wedge between the Royal Colleges and the BMA.

However, by the 1980's, this picture began to change, with challenges to the medical profession's status coming from a number of quarters. (Walt, 1994). Many of these challenges formed part of the background to the 1990 NHS reforms (discussed above). Others were more direct.. One of the most significant, I would argue, was the way in which the Thatcher government engaged in the policy -making process, which has been succinctly summarised by Webster:

> "Whereas all previous administrations had been reluctant to hazard even minor policy alterations without engaging in cumbersome and time-consuming routines involving expert committees and long spells of consultation with professional and NHS interests, the Thatcher team displayed greater self-confidence and faith in its own policy resources. When advice was needed, Mrs Thatcher relied on her levy of official and unofficial advisers; if wider enquiry was needed, this was delegated to some trusted individual or small team" (Webster, 1998, p.163)

This is not to say that the Thatcher government never sought advice from members of the medical profession in relation to health policy issues, but when it did, this was usually from individuals "drawn from the ranks of known political sympathisers." (Webster, 1998, p.164) The BMA and the Royal Colleges were frequently bypassed, and excluded completely from the NHS review.

> "As consensus about the role of the state in health provision has broken down, the medical profession has moved from a privileged position at the centre of health policy-making to a considerably more marginalised position." (Walt, 1994, p.103)

Publication of *Working for Patients* in the form of a White paper, rather than as a consultation document (Green Paper), probably added to the profession's sense of being marginalised from the policy-making process at this time.

Moreover, exclusion from the central policy arena was not the only challenge to professional power that was happening at this time. Medical power does not only operate at the 'macro' level. Indeed, Harrison and colleagues (1992) argue that it is at the 'micro' level, where the medical profession controls the admission and discharge of patients, diagnoses disease, and makes decisions about treatment and care, that their power is particularly hard to challenge. Medical decision-making is complex and difficult, and requires the specialist knowledge, skills and experience which only doctors have. Yet even this appeared to be under threat throughout the mid-late 1980s, with the introduction of general management following the Griffiths review. As this is discussed fully in Chapter 3, I will not deal with the impact of the 'new managerialism' here, except to suggest that the exclusion of the profession from the negotiating table nationally, at a time when its power was being challenged locally, must have significantly fuelled the profession's dissent, and would probably have been perceived as a systematic challenge to professional autonomy.

2.3 Implementing the 'internal' market

In spite of the considerable opposition to the 1991 reforms, many of the key proposals were nevertheless implemented on schedule. This achievement should not be underestimated, and has been describes as

> "... a monumental achievement in the face of an unremitting widespread opposition, effecting changes in structures, attitudes and working practices that might have been unimaginable within any timespan, least of all two years". (Butler, 1992, p.103)

Webster (1998) reinforces this view, comparing the 1991 reforms with the previous complete reorganisation in 1974, which had taken more than six years to plan and execute. In contrast, he argues, the "new upheaval was compressed into half that time." (Webster, 1998, p.193).

2.3.1 The pace of change

I think this picture is slightly misleading. Certainly, *Working for Patients* (Secretaries of State, 1989) appears to have achieved the targets it set for itself. The programme for reform laid out in the White paper identified three main phases, beginning in 1989 with the establishment of a new NHS Policy Board and reconstitution of the Management Board as a Management Executive, and culminating in the establishment of the first NHS Trusts and Fundholding GP practices in 1991. On 1 April, 1991, the date the 'internal market' was introduced across the whole NHS, all 190 English District Health Authorities became purchasers. On the provider side of the market, 57 NHS Trusts were approved, with a further 95 gaining Trust status during the 'second wave' the following year. However, this was really only the beginning of a process that took a further four years to complete. Beneath the surface, the changes were neither as sudden nor as dramatic as the rhetoric had led people to believe.

Indeed, the actual pace of change led some analysts to argue at the time that the process of change was being deliberately slowed, and that the market was in fact being implemented on a 'gradualist' basis, to avoid political embarrassment. (Ham, 1991) A number of Trusts were known to be in financial difficulties, and therefore particularly vulnerable to the effects of 'market forces.' This was especially relevant in London, where the major teaching hospitals relied heavily on patients being referred from the suburbs and other parts of the country for treatment. Yet the move towards weighted capitation was an incentive for purchasers outside the capital to support cheaper, local services. This was potentially destabilising at a time when the government would have been most anxious to demonstrate the success of its reforms, and to minimise the possibility of politically sensitive adverse consequences, in the run up to a general election. Within the South Thames Region, only one hospital gained Trust status during the first wave of applications. This was a London teaching hospital, initially seen as one of the 'flagships' of the reforms, expected to demonstrate the benefits of self-governing status and to encourage others to follow suit. This ran into substantial financial difficulties the following year, and had to be rescued by the Regional Health Authority.

There was still also widespread resistance to the reforms, especially within the medical and allied professions, and the importance of this influence on the pace of change must not be underestimated. Whilst the high-profile BMA campaign was eventually abandoned, there was a consultation process established for hospitals aspiring to self-governing status. During these consultations, many members of the medical and nursing professions voted against their own hospitals becoming NHS Trusts, although this did not always seem to make much difference to the outcome of any consultation process, except, perhaps, by delaying the inevitable. Furthermore, there was ongoing opposition to the establishment of Trusts by the general public, who were concerned that this was a preliminary step in the process of privatising the NHS - a view always denied by government, but frequently fuelled by the medical profession.

Many NHS managers were also beginning to argue that the reforms could not be implemented as quickly on the ground as the government would have liked. Information

systems designed to support contracting were still at an early stage of development, with the result that contracts for 1991/2 were generally block contracts with existing providers, based on levels of activity from the previous year. This stage of the introduction of the market became known as 'steady state', and increasingly, there were calls for the restrictions to be lifted in subsequent years.

2.3.2 Managing the market

Debates about the pace of change soon fed into discussion about the type of market that was being introduced. Was it, in fact, intended to be a 'free market' in the sense the right wing of the Conservative Party appeared to anticipate, or was it to be a more 'managed' market (or even, to use Enthoven's term, 'market socialism') in which major changes would be discouraged as being too politically sensitive? Terms such as 'quasi-market' and 'managed market' abounded, as the tension between the need to encourage competition between providers in order to drive down costs and increase efficiency, and recognition of the need to maintain a coherent pattern of service delivery became more apparent. As time went on, commentators increasingly began to discuss the role of markets in the delivery of welfare services, and for some time I began to explore market theory as a possible framework in which to locate my research. The taxonomy of markets, however, soon proved too narrow a focus for analysis of the research findings (see Chapter 8, section 3 for further discussion), though many of the main concepts within market theory, and their applicability to the NHS internal market (however defined) clearly need further elucidation before I could proceed. Debates about the meaning of 'commissioning' and 'purchasing' were especially salient, as was discussion around the 'customer' and 'consumer'. It is these terms that I will examine next.

2.4 The role of commissioning in the internal market

Donald Light, offering advice from the American experience of purchasing managed health care, recently argued that "commissioning is a fudge word that obscures accountability, and lack of accountability is a serious problem in the NHS." (Light, 1998,

p.5) He suggests that when the term was first coined in the early 1990s, it "...captured the essence of 'needs-based purchasing', the challenge still with us today to think through what configurations of health services will best meet the needs of the people served." (Light, 1998, p.6)

However, by the mid-1990s, the term had become fuzzy, and was being used instead to denote an advisory role, as in the notion of 'GP commissioning.' Light goes on to suggest that this is as a result of 'political correctness,' claiming that when he returned to the UK in 1997, "everyone had fallen into the line with the mythical Minister of Acceptable Language by dropping the p_ word and replacing it with 'commissioning'" (Light, 1998, p.5). However, my recollection is that the term 'purchasing' was being replaced by 'commissioning' much earlier than Light suggests. Certainly, at the time my own research began in South Thames, this was the term in general use by people working in health authorities in this part of the country. Furthermore, I do not think this was wholly the result of 'political correctness.' The meaning of 'commissioning', as understood by the key players within the South Thames Commissioning Forum (the Chief Executives and Directors of Public Health), is explored as part of the qualitative first phase of the research (see Chapter 6). For the remainder of this chapter, however, I will explore the development of the purchasing and commissioning roles as the internal market became established between 1991 and 1994, and attempt to tease out the various ways the different terms were being used.

2.4.1 What is purchasing?

Early definitions of the new purchasing role of health authorities were difficult to come by. The White paper gave a brief outline of the way the system would work, differentiating between 'core' services (such as accident and emergency); specialist services (Regional and supra-Regional services); and those services which "Districts will be able to buy in a more flexible way." (Secretaries of State, 1989) It contained a brief discussion of the ways in which NHS Trusts would receive their income through contracting with health authorities to provide services for their residents, and a

description of the proposed changes to the way in which Regional and District Health Authorities would receive their funding. (The move from allocating funds on the basis of the formula worked out by the Resource Allocation Working Party, to a system of weighted capitation.)

The working paper *Developing Districts* (Department of Health, 1990) was a little more forthcoming, referring to the new role of health authorities as "champions of the people" (a favourite phrase of the Secretary of State for Health, Kenneth Clark, in his many speeches during this period), describing the new tasks these organisations would need to undertake, and offering guidance on the skills and expertise needed to support this new role. There was around this time a strong emphasis, at least, as far as the rhetoric of purchasing was concerned, on the potential to shift the NHS from a provider-driven to a needs-based service, as well as to increase provider efficiency through the introduction of competition. As Brian Salter argued,

> "It is a deceptively simple model. It has the radical agenda of changing the NHS from a provider-driven to a purchaser-led system, and freeing it from the shackles of professional interest. No longer will money be passively allocated in response to further increases in the historical pattern of service delivery. Instead, purchasers will consciously use a range of new, non-medical skills to structure the supply of health care so that it fits the identified needs of the population." (Salter, 1993, p.174)

However, as Salter reminds us, the rationale for introducing the internal market was not only to increase provider efficiency by introducing competition, but to also to manage demand. The increase in public expectations of the NHS, it was argued, had constantly outstripped increases in the resources which successive governments had made available. As a consequence, rationing (in the form of waiting lists, and clinical prioritisation) were inevitable, unless demand could be self-regulated in some other way. In the thinking of the 'new right,' the argument ran,

> "If money and power were devolved to the consumer and competition introduced between providers, consumers would limit or increase the demand they placed upon the Health Service in the light of the price of the available supply. Self-regulation would become a reality, and render the traditional rationing mechanism obsolete." (Salter, 1993, p.174)

However, this notion of self-regulation of demand by patients was clearly too politically sensitive even for the Thatcher government, so the notion of health authorities (or GP Fundholders) acting as proxies for the consumer, purchasing on their behalf, took its place.

2.4.2 Who is the 'customer'?

In the early days of the internal market, there was a considerable debate about 'the customer' in the new internal market. The political rhetoric of the reforms used the language of consumerism at a number of levels, and with a range of meanings, many of which were not clearly articulated. Moreover, different meanings were frequently conflated. This led to what was sometimes called the 'the dog food dilemma.' Who was the customer in the transaction, the purchaser (who decides what to buy, at what price), or the consumer (who uses the service)? In some settings, the customer was conceptualised as the public, who, in their role as tax-payers, financed the provision of services (and presumably voted for, or against the government depending on how they felt about the levels of taxation in relation to the levels of health care provided). In this sense, purchasers (whether health authorities or GP Fundholders) were seen as acting on behalf of the public. This led to debates about the role of public accountability (or lack of this) in purchasing. A whole set of questions arose about the extent to which the public should be involved in purchasing decisions, from discussions around the most appropriate methodology for involving the public in health needs assessment , to public involvement in the setting of priorities, or rationing, of service provision.(cf the debates about rationing and prioritisation, Oregon etc.)

At another level, however, the customer was seen as the consumer of health care, the patient in receipt of treatment or care. At this level, there were issues about 'consumer choice' in the market-place. As Klein has noted, this concept of consumer choice within the NHS has always been limited:

> "In contrast to many other health care systems, the NHS has never offered consumers a menu of entitlements. It has from the start excluded some types of treatment...that are offered by health care systems in other countries. The consumer's only right is to have access to the health care system: once that has been achieved, it is for the professional providers to determine what treatment is appropriate." (Klein, 1995, p. 232)

In this sense, 'consumerism' was seen, not so much as a challenge to normative definitions of need (see the literature on health needs assessment, especially Bradshaw's taxonomy), or even as a lay challenge to clinical autonomy (quite a radical potential implication of such an approach), but rather as an active shopper, looking around for best buys and bargains among competing providers of health care. It is this notion that Pollitt (1990) challenged, arguing that the NHS market was operating with a peculiarly "stunted notion of the consumer" who, in many of the official documents of the time, "sounds rather like the abstract figure of elementary economics texts." This notion took no account of reality:

> "Unfortunately, this individual has never been seen outside the pages of such books. In the real world, many health care consumers are already disadvantaged by reason of race, gender, disability or some combination of these." (Pollitt 1990)

Even where patients were not socially or economically disadvantaged, the very fact that they needed health services was in itself sufficient to reduce their power as consumers. As Fedelma Winkler pointed out, "the consumer is not always articulate, well-informed, competent to make choices, but often frightened and in pain." (Winkler, 1993)

Again, these debates around the customer fuelled a parallel set of debates about the type of market that was being developed. It soon became clear that the 'internal market' in the NHS was not a 'simple' market, as customers (whether defined as the public who financed the services, or the patients who were the recipients - or even some combination of both, as the recognition that taxpayers and patients were often the same people in different guises!), did not purchaser their services directly. Health authorities (or GP Fundholders) were, in effect, acting as proxy purchasers, with all the attendant confusion about who they were acting as a proxy for. (This links back to debates about accountability of purchasers, which in theory might have led to the public or patients, or both; but in reality led - via the Corporate Contract between DHAs and RHAs, and RHAs and the NHSE, back up to Ministerial level. Decision-making might have been devolved, but accountability was not.)

2.4.3 Who were the purchasers?

This was also an interesting question, which was repeated at the beginning of my research, when deciding who to include in the category of 'commissioners.' In terms of the NHS internal market, there were always multiple purchasers, although the main players in "the new political game" as Salter describes purchasing, were the District Health Authorities (This was still the case in South Thames at the time of my research, hence the decision by the Steering Group to exclude primary care commissioning.)

The role of these health authorities had been set out prior to the introduction of the internal market, following publication of the Acheson report (1988). The circular in question, HC(88)64, gave health authorities responsibility for reviewing the health of their populations, defining policy aims and setting service objectives, and relating decisions on resource allocation to their impact on health. In addition, they were required to monitor and evaluate progress towards their objectives, and arrange for the surveillance, prevention, treatment and control of communicable diseases. To assist them in these functions, all health authorities were to appoint Directors of Public Health, who were to be supported by a team of staff, with skills in epidemiology and health service

evaluation. In many ways, it seemed an entirely logical step, therefore, for health authorities to take on the roles and responsibilities associated with purchasing - that is, to assess the health needs of their local populations, to evaluate the effectiveness of services, and to purchase services accordingly. What changed following *Working for Patients* was that this needs assessment process was, at least in theory, expected to inform the allocation of resources and the placing of contracts.

GP purchasing, or fundholding as it became known, was rather different. Firstly, it was entirely voluntary, and was initially available only to GPs with a practice population in excess of 11,000 (This was subsequently reduced to 9,000 then to 7,000 before further changes were introduced which allowed three different 'levels' of Fundholding - but this did not take place until after my research had begun.) To begin with, GP Fundholding covered a limited range of elective procedures, though this was also extended in subsequently years, until reaching its zenith in the 'Total Purchasing Pilots' established towards the end of the Conservative government's last term of office). During the first year of the internal market, only 7% of the population were covered by GP Fundholding, which was seen as something of a 'wild card' in purchasing terms, partly because it appears to have been something of a late addition to *Working for Patients,* and partly because it never quite fitted the purchaser-provider divide, as GPs were both purchasers (of secondary care) and providers (of primary care). Nevertheless, Fundholding increased rapidly, both in population coverage (25% by the end of the second year) and scope (from 1993, the range of services covered included community services, district nursing, health visiting and some mental health services.) (Levitt, Wall and Appleby, 1999). There has been some suggestion that Family Health Services Authorities also 'purchased' service, particularly primary care, but this is not an entirely accurate description of their role. Much of their work, at least until their eventual merger with DHAs following EL(94)76, was concerned with contracting for General Medical Services, and all GPs throughout this period remained independent contractors.

2.4.4 Developing purchasing

In their recent review of the research evidence on the impact of the NHS reforms, Le Grand and colleagues (1998) argue that the purchasing role did not attract the same degree of interest by academic researchers as other changes linked to the introduction of the internal market. One explanation for this (apart from the decision by the Secretary of State that there would be no centrally-funded programme of evaluation) suggests that "purchasing by Health Authorities did not really capture the essence of what the reforms meant to most people." It was, she argues, "a remote concept" which seemed "in part at least a 'rebadging' of the previous planning system" (Mulligan, 1998). Certainly, it is a concept which seems to have been inadequately understood at the outset of the NHS reforms, with considerable consequences for its subsequent development. (I speak as someone who joined the NHS during the summer of 1990, with a specific remit to support this new purchasing role within a Health Authority department of public health, and a strong suspicion that my own interest in this research topic is a small attempt, sometime after the event, to redress this imbalance.)

Indeed, it was not really until 1992 that the need to develop the 'demand' side of the market began to move up the policy agenda. By this time, many purchasers were beginning to recognise their limitations. (Ham and Hegginbothom, 1991) Some organisations felt they were too small to form viable purchasing organisations; there was a shortage of people with the necessary skills, and a need to achieve economies of scale. Some health authorities wanted to work with their local FHSAs to improve the interface between primary and secondary care; others were concerned with the need to work jointly with local authority departments on implementing community care legislation. There was also a feeling that the potential for competition between providers would only be realised if health authorities could end their 'cosy relationships' with their local hospital, and at least threaten to shift contracts (the notion of 'contestability' was also beginning to emerge around this time.) A number of organisational changes took place in response to these issues, some more formal than others. Mergers and joint commissioning arrangements became common, and 'locality commissioning' developed as a means of

engaging GPs who had not become fundholders in the commissioning process. (This was the 'fudge' that Light referred to, above.)

However, it was not until 1993 that purchasing achieved the kind of political profile previously reserved for other areas of health policy. During the spring of that year, the Minister for Health, Dr Brian Mawhinney, made a series of speeches outlining a vision for purchasing, a framework for making it happen, and setting some criteria by which its success could be judged. This 'blueprint' gave purchasers a clear purpose, "to force the pace of change", and some goals, "to improve health and health services." It defined purchasing as "the engine that would drive the reforms" and set out "seven stepping stones to successful purchasing." (Mawhinney, 1993) For the first time, there appeared also to be a shift in emphasis from the early days of 'Chinese walls' between purchasers and providers. Instead, purchasers were exhorted to work *with* providers, *including involving clinicians in the contracting process:*

> "The purchaser-provider relationship cannot simply be restricted to formal negotiations - the cat and mouse game of bid and counter-bid...a dialogue needs to be established...in which purchasers and providers jointly work to achieve their objectives." (Mawhinney, 1993)

2.4.5 The language of purchasing

Throughout the early days of the internal market, the language in which the purchasing function was described was somewhat fluid. A number of factors contributed to this. To some extent, this fluidity of language can be explained by the newness of the role, and the emphasis on 'learning by doing'. In this sense, people were not only describing what they were doing in different ways, they were also often doing different things - or at least, approaching the task required of them in different ways. Hence the words they used to describe their role were different. But there was also an ideological component. Language is not neutral, and, as the market developed, a 'softening' of the language became evident. This is not insignificant, as Hunter pointed out:

"the language is ever shifting to reflect the changing nuances of political discourse. There has been a metamorphosis since 1989 from the robust language of business, markets and contracts to the softer, more caring language of health gain, enabling and service agreements...The harsher edge given to the reforms at their birth has been replaced by a more conciliatory, soothing terminology. A new vocabulary is being fashioned, and any analysis of the reforms will need to reflect this if the changes are to be fully captured and understood" (Hunter, in Popay and Williams, 1994)

But the words used to describe the purchasing function were not simply reflections of changing political discourse. They began, over time, to represent different phases in the annual purchasing cycle, and were linked to a growing awareness of the complexity of the task in hand. So whilst at the outset of the process in 1991, purchasers concentrated on describing the services provided by local DMUs and NHS Trusts, and writing descriptions of these services into 'block' contracts, they soon began to think of the purchasing task as much broader than this. Drawing up contracts, agreeing terms, and monitoring performance against a service specification was increasingly seen as only part of their role, and many preferred the term 'commissioning' to 'purchasing' to describe the more complex task of working with GPs and social service departments to develop joint service strategies and joint purchasing plans - though, as one colleague of mine remarked at the time, "when you're doing it, you don't have time to bother with such fine linguistic distinctions."

So although many people used the terms 'purchasing' and 'commissioning' interchangeably, with some preferring the term 'commissioning' because it sounded less market-orientated than 'purchasing', whilst others used it to reflect what they felt was a more strategic, multi-agency approach (as in the term 'joint commissioning agency' for example - where two or three health authorities, with or without their local FHSA or local authority social services department, worked together to discharge their purchasing role), both terms refer to a role that is much broader than contracting. Contracting was the end point in an annual round of strategy development, needs assessment, service evaluation,

prioritisation and so on, which informed the decision-making process in terms of which services to purchase, to what level, and for what price.

2.5 Theoretical context

This research implicitly draws on a number of theoretical frameworks, most of which are located within different disciplines or subdisciplines. This chapter, for example, has drawn on market typologies and concepts derived from economics, and accounts of the policy process drawn from political science. Chapter 3 will include discussion of theories and concepts derived from management studies and the sociology of the professions. In Chapter 8, I will draw on a post-structuralism critique of social science to discuss the theoretical implications of my research findings. As the adoption of such an eclectic approach to theory may seem a little unconventional in a PhD thesis, the rationale for this clearly requires further explanation. However, before beginning this task, two points in particular require further elucidation. The first is the distinction between theoretical and conceptual frameworks, the second is the role of theory in health services research. As I am a sociologist by initial training, I will approach this discussion from a sociological perspective. I will then return to the task of documenting the search for a suitable theoretical framework (or frameworks) within which to locate my research.

2.5.1 Distinction between theoretical and conceptual frameworks

Firstly, I intend here to make a distinction between theoretical and conceptual frameworks. Not all researchers take this approach. Indeed, it is not unusual to find social science research methods books which conflate these two things, particularly when describing action-based approaches located within a phenomenological paradigm and using qualitative methods of data collection. Within such approaches, concepts are more than ideas or meanings. Jary and Jary (1991), for example, state that "Given the absence of tightly articulated explanatory theories in sociology, what is usually referred to as sociological theory is made up of looser articulations of descriptive and explanatory concepts." It is this definition, I would argue, that leads authors of books on qualitative

research design, such Maxwell (1996) to discuss theory and concept as though they were entirely interchangeable terms:

> "The most important thing to understand about your conceptual context is that it is a formulation of what you think is *going on* with the phenomena you are studying - a tentative *theory* of what is happening and why. The function of this theory is to inform the rest of your design...conceptual context *is* a theory, what is sometimes called the *theoretical framework* for the study." (Maxwell, 1996, p. 25)

In this sense, the terms 'theory' and 'concept' are being deployed in much the same way as a research hypothesis. They are considered essential prerequesits to research design, as they will inform the selection of an appropriate research methodology. (See Chapter 4 for further discussion of the issues around research design and method.)

However, an alternative view (and one to which I would more readily subscribe) is that concepts are the building blocks out of which theories are constructed. In this sense, a theory is a set of concepts, hypotheses or propositions which are linked in some way - usually by logical argument. Theoretical frameworks are therefore often more abstract than conceptual frameworks, and offer (or attempt) explanatory accounts of research findings. Theories at this level can, and often do, inform empirical research; but they are just as likely to be drawn on as a means of interpreting research findings. In the latter case, theoretical frameworks can be either derived from empirical data, as in Grounded Theory (Glaser and Strauss, 1967); or existing theories within the discipline in which the research is situated may be drawn upon to provide a framework for making sense of the data collected:

> "A useful high-level theory gives you a framework for making sense of what you see. Particular pieces of data that otherwise might seem unconnected or irrelevant to one another or to your research questions can be related by fitting them into the theory." (Maxwell, 1996, p.33)

In this sense, therefore, whilst concepts from market theory were important in designing my study (I needed, for example, to clarify what my clients and I understood by terms such as 'commissioning' and 'provider clinician' before the research could proceed), a higher-level theory might be necessary to enable me to understand my findings.

2.5.2 The role of theory in health services research

The second point that needs to be made before moving on to discussion of the theoretical frameworks which have informed this research is that not all research is theoretically driven. Researchable questions have diverse origins. Whilst it is normal practice in most academic circles for researchers (particularly those undertaking their doctoral research in the arts and social sciences) to spend a considerable amount of time familiarising themselves with their field of study and the established theoretical frameworks within this prior to identifying their research question and the theories and concepts which will inform their methodology, this is by no means universal. Some scientific research programmes in the UK, for example, employ research assistants who are expected to register for a doctoral degree, but whose specific area of research, the theoretical framework within which this is located, and the methods used for data collection and analysis have been determined for them by the programme director.

> "Research students in such a programme are treated as the most junior level of employee contributing to the overall work, in fact as junior research assistants. The Director of the programme sets very clear constraints on the work that is to be carried out and submitted for the doctorate and the student's contribution is correspondingly restricted in range." (Phillips and Pugh, 1994, p.189)

Much applied health service research, on the other hand, (particularly health policy and management research) is initiated by clients with 'real world' problems. Such clients may have their own theories about not only the source of these problems, but the type of research which will be needed to help them find a solution. The ways in which such

applied research is undertaken may be influenced by a number of factors (some of which are discussed in more detail in Chapter 4), including the way in which the research is commissioned, as well as the disciplinary background of the team or individual undertaking the research. Researchers undertaking applied research work are usually not only experienced in the methodological issues surrounding the research process, but are usually qualified to post-graduate level in their own discipline, and therefore well-informed about the theories which underpin this. Where such researchers are responding to calls for research proposals on specific topic areas of interest to their funders (such as happens under the NHS Research and Development Programme) they may have considerable flexibility in developing their approach. In this case, time spent exploring the literature and thinking through the theoretical frameworks which will inform the research is part of the process of developing the research proposal which will be submitted to the funding body.

However, this is not the only way in which NHS organisations can commission applied research. It is not uncommon for the organisation concerned, especially if it has some skills 'in-house,' to do much of the preliminary work itself. When this happens, a quite tightly - specified invitation to tender will be circulated. This may not only state the questions to be answered, but also the methods to be used to answer them. However, the location of such questions or methods in a particular body of knowledge or theoretical framework is frequently lacking. Moreover, the quality of such tender specifications is variable, depending as it does on the disciplinary knowledge-base and research skills of whoever was responsible for its drafting. In some cases, such tender specifications have been drafted by researchers located in academic departments, on behalf of the NHS. (This practice is common where the Department of Health commissions policy research, for example). In others, these may have been drafted 'in-house' by someone with a background in research. (For example, I recently responded to a tender specification from an NHS Executive Regional Office, for a project which was required by the Regional Director of Public Health. The tender specification had, however, been prepared by the Regional Research and Development Directorate.)

Occasionally, however, research specifications are written by the client themselves. These clients may be individuals or groups of people with limited understanding of the research process, or with a good understanding of research - but not within the discipline or methodology required for the work in question. (Examples of public health physicians familiar with epidemiological research methods drawing up specifications for research evaluations of health strategies and programmes requiring qualitative approaches immediately come to mind here.) Such tenders often prove challenging for those who respond to them. Nevertheless, responding to such tenders, in spite of the difficulties which are sometimes associated with them, may give researchers opportunities to undertake highly topical areas of work, that would be difficult to gain access to in other ways. This was very much the case during the early 1990s, when

> "Solid, long-term social research [was] no longer viewed as attractive or fashionable - if it ever was. Managers and policy-makers wanted] immediate and definitive answers and solutions to urgent problems and [were] not prepared to defer gratification. (Hunter, 1994, p.21)

The managerial need for instant answers led, inevitably, to what Hunter goes on to describe as "the recent conversion to, and seductive appeal of, 'quick fix' contract research and management consultancy." (Hunter, 1994)

Yet applied research, whether on a 'quick fix' or more conventional academic basis, has always posed dilemmas for social researchers. Issues around who sets the research agenda and who defines the research questions are not new. Neither is the tension between "policy-led and theoretically informed policy-relevant work." (Gabe, Calnan and Bury, 1991) The particular dilemmas I encountered in relation to these issues within my own research are discussed more fully in Chapter 4. For the remainder of this chapter, I wish to turn to the issue of theoretical frameworks, with a particular focus on those which had the potential to inform the ways in which I might interpret my research findings.

2.5.3 The search for theory

Health services research, like public health (with which it shares a great deal) is becoming increasingly multi-disciplinary. This has both strengths and weaknesses. As Hunter (1994) has argued, "Most health and health policy issues do not occur as simple economic, psychological, sociological epidemiological or clinical problems, but as a combination of all of these." (Hunter, 1994, p.24) In this sense, the increasing trend for such research to be undertaken in multi-disciplinary departments is to be very much welcomed. Nevertheless, many of these departments are located within medical schools, where there may be considerable risks for some disciplines:

> "Multi- or inter-disciplinary research is not a prospect which is generally welcomed by sociologists. Past experience has taught some of those who have tried it that the maintenance of any specifically sociological perspective is impossible. Genuine dialogue on an equal footing between scientists drawn from different disciplines rarely exists in situations where one occupational group - in this case, the medically qualified practitioner - dominates." (Jeffreys, 1991, p.230)

Nowhere (outside of biomedical research) is this domination more evident than in quest for 'evidence' to support NHS decision-making. The applied health service research agenda is currently heavily influenced by public health medicine and epidemiology - a position that has recently been considerably strengthened by the advent of 'evidence based' medicine (EBM). This movement, with its origins in the work of epidemiologists such as Cochrane (1971), has recently been reintroduced into the UK health care system from the USA by Sackett and colleagues (Sackett et al.1996). But it has extended well beyond the realm of clinical epidemiology. The randomised controlled trial, developed within epidemiology as the most appropriate method for testing the efficacy of new drug treatments, is now seen by the NHS research and development programme as the 'gold standard' for the evaluation of all health care interventions - whether medical or surgical; preventative, diagnostic or therapeutic. Furthermore, is frequently seen as the preferred

approach to research into health policy and management issues. (Gray, 1997). It is against this background that my study was set, working as I do in a department of public health medicine, where positivist approaches to social science are seen as the norm, and phenomenology has the status of metaphysics.

Nevertheless, in spite of considerable reservations, Jeffreys herself makes a case for pragmatism. She not only argues that sociologists interested in pursuing policy-relevant research should not regard working in such a multidisciplinary environment as a "betrayal," but goes on to insist that such researchers do not deserve "the calumny which may be heaped upon... [them] from those purist defenders of the sociological faith who deplore any tinge of eclecticism." (Jeffreys, 1991, p.230) Instead, she believes that sociologists should accept the situation they are faced with, and "use their energies in trying to ensure that their own contribution makes a significant impact on the research undertaken, even if it cannot permeate it to any great extent." There may also be advantages for sociology as a discipline from working in such settings, she continues, as these are "by no means devoid of contributions to sociological theory as well as illustrating its use to applied issues." (Jeffreys, 1991, p.230)

For a number of reasons, therefore, much applied health services research can initially appear, at least to social scientists such as myself from a theoretical background in sociology, as something of a 'theory-free zone' - making it difficult to ensure that research, especially that undertaken for clients who also take a pragmatic and empirical approach, is underpinned by sound theoretical assumptions and frameworks. The positivist paradigm which lies at the heart of epidemiology may shed light on the distribution of disease in populations, but it has little to say on the distribution of power between professional groups, and offers no means of studying the way this power is deployed within the policy process (two areas which, although not the immediate focus of my research, were to become of increasing interest to me as the South Thames project progressed). However, positivism can answer some research questions very well - the problem only arises when it is applied to questions beyond its methodological capacity. It does, after all, have a long tradition in sociology, including medical sociology, even

though it has come in and out of favour over time. For all its limitations, it is still after all (to take a key area of current policy) the most appropriate paradigm within which to measure inequalities in health status at a population level.

In the absence of readily-identifiable, appropriate sociological theory to inform empirical work, therefore, it becomes all too easy for those undertaking small pieces of commissioned research for NHS clients to fall prey to the criticism that they are simply engaging in some form of 'barefoot empiricism.' My clients, for example, had expressed no interest in theoretical insights, from any academic discipline, least of all from sociology. Though it is at least possible that one of the Chief Executives on the Steering Group might have been interested in insights derived from economic or management theory, the Directors of Public Health involved simply saw my research as a descriptive 'observation' study. The steering group wanted to collect 'facts' - and to find out about some 'feelings.' They had defined their research questions, and chosen their method of enquiry. Much of this was non-negotiable - although changes were made to the research design as the project progressed. (See Chapter 4 for discussion of the philosophical and methodological implications of this.)

Nevertheless, it is worth remembering at this point that the absence of an explicit theory does not mean that there was no theoretical underpinning to the research, and no conceptual framework to the research process. Empiricism, is, after all, itself a theoretical position, and whilst the term is used pejoratively in some circles, it has respectability in others. Moreover, it was a theoretical tradition which most members of The South Thames Commissioning Network would have been exposed to as they undertook their training in epidemiology, economics and management. The fact that the chair of the steering group (an economist by background) had his own hypothesis that he wished to test (see Chapter 4) suggests that he was working, consciously or unconsciously, within a positivist framework - probably influenced, albeit unconsciously, by philosophers of science such as Karl Popper. Furthermore, early discussion which had taken place between the steering group and my own department had been led by a public health physician and a statistician, who are likely to have taken a similar perspective. The notion

that it was possible to test a hypothesis through the administration of a large-scale survey, and that this approach was the most appropriate way of undertaking the research, is perhaps hardly surprising in these circumstances.

My immediate contribution to the empirical study was to make changes at the margins - by asking for the addition of a phenomenological phase to the fieldwork in the form of qualitative interviews with the Chief Executives and Directors of Public Health in the health authorities (see Chapter 4). In addition, I undertook some preliminary exploratory interviews with key informants in the Regional Health Authority and the Trust outpost; kept extensive field notes of meetings and telephone calls with individual members of the steering group as well as meetings of the whole group; made further field notes following interviews and throughout the duration of the survey, and recorded detailed observations and reflections in my research diary.

I then further extended my analysis to include a wider review of published and unpublished documentary evidence, mostly in the form of papers produced by national or local sources on the issue of professional advice to purchasers, or involving clinicians in the commissioning process (see Chapter 3 for more details of this review.) I also took an active part in all the meetings of the project steering group, and made presentations to the main commissioning development network. I was, therefore, not simply the project manager and sole researcher undertaking a commissioned empirical study, but was effectively a participant observer in the wider research process - attempting to gain a deeper understanding of the policy process within which the commissioned research was embedded.

This process, of course, has much more in common with more interpretive sociological frameworks, which draw on phenomenology to reach an understanding of events, than it does with positivist approaches towards observation and classification of the phenomena under scrutiny. It was this methodological extension, therefore, that I felt enabled me to take Jeffrey's advice, and to do my utmost to ensure that my own contribution had the potential for making an impact on the research, even if it could not

permeate it (see above). Furthermore, it was this additional work that eventually enabled me to move from the analysis *for* policy (ie data collection to inform local action) to analysis *of* policy - in the sense of undertaking an academic study of the policy process itself, and in the sense of moving from description of what was happening in South Thames to an analysis of why this was happening. (Changes to the research design, and the rationale for these changes, are discussed extensively in Chapter 4.)

2.5.4 Theorising the policy process

The search for theory in terms of the empirical work, where positivism was the taken-for-granted research paradigm and market theory the only higher-level framework which appeared to offer any immediate insights to inform the research process, was however, in sharp contrast to the search for theory in terms of the policy process in which the South Thames study was embedded. Theoretical frameworks for policy analysis (as opposed to descriptions of specific events within the policy process) are predominantly derived from social and political theory, thereby drawing on vast bodies of work, developed over many years, to theorise roles and relationships within and between the state and civil society. Depending on the orientation of the author and the particular aspect of the policy process under discussion, most texts on the policy process therefore provide brief summaries of the social and political theories from which their analytic frameworks are derived, as well as applying these theories to the material under discussion.

Authors such as Ham and Hill (1993), for example, include discussion of pluralism, Marxism, elite theory and corporatist theory in their analyse of the role of the state in the policy process, whilst turning to Weber's theory of bureaucracy to analyse the role of organisations and institutions within this process. Moving on from earlier rational and incremental models of the policy process, they develop a critique of so-called 'top-down' models of policy implementation, though remaining within a broadly structuralist framework. All of these theories have been derived from social and political theory. Weber's work on bureacracy, for example, is part of a an extensive body of theory which still underpins modern sociology - Weber was, after all, one of the 'founding fathers' of

the discipline. Marx and his followers, on the other hand, have always spanned social, political and economic theory. Marx's own writings, initially influenced by 19th century German philosophy, French political theory and English economics, became enormously influential across the social and political sciences throughout the 1960s and 1970s - though they tended to decline in favour somewhat during the 1980s and 1990s, as the 'zeitgeist' changed.

Ham and Hill's work (1993) has clearly had an important influence on policy analysis, and is frequently cited by other authors such as Walt (1994), Allsop (1995), Barker (1996) and Ranade (1997). These writers draw on a similar body of work to Ham and Hill, often extending the range to include discussion of social-democratic processes and the Fabian model of welfare, before moving into coverage of recent perspectives which have been more critical of this consensus around the welfare state, such as the 'new right' (derived from the free-market economics) or feminist theory (which has argued that social policy reinforces existing gender relations). Discussion of pluralism is much in evidence throughout, usually followed by critiques of pluralism drawn from elite and conflict theories. However, although these critiques of pluralism have resulted in its modification (into what some recent writers have begun to describe as 'neo-pluralism' or 'bounded pluralism'), Barker reminds us that, despite these critiques, "the pluralist approach is central to the policy literature of the Western World." (1996, p. 81) This centrality of pluralism is, I would argue, not simply a result of its explanatory value. Theories of the policy process cannot be entirely separated from the political ideologies in which they are located. Barker's observation that "Pluralist theory might be traced back to liberal theories of democracy based on the importance of widespread political participation on the behalf of individuals." (Barker, 1996, p. 81) is not only of historical interest. At the time of my research, pluralism, albeit in modified form, was clearly a resurgent theme in the policy literature.

One of the strengths of both Walt (1994) and Barker (1996), however, is that they highlight the importance of analysing the policy *process*, and the need to develop our understanding of the dynamics that make this process work. It is here that an analysis of

power becomes central to the debate. This theme of policy as process is taken up by Curtiss and Tacket (1996), who argue that, although it is conceptually possible to distinguish between the various stages, "beginning with policy initiation, moving through formulation and development, adoption, operationalisation, implementation, and finally review, evaluation, and monitoring of policy, which may then feed back into policy formulation" this process, "should not be regarded as a simple, linear, temporal progression or even as an iterative cyclical one." (Curtis and Tacket, 1996, p.200) Indeed, these different stages may be " intertwined, predetermined or omitted, may only be provisional, may be without causal links to each other, and may be only selectively or partially linked to policy outcomes." (Curtis and Tacket, 1996, p 201) Policy analysis within this framework is therefore a much more 'messy' process, and may require analysis at different levels. Furthermore, this approach recognises the complexity of 'policy communities' (ie the wide range of groups involved in policy making and implementation) and the need develop an understanding of the power dynamics within and between these.

It was this approach to the policy process, therefore, that began to influence my research as I moved from the initial empirical work for the South Thames Commissioning Forum to the wider academic study which was to become my PhD submission. Walt's work (1994) in particular, provided a number of key insights, and enabled me to explore the concepts of policy levels and policy communities referred to elsewhere in this chapter, and reminded me of the centrality of power as a 'policy driver.' However, this did not immediately solve the dilemmas I was experiencing in terms of the search for a theoretical framework. In their attempts to theorise the power dynamics within the policy process, policy analysts such as Walt (1994) and Barker (1996) simply revisit the ongoing debate within political science between pluralist and structuralist approaches, sometimes making marginal changes in one to accommodate the critique offered by the other, but otherwise offering no apparent way of deciding which has the greater explanatory capacity, beyond personal (or political) preference.

More recent theoretical developments within the social sciences, particularly post-structuralism, barely receive a mention. Where they do appear, they are dealt with in a highly simplistic way - Barker (1996) for example, refers very briefly to what she describes as "a useful typology of power" derived from Foucault's work, which she summarises in three lines, whereas Allsop (1995) and Ranade (1997) mention Foucault only in relation to his influence on the history of medicine.

Overall, there is a sense in which theoretical development of policy analysis has itself proceeded slowly and incrementally, evolving through a process of theory and counter-theory. However, as new theories (or minor modifications of existing theories) have developed, former theories have not been discarded. Indeed, each appears to have retained partial explanatory value, as well as its own academic following. Even those analysts who endeavour to remain even-handed (or cannot decide which side of the ideological fence they prefer) would recoil from attempting to synthesise these contradictory positions, though a few argue (with some justification) that different theoretical perspectives may be particularly suited to different levels of analysis. Whether this disciplinary and theoretical eclecticism, however, can ever achieve Walt's aim to "create an overarching framework for analysis that takes a kernel from each theory" (Walt 1994, p.3) and whether such a framework would enable us to gain a more comprehensive understanding of the dynamics of the policy process, remains to be seen.

CHAPTER 3 LITERATURE REVIEW

3.1 Purpose of the review

This chapter examines the published literature and other documentary sources that informed the research undertaken for the South East Thames Commissioning Network during 1994 - 1995. The initial project brief included a requirement to search the literature for examples of good practice in relation to the involvement of clinicians in commissioning or contracting. In addition, there was a need to identify any work that might inform the research process by, for example, illuminating the research questions, suggesting possible hypotheses or informing the development of research instruments, such as interview schedules and questionnaires. Finally, there was a need to locate the research within a theoretical framework which might assist in the analysis and interpretation of the reserach findings.

A number of inter-connected bodies of work are therefore explored in this chapter. The first of these is the subject of the empirical research for the South Thames Commissioning Network - that is, the issue of clinical involvement in commissioning and contracting. Following this, related literature on clinicians and managers will be examined, with a particular emphasis on questions around the changing relationships between these two groups. This will lead into a discussion of clinicians as managers, and the role of the clinical directorate. Finally, this chapter will assess the changes which were taking place in the formal mechanisms for obtaining professional advice within the NHS at the time of the research. Taken together, these topics provide the immediate context in which the research is located, and make it possible to deconstruct some of the major concepts, definitions and assumptions which underpin it.

3.1.1 Search Strategies

The literature search began in August 1994, in response to the initial project brief. Preliminary searches were undertaken (both on-line and on CD-Rom) on a number of

databases, including Medline, Health, the South Thames Regional Library database, the DHSS data base and Helmis, using key words and MESH headings related to medical/clinical involvement in contracting, purchasing and commissioning. As this initial search revealed very little of immediate relevance to the research questions, the justification for undertaking original research in this area was reinforced. Further searches were then undertaken to explore the clinical role in management, in the hope that this related body of work might lead into discussion of clinical involvement in commissioning or contracting. A considerable body of work was identified on clinical involvement in general management, models of clinical management, and the development of clinical directorates within Trusts. As this work is relevant to some of the questions the project steering group wished to address, and helped clarify a number of issues raised in discussions around the research design (see Chapter 4), this literature will be examined in some detail.

As the research progressed, the connection between involving local clinicians in commissioning, and the wider issue of medical advice within the NHS became relevant to the research. This occurred particularly in relation to the tension experienced by commissioning authority staff between local and non-local sources of professional advice (see Chapter 6). The need to address this issue in the research subsequently led into exploration of the literature on the changing role of the Regional Medical Advisory Committee (RMAC) and its complex structure of specialty sub-committees (SSCs).

The literature search was not, however, confined to published sources which could be retrieved electronically. Additional hand searching was also undertaken, and attempts were made to identify and retrieve any 'grey' literature (ie internal NHS reports, drafts of documents that had not yet been published, and other unpublished sources) which might be available on the research topic. This was achieved through informal networks - including the NHSE, the RHA, the Regional Trust 'outpost,' colleagues working within NHS commissioning and provider organisations, and telephone contact with organisations such as the British Association of Medical Managers. The Project Steering Group provided copies of some internal reports. Other 'grey' literature was available

within the collections held at the South East Institute of Public Health, the Regional Health Authority Library, and the South Thames Regional Library Service.

Finally, as the research topic continued to move up the political agenda nationally, a further source of contextual information emerged, in the form of a major national conference entitled *The Involvement of Clinicians in Commissioning and Purchasing* Care. This was a high profile event, held at the Royal College of Physicians in November 1994, and attended by nearly 200 delegates, of which I was one. The conference was a joint endeavour, organised by the Institute of Health Services Management and the Conference of Medical Royal Colleges and their Faculties in the UK. Speakers included Mr Gerry Malone, then Minister of State for Health and Dr Graham Winyard, Medical Director, NHS Executive. Sessions were chaired by equally high-profile individuals - Sir Leslie Turnberg, President of the Royal College of Physicians; Phillip Hunt, then Director of NAHAT (the National Association of Health Authorities and Trusts) and Peter Stansbie, President of the IHSM (Institute of Health Services Management), and there were presentations by managers and clinicians from across the country. Speeches, oral presentations and panel discussions from this conference, together with the outcome of the preliminary literature review, all influenced the research process in some way, and these early sources of influence will be discussed next.

3.2 Clinical involvement in commissioning and contracting - a review of the 'grey' literature

Whilst searches revealed no published work on clinical involvement in commissioning, a small amount of literature was beginning to become available on clinical involvement in contracting. (For an explanation of the difference, see Chapter 2). This did not, however, appear on the electronic databases, as it was unpublished - hand searching was the only way of identifying this work. It is also possible that, due to the time lag between publication and citation, some studies which were still in progress, or articles that had been completed but were awaiting publication, were overlooked. Those that were found are discussed below.

3.2.1 The Health Services Journal Editorial

In April 1994, the *Health Service Journal* had run an editorial entitled, 'Smile at a doctor today,' which argued that "mutual distrust between managers and clinicians is reaching epidemic proportions." It based this opinion on an unreferenced survey of 250 clinical directors, which it claimed had found that:

> "Three quarters of the senior clinicians who took part complained that they were excluded from contract negotiations with health authority and GP fundholders. Clinical issues were given low priority when contracts were drawn up...and financial considerations were 'always paramount.' " (Health Service Journal 7 April 1994. p.13)

This editorial continued by arguing that, whilst "it would be easy to dismiss these gripes as good old-fashioned gripes and whingeing" there was, nevertheless, a real concern about the breakdown of the relationship between clinicians and managers in the NHS, with "mutual distrust...reaching epidemic proportions." The editorial located this breakdown firmly within what has been described elsewhere as "the new managerialism" (Hunter, et al, 1992; Klein, 1995) introduced into the NHS following the Report of the NHS Management Inquiry (Griffiths, 1983), arguing that:

> "After wielding unchallenged power in the NHS for generations, consultants have taken unkindly to the rise of the health service manager. Feeling suddenly subordinated, having your most dearly cherished and long-held assumptions questioned or overturned, can be an uncomfortable and undignified experience." (HSJ, 7 April 1994, p.13)

This somewhat emotive editorial begs a number of questions. Firstly, it was not entirely clear whether the editorial was simply reporting the survey findings, or offering its own interpretation of these. As many researchers and users of research know, the media is often not only highly selective in its reporting of the research outcomes, but often draws

its own conclusions from these. Then there a question regarding the reliability of the survey findings themselves. How robust were these? How large was the sample, and what was the response rate? The survey methodology was not discussed in the journal, yet the findings were being treated as though they were valid, reliable and generalisable to all clinicians in the NHS. These assumptions clearly needed to be questioned. Finally, if this survey had been conducted in a way that would have enabled the findings to be trusted, could the results be explained in terms of the changing power dynamics between clinicians and managers? *Was* there sufficient evidence to support the assertion that power had shifted from doctors to managers? Or were the survey findings being used *as* evidence of such a shift? Finally, where might clinicians who are also mangers fit into this picture? The editorial continues, in the very next sentence, by bringing this group into the argument, adding that:

> "...plentiful evidence exists to suggest the great project to involve doctors more in management - begun by Griffiths in 1983, given further impetus by *Working for Patients* in 1989 - really is ailing rapidly. This latest survey comes after a draft Audit Commission report described clinicians' involvement in management as patchy" (HSJ, 7 April 1994, p.13)

However, it is not at all clear whether 'involving doctors more in management' was being offered here as part of the problem, or as a potential solution. Indeed, it is not entirely clear *why* this issue was presented as such a problem for NHS managers (the *HSJ*'s readership is largely health service managers, from across all sectors of the service). Were managers feeling uneasy about this evidence of the changing balance of power between themselves and the clinicians, or because they felt their increased power being challenged? Or was this perhaps more indicative of a general perception of a more widespread breakdown of relationships within the NHS? The editorial clearly indicated considerable concern about perceived high levels of mutual distrust, in which "many managers are quick to assume clinicians always act out of self-interest" whilst "most clinicians believe mangers will invariably pursue the cheapest, cost-cutting option" regardless of the impact on service quality. "The dangers if this trend is allowed to

continue unchecked are plain" the text continues, "not only mass disaffection and confrontation, but ineffective and poor quality services." Did the evidence from the survey and the Audit Commission report really indicate such as serious state of affairs? Or was this more an indication of a change in something more subtle, but more profound, such as the ethos within the internal market? Clearly, some kind of change in the *zeitgeist* appears to have been evident, as the final paragraph of the editorial indicates:

> "Wise up: collaboration and teamwork are once again watchwords in NHS management. That way lies efficiency and effectiveness. Clinical directors need to play a full role in deciding service strategy, allocating resources and managing quality...[t]he reformed NHS in the Langlands era will not be about power struggles and domination, but cooperation."

This editorial had considerable impact on the South East Thames Commissioning Network, and their decision to investigate the issue of clinical involvement in commissioning as part of their role in supporting commissioning development across the region (see Chapter 1). It also shaped the design of the project (see Chapter 4), by suggesting that the 'problem' lay with Trust management (though this was not explicitly stated within the editorial - no distinction had been made between NHS management on either side of the internal market), and that the key group to involve were clinical directors. But how strong was the evidence on which the editorial was based? To assess this, it is necessary to examine the survey on which the editorial was based - to critically appraise its design, method, results and conclusions - and to place this survey alongside other sources of evidence relevant to this issue. The following three sections of this chapter will therefore examine the survey and two other sources - the report of a Ministerial Task Force on clinical involvement in contracting, and a national conference on the same topic.

3.2.2 The management consultants' survey

The survey cited in the Health Services Journal editorial discussed above, had been undertaken by a firm of management consultants, McClean Jones McCarthy Ltd. A copy of the press release (embargoed until 7 April 1994, the date of the Health Service Journal editorial) and a brief report of survey results were both obtained via a colleague in a North Thames Regional Health Authority, but neither document contained any information on the survey methodology. There was no indication, for example, of the sampling frame, the sample size or the survey response rate, and no commentary on the survey findings. Written requests for further information received no reply, so a few weeks later, I telephoned the company and asked to speak to the researchers who had undertaken the study.

In response to this enquiry, I was told that the 250 clinical directors who had taken part in the survey had been ' randomly selected' from the company's own database, although I was not given any information on the size of the database, or who it included/excluded, on the grounds that this information was confidential. Neither was I told (I did ask) how randomisation had been undertaken, and whether there were any checks to ensure that the sample was representative. Questions about the response rate resulted in a somewhat hesitant response that it was "over a third, I think." Non-respondents had not been followed up, and no other information was available. My request for a copy of the full report was declined, even though I explained that the reason I wanted a copy was to inform my own research, and that I was willing and able to purchase this. This does not give me great confidence in the robustness of the survey findings, as the survey sample appears to have been drawn from an unrepresentative sample, and to have achieved a low response rate. Nevertheless, in spite of the uncertain validity, reliability and generalisability of the survey findings, these did nevertheless indicate some areas for further investigation.

3.2.3 The Ministerial Task Group's Draft Report

The only other written evidence of direct relevance to the research questions and available as part of the initial literature review was the draft report of the Ministerial Task Group on Clinical Involvement in Contracting. This report was not widely circulated beyond the civil service, but a copy was obtained from a colleague within the NHS Executive sometime during the autumn of 1994, on the basis that I could use it to inform my research. Although a final report was never published in full, many of the Task Group's recommendations were subsequently incorporated into the document *Clinical Involvement in Contracting: A Handbook of Good Practice* (NHSE, March 1995), which was published as my research was nearing completion. However, the *Handbook* contains none of the background discussion of the Task Group's findings. These can only be found in the draft report, which is discussed below.

In its preamble, the draft report asserted that, "The NHS Executive from the outset of the reforms has emphasised the importance of doctors, nurses and other professionals being involved in the contracting process" and cites as evidence no less than four Executive Letters: EL(90)221 - *Involving Professional Staff in drawing up NHS Contracts*; EL(93)10 *Managing Activity and Change*; EL(93)60 *Medical Advice to Purchasers*; and EL(93)103 *Review of Contracting-Guidance for the 1994-95 contracts cycle.* Nevertheless, it goes on to argue,

> "Despite clear messages coming from the centre there was a strong feeling amongst clinicians, voiced particularly at the JCC, that they were not being fully involved in the contracting process."

> "It was in response to these concerns that the former M(H) announced his proposal to establish a Task Group to assess clinical involvement in contracting in a speech to the Harveian Society in December 1993 "

The Task Group appears to have been established, by Dr Brian Mawhinney, sometime between March and June 1994 - around the time of the *Health Service Journal* editorial. It is difficult to be precise about dates, as the draft contains some contradictions. The Group's brief was to "review the clinical input and advice which has informed the current contracting round" with the aim of promoting clinical involvement during 1994 - 95 and beyond. Membership of the group included representatives from the Joint Consultants Committee (JCC), the British Medical Association (BMA), the Royal College of Nursing (RCN) and the National Association of Fundholding Practices (NAFP). There was in addition a core team of four - three senior civil servants from the NHS Executive (one each from the Health Care Directorate, Performance Management Directorate and Nursing Directorate), and an academic (from the University of Warwick). Finally, there was a Ministerial Nominee, who was a General Practitioner.

The task group makes no claim to have undertaken rigorous research, and says little about its approach, beyond listing the sites visited (with dates) and the contracts reviewed. Site selection is discussed very briefly, with the report stating that "The DHAs were chosen in part from the responses received to M(H)'s letter of 12 January 1994" (on involving local people and clinicians in purchasing), but no selection criteria are given. The report also states that visits covered a range of acute, community, mental health and learning disability services, thereby including a range of different services and professional groups, and that a total of 16 health authorities and provider units were visited during June and July 1994.

At each site, a single contract was selected to be studied in depth, but again, contract selection is given only cursory attention:

> "Each DHA was asked to identify three contracts where it was believed that the involvement of clinicians had led to improvements in quality, level of activity or efficiency." (para. 3.2)

One of these three 'nominated' contracts was then selected by the Task Group for in-depth study, and was used as the focus of the site visits. Types of contract covered included simple block, sophisticated block, block and cost per case, cost and volume, and 'unspecified'.

Teams of between 4 and 8 individuals undertook these visits. The Task Force terms of reference required the visits to be "focussed around a series of structured meetings" with "provider unit managers, their main or host purchaser, medical staff, nurses and other professionals." (Terms of Reference, para 6) and stated that the team would "expect to have access and the opportunity to examine" contracts, notes of contracting meetings, existing policies and guidelines, and minutes of 'cogwheel' meetings. However, the Terms of Reference were appended to the report, and had been prepared some time before work began, as they also required a report to be presented to Ministers by the end of June 1994 (only one site visit actually took place before the end of June. The others were all in July, and the final draft of the report was not produced until the autumn.) There is nothing in the report to give any information on whom the team visiting each site spoke to, what was discussed, or what other information was collected and analysed. Neither does the report give any indication of the level of consistency of approach between teams and across sites visited.

In view of the composition of the Task Group, the potential for biased reporting is considerable, and there is insufficient information given in the report to enable any informed assessment of the extent to which this could have influenced the reported findings. As a result, the draft report must be treated with some caution. This is not to imply that the Task Group's findings are inaccurate, simply that they may not be typical. A different group of people, visiting other sites, or even the same sites but with a different set of questions, might well have drawn quite different conclusions.

Nevertheless, this exploratory, case-study approach yielded some very interesting findings, which were to inform my research, and to provide a source of comparison for my own findings in the South Thames Region. For example, the Steering Group for the

South Thames study was having a debate about which clinicians to include in the proposed survey, and the Task Group finding that involvement of clinicians tended to be at Medical or Clinical Directorate level influenced the final choice of survey population. Other findings, such as that clinical audit, information on clinical effectiveness, epidemiological based approaches to needs assessment and contracting for outcomes were found to be failing to inform contracts, provided a number of areas for further investigation within the South Thames survey.

The Task Group's main finding, that "DHAs and provider units could demonstrate involvement of clinicians in the contracting process..." is, however, unsurprising - in spite of the fact that it contradicts the findings of the McClean Jones McCarthy survey. This is because being able to demonstrate evidence of such involvement was one of the selection criteria for the site visits (see above). However, the fact that "...in practice, the breadth and depth [of this involvement] varied significantly" and the suggested reasons for these variations, provided further background to my own survey, and offer some basis for comparison with my survey results (see Chapter 7). For example, the Task Force report argued that involvement of clinicians was "largely determined by the sophistication and type of contract set" and "largely dependent on provider management and their commitment to the process." It also argued that "Clinicians, where involved, tended to be more directly involved in the on-going management and monitoring of the contract than in negotiating and agreeing the contract."

Furthermore, the Task Group findings reinforced the need to consider the issue of clinical involvement in commissioning from the health authority perspective, through finding that, in many cases purchasers were "not sufficiently informed in their discussions with provider clinicians and had not made the necessary arrangement to access clinical expertise." To add to this, "a number of DHAs visited" were found to have "dismantled their existing professional advisory machinery" without evaluating other approaches to obtaining independent professional advice to support the purchasing role. Finally, the Task Group reported finding "a difference in perception between purchasers and providers about the actual level of clinical involvement and the level that is needed."

However, no further elaboration of this difference is given - and it is not easy to tease out the detail from the report. (This seems somewhat surprising, as all the other topics highlighted as key findings are discussed in more detail in the main body of the report). The draft Task Group report therefore provided invaluable contextual information to inform the South Thames study - suggesting areas for further investigation as well as offering baseline against which to compare the situation in the South East of England.

However, before moving on, it is important to highlight one other issue in relation to the Task Group report. This is that the existence of the Task Group, at a Ministerial level, is in itself an indication of the power and influence the provider clinicians appear to have had in making their views known to Government, in this case through the mechanism of the Joint Consultant's Committee (a sub-committee of the Medical Royal Colleges), and eliciting a response from a senior (in this case, Ministerial) level. Not only does the Task Group appear to have been established as a direct result of the JCC voicing the concerns of the medical profession, but the JCC representation formed the largest single group on the Task Force itself - outnumbering the BMA nominees by 2:1. This illustrates the extent to which consultants themselves appear to have been orchestrating the debate about their exclusion from the contracting process, and as such, will require further critical analysis (this issue will be picked up again later). It also has implications for interpretation of the reported findings, and these will be discussed in the following paragraph.

3.2.4. The Conference of Royal Colleges/IHSM Conference

This joint conference, organised by the Institute of Health Services Management and the Conference of Medical Royal Colleges and their Faculties in the UK, came to my attention during the summer of 1994, when I was undertaking the initial literature review. As the title of the event, *The Involvement of Clinicians in Commissioning and Purchasing Care,* was so similar to the title of my research, I felt it would be likely to offer some useful background information, and perhaps even some insights into the issues I was proposing to investigate. The conference was held in November 1994, by which

time I had already begun interviewing the Chief Executives and Directors of Public Health in the South East Thames health authorities, and the survey questionnaire for the clinical directors was still being drafted and piloted. The conference flyer neatly summarises many of the issues and concerns which my research set out to address:

> "There is concern amongst purchasers and providers of health care that there is insufficient clinical input in the contracting process. Mechanisms for advising both commissioners of health care and trust chief executives are often unclear, and in many cases, contracts for the delivery of services are agreed without consulting the clinicians who are required to deliver the services.
>
> The main theme of the conference is to explore how hospital consultants who have first hand knowledge of how clinical services operate, and of the effectiveness of different health care interventions can get this information across to purchasers in order that the best possible care can be commissioned. Some hospital consultants on the other hand need to develop a better understanding of broader health needs, which are known to purchasers." (IHSM Conferences flyer, for 28 November 1994)

The reasons for holding the conference were summarised by the Chair, who argued that provider-clinicians were unsure that purchasers were seeking their advice, whilst purchasers were unsure how and where to seek 'independent' clinical advice. The Task Force report was mentioned, with an indication that it was to be available towards the end of the year, and the Ministerial speech which followed was clearly based on its recommendations. Ministers were, apparently, concerned that clinicians didn't *feel* involved in the processes of commissioning and purchasing, and it was for this reason that the Task Force had been established. It's recommendations were being considered, and the Government was, the Minister reassured everyone present, fully committed to the issue of clinical involvement. Presentations and discussion throughout the day 'flushed out' many of the issues which were subsequently to become familiar to me, such as how to achieve changes in service delivery (especially reconfiguration of services, which were

often unpopular with the public, as well as clinicians); how to make clinicians accountable for the use of NHS resources; how to make the contracting process a vehicle for change, how to improve relationships between purchasers and providers, and between clinicians and managers, how to involve GPs (judging from the comments from the floor, this group felt even more excluded from the commissioning process than their hospital colleagues) and how to change clinical practice (through the incorporation of clinical audit, evidence-based medicine, and measurement of clinical outcomes).

Attending this conference provided me with valuable contextual information to support my research. It also highlighted the strength of feeling amongst the medical profession in relation to this issue (nearly 200 delegates attended this whole-day conference, and approximately 2/3 of these were doctors). However, there was also evidence of a great deal of infighting between the different professional groups - particularly between the GPs and the hospital consultants present (this was much more evident than any suggestion of conflict between managers and clinicians, or purchasers and providers), but also between different specialities. The complexity of the issue of involving clinicians in commissioning also became evident, not only because the clinicians in whom I was interested did not appear to be in any sense a homogeneous group, but also because they seemed confused about the purpose, scope and value of the commissioning process they were clamouring to be allowed access to. This is illustrated by the following anecdote I recorded in my notes. As I was leaving the conference I overheard one consultant discussing his confusion with a colleague, who explained it thus: "The difference between purchasing and commissioning, as I see it, is like this. I can go into an art gallery, and I can purchase a painting. Or I can go to an artist, and commission one."

3.2.5 Challenging assumptions and explanations

The project brief prepared by the Steering Group had been based on a number of assumptions, which the literature review has set out to address. Firstly, there was the assumption that there was an existing body of published literature documenting experience elsewhere in terms of involving clinicians in commissioning. Perhaps there

were other documented sources, but if there were, all my efforts, and those of the regional library staff, failed to locate them. The Steering Group had also assumed that there were examples of 'good practice' which could be used to inform local action. (This in itself presupposes that there were also some agreed criteria against which such practice could be evaluated, and defined as 'good'.) It was perhaps possible that in some other part of the UK, work was taking place that might constitute 'good practice' - but whether this was being systematically recorded in a form that could be used to inform managerial decision-making within South East Thames was unknown. If such work existed, it did not come to light during the course of my research. Even the *Good Practice Guidelines* developed by the Task Force were not published until my survey was complete. Whilst in some ways this was frustrating, in others it was reassuring - particularly to the Steering Group, who felt that their decision to commission some local research on this issue was justified.

Secondly, there was the assumption that clinicians were being systematically excluded from the commissioning process. This was based on anecdotal evidence presented in the media, and lobbying by the various associations representing the medical profession's interests. However, research evidence to support this annecdotal evidence was limited. The evidence that was available was contradictory, and could be considered unreliable on methodological grounds. Furthermore, it was by no means clear how much their exclusion was a perception and how much a reality (though to misquote a popular sociological truism, "perceptions are real if they are real in their consequences" - hence clinical exclusion from involvement in commissioning could be considered to be a problem area if any parties to the commissioning process perceived it to be so - whether or not the majority of clinicians were actually being actively excluded, or encountering more subtle barriers to such involvement). Certainly, there was plenty of observational evidence that the clinicians were voicing their concerns about this issue at a number of levels within the policy arena. Exploring what was actually happening locally therefore seemed to be a legitimate area for further research, and the 'grey' literature, in spite of its limitations, had provided much to illuminate the research questions, and to inform the research design (see Chapter 4).

At a more academic level, however, I was beginning to ask myself rather more fundamental questions about the reasons why this mattered so much to the clinicians, and why the South Thames Commissioning Network was so anxious to address these particular concerns. This led me back to a consideration of the various explanations offered by the *HSJ* editorial, which I felt warranted further exploration. Could any of these, for example, be turned into testable hypotheses? Or did they perhaps suggest a conceptual or theoretical framework in which to locate the research, or to interpret the research findings? To explore these further required a more extensive, but selective, review of a related body of literature, on the topic of clinical involvement in management. Here, on-line searches of the health management and health policy data-bases were more forthcoming, and the following section of this chapter will draw on this work.

3.3 Clinicians, managers, and clinical directors - from conflict to incorporation?

The explanations offered by the *HSJ* editorial for the worrying state of affairs on which it was commenting were as follows. Firstly, there was the suggestion that the senior clinicians' complaints were simply an example of "good old-fashioned tribalism," and could therefore be dismissed or ignored. Secondly, there was an assertion that the introduction of general management into the NHS had fundamentally altered the balance of power between doctors and health service managers, with the result that the clinicians were feeling disempowered. The language and tone of the editorial suggested that this situation may have reached an uncomfortable level, with concerns being expressed that if managers did not take steps to remedy the situation, "destructive passions will soon be unleashed." (*HSJ* 7 April 94 p.6) Finally, there was the claim, apparently supported by an Audit Commission report, that the clinicians' own involvement in management was "patchy and problematic." The connection between three proposed explanations, and their relevance (or otherwise) to the South Thames research, require further clarification.

3.3.1 'Tribalism' in the NHS

The term 'tribalism' means different things to different people. Management theorists such as Handy (1990), for example, argue that all organisations are collections of tribes, which can be very different in their assumptions, their traditions, and the ways they behave. In his analysis of the culture of organisations, Handy (1985) developed a typology of four 'ideal types' (though he does not use this term to describe them) of organisational culture. These comprised small, entrepreneurial organisations (the power culture); formal, structured organisations - elsewhere described as bureaucracies (role cultures); project oriented organisations (the task culture); and loose associations of (usually professional) individuals (the person culture). In his later work (Handy 1990) he uses these terms to describe groups within organisations, rather than organisations *per se*, and argues that, whilst every organisation is different, each will contain a different mix of cultures or 'tribes'- usually in different divisions within the organisation - and bigger organisations will have more tribes. One of Handy's tribal typolgies (the person tribe) is, he argues, very different from the other three in the ways in which they relate to organisations. Whereas club tribes (derived from the power culture), role tribes (bureaucratic types) and task tribes (project-oriented groups) put the purpose of the organisation first; person tribes (professionals grouping together for their own convenience), on the other hand, "put the individual first, and makes the organisation the resource for the individuals' talents." (Handy 1990, p. 151)

Doctors are, according to Handy's analysis, the best example of the person tribe, though all the senior professions (other examples include architects and barristers) could fall into this category. Using Handy's analysis, therefore, it could be argued that the differences between health service managers (who are likely to be from club, role or task tribes) and clinical professionals (especially members of the medical profession) are linked to fundamental differences in mind sets and priorities - with managers caring about the purpose of the organisation, and ensuring organisational objectives are being met, whilst clinicians place their main emphasis on maximising their professional interests - ie providing medical care. Blakemore and Symonds (1997) illustrate this view when

discussing the impact of the introduction of general management on health care systems:

> "Managerialism claims to be neutral and impersonal, having no narrow or personal professional interests, placing the value of efficiency above all other interests. It contrasts with professionalism, which claims specialisms and bodies of knowledge. Managerialism is not about protecting and demarcating specialist activities, but rather it is about leading and controlling the entire organisation."
> (Blakemore and Symonds, 1997, p. 227)

This is a popular conceptualisation in the health policy and management literature, as well as in the popular press. (Around this time there was a great deal of discussion in the media about the relative number of managers and doctors in the NHS, frequently stereotyped as 'grey suits' versus 'white coats.').Yet this description is, as we shall see when we come on to the discussion around the role of clinicians as managers, more likely to be ideological than empirical in origin. Nevetheless, recognition of these contrasting ideologies is important, as different ideologies may be an important source of conflict. However, for me, the notion of 'old fashioned tribalism' as it is used here fails to analyse the basis of that conflict, or to address the power relations that underpin it. To understand these issues, might a rather more sociological analysis offer any compelling insights?

In sociology, the term 'tribe' simply refers to a social group whose members share cultural and linguistic characteristics, and are bound together by reciprocal rights and responsibilities. (Jary and Jary, 1991) This is a description which undoubtedly fits the medical profession, whose professional socialisation ensures the development of a shared culture and language, and the acquisition of a body of specialist knowledge. (Blane, 1997) However, once again, this notion of tribalism does not extend to an analysis of tribal conflict, or the power relations between the medical and managerial 'tribes' within organisations. Nor does it throw any light on the *HSJ* editorial's assertion that the balance of power between the two tribes under discussion has shifted from clinicians to managers. This assumption, although commonly-held, is by no means unproblematic, but we need more than an unpacking of the notion of 'tribalism' to explore it further. It

is here that insights from the sociology of the professions can shed some light on the issues under debate.

Within sociology, much has been written on the role of the professions, usually in relation to the issues of social and occupational stratification. Attempts have been made to define the characteristics which all professions have in common and which, it is argued, distinguish them from other occupational groups. Whilst what is included or excluded from any given list of characteristics tends to vary depending on the profession under scrutiny or the particular perspective of the scrutineer, a list of 'core' features usually includes such characteristics as a specialised body of knowledge, a code of ethics, monopoly control over an area of practice (often reinforced by State registration) and 'professional autonomy' ie the freedom to define and organise their own workload. (See for example, the work of Freidson, 1970).

However, as a number of sociologists have argued, these attributes are not simply 'givens'- professionals are not the passive recipients of their particular occupational position; professional status and professional power are achieved by social actors, working individually and collectively to improve and maintain their professional status. (Macdonald, 1995). Indeed, in some analyses, the extent to which the core characteristics that indicate professional status have actually been acquired is seen as an indication of the success (or otherwise) of the professionalisation process - with failure to achieve any one of these attributes taken as an evidence of unsuccessful or incomplete professionalisation. (Turner, 1995). Seeing professionalisation as a dynamic process, however, also implies that professional power is, at least potentially, open to challenge. As Blane (1997) argues, "an occupation's professional status is not guaranteed for all time, and ...the level of its professional powers can change." It is this possibility of challenge that underpins a further set of debates within the sociology of the professions, around de-skilling (sometimes referred to as proletarianisation) and deprofessionalisation. I believe that is this potential challenge to professional power which is significant, and will require further exploration in the light of the findings within South Thames (see Chapter 8). But first, I shall turn to the discussion of the power balance between

managers and clinicians, and examine the evidence to support (or refute) the assertion that the introduction of general management into the NHS in the mid-1980s had shifted power between the medical profession and health service managers in favour of the managers.

3.3.2 The impact of general management on professional power in the NHS

Commentators from sociology and from social policy have argued that, prior to 1984, control of the NHS was exercised centrally, by civil servants and Ministers, who delegated power to "the most crucial health service trade" (Strong and Robinson, 1990) the medical profession. Until this point, it is claimed, there was an assumption that health care organisations were fundamentally different to private sector organisations, and the professional autonomy of doctors remained unquestioned. Medical services were 'administered' rather than managed, and this administration was undertaken by a group of "low level functionaries." (Strong and Robinson, 1990)

The Griffiths Report (1983), it is argued, challenged these arrangements. Implementation of the Griffiths recommendations brought about a "tidal wave of change" (Strong and Robinson, 1990) that swept over the NHS at all levels, introducing an "ambitious new model of management which aimed to put the clinical trades on an integrated, monitored, and subordinate footing." (p.xiii). Needless to say, the story continues, these reforms were resisted by the clinical professionals, who continued to argue that clinical care was a matter for the professional judgement, therefore beyond the jurisdiction of general management. Although the medical profession was the chief target of the Griffiths reforms, however, it is suggested that "the power of doctors was too great for an initial assault." As a consequence, it would seem that this new breed of general managers were compelled to move slowly, and frequently had to "cover their tracks." (Strong and Robinson, 1990)

As Strong and Robinson are quick to point out, their study of the introduction of general management into the NHS during the mid-1980's set out capture a culture in the making.

The extent to which this cultural change was actually achieved is, however, much less clear, and would seem to be the subject of some ongoing debate. Klein (1995) for example, argues that:

> "the impact of the new managerialism on the way the NHS conducted its business at district and hospital level was perhaps not as revolutionary as the rhetoric implied, and certainly not as immediate as Ministers might have hoped." (Klein, 1995, p.149)

This gap between the rhetoric and the reality is also examined by Harrison and Pollitt (1994), who argue that, whilst the new breed of general managers did acquire some additional powers, these were limited to areas such as questioning the professional roles and skill-mix of nurses, the closure of hospital beds, and the pro-active management of new initiatives.

> "In other areas of organisational life, doctors retained almost undiminished their ability to obstruct changes of which they disapproved. Indeed, in some research they tended to report that the Griffiths changes had not decreased their influence. Moreover, it seems that doctors retained a good deal of *covert* influence; many general managers expected doctors to be difficult, and therefore refrained from raising issues that might arouse opposition..." (Harrrison and Pollitt, 1994, p.50)

Klein reinforces this argument, adding the view that professional resistance on the part of the medical profession was only part of the story. The conversion of NHS administrators, who had seen themselves as brokers between conflicting interests, into the new breed of general managers ready and willing to challenge the status quo, was he argues, rather slow. Whilst some were willing to embrace the changes, to take risks and to challenge the medical profession, others were more circumspect and "resentfully questioned the applicability of what they saw as a supermarket management style." (Klein, 1995, p.149) Furthermore, Klein goes on to argue, there were few incentives or sanctions to support cultural change:

> "However elegant the Griffiths model may have appeared, it lacked an engine to drive it. Its weakness lay not so much in seeking to impose on the NHS an approach to management drawn from the private, for-profit sector of the economy...as in assuming that it was possible to change the style without also re-engineering they dynamics of the system" (Klein, 1995, p. 152).

That the introduction of general management into the NHS following the Griffiths review set out to challenge the hegemony of the medical profession appears to be taken for granted within the health policy and management literature. It is only the extent to which this challenge succeeded, and the reasons for the degree of success or failure that are still the subject of debate. Yet, as Causer and Exworthy (1999) argue, the conventional wisdom that professionals and managers "stand in a necessarily antagonistic relationship" (ibid. p.83) may be an oversimplification, as it fails to recognise the extent to which professionals become managers within their own organisations. It is this issue that the final claim in the *HSJ* editorial was referring to, when it argued that "the great project to involve doctors more in management" had also run into problems. The role of clinicians *as* managers therefore also needs to be taken into account.

3.3.3 Involving clinicians in management - before and after Griffiths

The history of involving clinicians in management pre-dates both the Griffiths reforms and the introduction of the 'internal market' in the NHS. There are a number of strands, with at least one predating the introduction of the NHS itself. For example, in 1929, when local authorities took over the former poor law hospitals, Medical Officers of Health became key players in the management and administration of a wide range of municipal hospitals and community health services (Lewis, 1986). More recently, there appear to be two main antecedents to current arrangements - the cogwheel system, and consensus management. Both would seem to have contributed to the eventual development of the now common system of clinical directorates, which will be discussed in more detail a little further on. Yet in both cases, a different purpose appears to have been driving these initiatives. The impetus for the cogwheel system would seem to have

been the need to rationalise the division of medical labour, whereas consensus management teams were established in an attempt to achieve a fairer allocation of resources between the acute and community sectors. Both will be explored a little more fully, before moving on to a discussion of attempts to involve clinicians in general management, and the subsequent development of clinical directorates.

Ham (1992) argues that, in the past, the main vehicle for involving the medical profession in NHS management was the so-called 'cogwheel' system. This dates back to three reports on the organisation of medical work, published between 1967 and 1974, popularly known as the 'cogwheel reports' because of the design on their covers. The first cogwheel report recommended the creation of broadly-linked, specialty-based divisions, with representation from consultant and junior medical staff. Representatives would come together to form an executive committee, to oversee service provision within a division, and liaise with other professional groups as necessary. (Levitt, Wall and Appleby, 1999) This system appears to have had considerable longevity - it was still in place when I joined the NHS in 1990, shortly after publication of *Working for Patients.* The Director of Public Health in whose department I was based often described the lead clinicians in our local acute unit as 'cogwheel chairs.' Moreover, these cogwheel chairs were still *in situ* more than a year later, as I discovered when organising a health authority consultation on the Green Paper *Health of the Nation* (1991), at a time when the local acute unit had recieved Ministerial approval for transfer from DMU to trust status. Indeed, it was the cogwheel system that was suggested by Griffiths as a suitable basis for clinical participation in decisions about resource management within the NHS (Ham, 1992) though to some extent management budgeting and the Resource Management Initiative superseded this arrangement. Cogwheel divisions were finally replaced by clinical directorates as NHS trusts became established, though, as we will see below, the introduction of clinical directorates as the preferred model for internal management within trusts was not unopposed, and took many years to implement fully across the NHS.

The other important strand in the history of attempts to involve clinicians in management has its roots in the 1974 reorganisation of the NHS, which established the process now referred to as 'consensus management.' Multi-disciplinary management teams, made up of representative consultants, GPs, nurses, administrators, treasurers, and medical officers, were established, and charged with managing health services at various levels of the NHS. (Austin and Dopson, 1997)

Whilst this approach aimed to build on earlier management changes (including the introduction of the cogwheel system), and was underpinned by concepts of team working and consensus management (Ham, 1992), it in fact institutionalised medical influence (Harrison and Pollitt 1994) and gave members of the medical profession the right of veto (Klein 1995). It is these arrangements which were subsequently abolished by the Griffiths reforms of the mid-1980s, when general management was introduced, though there is a certain irony in this, as Levitt and colleagues (1999) argue that "it was hospital doctors' criticisms of consensus management which probably did most to encourage the Secretary of State to commission the Griffiths report in the first place." (Levitt, Wall and Appleby, 1999).

Meanwhile, returning to the discussion of the new managerialism introduced following the Griffiths review, it is time to examine the role of the clinical manager - the hybrid model who, according to NHS mythology, sits astride the professional-managerial divide. As Klein points out, Griffiths himself was always anxious to assure doctors "that the new managerialism did not represent a threat to them but rather an opportunity to participate more in the decision-making process." (Klein, 1995 p. 150) Griffiths was, in fact, arguing that clinicians should join the ranks of the new breed of general managers. Few took up this offer, in spite of a number of initiative designed to encourage them to do so. When the new posts were established, only 9.1% of general managers appointed came from the medical profession. (Mark, 1991) Whilst this can in part be explained by the lack of experience and management training which was initially available to the profession, numbers actually halved in subsequent years (Millar, 1991), suggesting a more complex set of contributing factors. Indeed, the health management literature of the early 1990s

is littered with articles attempting to explain why clinicians (usually referring to the medical profession) were so reluctant to become involved in general management, in spite of having argued that the NHS needed more clinically-qualified managers. (Fitzgerald, 1991a).

Reasons identified, in addition to lack of appropriate training and experience, included such factors as loss of income (particularly from private practice) and status (the view that only poor doctors become managers) and role conflict. Those who took on general management on a part-time basis alongside their clinical commitments, found combining both roles particularly difficult. (Millar, 1991). The difficulties experienced in drawing the medical profession into general management raised a number of questions about the 'traditional' barriers between doctors and managers, and how these might be overcome (Fitzgerald, 1991a). It also raised a more fundamental question about the appropriateness of the general management role as a 'template' for clinical managers, and whether alternative models of clinical management might in fact be more appropriate. (Fitzgerald, 1991b).

All this, however, assumes that medical involvement in management is a desirable objective. Whilst this might well have been government policy, it is worth clarifying why this was felt to be necessary, and whether clinicians might have shared this view. It is here that Klein's commentary throws some light on the issues. He argues that the hostility of nurses and doctors to the Griffiths reforms had deep roots. Nurses were disadvantaged by the changes, he claims, as they both lost the right to be managed by a member of their own profession, and the right to be represented on district management teams, though he fails to mention that they gained the right to become general managers (and later, clinical directors). Doctors, however, saw the report as "questioning whether their clinical autonomy extended to immunity from being questioned as to how resources were being used." (Klein, 1995) This is a key issue, and links to the issue of deprofessionalisation, discussed above - as challenges to resource use cannot easily be divorced from challenges to professional judgement. Although the decision-making Griffiths seemed to have in mind when he had invited doctors to become managers was financial, the link between

making doctors accountable for the use of resources and the process of clinical decision-making was made quite explicit. Clinical decisions, especially those made by doctors, have financial consequences:

> "Their decisions largely dictate the use of resources and they must accept the management responsibility which goes with clinical freedom. This implies active involvement in securing the most effective use and management of all resources. The nearer that the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers." (Griffiths, 1983, p.18 - 19)

It is not surprising, therefore, that the Griffiths report was an important stimulus to the development of a number of approaches designed to make clinicians accountable for their use of resources. What is interesting, however, is that unlike many other reforms, these were initially established as 'demonstration' projects, in a number of pilot sites. Furthermore these 'demonstrations' were evaluated, and findings from these evaluations informed further development. The first, management budgeting, allocated budgets to consultants, and gave them responsibility for managing programmes of clinical care. (Harrison and Pollitt, 1994). Management Budgeting was superceded in 1986 by the Resource Management Initiative, introduced in 1986 (Ham, 1992). Resource management sought to improve information systems and to involve clinicians directly in the management of their own resources, with the aim of increasing their efficiency in the use of resources. Budgets were devolved to departments, and lead clinicians given managerial responsibility for their use. This simultaneously increased the pressure for clinical involvement in management decision-making, and for management control over resource allocation and prioritisation of services (Fitzgerald, 1991a)

The Resource Management Initiative was, along with the 'cogwheel' system described above, an important influencing factor on the introduction and development of Clinical Directorates. These transatlantic imports brought a new focus to the ongoing attempt to involve clinicians in management, with some health policy and management analysts

arguing that these offered a more 'clinician friendly' approach than previous attempts. However, initial concerns about their potential for challenging clinicians' independence were also raised (BMJ, February 4th, 1990) and potential flaws in the model identified (Kennedy, 1990). Basically, Clinical Directorates are business units within NHS trusts, usually (but not always) built around a more-or-less self-contained clinical service. Each business unit is headed by a Clinical Director (often, but not always, a consultant) who exerts budgetary control over staff, equipment and supplies (Capewell, 1992). The number of clinical directorates within a trust, and the size of the budget held, show considerable variation, and determined attempts were made not to appear prescriptive:

> "There is no single 'right' structure for clinical directorates, and a wide range of different models has been adopted. In most places the structures are still evolving. In acute units directorates are usually based on clinical specialties. Community units have a more varied approach." (Audit Commission, 1994)

This is exactly the position we encountered in South Thames in 1994, when attempting to identify the survey population (see Chapter 5). Many of the trusts which took part had not established clinical directorates, and some were questioning whether this was an appropriate way forward. However, there was considerable pressure being put on them to address their internal management arrangements, as *Trusting in the Future* (Audit Commission, 1994) demonstrates.

This document, which formed part of the research background material provided for me by the project steering group, set out the management agenda for NHS Trust Boards, exhorting them to "strive constantly to improve their efficiency and the quality of their services" (p.1) Whilst it emphasised the need for Trusts to work closely with their main purchasers "to develop a shared understanding of future trends and options for the delivery of health care" it focussed particularly on the need for them to put their own internal structures and processes in order, to enable them to become more responsive to change. It recognised that "many Trusts are devolving more responsibility for management and resource allocation to to semi-autonomous sub-units, such as clinical

directorates" but then went on to claim that, with a few exceptions, these arrangements were not working well. Problems were occurring particularly around the area of clarifying roles and responsibilities:

> "There has always been a tension for professionals between clinical freedom and organisational accountability and simply giving some clinicians a management role may not be sufficient to resolve the issue.". (Audit Commission, 1994. p.1)

The introduction of clinical directorates and business units, and the issue of clinical accountability for resource use run through the report, which deals with both strategic (management of change) and operational (day-to-day running of the organisation) issues. Core responsibilities are set out for Trust Boards, but much of the report concentrates on more specific management issues, including the need to involve clinical professionals in management processes. The establishment of clinical directorates or business units is the recommended approach, in spite of the determined efforts not to appear prescriptive.

If these approaches were encountering difficulties, why were they being advocated? After all, one of the criteria for eligibility for trust status was the extent to which professional staff were involved in management. By the time this report was published, and the South Thames project was being set up, the 'fourth wave' of Trust applications had been approved, and over 95% of NHS services were being provided in Trust hospital and community services. The introduction of the internal market, with its separation of purchasers and providers, was, in effect, now complete. So why was the issue of clinical involvement in management still an issue? It did appear, after all, that what the *HSJ* editorial called "the great project to involve doctors more in management" which in fact dated back even earlier than the Griffiths review of 1983, was not a resounding success.

3.3.4. Theorising the debate

There are a number of issues which arise from the literature on clinical involvment (or lack of involvement) in management within the NHS, and many of these are now being

addressed in the health policy and managment literature. Firstly, as the above discussion illustrates, a simple dichotomous mapping of the relationship between professional and managerial roles and functions is not conceptually adequate. The ways in which professionals become involved in management are much more complex than discussion of the ideologies of managerialism and professionalism imply.

One way of representing this complexity is to draw on recent work by Causer and Exworthy (1999), who identify six categories of professional management, five of which are characterised by their past or present engagement in professional practice. Although this analysis was not available at the time the research into clinical involvement in commissioning was undertaken, it can be used to provide a framework in which to locate the survey population, and to understand the literature on clinical involvement in management within the NHS. Table 3.1 (below), sets out these typologies.

Practising professional	pure practitioner
	quasi-managerial practitioner
Managing professional	practising managing professional
	non-practising managing professional
General managers	professionally - grounded general managers
	non-professionally grounded general managers

Table 3.1 Typology of professional management (adapted from Causer and Exworthy, 1999)

Practising professionals, Causer and Exworthy argue, can be sub-divided into those with and without responsibility for supervising others, or for allocating resources. Nursing is a good example; fully qualified nurses have always had supervisory responsibilities over junior and unqualified nursing staff, and many commentators have commented that it was this group that was most successfully challenged by the introduction of general management into the NHS, as it cut across traditional professional management hierarchies. (Klein, 1995). Managing professionals, on the other hand, although drawn from the ranks of practising professionals, have management as their primary

responsibility. This group can also be subdivided - into those who retain, alongisde their managerial activity, some direct engagement in their professional activity and those who do not. Again, nurses and professions allied to medicine can be found in both groups, but so, too, can doctors. Most clinical directors, for example, would fall easily into the 'practising managing professional' category. Indeed, for some professionals, continued engagement in professional practice appears to be fundamental to their credibility as managers. (Causer and Exworthy, 1999). Finally, even some general managers are also professionals, though they do not continue to practice as such. A number of general managers in the NHS have come from nursing and the professions allied to medicine, and a few have been drawn into general management from the medical profession. Whilst this typology is descriptive rather than explanatory, its does provides a strong challenge to the notion that clinicians and managers are two wholly distinct tribes.

Nevertheless, the ideologies of professionalism and managerialism also need to be taken into account. For example, Clarke, Cochrane and McLaughlin (1994) argue that both the introduction of general management and related debates around the impact this had on professional power within the NHS, and the successive attempts to involve the professionals themselves in management through initiatives such as Resource Management and the introduction of Clinical Directorates, need to be seen within the context of the 'managerialisation' of the NHS. This both preceeded and accompanied the introduction of the NHS internal market, but, whilst the Griffiths review, which introduced general management was predominantly 'Taylorist' (or more accurately, neo-Taylorist) in approach, *Working for Patients* drew on the 'new wave' managerialsim of Peters and Waterman. (Walby and Greenwell, 1994). The result of this was that, following the introduction of general management into the post-Griffiths NHS,

> "General managers were expected to subordinate the health professions, especially medicine, to a single chain of command. It was supposed to overcome the syndicalist structure which had developed in the post-war period in which each profession was effectively self-governing." (Walby and Greenwell, in Clarke et al. 1994, p.59)

These changes, they acknowledge, were bitterly contested by the health professionals, especially medicine. However, the authors go on to argue that the next wave of managerialisation, which followed *Working for Patients* and the introduction of the internal market, took an entirely different approach. In seeking "to turn doctors into managers rather than setting managers to control doctors" the authors argue, the development of managerialism *within* professional groups, rather than in opposition to them, adopted "a more subtle and more effective strategy."

This analysis, with its emphasis on different approaches to management, is similar to that posed by Harrison and Pollit (1994), who, drawing on a wide range of research studies, argue that strategies for controlling health professionals have changed over time, and are now a long way removed from the 'diplomat'role of the pre-1982 hospital administrator, in which the role of managers within the health services was primarily to provide and organise the facilities and resources for professionals to get on with their work, and to mediate conflict within the organisation. The 'diplomat' model, they argue, was "rather rapidly discarded" by government during the early 1980's, as a result of an urgent need to control increases in public expenditure, combined with a firm belief that public sector services were financially inefficient and unresponsive to their users. An attempt was made to replace it with "a more pro-active vision of management" which would challenge the claims to autonomy made by professional groups. Whilst this approach achieved some success in relation to nursing and the professions allied to medicine, the authors argue, its impact on medical autonomy was much less marked, and it was subsequently replaced by what they describe as a "more oblique" approach - incorporation. Within this model, governmental and managerial tactics are deployed "to control health professionals by encouraging some of them to become involved on managers' terms, in management processes which include a degree of control over their professional colleagues." (Harrison and Pollit, 1994, p. 74) These 'incorporation' tactics, the authors argue, included not only initiatives such as management budgeting, the Resource Management Initiative and the introduction of Clinical Directorates, but also Total Quality Management, clinical audit, and the development of clinical guidelines.

3.3.5. The micro-politics of medical power

What this review suggests is that attempts to manage clinicians, or to encourage clinicians to manage themselves (and their professional colleagues) are by no means a new phenomenon, but date back at least as far as the 1974 NHS reorganisation and, some would argue, even pre-date the establishement of the NHS itself. Moreover, these attempts have taken a number of different approaches, and their purpose appears to have changed over time. However, a common thread running through all of the literature is the widespread and pervasive *reluctance* of the medical profession to get involved in managing local health care delivery. Explanations for this reluctance abound - but those cited in the literature on the different models (resource management, general management, clinical directorates) tend to focus on the particular issues in relation to the model under consideration - usually recommending an alternative, and by implication, more suitable ('clinician-friendly') approach.

However, many of these explanations (such as shortage of time, inadequate training and so on) appear to fall into the 'necessary but not sufficient' category. They do not seem wholly adequate to account for the fact that concerted efforts have clearly been made, by successive governments over a long period of time, to involve the medical profession in the day-to-day management of clinical services, and that all these attempts - whatever form they have taken - have met with considerable professional reluctance to take on this role. Why might this be the case? The most likely explanation, it would seem to me, is the one offered by Austin and Dopson (1997), who argue that the most significant reason for the reluctance of doctors to be involved in managing local health care delivery is because they can exercise great influence on health service priorities and shape the provision of services without needing to take up formal management roles and responsibilities.

Some of the mechanisms for achieving this (particularly in terms of the medical profession and their associations as key players in the policy process at the 'macro'level) are discussed in Chapter 2. Others are effectively built into their professional status, in

that doctors effectively control the means of medical production, through the clinical decision-making process - which includes decisions about diagnosis, treatment, care, referral, admission to hospital, length of stay, time of discharge and so on. It is at this 'micro' level, Harrison et al (1992) argue, that medical power is particularly difficult to challenge, because medical decision-making is complex and difficult, and doctors are the only group with the knowledge, skills and experience to undertake this. Yet each of these medical decisions has resource implications, which, as Klein argues, creates considerable tension within a system where financial control is exercised centrally. (Klein 1995) Moreover, it could be argued that it is the sum total of these decisions that effectively shapes the provision of health services - or does it? . There is one other mechanism at work that has not been explored. This is the role of professional advice, particularly as exercised through the medical advisory machinery, which was created in the 1974 reorganisation, and began to change with the introduction of the internal market.

3.4 Professional advice in the NHS

As Ham (1992) demonstrates, professional influence on health policy and management issues can occur at a number of different structural levels, through a number of different mechanisms. Within the Department of Health, for example, there are a wide range of civil servants who come from professional backgrounds (the Chief Medical Officer and the Chief Nurse are two of the most visible, but each of these is supported by a number of other professional staff). In addition to this, the Department has its own consultative mechanisms, which includes standing advisory committees, ad hoc working groups, and meetings with professional interest groups such as the Medical Royal Colleges and the British Medical Association.

3.4.1 The Regional Medical Advisory Mechanism

At the time of my research, formal mechanisms for incorporating professional advice and professional opinion into the NHS planning process also existed at Regional Health Authority level - in the guise of the Regional Medical Advisory Mechanism (RMAC) and

its Specialty Sub-committees (SSCs). However, the future of the Regional Health Authority was itself coming under scrutiny following the introduction of the 'internal market,' and a number of questions about functions and responsibilities at this level were being posed. (This process culminated in the abolition of RHAs following the 'Functions and Manpower Review' within the department of Health, and the incorporation of RHA residual functions into the NHS Executive Regional Offices, in April 1995).

During 1992, I was myself working at an inter-regional level, for the Regional Directors of Public Health Group. One of my tasks that year was to conduct a series of visits to all fourteen Regional Departments of Public Health, to investigate how they were each approaching a number of strategic issues. One of these issues was professional advice. Eleven of the RHAs I visited that spring had either reorganised their RMAC or were in the process of reviewing this with a proposal for change being the intended outcome of the review. (Of those that were not contemplating change, only one was happy with the way things were working. Another felt the mechanism was not working successfully, but anticipated that reform would be a difficult task, so did not consider attempting this a high priority. The third had attempted change, but this had been resisted by the RMAC, which insisted on retaining its existing structure. As a result, an alternative mechanism was being established to 'bypass' the formal mechanism.)

In nearly all cases, the RMAC and its SSCs were perceived (by the RHA) to be bureaucratic and unresponsive. Professional advice, in theory, passed upwards - from the SSCs to the RMAC, which usually reported to the RHA via the Regional Director of Public Health, with RMAC minutes usually going to the RHA. However, the success of this mechanism was considered to be variable, at best. Committees in general were felt to work well when they had a specific brief, but otherwise they were considered to be unproductive. Their working processes were also slow and cumbersome, with the result that most, if not all, Regional Directors of Public Health had found alternative ways to obtain advice quickly - either by setting up specific mechanisms for obtaining a 'rapid response from a specially-selected 'core group', or by bypassing the mechanism altogether and drawing on informal networks and professional contacts.

In addition, the NHS reforms were felt to have had a considerable impact on the need for professional advice. Prior to the reforms, the RMAC and its subcommittees had provided professional (medical) advice to the RHA on a wide range of issues, including the long-term planning of health services; supra-regional clinical services; regional and sub-regional services; allocation of revenue and capital between districts; priorities for major capital investment; deployment of medical and dental manpower; provision of resources for undergraduate teaching and research; promotion of health services research; development of post-graduate medical and dental education policy; and careers advice for doctors in service. (Perkins, 1984)

By the early 1990s, many of the issues listed above were no longer the responsibility of Regional Health Authorities, either because these had been devolved to Districts, or had been designated 'provider functions' and therefore become the responsibility of NHS Trusts. New advice needs had also arisen, as issues such as the introduction of medical and clinical audit, the development of treatment protocols and guidelines, continuing medical education (CME) and health policy advice, moved up the RHA agenda.

3.4.2 Professional Advice for Purchasers

Meanwhile, there was also a concern around the professional advice needs of purchasers. The first guidance on this was issued in February 1991, as *Professional Advice to Purchasers* (NHSE, 1991). Prior to the introduction of the NHS reforms, service planning had been the responsibility of the RHAs. With the introduction of the internal market, however, 'planning' had apparently ceased to exist. (Within South East Thames RHA, for example, a planning department containing over 60 staff was effectively abolished, leaving a small core of public health and information staff, many of whom were subsequently 'hived off' into the South East Institute of Public Health during a period of exceptionally 'macho' management) Planning was, effectively to be replaced by the purchasing function, which was, of course, the role of DHAs (see above). 'Working for Patients' had highlighted the need for purchasers to secure professional

advice to inform contracting, but, until the DHA discussion paper, there had been little guidance to purchasers on how this was to be obtained.

Professional Advice for Purchasers (NHSE, 1991), however, challenged DHAs to ensure that this advice did not simply come from their local providers, but needed to include "independent advice." This independent advice, the document went on, should be taken to mean

> "firstly, views obtained either formally or informally from professionals who are not associated with providing services in a contract with the DHA; and secondly, views concerned with the nature of services to the District's residents generally, not the care and treatment of individual patients." (NHSE Feb 1991)

A number of sources of professional advice, to which health authorities already had access, were identified, including the Royal Colleges, the Local Medical Committee, District Medical Advisory Committees (with the proviso that these are "often secondary to advice from clinical directorates or departments"), and, of course, the Regional Medical Advisory Committee and its specialist sub-committees. (NHSE, Annex A, p.9) In terms of future sources of professional advice, there was a suggestion that "the local sources are more relevant in the short term, others as the new systems develop." (Annex B p. 11) Among the 'others,' the first on the list was the RMAC!

> "RHA machinery: Regional advisory machinery will continue to offer strategic direction for the development of DHAs' purchasing plans. But there could also be scope for a different RHA role, eg in the identification of suitable advisors, or to ensure consistency of advice on primary and secondary care." (Ibid. p 11)

In June, 1994, the South Thames (West) RHA published a report by Peter Littlejohn and Carol Dumelow, of the Health Care Evaluation Unit at St George's Hospital Medical School, entitled 'Professional Advice to Purchasers.' This report documented the findings from a project designed to explore the ways in which "purchasers, professionals and

providers in South West Thames viewed the difficulties and possible solutions to achieving sound professional advice." (Foreword). The project was undertaken in two stages. The first stage comprised a literature review and discussions with health care professionals "on the future of professional advisory machinery and the interface between R&D, Clinical Audit, Post Graduate Education and local professional advice." (p.9) The second stage took the form of three multi-professional seminars, to enable participants to "explore the different options available [to them] for ensuring that professional advice informs the purchasing process." (P 9)

Conclusions from this project are interesting, particularly as they form some basis for comparison with my own findings, as many of the areas discussed were similar, even though the key questions and the methods used were different. For example, Dumelow and Littlejohn claim that "it is inevitable that professionals and purchasers have different views of what is required in terms of giving and receiving professional advice." Whilst some of these differences are based on preconceptions about each other's agendas, (for example, "professionals believe purchasers are driven primarily by political imperatives to control costs" whilst "purchasers feel that local professional advice is likely to be belief rather than knowledge-based and biased to their own service"), Dumelow and Littlejohn suggest that "more often, conflict occurs because of a different understanding of the reasons for seeking advice." Their illustration of this point is worth quoting in full:

> "In general, professionals wanted the provision of advice to purchasers to be a local affair, in which their opinion was sought, either individually or collectively, acted on, and the results fed back to them. In contrast, purchasers considered local professionals as only one source of professional advice, albeit an important one, to be utilised in coming to a decision." (Dumelow and Littlejohn, 1994, p. 28)

The authors go on to argue that, "with the present vogue in challenging the validity of clinical practice," purchasers are increasingly likely to move towards more national and regional sources of professional advice, referring to local clinicians to interpret this advice in the light of local circumstances. They conclude that "changing regional and

health authority structures require new models of professional advisory machinery to be developed." Their report describes a number of possible models, but recognises that none of these are likely to be suitable in all cases. "No one model of professional advice is likely to be tenable" They argue that local mechanisms, which may not be equally acceptable to all parties, need to be developed. One issue of great interest is added almost as an aside,

> "Most discussion concentrated on Health Authorities...[who] were more inclined to sample local and national sources of advice than the majority of GP Fundholders, who seemed happier to rely on their local experience and contacts."(p. 29)

The possible impact of this on the future of primary care led purchasing was not discussed, as, although the numbers of patients covered by Fundholding GPs was increasing year on year, the range of services purchased by fundholders was still restricted. Total purchasing pilots and primary care groups were yet to emerge.

What seems particularly interesting about Dumelow and Littlejohn's work is the recognition of the very different agendas of purchasers and provider clinicians. The passage quoted above indicates to me that this was more than a simple misunderstanding, or a failure to communicate - even though the researchers recommend that the way to overcome this difference is for greater clarity about the basis on which advice is being sought. My reading of this report suggests that there are deeper issues at stake. Both sides appear to wish to mobilise professional power to influence the agenda, but both are adopting different strategies to do this, because they have quite different implicit objectives. As Ham has argued, "provider groups are well able to promote and defend their own interests." (Ham, 1992, p.127)

Provider clinicians, it could be argued, are very keen to maintain their dominant role in the policy hierarchy. Being the sole source of professional advice to local purchasers would enable them to control the purchasing agenda. Whilst this may not guarantee

access to greater resources, or enable them to ensure local services are developed in line with their particular professional ambitions, it would, nevertheless, make it very difficult for purchasers to challenge them. They could thus ensure change did not occur, unless it was a change which they would support. This suggests, perhaps, that clinicians could be as or more concerned with resisting change as with leading it. Increasing the involvement of local clinicians could, therefore, be one strategy for maintaining existing services, which might be perceived to have been brought under threat by market forces. Purchasers, on the other hand, appear to want to obtain a range of advice, some of it from very powerful national and regional sources, to enable them to challenge their local clinicians, presumably in order to bring about change in service delivery of configuration. Improving communication will not resolve this difference. Neither, I would suggest, would another reorganisation of the RMAC, however radical. These issues will be explored further in the light of the findings from the South Thames study (see Chapter 8).

3.5 Conclusion

This chapter has covered three interconnected areas of work. The first, clinical involvement in contracting and commissioning, formed the immediate context for the research into this topic undertaken in South Thames during the 1994-5 commissioning cycle. There was at the time little published work on this topic. What was available mostly took the form of 'grey' (unpublished) literature. Whilst this initial review failed to establish a clear baseline of 'good practice'against which practice in South Thames could be judged, it nevertheless provided a number of useful insights into the research topic, informed the research questions, and influenced the development of the research instruments used in both the interviews with commissioners and the survey of clinical directors. The literature on clinical involvement in management was also reviewed in relation to the research brief, which initially required a study of the management structures within trusts, although this requirement was later discarded (see Chapter 4). Nevertheless, this aspect of the literature review has been retained, as it forms part of the wider context in which the research is situated. Indeed, one of the reasons for continuing

to engage with this literature once the initial impetus (in the shape of a proposed survey of trust managment structures) was abandoned, was to explore the potential of this body of work as a source of conceptual, analytic or theoretical frameworks in which to situate the research. Finally, the literature on professional advisory mechanisms has been examined, particularly with regard to the changing structures and processes within these mechanisms, which have begun to emerge with the advent of the NHS internal market and the structural reorganisation which has occured following this. Each of these three areas will be returned to in discussion of the research results, in Chapter 8.

CHAPTER 4 RESEARCH DESIGN

This chapter describes and discusses the development of the research design, and its translation into a project plan. Taken together with Chapter 5, which describes in detail the methods used for collecting and analysing the data, (ie how the project plan was implemented) these two chapters cover what is more conventionally included in a single chapter headed 'methodology'. The reason for this separation is to ensure clarity of discussion around the main areas which influenced the design and implementation of this particular piece of research.

4.1 An unfolding research brief

As many of the books on research methodology make clear, the design of any research project is probably the single most important factor in determining the quality of research findings. Good data analysis can rarely, if ever, compensate for poor research design. Yet research design, like the conduct of research, is influenced by many factors - philosophical, political and pragmatic - and not all of them are within the researcher's control.

This is particularly the case in applied research, where the client approaches the researcher with a problem which requires a solution. In some cases, the client has simply identified a 'problem area' which the researcher has to turn into a researchable question. In other cases, the client may already know the research question they wish to ask, and even have strong ideas about the methods they think should be used to answer it. It is not uncommon therefore for applied researchers such as myself, to be invited to tender for work against a tightly specified project brief which outlines the aims of the research, the questions to be addressed, and also the approach which should be taken.

Nevertheless, even when a project brief is tightly specified at the outset, there is often some room to manoeuvre. In fact, this may be essential, as the client may have only a hazy understanding of the principles of research design, and is frequently unaware of the

full range of methods which researchers can use to collect and analyse data. For this reason, it is always necessary for the researcher to think through the design and methods outlined in any project brief, to ensure that the design is appropriate to the research question, and that the methods for collecting and analysing data are robust. If necessary, aspects of the methodology may need to be renegotiated with the client before any data collection begins.

This particular project was no exception. I had not been involved personally in the early negotiations which had led to the development of the project brief and the commissioning of the research. The project was, as already stated, one of three which the South East Institute of Public Health had been commissioned to undertake to support the developing of commissioning across the region, and the Commissioning Network sub-group (which subsequently became the Project Steering Group) had already formulated a number of questions which they wished to address. (See 'Project Brief', Chapter 1) Clearly, to address these questions would require some gathering of original data, but what form should this take? Was the proposed approach "a survey of clinicians...to see what level of involvement they have..." together with "a survey of all NHS Trusts...to ascertain the precise structure of their clinical directorates and the resources and functions and attributed to those directorates" followed by "a scrutiny of good practice" (letter from the Chair of the Group to the Institute, 14 July 1994) the most appropriate way of answering the questions the project group wished to address? What was the relationship between the various components, and should they be undertaken concurrently or sequentially? If they were to be undertaken sequentially, what would be the most effective order for the work?

For the reasons outlined above, I felt it was important for me to begin by examining the proposed project design, and, if necessary, to take it back to the steering group for further discussion. I was anxious to reassure myself that the project was feasible, and that the findings would be likely to answer the questions the client wished to address. However, as I was planning to use the project as the basis of a post-graduate research degree, I also needed to feel confident that the methodology would be robust from an academic

perspective. Furthermore, for the purpose of my thesis, the project findings would need to be sufficiently robust to enable me to move from description (required by the client) to analysis (to fulfill the academic requirements and my own intellectual curiosity). As I was to discover, these two purposes were not always entirely compatible with one another!

One of the first things I therefore set out to do when I took on responsibility for this particular project was to examine the project brief in relation to operational definitions, questions to be addressed, and the methods proposed. This led me to recommend a number of changes, which were negotiated with the client (the steering group) and subsequently accepted by the major stakeholders. As this process so clearly illustrates many of the philosophical, political and pragmatic influences in management research, the remainder of this chapter will describe this process of methodological development and negotiation in more detail, and highlight some of the theoretical issues raised.

4.2 The focus of the research

In the case of this project, the topic, or 'problem area' was clear. The issue in question was the current level of clinical involvement in the commissioning process across South East Thames. However, there was a need to clarify what was meant by the terms 'clinician' and 'commissioning' before it was possible to move forward, and the steering group had already had some discussions about operational definitions of these terms, and the overall scope of the research.

We subsequently agreed to use the term 'clinicians' to include all the main clinical professional groups (medical, nursing and professions allied to medicine) working in NHS Trusts across South Thames (East), so that the focus of the research was in fact, provider clinicians in acute and community services. (The final survey population was subsequently confined to Clinical Directors and those in broadly similar roles, such as clinical managers of business units. Further information is given in Chapter 5.)

In terms of the commissioning process, the steering group was clear that it was interested in exploring the levels to which they were involving relevant provider clinicians in all stages of the commissioning process, through the development of local strategies and their translation into purchasing plans, to the details of the contract specification and final contract negotiations (see project brief, Chapter 1 and discussion of the difference between commissioning, purchasing and contracting, Chapter 2).

For this reason, and because members of the steering group shared my view that commissioning for health is much broader and more intellectually challenging than simply negotiating contracts, we defined commissioning in as broad a way as we felt was compatible with the contemporary usage of the term, and the group of clinicians we were researching. We did not, for example, consider areas such as primary care commissioning, or joint commissioning with local authorities. Although these were becoming an increasingly important part of the work of (health) commissioning authorities, it was the apparently low levels of involvement in commissioning by clinicians in NHS Trusts which was provoking the concern of politicians and NHS managers. Agreeing the focus and operational definitions of the research was therefore straightforward, and did not seem to raise any major philosophical, political or pragmatic issues. However, this was not to be the case when we considered the remainder of the proposed research design, and the next section explores some of the issues raised in more detail.

4.3 Framing the question

Once the focus of any piece of research has been decided, the next stage is to identify the research question which lies at the heart of the project. It is this research question, and the way it is framed, that will enable the researcher to select an appropriate research design (or research strategy, as it is sometimes known). Once an appropriate research design has been chosen, the various options for data collection and data analysis (methods) can be discussed. Identifying the 'research question' which underpinned this project therefore became my next priority.

As stated in the project brief (see Chapter 1), the steering group had already identified a number of questions it wished to address, and these questions fell into two broad categories. The first set of questions were about *what* was happening, in terms of levels of participation (or non-participation) by clinicians, in all aspects of the commissioning cycle. The second set of questions were about eliciting participants' perceptions - *how did they feel* about their current level of involvement? How did they think the current situation could be improved, and who was responsible for ensuring this would happen?

In terms of research design, this therefore appeared to be a simple piece of descriptive research, drawing on two distinct approaches - the collection of quantitative data to establish *what* was happening, and of qualitative data to capture respondents' *feelings*. However, the initial (and apparent) simplicity of this, linked to my initial difficulty in identifying a theoretical framework in which to locate the work, led me to begin to query whether the set of questions I had received from the client in fact constituted a 'research question' or was this simply a data gathering exercise?

In other words, was the project I was about to undertake, in fact, a research project at all? Phillips and Pugh (1994) describe these 'what' questions as essentially 'intelligence gathering', because they are exploratory and descriptive, rather than analytical. Such questions, they argue, do not seek understanding or attempt to explore causality..They do not ask *why* something happens, or does not happen. Nevertheless, the questions outlined in the project brief were of great importance to the clients who had commissioned the project. They wanted to know what was happening, to inform local policies and to influence managerial action. The project findings were to be reported back to the full commissioning development forum, who would be charged with implementing any recommendations which emerged. These 'what' questions could not therefore be ignored or sidestepped. Whatever the design and method I eventually selected, I would need to ensure that my approach was sufficiently robust to address these questions, and to find valid answers.

However, finding out what was happening, and how participants felt about it was only one of three main elements which made up the project brief (see Chapter 1). The

steering group had also proposed a survey of Trusts in the region, to find out about the structure and function of their clinical directorates, and the resources available to these. The rationale for undertaking this second survey, and the way in which it related to the survey of clinicians was not entirely clear from either the project brief or from notes of steering group discussions. On reflection, I suspected that the then recently-published Audit Commission report ('Trusting in the Future' op.cit), which discussed management arrangements within NHS Trusts, had influenced the steering group's thinking on this subject, and this was subsequently verified in the second steering group meeting, where it became clear to me that the issue of what was happening *within* Trusts was moving up the agenda for commissioning health authorities, and that they seemed to wish to be able to influence this in some way.

Some members of the steering group did seem particularly concerned with what they considered to be deteriorating working relationships between clinicians and managers within their local Trusts, and the impact this was having on their own access to clinical advice and expertise. There was clearly a feeling that the development of the market was having an impact on working relationships, both within provider organisations, and between the purchasers and the providers. This was, in fact, reflected in the project brief, which stated that:

> "Whilst many managers are unlikely to be sympathetic to clinicians who feel subordinated and disenfranchised by the recent management changes, it is undoubtedly true that the fragmentation of clinical/professional influence coupled with the increasingly parochial view of NHS Trusts makes it more difficult for commissioners to capture accurate and relevant input to new strategies and policies when they require it and inhibits a consensus emerging of service issues..." (Project team notes, 15 April 1994)

I therefore became concerned that project steering group were in danger of making assumptions that they knew the answer to the research questions they were posing already, and that they believed their difficulties in accessing clinical input resided in

Trust management structures and processes. This feeling was further reinforced when I had an informal meeting with the Chair of the group, and asked why they wished to explore Trust clinical directorate structures. From this discussion, it soon became clear that the Chair, at least, wished to test a tentative hypothesis he held, that some types of clinical directorate structure within Trusts were likely to be more conducive to increasing levels of clinical involvement in commissioning than others. This part of the project therefore seemed to require a research design that would enable us to test this hypothesis - a different requirement altogether to the 'information gathering' of the descriptive survey on levels of involvement in and feelings about the commissioning process.

The third area of work the project group wished to undertake was the "scrutiny of good practice". Initially, I assumed this was to be the purpose of the two surveys - ie, could we identify, from the survey responses, what counted as 'good practice' locally. However, it was clear from the outset that the rationale for undertaking this work was that this whole area was problematic - there was no suggestion that some health authorities or Trusts were already known to be successfully involving clinicians in commissioning and some were not. The purpose of the first survey was to find out what was happening, without any consideration of the factors which supported or inhibited involvement. Sharing examples of good practice across the region had never been an explicit project objective. Furthermore, this thread of the research seemed to contradict the hypothesis - testing approach.

If the research was to succeed in establishing that the clinical directorate structure was influential, it was this that would need to be changed. However, commissioners had no power to define internal management arrangements within Trusts, or even to make recommendations in this direction. One of the key factors in the establishment of NHS Trusts was that they would be autonomous, accountable directly to the Secretary of State, through the Trust monitoring function of the Regional Health Authorities. District Health Authorities were no longer responsible for managing hospitals, and their interference in this process was unlikely to be welcomed by Trust Chief Executives. If, on the other hand, the hypothesis was falsified, we would presumably be unlikely to have examples

of 'good practice' to disseminate. In any case, both objectives would be likely to require a different research design.

To some extent, the issue of scrutinising examples of good practice was resolved, when, following further discussion with the steering group, it emerged that the member who had suggested this approach considered a literature review to identify good practice in other areas of the country as the appropriate way forward. However, as very little appeared to have been published on this topic at that time, this strategy proved to be of limited use, though it did clearly reinforce the need for some original research in this area. There was, however, rather more literature on clinical directorates, and the roles of clinicians in management, which has been dealt with elsewhere. (See Chapter 3).

4.4 Developing a project plan

One of the first things the steering group required from me when I began working with them, was a detailed project plan and work programme. A full project proposal was therefore prepared, with revised project objectives and methodology, together with a provisional Gaant Chart, for discussion at the next meeting of the project steering group. The project objectives at this point were expressed as follows:

(i) to describe the current organisational arrangements for involving clinicians in management within provider units

(ii) to explore clinicians' own experience of involvement in the commissioning process

(iii) to examine whether there [was] any relationship between organisational arrangements to involve clinicians in management and their effective involvement in the commissioning process

The methods were to include

(i) a literature search and review

(ii) a survey of organisational and management arrangements within Trusts

(iii) a survey of clinical directors

I was still at this time concerned about the absence of a clear 'research question' in terms of my academic requirements, and began to experience some of the difficulties of undertaking applied research for academic purposes. For the purpose of my research degree, it would clearly be necessary for me to be able to go beyond description to some kind of analysis, but this was not a priority for the client. It might also be desirable to develop, or even to test, a hypothesis, or series of hypotheses, about the factors that might be linked to the levels of clinical involvement in commissioning. Would the collection of management 'intelligence' enable me to achieve this? Was this compatible with the Chair's wish to test the hypothesis of a link between clinical directorate structures and levels of clinical involvement in commissioning? Would we at least be able to identify criteria for 'good practice' - if not examples of good practice per se? Finally, was the project feasible from the client's perspective, and was it appropriate for a post-graduate research degree?

4.5 Turning a management problem into a research question

It was, I think, at this point that I began to understand that what I was in fact dealing with was not a set of research questions, but a set of management problems, which would need to be turned into a research question. Suddenly, the tension I had anticipated experiencing in terms of the conflicting demands of applied and academic research came sharply into focus. To reconcile these differences, I would not simply have to write two project reports, as recommended in the management research literature (Easterby-Smith, 1991; Edwards and Talbot, 1994). I would have to renegotiate the project brief to enable me to use a research design that would meet both my own needs and those of my clients.

To achieve this, I still needed a robust research question, and a research design that would meet the client's needs and be supported by the major stakeholders. What is interesting is that it was political influences on the project that gave me this opportunity to renegotiate the project brief, and to further explore some of the philosophical issues related to the research design. It is, however, the philosophical issues influencing research design that I will outline first.

4.6 The philosophy of management research

In addition to the research question, another factor which will influence research design is the academic discipline in which the researcher is working. In the case of management research, which draws on the knowledge bases and traditions of sociology, anthropology, economics, statistics, mathematics and even engineering, the approaches taken to research tend to be somewhat eclectic. This has enormous advantages, in that management researchers can draw on a whole range of conceptual and practical tools. However, it also has weaknesses, in that indiscriminate or inappropriate use of approaches and methods, or the use of multiple methods in a single piece of research (an approach which is becoming increasingly popular) can, if used carelessly, seriously impair the validity, reliability and where appropriate, the generalisablity of the research findings. Choosing the appropriate tool for the job, therefore, is even more important in a discipline which draws from an eclectic knowledge base than in one which has a narrower methodological focus.

The philosophy and politics of research are often dealt with quite separately in the methodology literature, but I would argue that they cannot be as easily disentangled in practice. All research is underpinned by philosophical assumptions. As the sociology textbooks remind us constantly, the questions we investigate through research do not arise in a vacuum, but are constructed within systems of meaning, or models of reality, which themselves

> "lead to different propositions about what reality *is*, and so different ways of *establishing what can be accepted as real*, different ways of *justifying the data relevant to* reality, and different *strategies for collecting* such data. (Bilton, et al. 1981, p 628-9)

These four aspects, ontology (concerned with being); epistemology (concerned with knowing); methodology (concerned with the logic of enquiry) and method (the techniques for collecting data) are interrelated, but conceptually distinct. Many problems which can occur when undertaking research arise as a result of lack of clarity at the design stage. Sometimes this takes the form of a failure to distinguish between some of these concepts, in particular from the conflation of methodology and method. Techniques of data collection, however carefully employed, cannot adequately answer questions they were not designed to investigate, and the tendency in some areas of research to chose a method on purely pragmatic grounds, without adequate consideration of the 'logic of enquiry' can lead to false starts or worse.

Within the social sciences, there are a number of theoretical positions that can, and do, inform research, but these can be broadly categorised into two main philosophical traditions - positivism and phenomenology. Both have different implications for the methods used to collect and interpret data. To summarise briefly (at the risk of over-simplification) positivist approaches are usually favoured by those who take the view that the object of the research exists in an external reality and can be measured through objective methods. Positivism in the social and behavioural sciences is derived from experimental methods used in the natural sciences.

In such cases the researcher is deemed to be independent of the phenomenon under observation (and vice versa), and the choice of research area or question can be determined by objective criteria. The methods chosen for investigation within this paradigm are quantitative, reductionist, and hypothetico-deductive. There is an emphasis on statistical analysis which may result in the verification (or failure to refute, if one is working within a Popperian model of falsification) of testable hypotheses. 'Good'

research within this paradigm is research which attempts to describe events, to look for patterns within the data (correlation of variables) and thereby to establish causation, through the use of appropriate statistical tests. Such research, if carefully conducted, is usually generalisable to other settings.

Phenomenologists, on the other hand, attempt to understand the meanings constructed by social actors. Their starting point is that reality is socially constructed, hence the task of the researcher

> "should not be to gather facts and measure how often certain patterns occur, but to appreciate the different constructions and meanings that people place upon their experience. One should therefore try to understand and explain why people have different experiences, rather than search for external causes and fundamental laws to explain their behaviour." (Easterby-Smith and colleagues, p 24)

Research undertaken within this paradigm explores the values and meanings of the participants (the subjects of the research); the researchers aim to set aside their own pre-conceptions, and to avoid 'tainting' the research by offering their own explanations of events. The research setting is naturalistic, the logic of enquiry is usually inductive, and data are regarded as valid when a mutual understanding between investigator and respondent has been achieved.

Thus positivist approaches tend to lead to the use of quantitative methods, whilst phenomenological approaches favour a more qualitative approach. However, as Easterby-Smith and colleagues are quick to point out, these two philosophical positions are not the only ones available to social researchers (p25), though they are probably the most common. Nevertheless, these dualisms - between positivist and anti-positivist, quantitative and qualitative - are, in practice, oversimplifications. In many areas of social research, and especially in management research, it is becoming increasingly common

to adopt a 'multi-method' approach, in order to build a 'richer' picture of the phenomena under investigation. In this way, the limitations of any one method can be compensated for by the strengths of a different method (Brewer and Hunter, 1989)

In terms of the research design for investigating clinical involvement in commissioning, the original project brief required two apparently straightforward pieces of descriptive research which would need to use a mix of methods - not for the purposes of triangulation (which is an approach used to enhance the validity of research findings, by approaching the same question with more than one research method, each with non-overlapping sources of potential bias), but rather as a way of capturing different information. To elicit information on *what* was happening potentially required a different approach to capturing people's perceptions of events. In this case, therefore, the use of a 'multi-method' approach was more about answering different types of question, which required different approaches to the 'logic of enquiry'. The 'what' questions could be answered by gathering quantitative data, whereas the perceptions (the feelings and understandings of participants) required a more qualitative approach. As it was quite feasible to design a questionnaire which could collect both qualitative and quantitative data, two postal surveys, one to Trusts to ask about their clinical directorate structures and one to clinical directors to explore their levels of involvement in, and feelings about, a number of aspects of the commissioning process, appeared to be an appropriate research strategy.

The only philosophical problem I had at this stage (apart from the lack of a 'why' question to inform my thesis), was that the Chair of the steering group (a high-profile local Director of Commissioning with a background in economics) was, as stated earlier, developing his own tentative hypothesis that the levels of clinical involvement in commissioning were linked in some way to the internal Trust management structures. Although this potentially met my need for a more analytical approach, I was unsure that the research design we had already agreed would enable me to test this hypothesis, as we had a relatively small number of Trusts, which had a number of differences in addition to their internal management structures. For example, Trusts could be categorised as

acute, community or mixed; there were teaching and non-teaching hospitals; Trusts were based in central London, in outer London, and in the counties of Kent and Sussex; one had achieved Trust status in the 'first wave' whilst others followed in the second and third waves, and a very small number of 'DMU's (directly-managed units - ie hospitals still under the control of their local health authority) were still going through the process of determining whether they would become Trusts themselves, or be merged with other local providers who already had Trust status.

In addition, the literature suggested a range of models for clinical directorates, and these were at various stages of development across the region. It appeared, therefore, that there were potentially too many confounding variables to enable us to be able to draw any conclusions about statistically significant differences in levels of clinical involvement in commissioning by Trust management structure. Furthermore, even if this were to be possible, and the findings were to prove significant, I was still unsure that the clients' needs would be met. What could the Commissioning Network do as a result of such findings? What recommendations would the steering group be able to make, and who would be responsible for implementing them?

At the time that this research was being undertaken, the national health policy agenda was giving out strong messages that health authorities were not expected to interfere in any way with Trust management issues (the setting up of the regional 'outposts' to manage Trusts was a clear indication of this; Trust accountability was, to all appearances, bypassing even the Regional Health Authority , and passing directly, via the 'outposts' to the Secretary of State). It was this aspect of the research that subsequently delayed the project, as the Trust stakeholders objected to the research proposal and initially refused to cooperate with the steering group. The politics of management research rapidly became an issue we needed to address with some urgency, and a description of how these issues were resolved follows.

4.7 The politics of management research

All areas of the research process can be influenced by political considerations. There are plenty of examples in the social science literature of researchers experiencing difficulties with dissemination or publication of research findings which are unacceptable in some way to those who funded the research. However, in this piece of research, the political difficulties arose early, at the stage of defining the problem area and research question, and selecting and justifying the tools for collecting data - in other words, at the research design stage. These political difficulties became interwoven with the philosophical issues discussed above, and for all practical purposes, inseparable from them .

Doing research is itself a social process, in that the question formation, the research design, data collection and analysis and the final report are all embedded in social relationships. The various players in this relationship are able to mobilise different sources of power, to which they do not all have equal access, and to deploy this power in different ways. Research of any kind (including scientific research) is therefore inherently political, as the power relationships between the individuals and institutions involved in the research result in different strategies being adopted by different actors - whether sponsors or subjects of the research. In the case of management research, where the research subjects are frequently in more powerful positions than the researchers, these power relationships have a particular potential for consequences on the research process. What took place next provides an excellent illustration of the impact that power and politics can have on the research process - even though, in this case, it was the impact of political manoeuvring by various stakeholders in the process that in fact gave me the space to renegotiate the project brief in a way that was to my advantage.

At this point in the development of the project, the Chair of the Steering Group became increasingly concerned about the best way of achieving 'ownership' of the project by those who would both need to participate, and those who need to be involved in the implementation of the project findings. The steering group was clearly expecting some resistance. The Chair was particularly worried that he would be open to criticism for

spending money on research into a subject where many people (eg clinicians) already felt they already knew the answer (ie that they weren't involved). Also, there were concerns that Trust Chief Executives might refuse to cooperate with the research, as they could perceive it to be an opportunity for commissioning authorities to take an inappropriate interest in internal management arrangements within their Trusts. This was, after all, at a time when Trust independence was very much part of the policy rhetoric, and many local providers were keen to distance themselves from the health authorities that had previously directly managed them. The Chair of the group therefore felt it was important to gain commitment from the Trusts, and sought advice from the Trust monitoring unit within the Regional 'Outpost'. The response was outlined in a letter written by the Chair to members of the steering group, as follows:

> "I have been pursuing the issue of provider cooperation and involvement in the exercise. [blank]... has advised me to test the water with one or two of the local Trust Chief Executives and so I am in the process of giving them sight of Yvonne's proposal and getting their reaction. Although the process is more long winded than I had hoped I still aim to have a provider representative on board by the time we finalise the questionnaire and send it out..." (Chair of the Steering Group, 22 July 1994)

Two Chief Executives contacted were very supportive, and one offered to join the steering group. However, they both thought the project should be discussed at the next meeting of the Trust Chief Executives Forum, which was not due until the 21 September. They were also concerned that anonymity should be guaranteed, for clinical directors and for their organisations. Reassurance of this was, of course given. They also asked, "What's in it for the clinicians?" and expressed the view that they would have a "slightly different agenda to that of the commissioners." (Personal communication from the Chair of the Steering Group, 29 July 1994).

That was not, however, the end of the process of 'gaining ownership' of the project. Over the next two or three weeks, the Chair received a number of letters from Trust Chief

Executives, some of whom were considerably less supportive of the project than others. One particularly detailed response, which was influential in formulating the way the project was subsequently carried out, included the following comments

> "Whilst I understand and support the notion that clinicians must be involved in the planning processes of the NHS (and my comments should not be read to the contrary), I am not particularly happy with the methodology you describe. In fact, given the purity with which my fellow Chief Executives and I would like to see the purchaser/provider split the project as described is a little worrying.
>
> "For example, I don't think it sends the right messages for commissioning organisations to do research into the 'current organisational arrangements for involving clinicians in management within provider units.' This is our business and although it would seem you want the information to try to see whether clinicians are involved enough in planning, it opens up the prospect of commissioners trying to influence our internal structures.
>
> "Basically what I am saying is that health authorities being sure they have proper professional advice can be a completely different issue than how Trusts are organised internally and how Trusts involve their staff in the contracting process. I think the project should therefore be approached from a different direction...I would suggest that they key question for the project is 'how do commissioners ensure their decisions include appropriate professional advice?' This would lead you to a whole different set of sub-questions. I do not think it is appropriate for commissioning organisations to survey our internal organisation ..."(Trust Chief Executive letter to Chair of Project Steering Group, 27 July 1994)

Whilst other Chief Executives who commented on the proposal were less forthright than this, the view that there was "a difference between involving doctors in management and contracting internally, and involving them in commissioning" (Trust Chief Executive letter to Chair of Steering Group, 29 July 1994) was expressed repeatedly, in some form

or another, as was the issue of the need for commissioners to seek independent clinical advice. Whether this was a defensive reaction to a perceived interference by purchasers, or a valid criticism of the research design posed an interesting question, but not an easy one to answer.

What it did clearly demonstrate, however, was the power dynamics between purchasers and providers, and how this could influence the questions which could be asked as part of the research process. For the steering group, this was, I think, seen as something of a setback, which led them to need to revise the project approach in ways which they saw as an uneasy compromise between meeting commissioning authority needs and provider demands. However, this in fact gave me the opportunity I needed to renegotiate the project brief, and to change the design of the research to ensure that it not only met the clients' needs and addressed the stakeholders concerns, but would also enable me to develop an appropriate question to underpin the research, and to inform its methodology.

4.8 Pragmatic considerations

Finally, there are pragmatic considerations which will influence research design and the methods used for the collection and analysis of data. Issues which arise under this heading are mainly associated with access (to people and/or organisations), timescales for the completion of work (often a major consideration when a project is being funded by a client, to meet their need for information to inform policy or management), levels of cooperation from participants and so on. Management problems frequently require 'quick and dirty' solutions, which can seriously threaten not only academic rigour, but the validity (and therefore the usefulness) of the research findings. However, in the case of this project, the clients had set a reasonable timescale (the research had to be completed in time to inform the next year's commissioning cycle); and the commitment of the steering group, particularly its Chair, helped considerably when it came to gaining access to the organisations and individuals which were to be the subject of the research. In terms of time to undertake the fieldwork, I was fortunate in having a six month part-time secondment from my post in the North West Thames Regional Health Authority, to the

South East Institute of Public Health, where I had access to secretarial and administrative support, and professional supervision.

4.9 Back to the drawing board

By the middle of September, I was able to make a presentation to the Project Steering Group outlining progress. By this time, I had searched for literature on clinical involvement in commissioning, and found no published research available on this topic, though there were references in the health management press to the survey by McLean, Jones and McCarthy. (See Chapter 3). There was, however, a considerable amount of literature on clinical involvement in management, and around the development of clinical directorates (This has been covered in Chapter 3). We had circulated a detailed project proposal and project plan in July, and had received a number of salient comments in response (see above). I had also done a considerable amount of thinking around the subject, to establish what we needed to know, what we knew already, what we needed to find out, and what we could exclude (as being either beyond the scope of the project, or pragmatically unobtainable).

In order to focus my thinking, I began to ask myself a series of 'Why?' questions. Why do the commissioning network want to involve clinicians in commissioning? What do the Chief Executives and Directors of Public Health think it will enable them to achieve? Do the provider clinicians want to be involved? Why? What do they hope to achieve? Do these views have anything in common, or are they likely to be working to different political, professional or managerial agendas? I also felt I needed to address some political questions, such as who wants this information? Why do they want it? How will they use it? I took these questions, together with the draft questionnaires, to the next meeting of the steering group for discussion.

As a result of this meeting, we agreed to leave the survey of Trust organisational structures out of the project, as we could pick up much of the descriptive information from the literature and the survey of clinicians. I also obtained permission to undertake

some qualitative work with Chief Executives and Directors of Public Health in all the participating health authorities, to explore the following:

i. Why they wanted to involve clinicians in commissioning
ii. Which clinicians they felt should be involved
iii. How this related to other sources of professional advice available to them
iv. Which aspects of the commissioning process they thought were most suitable for clinical input
v. Whether they felt clinical involvement should be increased, and if so, whose responsibility it was to ensure this happened; what structures and processes needed to be in place to facilitate this, and what were the implications ·
vi. Whether there were any perceived risks to involving clinicians in commissioning, and if so, who/what would this affect most, and what could be done to minimise this impact.

The purpose of this stage of the research was twofold. Firstly, I felt it would enable me to answer my research questions - why was this an issue, for this group of people, at this moment in time - from the perspective of the participants themselves. I also felt (and I think it was this that influenced the steering group to endorse this approach) that this qualitative work would help inform the development of the survey questionnaire, which would subsequently be sent to Clinical Directors. I did have some concerns about the potential response rate of a postal survey of clinicians, and I was very much hoping to ensure that this achieved optimum levels. A well-designed questionnaire, I argued, would be likely to ensure a good response rate.

4.10 From methodology to method

To summarise, then, I would argue that research methodology (design) differs from research method, in that it is more than simply the techniques used for collecting and analysing data. It is described in the methodology literature as a "plan, blueprint or guide for data collection and interpretation...sets of rules that enable the investigator to

conceptualise and observe the problem under study." (Adams and Shvaneveldt, 1994) Research design has been described as

> "...the overall configuration of a piece of research: what kind of evidence is gathered from where, and how such evidence is interpreted in order to provide good answers to the basic research question." (Easterby-Smith et al, 1991)

The design of a piece of research will inform the choice of methods used for data collection, for data analysis and for the interpretation of findings; it is for this reason that it is generally considered important to explore a range of design options before adopting any research strategy, and before agreeing the research methods to be used.

However, the research question is not the only influential factor. A number of conceptual, philosophical and political processes also influence the choice of research design, and are not easily separated from each other, or from the pragmatic considerations which also need to be taken into account. It is this process of exploration, and the iterative nature of the philosophical, political and pragmatic factors which influenced it, which has been documented in this chapter. In the chapter that follows, I will turn to the operationalisation of this research design, and describe the research process, giving details of the methods used for collecting and analysing the data. Before moving on, however, it may be useful to review the methodology which was eventually chosen for undertaking this research, with particular emphasis on its potential limitations. I will also describe how I attempted to address these limitations within the constraints which were imposed on the work by my clients, and where appropriate, suggest alternative ways in which I might have approached this research.

4.11 Review of methodology

There were, as already stated, a number of tensions in the research methodology chosen to undertake this project. Some of these have already been covered Chapter 2, where many of the dilemas surrounding the undertaking of high-quality, theoretically-informed

sociological research within the confines of an applied health services research unit - especially one which derives its income from undertaking small-scale empirical studies for local health services, rather than bidding for work from the research councils - are discussed in some detail. Other tensions, which surrounded this particular project (rather than applied research in general), have been documented above. The main issue under analysis here is the extent to which the ways in which these tensions were resolved might have affected the methodological quality of the research, and the steps that were taken to minimise the damage which might have occurred as a consequence. To examine these issues, I shall outline the most common critiques of the methodologies I employed, derived from the social science research methodology literature. I will then discuss how I addressed these issues within my own research.

4.11.1 Surveys in sociological research

One of the key texts used by social researchers undertaking survey work is the volume by de Vaus (1991). After extensive coverage of the methodology and its uses, the author feels a need to defend this approach, drawing extensively on the work of his major critics to do so. Citing a seminal critique by Marsh (1982), de Vaus acknowledges that survey research has frequently been criticised by British sociologists, who are reputed to regard the approach as "hopelessly empiricist, the product of vulgar American sociology." Within the current sociological orthodoxy, apparently, "the survey is rejected out of hand as being incapable of producing any information worth having." (Marsh, 1982) Surveys are often criticised for being "inherently positivistic" de Vaus continues, and are often accused of being "incapable of getting at the meaningful aspects of social behaviour." De Vaus of course challenges this view, and the oft-quoted observation of such major critics of positivist sociology as C. Wright Mills (1959), who "has contended that the design, implementation and analysis of surveys requires no sociological imagination" (de Vaus, 1991) by arguing that

> "Depending on how information is collected, how much is collected and the way it is analysed the survey researcher who is conscious of the problem of context

can go a long way towards interpreting the meaning of behaviour and opinions in the light of their context" (de Vaus, 1991, p. 333)

Furthermore, de Vaus argues, many of the critics of surveys either do not fully understand the methodology and its appropriate use, or have been exposed to examples of the method which have been "poorly-designed, executed and analysed." (De Vaus, 1991)

4.11.2. Addressing the critics

As far as my own survey was concerned, therefore, I felt it was essential to ensure that the questionnaire was as well-designed, the survey as well-executed and the data as well-analysed as I could achieve within the given contraints. Furthermore, I felt that my interpretation of the data gathered in this way should be fully informed by the context in which the survey was undertaken. In order to achieve this, the survey instrument was designed following a considerable amount of preliminary work. This included the initial literature review outlined in Chapter 3, a number of detailed informal discussions with what my anthropological colleagues would probably describe as 'key informants' (these included the Medical Director of the Trust 'outpost,' members of the South Thames Commissioning Network, and two Directors of Commissioning). I attended a national conference on the subject of my research (see Chapter 3). I also undertook a series of in-depth interviews with health authority Chief Executives and Directors of Public Health (see above). Although these interviews had been included to answer a different set of questions to those being explored in the survey, I feel that the understanding I gained from conducting these interviews considerably enhanced the quality of the survey questionnaire. Finally, the draft questionnaire was piloted in two NHS Trusts in a neighbouring NHS Region, where recipients were invited to feed back their comments on the questionnaire design, as well as being asked to complete the proforma. (See Chapter 5 for more details on the development and administration of the survey.)

Interpretation of the survey findings was informed by the wider research context, which was also incorporated into the research process through the documentary analysis,

qualitative interviews, and relective research diary. As I collected, processed and analysed all the data myself, I was able to build a complex picture of the issues which I was investigating, and to develop my understanding of what was happening, and the ways in which events could be interpreted, throughout the duration of the project. Furthermore, I wrote frequent briefing papers for the steering group, so was able to feed back emerging themes and issues to this group, thereby giving them an opportunity to challenge my interpretation of the data. At the end of the project, I presented my findings to the wider Commissioning Development Forum at a regional seminar. This seminar was well-attended, with delegates coming not only from the Commissioning Development Forum, but from commissioning teams on both sides of the purchaser-provider divide. Finally, a synopsis of the project was distributed to all participants (see Chapter 8 for a fuller account of this feedback).

Academic supervision was, of course, available from my PhD supervisor, and I had a number of discussions with colleagues within my own department as the work progressed. However, as the other members of my department at that time were all statisticians, public health physicians and information specialists, rather than fellow sociologists, there was inevitably a bias towards positivist frameworks in these discussions. Indeed, there was even one occasion when a public health physician in my department criticised the use of a survey on the basis that it was "an observational study", which would only yield qualitative data. (He did insist, admittedly, that he was comparing surveys in general, rather than mine in particular, to the perceived 'gold standard' of the randomised controlled trial much favoured by epidemiology. Nevertheless, I was left with the distinct impression that my study did not count as 'research' because it was not an RCT - though quite how such a quasi-experimental research design could have been expected to address my particular research questions, or how I would have practically managed to apply such a design in this particular set of circumstances, was an issue my colleague avoided addressing). There is however, a serious point in here, in that critiques of survey methodology do not only come from sociologists, or even from other qualitative researchers.

Those working within the natural sciences, or within those social sciences which rely heavily on their research methods, would be quick to argue that self-completed questionnaires are also limited in their abity to elicit 'facts' about a situation, as respondents will answer in the light of their subjective experience of events, rather than from the more objective perspective which should be available to the researcher. Furthermore, those coming from a more experimental persuasion frequently argue that surveys are a poor way of exploring causal inferences (this is a favorite criticism from my more epidemiological colleagues), "because of the difficulty of establishing causal links with correlational data." (De Vaus, 1991) Whilst a number of criteria have been established by epidemiologists to assess the extent to which correlation indicates causation (the so-called 'Bradford Hills criteria'), quasi-experimental research designs are often the preferred approach of this group wherever this is feasible. Other designs, which incorporate randomisation in some way, such as case-control studies are frequently used where RCTs are not feasible, and are preferred to surveys, which come some way down the 'hierarchy of evidence.' Neverthless, de Vaus would challenge this position, on the grounds that it is possible to avoid the risk of drawing faulty causal inferences from correlational data through techniques such as multi-variate analysis. However, as I was not attempting to use my survey data to investigate causality, there was no particular need for me to address these particular potential methodological weaknesses.

Nevertheless, some limitations of the survey as a research design must be acknowledged. The limitations fall into two categories. First, as a qualitative sociologist, I am acutely aware of the criticism that postal surveys are not the most effective approach to gaining an understanding of participants' own perspectives. The open questions on the survey, which were designed to explore respondent's feelings about the commissioning process, would have been less sensitive than face-to-face, in-depth interviews in capturing the subtlety and complexity of their feelings. Ideally, it would have been helpful to have been able to undertake a series of interviews with a sub-set of the survey sample, to explore these issues in more depth. This would have enabled the quantitative data to be 'enriched' with insights drawn from qualitative research. This kind of mulit-method approach has more credibility within sociology, as a means of eliciting participants perceptions, than

the inclusion of open-ended questions in a postal survey. However, this was unfortunately not feasible within the time-scale and budget allocated for the project.

The second group of limitations are concerned with the more technical issues of the validity, reliability and generalisability of the survey. (I am using these terms here in a way commonly understood within the social sciences, that is 'validity' refers to the extent to which a test, questionnaire or other instrument "is really measuring what the researcher intends it to measure"; 'reliability' refers to the extent to which use of the same method or instrument would give the same result if applied more than once to the same group, under the same circumstances; and 'generalisability' refers to the extent to which the survey findings might be considered applicable to subjects or settings other than those in which my study was undertaken.)

Validity within survey methodology takes a number of forms (for a full description of these, see for example, Miller and Wilson, 1983), and I am not sure that my approach to questionnaire development was robust on all counts (I did not, for example, test individual questions for their concurrent or predictive validity, nor was I able to use questions which had already been validated by other researchers in other similar settings, as these were not available), but face validity was established, I would argue, through the way in which the questionnaire was developed and piloted (see above). I was fully aware that I was gathering data on respondents' opinions of what was happening locally, rather than collecting 'robust' measurements of what was 'really' happening; and that I had no way of cross-checking the extent to which participants' perceptions were in accord with that 'reality'. It is quite possible, for example, that other individuals, even within the same Trust, might be working with a very different interpretation of events. However, as I was conducting a census (rather than surveying a sub-set of my population) there was at least the opportunity for all respondents to express their opinions - and it was their opinions and perceptions that my clients were interested in exploring. Finally, I used a test of validity often employed by qualitative researchers, that of feeding back my findings to the research participants. All those who took part in any way were sent a copy of the summary and key findings (see appendix), and invited to comment. There was no

challenge to my findings. Comments received were postive and simply thanked me for doing the work.

Reliability was less of an issue within this particular project, as the research was highly context-specific. It took place at a particular moment in time, during a period of rapid change. It is therefore reasonable to assume that the research is not reliable in the conventional sense, in that it would be very unlikely that the same results could ever be obtained by using the same questionnaire on another occasion with the same group of people - unless such a repeat study was undertaken almost simultaneously. The level of involvement in commissioning among this group of clinicians was changing rapidly as the internal market was being developed, so it could be expected that clinicians knowledge of, and feeling about, the whole process would be changing too. Furthermore, there would inevitably have been contamination of the research enviroment during the initial survey - the research itself would have raised the profile of the topics under investigation, and increased participants' knowledge of the issues involved. It might also have changed their feelings about the process - especially as the findings were fed back to the Commissioning Forum, in time to inform the next round of commissioning. Indeed, the need to inform this process, and for those participating in the research to act on the findings to improve what was seen to be a management problem, was the purpose of the research. This factor, I feel, makes discussion of the survey's reliablity somewhat redundant in this particular study.

Generalisablity is also an area where there is a need to consider the possible limitations in my study design. Because of the size of the survey population, and the range of organisations within the South East region of the NHS, I would argue that the group of clinicians under investigation were likely to be typical of clinicians elsewhere in the country (ie they have been drawn from acute, community and combined NHS Trusts, from all the clinical professions and sub-specialties, and from a similar level of managerial responsibility) However, the organisational context in which the research was undertaken may have been different in a number of ways. Although national policy was certainly consistent across the 14 English Regional Health Authorities, the local context

in which this national health policy was being implemented varied considerably across the country. The main difference, I would argue, was the pace of organisational change - on both sides of the 'purchaser-provider' divide.

During the early 1990s, immediately before I began this research, I was working for the Regional Directors of Public Health Group, and was very much aware from my own experience in this role that the market was not being introduced at the same speed across all 14 NHS Regions. Whilst the overall policy goals were the same across the country, the political and organisational context within which these policies were being implemented was quite different. Some RHAs were very keen to be seen as being at the forefront of change, others were either more circumspect, or encountered greater local resistance. A number of Regional Directors of Public Health (particularly in the North of England and the West Midlands) had told me how their RHA was having to respond to conflicting national and local political agendas, although within the South East region, this particular conflict was not in evidence at the time of my research. It is, therefore, at least possible that my research findings would not have been generalisable to NHS Regions where there was stronger opposition to the introduction of the internal market from local politicians.

4.11.3. Qualitative methods in health service research

The tendency of sociologists from an interpretivist tradition to be critical of the use of surveys in research is not, however, unreciprocated by colleagues within and beyond the discipline. Among health service researchers, especially those emanating from public health medicine or from academic epidemiolgy, there are considerable reservations about the use of qualitative research. Indeed, when I joined the NHS in 1990, with a degree in sociology and a masters in social policy (both of which had included extensive study of social science research methodology), I was regarded as having had no traïning in research methods, because I did not know how to design or critically appraise a randomised controlled trial! (Neither, it would seem, did many of my medical colleagues - why else would the NHS Research and Development division have needed to spend a

considerable portion of its budget on teaching these skills to qualified medical professionals, in its drive to promote 'evidence based' clinical practice?) For many years, within the NHS, qualitative research was dismissed as 'anecdotal evidence,' and was placed near the bottom of the 'heirarchy of evidence' advocated by the 'evidence-based healthcare' movement - or even excluded altogether - although this view did not go unchallenged by those involved in nursing reasearch, or by many sociologists of health and illness, who have always used qualitative approaches. (An often-used example of the 'Heirarchy of Evidence'can be found in the CRD Report 4, 1996.)

The importance of qualititive methodolgies within health service research is, however, becoming increasingly recognised. Articles challenging the quantitative orthodoxy began appearing in mainstream medical journals in the early 1990s. See, for example, the BMJ article by Pope and Mays (1993), which opened the 'black box'; and the series which followed two years later in the same journal (Pope and Mays, 1995a, 1995b, 1995c; Britten, 1995; Kitzinger, 1995; Jones and Hunter, 1995; Keen and Packwood, 1995). By 1997, authors such as Greenhalgh (a high-profile advocate of evidence-based-medicine, with a background in General Practice) claimed that

"the pendulum is swinging...ten years ago, when I took up my first research post, a work weary colleague advised me: 'Find something to measure, and keep on measuring it until you've got a boxful of data. Then stop measuring and start writing up.'...[whereas]...it is currently rather trendy, particularly in the fields of primary care...to say that you are doing some qualitiative research." (Greenhalgh, 1997, p. 151 - 152)

However, the fact that qualitative research has now become fashionable in certain circles, does not mean it can be used indiscriminantly, nor that it is has no methodological limitations. Appropriate use of qualitative research methods is discussed above (sections 4.6, 4.9 and 4.10). From this discussion, it should be evident that the main consideration in the choice of research design and method is its appropriateness to the research

question. The limitations of qualitative approaches to research, with particular reference to my study, are briefly reviewed below.

4.11.4 Methodological rigour in qualitative research

One of the most frequent critisicms of qualitative research, especially when underaken by a single researcher, is that of researcher bias. This is not surprising, when

> "Most qualitative researchers work alone in the field. Each is a one-person research machine: defining the problem, doing the sampling, designing the instruments, collecting the information, reducing the information, analysing it, interpreting it, writing it up. A vertical monopololy." (Miles and Huberman, 1994, p.262)

The researcher's own theories, values, and preconceptions will therefore, at least potentially, influence the research process at any of these stages, thereby compromising the validity of the research findings. As it is clearly impossible to eliminate the researcher's theories, values and preconceptions entirely from the research process (and some qualitative researchers would argue that this would be undesirable even if it were possible), qualitative researchers have developed a number of strategies for addressing this criticism. As these are well-documented and discussed in the research methods literature, I feel it is unnecessary to repeat these here. In any case, many writers on qualitative methodology advocate caution in adopting a 'checklist' approach, arguing that "the risk of such checklists is that they become rigid constraints which become an end in themselves rather than serving to enhance the validity of the study." (Murphy et al, 1998). Transparency and honesty in documenting the research process is, I believe, the key requirement of any researcher, whatever their discipline or research paradigm - and it is this that I have tried to achieve in this chapter, and the one that follows. This approach will enable critical readers to judge the validity of my findings for themselves. (Reliability and generalisability in this study have, I feel, been adequately covered in the discussion of the reliability and generalisability of the survey, above.)

CHAPTER 5 RESEARCH METHOD

This chapter describes the research methods used throughout the project, and provides further contextual information relevant to the fieldwork. The research timetable is outlined, and each of the techniques used for data collection and analysis is described, justified and evaluated. The chapter begins with a research timetable, detailing the main milestones of the data collection and analysis process in sequential order. It describes the organisations in which the research was carried out, how interviewees were selected, and how the survey population was identified. It then goes on to describe each of the methods of data collection used at the various stages of the research, explaining why these methods were chosen and how they were applied. The strengths and weaknesses of each method are discussed, together with an assessment of the risk of bias inherent in these, drawing on the research methods literature where appropriate. The methods used for analysing both the quantitative and qualitative data are then described and evaluated. Finally, the limitations of the research are considered.

5.1 Research timetable

The project began in the summer of 1994, and was completed (as far as the client was concerned) a year later, when the findings were presented to a South East Regional Commissioning Network Seminar held at David Salomon's House (a regional training venue) on 16th June, 1995. The research began with an initial literature search and review, which was undertaken during August and September 1994 (see Chapter 3). During this time, there were also further meetings with the Steering Group to refine the project brief, and to discuss the research design. (See Chapter 4).

Data collection for the research took place during the autumn and winter of 1994/95, in two main stages. The first stage was a series of interviews with Chief Executives and Directors of Public Health in the six District Health Authorities in the former South Thames (East) Region. These took place during October and November. The second stage was a postal survey of Clinical Directors in thirty NHS Trusts across the region,

which was sent out early in December. A pilot survey was conducted in three Trusts in South Thames (West), immediately prior to the main survey. Data was analysed during the February and March of 1995.

Research findings (see Chapters 6 and 7) were fed back to the Project Steering Group via presentations at their meetings, and in a the form of a draft end-of-project report. A final presentation of the findings was made to the whole South East Commissioning Network at the June seminar (see above). To ensure that dissemination of the findings was as wide as possible, everyone who took part in the research was sent a copy of the 'Summary and Key Findings' (a written report of the final seminar presentation) during July, and a series of three articles based on the research were subsequently published in the journal 'Clinician in Management.' (Cornish 1995a, 1995b and 1996)

The project timetable was set to inform the 1995/96 commissioning cycle, and is summarised in Table 5.1 below.

5.2 Participating Organisations

5.2.1 Health Authorities

The six participating Health Authorities were:

South East London Health Authority

Bexley and Greenwich Health

Bromley Health

East Kent Health Authority

West Kent Health Authority

East Sussex Health Authority

Although all based in the South East of England, these six health authorities covered a diverse population, ranging from inner London, through the suburbs, to the 'shire' counties; and included urban and rural environments. They also covered a wide range of

NHS Trusts, from major teaching hospitals through average-sized district general hospitals to small, specialist units.

These Health Authorities, with the exception of Bromley, were all made up of a number of smaller former District Health Authorities, which had been merged to achieve economies of scale. Some of these mergers had been recently completed, others dated back to shortly after the introduction of the NHS internal market in 1990. All of the health authorities included in the project were also in various stages of joint working with their Family Health Services Authorities, with which they were all now geographically coterminous. However, no formal DHA/FHSA mergers had taken place at this point in time, and commissioning authorities were still awaiting further clarification on their role, and on the extension of GP Fundholding, which was subsequently outlined in EL(94)79. This guidance was published on 20 October 1994, which was about mid-way through the interviewing period.

TASK	July 94	Aug 94	Sept 94	Oct 94	Nov 94	Dec 94	Jan 95	Feb 95	March 95	April 95	May 95	June 95
Lit. Rev												
Res Design												
Contact Trusts												
Identify Clinicians												
Interview CE&DPH												
Analyse Interviews												
Develop Quest're												
Pilot Qu												
Revise Qu												
Mailout Qu												
Reminder												
Data entry												
Data analy.												
Report												
Seminar												
Report												

TABLE 5.1 RESEARCH TIMETABLE

5.2.2 Participating Trusts

A list of NHS Trust Chief Executives was obtained from the Regional Outpost (the Trust monitoring arm of the Regional Health Authority). This was compared with details of providers in the region derived from the 'flat-files' - the regional database of hospital and community health service activity, to which staff within the South East Institute of Public Health had access. There were a number of discrepancies between these lists, which needed to be resolved. These could be accounted for by the fact that there were still a small number of 'Directly Managed Units' (DMUs) in the region, whose future was under discussion. (This was linked to issues around local service reconfiguration, and decisions were being taken on closure, merger, or application for Trust status.) A number of Trust mergers were also in progress, and at least one de-merger had already taken place. Furthermore, the regional flat-file database included the Ambulance services in East Sussex (which was an NHS Trust) and in Kent (which was a DMU).

The two ambulance services were excluded on the grounds that they were not felt to be appropriate to the research, and two of the other DMUs (Hastings Health Unit, and Greenwich Mental Handicap Unit) were excluded at their own request, because of the uncertainty surrounding their future. South Kent Community Healthcare, listed as a DMU on the regional flat-file data base, was subsequently included, as initial contact revealed that it had just achieved Trust status. The Queen Victoria NHS Trust was excluded, as it was atypical in a number of ways - though the deciding factor was that its geographical location on the border between South East and South West Thames meant that its major purchaser was not one of the six health authorities included in the project. This left a total of 30 participating Trusts. (See Table 5.2)

SOUTH EAST LONDON
Guy's and St Thomas' Hospitals NHS Trust West Lambeth Community Care NHS Trust King's Health Care NHS Trust Optimum Health Services NHS Trust Lewisham Hospital NHS Trust Lewisham and Guy's Mental Health NHS Trust The Bethlem and Maudsley NHS Trust
BROMLEY
Ravensbourne Priority Health NHS Trust Bromley Hospitals NHS Trust
GREENWICH AND BEXLEY
Bexley Community Health NHS Trust Queen Mary's Sidcup NHS Trust Greenwich Healthcare NHS Trust
EAST KENT
South Kent Hospitals NHS Trust South Kent Community Health Care NHS Trust Thanet Health Care Trust Kent and Canterbury NHS Trust Canterbury and Thanet Community Health Care Trust
WEST KENT
Dartford and Gravesham Acute Health Services NHS Trust Thameslink Healthcare Services NHS Trust Mid Kent Healthcare NHS Trust Maidstone Priority Care NHS Trust Medway Acute NHS Trust North Kent Healthcare NHS Trust Kent and Sussex Weald NHS Trust Weald of Kent NHS Trust
EAST SUSSEX
South Downs NHS Trust Brighton Health Care NHS Trust Eastbourne and County Healthcare NHS Trust Eastbourne Hospitals NHS Trust Hastings and Rother NHS Trust

TABLE 5.2 PARTICIPATING TRUSTS

5.3 Identifying the clinicians

On 7th October, I wrote to all Trust Chief Executives, explaining the project and asking for their cooperation. (This was, in a sense, simply a matter of courtesy, as agreement to participate had been achieved through the Trust Chief Executive Forum, which had considered the revised project proposal at its meeting on 21st September) These letters also, however, asked Chief Executives to identify the clinicians within their organisation who they felt should be included in the survey. They were given the following selection criteria:

> "the people I have in mind will be lead clinicians who currently combine managerial responsibility with clinical practice. They may be described as clinical directors, clinical managers, clinical coordinators, clinical executives or similar. They may also be from any of the clinical professions." (Letter to Trust Chief Executives, 7 October 1994)

Assurances of confidentiality were also given, and Chief Executives were invited to contact me if they had any queries about the survey.

Responses came throughout November, and included the names of Clinical Directors, Consultant Managers, Clinical Chairmen (sic), Clinical Services Managers, Heads of Department, Heads of Service, Clinical Nurse Managers, and other assorted job titles. Clearly, clinical management arrangements within Trusts were not uniform. Indeed, one Chief Executive replied

> "Our arrangements don't allow the easy identification of those you would like to contact...We have a matrix structure and systems approach given our perceived need to balance both functional and geographical management/clinical responsibilities. There is, too, a heavy emphasis on teamwork..." (Chief Executive of a Community Trust)

In general, the pattern of clinical directorate structures which most closely approximated those described in the literature (see Chapter 3) occurred within the Acute Trusts; and most especially those that had been established in the first and second 'waves'. Many Community Services, although they had achieved Trust status in the second and third 'waves,' were, nevertheless, working across wide geographical areas, on many sites, and in some cases operating a 'patch-based' service, working in multi-disciplinary teams. As a result, a number of Community Trust Chief Executives had made a decision not to follow the Clinical Directorate model.

5.4 The survey population

This identification process enabled me to compile a list of approximately 316 clinical managers and lead clinicians, who combined a clinical workload with management of a business unit or clinical directorate. This number is described as 'approximate' because the survey population was not only more difficult to define than anticipated, but also rather more fluid than expected. Interviews with health authority Chief Executives and Directors of Public Health (see below) had indicated that senior clinicians remained in post for considerable periods of time - but managerial responsibility, especially amongst the medical profession, tended to be undertaken on a temporary basis, often rotating over a period of two or three years. In addition to this, a number of participating Trusts were in the process of internal reorganisation (in some cases into Clinical Directorates or business units), or the bringing together of former 'units' in response to the achievement of Trust status. There were also the usual personnel issues to take into account, including long-term sick leave, maternity leave and forthcoming retirement, as well as people in the process of changing post in response to reorganisation or promotion. Finally, there were some arguments over appropriate categorisation, in that a small number of individuals who had been identified as appropriate for inclusion by their Chief Executive, subsequently made contact with me to tell me they did not feel they fitted my criteria, and asked to be excluded. (Following discussion with these individuals, they were excluded from the survey population on the grounds of ineligibility, rather than being counted as non-respondents, even if they did not make contact until they had been sent a

questionnaire.) This is probably accounted for by a slight 'over inclusion' at the initial identification stage, as I initially mailed out 325 questionnaires to named individuals, and 315 of these appeared to be 'valid' (ie they were not returned incompleted because the individual identifed was no longer in post, or had been inappropriately included.)

5.5 Data collection: Phase I - Interviews with Commissioners

5.5.1 Purpose

Interviews with the health authority Chief Executives and Directors of Public Health were carried out during October and November 1994. The purpose of conducting these interviews was threefold. Firstly, I wanted to be able to explore a number of issues from the commissioning authorities' perspective. The project rationale articulated by the steering group (see Chapter 1) had not satisfied my curiosity. After all, it was not usual for letters to Chairs of Health Authorities asking for a particular course of action to lead to health authorities collectively commissioning a substantial piece of applied research. Whilst I could understand why clinicians might be complaining about being excluded from the commissioning process (they were, after all, very accustomed to being powerful players in the health policy agenda) I was finding it harder to understand why this might be important to commissioners, many of whom had talked in the past of the opportunities that the purchaser - provider separation would give them for reducing the power of the medical profession in defining the ways in which services were provided. How, therefore, would commissioners be likely to benefit from increasing clinical involvement in their decision-making? What would it enable them to achieve that they believed they could not achieve otherwise? Why did commissioners feel it was necessary for them to involve Trust clinicians in the commissioning process? It did seem to me that their reasons may be more complex than appeared from the project brief, and this had, as the project design had developed, become my 'core' research question. (See Chapter 4).

Secondly, qualitative work with health authority staff would enable me to satisfy the critics of the original research design (see Chapter 4), those Trust Chief Executives who

had argued that commissioners views also needed to be explored. One Trust Chief Executive (see Chapter 4) had expressed concern about how commissioners ensured their decisions were informed by appropriate professional advice. Others had asked if commissioners were actually committed to making this happen. There were clearly issues for managers on both sides of the purchaser/provider divide, and ownership of the project by the Trust Chief Executives was dependant on this exploration of the commissioning authorities' agenda.

Finally, it would assist with the design of the questionnaire. Whilst I was not unfamiliar with the work being undertaken in commissioning authorities, having worked in a District Health Authority until 1992, I was aware that the agenda was changing rapidly, and anticipated that commissioning might have developed considerably since I had moved on. I was also aware of the changes which were occurring in the Regional Medical Advisory Committee and the Specialists Sub-Committees, and wished to explore the impact of this on purchasers in a little more depth. Finally, the steering group had been a little vague about exactly which aspects of the commissioning process they felt were most appropriate for the involvement of local clinicians. Although they were clearly interested in much more than the contract negotiations, there was a lack of agreement by group members on which other aspects of commissioning should be included. However, as this divergence of views had not been very clearly articulated in the Steering Group meetings, I felt that qualitative work with the commissioners would enable me to tease out these issues, and therefore assist with the design of the survey questionnaire. I was particularly interested in finding out which aspects of the commissioning process were felt to be most appropriate for clinical involvement and how they felt this should be facilitated.

Face to face interviews were the chosen method for this stage of data collection because I felt this approach would enable me to develop the trust and confidence of those I was interviewing, and give me "an opportunity to probe deeply to uncover new clues, open up new dimensions of [the] problem, and to secure a vivid, accurate inclusive account...based on personal experience." (Burgess, 1982) This stage of the work was,

after all, exploratory; but I was also concerned that "the interviewee may be reluctant to be truthful about the issues other than confidentially in a one-to-one situation." (Easterby-Smith et al, 1991, p.74) My own experience of working with Regional Directors of Public Health had shown me that Board level staff may be cautious about being openly critical of policy directives, and unwilling to discuss their reservations about a particular course of action with their peers. I hoped they would be more forthcoming in private.

The reasons for selecting Chief Executives and Directors of Public Health to be interviewed also had a number of dimensions. Firstly, the Chair of the Steering Group felt these would be the most appropriate individuals to give me an overview of the issues - Chief Executives because of their strategic overview of the whole organisation and its priorities, and Directors of Public Health because they were most likely to have direct involvement with clinical colleagues around issues of clinical advice. I was also keen to interview these individuals because they seemed to me to be the most appropriate - not necessarily in terms of the level of detailed information they could provide (staff working at a more operational level are often more aware of specific work being undertaken locally, and better able to comment on this than Board level executives), but because they were the most powerful players in defining the authorities' commissioning priorities and processes (apart, perhaps, from the Director of Finance - but he or she would be likely to be working to a different set of criteria). Nevertheless, the issue of whether or not to include Assistant Directors of Commissioning and Contracts Managers working in the health authorities was raised, and subsequently discussed within the steering group. However, the group felt that increasing the number of interviews would increase the time needed to complete the first stage of the work, thereby delaying the survey of clinicians, which was, of course, the part of the project which was most important to my clients. As a result, interviews were confined to the Chief Executives and Directors of Public Health.

5.5.2 Gaining access

Gaining access to interviewees is often an issue for researchers in all fields, and this is no less the case in management research, where those being investigated are often senior members of organisations. In fact, as Easterby-Smith and colleagues (1991) point out, management research is quite distinctive in this way. Unlike research in many of the fields which inform management research (such as education, sociology, psychology) where the researcher can often be in a more powerful position than those being researched (eg a teacher undertaking research on children, a health professional researching patients, or an academic researching people in difficult social circumstances),

> "managers tend to be *powerful* and busy people. They are unlikely to allow research access to their organisations unless they can see some commercial or personal advantage to be derived from it. This means...that access ...can be very difficult and may be hedged with many conditions...(p 6-7)

Whilst access to Trusts had been a contentious issue from the start of this project (see Chapter three), access to Board level staff within the commissioning organisations was comparatively straightforward. I wrote to each health authority Chief Executive and Director of Public Health on 23 September 1994, explaining the purpose of the research and asking for an opportunity to interview them as soon as possible. I enclosed an outline of possible areas for discussion, to enable them to give the issues some prior thought if they wished to do so, though I did not let them have sight of the interview schedule itself. Interviews were then arranged by telephone. Any difficulties or delay I encountered were simply the result of people I wished to interview having very full diaries. This ease of access was, of course, facilitated by the fact that this project was initiated by the South Thames Commissioning Development Forum, and all the Chief Executives and Directors of Public Health were committed to its successful completion. Nevertheless, the original project proposal, which had been circulated to them all during the summer,

had not included an exploration of their agenda, so the reasons for the interviews needed to be explained to them. I was, after all, asking for an hour of their time, and at very short notice.

Interviews took place between early October and the middle of November 1994, and were conducted in the interviewees office, with the exception of one Chief Executive, who was interviewed in an office at the South East Institute of Public Health. This change in venue was at his request, as he was attending two meetings nearby, and had an hour between them. Each interview was scheduled to last for one hour, and most took approximately an hour to conclude, although one was a little shorter (it was completed in about forty-five minutes) and one, with a Director of Public Health, lasted for nearly an hour and a half.

5.5.3 Structuring the interviews

Having decided that face-to-face interviews were the most appropriate method for exploring the issues I wished to address with the commissioning authority Chief Executives and Directors of Public Health, the next decision that needed to be made was the degree of structure to impose on the interview process. Whilst there were a number of questions I wished to ask, and which I felt I needed to cover with all those interviewed, I also wished to allow sufficient scope for respondents to expand on areas of particular concern to them, to enable me to reach an understanding of the issues from their point of view. However, there were inherent risks in taking an unstructured approach. As Easterby Smith and colleagues (1991) point out, "managers have to count very carefully the cost of their time, and therefore short interviews are likely to be much more feasible than unstructured observations and discussion" (p.6). Furthermore, the interviews were seen by my clients as merely a preliminary stage to the main body of the research. They were therefore not keen for these to take up too much of my time (for which they were being charged), so I needed to 'get it right first time.' I would, after all, only have one opportunity to interview these people, and therefore needed to get all the information I could from them in the limited time available. 'Non-directive' interviews, whilst

excellent for building rapport and trust, can lead to large amounts of poor data, and the need for 'follow up' interviews for further clarification. These options were not available to me.

Finally, prior to undertaking the interviews I had two main areas of concern. The first was that I might only be able to access the 'official' view of what was happening locally - ie that interviewees would wish to tell me the 'good news' about how well they were making progress in this area, but be more reticent about problems and difficulties. The other concern was that they would try to control the interview, and perhaps prevent me from asking the questions I felt to be important. These concerns arose from two sources. One source was the methods literature, which discusses the power dimension between the researcher and the researched. In this instance, I was very aware that I was interviewing people who were considerably more powerful than me, and that they might use this power to manipulate the interview in some way. The other reason for being concerned about this was my own experience. I had worked for three years with a group of Regional Directors, and was very aware of the tendency for such managers to be quite competitive with each other, and to attempt to take the credit for local innovation and success, especially if the 'intelligence' I was gathering was to be shared with colleagues in other regions.

I needed a way to ensure that I was getting honest answers to my questions, and that the truth would not be 'glossed' in any way. I therefore decided to use semi-structured interviews, using a 'topic guide' as a way of structuring the questions I wished to ask. In this way, I was able to ensure that all the issues I needed to address were covered in a systematic way during each of the interviews, but that sufficient flexibility was left for interviewees to raise issues that were important for them, and for us to reach a mutual understanding on these.

The topic guide covered the following themes and issues:

(i) If/why they think clinicians should be involved in commissioning - who might benefit, and what might the benefits be?

(ii) Which clinicians they think should be involved - and how this relates to other sources of professional advice (including independent advice).

(iii) Which aspects of commissioning are most suitable for clinical involvement - and how this relates to commissioning objectives.

(iv) What is currently happening locally - including any levers they have available to them, any barriers they encounter, and how these might be overcome.

(v) Whether they think clinical involvement should be increased - and if so, who's responsibility is this, what are the implications for workloads, and what processes and mechanisms will be most effective at facilitating these changes?

(vi) Whether they think there are any risks and/or perverse incentives to increasing the current level of clinical involvement in commissioning - and if so, who might his affect most, and how might the impact be minimalised?

5.5.4 Recording the interview data

The next decision concerned the issue of whether or not to tape record the interviews. All the social science research methods books I consulted recommend tape recording interviews, but again, I had a number of reservations about taking this advice. Easterby-Smith and colleagues once more offered some helpful advice, "The decision on whether or not to use a tape recorder depends much on an interviewee's anxiety about confidentiality and the use to which any information divulged can be put." (P. 79)

As already stated, I was very concerned about the issue of honesty on the part of my interviewees, and I felt that asking to use a tape recorder may make interviewees more guarded, as they would be 'on record.' I also recalled a research methods seminar from my student days, when our lecturer (Dr Jennifer Platt) discussed this very issue, and how she had resolved it when interviewing senior academics. (She decided not to tape record interviews because of the power relationship and the confidential nature of the subject matter.) Easterby-Smith cautions:

"..although using a tape recorder aids the listening process and gives the opportunity of an unbiased record of an interviewee's responses, it is in our view counterproductive to lose potentially revealing insights by its use. Most managers are not self-conscious when interviews are recorded and quickly forget the machine; but for others notes may be the only answer. The deciding factor should not be whether or not to tape, or whether permission will or will not be given, but rather what effect its use will have on the interview interaction in terms of the relationship and the data created." (P. 79)

After a great deal of consideration and discussion with colleagues, I somewhat reluctantly decided not to tape record the interviews. This has obviously had some disadvantages, in that I do not have full transcripts of the interviews to go back to, but it was possible to take comprehensive notes, which included some direct quotations, during all the interviews. (These managers seemed very at ease with people taking notes as they talked). I also took time immediately after each interview, either in the car park or on the train home, to make detailed field notes. Notes of the interviews were typed up at the next available opportunity - usually the following day; and I typed these myself. I also kept a detailed research diary throughout the duration of the project, in which I entered comments on the interview process, and further thoughts arising from the interview data.

5.6 Data collection: Phase II - Survey of Provider Clinicians

5.6.1 Purpose

This stage of the research project addressed the main issues of concern to the client. Its purpose was twofold. Firstly, the Steering Group wished to ascertain the current levels of involvement, by provider clinicians, in the commissioning process across the whole of the South Thames (East) region, and to answer a number of related questions already identified by them at their meeting on 15 April 1994. Secondly, they wanted to gain an understanding of 'how this process feels to the clinicians.' (See Chapter 1) To address these issues would require collection of a combination of quantitative and qualitative data. However, the number of staff involved in this stage of the research, their geographical and organisational spread, and their professional responsibilities meant that face-to-face interviews, although the preferred method for obtaining understanding of participants feelings, would be quite impractical for the whole group.

One solution would have been to conduct an initial postal survey of the whole population to find out how involved they were in commissioning, then to follow-up a representative sample to explore their feelings about the process, through in-depth interviews. However, two factors made me decide against this approach. Firstly, it would have been very difficult, even impossible, to ensure I had a representative sample to interview. There were just too many variables to control for, in terms of type of Trust (acute, community or combined) and how long the Trust had been established (first, second, third or forth wave); the internal management arrangements within the Trusts (the number and type of clinical directorate structures, and the length of time they had been in existence); the clinical specialty being managed; and geographical issues (inner City or Shire County) - before we even considered the fact that there were six commissioning authorities to which they might relate.

Secondly, a clinician's time is at a premium, and this was likely to be even more of an issue for those combining a clinical workload with management responsibilities for a

department or business unit. This group might also be less committed to finding the time for a lengthy interview, whereas a clear, accessible questionnaire that addressed issues of importance to them, and gave them space to vent their feelings, may, I hoped, elicit a high response rate. It was therefore necessary to design a postal questionnaire which would enable me to collect both quantitative and qualitative data; to both capture an overall picture and to take me "below the surface to examine feelings towards events." (Edwards and Talbot, 1994) The questionnaire would therefore need to contain a mix of open and closed questions, and some attitude scales.

5.6.2 Developing and piloting the questionnaire

A first draft of the survey questionnaire was developed following the initial literature review (see Chapter 3). This was subsequently refined after discussion with the steering group during September. Further revisions and refinement were undertaken in October, as the interviews with commissioners underwent preliminary analysis. Drafts were also commented on by staff within the South East Institute of Public Health, and the Department of Public Health at UMDS (Guy's and St Thomas's Medical and Dental School). A final draft was circulated to all members of the steering group in late October. In November, the questionnaire was piloted in two Trusts (one acute and one community service) in South Thames (West), selected because they were comparable to similar Trusts in the East of the Region, but would enable us to test the questionnaire without letting any of our survey population have advance sight of it.

Minor revisions were made following the pilot, and, at the suggestion of a colleague, the final version of the questionnaire was printed on yellow paper. The reasoning behind this decision was that it would attract people's attention, and avoid it becoming submerged in the mountain of paperwork on people's desks. (This also gave me the idea of sending out reminders with a duplicate copies of the questionnaire printed on a different colour, to enable me to see at a glance who had responded first time around, and who had replied in response to the reminder.)

5.6.3 The survey questionnaire

Survey questions were derived from the literature, from discussion with the steering group, and from the first stage of the research. Interviews with Directors of Public Health and Chief Executives of Health Authorities had identified a number of potential lines of enquiry, raising further questions which needed to be addressed by the research. For example, working relationships between commissioners and provider clinicians became a topic for further investigation as a direct result of the interviews with commissioning Chief Executives and Directors of Public Health (see Chapter 5).

There were a total of fifty questions included in the final survey questionnaire. These were grouped into the following broad areas:

(i) Links with major commissioners
(ii) Involvement in the commissioning process
(iii) Involvement in the contracting process
(iv) Benefits and barriers
(v) Background information

Involvement in commissioning and involvement in contracting were treated separately, as the steering group anticipated that clinicians may be more likely to be involved in contract negotiations than in discussion about the wider commissioning agenda. They wanted to be able to differentiate what the clinicians were currently involved in from what they believed they ought to be involved in. Also, it was hoped that by asking about involvement in the contract negotiations, there may be an opportunity to undertake some comparative analysis, as other work (eg the survey and the DoH task force report discussed in Chapter 3) had confined their investigation to contracting, rather than exploring the whole commissioning cycle, as we were doing.

5.6.4 Administering the questionnaire

The questionnaire was sent by post, to all those people whose names had been provided by the Trust Chief Executives (see above). As the steering group were clear that the group of clinicians who were most likely to have some involvement in the commissioning and/or contracting process within Trusts were those who combined clinical and management responsibilities, there seemed little to be gained from extending the survey beyond this group. However, as the total survey population was just over 300 individuals, it made sense to survey the whole population, rather than attempting to take a representative sample. This would seem to be in accordance with advice on sample size in Easterby-Smith et al (op cit) who state that, "When the population is small (perhaps less than 500) it is customary to send the questionnaire to all members." (p122) As they go on to say, this 100% sample is commonly known as a 'census.' Because I was undertaking a census survey, there are no further issues of sample size to discuss.

The mail-out date was agreed, and 325 copies of the questionnaire were sent to named individuals on 6th December 1994, with a covering letter and a stamped, addressed envelope for their return. One reminder was sent to non-respondents during the second week of January, and a cut-off date for receipt of returned questionnaires was set for the end of February. (No cut-off date was given in the covering letter, as it was felt that this may influence the response rate. For example, if the required return rate was some weeks away, respondents may delay their reply. On the other hand, if it was too soon, those who inadvertently missed the date might not complete the questionnaire, as they would believe they had missed the opportunity to do so.)

5.6.5 Response rate

One of the main areas of concern when undertaking any survey is the response rate. Postal surveys in particular "have developed the reputation of being plagued by low response rates" (de Vaus, 1991) and this was, of course an area which needed to be addressed. To ensure that survey findings are robust, it is necessary to achieve a response

rate of at least 60%, and higher response rates are clearly desirable if these can be achieved. The social science methodology text books have a number of suggestions for boosting response rates in postal surveys, including offering material incentives. However, these add considerably to the cost of a study, and this was not an option I had available to me. Indeed, the Chair of the steering group did not even want participants to know that the South East Institute of Public Health was being funded to undertake the research, as there was potential for clinicians to complain about this being a waste of NHS resources (even though the study was being financed from money specifically earmarked for developing the commissioning function). So, incentives of any sort, and material incentives in particular, were quite out of the question.

I decided instead to rely on the fact that this was a high profile issue, on which participants were likely to wish to express their views, to ensure a good response rate - combined, of course, with a well-designed questionnaire. This view was reinforced by the methods literature, in particular de Vaus (1991), who stresses that, whilst "well conducted mail surveys of the general public" can be expected to achieve a response rate of between 60% and 75%, and adds that

> "In surveys of *specific, more homogeneous groups* (eg members of an organisation, teachers, nurses) mail surveys seem to be about as good as other techniques - especially when the topic under investigation is of particular relevance to the group." (De Vaus, p. 107)

5.7 Data analysis: Phase I - Interview data

As the total number of interviews undertaken in this first stage of the research (with the health authority Chief Executives and Directors of Public Health) was quite small, and had been recorded in note form, interview data was analysed manually, using a modified form of ' grounded theory.' Preliminary analysis was undertaken as soon as possible after each interview, to enable me to draw on unrecorded as well as recorded information throughout this 'familiarisation stage' (Easterby-Smith et al, 1991): I was aware that, as

I did not have tapes or verbatim transcripts to return to, I could not risk leaving analysis too long, as my interpretation of the data might be influenced by my ability to recall salient issues more readily than less salient ones. This early analysis was also useful in identifying issues which needed to be included in the development of the questionnaire for the survey of provider clinicians. Further, more detailed, analysis continued throughout the next two months, and overlapped with the period in which the final survey questionnaire was being mailed out.

Data-driven categories were derived from transcripts of interview notes and field notes, and cross-checked against entries in the research diary. As the interviews, although semi-structured, had been quite focussed, it was possible to catalogue data under the main themes identified in the interview schedule by 'cutting and pasting' copies of interview notes, highlighting key phrases and picking out relevant direct quotations (some particularly salient quotes had been noted verbatim). By working through notes taken during and immediately following each interview at the first available opportunity, I was able to undertake a systematic analysis and tease out themes, categories and key issues in sufficient detail to enable me to identify the issues required to meet the client's needs, and to support the development of the survey questionnaire.

Analysing interviews which have not been tape recorded is a considerably less time-consuming process than transcribing and analysing verbatim transcripts - as Edwards and Talbot (1994) point out, a one-hour interview takes at least four hours to type, and produces around thirty pages of transcript. Working from interview and field notes rather than transcripts cut this time by at least fifty per cent, but there was inevitably some loss of detail as a consequence. In the case of this particular project, what has been lost is the opportunity to revisit the interviews by returning to transcripts, to interrogate them with further questions and subject them to subsequent analysis for the purpose of this thesis. The level of detail I was able to achieve was more than adequate to meet the needs of my client.

5.8 Data analysis: Phase II - Survey data

The questionnaire used for the survey included a mix of closed and open questions. As Edwards and Talbot (1994) point out,

> "Many practitioner researchers wisely use a combination of qualitative and quantitative methods of data collection/analysis. This is to be encouraged. However, if you do choose to do this do strike a balance of tabulation/explanation and of description/evaluation." (Edwards and Talbot, 1994, p. 111)

5.8.1 Checking and coding the questionnaires

All questionnaires were checked for consistency on their return, and a coding frame was developed to enable all closed questions to be coded numerically. This data was then entered onto a computer, using Epi- Info. This particular software was chosen for its availability (most public health departments have a copy) and because it is reasonably user-friendly. Templates for data entry can be generated from questionnaires, and records can be checked, revised and manipulated. This package also produces lists and cross tabulations, and will undertake most of the descriptive statistics and statistical calculations I expected to use. Data was entered as the completed questionnaires were returned, checked and coded.

The open questions were initially left uncoded, and responses examined when all the completed questionnaires had been received. This enabled me to decide whether it was possible to develop a coding structure for the written comments. Some questions were subsequently coded, as it was clear that answers fell into a limited number of broad categories. Where coding was possible, this data was included with the quantative data for the purpose of analysis. It was therefore entered into the computer using Epi-Info. For those questions which could not be coded in this way, or where this was not appropriate, responses were analysed using qualitative techniques, as used with the

interview data - including selecting verbatim quotes for the purpose of illustration. (see Chapter 6).

5.8.2 Statistical analysis

Quantitative data derived from the questionnaire was, for the most part, descriptive. Statistical analysis therefore took the form of producing simple frequencies for many responses, with some two-way tables for key variables. These two-way tables made it possible to take the analysis a little further, and to test some hypotheses. As the data used to test these hypotheses was categorical and categories were independent from each other, the chi square test was used to investigate whether the observed results were significantly in agreement with, or significantly different from, the results which would have been expected. (Edwards and Talbot, 1994, p.125). The level of significance followed "the normal convention in most social science and educational research...the 0.05 significance level." (Edwards and Talbot, 1994, p.120).

CHAPTER 6 EXPLORING THE ISSUES WITH THE COMMISSIONERS

6.1 Introduction to first stage of the fieldwork

This Chapter reports on the findings from the first phase of the research fieldwork: the qualitative study undertaken in the former South East Region of the NHS, during the autumn of 1994.The study took the form of face-to-face, in-depth interviews with the Chief Executives and Directors of Public Health in the six health authorities in the region. My aim during this phase of the research was to explore a number of questions and assumptions which underpinned the research brief provided by the South East Commissioning Network, who had commissioned the work (See Chapters 1 and 4) Full details of the research design and method are covered in Chapters 4 and 5, and a copy of the interview schedule is included in the appendices. This chapter sets out the main purpose of the interviews and describes the interview process. This is followed by a brief discussion of the issues addressed during the interviews, and the themes which subsequently emerged during the process of data analysis. The interview data is then presented in accordance with these themes, and discussed in some detail Further discussion of the findings, particularly in terms of the relationship between the interview findings and the findings from the survey of clinicians (reported in Chapter 7) and to the wider research questions, are covered in the discussion and conclusions. (Chapter 8).

6.1.1. Purpose of the interviews

The purpose of the interviews was two-fold. Firstly, this stage of the fieldwork was set up to enable me to begin to address the broader research question which I felt underpinned the more immediate questions my clients wished to answer. In other words, why was clinical involvement in commissioning such an important issue for the members of the Commissioning Development Network that they felt it warranted further investigation in this way? A number of reasons had been identified by the

Steering Group, and were included in the rationale for undertaking the research. (See Chapter 1). Other reasons had been suggested in the health management literature. (See Chapter 3) Finally, there was considerable pressure from the clinicians themselves, as well as Ministerial pressure. (See Chapters 1 and 3). However, these reasons did not, for me, constitute an adequate explanation for either the high profile of this issue, or the response it elicited nationally and locally.

I therefore felt it was necessary to explore, in some depth, what the issue of involving clinicians in commissioning meant for the research clients themselves. Why did they want to know how involved their local provider clinicians were in commissioning, and how these clinicians felt about the process? How would this knowledge help them? They were, after all, committing time and money to undertake a large-scale survey to explore these issues. Presumably, they would also expect to be able to use the survey findings to inform future managerial action in some way. What, if anything, might they hope to gain from attempts to increase the current levels of clinical input into their own commissioning? Or perhaps there were no advantages to them from undertaking this work - was it possible, after all, that the commissioning network was simply responding to Ministerial pressure, or to a combination of pressure from the Minister and from the Royal Colleges or other professional interest groups? What exactly were the commissioners' concerns, and what did they hope to achieve? How did their agenda, their purpose, values and objectives fit with what the clinicians wanted?

The second reason for undertaking these interviews was to enable me to formulate the questionnaire which would be sent to the provider clinicians in the survey. There was clearly a risk that a postal survey of busy clinicians might result in a low response rate, which could weaken the validity of the survey findings. I believed this risk could be reduced by ensuring that the survey questions were relevant, covered all the anticipated areas of major concern, and were formulated in such as way as to allow the respondents to express their views openly to the health authorities with whom their organisations had service contracts. In this sense, the interviews acted as a way of enabling me, as the researcher, to orientate myself to the field of enquiry, and develop an appropriate

set of questions for phase II of the project. (See Chapters 4 and 5 for further details of the survey design and method, and the appendices for a copy of the survey questionnaire.)

Exploring the issue of clinical involvement in commissioning from the perspective of the health authority commissioners therefore both strengthened the 'analysis for policy' by enabling the survey to be designed in such a way that it would capture information directly relevant to the needs of the clients, and opened up the possibility of undertaking some initial 'analysis of policy,' by expanding the research objectives beyond the explicit rationale set out in the research brief provided by the Commissioning Development Network and the project steering group. Data collected during this exploratory phase of the research provided an opportunity for me to question many of the assumptions which I felt underpinned the Ministerial directive and the publicity surrounding the research topic. For example, why did this issue arise when it did? Why did it gain such a high profile? What influenced the commissioners' response? The interview process is described next, followed by a brief discussion of the main topics covered by the interviews schedule, with a brief explanation of why these were included.

6.1.2 The interview process

Face-to-face interviews with Chief Executives and Directors of Public Health in each of the participating Health Authorities (Commissioning Agencies) took place during October and November 1994, at the interviewees place of work. Most of the interviews lasted for around one hour, though one took only forty-five minutes, and another lasted for one-and-a-half hours. Ten interviews were undertaken in all, out of a possible total of twelve. One Chief Executive did not want to be interviewed as he was in the process of moving to another post, and one Director of Public Health post was vacant. In both cases, attempts were made to find suitable alternatives, but this did not subsequently prove to be feasible. The Chief Executive's deputy was in fact the Chair of the Steering Group, who felt that his views had been expressed during Steering

Group meetings; but no alternative to the Director of Public Health was forthcoming, for reasons that were not easy to establish. On the advice of the Chair of the Steering Group, attempts to arrange an alternatives were therefore abandoned.

Interviews were semi-structured around a topic guide (see next section and Appendices) and data was recorded in note form (see Chapter 4). In most cases, this worked well - though one Chief Executive insisted on telling me what he thought about the issues before I began to ask questions. This then took up the bulk of the interview, but there was an opportunity to use the schedule as a check-list, and to ask supplementary questions to fill in gaps in the data, during the latter part of the interview. This was, however, the only interview in which I felt I was being given the 'official' version of the issues under investigation, rather than an open and honest account - and this changed as the interview progressed, and the interviewee became less defensive. However, this experience reinforced my decision not to tape record responses, even though there were occasions when I was aware of missing some of the details or subtleties within the data. By the third interview, I found the schedule was working well, and felt I was establishing an effective dialogue with participants (Research diary, 19th October). Field notes (usually made immediately following interviews) provided supplementary data, and enabled me to capture 'off the record' comments which were sometimes made when the interview appeared to be over, and I had put my notepad away.

6.1.3 Interview topics

The first thing I needed to establish with interviewees was the salience of this issue for them, within their own organisation (rather than in their role as part of the Commissioning Network, or as a member of the project Steering Group.) Was there, in fact, even a consensus on the need to involve clinicians in commissioning locally? If so, why? (And equally, if not, why not?) How might doing so help (or hinder) them in achieving their role objectives as commissioners? After all, it seemed at least possible to argue that, if clinicians were being excluded from the commissioning process, this might be an intentional act on the part of the health authority commissioning teams.

Interviewees were therefore asked whether they thought clinicians should be included, and if so, why.

There was also a need to ask some pragmatic questions about the potential risks and benefits which might result from such involvement. Who did the interviewees think would benefit, and what form might these benefits take? The project Steering Group had expressed the view that the key players would be more likely to be committed to increasing levels of clinical involvement if the potential benefits of doing so could be clearly identified and articulated by the research. Increasing clinical input was expected to have implications for the workload of both purchasers and providers; it would therefore need to be seen as at least potentially 'adding value' to the commissioning process if change were to be successfully implemented. Furthermore, identification of the benefits might facilitate development of monitoring mechanisms, such as auditing commissioning to identify progress in this area.

It was also important to identify which clinicians should be involved, in the sense of which professional groups (the Chair of the Steering Group felt this ought to be broader than the medical profession, but was not sure whether his colleagues would share this view), and at what organisational level- that is, should all clinicians be involved, for example, or only those with substantial management roles, such as Clinical Directors? Then there were questions about the mechanisms for facilitating this. What form should these take? How formal did the process need to be? How might such a mechanism relate to other arrangements for obtaining professional advice, either locally or independently? Interviews were, after all, being undertaken at a time when the role and function of Regional Health Authorities was under review, and regional structures such as the Regional Medical Advisory Mechanism and its Specialty Sub-committees was undergoing a period of change (see Chapter 3). This led to a set of questions about the available sources of professional advice, and the appropriate balance between 'internal' (ie from local clinicians) and 'external' (ie from non-local) sources.

Finally, as the commissioning process had a number of stages, it was important to ask interviewees to identify which aspects of the commissioning cycle they felt were most appropriate for clinical involvement. At what point in the annual cycle might clinical input be used to best advantage? Were there any areas where it might be less productive, or perhaps should be avoided? This led into a discussion of the commissioning function itself, how health authorities were going about this task, and how they saw it developing in the future.

6.1.4 Themes, issues and concepts

The remainder of this chapter uses the interview data to describe and illustrate the main themes and issues which emerged from this stage of the research, and some of the concepts which emerged from an analysis of these issues. Whilst there is some overlap with the interview schedule, it is worth stressing at this point that interview questions do not necessarily 'map' directly onto the research questions. As Maxwell (1996) argues, "your research questions formulate what you want to understand; your *interview* questions are what you ask people in order to gain that understanding." This means that although interviewees were, in fact asked direct questions about issues at the centre of the research question, for example, why they thought clinicians should be involved in commissioning, their responses to this question will contribute only part of the overall picture required to achieve an understanding of the wider context in which this issue is embedded. Answers to other interview questions, as well as data gathered by the survey of clinicians, will also be needed to address the research questions. For this reason, analysis of the data in relation to the wider research questions will be left until Chapter 8, which follows reporting of the survey data.

6.2 Contextualising the research problem

Interviewees frequently set the issue of clinical involvement in commissioning within a wider context, which usually included discussion around the complexity of the commissioning process and the fluidity of the policy and organisational environment

in which they were trying to develop this function. Within these constraints, however, they were unanimous in their view that clinicians should be involved in commissioning. Where respondents differed was in their reasons for this, and the stage of the commissioning cycle in which they felt clinical involvement was appropriate. This context is described more fully below, drawing on the interview data.

6.2.1 Policy and organisational change

All except one of the health authorities taking part in the research had been formed out of mergers between smaller District Health Authorities. In some cases these mergers were very recent, and the processes of 'bedding down' new organisational structures and functions was felt to be incomplete. This clearly had a number of consequences for the commissioning role, especially in relation to commissioning objectives. Whilst this issue of commissioning objectives was raised during interviews (usually in terms of asking interviewees how clinical involvement might assist them in achieving these), this question was usually either avoided, or bypassed in some way by respondents. Where further probing did elicit a response, it became obvious that commissioning objectives were often unclear - although this was usually felt to be the result of circumstances beyond managerial control. Recent reorganisation was one such factor. In one health authority, the Chief Executive told me:

> "We're a very new organisation...I'm now Chief Executive, and we've a new Director of Public Health. We've started to think about the issues, and this will be a major priority for us..."

Her colleague, the Director of Public Health, apologised for this deficit, but also felt that this was beyond his control, "Our commissioning objectives are unclear...we're a new organisation, we still need to sort this out."

However, another Director of Public Health talked of having "different objectives in different parts of the organisation to start with..." hinting that a lack of clear objectives

may be less to do with the newness of the organisation (this was also the result of a recent merger) and more to do with power struggles within the organisation, although this respondent did emphasise that managers were attempting to develop a corporate agenda.

At least one Director of Public Health hinted that there had been difficulties integrating public health into the commissioning process, "but now [we're] much more closely integrated...and very much influenced by the public health agenda." (Director of Public Health) "Time is a big issue for commissioners", said one Chief Executive, "first, we need to establish a stable commissioning team, then we need to be able to bring together the various components." Commissioning, public health, information and finance departments all needed to gain a better understanding of their role in the process, and to become more focussed, he added.

Others interviewees were more focussed on forthcoming policy and organisation changes. Central guidance, in the form of EL(94)79, was published on 20th October 1994, whilst the interviews were in progress. This represented a significant move towards the development of a primary care-led NHS, by considerably extending GP fundholding, in terms of the numbers of GPs involved in the scheme, and the range of services they could purchase. As a result, several interviewees reported that they were either awaiting further guidance for their organisation, or only just beginning to think through what this guidance meant for them. "Constant change is not helping this. It is difficult to convey the commissioning agenda to providers, when the commissioners are not clear about this themselves." one Chief Executive remarked. Forthcoming mergers between DHAs and FHSAs were contributing to this organisational instability.

So, too, was the increasing number of players in the internal market. Although at the time of this research, primary care was still mostly purchasing at the margins of the market (in that they were able to contract for elective procedures and some community services), some respondents were clearly anticipating or already experiencing an increase in the power and influence of local GPs in the commissioning process.

Responses to this differed widely. One Chief Executive, for example, was attempting to address this quite explicitly and pro-actively. He talked of the need to "support effective devolution of commissioning." This was, however, in a health authority that was in the process of moving towards a model of locality commissioning in which GP Fundholders and non-fundholders would have similar roles and responsibilities. (This was felt to be necessary in order to avoid the development of a 'two tier' approach to commissioning.)

Others seemed less clear of the role of GPs in the internal market. For example, one Director of Public Health, asked if there was anything he wanted to add at the end of the interview, replied, "GPs are also important... but mainly as commissioners, rather than co-providers." Another added that the role of GPs in commissioning was a "difficult issue" but was becoming more important. "We need to balance their agenda against the clinical agenda" another Director of Public Health told me. To achieve this, he felt the health authority needed to include them more in the commissioning process. However, there were concerns about the decisions that Fundholding GPs were taking, and the impact of these on secondary care, "But are GP Fundholders taking sensible decisions?" one Chief Executive asked, "What are their decisions informed by?"

Another Chief Executive was much more positive about the anticipated extension of GP fundholding, outlined in EL(94)79:

> "I'm all in favour of this. Primary care led purchasing is the right way forward. GPs should move towards total purchasing...so that clinicians (on behalf of patients) are dealing with clinicians (who are providing health care). But this will take time... It also needs greater recognition that there are different ways of doing it."

However, what the above respondent clearly saw as an opportunity, others saw as a risk. As GP fundholding increases, one Chief Executive commented, "it's becoming less clear where the power lies." This respondent appeared to be discussing the power

balance between GPs and hospital consultants, which he felt had shifted in favour of GPs, but elsewhere in the same interview, another aspect of this changing power relationship emerged. Returning to the potential impact of the forthcoming extension of GP fundholding, this respondent argued that "the power base will continue to shift," but began to suggest that this would also have an impact on the power base within the health authority.

> "How will this link in? How do commissioning agendas and multiple commissioners fit together? How do clinicians in provider links get into a dialogue with this fragmented process? Who do they talk to? (Chief Executive)

However, it was not only the changing policy and organisational environment that was causing interviewees difficulties with commissioning. The complexity of the commissioning function itself was frequently raised as a preamble to discussion of the issues raised in the interview schedule.

6.2.2 The complexity of the commissioning process

A number of interviewees began their response to my first question ('Should clinicians be involved in commissioning?') by telling me that the issue needed to be set into the context of the complexity of the commissioning process. This was often linked to discussion on the role of commissioning, the health authorities' capacity to undertake this task, or to commissioners' need to seek independent professional advice. A Director of Public Health replied, "there is another question, which precedes this..." This question was, he thought, "What is the role of commissioning?" Once we have clarified this, he continued, "we can think of the role of clinicians in this." The first Chief Executive interviewed began by saying that he wanted to locate our discussion in the context of two issues - the complexity of the commissioning process, and the issue of independent professional advice. He proceeded to spend at least the first half of the interview discussing the role of professional advice - clearly a central issue, and one which will be covered in detail in a little later in this chapter.

The commissioning cycle was described by another Chief Executive as "very intense and complex" and he was clearly not alone in this view, as a number of other respondents appeared to feel pressured by this. Some felt this to be a case of needing a longer time-frame in which to work, "we need longer-term contracts...if the first year of the reforms, with 'steady state' had been followed by 3 year contracts, we'd be there by now..." (Chief Executive). Another commented, "we're trying to do everything...too frequently." A move toward longer-term contracts "would enable a dialogue to be opened up in agreed areas...between appropriate professional and organisational levels" of purchasers and providers, (Chief Executive). One Director of Public Health sensed a change in the way that purchasing was being done, "The early view of purchasing...took a 'stand-off' approach. But it's impossible to make this effective."

6.2.3 Capacity within commissioning organisations

Others expressed concerns about the organisational capacity within commissioning authorities to undertake this work. There was a strong feeling that commissioning was being expected to take on "the entire policy agenda," including issues which were felt to be quite legitimately, the role of the new provider Trust management. As one interviewee put it, "there's a lot of 'purchaser dumping' going on...we're trying to do everything" (Chief Executive).

But this was not only an issue of workload. "Credibility of commissioners is a big issue, in general, and in this organisation" one Chief Executive reported. Constant organisational change, according to another Chief Executive, "is not helping this" as "new people in new organisations" lack confidence and competence. "Some of this is due to lack of recent experience within provider organisations" he observed, "but I think its mainly an issue of organisational maturity." Not all purchasers, he felt, were in a purchasing role as a conscious choice, "...some just happened to be there when the music stopped." These staff, who may have remained in health authorities by

default when the purchaser-provider separation took place, may not, he thought, be fully committed to purchasing.

This issue of commissioning teams needing the confidence to handle powerful clinicians was a recurring one. "All commissioners are at a disadvantage when working with clinicians!" confessed a Director of Public Health, though he conceded that this was "probably less true for public health physicians" as they "can use the same language...and straddle the two camps, which does make things easier..." As a result, some contracts managers "want public health with them, to hold their hands" commented a Director of Public Health, "they tend to feel uneasy without a structured agenda." "Mangers' skills need developing" one Chief Executive remarked, "all managers in the commissioning agency are expected to be able to talk to the clinicians." The importance of commissioning managers reaching appropriate level of expertise was clearly an issue respondents thought the health authorities needed to address.

It is not, therefore, surprising, that interviewees made a number of suggestions for improving this state of affairs. These included maintaining organisational stability, better team building within purchasing organisations, improving staff training and career structures, and clarification of the purchasing role. Clarification of purchasing objectives, and the development of 'in-house' expertise to deliver, were both highlighted by a number of respondents. One Chief Executive summarised this, "Commissioners need to focus better on a limited number of objectives...and become an expert on some things, leaving others to handle areas where they do not have the expertise..." The advantage of being in an enlarged commissioning authority (following a recent merger) was highlighted by one Director of Public Health. This, he said, enabled key people from the department of public health to liaise with commissioning teams, "and go in pairs into the contracting process."

6.3 Reasons for involving clinicians in commissioning

There initially appeared to be as many reasons for involving clinicians in commissioning as there were interviewees, but with further analysis, a number of common themes emerged. These were: access to the clinical knowledge-base needed to support commissioning; ensuring clinical accountability for the delivery of services; and facilitating the management of change. Each of these is discussed under a separate heading below. Interestingly, pressure from the government, or the medical Royal Colleges, did not appear high on the list of issues raised, and 'external' policy drivers did not emerge as a theme warranting further analysis. Indeed, only one respondent appeared to feel under any pressure from central policy guidance: "The cynical reason...is that commissioners are being told to do this, by Regions and by the NHS Executive, probably in response to pressure from the Royal Colleges, which are very powerful." (Director of Public Health). Nevertheless, this respondent felt there were good reasons for him to ensure that this was happening locally (apart from having been told to), and the reasons given were very much in line with those offered by his colleagues across the region, and very much driven by the needs of his own organisation.

6.3.1. A broad consensus

There was a clear consensus in favour of involving provider clinicians in the commissioning process. All the Chief Executives and Directors of Public Health interviewed answered 'yes' to the question, "Should clinicians be involved in commissioning." What varied was the strength with which they asserted this agreement, the reasons for taking this view, and their perceptions of the risks and benefits involved. "Yes, it's vital" (Chief Executive); "yes, they need to be involved in a number of ways" (Chief Executive); "yes, of course, it's *essential* that they're involved..." (Director of Public Health); "yes, I overwhelmingly agree!" (Chief Executive) were typical replies to my opening question. Nevertheless, many respondents then qualified their responses in some way - for example, by setting their

answer in the context of either the complexity of the commissioning agenda, or the pace of organisational change. (See above)

There were two more measured responses. One Director of Public Health, who initially answered, "yes, it's vital" then went on to add, "as commissioning stands at the moment." Another Director of Public Health qualified his initial agreement as follows:

> "Yes, but....the ground is shifting. A few years ago there would have been no question about this...clinicians defined the services, as well as delivering them...But the changes brought about by the reforms should make them less dominant in the process now. Their role is less obvious...as overall aims and objectives for health become broader-based. Clinical input needs to be balanced by the wider, 'democratic' view...especially on priorities...and a population perspective from public health"

This broad, if qualified, consensus would seem suggest that the policy directive emerging from the Minister fell on fertile ground. Commissioners were not being asked to do something with which they fundamentally disagreed. However, it was obviously important to probe more deeply, to explore why the commissioners felt this was important, who they thought might benefit, and what the benefits might be. Here, consensus was not obvious - there was a strong sense of alternative agendas, and different 'policy drivers' operating at a local level.

6.3.2 Access to the knowledge base

This issue of organisational capacity within health authorities was clearly linked to another theme which recurred across the interviews - access to the knowledge base to support the commissioning process. There were real concerns that this was not adequate, and that the way to remedy this was to draw on provider knowledge. Only the provider clinicians were thought to have the detailed knowledge of the services which the commissioning authority needed to draw on in order to develop realistic,

achievable contracts. "They hold the knowledge base the commissioners need, as well as delivering the service commissioners want" was how one Chief Executive expressed this. This 'knowledge base' included not only clinical knowledge, but also detailed knowledge of existing service provision, of new ways of delivering services, and of new and emerging technologies.

The reasons the provider clinicians were perceived to hold the knowledge base commissioners needed, however, did not seem to be entirely due to their clinical expertise. Several of the Chief Executives also raised the issue of local knowledge in relation to managerial mobility. As one expressed it, "whilst these [contracts] can be negotiated by managers, they are unlikely to have experienced the 'total immersion' in the service that the clinicians have." This total emersion, they argued, was not simply due to their role in service delivery, but also linked to their length of service, "managers, however good, are less deeply immersed, as they get promoted by moving on. Clinicians are there for life." (Chief Executive).

However, as one Director of Public Health pointed out, "providers don't have all the expertise." From the commissioners' perspective, clinical knowledge was available on both sides of the purchaser-provider divide. Chief Executives commonly claimed that their commissioning teams drew heavily on what they describes as their `in-house' clinicians - particularly their medical colleagues in the public health directorates. Moreover, as mergers between Health Authorities and Family Health Service Authorities were completed, they suggested, the new commissioning authorities which emerged would in any case have increased access to a wide range of clinical staff, including nursing, pharmacy and dentistry. Advice on clinical issues from GPS was also felt to be important, particularly where GPs could be involved in their role as fellow commissioners - either because they were local Fundholders, or involved in locality commissioning arrangements.

However, Directors of Public Health were more circumspect, insisting that detailed clinical knowledge was lacking in health authorities. "Clinical input and public health

input are different, and this needs to be emphasised. Public health is often asked to give a clinical view, which is not appropriate" one Director of Public Health reported. "Public health is often used as a proxy for clinical advice" another responded, "and this is highly problematic." He went on to emphasise that, although medically qualified, public health physicians were "not experts on clinical practice, and often haven't practised for a long time."

This impossibility of being both expert and up-to-date in all clinical areas was a common theme among public health respondents, though some felt it was important to stress that this was not, in any case, their role. "Public health doesn't know the answers" one told me, "what it does know, is the right questions to ask!" The role of public health in terms of clinical advice was expressed, by Directors of Public Health, as being about 'taking an overview from both the population and the clinical perspective, and seeing how the service provision fits with this to make a coherent pattern." This theme of providing a public health overview, or a public health 'spin' on professional advice, was obviously one with which public health was more comfortable, and this appeared to be necessary for both 'independent' sources of advice, such as that offered by the Royal Colleges and other regional committees, and for clinical advice from local providers and primary care.

6.3.3 Accountability for the delivery of services

Alongside the issue of access to the 'knowledge base' to support purchasing, was the need to ensure that the service contracted for would be deliverable. It was clear from their responses that interviewees felt strongly that the commissioning process would not work without the direct involvement of local clinicians. The rationale for this was that clinicians deliver the service, therefore they need to be involved in discussions around what form that service should take, and how it should be delivered. Commissioning was seen as a negotiating framework, with clinicians as part of the negotiating process. "Yes, it's vital that they're involved" one Chief Executive explained, "...otherwise, how can we achieve contracts that are valid, have clinical relevance, and are practical,

achievable, and so on..." The need to gain ownership of the commissioning process by the clinicians was a common theme. "It's the only way to agree volumes of work, quality of service...and so on" one Chief Executive told me. "Because they deliver the service, their involvement and ownership is necessary to reflect reality, both in terms of constraints and possibilities," another commented. One Director of Public Health felt that provider clinicians should be at the table in contract negotiations, "it's very important to have their input at the deal-clinching phase, to ensure their commitment to activity levels, service quality and so on."

These clinicians need not be experts in their field. In fact, one Chief Executive felt that local clinicians needed to be involved "whatever their quality." This was quite different to the issue around obtaining expert professional opinion, and much more about accountability for clinical practice. As one Chief Executive explained during discussion of which clinicians needed to be included in negotiations, "Choosing good people is important, but its also important to pick up those whose practice may be causing some concerns." This respondent favoured the practice of bringing together clinicians from the same speciality, but different providers, to influence each other, as a means of improving clinical practice, and used the commissioning process as a vehicle for achieving this.

This issue of clinicians being effective at influencing their colleagues was a recurrent one. One respondent, who was quite confident that managers could negotiate volumes of work and quality standards, nevertheless felt that clinical directors had a particular role in managing services:

> "Clinical Directors can influence their colleagues in a way that managers cannot, especially around changes in clinical care or clinical practice, for example, looking at areas where clinical effectiveness can be increased, or treatment and care made more appropriate and so on..." (Chief Executive)

The importance of this clinician-to-clinician interface was also raised by Directors of Public Health. One expressed this succinctly, "As DPH, I'm still very much part of the medical fraternity" with the result that he felt "able to tap into an extensive network of professional advice and influence as required." This particular Director of Public Health felt his relationship with the acute Trust was "particularly strong", though relating to the community Trust was "more messy - as there's a number of other agencies involved."

Other respondents wanted to make local clinicians accountable for particular aspects of work which were either felt to be inappropriate for commissioners to be doing themselves, or which they found particularly difficult to manage. Referral patterns fell into this category, including agreeing criteria for referral from primary to secondary care, and secondary to tertiary (specialist) services. Extra-contractual referrals (ECRs) and tertiary referrals (from one consultant to another) were clearly both causing commissioning authorities some difficulties at the time of the interviews. One Director of Public Health talked of the role that clinical involvement might have in reducing "perverse incentives in the system," especially in relation to ECRs and tertiary care. "ECRs are very important. The way providers are handling these is upsetting contracting," one Chief Executive told me. However, whilst many Directors of Public Health were involved in advising on ECRs, not all felt this was an appropriate use of their time or skills. "These take up too much public health time and energy," on Director of Public Health complained, "The issue is, who should be doing them, and how? Public health input doesn't usually alter the decision much."

A number of Chief Executives, on the other hand, were very concerned about the financial implications of tertiary referrals, and the lack of control which the health authority had over these. One Chief Executive quoted the example of mental health services, where, following a high -profile enquiry, changes in referral patterns had considerable financial consequences for the purchasing authority:

> "following Clunis, there was a huge increase in the use of private provision for acute psychiatric care...although there had been no conscious decision by clinicians to change their referral practice, they had probably become more cautious." (Chief Executive)

One Chief Executive described how he was planning to devolve responsibility for tertiary referrals to local provider units, to "involve clinicians *as* commissioners," in order to influence clinical behaviour in an area where "there is currently a perverse incentive at work." Such direct involvement, he thought, "should increase the sensitivity and responsiveness of tertiary referrals, and, in addition, give clinicians responsibility for their referral decisions."

This desire to involve clinicians as a means of gaining ownership of contracts, or of changing clinical practice, ran through responses to a number of the questions raised in the interviews, and reflected a level of dissatisfaction with arrangements whereby commissioning issues were dealt with indirectly:

> "They deliver the care - its as simple as that. Therefore...they are the ones that need to be influenced. If commissioners only talk to the Trust Board, they can't be sure of achieving their objectives. Direct dialogue with clinicians is needed." (Chief Executive)

Nevertheless, bypassing Trust management to negotiate directly with clinicians was not without risks, and one Director of Public Health expressed these concerns, "There may be some tensions between increasing clinical involvement in commissioning with commissioners and with their own organisations...clinicians need to stay integrated within their Trusts, and influence the Trust agenda." This DPH went on to argue that there were a number of ways of dealing with this, "sometimes it may be more effective for commissioners to influence Trust management and ensure they get their clinicians on board, sometimes Trust management can be influenced most effectively by working

through the clinicians." Direct clinician-commissioner involvement was not, he felt the only route, nor was it always the most appropriate.

This was reinforced by another respondent, a Chief Executive, who talked of the need for education within providers, "so that clinicians understand management objectives, and don't begin to undermine the Trust agenda." This interviewee had clearly experienced the 'direct' approach, and was not sure that she supported it! "There is a tendency for the more 'switched on' clinicians to 'sell' their pet projects to commissioners, without the commissioner necessarily being clear how or whether this fits with Trust objectives." This could have unintended consequences, as another Director of Public Health had learned, "Dealing directly with clinicians risks marginalising Trust management. This causes problems for commissioners, who end up indirectly 'managing' the service, which is not their role." This tension around who managed the clinicians, and who clinicians were accountable to, runs through the interview data, reflecting, I suspect, the relative 'newness' of the purchaser-provider separation, and the employment history of many of the senior team in the commissioning authorities.

6.3.4 Management of change

Achieving change was another key reason for commissioners wanting to involve clinicians in commissioning. Many of those interviewed felt that achieving change was central to their role, and that the only way they would achieve this would be to have the clinicians 'on board' - not only in terms of achieving change within services, but also in terms of 'selling' these changed services to those who refer patients to them, the GPs. "Clinical Directors' involvement is crucial in achieving service change" one Chief Executive told me, "otherwise, the combination of GPs and clinicians will prevent change happening..." These changes might include changes within specialities - including areas such as changes in clinical focus, addressing clinical effectiveness and productivity levels (not just in terms of agreement on levels of activity, but also on changes in length of stay, shifts to day-case services and other changes in the way

services are delivered). Analysis of the impact of service changes was also highlighted as an area where clinicians and commissioners needed to work together, including developing outcome measures and mechanisms for monitoring changes.

The need to develop new services was also clearly important, and there seemed to be considerable confusion on the part of commissioners regarding how service development should be achieved. One DPH said, "Enthusiastic clinicians want to develop services, and the issue of service development is not clear." As a result of this, "clinicians loose heart, become cynical or leave if things don't happen as a result..." This situation is compounded by discussions that raise expectations that cannot be met, "how do we ensure we keep good people, if we can't ensure service development?"

That there was a need to involve provider clinicians more broadly than in the negotiations around existing services was clear from respondents' answers to a number of questions. For example, asked why clinicians needed to be involved in commissioning, one Chief Executive, in addition to stressing the importance of this for "getting commissioning right," also talked of the need to develop a shared view of the future, "Sharing the processes and the thinking are important..." The "early view of purchasing" with its "stand-off" approach was impossible to make effective, he felt. Commissioning "is broader than collaboration over service agreements...it also encompasses areas such as service development, service change, investment and disinvestment..." Access to the clinical knowledge-base was also important here, as another respondent emphasised, when talking of the need for purchasers to be kept up to date on new technologies, "clinicians are the major sources of information for purchasers in this area"

However, involving clinicians in service development was more than a means of obtaining up- to-date clinical advice. The dialogue was clearly not one-way. "The exchange of ideas is as important as advice. It's a two-way process, negotiating what each side wishes to achieve, and how it can be achieved in the current situation."

(Chief Executive) "We need to be open-minded about possibilities in a changing environment, and see how we can make it work." (DPH)

However, the political dimension of the relationship becomes particularly salient when service developments or reconfigurations are involved. A number of interviewees talked of the shifting patterns of power and influence, between hospital consultants and GPs, and between clinicians and managers. "Its becoming less clear where the power lies," one Chief Executive argued, "The balance between GPs and hospital clinicians has shifted, especially towards GP fundholders." However, this was not the only issue. There was also a "manager-clinician" battle going on, another Chief Executive felt, with

> "...changes...breaking up the old hierarchies and power-bases. One of the major issues for health authority management is 'holding the ring' between the various players, and trying to ensure that clinical quality and clinical standards are maintained as the ground shifts."

Some of these changes were structural, for example, when two hospitals merged, or Accident and Emergency services were being rationalised onto a single sight. Getting clinicians 'on board' in these circumstances was essential, not simply to prevent them blocking change, but to manage local opposition, including opposition form the public. "Clinical support is the key to achieving public support" one Chief Executive told me, "there's a major role for clinicians...selling change on clinical grounds." One positive outcome of the process of involving clinicians locally was the managers' recognition that "when clinicians are on board, major change is achieved more successfully, and with less local opposition." As a result, this Chief Executive believed that "Clinical support is crucial for developing clinical policy and selling it internally, within the Trust, and externally, within the wider community."

6.4 Which clinicians should be involved, and at what stage in the process?

6.4.1 Clinical Directors

When asked which clinicians should be involved in commissioning, respondents also gave a diverse picture. It was clearly desirable to achieve some consensus on this issue, as this was to inform the selection of the subjects for the survey of Trust clinicians. As a result of discussions with the Steering Group, supported by preliminary analysis of the interview data, the decision was made to involve clinical directors and their equivalent, from all the clinical professions - that is, medicine, nursing, and the professions allied to medicine. (For more details, see previous chapter)

Interview respondents, however, sometimes drew more widely than this. For many, clinical directors were necessary, but not sufficient. "Clinical directors will be key players, but there is a fundamental need to get all clinicians whenever fundamental changes are envisaged, such as where services are being rationalised, as all clinical staff will be affected by this." (Chief Executive) This opportunity to draw in others as appropriate was echoed elsewhere. For example, one Chief Executive, whilst insisting that it was the responsibility of Trust management to involve clinicians "up to clinical directorate level," nevertheless felt that "there should be the option of involving others," and the process should be monitored:

> "Chief Executives don't care about the process here...but they do need indicators of success - ie how its done is not the issue, but commissioners need to measure [that] its happening, and that it is achieving change in patient care." (Chief Executive)

Again, a Director of Public Health sounded a note of caution, expressing the view that, "it's difficult to involve them all...there is the possibility that if they are all involved, no decisions would actually be made!" Nevertheless, in terms of accountability for the

delivery of services, as one Chief Executive emphasised, "It's most important now to get the consultants involved, in both the acute and community providers."

The emphasis was clearly on the involvement of the medical profession, although there was recognition that other professional groups needed to be included. One Director of Public Health felt that this emphasis on doctors was "more for structural than professional reasons" in that "doctors have higher status, therefore more power to influence things," and that services are configured around medical specialties, therefore "doctors are the obvious focal point." Contracts were also in many cases moving from whole hospital 'block' contracts to service specific 'block' or even, in some cases, 'cost and volume' arrangements, also based on medical specialties (particularly in the acute sector), further reinforcing the pragmatic reasons for involving doctors.

6.4.2 Nursing and allied professions

However, in community sector, "where contracts are more amorphous," the situation was different, and one Director of Public Health talked of the need to ensure nursing input at this level, though felt that the question of 'which clinicians should be involved' needed to be linked back to the reasons for seeking professional advice in the first place. This led back into a discussion of the balance between ownership (the power to deliver) and science (advice on evidence), with the respondent explaining,

> "There is a tension built in here...in that clinicians are not in fact wanted for their professional background, but for their skills and knowledge. This raises questions about how advice can be based on the perspective of a particular professional group...What is 'nursing advice?' The definition seems to be 'advice given by nurses' but this is tautologous, Why should advice given by a particular professional group be relevant?" (Director of Public Health).

There were also some concerns about local provider clinicians "wearing two hats" ie having interests of their own to consider, whilst being asked to "make logical decisions

with commissioners that may conflict with them." (Director of Public Health) This could, to some extent, be resolved (in the view of this respondent) by maintaining informal arrangements, as "more formal ones may lead to domination by the Trust agenda."

6.4.3 Wider involvement

As one Chief Executive pointed out, commissioners need to look at what they're trying to achieve, identify the knowledge they need to support this, and where the gaps in their knowledge base are, then ask themselves, "what is the role of the various groups, such as clinicians, managers, public health, non-executives and so on in addressing this?" Clearly, from a commissioner's perspective, not all of these players were equally important. There was, for example, very little mention of involving the wider community. When probed on this, one interviewee replied, "it's a big area. We'd need another half an hour - there's a lot happening..." but volunteered no further information.

Public health was a little more forthcoming on this issue than were the Chief Executives. For example, one Director of Public Health raised the issue of wider involvement unprompted, emphasising the need to balance clinical input against "public debate" - though again, when prompted, this seemed quite limited. Asked how he was approaching this, he responded, "via a debate with GPs, and of course, public health medicine has an important advocacy role." Another Director of Public Health raised the issue of the role of Community Health Councils, voluntary organisations and consumer groups, which were particularly strong in relation to community service provision. " The community model has closer links with consumer groups than acute providers, with the exception of specialties such as maternity services, which has its liaison committee," he explained. He then went on to argue that the commissioners' role was to "facilitate this input into the acute service providers," although he rather sadly added, "this is often with some resistance from the clinicians."

One explanation for this preponderance of clinicians over the wider democratic processes was suggested by a Director of Public Health when he was asked whether he had any concerns about increasing levels of clinical involvement in commissioning. There were "all sorts of problems" he felt, one of which was that "its easy to get hold of clinicians....therefore, they can become a substitute for other input, particularly involving the wider community..." He added that he felt there was also "a real risk of being seduced by 'experts' in an area, whereas it's the role of commissioners to balance the various views, and to stand back and take a more objective view."

6.4.4 Which aspects of commissioning?

There was also no overall consensus amongst respondents on which aspects of the annual commissioning and contracting cycle were most appropriate for clinical input. Between them, interviewees covered all stages of the process. Some felt it was difficult to be prescriptive, "how long is a piece of string?" on Chief Executive remarked! "It depends on what we want to achieve," a Director of Public Health told me, "sometimes this will mean the whole process, sometimes only parts..." Others were more clear on where clinical involvement wasn't necessary, "definitely not day to day contract monitoring" one Director of Public Health insisted, but "it's very important to have them on board at the deal-clinching stage, to ensure their commitment."

Whilst some insisted that the clinicians needed to be closely involved at all stages of the process, including the contract negotiations, where clinical input needed to be "on both sides of the table" others felt that, as long as the clinicians had been involved at an early stage in the more strategic decisions, and had a good relationship with their own trust managers, the detail of contract negotiations could be safely be left to their respective contracting teams.

Appropriate aspects identified ranged from strategic issues such as major service developments and changes, to more operational issues such as drafting contract specifications, agreeing performance targets for contract monitoring and evaluation of

clinical care. Some felt it particularly important for the clinicians to be included in strategic issues, especially service developments and areas of major service change (see 6.3.4 above). In terms of health needs assessment, there was an emphasis on involving the clinicians in "needs assessment in their own specialty" (Director of Public Health) rather then population-based health needs assessment, which was seen as a public health responsibility. The Clinicians were also felt to have an important role in "corporate needs assessment" - an allusion to the Project 26 work (Department of Health). However, it is not entirely clear whether these differences form part of a wider debate about the role of local clinicians in developing the knowledge base for purchasing, or are simply a reflection of local practice.

6.5 Accessing independent professional advice

So, how were commissioners obtaining the clinical knowledge they needed to support commissioning at the time of the research? There were clearly a number of routes open to them, and these were explored further in the interviews. Discussion with the steering group had identified the need to explore commissioning authority's access to 'independent' professional advice (see Chapter 4), and an attempt was made during interviews to explore with Chief Executives and Directors of Public Health what they felt to be the appropriate balance between 'local' and 'independent' sources of clinical advice. However, whilst this distinction seemed clear to the Steering Group, and was certainly evident in the literature (See Chapter 3), it soon became evident that, for those being interviewed, this distinction was far from clear-cut. Access to professional advice from sources other than local clinicians formed a large part of the discussion during interviews with both Chief Executives and Directors of Public Health, though interviewees almost unanimously favoured the term `external' professional advice rather than the more commonly-used term, `independent' professional advice. "Independent advice has some major problems," one Chief Executive told me, "it's not 'best practice', and its not 'independent'!"

The composition of Royal Colleges Advisory Bodies was raised by one Chief Executive, and another questioned their role, in that they "are not currently meeting purchasers' needs." The potential for professional advice to be influenced by professional self-interest was clearly a major concern, and this applied whether national or local sources of advice were being sought. There were also cases reported of different professional groups giving conflicting advice, such as when the views of paediatricians and neurosurgeons were sought on the appropriate location of paediatric neurosurgery; and of national guidance having unwanted consequences for local services, such as when Royal College guidance on the numbers needed for effective service delivery may reduce equity and access. Furthermore, the implications for teaching and research were frequently felt to influence the advice around minor specialties. Moreover, in small specialties, "experts in the field are thin on the ground, and know each other." (Chief Executive). The whole issue of whether 'independence' was possible in terms of clinical advice, from whatever source, therefore seemed to be at issue.

Nevertheless, many respondents expressed a desire to be able to look beyond their own organisational or geographical boundaries and their own professional networks to gain the professional advice they needed to support their commissioning role. Some had previously sought advice from regional advisers, or, more commonly, used some of the various specialty sub-committees of the Regional Medical Advisory Committee. However, the RMAC itself was, as more than one respondent described it, now "moribund" - whilst it had not actually been formally abolished, it had apparently ceased to function. Whilst some of those interviewed were relatively indifferent to this state of affairs, as they had made little use of it in the past, others were more concerned. For example, one Chief Executive felt its loss had "increased the role of the Royal Colleges, with local implications", a view expressed in similar vein by some of his colleagues; whilst a Director of Public Health felt strongly that "it needs to be re-invented, in a more appropriate form, to advise commissioners."

Meanwhile, two or three health authorities were busy establishing their own local advisory committees, though by no means all favoured this approach. In fact, one Director of Public Health who had attempted to set up a local mechanism, had "been instructed not to by the Chief Executive." Those without formal local mechanisms were heavily dependent on informal arrangements, which had some clear advantages, in that they were "fluid and flexible." These included approaches such as seeking professional advice on a 'case by case' basis, or 'buying in' independent advice on a consultancy basis, sometimes from a university department. An alternative used by one health authority was to seek informal advice from clinicians in Trusts with which they did not have a service contract. One Director of Public Health talked of "commissioners [who] now have access to almost unlimited sources of advice, mainly in written form", such as 'grey' literature coming from other organisations and professional bodies. Nevertheless, he acknowledged, this could be difficult to access, and difficult to ensure "how good it is, or how best to use it." Both Chief Executives and Directors of Public Health clearly had their own network of professional contacts, "Informal networks are very effective," said one Chief Executive, "There is no need for formal structures, which will only add to bureaucracy."

6.6 Current purchaser-provider relationships

Analysis of the interview data also suggests that there was considerable variation in levels of clinical participation in commissioning at the time of this research, not only within and between health authorities, but also between specialties. "It differs across providers" one Director of Public Health reported, whilst another stated, "It's very patchy. Very good in some areas, totally absent in others." This health authority had a number of standing groups on key diseases and client groups (such as asthma, diabetes and care of the elderly), to provide a clear mechanism for clinicians to have an input into commissioning, and to enable commissioners to seek professional advice; but other areas (for example, cardiology) where there was no mechanism in place, advice and involvement was much more 'ad hoc'. This was considered to be a 'no-win' situation, "it's impossible to please all of the people all of the time. If we did...we'd

probably be doing something wrong!" (Director of Public Health)

One DPH , who felt he had "good local links" also expressed worries about "how much of this is based on past relationships, that may be difficult to sustain as organisations change." This view was supported by colleagues in other health authorities, who repeatedly emphasised the need for commissioners to spend time and energy on these relationships, "macho approaches don't work; commissioners need to take on a more supportive, facilitating, almost counselling role." (Director of Public Health). The need for commissioning staff to "get out and about" and to spend time with their providers, discussing mutual concerns, was also raised by a Chief Executives from a newly-merged health authority. This commissioning organisation reported good relationships with its local clinicians (which could be measured, they suggested, by the fact that "Trust managers are getting uneasy about it!"), and "getting processes right" was felt to be an important contributing factor. In spite of the merger, staff on both sides of the purchaser-provider divide had good networks, which had been established for some time, and it was possible for them to bring these into the new organisations with them. A lot of informal links existed, including social links. "Clinicians learn about the process from being involved...that is, they learn by doing it, and discover how the process works, and how to make things happen in a new environment..."(Chief Executive). "Relationships are the key to influencing the clinical agenda" this Director of Public Health argued.

However, not everyone was so positive. Some were clearly finding the whole issue very difficult. "We're a new organisation" a newly-appointed Chief Executive in a neighbouring health authority explained, "...we're not achieving much in this area. New people in post, so no old networks to draw on..." Provider clinical involvement was described as "the weak link in the chain" by another Chief Executive, where all the Trusts with whom they had contracts were recently established ('Third Wave'), and the commissioning authority had only recently been reorganised. "We've no history of collaborative working with hospital clinicians...we need to build this up from scratch." The difficulties of achieving this, with "immature organisations" on both sides of the

purchaser/provider divide, were causing some concern in this particular authority, highlighting the need for organisational stability and the need to develop good working relationships.

Nevertheless, there was recognition that commissioners and provider clinicians "do not necessarily [have] a shared agenda, though there will be some overlap" (Director of Public Health). Involving the provider clinicians might, therefore, be seen as one way of overcoming this. Another interviewee felt that this was nothing new, "the different agendas and different objectives of key players...pose a risk...but these exist anyway, and are better got into the open..."(Chief Executive). It could be argued that this lack of a common agenda links to the issue of commissioning objectives, and how clinical involvement might help or hinder the achievement of these.

This was being made more difficult by the lack of clarity over commissioning, and how it was going to evolve. Structures and objectives of many commissioning authorities had changed repeatedly, and mergers with FHSAs were imminent - with moves towards primary care led purchasing and the extension of GP Fundholding awaited. "Constant change is not helping" explained one Chief Executive, "its difficult to convey the commissioning agenda to providers when the commissioners are not clear about this themselves."

What appeared to be happening is that where commissioners had experienced good working relationships with local clinicians prior to the introduction of the purchaser/provider separation, and where these relationships had not been disrupted by organisational changes, this process of mutual dialogue appeared to have continued, even though some commissioners worried about the implications of increasing competition between providers as the market develops. On the other hand, where organisational changes in either the commissioning authority or the major providers had led to frequent changes of people in key posts, this mutual dialogue no longer existed.

For example, a Director of Public Health in a longer-established health authority which was trying to reconfigure local services told me regretfully, "It seems slow, and is taking longer than we anticipated to set things up...To begin with, we got the relationship with providers wrong...the...A&E review did not have any Trust Managers on it, and the clinicians were not seen as representing their Trusts." This issue of clinicians' relationships within their own organisation was discussed above (see section on accountability), and was raised when interviewees were asked to talk about any perceived risks to involving local clinicians in commissioning. "For it to work, clinicians must have good working relationships with their own clinical managers" one Director of Public Health stressed. "Clinicians need to stay integrated within their Trusts, and influence the Trust agenda" another explained.

One way of minimising this risk was to mediate clinical involvement through Trust management, and one health authority in particular had been careful to take this route. "Our levels of clinical involvement are very high...with total access to provider databases, enabling us to analyse [it] on a joint purchaser/provider basis." (Chief Executive). In this case, "discussions are all at the level of Trust management, rather than clinical directors" but there is a clear assumption that the Trust management is handling this process adequately within the Trust. (This Chief Executive had a number of service providers involved in the Tomlinson Review, and the reviews of individual specialties which were part of this.) Direct involvement was not always therefore seen as the most appropriate approach.

6.7 Conclusion

This chapter has explored the issue of clinical involvement in commissioning from the perspective of the health authority Chief Executives and Directors of Public Health in the South East Thames region, immediately prior to the survey of provider clinicians. It has established that there is a broad consensus for including local clinicians in all stages of the commissioning cycle, not simply when contracts are being negotiated. Reasons for this include the need that commissioning authorities have to access clinical

advice, to influence clinical behaviour, to ensure that contracted services are deliverable, and to achieve joint ownership of change. The complexity of the commissioning process, the lack of clarity over the role and purpose of commissioning, the shortage of appropriate skills within commissioning authorities, and the fragmentation of relationships resulting from the introduction of the internal market, and the constant organisational changes which have occurred as a result of this, on both the purchaser and provider side, have all been highlighted. The need for organisational stability, clarity of purpose, and effective working relationships around a shared agenda, are all issues that will be picked up in the concluding chapter, after the findings from the survey of clinicians have been considered.(see Chapter 7).

CHAPTER 7 THE SURVEY OF PROVIDER CLINICIANS

7.1 Introduction to the survey

This chapter reports the findings from the postal survey of Clinical Directors and Clinical Managers in the 30 participating NHS Trusts (see Table 4.2). As indicated elsewhere, the purpose of this stage of the research was to provide information for the South East Commissioning Network on the current level of clinical involvement in the commissioning process, and to explore the clinicians' views on "how it has felt to them." (Chair of the Steering Group, 14 June 1994). Building on the initial questions raised by the Project Steering Group, the literature review and analysis of the interviews with commissioning Chief Executives and Directors of Public Health, the survey therefore set out to explore the level of clinical participation in commissioning in South Thames (East) during the 1994/5 commissioning cycle, by asking respondents specific questions about direct contact with their major commissioners; joint work with commissioners on the broader commissioning agenda; specific involvement in the negotiation, management and monitoring of contracts, and what they would like to change. Information was also sought on the age, sex and clinical background of respondents, together with data on the type of trust in which they were employed, and the balance of their clinical/managerial responsibilities.

This chapter is broken down into a number of sub-sections, in line with the survey questionnaire. The main emphasis throughout the chapter is on descriptive data (qualitative and quantitative), reflecting the exploratory, information-gathering design of the research (see Chapter 4), with further analysis where appropriate. The chapter begins by discussing the survey response rate. It goes on to describe the survey respondents, not only in terms of their age and sex, but also in terms of the type of Trust in which they worked at the time of the survey, the directorate or division they managed, and the balance between their clinical and managerial responsibilities. It then presents the main findings from this stage of the research, describing how involved these clinicians were in the various stages of the commissioning and contracting process, and how they felt

about this, as well as identifying other issues of relevance to the research objectives and questions. Finally, it attempts to identify reasons for the observed differences in responses, drawing on both qualitative and quantitative data. Detailed discussion of the survey results reported in this chapter is covered in Chapter 8.

7.2 Survey response

The survey questionnaire was sent out in December 1994, to over 325 named clinical directors and other clinicians with clinical and managerial responsibilities who fulfilled a broadly similar role, in the thirty participating NHS Trusts (see Chapter 6). By the end of February, a response rate of over 75% had been achieved. The next section describes how this was achieved and how the rate was calculated. This is followed by discussion of non-respondents.

7.2.1 Response rate

By the end of the first week in January 1995, 56% had already responded. Reminder letters and duplicate questionnaires were sent out on 6th January, in the hope of boosting this response rate by a further 10% - 15%. This was quite successful, as by the end of January the response rate reached 66%. Further questionnaires continued to come in throughout early February, so no further reminders were sent, as the response was felt by this time to be satisfactory. By mid-February, the rate of returns had slowed considerably. When the third week of February elapsed with no further questionnaires being returned, a 'cut-off' date was set for the end of that month. The final response rate was then calculated as follows: 325 questionnaires were sent out to named individuals; 10 names were subsequently removed from survey population for the following reasons: the questionnaire did not apply to them (7); the postholder new in post, and had completed the survey in a previous post (1); there was a duplicate questionnaire sent, as a result of an administrative error (1); the post-holder had retired, and the post was still vacant (1). Of the remaining 315 valid questionnaires, 237 were returned completed, making a final response rate of 75.2%.

7.2.2 Non-respondents

There were 3 uncompleted questionnaires returned from individuals who did fall into the survey population identified. As they had refused to complete the questionnaire, they were treated as non-responses. A visual check of the mailing list was carried out, to see if non-respondents were clustered in particular organisations, professional groups or geographical areas. As there was no evidence of this (non-responses appeared to be randomly distributed across the region, across Trusts within this, and across directorates within Trusts) , no further attempts were made to boost returns. As the steering group was satisfied with the response rate achieved, no further follow-up of non-respondents was undertaken. It is not therefore known whether non-respondents are likely to differ in any way from their colleagues who returned completed questionnaires, but there is no reason to suspect that non-respondents form a homogeneous group.

7.3 Characteristics of respondents

As stated in Chapters 4 and 5, the survey was aimed at clinical directors, and other clinicians with managerial responsibility who fulfilled a broadly similar role. The main reason for choosing this group of clinicians was that they would be likely to have had sufficient involvement in at least some aspects of commissioning or contracting to be able to comment on the process, and would also be responsible to some extent for contract delivery (performance).

However, the literature review and the initial contact with the Trust Chief Executives suggested that this would not be a homogenous group. The extent to which this expectation of diversity was borne out can be ascertained from an analysis of the background data collected in the final section of the questionnaire, which requested some basic personal, professional and organisation information from respondents. This information is reported in the following order:

(i) individual characteristics (age, sex, professional background)

(ii) current role and responsibilities (job title, clinical grouping, managerial accountability)

(iii) workload in relation to this role (time allocated and spent; clinical/managerial balance)

Characteristics of the organisation in which respondents were working (type of Trust, and length of time established) are also described.

7.3.1 Individual characteristics

Age and Sex

Over 80% of respondents fell within the 35 - 54 age range (Table 7.1), with twice as many males (68.6%) as females (31.4%), although the male:female ratio varied by professional group (see Table 7.2).

Age Band (years)	Number	Per cent
25 - 34	12	5.2%
35 - 44	81	35.2%
45 - 54	107	46.5%
55 plus	30	13.0%
Total	230	100%

Table 7. 1 Survey respondents by age

Professional background

The professional background of respondents was predominantly medical (61.4%), with nursing (18.8%) a considerable way behind. Professions allied to medicine (dieticians, physiotherapists, speech and language therapists and chiropodists) comprised a further 6.3% of respondents, with clinical scientists, at 1.8%, being the smallest professional group. 'Other clinical' (which included clinical psychologist, clinical engineers, and

community dentists) made up 7.6%, and a further 4% described themselves as 'non-clinical'. This small group of 'non-clinical' respondents was a surprise, as considerable effort had been made to screen general managers out of the survey population. It would appear from further checking that these can be accounted for by former nurses or therapists who have transferred to managerial grades and no longer have defined clinical responsibilities, or may alternatively be the result of some clinicians asking their Business Managers to complete the survey on their behalf (which is known to have happened on at least two occasions, as there was a covering note attached to the returned questionnaire to this effect.)

As reported above, there was a majority of male respondents, but this did not apply to all professional groups. Among nurses and professions allied to medicine, there were more females than males. (See table 7.2)

Professional Group	Males	Females	Total
Doctor	114	22	136
Nurse	13	29	42
PAM	6	8	14
Clinical Scientist	2	1	3
Other Clinical	13	4	17
Non-clinical	4	5	9
Total	152	69	221

Table 7.2 Respondent by sex and professional group*

* As a few respondents had omitted to answer either the question on sex or on professional group, totals do not add up to total numbers of respondents.

7.3.2 Current role and responsibilities

Job title

As reported in the literature (see Chapter 3), the lead clinician in any NHS trust clinical division or business unit may have any one of a number of job titles, though, as far as the South East Thames survey was concerned, Clinical Director (50%) and Clinical Manager (31%) were the most commonly-reported. Other titles occurring frequently enough to be given coding categories included Clinical Coordinator and Clinical Chair, but this still did not account for 13% of respondents, who were categorised as 'other' because of the wide diversity of titles (though they clearly combined clinical and managerial responsibilities).

Clinical grouping

Clinical directorates or business units managed by these clinicians were organised in very different ways, with 53% being based on clinical specialty or sub-specialty. A further 12% were care group based, and 19% service based. The remainder were either locality based, or some combination of approaches. (One very recently formed Trust was still organised on a site basis, but was moving to service-based directorates later that year).

Managerial accountability

Accountability also varied, with 40% of respondents accountable directly to the Chief Executive, 6% to the Medical Director, and 4% jointly accountable to both. A further 20% were accountable to an 'other Director'.

7.3.3 Workload in relation to this role

Time allocated and time spent on management duties

Because the role of clinical manager obviously has workload implications, and involving clinical managers in contracting and commissioning is likely to add an additional burden to this (see Chapter 6), there was a need to establish how much time respondents had

allocated for their managerial role, and how much time they felt it was actually taking them. Responses to these two questions are given in Tables 7.3 and 7.4).

No of Sessions	Number	Per cent
none	28	13.5%
half - four	130	62.5%
five - nine	11	5.3%
ten or more	39	18.8%
TOTAL	208	100%

Table 7. 3 Number of sessions allocated for management duties.

No of Sessions	Number	Per Cent
none	1	0.5%
half - four	130	63.4%
five - nine	39	19%
ten or more	35	17.1%
TOTAL	205	100%

Table 7.4 Number of sessions actually spent on this work.

Balance of clinical/managerial roles

The above tables suggest that between 17% - 19% of respondents are full-time managers, who no longer carry a clinical workload. This finding is corroborated by the answers to a related question, which asked about the number of sessions per week spent of clinical practice (see Table 7.5)

At the other end of the spectrum, however, 13.5% of respondents report having no designated sessions for management duties, and double this number (28%) appear to be carrying a full clinical workload in addition to their management role.

No of Sessions	Number	Per Cent
none and not applicable	36	17.2%
Half - four	22	10.5%
Five - nine	91	43.5%
Ten or more	60	28.7%
Total	209	100%

Table 7.5 Clinical workload of respondents

The overall picture that emerges is one in which the bulk of respondents' time is spent on clinical work, with the management role taking a significant, though secondary place. There does not appear to be evidence to support a more recent assertion that "Very often doctors have a managerial workload that far exceeds the 'official' time allowed for it" (Austin and Dopson, 1997, p xv), though it is, of course, possible that the workload of clinical managers has increased since my study was completed, without further time for this being allocated.

What seems to be more problematic is that a significant minority appear to have little or no time allocated for their management duties, or that those with small amounts of allocated time may nevertheless be finding it difficult to reduce their clinical workload in line with this.

These findings broadly support earlier work by Disken et al (1990), who explored a number of models of clinical management in acute NHS hospitals in the UK, shortly before the introduction of the 'internal market,' and concluded

"The role of the lead consultant has many titles - clinical director, clinical head of department, medical representative, clinical services director, director of service, clinical manager. Such consultants are invariably part-time in the 'management role' and continue to spend most of their working week on clinical work. (In some places, the clinical manager is a nurse or therapist but generally

> it has been seen as essential that consultants take on these roles initially in order 'to be credible' to the other consultants. (Disken et.al. 1990. p10)

However, Disken and colleagues confined their study to acute hospitals, and undertook their study prior to the establishment of NHS Trusts. Four years later, when this survey was conducted, both acute and community services were included, and all participating hospitals had NHS Trust status. It is therefore also necessary to consider the type of hospital service in which respondents were employed. For this reason, the survey asked about the type of Trust in which participant were working, and when it became an NHS Trust. Responses to these questions are described next.

7.3.4 Characteristics of employing organisation

Type of trust

The largest single group of respondents came from acute sector trusts, with those from integrated trusts (ie combining acute and community services) being the next largest group. A small number of respondents came from specialist, single-service trusts, and two respondents did not know which type of trust they actually worked in. (See Table 7.6)

Trust type	Percentage of respondents
Acute	44.7%
Community	16.7%
Integrated (Acute and Community)	35.51%
Other (specialist service)	3.1%
Don't know	0.9%

Table 7.6 Organisational location of respondent (employing trust)

Length of time Trust established

As South Thames (East) had only one 'first wave' trust, the majority of respondents came

from Trusts which were established in the second and third rounds (See Table 7.4). Only 1% of respondents did not know in which 'wave' their hospital achieved trust status, and 9% reported that they had taken part in more than one wave. This is probably accounted for by the reconfiguration of one particular participating Trust, a major teaching hospital, which initially became a trust by integrating its local district general hospital, and was later separated from this, to be merged with an adjacent teaching hospital. Many staff within this particular organisation would therefore have been affected by two organisational changes. An alternative explanation for taking part in more than one 'wave' could be occupational mobility - although respondents were asked about the organisation in which they were currently employed, rather than their own experience. However, as one respondent reported having been in all four waves, (adding "it might just feel like this!") it is also possible that this reflects perceptions as much as reality. None of the Trusts which took part in the survey had, in fact, been involved in this number of changes, although some would have applied for trust status on more than one occasion before this was approved by the Secretary of State.

Trust Established	Percentage of respondents
'First wave' (1991)	7.0%
'Second wave' (1992)	49.3%
'Third wave' (1993)	30%
'Fourth wave' (1994)	11.5%
Don't know	1.3%
More than one	0.9%

Table 7.7 Respondents by length of time Trust established

From the above table, we can note that nearly half of all respondents came from Trusts that had been established in the second 'wave,' with a further third coming from Trusts that has only achieved this status in the third wave. As clinical directorates and other models of devolved management were usually introduced into hospitals prior to their attaining Trust status (often prior to or during the preparatory phase), it can reasonably

be assumed that most of the departments or clinical groupings for which respondents were managerially responsible had been established for at least two years - although one Trust (a large London teaching hospital) was known to have introduced clinical directorates somewhat earlier (this was the only 'first wave' Trust in South East Thames). Furthermore, as each clinical directorate would have needed a director, it is also likely (although no direct questions were asked about this) that most respondents would have been in their management role for between one and three years at the time of the survey.

7.4 Working relationships with commissioners

Interviews with commissioners (see Chapter 6) had highlighted the importance of good working relationships between commissioners and providers, both as a means of facilitating appropriate clinical input into commissioning and as a means of ensuring smooth contract negotiations leading to realistic, deliverable contracts. The opening section of the survey questionnaire therefore asked a number of questions to explore this issue further, from the provider clinicians's point of view.

This included questions about frequency of direct contact between clinicians and their major commissioners (ie the commissioning authority with which the Trust held its major contract for the service managed); how useful this contact was felt to be and with whom (in terms of which Directorate/ professional group) this contact usually occurred; whether respondents felt that they understood the commissioners' agenda (and vice versa) and had achieved a shared vision of the future for their services; and whether they felt there was scope for their relationship to be improved.

7.4.1 Direct contact with commissioners

Only 23% of respondents reported direct contact with commissioners as 'frequent,' with a further 37% claiming to have such contact 'sometimes.' For 32%, direct contact was a rare occurance, and 8% reported that it was non-existent. Contact, where it occurred,

was usually on a formal basis (43%), though it could also be in the form of a mix of formal and informal (33%) contact. Only 16% of respondents made contact with their commissioners solely on an informal basis. Nevertheless, wherever contact occurred, and whatever form it took, it was mostly perceived as quite useful (40%) or very useful (30%). Table 7.8 gives a breakdown of frequency of contact by usefulness of contact, and suggests there may be a positive correlation between the two frequency of contact and how useful this contact was felt to be.

Usefulness of contact	Frequently	Sometimes	Rarely	Never	Total
n/a	0	0	0	19	19
very .useful	31	32	10	0	73
quite useful	22	42	30	0	94
not very useful	1	15	30	0	46
useless	0	0	5	0	5
Total	54	89	75	19	237

Table 7.8 Frequency of direct contact with commissioners by usefulness of contact

Most frequent reported contact was with contracts staff (39%), followed by contract and public health (14%) and public health only (13%). However, there are clear indications that this is not quite the balance the clinicians would chose for themselves. Asked which members of the commissioning team they would like to see more often, only 12% answered 'contracts' and 11% public health. 22% were happy to see 'all or any' of them, whilst a further 21% opted for 'other' - including Chief Executives, Chairmen, Medical Advisers, other specialist staff; or qualifying this choice by adding comments such as "anyone who can make a decision." Asked who they would like to see less often, however, 30% chose 'finance and contracting.

Two-thirds of respondents reported that their major commissioners had visited their service, though this was only 'sometimes'(34%) or ' rarely' (33%). A mere 3% reported

being visited 'frequently', whilst for 30%, such visits had never taken place. In spite of this, three-quarters of all respondents replied 'yes' to the question, "Do you welcome these visits?"

7.4.2. Understanding of each other's agenda

Just over a third of respondents (35%) described themselves as sharing a vision for the future of their service with their main commissioners, whilst a further third (34%) unsure about this, and the remainder felt they did not have this at all. As achievement of a shared vision of the future is likely to be built on a clear understanding of each other's objectives, the survey also asked whether participants felt they understood the commissioning agenda, and vice versa. Interestingly, 41% of respondents felt they understood the commissioner's agenda, whilst only 17% felt that the commissioners understood the clinical agenda. As an understanding of clinical issues was an issue raised in the interviews with commissioning Chief Executives and Directors of Public Health (see Chapter 6), respondents answering 'no' to this question (over 50%) were offered an opportunity to outline what they perceived to be the major gaps in their (commissioners) understanding. In total, 157 respondents replied to this open question, and their responses were subjected to qualitative analysis. From this analysis, it is clear that the provider clinicians feel that the commissioners do not understand the services they are commissioning. Gaps in their understanding include a failure to comprehend clinical issues, patient needs, or resource constraints. Moreover, commissioners are felt by many of the respondents to be at best, inexperienced, and at worst, incompetent.

The commissioners' "ignorance of clinical practice" (consultant neurologist) includes referral criteria, diagnosis and case-mix, treatment and the quality of care, and an understanding of clinical outcomes and how these can be measured. "They do not understand the service - they have no 'grass-roots' experience and do not understand basic terminology" commented one clinical manager. "They lack perception about which services offer high quality and which offer low quality" added another (Consultant psychiatrist). According to other respondents, commissioners exhibit a "lack of

comprehension about diagnosis and treatment" (consultant psychiatrist) and "...gaps in areas of sub-specialties and need for tertiary referrals" (consultant physician). In addition, commissioners are seen to focus on what the clinicians feel to be the wrong things, such as "constant pressure on numbers, rather than consideration of quality issues that really matter, such as clinical outcomes." (consultant physician). "They understand numbers, but not case-mix or clinical need" (consultant neurologist).

There was some recognition of the variation in knowledge and skill within commissioning authorities. For example, one respondent commented, "Some commissioners have excellent background experience and knowledge. Others have little experience and insufficient knowledge" (Clinical Nurse Manager). For others, there may be a gap between theoretical knowledge and practical experience: "Sometimes they know a lot of theory and have ideas which are not practicable" (consultant psychiatrist). Some are seen as wanting a 'quick fix' "They need simplistic solutions to complex issues, and do not wish to concern themselves with details" (consultant physician)

Public health advice was clearly not seen as a substitute for clinical knowledge, as one response made clear:

> "There is to my knowledge no-one within the commissioners with a mental health background. One highly specialised mental health contract was led by a public health trainee with no mental health experience." (Consultant psychiatrist)

Patient needs were felt to be another area where there were gaps in the commissioners understanding, " They do not understand the nature of client groups" commented one (consultant, general medicine); they "lack...perception about the difficulties of access to services for clients" argued another (consultant psychiatrist). Another commented that commissioners showed "very little understanding of what GPs are demanding." (consultant physician).

Overall, there was a feeling that this understanding could not be acquired quickly - "it takes a long time for commissioners to learn the implications of contracts for the patient groups" remarked a consultant physician. This need for commissioners to learn, or for clinicians to 'teach' them, was a recurring one - but it was felt to be being undermined by organisational changes and changes of personnel: "The high turnover of staff within the commissioning agency means that frequent 'teaching' session have to be held!" remarked an oncologist.

However, the identified gaps in commissioners' understanding were not confined to gaps in the clinical knowledge base of commissioners. Human resource issues at provider level were also raised, and the commissioners "failure to understand the clinical workload" was commented on. For example, the "lack of knowledge of the rapidly changing scene re Calman, Junior Doctors Hours etc" was felt by one respondent to be " having a major impact on capacity to deliver services" (consultant surgeon). This impact was felt to be particularly important in terms of the need to train clinical staff, and to achieve "the balance between service delivery and teaching/training commitments" (consultant anaesthetics). "We need to meet training requirements if we are to keep junior staff" commented one clinical director, but this was seen as being a commissioner, rather than a provider, responsibility: "My concern is that commissioners recognise the need for commissioning and funding educational time for doctors in training as well as consultants" commented a clinical tutor (consultant, general medicine).

However, not all of the problems are laid at the door of the commissioners. Some respondents took a broader view, locating the problems within the dynamics of the internal market, and the need for commissioners to achieve political objectives:

"Commissioners quite obviously have their own agenda...discussion is obviously difficult because of this." (Clinical Director, consultant psychiatrist)

"Our purchasers are heavily committed to rhetoric and the funding of politically-correct services" (Clinical Director, consultant surgeon)

The need to work together was acknowledged by some:

> "The system can only work if there is a partnership atmosphere...we don't seem to be doing this." (Clinical Director, consultant physician)

However, by no means all of those who answered this question were negative about the commissioner's ability to understand the clinical agenda. One Clinical Director who had answered 'not sure' to the main question, added the following observation in response to the invitation to outline the gaps, suggesting that there was an alternative explanation, even, perhaps, a 'hidden agenda':

"In general they do understand, and we are open to discussion. I think the gaps are probably disagreement rather than gaps in understanding. There have, however, been occasions when commissioners have been less than open in their dealings with providers"

Whether this lack of openness is perceived as a failure of communication or a deliberate strategy is not clear. Asked whether they felt that the commissioners communicated their requirements and expectations effectively, 67% of respondents replied, "No." Nevertheless, 45% believed that the commissioners were driving the agenda, whilst only 8% felt this was being driven by Trust management, and 3% by clinical staff. (Others felt it was been driven by some combination of players, including the Government, Ministers, local politicians, the Department of Health, the Regional Office, local GP Fundholders, or, in a few cases, "no-one").

7.4.3 Can the relationship be improved?

The last two questions in this first section of the questionnaire asked the clinicians if they thought their relationship with their commissioners could be improved, and, if so, who should take responsibility for this. An overwhelming majority (86%) thought that improvement could be achieved, and there was a wide range of suggestions for how this might be brought about. Suggestions included formal and informal mechanisms - such

as greater sharing of information; more frequent and more regular meetings; formal and informal visits to services; earlier consultation; opening up of dialogue; greater willingness to listen to each other and so on. The following quotation illustrates this well: "More informal liaison to improve understanding both from our and their perspectives. Neither party can realistically not afford to talk." (Chiropodist)

There was, however, a divergence of views regarding whose responsibility it was to ensure that this dialogue happened. This was again an open question, but responses were subsequently coded, and the data was therefore analysed quantitatively (Table 7.9) . Interestingly, the feeling that it was up to the clinicians themselves to make this happen was very much a minority voice: "We ought to do this - we already know who they are, and could set up meetings, both formal and informal" suggested one (consultant, A&E), whilst another simply stated "I will." Even combining the category ' clinicians' with 'Trust management' and 'providers' results in under 10% of respondents feeling this was a provider responsibility. Just under a further 10% advocated that the responsibility for improving the purchaser/provider relationship lay beyond the local setting, and appeared to be advocating a more 'centralist' approach - suggesting that either the Government, the Secretary of State, Ministers, politicians, the NHS Executive, the Regional Health Authority, the Trust 'Outpost', or the Chairs of the various organisations involved should be held responsible.

	Per cent. response
Commissioners/purchasers	32.7
Providers	0.5
Trust management	5.9
Clinicians	2.7
Joint	37.3
Other	9.1
Not applicable	11.8

Table 7.9 Who should take responsibility for improving this relationship?

A third of respondents argued that improving the purchaser/provider relationship was solely the responsibility of the commissioning authority, though few gave reasons for this answer. Of those who did, one added "...they have to acknowledge that they need clinical information rather than we feeling we have to force it on them." (Consultant radiologist).

Over a third, however, argued that this was a joint responsibility - though many of these qualified their answer in some way, for example: "Both parties - but there needs to be a commitment from everyone to make things work" (Chiropody); [it's] "a joint responsibility. It is galling to feel, as currently, that all the effort comes from 'our side', with very little take-up on theirs" (Speech and language therapist); "Mutual responsibility. Because we are aware of how busy we all are..." (Clinical psychologist); "Mutual responsibility. To be fair, all invitations to commissioners for meetings have been granted. However, *we* have issued the invitations." (Consultant, general medicine).

At the time this survey was undertaken, the concept of Relational Health Care (as currently being undertaken by the Relationship Foundation, Cambridge) was relatively undeveloped, and there was no accessible body of published work to inform research into the organisational relationships developing (or failing to develop) between purchasers and providers. Indeed, even now, fully-validated measures of NHS relationships have not been developed, and, as Meads and Ashcroft (2000) argue, there are many methodological obstacles to achieving this. This section of the survey sought information on aspects of the working relationship between commissioners and local provider clinicians on the basis of interview data in which concerns about these relationships had been raised (see Chapter 6). Further discussion of the issues arising from responses to this section of the survey questionnaire will be undertaken in Chapter 8. It is now time to turn to the first of the South Thames Commissioning Network's research questions, and ask just how involved the lead clinicians in our 30 NHS Trusts in the South East Region of the NHS were in the commissioning process, in the financial year 1994-95?

7.5 Current clinical involvement in commissioning and contracting

7.5.1 The wider commissioning process

As indicated in earlier chapters, the Project Steering Group were interested in the views of the clinicians on their involvement (or potential involvement) in all aspects of commissioning health services, not simply in the process of contract negotiation. The interviews with Chief Executives and Directors of Public Health in the Health Authorities (see Chapter 6) had also identified a number of areas beyond the contract negotiations, particularly in terms of the wider commissioning agenda, where commissioners believed that local clinical involvement was either desirable or essential. The next section of the survey questionnaire therefore sought to explore the provider clinicians' awareness of, involvement in, and feelings about, various stages of the annual commissioning cycle, beginning with questions about local health strategies, population-based health needs assessment, service reviews, service developments and annual purchasing plans. Participants were also asked whether they felt that the commissioners communicated their requirements and expectations to them effectively, and who they felt was driving the commissioning process, as a means of beginning to elicit their feelings about the commissioning process (our second research question, which will be dealt with a little later in this chapter).

Local health and health service strategies

The Government health strategy, *Health of the Nation* (DoH, 1992) had been a key strategic goal for the NHS since 1992, and had been included in successive NHS Priority and Planning Guidance (Hunter et. al. 1998, p. 23). It was seen by Ministers as one of a number of central policy directives which were expected to informing local purchasing priorities and purchasing plans. (The Patient's Charter and the Community Care White Paper were the two others highlighted by the Secretary of State for Health, Virginia Bottomley, in her keynote address to the NAHAT conference, 'Managing the Market' on 23 February 1993). Although *Health of the Nation* did not require the development of local health strategies and targets, a number of health authorities were known to be

developing these. Many also had a complex mix of condition-specific, client-group centred, or service-specific local strategies (eg mental health strategies, elderly care strategies, acute service strategies). Asking clinicians about 'local health strategy' was an attempt to explore clinicians' awareness of, and involvement in, the process of developing any of these local strategies for improving health and health services.

In response to the question, "Does your major purchaser have a local health strategy?" two thirds of all respondents replied "Yes" although only a third of these recalled having had any involvement in the development of this. When asked to describe this involvement (an open question), few respondents gave any further information. Those that did usually described what appeared to be a process of commenting on drafts of specific service strategies - local consultation on the reconfiguration of Accident and Emergency Services was referred to, as were changes to maternity provision in response to the Cumberledge Report, and the specialty reviews prompted by the Tomlinson report on the future of health services in London. Also, discussion of particular aspects of their own services were mentioned, for example "Meetings between commissioners and clinical managers to set standards and protocols for services - very, very useful meetings." (Community physiotherapist).

These responses would suggest that clinical involvement in the development and implementation of 'health strategy' was not only limited, but that clinicians and commissioners did not appear to share a common understanding of what was meant by 'health strategy' - with commissioners thinking in terms of the clinical contribution to achieving 'Health of the Nation' targets, and clinicians more concerned with being consulted on local service strategies. This would seem to be supported by answers to three further questions, which asked about joint service reviews, future service developments and strategic service changes - where 44% of respondents reported having worked jointly with commissioners to review their own services, 39% said they had agreed future service developments with their commissioners, and 39% reported that the commissioners had discussed strategic service changes with them.

Population health needs assessment and purchasing plans

One of the key features of the commissioning process is that it is expected to be based on population health needs assessment, which should then inform purchasing plans. Whilst in the early stages of the NHS internal market, health needs assessment was seen as a purchaser responsibility, as commissioning developed, there was increasing recognition of the need to involve clinicians and others (the notion of 'Corporate Needs Assessment' as outlined in Chapter 2). The survey therefore asked clinicians whether they had been involved in any work with their commissioners on population based health needs assessment, and whether they had been involved in any way in the development of their local purchasing plans. Reported involvement in both these activities was low, with only one-fifth having any input into health needs assessment, and less than a third having any involvement in the development of purchasing plans - and this usually took the form of either providing information on activity levels, attending meetings, or commenting on draft documents.

7.5.2 The contracting cycle

The next section of the questionnaire began by asking a number of questions to gain information on clinicians' levels of awareness of the current contracting arrangements within their trust, for example, what type of contract was being used, what it included, and who writes the contract specification. It then asked respondents to describe any involvement they had in the contracting process (an open question, with a box for a free text response). Additional questions in this section enquire whether the outcome of clinical audit or information on clinical effectiveness influence the contract specification. Finally, the participants were asked to describe their feelings about the contracting process, and offered an opportunity to explain the reasons for these feelings in free text.

Type of contract being used

Levels of knowledge about the type of contract being used, and what it contained, appeared to be high. Only 11% of respondents were unable to identify this. Of the rest,

45% reported that they were using simple block contracts, 17% block with triggers, 13% cost and volume, and a further 13% were using a combination of these. For 70%, contracts were specialty based, although there were still 18% 'whole hospital' contracts reportedly in use. Levels of awareness of the detail within the contract were elicited by asking questions about what was included (case mix, quality standards, exclusions, incentives, sanctions base line activity and waiting list targets), with respondents being asked to tick all which applied. The level of response to this question was, however, lower - with 41 respondents leaving it unanswered. Two further questions asked whether the contract specification was influenced by clinical audit (Yes 12%; No 62%; Don't know 25%) or information on clinical effectiveness (Yes 17%; No 53%; Don't know 29%).

Who writes the contract specification?

When asked who writes the contract specification, 52% of respondents reported that this was done by the commissioner, 7% by the provider, and 35% replying that both sides were involved in this. Asked to describe their own involvement (an open question), 173 respondents offered further information, describing both involvement and lack of involvement. Some illustrative examples of these are given below.

Examples of Involvement in the process

Most reported involvement seems to be either through the Trust's internal business planning process, directly with commissioners, or some combination of these. For example, a number of Clinical Directors reported feeding into a business plan, which in turn informs the contract, "Have developed business plans for new services, which fed into contract discussion" (Consultant radiology). Others reported meeting directly with the commissioners, usually on an annual basis, though with varying degrees of satisfaction with the process.

> "One annual meeting with commissioners to discuss contract specification for each of three parts of directorate - acute hospital paediatrics, neonatal unit, community child health." (Consultant, paediatrics)

"Meeting with commissioners to agree quality standards and discuss contract." (Consultant, a&E)

"Discussion once a year with commissioning manager and directorate team" (Health Visitor).

These annual meetings were not always satisfactory, however, with a number of respondents saying they were very brief, superficial, or inadequate in some other way: eg

"Brief meeting. No two way negotiation of a contract evident - it always seems thatsomething is required for nothing with no pro-active contribution". (Consultant, radiology)

"All contract specifications are discussed with consultants in the specialty, but after drafting. Level of discussion is not sophisticated on either side - consultants not prepared to accept responsibility for rationing/savings targets, commissioners unclear about role of consultants." (Consultant physician)

Some of those who had been involved in direct discussion with their commissioners seemed unsure whether this was to be regular occurance, describing "a one-off meeting with manager and commissioner" (Nurse, oncology) or turning the answer into another question, such as "One meeting in 1994 to discuss service specification - others to follow? (Clinical nurse manger).

Others reported being asked to comment on draft service specifications, but again, the extent to which they felt that their comments were able to influence the final product was variable, eg: "When it is issued in draft, I go through it, exclude what is impossible, and sign up to the rest" (consultant orthopaedics); "Contract specifications have always been sent out for comment, but rarely are their comments taken into account." (Consultant physician).

A few seemed more positive:

> "I am involved in regular informal and formal meetings with commissioners to both review and set contracts. Also involved internally with Director of Development." (Clinical manager)

> "Recently I have become more directly involved in issues relating to the wording of the contract specification for 1995/6 with particular reference to the reporting requirements and quality standards." (Therapist, speech and language)

Examples of non-involvement in the process

However, many respondents simply wrote 'none' or 'not much' or 'very little' in the box asking them to describe their involvement in contracting. Others gave more detailed descriptions of attempts to become involved, which appeared to have been less than welcome, or had little impact. For example:

> "No direct involvement. Initially, I wrote the service specification, which was then ignored each year. We have very little impact on activity targets or quality standards...and costings provided by us are then renegotiated!" (Consultant, radiology)

> "I talk to the GP fundholders about their needs. I am also our Mental Health Management team, but I still have very little direct involvement in the contracting process." (Clinical psychologist)

What emerges from these responses is an overall picture of low levels of involvement in the wider, more strategic aspects of commissioning, combined with limited involvement in contracting negotiations. Furthermore, there is general sense of dissatisfaction and frustration with much (though by no means all) of the involvement that has occurred. This would very much seem to support the anecdotal evidence that provider clinicians were not being involved in commissioning' process, and that they

were very unhappy with this state of affairs (see Chapter 3). However, is the matter quite this straightforward? Will increasing local clinical input into contracting, as advocated in the good practice guidelines produced in response to the Ministerial Task Group report (NHSE, March 1995) be likely to satisfy those clinicians who responded to our survey? Did they, in fact, want to become more involved, or were they simply unhappy about the process *per se*? What did they see as the potential benefits to increasing their current level of involvement (if, in fact, that is what they wanted to do). Were there any potential problems in this?

7.6 Future involvement in the commissioning process

Asked whether they would describe their own involvement in the commissioning process as 'more than you would like, 'about right' or 'less than you would like,' only two individuals (under 1%) reported being more involved in the process than they would like to be, with 22% expressing the feeling that their current level of input was 'about right.' However, 80% of respondents indicated that they were currently less involved than they would like to be - in other words, an overwhelming majority of the clinician/managers who responded to our survey wanted to become more involved than they currently were in the commissioning process. But which aspect of the process did they want to get involved in, and what did they feel they could bring to the process?

7.6.1 Which aspects of commissioning did the clinicians want to become involved in?

To find this out, each stage of the commissioning process identified during the interviews with health authority Chief Executives and Directors of Public Health, was listed; in the order in which they might occur throughout the commissioning cycle. Respondents were asked to rate each as either 'very important' 'quite important' or 'not very important.' (See Table 7.10)

Commissioning area	Very Imp.	Qu. Imp.	Not V Imp.
Developing local health strategies	67.1%	30.7%	2.2%
Developing individual service strategies	81.8%	16.9%	1.3%
Agreeing strategic changes in services	83.2%	15.9%	0.9%
Agreeing service development	83.2%	15.5%	1.3%
Population health needs assessment	36.4%	52.8%	10.8%
Specialty based needs assessment	71.6%	26.6%	1.7%
Developing purchasing plans	48.1%	46.3%	5.6%
Agreeing purchasing priorities	61.1%	34.6%	4.3%
Contract negotiation - service spec.	58.4%	35.1%	6.5%
Contract setting - volumes and case mix	57%	36.5%	6.5%
Contract monitoring - agreeing performance targets	56.1%	34.8%	9.1%
Developing clinical audit	67.5%	25.0%	7.5%
Agreeing extra-contractual referrals	47.2%	38.1%	14.7%
Agreeing referral criteria	64.3%	29.6%	6.1%
Introducing work on effective clinical care	71.8%	26.0%	2.2%

Table 7.10 Areas of commissioning cycle identified as important for clinical involvement

Responses to this question are particularly interesting, in that they suggest that contract negotiation, contract setting and contract monitoring are seen by these clinicians as a rather less important activity for them than getting to grips with than the more strategic issues of agreeing services changes and service developments. This raises a number of questions in relation to the sense of exclusion and frustration felt by the clinicians with the whole commissioning process (see section 7.7), in that at least some of the explanation for their feelings might be that they are being involved in what they perceive to be the least important areas of the process - ie their involvement is not only 'too little'

but also 'too late' in the annual commissioning cycle. As the previous research, including that done by the Ministerial Task Group (see Chapter 3) has only looked at clinical involvement in contracting, it would have failed to identified this as an issue. Further discussion of this will be undertaken in Chapter 8.

7.6.2 Perceived benefits to increasing clinical involvement

Respondents were also asked to identify the major benefits to increasing clinical involvement in commissioning. This was another open question, but it has a particularly high response rate, with 215 replies (out of a possible 238). These qualitative responses were subsequently analysed into a number of broad based categories, which were then further refined. These can be summarised as benefits to the commissioners, to the clinicians, to the overall service, and to patients. These are explored in more detail next.

Benefits to commissioners which were identified included increasing the sensitivity of the needs assessment process, by including patients needs alongside a population perspective; improved knowledge of the service being purchased - especially in relation to technological developments in health care delivery; improving commissioners' understanding of clinical issues and clinically-defined need; better decision-making; realistic target-setting and appropriate monitoring of activity and service quality; and better-informed priority setting.

Clinicians also saw benefits to themselves, in that they felt that their increased involvement would improve their understanding of the commissioning process and the commissioning authorities' requirements and constraints; it would increase their ownership of contracts, and improve performance; it would give them a better understanding of resource issues, and enable them to influence the commissioning process.

There were in addition some anticipated joint benefits, in that service strategies would become clear and achievable; business planning and service delivery would improve,

resources could be better targeted and the management of change - including the introduction of the clinical effectiveness agenda - would be improved.

Finally, many clinicians placed a strong emphasis on the benefits increasing their involvement in commissioning would bring to patients. They frequently saw themselves as the patients' representative, or patients' advocate in the commissioning and contracting process, believing that their understanding of patients' needs would result in more sensitive and responsive services, and improvements in service quality.

7.6.3 Perceived barriers to change

A number of perceived barriers to increasing clinical involvement had been identified prior to this stage of the research, from the literature, from discussions within the Steering Group, from the National Conference and the draft Task Group report. From these, it was possible to compile a list, which included the type of contract; problems with information systems; lack of an appropriate organisational mechanism; insufficient time or support; being insufficiently informed about each other's issues; resistance from Trust managers or commissioners; and lack of incentives to get more involved. Respondents were asked to tick all which applied. Responses are given in Table 7.11 which have been arranged in order of importance.

Once again, the knowledge base of commissioning is raised as an issue. There is also an awareness that the lack of understanding of commissioning on the clinicians side is likely to impede progress, but this is given less weight than the lack of time for this additional work.

Barriers to increasing clinical involvement	frequency	per cent
Purchasers insufficiently informed about clinical issues	168	70.5%
Insufficient time for this work	153	64.3%
Clinicians insufficiently informed about commissioning	138	58%
Problems with information systems	133	55.9%
No appropriate organisational mechanism	113	47.4%
Resistance from commissioners	69	30%
No incentive to get more involved	60	25.2%
Type of contract	56	23.5%
Not enough support within your department	40	16.8%
Resistance from Trust managers	34	14.3%
Other	10	4.2%

Table 7.11 Barriers to increasing involvement, in order of importance

However, respondents did not feel they should be the sole source of clinical advice to their purchasers. When asked what other sources commissioners should have access to, over 75% of respondents made suggestions - such as the Royal Colleges, Professional bodies, Post-graduate Deans, Academic departments, 'experts' in specific fields, Specialty Sub-committees, Public Health advisors, and other commissioners. Nevertheless, as far as the balance between local and non-local sources of professional advice were concerned, there was a clear preference (41%) in favour of 'mainly local' local advice. Equal input from local and other sources came fairly closely behind (30%), but under 5% of respondents favoured sources which could be classified as 'mainly independent.'

Factors which respondents felt would help increase their involvement were also categorised from the responses to open questions. Main categories identified included

practical issues, such as more time for this work, adequate notice of meetings, and more frequent visits by commissioners to the provider's services. There was felt to be a need for appropriate structures and mechanisms to facilitate the process, at a formal as well as at an informal level. Such mechanisms needed to be designed to increase the levels of direct contact between commissioners and clinicians, as well as to increase participation. A number of process issues were also highlighted, including the need for early involvement, improved dialogue and development of a shared agenda. However, education and professional development were also felt to be important, with the need for greater knowledge and understanding of each other's aims and priorities, as well as of commissioning issues and the contracting process, all acknowledged. Finally, respondents were pressed on the issue of which clinicians should be involved in commissioning. a number of options were offered, and, perhaps unsurprisingly in view of the professional breakdown of respondents, Clinical Directors and Nurse Managers were the most frequently selected groups.

7.7 How did these clinicians feel about contracting?

So, finally, to return to the second research question set by the Project Steering Group: how does the commissioning process feel to clinical directors and other lead clinicians whose responsibility it is to actually deliver the service? To explore this issue, the questionnaire focussed on respondents' experience of the contracting process, as the anecdotal evidence had suggested that this was where any involvement they had experienced was likely to be focussed. Respondents were asked to classify their overall feelings about the contracting process as positive, neutral or negative. Positive feelings were clearly in a minority, with the largest number reporting feeling 'neutral.' However, over one third of respondents actually reported feeling negative (see Table 7.12). This was followed by an open question ('why?') aimed at eliciting more detailed comments, with a box provided for an open-text response.

Overall feelings about contracting	Number	Per Cent
Positive	40	17.1%
Neutral	100	42.7%
Negative	94	40.2%
Total	234	100%

Table 7.12 Clinicians' feelings about the contracting process

7.7.1 Sub-group differences in feelings about contracting

Because this was such a central question, it was decided to analyse responses by sub-group of the survey population, to establish whether there were any differences by age, gender or professional group. Although differences can be observed, differences by age and by gender did not reach statistical significance (Chi-sqare test). Difference by professional group was not tested for significance due to the very small numbers falling within some of the groups. Consideration was given to combining small groups, but this was not felt to be appropriate. Feelings about contracting, broken down by sex and by professional group are however illustrated in Tables 7.13 and 7.14 below.

Gender	Positive	Neutral	Negative
Male	21 (14%)	68 (44%)	65 (42%)
Female	18 (25%)	30 (42%)	23 (32%)
Total	39 (17%)	98 (44%)	88 (39%)

Table 7.13 Feelings about contracting by sex of respondent (n = 225) (p = 0.078)

Professional group	Positive	Neutral	Negative
Doctor	19 (14.1%)	51 (38.6%)	64 (47.8%)
Nurse	12 (28.6%)	21 (50%)	9 (21.4%)
PAM	3 (23.1%)	6 (46.2%)	4 (30.8%)
Clinical Scientist	0	3 (75%)	1 (25%)
Other clinical	1 (5.9%)	11 (64.7%)	5 (29.4%)
non-clinical	3 (33.3%)	4 (44.4%)	2 (22.2%)
Total	38 (17.4%)	96 (43.8%)	85 (38.8%)

Table 7.14 Feelings about contracting by professional group

Nb. a Chi-square test was not applied to this contingency table, due to the number of cells with fewer than 5 observations.

Similarly, feelings about the contracting process did not differ significantly by the type of Trust in which the clinician was employed, or by when the employing organisation had achieved Trust status. So, are there any other factors which might have influenced the ways in which respondents felt about the contracting process? To explore this, it important to let the clinicians speak for themselves. Nearly three-quarters of respondents gave their own reasons for their feelings, and these answers were subjected to qualitative analysis. Illustrative examples of this follow.

7.7.2 Respondents' own reasons for their reported feelings

Those who reported feeling positive about the process

Respondents in this group emphasised the positive impact on service delivery of working together, the opportunities for mutual learning this provided, and the improved understanding of each other's roles and responsibilities. "It's a two-way process" one clinical manager emphasised, "Because we meet with commissioners to discuss future needs and it's a joint process" another stated. There were clear opportunities for this process to improve service delivery, according to some respondents in this group. For

example, one Clinical Director (consultant surgeon) felt that "it should leave scope for improved patient care," whilst another (consultant paediatrician) said, "It's forcing us to confront issues of service provision and health needs," "I think it can be a useful tool for service development, being both appropriate in terms of clinical effectiveness and population need" (Clinical Manager, Midwifery) "There have been clear improvements in waiting times and quality of service" (Clinical Coordinator) and "it enables quality issues to be addressed (Clinical Manager, nurse) were other comments on the improvement to service delivery. However, there was also recognition that this process was not only about improving service delivery to patients:

> "I do think that good, clear contracts can improve value and effectiveness. Time is always a problem, and discussions tend to be centred on money and volume, with little time to discuss effectiveness and quality issues. That being said, my views are positive" (Nurse manager)

Nevertheless, these opportunities for service improvement had not been achieved without other changes, such as improvements in communication between both commissioners and providers, and shared learning. "Dialogue with commissioners is improving since a clinician has been appointed" reported one Clinical Manager (a nurse); "Commissioners are listening and communicating" said another (Head of Service, psychology) adding, "we are all learning together, and there is a genuine wish to get things right." "There is a mutual learning process which so far we are being encouraged to maintain" one Clinical Director (Consultant Physician) stressed; though some clearly felt there was more learning needed on one side of the purchaser/provider divide than the other:

> "We know what is needed. We have taught the commissioners the 'bricks and mortar' of our business. They have listened to us, and to the national voice, and bought what is needed." (Clinical Director, medicine)

This sense that the providers needed to 'teach' the commissioners their job arose in response to a number of the questions asked during the survey, and is a theme I will

return to at a later stage of analysis. However, on balance, those who felt positive about the contracting process were more likely to express views which suggested that the process worked because of good communication, mutual understanding, and a willingness to work together. This was not always achieved, and needed to be worked at, but even where things had been difficult to begin with, there was a sense that these initial difficulties were slowly being overcome:

> "Over the years this process, and our relationship with the commissioners, have improved considerably. Both me and they understand each other's problems better. I greatly welcome involvement in the contracting meetings, and as confidence has increased on both sides, this has become more of a 'way of doing business.' At first, it felt like a battle!" (Clinical Director, consultant psychiatrist.)

Those who reported feeling neutral about the process

Closer analysis of the qualitative responses of those who claimed to feel 'neutral' about the contracting process suggests that many felt quite positive about the potential benefits of contracting, but that they did not feel these potential benefits were yet being realised. "I believe that the purchaser/provider split is a good one, but because of lack of information, it is going blindly" This feeling that the process needed to develop, and to become more sophisticated was a common one, but was perhaps best summarised by this respondent:

> "I think that the contracting process has merits, but it is not sophisticated enough yet to influence service provision in a major and radical way. Trusts still seem to have the greatest influence on current services. I also have concerns about the proliferating bureaucracy, the costs of this, and its ultimate effectiveness, Many impressive documents are produced, but does this influence the service which is possible?"

Apart from the bureaucracy generated by the contracting process, and the paucity of information to support it, one of the main reasons for the failure of the market to reach its potential, according to this group of respondents, was the lack of knowledge and experience on the commissioning side. "The purchasers do not have enough knowledge to differentiate good services...they do not know the appropriate questions to ask" argued a Clinical Manager (consultant in paediatrics). "I feel there are a lot of people at the lower end of the learning curve" another respondent commented. The theme of provider clinicians needing to 'educate' the commissioners arose again, "I don't believe contracting is carried out by people who have the full competencies to do their job, but we are helping them from within the Trust..." and "Commissioning is still relatively immature. As providers we have a role in educating people in health authorities for longer term benefits. We must invest the time..." were two fairly typical comments. a few respondents had started off being cautiously optimistic, but the reality had led to disappointment, "I am working with it, but...I have yet to see any benefits and I find my scepticism increasing almost daily" reported one Clinical Director. Another stated "I have confidence in local management, but not in the commissions realisation of what is happening at the sharp end."

Those who reported feeling negative about the process

Not all of those who felt negative about the commissioning process where wholly resistant to the process. Some respondents expressed constructive criticism, with an indication that the process had potential which was not being realised. "Nettles are not being grasped." was one comment which suggested this, as was the following response:

> "My feelings about appropriate contracting are positive, but one of my main commissioners does not appear to commission in this manner. The other attempts to do so, but he does not specify quality standards that would apply to our service." (Clinical Director, Psychiatry)

Most of those who expressed negative feelings about contracting, however, seemed either resistant to the process, or showed outright hostility to it. There were feelings that it was

insufficiently sensitive, inflexible, poorly managed and badly informed. "Divorced from the real issues" "only important factor is activity" "lack of understanding of clinical need" "it's just guesstimate and guesswork" were some of the brief replies. Those who went into more detail tended to express even stronger negative feelings. "The commissioning process is a disaster" replied one Clinical Director, "Its not a *contract*, its an *edict*" claimed another. This view was reinforced and extended by another respondent: "Its not a contracting process...its a diktat to clinicians as to how to do their job." This potential for contracting to challenge clinical autonomy was not the only criticism. The thorny issue of rationing was also raised, "too much in terms of activity is expected from too little resources" one respondent claimed, and "It's an expensive way of rationing health care" suggested another. "Cumbersome, time consuming and unrelated to clinical need" was the way one Clinical Director expressed it, summarising the views of many of his colleagues.

7.7.3. A tentative hypothesis

Following the above analyses, I began to develop a tentative hypothesis that the clinicians' feelings about contracting may be associated in some way with the strength or quality of their relationship with their commissioners. The questionnaire had collected data on the frequency and usefulness of direct contact between the clinicians and their major commissioners, and it was clear from the responses that frequent contact was welcomed, and found to be useful (see Table 7.8 above). Frequency of direct contact was therefore selected as a 'proxy' measure of the clinician-commissioner relationship, and cross-tabulated with reported feelings about the contracting process. The resulting contingency table was subjected to the Chi-square test, and results were found to be highly significant (see Table 7.15).

Direct contact	Positive	Neutral	Negative	Total
Frequently	16 (29.6%)	26 (48.1%)	12 (22.2%)	54
Sometimes	18 (20.6%)	34 (39%)	35 (40.2%)	87
Rarely	6 (8%)	32 (42.6%)	37 (49.3%)	75
Never	0	8 (44%)	10 (55%)	18
Total	40 (17%)	100 (42.7%)	94 (40%)	234

Table 7.15 Feelings about contracting, by reported frequency of direct contact ($p = 0.002$)

The strong association between these two variables suggests that there may be a positive relationship between the level of direct contact between the clinicians, and their feelings about the contracting process, with clinicians feeling more positive about contracting the more frequently direct contact occurs. However, a note of caution needs to be made here. It is not possible to tell from this data whether, for example, it is the frequency of direct contact with their commissioners that is responsible for, or even contributing to, the more positive feelings about the contracting process. It is equally plausible to suggest that commissioners may be more ready to make direct contact on a more frequent basis where they know that they will not encounter negative feelings from the clinicians they encounter.

Alternatively, it may be there is a third variable at work, which has not been captured by this study, which is contributing to both the higher levels of direct commissioner-clinician contact, and to the higher levels of positive feelings about contacting, in such a way as to result in this positive association. Clearly, there would seem to be room for further research to explore this tentative hypothesis. Nevertheless, it does seem that this association, especially when combined with the responses to other questions in the survey, provides strong evidence to support a recommendation that commissioners should ensure that they make direct contact with 'their' clinicians on a regular basis if they wish to increase their satisfaction with the commissioning and contracting process.

7.8 Summary and conclusions

7.8.1 Summary

This chapter has presented the findings from a postal survey of 325 clinical directors, clinical managers and other lead clinicians, working in the 30 NHS Trusts based in the South East Thames Region of the NHS, during the winter of 1994 - 95. The survey achieved a response rate of over 75%, and there are no reasons to suspect that respondents differed substantially from non-respondents. Two thirds of respondents were male, and over 60% were from the medical profession. The majority carried a predominantly clinical workload, with their management duties taking a significant, though secondary, place to service delivery.

Less than a quarter of respondents reported having frequent contact with their main commissioners, and direct contact, where it did occur, was usually on a formal basis. Nevertheless, they welcomed this contact, and found it useful. However, only a third of the clinicians surveyed felt they shared a vision for the future of their services with their commissioners. Clinicians were particularly concerned that their commissioners did not understand the services they were commissioning, especially in terms of clinical issues, patient needs and resource constraints. Most located these weaknesses within the commissioning organisation, though a minority blamed the structure of the internal market, and the need for commissioners to achieve political objectives. Nevertheless, the majority of respondents felt that the commissioning authority was driving the commissioning process.

Their involvement in commissioning, where it had occurred, was mostly at the contracting stage of the annual commissioning cycle. Just over a third of respondents reported some involvement in developing the contract specification. This usually took the form of attending meetings, commenting of draft documents, or providing information. Most felt this was inadequate, and would have preferred to have been involved much

earlier in the process. Contract negotiation, contract setting and contract monitoring were in any case considered by these clinicians to be less important areas for their involvement than more strategic aspects of the process, such as agreeing service changes and developments, and working together on service strategies. Speciality-based needs assessment was also given a higher priority than population health needs assessment or developing purchasing plans.

Clinicians' feelings about the contracting process were mixed, with a minority feeling positive. Those who did feel positive did not differ significantly by age, sex or professional group from their more neutral or negative colleagues, and the type of contract being used, or the type of Trust in which they worked did not seem to be important influences on their feelings. The only factor which did appear significant was the relationship between the clinician and the commissioners, as measured by frequency of direct contact. This finding does, however, need to be interpreted with caution, as there are a number of possible explanations, and a number of further questions raised (see Chapter 8 for a fuller discussion of these).

Overall, there was strong support for increasing levels of clinical involvement in commissioning, and evidence of considerable scope for improving the relationships between commissioners and provider clinicians. The main responsibility for undertaking this was felt to lie with the commissioning authority, though there was support for working together on this, and a feeling that mutual benefits would result.

7.8.2 Conclusion

This chapter has described the issues around clinical involvement in commissioning from the point of view of those provider clinicians, who, as a professional group, were clearly able to lobby effectively to make their voices heard. Although it is possible to argue that these findings are likely to be representative of this particular group, because the survey included all clinical directors and clinical managers in one region of the NHS and achieved a high response rate, nevertheless, their views must be treated with caution.

This is not only because of the reliance on 'self-reporting' on their levels of involvement in commissioning, rather than more objective measures, but also because this group could be described as at least potentially offering a highly partisan perspective on the workings of the NHS 'internal market' at a particular moment in time.

It will therefore be necessary to question these findings in more detail, and assess their validity alongside other examples of research into the commissioning process. This will be the subject of the following chapter, which will link the survey findings to the interview data from the exploratory work with the commissioning Chief Executives, to provide an overall picture of the issue of clinical involvement in commissioning in the South East Region during the 1994-5 commissioning cycle. The following chapter will then relate these findings to previous research in this area (as highlighted in Chapter 3) and more recent work (done since this study was completed) to evaluate the working of the NHS 'internal market.' Finally, many of the themes, issues and questions raised will be subject to further critical analysis, drawing on theoretical perspectives derived from the sociology of the professions, and the role of health professionals in the health policy and process.

CHAPTER 8 DISCUSSION AND CONCLUSION

8.1 Introduction

In this, the final chapter, I will return to the argument raised in my introduction (Chapter 1), ie that the change in emphasis from the early rhetoric of the separation between the purchaser and provider roles within the NHS internal market to a policy which emphasised the importance of collaboration, and the factors which brought about this change, is every bit as interesting as the more specific set of questions being asked by my clients about the level of clinical involvement in commissioning in South East Thames, or how the clinicians' felt about this process. Yet it is the answers to the questions initially raised by the South East Thames Commissioning Network that will enable me to explore these wider themes, to suggest a number of tentative hypotheses, and to examine a range of alternative explanations for this change.

In other words, I will not only set the analysis *for* policy, that is, the particular set of questions which the South East Commissioning Network had wanted to address, within an analysis *of* policy, by using the research findings as a basis for discussion of broader policy issues (in the conventional sense of setting discussion of research findings from any empirical study into its wider context to draw some conclusions); but will also draw on the findings from the applied research to illuminate the context in which the research was embedded. The South Thames case study will, therefore, be used to enable me to move from the 'micro' level of policy analysis to the 'macro' level, and from synthesis to analysis. This process will not only raise questions about the process of policy analysis and some of the methodological issues which underpin this, but also consider whether it is possible to move beyond some of the currently unresolved questions in the policy literature, by reframing the questions being asked, and adopting alternative methodological paradigms for researching them.

In terms of structure, this chapter will begin with a brief summary of the results of the research into clinical involvement in commissioning in South Thames, linking the

findings from the interviews with the commissioning Chief Executives and Directors of Public Health (reported in Chapter 6) with the findings from the survey of trust Clinical Directors (reported in Chapter 7). The purpose of this summary will be to synthesise the different aspects of the research, in order to provide an overview of the commissioning process in one region of the NHS, at a particular moment in the development of the NHS internal market. This summary will relate the research findings to the original questions posed by the research clients (see Chapter 1 and Chapter 4); to relevant related research, as discussed in the literature review (Chapter 3); and to significant work undertaken since my study was completed. This section, together with a brief description of the process by which the research findings were disseminated across the region, and more widely via publication, will complete the analysis *for* policy.

However, as I have argued already (Chapter 1), the empirical study in South East Thames needs to be set within a wider policy and organisational context. Whilst a description of this context has been extensively covered in Chapter 2, it is important to recognise that neither the policy nor the organisational environment remained constant throughout the duration of the research. Whilst the development of the commissioning function within the NHS internal market and the issue of clinical involvement within this were high on the national and local policy agenda at the time the research was commissioned, by the time the work was completed and reported back to the clients, less than 12 months later, the health policy agenda had already moved on. With the publication of *Developing NHS Purchasing and GP Fundholding* (Department of Health, 1994) the government had made a clear commitment to further devolution of the commissioning function to the primary care sector, through the extension of GP fundholding to an increasing number of general practices, and by broadening the range of services which fundholding practices could purchase. Finally, the necessary legislation to enable the formal merger of District Health Authorities and Family Health Services Authorities, was also in preparation. Whilst this shift towards what quickly became known as 'a primary care led NHS' was felt by the Project Steering Group to be beyond the scope of the South Thames study, it clearly had implications for implementing the research findings. Not only did the number of purchasers within the internal market continue to proliferate (with all that this implied

in terms of the number and complexity of the purchaser-provider relationships), but an increasing number of clinicians became both purchasers and providers of services - further blurring the boundaries between these two functions within the internal market. Moreover, the merger of DHAs and FHSAs undoubtedly had its own impact on the development of commissioning, as the newly-formed health authorities continued to restructure internally.

Finally, this chapter will move from discussion of the analysis *for* policy into consideration of the research findings in relation to an analysis *of* policy. What does this 'case study', undertaken at a specific moment in the development of the NHS internal market, tell us about the policy process itself? As the research progressed, I found myself reflecting on both the research process and the research findings. This led me to begin to formulate a further set of questions, beyond those set out in the brief set by my clients, and beyond even my own original research questions. I became interested not only in what was happening, and why it was happening, (ie how involved clinicians were in commissioning, how they felt about it, and why this was an issue for the South Thames Commissioning Development Network) but also in the 'bigger questions' in which these more specific research questions were embedded.

In this sense, I began to explore whether the analysis *for* policy, that is, the applied study I had undertaken to meet my client's needs, could offer any useful insights into analysis *of* policy, for example, by indicating what type of market was being implemented in response to *Working for Patients*; what knowledge and skills were needed to underpin the "new task and...emerging health management discipline" of purchasing for health (Ovretveit, 1995), or by illuminating the changing power balance between the main actors in the health policy arena within the new structure of the internal market. It is to these questions that I will turn in the second half of this chapter. But first, it is time to return to the original research questions, and to assess the research findings in the light of these, and of related research.

8.2 Summarising the research findings

Any research report contains within it a number of potential narratives, and this is no exception. Furthermore, it is rarely possible for policy analysts to reach an agreed version of events (see, for example, discussion of the different ways of telling the story of the NHS review identified by Klein (1995), in Chapter 2). We can only ever hope to achieve "plausible interpretations" (Ham and Hill, 1993), based on our own histories and biases. My own history includes an academic background in sociology and social policy, overlaid with professional experience in health authority purchasing, within a public health department. Perhaps a health service manager working in a provider trust, or a clinician, would have interpreted my data differently, or placed a different emphasis on my findings. Furthermore, as a practising health service researcher, I frequently find myself writing for different audiences, with quite different requirements. This project was no exception, and as a result, the findings have been presented in a number of different ways, for different purposes. These summaries for wider dissemination will be discussed next.

8.2.1 The final project report

The initial literature review and two phases of data collection and data analysis undertaken for the South Thames Commissioning Network were completed during the Spring of 1995, and a draft report was prepared for consideration by the Project Steering Group (see the research timetable set out in Chapter 5). The report drew together the findings from each phase of the study, identified some key messages for the development of the commissioning process across the region, and made recommendations for local action. The emphasis at this stage was on answering the specific research questions identified at the outset of the project, by providing some baseline data on the level of involvement of local provider clinicians in the commissioning and contracting process, and providing the commissioners with a better understanding of how the process felt to those clinicians.

The report therefore explored and described what was happening during the 1994-95 commissioning cycle, on both the commissioning and provider sides of the internal market. It clarified what the key players were thinking and feeling about this process, and highlighted changes they would like to see implemented in future commissioning rounds. Finally, it identified opportunities and barriers to change. The final project report was initially written as a draft document for the Project Steering Group, and fell some way between a management report and a research report in format. Findings were documented in sufficient detail to answer the questions set out by the client, but were not as comprehensively covered as they have been in Chapter 6 and Chapter 7 of this thesis, and there was a greater emphasis on the results of the survey of provider clinicians than on the interviews with commissioners. Also, it was important to frame the research findings within the context of the questions set out in the project brief (see Chapter 1). It is this that I will turn to next.

8.2.2 Relating the research findings to the client's questions

The final report to the Project Steering Group began by establishing that there was a broad consensus amongst commissioners that clinicians should be involved in commissioning. This was regarded by health authority Chief Executives and Directors of Public Health as being essential in order to ensure that contracts were robust and deliverable, in terms of being clinically relevant, and 'owned' by those responsible for delivering the service. Furthermore, commissioners recognised that they needed access to appropriate sources of clinical advice to support the commissioning function, in addition to the advice they could obtain from their 'in-house' clinicians (public health physicians or specialist advisers) or from external sources (the relevant Royal Colleges, or the RMAC and its specialty sub-committees). In terms of answers to specific questions identified in the brief, the research found the following (what was happening, and how the clinicians felt about this, are combined in this summary):

What are the expected benefits?

All the key players could readily identify a wide range of potential benefits from

involving clinicians more fully in the commissioning process, and these benefits clearly extended beyond the annual round of contract planning, contract negotiation and contract monitoring. Benefits identified included benefits for the commissioners in terms of more sensitive needs assessment, improved knowledge of the service being purchased, improvement to the commissioners' understanding of clinical issues; better decision-making; more realistic target-setting and monitoring; and better-informed priority-setting. Clinicians themselves acknowledged that they would benefit through improved understanding of the commissioning process; increased ownership of the contract and its performance; better appreciation of resource issues; and an ability to influence commissioning decisions. Both commissioners and clinicians believed that whole service would benefit from clear and achievable service strategies, improved business planning, and better targeting of resources; as well as improved management of change. Finally, there were some benefits to patients identified, through clinicians' understanding of individual patient needs, which they argued would lead to more sensitive and responsive services.

What areas of commissioning stand to gain from increased clinical participation?

Participants on both sides of the purchaser-provider divide held a wide variety of views on which aspects of the commissioning process they felt would gain most from increased clinical participation. However, they all agreed that clinical involvement should not be confined to contracting. For the commissioners, appropriate areas for clinical involvement ranged from strategic issues such as major service development, through to more operational issues, such as drafting contract specifications, agreeing performance targets and monitoring progress towards achieving these. There seemed to be two broad divisions - those who wanted clinicians present at the 'deal-clinching' phase of negotiations, to ensure they were 'signed up' to the process, and those who felt this was the least important aspect, preferring to include clinicians early in the process, and leaving the detail to respective contracts teams. Clinicians, on the other hand, showed a clear preference for involvement in the more strategic issues - but in relation to development of their own service and its future development, rather than in broad, population-based health needs assessment or health strategy development and

implementation. They felt that their involvement in the contracting process, such as developing service specifications, agreeing activity levels and case-mix, or monitoring performance, were rather less important than agreeing strategic service changes and service developments with the commissioners.

What is the current level of clinical participation in appropriate areas?

Clinical participation in the more strategic aspects of commissioning (health strategy, population health needs assessment, and development of purchasing plans) was very low, though levels improved a little in relation to service reviews and agreeing service developments. Over three-quarters of clinicians wanted to be more involved in areas which they felt concerned them, with many feeling that they were consulted too little, and too late in the process. Although levels of involvement in contracting were higher, only a third of respondents reported that contract specifications were written jointly. Feelings about the contracting process were generally negative or neutral, and working relationships between commissioners and providers were felt to be inadequate. Overall, there was felt to be considerable scope for improvement, and a great willingness to work together to achieve this.

Whose responsibility is it to bring about change?

Clinicians clearly felt that it was the commissioners' responsibility to bring about the necessary changes. They believed that the main barrier to increasing their involvement in commissioning was that the purchasers were not sufficiently informed about clinical issues. There was also insufficient time set aside for this additional work, and more notice needed to be given of meetings.

How should such change be effected?

Change was felt to be needed at a structural level, in that there was a need to find appropriate mechanisms to increase clinical participation in commissioning, and to facilitate more direct contact between commissioners and provider clinicians. However, process issues were also felt to be important, especially in terms of improving dialogue

and communication, and developing a common agenda. Early involvement was seen as the ideal, and time needed to be set aside for this.

8.2.3 Wider dissemination of the research findings

The South Thames study enabled the Commissioning Network to move from a position where they had anecdotal evidence of a problem, to having some clear base-line data on the extent of this problem within and across their own region. The study also provided them with detailed information to help them understand some of the main difficulties, and how these might be overcome by local managerial action.

Following discussion with the Project Steering Group, it was agreed that the main findings from the project needed more extensive dissemination than could be provided by a detailed report. A summary of key findings was then prepared, and jointly presented to the full Commissioning Development Network by the Chair of the Project Steering Group and myself at a regional seminar held at the Salomon Centre (a regional management training venue in Tunbridge Wells) during June 1995. This was followed by a workshop which discussed implementation of the project findings. Shortly after the seminar presentation and workshop, the summary and key findings were developed into a brief document for wider dissemination. This was sent out during July 1995, with a covering letter from the Chair of the Steering Group, to all those who took part in the research.

Later that year, three articles based on the research were commissioned by the British Association of Medical Managers, for publication in *Clinician in Management*. These publications enabled the research findings to be disseminated beyond the South East of England, to an audience predominantly made up of the 'new hybrid' clinical managers and clinical directors. These articles synthesised the data from the interviews with the commissioning Chief Executives and Directors of Public Health and the responses to the survey of clinical managers, to answer three questions, 'Why involve clinicians in commissioning?' (Cornish, 1995a); 'Which aspects of commissioning should clinicians

be involved in?' (Cornish 1995b); and finally, 'How can clinicians become more involved in commissioning?' (Cornish 1996) The following section will build on these summaries, in addition to the those presented in the conclusions to Chapter 6 and Chapter 7, to identify the main themes and issues which the research findings raise, to lay the ground for the more analytical discussion which will follow in subsequent sections of this chapter.

8.2. 4 Setting the research findings in context

The overall picture presented by the research findings is one in which the separation of the purchaser and provider roles within the NHS market was effectively complete, as all providers in the region where the research took place had achieved independent trust status. Furthermore, the development of clinical directorate structures within trusts was clearly becoming well-established, particularly (but not only) in the acute sector. Meanwhile, health authorities still remained the major purchasers within the internal market, although GP Fundholding was growing in scope and influence. There were also a limited number of locality commissioning arrangements, which had been introduced either as a means of involving non-fundholders in purchasing decisions, or in an attempt to encourage fundholders and non-fundholders to work collaboratively on commissioning issues.

In terms of the questions outlined in the research specification, the overall picture did not appear quite as bleak as the health management media (Health Services Journal, 7 April, 1994) had suggested. The high response rate to the survey would seem to indicate that this was an issue that aroused strong feelings, but the detail of the responses would suggest considerable awareness by clinical directors and other lead clinicians of many aspects of the commissioning process. For example, almost all respondents were able to answer quite detailed questions on the type of contract being used, what it contained, and who wrote the specification. Most were able to complete the whole questionnaire fully, including being able to answer questions about aspects in which they had had no direct

involvement, and open questions requesting further information were usually completed, often in great detail.

Nevertheless, there does appear to be a great deal of frustration and dissatisfaction being expressed by the clinicians who responded to the survey. Overall levels of clinical involvement in commissioning was clearly limited, and mostly confined to the contracting process, about which the majority of clinicians felt either negative or neutral. This appeared to support the findings of the management consultants' survey (McLean, Jones and McCarthy, 1994) and of the Ministerial Task Group (see Chapter 2). Whilst some degree of involvement could be demonstrated, the extent of this appeared to vary considerably.

However, whilst both the management consultants' survey and the Ministerial Task Force had concentrated on the issue of clinical involvement in contracting, the South Thames study had widened its remit to include other aspects of the commissioning process, and this provided new information. Two particular findings are worth further elaboration here, because they differ from the previous work covered in the literature review.

Firstly, what emerges from the South Thames findings is a fuller, more complex picture - in which it becomes clear that it is not the setting, negotiating or monitoring of contracts where clinicians wanted greater involvement, but the more strategic issues of service development and change, in relation to their own service. This was also an area where the commissioners felt they had most need of access to detailed clinical advice, over and above that which was available to them from other in-house and external sources. Whereas involving clinicians in contracting could be argued to be about ensuring clinical accountability for service delivery, involving them in strategic discussions around service development or the reconfiguration of services would seem to have rather more in common with enabling them to influence health policy decisions, at least at a local level. It was this insight that led me into a consideration of the changing role of the medical profession in influencing health policy, and the way this might have changed with the introduction of the internal market (see discussion, below).

Secondly, levels of satisfaction with the contracting process appeared to have much more to do with relationships between purchasers and providers than factors identified by the Ministerial Task Force report. Whilst my research had not specifically asked about provider management commitment to the process of involving clinicians in commissioning, there had been plenty of opportunities within the open questions in the survey questionnaire for this issue to emerge, had respondents felt it to be important. It had not done so. Neither was there any evidence that many of the other factors (the type of contract, type of trust, professional background of clinician) had any influence on the clinicians' feelings about the contracting process. What did matter was the quality of the relationship between the key players within the market (see Chapter 7), as measured by the reported frequency and usefulness of direct contact between the clinicians and members of their purchasing teams.

This was an unexpected finding. Questions about the relationship between clinicians and commissioners had been included in the survey after the main research questions had been decided, they were not part of the original project brief. These questions had been developed in response to findings from the initial interviews with the Chief Executives and Directors of Public Health (see Chapter 6), who had expressed concerns about the fragmentation of working relationships which the combination of the separation of the purchaser and provider roles, combined with the continuing organisational change within commissioning authorities, had brought about. Prior to my research, the significance of the quality of these relationships had not been recognised, though there is now a growing body of work in relational health care (Meads and Ashcroft, 2000), and a renewed emphasis on the need for partnerships between organisations, including between commissioners and providers of services, within local health economies. This raises a number of questions about the type of market that was introduced into the NHS following the 1990 reforms, whether this was appropriate to the delivery of health care within a publicly-funded system, and whether it changed in the process of implementation.

These differences between the South Thames research and related work raise further issues around the interpretation of my research findings, which will be covered in the

discussion below. To a great extent, theoretical interpretation of this study has only been available to me in retrospect, as I have moved from description of what was happening during the 1994/95 commissioning cycle, to a consideration of why this was happening. My own research question (see Chapter 4), which both preceded and underpinned the clients' questions, was 'Why was this an issue for the Commissioning Network?' Why was it important enough for them to want to commission some research to ascertain how well they were doing on this, and how they could do better? It was the answers to these questions, which placed a greater emphasis on the needs of the commissioning organisations in terms of this issue, that led me from description to analysis. To rather misquote a well-known 19th century political theorist, the client wanted to describe what was happening, I wanted to understand it!

8. 3 Discussion

In discussing the wider implications of the findings from the South Thames research, it is necessary to move beyond the analysis *for* policy - ie the research undertaken to inform local managerial action to implement a government policy directive, to ask questions about the policy process itself - ie to undertake an analysis *of* policy. It is this wider analysis that needs to begin with my own immediate area of interest, which was why this was an issue of sufficient importance for the South Thames Commissioning Network to fund a year-long research project into it. To some extent, this question has already been answered (see Chapter 6). The interviews with the commissioning Chief Executives and Directors of Public Health began, after all, by exploring what the issue meant for the research clients themselves, and asking them about their own reasons for wanting to involve clinicians in commissioning. These reasons, which are described in detail in Chapter 6, included the need to access the clinical knowledge needed to support their commissioning role; a desire to ensure clinical accountability for delivery of the service as specified in the contract; and a wish to achieve service change and development.

However, does this constitute a sufficient explanation? As Silverman (2000) argues, lay accounts do not do the work of analysis. To do this, it is necessary to move beyond "the

gaze of the tourist" and to tackle the more interesting analytical questions. Why was access to clinical knowledge necessary? Why were provider clinicians seen as the appropriate people to provide this? Why was it the commissioners, rather than, for example, the provider managers, who felt a need to ensure that clinicians were held accountable for the delivery of services? And why were both commissioners and provider clinicians so concerned about the need to manage service change and service developments together? As I analysed my data and began to reflect more deeply on my research findings, I eventually found myself moving on - not only from the questions my clients had wished to answer, but also from my own underpinning research question (why was this an issue for the Commissioning Network?) to a broader question. What might this whole project signifying in terms of what was happening within health policy or the health policy process, at this moment in time? Was this simply a change in the language and rhetoric of the market, or was some deeper, more profound, change in progress?

Did it, for example, indicate the development of a change, perhaps even a 'fault line' around which some kind of seismic shift was taking place within the development of the NHS internal market, for example, from a neo-classical to a relational market? Or was it perhaps an indication of the failure of health authority purchasing? Were purchasers in fact simply giving up on the difficult intellectual task of assessing the need for health care in their local populations, and taking the view (as argued by Opit, 1993) that clinicians know best? Alternatively, did it indicate an increase in provider domination of the market, for example, by challenging the legitimacy of purchasers as representatives of the patient, and refocussing the commissioning agenda away from an emphasis on the wider determinants of health, and back on to a more 'normative' (ie professionally defined) approach to assessment of the need for health care?

Or perhaps this change in rhetoric was disguising yet another attempt by politicians to control clinical behaviour, by making clinicians accountable for their use of resources? For example, did Ministers and civil servants believe that involving clinicians in commissioning would succeed where other initiatives, such as Resource Management or attempts to tempt clinicians into management had failed? Or was something more

complex happening, in terms of the power relations within the NHS? I found it rather perplexing that no-one appeared to be asking why the same clinicians, who had been so opposed to the NHS reforms which had introduced the internal market four years earlier, and who, according to my reading of the literature, had been remarkably unwilling to take on management roles and responsibilities following the earlier Griffiths reforms, were now clamouring to become involved in the whole commissioning process. Perhaps, I found myself asking, this was an attempt by the clinicians, to wrest back the influence they felt they were losing elsewhere in the health care system? They had, after all, been systematically excluded from the macro level of policy-making, by not being invited to take part in the Thatcher review. Many had also been sidelined at the micro level, as decisions around application for independent trust status ignored their often oppositional views. Now at even the meso level, their formal channels of influence were being weakened, as the Regional Medical Advisory structures and processes fell into decline.

These were not questions I set out to answer at the start of my research, but ones which have been raised by my research findings. Any attempt to answer them definitively would require a much more thorough and fundamental reassessment of the nature of the internal market within the NHS, the role of commissioning within this, and the ways in which the introduction of the internal market impacted upon the existing practice, power and perceptions of the medical profession than it is possible to undertake here. Nevertheless, in the absence of such research, I would argue that the South Thames case study reported in this thesis begins to address a gap in our knowledge of the way in which the internal market was functioning during the mid 1990s, by illustrating what was happening in six health authorities and thirty NHS trusts which made up one NHS region in the UK.

8.3.1 Revisiting the internal market

In attempting the analysis outlined above, it may be helpful to return briefly to the earlier discussion of the type of market that was being introduced into the NHS (see Chapter 3). As stated in the literature review, discussion at the time of my research focussed on the type of market that was being introduced into the NHS following *Working for Patients*,

and the pace at which this was being implemented. Debates proliferated about the extent to which the market was modelled on the free market ideology so favoured by the 'new-right' thinkers of the Thatcher government; the degree to which this was being 'managed' for reasons of political expediency; whether the term 'internal market' was an accurate reflection of reality given that purchasers were able to commission services from the private and voluntary sector; the pace of implementation and arrangements for market regulation. The emphasis within these debates was focussed on the provider side of the market, and on the feasibility of 'unleashing market forces' through the introduction of competition between providers. There was much less discussion about the demand side of the market, apart from some early speculation about the identity of the 'customer' (see Chapter 3), and occasional suggestions that it might be desirable to introduce competition between purchasers, perhaps through some kind of franchising arrangement.

Gradually, a consensus emerged that what was being implemented was not, and probably never could be, a 'pure' or neo-classical market, as markets in health care are inherently 'imperfect' on both the supply and the demand side. To briefly paraphrase the argument: on the demand side, the customer (in this case, presumably, the patient) can never have 'perfect' information on which to make choices about what to purchase, because detailed knowledge of their condition or the range of possible treatments available to them falls within the remit of the health professionals who are responsible for providing their treatment and care; whilst on the supply side, it is difficult to ensure free competition between providers, not only because of the anticipated political risk of market failure, but also because of the high entry costs for new suppliers who might wish to enter the market, and the need for purchasers to ensure that a full range of appropriate services are available and within reach of all their population.

As a result, the market that was introduced into the NHS has usually been portrayed as a modified form of neo-classical market, in which purchasers (either health authority or fundholding GP) acted as 'proxy' customers, and the notion of 'contestability' replaced outright competition between providers. There was initially much discussion about how this should be described, with terms such as 'internal market,' 'quasi market' and

'managed market' competing for position. Theoretical analysis throughout has, perhaps unsurprisingly, been dominated by economists, who have most often limited themselves to the identification of potential sources of market failure in 'quasi markets,' or to criticising politicians for misunderstanding how such markets operated. (A good overview of some of these debates is provided by Ranade, 1997) It is only recently that health policy analysts have returned to the discussion, to pose questions about the extent to which the market has achieved its objectives, and what lessons can be learnt from its implementation. (See, for example, the review provided by Le Grand, Mays and Mulligan, 1998) It is within this review of the evidence that the authors conclude that the internal market either brought about little change, or brought about changes which were not picked up by the research they reviewed (Le Grand et al. 1998)

8.3.2 A relational market?

Yet I would argue that my research findings suggest at least one major change took place in the period around this period, and that was a change in the policy rhetoric around the type of market that was being introduced. Whilst the economists continued to debate market conditions and the extent to which these were achievable within publicly-funded health care systems, the political discourse was beginning to move away from a neo-classical model to a more relational market - though official documents used neither of these terms. Although no-one in the Steering Group, in the interviews with Chief Executives and Directors of Public Health, or in the survey of clinicians, used the term 'relational market' the issue of the relationships between purchasers and providers was a recurring theme throughout, and all the more significant, I would argue, because it was an issue which, at least initially, arose without having been solicited. (The survey questionnaire did have a section on working relationships, but it was also this survey that found a strong statistical association between positive feelings about the contracting process, and levels of direct contact between purchasers and providers.)

Relational markets have received relatively little attention in the health policy literature, though it has been argued that their development was "a predictable response to problems

of monopoly, asymmetry of information, uncertainty and purchaser concern about quality." (Ranade, 1997) Whilst such markets are not uncommon in the commercial world, it is likely that they did not fit comfortably alongside the ideology of the free market favoured by the 'new right' thinkers within the Thatcher administration. A year before my research began, Fernlie, Cairncross and Pettigrew (1993) argued that there had been little strategic discussion about the type of market that was likely to emerge within the NHS, and that the nature of such markets might vary from locality to locality and specialty to specialty. They identified and distinguished between a number of typologies, including what they described as 'an unregulated relational market' in which buyer-seller relationships are part of a much wider group of relationships which might include social exchange, undertaken so as to reduce uncertainty and to build trust. Power, trust and influence emerge as important concepts in such arrangements, they argue, and the pattern of negotiations may be shaped by a number of factors which place boundaries on acceptable behaviour, including rules set by small groups of power holders. (Fernlie, Cairncoss and Pettigrew, 1993, p. 72)

Many of the assumptions of relational markets, as outlined by Fernlie and colleagues, can be seen within the South Thames study. For instance, there was a relatively small number of well-established buyers and sellers locked into repeat buying, and purchasing decisions were often made on the basis of 'soft' information (trust). There was also evidence of inter-organisational cooperation between purchasers (especially health authorities and GP fundholders, but also through locality purchasing) and purchasers retained developmental responsibilities towards their providers (although their former DMUs had now all achieved independent trust status, purchasers clearly had a key role to play in terms of service developments and service reconfiguration). Many respondents alluded to social (and sometimes professional) groupings which brought purchasers and providers together (particularly in the case of public health and medical colleagues, but there were also a number of informal relationships in many places). Furthermore, historical patterns of referral were of continuing performance; 'reputation' was an intangible asset; and finally, rules of engagement appeared to be emerging, and this seemed to be in some way linked to possession of organisational power. (Though there

appeared to be a divergence of view around where this power lay, a point which I will return to a little later in this discussion.)

Whether this change was the result of political expediency, or simply an attempt to bring the policy rhetoric more closely in line with what was actually happening on the ground, is more difficult to determine from the evidence. Certainly, there is widespread agreement in the literature that the task of introducing a 'pure' market into the NHS was proving difficult. It is the source of these difficulties, however, which seems to me be open to argument. Le Grand and colleagues (1998) for example, in their recent evaluation of the impact of the NHS reforms, conclude that introduction of the internal market brought about little perceptible change in health service delivery, and then proceed to argue that the only tenable explanation for this must lie with the way in which the market was implemented. This seems reasonable enough. However, in summarising the evidence, I feel they fall too readily into providing what they themselves describe as "a ready economic answer," drawing on market theory to suggest that it was the extent of market management that impeded progress, "For markets of any kind (pure, internal or quasi) to work, all the relevant agents must be motivated by the relevant market signals" and have the freedom to respond to these. This freedom, they argue, was "heavily constrained by central government intervention." (Le Grand, Mays and Mulligan, 1998, p. 130)

Whilst this explanation is plausible, in that it is logical and supported by the evidence reviewed by the authors cited, I would argue that it is inadequate. For me, it fails to acknowledge the sheer complexity of the NHS into which the internal market was introduced, and then compounds matters by going on to try to explain a complex, multi-dimensional issue within the limited theoretical paradigm provided by a single discipline. This is particularly surprising in a volume which has acknowledged that the evidence on which it draws is scattered across several disciplines. Economics as a discipline tends to simplify human agency, and takes little account of the social systems in which markets are embedded. Klein (1995) on the other hand, has argued that at least part of the reason for the limited impact of the market was because "a market system was injected into the shell of a hierarchic, paternalistic institution." How the key players within that institution

responded to the introduction of that market is, then, not only of considerable interest to policy analysts, but is likely to have had at least some impact on what the market was able to achieve, and the type of market that finally emerged. The South Thames research presented here shows some of the ways in which the key players responded, in one NHS region, and suggests that their response was much more proactive than simply being constrained from responding to market signals by government intervention. Participants in the research were clearly active players in the creation of the market at a local level, it was not simply something imposed upon them.

The assumption that markets could ever be 'free' - in the sense of being beyond the reach of the power relationships inherent within and between market players (individual and organisational) was, therefore, inherently flawed. This is not simply an argument about the type of market which was being introduced into the NHS (ie whether it was 'free' or 'managed', 'pure' or 'quasi'); what needs to be argued here, I feel, is that the market was not a ready-made reality, which could be 'introduced' into a pre-existing system (in the way suggested by analysts such as Klein), but was created (constructed) by the actors themselves. The type of market which emerged was, inevitably, the product of the social relations in which it was embedded - it was the outcome of the negotiations, conflicts and compromises made by all the players. It was, therefore, a site of power and resistance, a new arena for policy-making and implementation - not only in the sense of being a level which was somehow expected to mediate between the macro and the micro levels of policy formation and implementation, but a policy level in its own right. As such, it was rapidly colonised by actors from clinical and managerial backgrounds on both sides of the purchaser-provider divide (This theme will be further developed in discussion of the changing policy arena, in the final section of this chapter).

8.3.3 The development of commissioning

As stated elsewhere in the literature and in this thesis, there was a greater emphasis throughout the early 1990s on the development of the provider side of the internal market than on the role of purchasing. This emphasis is reflected not only in the discussions

around the type of market that was introduced, but also in the research evidence - including more recent reviews evaluating the impact the market had, or failed to have, on the delivery of health care (see my discussion of this in Chapter 2). This has, I feel, provided a rather one-sided analysis of the market, and of its impact. The role of health authority purchasing has not only received less attention from researchers than other aspects of the 1990 NHS reforms, however; it also received considerably less attention from policy makers, at least until 1993, when the Minister for Health, Dr Brian Mawhinney, delivered his trilogy of speeches, and argued that politicians had always intended that purchasing should become "the engine that would drive the reforms." (Mawhinney, 1993)

This sudden Ministerial interest in the "engine" - occurring as it does some three years after the vehicle has been set in motion - might seem to suggest that the development of purchasing was simply an afterthought. However, it is equally possible to argue that this political interest could have occurred in response to a number of other pressures, for example, a perception that the vehicle was floundering (or even, perhaps, that it was beginning to succeed, but in ways with which the government was not entirely happy - it is, after all, not unknown for policies to have unintended consequences.) The Ministerial explanation, that "the development of purchasing is the next, most crucial stage of the health reforms" and that "the last two years have seen essential developments which have prepared the ground" for the development of effective purchasing (Mawhinney, 1993) may not have convinced all the critics, but the purchaser development fund (part of which funded my research) would certainly have helped to 'oil the wheels.'

However, as Ranade (1997) has since argued, whilst these speeches were important in setting out a much-needed framework for purchasing, they rather glossed over the many difficulties health authorities were facing in taking on this role. Health authorities had, Ranade argues, been "saddled with a huge agenda which they had neither the expertise nor the appropriate support to fulfil", and were continually being asked to absorb new responsibilities (Ranade, 1997, p.97). In addition to their purchasing role (which included

reducing waiting lists and managing financial pressures in their main providers), health authorities had a rapidly-expanding national policy agenda to manage. This included implementing major policy initiative which had followed *Working for Patients*, such as the *Patient's Charter* and the *Health of the Nation*, as well as working with local Social Services to implement the community care reforms, and with primary care to develop Fundholding. Evidence from the research in South Thames certainly confirms this picture. Interview data shows commissioners attempting to reconcile a range of conflicting priorities and demands - taking on national policy developments, working with local providers to develop and reconfigure local health and social services, attempting to 'tie in' maverick GP fundholders to (and involve non-fundholders in) their local commissioning agenda, and, in at least some cases, attempting the difficult process of consulting their wider communities about their purchasing decisions.

Yet commentators such as Kirup and Donaldson (1994), recognising that purchasing had not achieved its full potential, were still placing the responsibility for this on the 'gradualist' approach to market development! Falling into the trap offered by economists, they argue that it was the conflict of interest which resulted from the dual role of health authorities, who continued to be responsible for their directly managed units, that hampered their development as 'consumer-sensitive purchasers. These traditional loyalties, they suggest,

> "weakened the resolve of many district health authorities to make purchasing decisions which, although they may have benefitted patients...could have put the local hospital's longer-term viability in jeopardy." (Kirup and Donaldson, 1994, p. 256)

My research was undertaken at a time when the health authorities which took part had no direct management responsibilities for their providers, yet there was little evidence of them developing a more aggressive approach to purchasing. This may, of course, be at least partially explained by my earlier argument that what was being introduced, at least in the South Thames region, was not a simple, or classical market, or even a managed

version of this, but some kind of relational market - in which traditional loyalties would be expected to be considered important. However, the evidence from my research suggests that this is not the whole picture. What is at issue here is Kirup and Donaldson's assertion that "the process of purchasing health care is not conceptually complex." This assertion, I believe, can also be challenged in the light of my research findings. It is therefore to the complexity of the commissioning process, and the knowledge-bases needed to underpin this, that I will turn my attention next.

8.3.4 The knowledge bases to support commissioning

The commissioning function in South Thames was at this time considerably broader in scope than simply purchasing secondary health care services. As the interview data presented in Chapter 6 clearly illustrates, 'commissioning' was not just "a fudge word" as has been suggested by some critics (Light, 1998), but a complex process, which encompassed a whole range of activities, from undertaking population-based health needs assessment, through the development of local health strategies (the national health strategy, *Health of the Nation*, was published in 1992, setting out five key areas for health improvement, with targets attached) and service development strategies, through to the evaluation of local services, the development of outcome indicators, and supporting the development and introduction of clinical audit and evidence-based medicine.

However, what is also clear from the interview data is that the full range of technical skills and expertise commissioners needed to support their commissioning function was not in place. Interviewees consistently articulated their concerns about health authorities' organisational capacity to undertake the tasks required by their new role, as well as their worries about the capability of staff within local commissioning teams. Whilst according to some health policy analysts, "it seemed that the technicians - economists, epidemiologists and others - might be able to provide managers with tools for determining priorities" (Klein, 1995, p.153) there is plenty of evidence, here and elsewhere in the literature (see, for example, work on the role of public health physicians in purchasing, by Richardson, Duggan and Hunter, 1994) that these skills were taking

time to develop. Neither the reorientation of health services to a needs-led system (as envisaged by Salter, 1993 and others - including Kenneth Clarke) nor the determination of priorities within a cash-limited budget, could be simply 'read off' the technical knowledge-base.

Nevertheless, considerable progress in these two areas was being been achieved by the mid-1990's, at least in terms of opening up the debate. (Discussion of this is beyond the scope of this thesis, but ample evidence is provided by the growing literature on health needs assessment and on priority-setting that was available by this point.) As the results of my survey show, health needs assessment, at least, at a population level, was not an area in which the South Thames provider clinicians showed much interest. Rationing, however, may have been rather more of a concern. (See, for example, the collection of papers on the subject of rationing, from a major conference on the topic, BMJ, 1993) It is therefore possible to argue that this growing national debate, combined as it was with an increasing pace in the introduction of medical and clinical audit (one of the few initiatives within *Working for Patients* that the BMJ had themselves endorsed) and growing pressure to demonstrate that existing services were effective, was beginning to appear, at least potentially, "a threatening prospect for consultants." (Klein, 1993, p.153) Was this, in fact, the first indication that provider clinicians (particularly consultants) were beginning to feel threatened by purchasing's radical potential, even though this potential was not yet being fully realised?

It was not only skills and expertise in population-based health needs assessment, service evaluation and priority-setting, however, that needed further development within commissioning organisations. As the interviews in South Thames illustrate, one of the main components of the knowledge-base required to support effective commissioning was detailed, impartial clinical knowledge - especially in relation to the introduction of new medical technologies. The Regional Medical Advisory Machinery, which was one of the means by which such advice had previously been given to the Regional Health Authority, was by this time effectively moribund (though a number of its specialty sub-committees continued to meet, they were tending to refocus on supporting the

introduction of clinical audit, or developing local clinical guidelines). Furthermore, there were no plans either to 'reinvent' it in a way that could support commissioning, or to develop local alternatives - in spite of the recommendations from research in a neighbouring region (Dumelow and Littlejohn, 1994). The Medical Royal Colleges, whilst seen as independent of local politics, were perceived as largely representative of professional interest. However, expertise provided by clinicians working within health authorities - such as nurse advisers, pharmaceutical advisers, or public health physicians - was no substitute for the detailed knowledge of local services, of clinical diagnoses and treatment options, or of emerging health care technologies that could clearly be offered by local provider clinicians.

Yet it is this dependence on clinical knowledge and expertise, combined with a willingness to access this knowledge from local providers, that some analysts would argue was a significant factor in ensuring that the purchasing function remained weak. As Light (1998) reminds us, purchasing or commissioning in health care, wherever it is undertaken (and he is drawing lessons from experience within the US market-based health care system) is highly vulnerable to provider capture, as the provider clinicians "control the technology, make the diagnoses, control what is ordered and control the information that the buyers need." (Light, 1998, p. 14) The only way to counteract this risk, Light argues, is by developing effective commissioning, with "the political will to withstand the pressures of those whose entrenched interests are challenged..."(Light, 1998, p.9)

Light argues that experience in the US, where it has been "a long struggle for American commissioning groups...to learn how to do it effectively" (Light, 1998, p. 14) suggests there are a number of prerequisites. The first of these is the need for clear goals. Yet within South Thames, during the 1994-95 commissioning cycle, there is ample evidence that one of the things the health authority Chief Executives and Directors of Public Health did *not* have was clear goals. At the time of the interviews, recent mergers and anticipated policy and organisational changes together contributed to the failure by health authorities to develop a clear set of commissioning objectives, but so, too, did power

struggles within commissioning organisations (see section 6.2.1). However, this is perhaps unsurprising, as even the politicians seemed a little hazy on the purpose of commissioning (as Mawhinney's speeches illustrate). Yet as Ovretveit has argued, "a suitable conception of the purpose of commissioning" is essential to both the future of the NHS, and to the health of the population it sets out to serve:

> "A sense of purpose is essential to individual and organisational effectiveness. It is a source of energy and motivation for staff, and it is the basis for deciding organisation and project timetables. A shared sense of purpose is the most effective 'coordinating mechanism' there is. It provides a touchstone against which people judge what to do." (Ovretveit, 1995, p.54)

This sense of a lack of purpose for the commissioning function within the internal market, combined with the absence of clear organisational goals within commissioning authorities, would almost certainly have impeded the development of effective commissioning. Furthermore, these factors probably contributed to the provider-clinicians' perceptions that commissioners did not understand the services they were purchasing (see section 7.4.2). This lack of purpose and goals would, if Light (1998) is correct in his analysis, have also left commissioning organisations within the newly-established market highly susceptible to 'provider capture'.

The purchaser-provider separation in general, and the issue of the knowledge needed to undertake effective commissioning in particular, highlights one of the main tensions within health care commissioning. This tension is not simply about what, or even how much, to buy in the health care market-place. Nor is it confined to debates about what not to buy (the thorny issue of rationing). I would agree strongly with Klein (1995), who argues that introduction of the internal market gradually began to bring to the surface a deeper, more profound conflict, that had been endemic in the NHS from its inception. Finally, it seemed,

> "The ethical individualism of the medical profession (emphasising the doctor's responsibility to the individual patient) was...being confronted by the utilitarianism of the economist and the epidemiologist (emphasising the impact of any individual decision on the population as a whole)" (Klein, 1995 p.153)

It is this fundamental tension between the ethical individualism of the medical profession and the utilitarianism of the population approach, that lies at the heart of the commissioning process, and this tension that therefore underpinned the issue of clinical involvement in commissioning, which was the subject of my research. Involving provider clinicians in the commissioning process, however the health authority interviewees justified it, could never be simply a matter of collecting useful information, or gaining ownership of contracts. I would argue that it was an indication of a deeper conflict around knowledge and values, about which paradigm (the individual or the population) would become the dominant 'currency' within the new health care market. Furthermore, this emerging market (however the analysts chose to describe it, and whatever form it was eventually to achieve) was creating a new policy space - thereby reconfiguring the health policy arena, and facilitating new alliances and fractures within the health policy community. What were the implications of these changes for the ways in which the policy process is currently theorised? To explore this further, the final section of this thesis will revisit the discussion of the health policy process, and the theoretical frameworks which inform it, which were set out in Chapter 2.

8.4 Conclusion: a case study of policy and process

In Chapter 2, I described some of the difficulties I had experienced in selecting an appropriate theoretical framework for this research, and attributed some of these problems to the eclectic nature of current approaches to policy analysis. Attaching theoretical models of the policy process to the development and implementation of any particular policy is a complex task, made even more difficult by the range of possible options available. Nevertheless, it is worth attempting here for two reasons. One, obviously, is related to the need to move from description to analysis. The other is to

revisit the earlier theoretical discussion in the light of my research findings, to explore whether any of the existing theoretical frameworks can be used to interpret my findings, and to explore the theoretical implications arising from the research. In this sense, the empirical study undertaken in South Thames, combined with the discussion of the context in which it was set, together form a case study to examine the policy process within the reformed NHS.

Before continuing with this discussion, however, I feel it is essential to emphasise the need for caution. Drawing theoretical conclusions from a single empirical study is always surrounded by methodological caveats, and this research is no exception. (For a review of the methodological issues, see Chapter 5) Indeed, I feel it is especially salient in the case of this research, which, as I emphasised in Chapter 2, was not designed to test existing theoretical frameworks. Nevertheless, I would argue that the study does have theoretical implications for the analysis of the policy process, especially in terms of the ways in which professional power within this process is theorised. It was the very difficulty of locating my research findings within existing theoretical frameworks, after all, that led me to feel I was becoming "terrorised by the literature" (Becker, 1986). Not only could I find no single theoretical framework that 'worked' in terms of my research questions, but I also became increasingly dissatisfied with the 'pick and mix' approach I had initially taken, on the advice of analysts such as Walt (1994), to the interpretation of my data. It was these theoretical difficulties that finally made me question whether the frameworks I was attempting to use were adequate for the phenomena I was observing. As Becker argues, "The feeling that you can't say what you mean in the language you are using will warn you that the literature is crowding you." (Becker, 1986, p. 149).

8.4.1 Setting the agenda: the Ministerial directive

The ministerial letter, sent out to all Chairs of District Health Authorities in January 1994, which stressed the importance of involving provider clinicians in the contracting process and requested information on the steps being taken to ensure this was happening (see Chapter 1) was, in Walt's terminology, a case of sectoral, or 'low politics.' It was

clearly a policy decision, but not one that needed to be considered by government as a whole. It was simply a departmental matter, and as such, could be "communicated through circulars or letters rather than legislation." (Walt, 1994, p.43).

As such, it initially appears to be a very good example of what some policy theorists have dubbed *incrementalism*, sometimes also described as 'muddling through.' This approach, which draws on the work of Lindblom, has been described as "both a good description of how policies are actually made, and a model for how decisions should be made." (Ham and Hill, 1993, p. 85). It makes assumptions that policies are made-one-at-a-time, by a process of "successive limited comparisons" -

> "That is, instead of specifying objectives and then assessing what policies would fulfil these objectives, the decision-maker reaches decisions by comparing specific policies and the extent to which these policies will result in the attainment of objectives. For Lindblom, the test of a good policy is not, as the rational comprehensive posits, that the policy maximises the decision-maker's values. Rather it is whether the policy secures agreement of the interests involved." (Ham and Hill, 1993, p. 85)

Certainly, there is little evidence that the decision to involve clinicians in commissioning could be categorised as an example of the alternative model derived from the literature, the *rational-comprehensive* approach. There is no indication, either in the literature of the time, or in my own research, that the Department of Health had identified any particular problem within the internal market, nor had it undertaken a thorough analysis of the early development of the commissioning function and discovered a need to make it work more effectively. (Indeed, as noted earlier, a previous Minister for Health had argued strongly against research to evaluate the implementation of *Working for Patients.*) Neither does it appear that politicians or their civil servants had been asked to identify or assess a number of policy options for developing the purchasing function, although

additional funding had been allocated to support this work.[1] All that appeared to be happening, at least to an external observer, was that an incremental change was being made to existing policy. (Although in policy terms, appearances can, of course, be very deceptive.) Unlike the policy which came before it, and to which it was making a minor adjustment (I am, of course, referring to *Working for Patients*), this seemed very much a return to 'policy as usual.'

However, as policy analysts would argue, this approach simply describes what appeared to have been happening. Both rational-comprehensive and incremental approaches to policy are regarded by policy theorists as unsatisfactory in terms of their explanatory power, as

> "They do not help our understanding of why some issues find prominence on the policy agenda at a particular time, and why other issues never take prominence, or are even ignored. Neither offers much explanation of the interaction between the different groups which may be involved in the policy process, nor do they include the means to examine the distribution of power and influence between them, and the effect this has." (Curtis and Taket, 1996, p. 204)

To address these deeper issues, we need a theory of power - a point I will return to in the final section of this discussion. At this point, it is sufficient to recall the immediate 'policy drivers' which led to this Ministerial letter, which were first discussed in the introduction to the thesis (Chapter 1)

As argued in Chapter 2, in making this particular incremental policy change, the Minister was clearly responding to pressure from within the medical profession. Until the 1980s, such an observation would have been barely worthy of further comment. As the major providers of services, the medical profession had always enjoyed a privileged status within the health policy community, and expected to be consulted by government on

---

[1] Although a Task Group had been established to look at this issue, this was set up after the Ministerial letter had been sent out, and its brief did not include looking at alternative ways of obtaining professional advice. (See Chapter 3 for more details.)

matters of health policy. Indeed, some policy analysts have continued to argue that "it is difficult to overemphasise the strength of medical interests" in this area. (Ham, 1992, p. 186) Nor the difficulty in challenging this dominance, it would seem! A key point to appreciate, Ham argues, is that "because the medical profession is in an established position, small changes do not seriously threaten professional dominance." (Ham, 1992, p. 183)

Nevertheless, by the early 1990s, there had been a number of significant challenges to to the medical profession's privileged status. (Walt, 1994, p.102 - 103) According to Barker (1996) these challenges had led health policy analysts into a "broad debate" which has "tended to work from agreement that the medical profession is in some way losing ground." (Barker, 1996, p. 90) Some of these challenges and debates have been documented already in this thesis. For example, Chapter 2 included a description of the unprecedented way in which the medical profession was excluded by Prime Minister Thatcher from the NHS Review and the way the BMA subsequently responded to later 'consultation' on *Working for Patients*; Chapter 3 then discussed the impact the Griffiths review and the introduction of general management which it initiated, on the autonomy of the medical profession.

What is particularly interesting here, therefore, is that the issue of clinical involvement (or rather, lack of involvement) in the commissioning process elicited any Ministerial response at all. Ministers of Health in the Thatcher government were not, after all, renowned for listening to, or acting on the recommendations of, the medical profession in health policy matters. Indeed, one of the Minister's predecessors had achieved considerable publicity for doing the opposite. (The BMA's campaign in opposition to *Working for Patients*, already discussed in Chapter 2, included a poster asking, "What do you call a man who doesn't take medical advice" The answer given was, of course, the name of the then current Secretary of State for Health, Kenneth Clarke.)

Certainly, the political climate had changed somewhat by this time. Although the Conservative party was still in government, it had a considerably reduced majority in the

House of Commons. There was also a new Prime Minister (John Major) and a new Secretary of State for Health (Virginia Bottomley). However, I am not convinced that this was the only reason that the medical profession finally, after several years out in the policy wilderness, received a warm response when they chose to lobby the Minister for Health on this issue. After all, the Minister in question was himself a member of the medical profession, Dr Brian Mawhiney. Even when they become politicians, it would seem, the medical profession retain a strong sense of loyalty to their professional colleagues. This phenomenon was observed by Ham (1992) in relation to doctors within the civil service (such as the Chief Medical Officer and his colleagues in the Medical Division of the Department of Health). Drawing on the memoirs of a former CMO, Sir George Godber, Ham argues that "duel loyalties create the possibility that conflicts may arise in which professional ties will emerge the stronger." (Ham, 1992, p. 141) Any analysis of why this particular issue got onto the policy agenda when it did, therefore (rather than simply being ignored, as was the vehement opposition to *Working for Patients*) needs to take account of the fact that the medical profession and the Minister were members of the same 'elite' professional group. They could, therefore, be expected to share the same class interests, the same professional networks, and even belong to the same institutions and associations.

This is, of course, a very structural view of power in the policy process, heavily influenced by Marxist and post-marxist thought. As such, it would be likely to be challenged by those of a more pluralist persuasion, who would perhaps be more inclined to argue that the medical profession is just one of a number of interest groups, and the fact that this particular Minister for Health was a doctor was simply coincidence. However, many policy analysts feel that structuralist theories can be supported by empirical evidence, particularly at the level of 'high politics.' Some argue that such theories have greater explanatory power the nearer one gets to the centre of power. As the debate between structuralism and pluralism is something I will return to a little later, for the moment I will simply suggest that, from the evidence available to me at the time of my research, I find elite theory has some credence in this particular instance. Considerable caution needs to be exercised, however, in making any generalisations from

a single case study, at a specific moment in time, where particular individuals are concerned.

However, the Ministerial letter which formed the starting point for my research was not enacted in isolation from the wider health policy agenda, and, as we have seen, this particular government did not have a history of listening to the medical profession's views on health policy matters. Nevertheless, it was a now a government with a considerably reduced majority in the House of Commons, and was soon to come under electoral pressure once again. No doubt many sitting Members of Parliament would have been anxious to ensure the continued success of the reform programme it had put in place for the NHS. Recurrent periods of opposition from within the service, especially from the medical profession, would not have been something it would have wanted to encourage. (Politicians are very aware of the electoral risks in relation to the NHS, and often know from bitter experience how effectively the profession can mobilise public and media support to demand, or resist, change).

Furthermore, by this point in the development of the internal market, when almost all hospitals had achieved Trust status (in spite of ongoing opposition from many of the consultants and other staff working within the hospitals), the government probably felt it could afford to make some minor concessions to the demands of the profession. Perhaps it even felt that it had successfully reduced medical power, and that this was no longer a threat to its policy agenda? Admittedly, achieving clinical accountability for resource use remained an issue, although progress was at last being made on this front (through the introduction of Clinical Directorates); but the literature also supports the argument that politicians believed increasing clinical involvement in contracting could contribute to improving clinical accountability (a view shared, as we have seen, by some commissioning Chief Executives).

Finally, this particular issue did not require any further action by Ministers or their civil servants, and there were no apparent resource implications to upset the Treasury. Taken together, these factors could be argued to fall within broadly within three concepts

identified by Hall et.al. (1975): legitimacy (in this case, the government was asked to intervene); feasibility (there were no resource implications); and support (the most important interest groups were demanding the change, and the likely challenging group was not actively opposing it). Only when an issue is high in all three of these concepts, it is argued, does it become an agenda item. (Walt, 1994) Furthermore, since the introduction of the internal market, and the devolution of responsibility for many aspects of policy to the periphery of the health policy arena, the issue could simply be passed to health authorities for action, and The Royal Colleges and the BMA could simply be informed to this effect. The power of the medical profession had been successfully deflected to the new policy space that was being created in the market place. It is to this policy space, and the theoretical frameworks required to analyse policy within it, that I shall therefore turn next.

8.4.2 The policy process in the NHS market

The South East Thames Commissioning Development Forum took a rather more *rational-comprehensive* approach to the pressure put upon them by the Minister, than the Minister had to the pressure applied by the medical profession. As we have seen, it commissioned some research to enable it to better understand 'the problem', and to inform local action. It was this research, as I have already explained, that not only provided some base-line information for the research clients, which they could then use to inform managerial action to implement the Ministerial directive at a local level, but also enabled me to begin to question what my findings might be telling me about the policy process within the newly-established NHS internal market. The recommendations for local action that emerged from the research were summarised at the beginning of this chapter, followed by discussion of the insights gained into the type of market that was emerging, and the development of the commissioning role within this market. I shall now turn to a discussion of the impact of the market on the local policy arena.

One of the insights gained from the research was the way in which the introduction of the market, and the changes which took place as part of this, fundamentally reconfigured the

health policy community at a local level. Whilst my empirical study was not set up to look at all the groups who could be considered to have had an interest in health policy formation and implementation at a local level, (I did not, for example, include any general practitioners in either the interviews or the survey - for reasons already discussed) among those who were included, some interesting observations can be made. For example, I would argue that debates around the shift in power (if, indeed, there was one) between the medical profession and managers, highlighted in Chapter 3, become more complex following the introduction of the market. This is not only because of the introduction of the 'new hybrid' role of Clinical Director. It is also because the market itself created new relationships within and between the categories 'manager' and 'clinician.' Managers and clinicians now existed on both sides of the purchaser-provider divide, and their professional interests and organisational interests would have intersected in new ways. Yet this particular fault line, creating as it did the potential for a common interest developing between commissioning teams and their public health departments within health authorities, or between clinical and general managers in NHS Trusts, is rarely alluded to in the debates on 'managerialism.'

The addition of GP Fundholding and the existence of arrangements to involve non-fundholding general practitioners in the commissioning process, also changed the balance of power between the hospital consultants and primary care, with GPs sometimes sharing an interest with their medical colleagues, and at other times, having more to gain from challenging them. Whilst there is little research evidence of the comparative effectiveness of GP fundholders as purchasers (particularly in terms of the impact of their purchasing decisions on the quality of patient care) Goodwin (1998) argues that "a fundholder with a choice of providers is more likely to gain service improvements than a fundholder with a monopoly provider: the former can use the threat of contract-shifting as a lever for service improvements." (Goodwin, in Le Grand et al, 1998, p.42) Whatever the evidence, ambitious fundholders were seen by both politicians and providers as innovative and demanding purchasers, and it was their perceived success that subsequently led to the introduction of Total Purchasing Pilots (TPPs) which were formally evaluated by researchers. Furthermore, non-fundholding GPs were also increasingly encouraged to

become active players in the local health policy arena. Initiatives such as GP and locality commissioning offered "collective, non-budget-holding alternatives" to fundholding, and although both models varied considerably in the ways in which they were organised,

> "all relied heavily on their ability to *influence* local providers and the HA, without necessarily having the independent purchasing power to make their views count in the face of concerted opposition." (Mulligan, in Le Grand et al, 1998, p.70)

Finally, even the population was being fragmented, it would seem - into 'the public,' 'local voices,' 'customers,' and 'patients' - with different sections of the 'professional' health community (NHS doctors and managers) claiming to represent their interests. In the South Thames study, for example, *it is particularly* interesting to note that both the purchasers and the providers claim to be acting in the best interests of, and to have the most knowledge about, the health needs of patients - though as we have seen, the health authority is claiming this on the basis of its knowledge of the population (its 'champion of the people' role, or public health advocacy), whilst the hospital clinicians claim to have their individual patients interests at heart at all times. (The clash between utilitarianism and individualism is again evident here.)

All of these observations have theoretical implications. For example, observation of the policy process at the level of the internal market, combined with a reading of the documentary evidence on the role and responsibility of purchasers, would seem to suggest that the process was inherently pluralistic. Health authorities were, as we have seen, expected to be 'champions of the people', acting as 'proxies' for the consumer in the new health care market-place. They were expected to develop a 'corporate' approach to health needs assessment, which took account of the epidemiological evidence, but also sought the views of health professionals and the wider community which they represented. They were expected to listen to 'local voices,' and to involve the public in the debates around their purchasing priorities. But as we have seen, they were finding these tasks very difficult. They lacked the capacity and capability necessary to undertake their new role effectively. But even if they had been more effective, would all the actors

in the policy community have had equal access to the debate? If the health authority had had the technical competence it needed to prevent 'provider capture' in the market, would it not simply have been replacing one set of 'expert' knowledge with another? How would this have ensured its legitimacy?

At this point, it is worth returning briefly to the debate between pluralist and structuralist accounts of power in the policy process. Perhaps a superficial analysis of the local health policy arena could lead an unwary observer to argue that the introduction of the market had made the local policy process more pluralistic? Certainly, as the market continued to develop, the fragmentation of purchasing into health authorities, fundholding and locality commissioning, combined with the introduction of competition (or at least, 'contestability') between providers, would seem to suggest that no single group was dominant in the decision-making process. Most of the key players in the local health policy community had at least some access to the decision-making process, and therefore, at least potentially, the power to influence its outcome. However, some clearly had more power than others, suggesting perhaps that the notion of 'bounded' pluralism is explanatory at this level. Indeed, Walt (1994) argues that "while high-politics or systemic policies may well be formulated and imposed by policy elites" (as we have seen above, in the case of the national policy directive)...low politics or sectoral (micro) policies are influenced by many different groups." (Walt, 1994, p. 202)

Others might argue that this return to pluralism was itself ideological. As we saw in Chapter 2, pluralist theories of power are embedded in Western liberal democracies, and it would clearly have been in keeping with 'new right' ideology to promote the view that, just as all consumers had unfettered access to the market, so all citizens had equal access to the political process. Structural theories had, as we have seen, fallen from favour. In a political climate which denied the existence of society, analysis of social and economic structures in relation to the policy process were rather unlikely to receive much attention in policy circles. Yet structural analysis at a more local level still found considerable space in the policy literature, often drawing on Alford's study of the New York health care system in the 1970s. (See, for example, Ham and Hill, 1993; Walt, 1994; Barker,

1996; Curtis and Taket, 1996.) Within this framework, the medical profession (known as the 'professional monopolists') are the dominant interest. The health care sector, it is argued, is structured in their interests, with the result that they tend to defend the status quo. Other groups, whose interests may be better served by structural change, are described as 'challenging.' Membership of such groups (the 'corporate rationalisers') is fluid, and may include health service managers, health care planners and researchers - all of whom have a shared interest in breaking the monopoly of the medical profession over the production and distribution of health care. (Curtis and Taket, 1996) Finally, Alford identifies a repressed group, containing

> "those whose interests are by and large submerged, and for whom there are no social institutions or political mechanisms that ensure [their] interests are served...Most frequently we find the community or consumer in this position...which demonstrates the failure in implementation of various different policy initiatives designed to improve service availability and access to particular sections of the urban population." (Curtis and Taket, 1996, p.209)

Alford's typology is very useful, particularly in the way in which it emphasises the structural basis of medical power in the health policy process. Unlike pluralism, it does not see the profession as 'just another pressure group' in the policy community, gaining its power from the status that society confers upon it, but argues that "it is the doctors' power which generates the societal consensus." (Alford, 1975) The other strength of Alford's analysis, I feel, is its acknowledgement of the repressed group, who still barely had a voice in the local health policy community in the post 1990 reforms, in spite of the government's rhetoric of consumerism. Nevertheless, I feel that Alford's typology would require considerable modification to make it a useful analytic framework for the health policy process in the NHS internal market, as it would need to to take account of the complexity of the local health policy arena across the purchaser-provider divide. Which doctors, for example, would be the 'professional monopolisers'? Hospital consultants in the provider Trusts, or GP Fundholders? Which managers would take the role of

'corporate rationalisers'? Health authority commissioning teams, or Trust general managers? Where might public health professionals fit in? The problem with structural theories, it seems to me, is that they are too static to analyse process. As soon as one defines a structural model, it becomes fixed. Its explanatory power is therefore limited, to synchronic analyses (ie taking a slice through a system, to examine its structure). In terms of the health policy process, I would argue, a diachronic approach would be much more useful. We need a framework that can analyse change - not only because the health policy environment is changing rapidly, but because the policy process is itself dynamic.

8.4.3. Regaining the agenda: clinical knowledge and clinical power

As I completed my research, it became increasingly important for me to find out whether it was possible to move beyond structuralist and pluralist accounts of power in the policy process. Both seemed to offer inadequate explanatory frameworks for my purpose. Structuralism (as well as all the usual criticisms that it was too prescriptive and deterministic) seemed too 'static' to theorise power in the policy process as a dynamic concept. Pluralism, even in its modified form of 'bounded' pluralism (which recognised that all interest groups do not have equal access to the policy process, and therefore do not have an equal opportunity to set the agenda, decide over the distribution of resources or whatever) under theorises power. Moreover, both approaches failed to explain why, or how, the groups concerned behaved in the ways documented by my research.

If the medical profession was as dominant as Alford would suggest, why did it need to lobby government to enable it to gain access to the commissioning process at a local level? (It has not, after all, shown anything like the same level of interest in getting involved in general management following the Griffiths review.) And why were the clinicians in the South Thames survey feeling so disempowered? As I have already stated (see Chapter 7) this powerful group of clinical managers - senior members of their profession, with budgets and departments of their own - sincerely believed that someone other than themselves (most often, but not always, the commissioning authority) was

driving the local health policy agenda. It is at least possible to interpret the clinicians' discontent over this matter as an indication that the commissioning process was beginning to challenge their hegemonic position in defining the health policy agenda. It might even be reasonable to suggest that commissioners appeared to be on the verge of succeeding where the 'new managerialism' had failed - in making clinicians accountable for their use of resources.

In this sense, it could be argued, the fact that clinical involvement in commissioning arose as a policy issue at the time it did, was in fact an indication that the medical profession *had* lost power in the policy process. It had clearly been disempowered by the Thatcher government at the 'macro' level, and there is some evidence to suggest its power was being challenged by the introduction of general management at the 'micro' level. Whilst their professional associations had lobbied intensely against the introduction of both general management and *Working for Patients,* and most hospital consultants had voted against their hospitals becoming NHS Trusts, the changes to the NHS imposed by the Thatcher government had nevertheless been fully implemented. There had been nothing remotely pluralist about the NHS Review, or about the introduction of the internal market which emerged as the solution to the perceived crisis in the service. (Even the majority of the electorate did not support the government's policies for NHS reform at the time.) Finally, as the survey showed, the medical profession - or at least, that sector of the profession employed by the NHS (general practitioners were still, of course, independent contractors to the NHS, not employees of it - a fine distinction, perhaps, but perhaps not an irrelevant one) was beginning to feel its power ebbing away in its relationship with the health authority, both at regional level, as the RMAC was being disbanded prior to the abolition of RHAs, and then in the new policy space that had opened up in the market-place. It was time to fight back. As Harrison, Hunter and Pollitt (1992) have argued, "No student of the NHS should underestimate the capacity of doctors to adapt central initiatives and divert them locally, to their own ends." At this point, I realised I had "blundered onto, and then proceeded to ignore, a much larger and more interesting question" than that which had formed the original focus of my research. (Becker, 1986). I had begun to recognise that what I was in fact observing was an

illustration of the way in which one particular group of professionals responded to a series of challenges to their professional power.

8.4.4 Rethinking power in the policy process

To understand my research findings, I now felt I needed a theory of power which could not only enable me to analyse the relationship between clinical knowledge and clinical power, but which would also accomodate the concept of resistance. Furthermore, it needed to be able to take account of the variety of forms which power might take, and how these might be used in different circumstances. After all, whilst the medical profession appeared to have used its elite power ('it's not what you know, it's who you know') to get the issue of clinical involvement in commissioning onto the Ministerial agenda, at a local level, it had done just the opposite ('its not who you know its what you know.') As I argued in Chapter 3, it is at the local level that the source of clinical power is often argued to be most closely connected to professional knowledge. The basis for this claim is usually that clinical knowledge is deployed in the day-to-day business of diagnosis, treatment and care of patients; but in my research it was also an essential ingredient in the development and implementation of policy within what we would now term, 'local health economies.' Even where (or perhaps even especially where) the relationship between commissioners and provider clinicians was poor, the health authority needed to gain access to clinical knowledge to enable it to commission services more effectively. Yet in doing so, it not only opened up the possibility of 'provider capture' of the health care market, it also enabled the medical profession (in the form of the hospital consultants) to recapture the local health policy agenda - thereby ensuring the continuing hegemony of ethical individualism.

What does this indicate about the role of power in the policy process? To understand this, I would argue that we need to take a radically different approach to theorising power. Both the structuralist and the pluralist paradigms discussed above reify power. That is, they treat it as if it had a concrete reality, as something that can exist independently of the actors in the policy community. This is particularly evident in Barker's analysis, where

she talks of power as the fuel that drives the policy process. In many ways, this seems like a helpful analogy, but I would argue that it is potentially misleading - causing us to concentrate on questions about its nature and origins. In the case of the power of the medical profession, for example, it leads us into a reductionist debate about whether the origins of professional power lie in the 19th Century bargain with the State, or in the profession's relationship to the means of production, rather than examining how power is exercised, or what effect this has within the policy arena.

An alternative theorisation of power, which has become very influential within the social sciences over the past decade, is derived from a post-structuralist analysis. There is an extensive body of work on post-structuralism within social theory, linked to an even more extensive theoretical debate on post-modernism, which extends well beyond the social sciences. Whilst it is beyond the scope of this thesis to do more than touch on one area of particular relevance to policy analysis, it is important to emphasise that these debates are beginning to have an impact on policy studies. Hollinger (1994) illustrates this point in the following passage, which I will quote in full:

"Political positions within modernity run the gamut from anarchism and socialism to liberalism, conservatism, and fascism. The social sciences have been influenced by all of these ideas, but the policy sciences are not the only places where these gods and demons have battled. Postmodernists believe that the political has to be rethought...if the effect of this is to make everything political, perhaps that is inevitable. Postmodernists believe that everything always has been and will be political. But once one abandons modernity's ideas and distinctions and focuses on the interactions between knowledge and power, on the local level, and on the institutional contexts that dominate power/knowledge relationships...this idea is put into a new light. " (Hollinger, 1994, p. 176)

This linking of the concepts of power and knowledge is derived from the work of the French thinker, Michel Foucault, who has written extensively on this theme in areas such as the history of madness and medical knowledge; the history of methods of surveillance

and punishment; and the history of sexuality. Foucault's conceptualisation of power is complex. Rather than asking *what power is, and where it comes from,* "The questions which Foucault has posed of power are first, 'how is it exercised; by what means,' and second, what are the effects of the exercise of power." (Smart, 1985, p. 77)

> "Briefly, power is not conceived as a property or posession of a dominant class, state, or sovereign but as a strategy...in short, Foucault conceptualises power neither as an institution nor a structure but as 'complex strategical situation,' as a 'multiplicity of force relations' ...last but by no means least significantly of all, Foucault argued that 'where there is power there is resistance'..." (Smart, 1985, p. 77)

Furthermore, for Foucault, power and knowledge are inseperable - indeed, he frequently uses the concept as a single entity (power/knowledge), which also has theoretical implications:

> "The linking by Foucault of power to knowledge abandons the view that power is unitary and coercive. For example, medical power is seen to be a consequence of expertise, a body of knowledge which is able to legitimate the rights of those who hold it to subject others to particular practices. Power is exercised in the micro-processes of interaction, in every encounter which is organised by a discourse of knowledge. It may be contested by rival discourses, based on alternative bodies of knowledge" (Fox, 1993, p.163)

This moves beyond the concept of 'expert power' derived from pluralist analyses (in which the medical profession are seen as one of a number of pressure groups in the policy process), and beyond the sociology of the professions (in which medical power is viewed as the result of strategies such as self-regulation). Instead, there is the recognition of the interdependence of professional power and knowledge, in which each reinforce each other, so that,

> "in the study of the professionalisation of a group, we would look not look at the macro-social phenomena such as state registration, but at the ways that knowledgeability legitimates actions, which in turn legitimates the knowledge-base." (Fox, 1993, p. 62)

However, I did not set out, at the beginning of my research, to undertake a Foucauldian analysis of the power of the medical profession in the commissioning process, although this, in retrospect, might be what I wish I had been able to do! I was constrained by the research agenda set by my clients, and the decisions that arose from this. As Becker has illustrated,

> "Students (and others) often...talk about 'using' this or that approach - 'I think I'll use Durkheim' - as though they had a free choice of theory. In fact, by the time they begin to write about their research, they have made many seemingly unimportant choices of details that have foreclosed their choice of a theoretical approach." (Becker, 1986, p. 135)

As I have demonstrated, my choices increasingly committed me to a way of thinking, and limited my choice of theoretical frameworks - even within a theoretically eclectic discipline. The prospect of revisiting my research questions, and developing a different methodology to answer them - one that would be coherent with my preferred theoretical approach - was not an option that was open to me.

REFERENCES

Acheson D (1988) Public Health in England. The Report of the Committee of Inquiry into the Future Development of the Public Health Function (HMSO: London)

Allsop J (1995) Health Policy and the NHS, Towards 2000 (2nd edition) (Harlow, Essex: Longman)

Appleby J, Smith P, Ranade W, Little V, Robinson R (1994) Monitoring Managed Competion *in* Evaluating the NHS Reforms edited by R Robinson and J Le Grand (London: King's Fund Institute)

Audit Commission (1994) Trusting in the future: towards an audit agenda for NHS providers. (London: HMSO)

Austin N and Dopson S (eds.) (1997) The clinical directorate (Oxford: Radcliffe Medical Press)

Barker C (1996) The health care policy process (London: Sage)

Becker H S (1986) Writing for Social Scientists, How to Start and Finish Your Thesis, Book or Article (Chicago: Chicago University Press)

Blane D (1997) Health professions *in* Sociology as applied to health (4th edition), edited by G Scambler (London: W B Saunders)

BMA (1989) Special report on the government's white paper: working for patients (London: BMA)

Brewer J and Hunter A (1989) Multi-method research: a synthesis of styles (Newbury Park, California: Sage)

British Association of Medical Managers (1996) Leading clinical services: the evolving role of the clinical director (NHS Staff College: Wales)

Britten N (1995) Qualitative interviews in medical research *British Medical Journal* Vol 311 (p 251-2530

Bryman A and Burgess R G (eds.) (1994) Analyzing qualitative data (London:Routledge)

Burgess R G (ed) (1982) Field Research: a Sourcebook and Field Manual

Burgess R G (1984) In the Field: an Introduction to Field Research (London: Allen and Unwin)

Butler J (1992) Patients, policies and politics (Buckingham: Open University Press)

Capewell M D (1992) Clinical directorates: a panacea for clinicians involved in management? *Health Bulletin* 50 (6) November 1992 (pp441- 447)

Causer G and Exworthy M (1999) Professionals as managers across the public sector *in* Professionals and the new managerialism in the public sector, edited by M Exworthy and S Halford (Buckingham: Open University Press)

Clarke J, Cochrane A and McLaughlin E (1994) Managing Social Policy (London: Sage)

Cornish Y (1995a) Why involve clinicians in commissioning? *Clinician in Management,* Vol 4 No 5 (November 1995)

Cornish Y (1995b) Which aspects of commissioning should clinicians be involved in? *Clinician in Management,* Vol 4 No 6 (December 1995)

Cornish Y (1996) How can clinicians become more involved in commissioning? *Clinician in Management,* Vol 5 No 1 (February 96)

Curtis S and Taket A (1996) Health and Societies (London: Arnold)

de Vaus, D A (1991) Surveys in social research (3rd edition) (London: UCL Press)

Department of Health and Social Security (1983) The NHS management enquiry (Griffiths Report) (London: DHSS)

Department of Health (1990) Working for patients: developing districts (London: HMSO)

Department of Health (1992) The health of the nation: a strategy for health in England (London: HMSO)

DHA Project Team (1991) Professional advice for purchasers - a DHA project discussion paper (London: NHS Management Executive)

Disken S, Dixon, M, Halpern S, Godfrey S (1990) Models of clinical management (London: Institute of Health Services Management)

Dixon J (1998) The context *in* Learning from the internal market - a review of the evidence, edited by J Le Grand, N Mays and J Mulligan (London: King's Fund)

Dumelow C, Littlejohn P, Griffiths S and Younger T (1994) Professional advice to purchasers (London: South Thames (West) RHA)

Easterby-Smith, M, Thorpe, R, and Lowe, A (1991) Management research: an introduction (London: Sage)

Edwards A and Talbot R (1994) The hard-pressed researcher (Longman: London)

Enthoven, A C (1985) Reflections on the management of the National Health Service (London: Nuffield Provincial Hospitals Trust)

Enthoven, A C (1991) Internal market reform of the British National Health Service *Health Affairs* Vol 10:no3, pp60-70

Ferlie E, Cairncross L and Pettigrew A (1993) Understanding internal markets in the NHS *in* Managing the Internal Market, edited by I Tilley (London: Paul Chapman)

Fitzgerald L (1991a) Made to measure *Health Service Journal* 31 Oct 1991 (p 24-25)

Fitzgerald L (1991b) This year's model *Health Service Journal* 7 Nov (p 26-27)

Fox, N J (1993) Postmodernism, sociology and health (Open Univeristy Press: Buckingham)

Gabe J, Calnan M and Bury M eds. (1991) The Sociology of the Health Service (London: Routledge)

Glaser, W (1993) The competition vogue and its outcomes *Lancet* Vol 341, pp 805-811

Gray J A M (1997) Evidence-based Healthcare: How to Make Health Policy and Management Decisions (London: Churchill Livingstone)

Greenhalgh, T (1997) How to read a paper (London: BMJ Publishing)

Ham, C (1991) Revisiting the internal market *BMJ* Vol 302 pp 250 - 251

Ham C and Hill (1993) The policy process in the modern capitalist state (2nd edition) (Hemel Hempstead, Herts: Harvester Wheatsheaf)

Ham, C (ed) (1997) Health care reform: learning from international experience *(Buckingham: Open* University Press)

Ham, C (1992) Health policy in Britain (3rd edition) (Basingstoke, Hants: Macmillan)

Handy C B (1990) Inside organisations (London: BBC Books)

Handy C B (1985) Understanding organisations (3rd edition) (London: Penguin)

Harrison S, Hunter D J, Marnoch G and Pollitt C (1992) Just managing:power and culture in the National Health Service (Basingstoke: Macmillan)

Harrison S and Pollitt C (1994) Controlling Health Professionals (Buckingham: Open University Press)

Health Services Journal, London (1994) Smile at a doctor today. April 7th, p.13

Hegginbotham C and Ham C (1991) Purchasing Dilemmas (London: King's Fund)

Hoggett P, Jeffers S and Harrison, L (1994) Reflexivity and uncertainty in the research process *Policy and Politics* Vol 22 No 1 (pp 59-70)

Hollinger R (1994) Postmodernism and the Social Sciences (Sage: London)

Hunter D (1994) Social research and health policy in the aftermath of the NHS reforms *in* Researching the people's health, edited by J Popay and G Williams (London: Routledge)

Jary D and Jary J (1991) Dictionary of Sociology (Glasgow: Harper Collins)

Jeffreys M (1991) The agenda for sociological health-policy research for the 1990s *in* The Sociology of the Health Service, edited by J Gabe, M Calnan and M Bury (London: Routledge)

Jones J and Hunter D (1995) Consensus methods for medical and health services research *British Medical Journal* Vol 311 (p 376-380)

Keen and Packwood (1995) Case Study Evaluation *British Medical Journal* Vol 311 (p 444-446)

Kennedy P (1990) Better way than clinical directorates *Health Services Management* October 1990 (p 211 - 215)

Kirkup B and Donaldson L J (1994) Is health care a commodity: how will purchasing improve the National Health Service? *Journal of Public Health Medicine* Vol.16 No 3 (pp 256-262)

Kitzinger J (1995) Introducing focus groups *British Medical Journal* Vol 311 (p 299 - 302)

Klein, R (1995) The new politics of the NHS (3rd edition) (Harlow, Essex: Longman)

Laing, W (1994) Managing the NHS: past, present and an agenda for the future (London: Office of Health Economics

Le Grand, J; Mays, N and Mulligan, J (eds) (1998) Learning from the NHS internal market (London: King's Fund)

Levitt, R, Wall A and Appleby J (1999) The reorganised National Health Service (6th edition) (Cheltenham, Glos: Stanley Thornes)

Levitt, R and Wall, A (1992) The reorganised National Health Service (4th edition) (London: Chapman and Hall)

Lewis J (1986) What price community medicine? (Brighton: Wheatsheaf)

Light, D (1998) Effective Commissioning (London: Office of Health Economics)

Macdonald K M (1995) The sociology of the professions (London: Sage)

Mark A (1991) Where are the medical managers? *Journal of Management in Medicine* Vol.5 No.4 (pp 6-12)

Marsh, C (1982) The Survey Method: the contribution of surveys to sociological explanation (London: George Allen and Unwin)

Mawhinney B (1993) Purchasing for health: a framework for action (Heywood: Health Publications Unit)

Maxwell, J A (1996) Qualitative research design (London: Sage)

McLean Jones McCarthy Ltd. (1994) Connecting clinical directors: analysis of clinical directors questionnaire. Unpublished report.

Meads, G and Ashcroft J (2000) Relationships in the NHS (London: Royal Society of Medicine)

Miles, M B, and Huberman, A M (1994) Qualitative data analysis (2nd edition) (Thousand Oaks, California: Sage)

Millar (1991) Clinicians as managers: medics make their minds up *Health Service Journal* 21 Feb (p 17)

Miller P McC and Wilson M J (1983) A Dictionary of Social Science Methods (Chichester: John Wiley)

Mills, C W (1959) The Sociological Imagination (New York: Harper and Row)

Moser C A and Kalton G (1979) Surveys methods in social investigation (2nd edition) (Aldershot, Hampshire: Dartmouth Publishing)

Murphy E, Dingwall R, Greatbatch D, Parker S and Watson P (1998) Qualitative research methods in health technology assessment: a review of the literature *Health Technology Assessment* 1998: 2 (16)

Newman J and Clarke J (1994) Going about our business? The managerialisation of public services *in* Managing Social Policy, edited by Clarke, Cochrane and McLaughlin (London: Sage)

NHS Executive (1995) Clinical involvement in contracting: a handbook of good practice (Leeds: NHS Purchasing Branch)

NHS Centre for Reviews and Dissemination (1996) Undertaking Systematic Reviews of Research and Effectiveness (CRD Report 4) (University of York: York)

Opit L (1993) Commissioning: an appraisal of a new role *in* Managing the internal market, edited by I Tilley (London: Paul Chapman)

Ovretveit, J (1995) Purchasing for health (Buckingham: Open University Press)

Phillips E M and Pugh D S (1994) How to get a PhD (Buckingham: Open University Press)

Platt, J (1981) On interviewing one's peers. *British Journal of Sociology*, Vol 32 no 1

Popay, J and Williams, G (1994) Researching the people's health (London: Routledge)

Pope C and Mays N (1995b) Rigour and qualitative research *British Medical Journal* Vol 311 (p 109-112)

Pope C and Mays N (1993) Opening the black box: an encounter in the corridors of health services research *British Medical Journal* Vol 306 (p 315-318)

Pope C and Mays N (1995c) Observational methods in health care settings *British Medical Journal* Vol 311 (p 182-184)

Pope C and Mays N (1995a) Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research *British Medical Journal* Vol 311 (p 42-45)

Ranade, W (1997) A future for the NHS? (2nd edition) (Addison Weslet Longman: Harlow, Essex)

Richardson A, Duggan M and Hunter D J (1994) Adapting to new tasks: The role of public health physicians in purchasing health care (Leeds, Nuffield Institute for Health)

Riley, J (1990) Getting the most from your data (Bristol: Technical and Educational Services Ltd)

Robinson, R and Le Grand, J (eds) (1994) Evaluating the NHS Reforms (London: King's Fund Institute)

Robinson, R (1994) Introduction *in* Evaluating the NHS Reforms, edited by R Robinson and J Le Grand (London: King's Fund Institute)

Sackett D L, Richardson W S, Rosenberg W and Haynes R B (1997) Evidence-based Medicine (Churchill Livingstone: New York)

Salter B (1993) The politics of purchasing in the National Health Service *Policy and Politics* Vol.21 No.3 (p 171-184)

Secretaries of State for Health (1989) Working for Patients (London: HMSO) (Cmnd 555)

Silverman, D (2000) Doing qualitative research (London: Sage)

Smart, B (1985) Michel Foucault (Ellis Horwood: Chichester)

Strong, P and Robinson, J (1990) The NHS under new management (Milton Keynes: Open University Press)

Task Group on Clinical Involvement in Contracting (1994) Unpublished manuscript

Tilley, I (ed) (1993) Managing the internal market (London: Paul Chapman)

Turner B S (1995) Medical power and social knowledge (2nd edition) (London: Sage)

Walby S and Greenwell J (1994) Managing the National Health Service *in* Managing Social Policy, edited by J Clarke, A Cochrane and E McLaughlin (London:Sage)

Walt, G (1994) Health policy: an introduction to process and power (London: Zed Books)

Webster, C (1998) The National Health Service - a political history (Oxford: Oxford University Press)

Yin, R (1994) Case study research design and methods (2nd edition) (Thousand Oaks: Sage)

INTERVIEW SCHEDULE FOR COMMISSIONERS (Chief Execs & DsPH)

- **Should clinicians be involved in commissioning?**

  why?
  who might benefit?
  what might the benefits be?

- **Which clinicians should be involved?**

  which clinical/professional individuals/groups?
  at which organisational levels?
  how? formal/informal?

- **How does should this relate to other sources of professional advice?**

  what other sources of professional advice do you have access to?
  how is this currently working?
  what is the appropriate balance between independent/provider-specific advice?

- **Which aspects of commissioning are most appropriate for clinical input?**

  population needs assessment?
  development of local health strategy?
  service reviews?
  strategic change/service development?
  purchasing plans?
  contract negotiation/management
  clinical effectiveness/developing outcome measures?
  involving commissioners in clinical audit, quality, R&D?

- **How can this input help you achieve your (commissioning/public health) objectives?**

  describe objectives and clinical contribution

- **Which commissioners should be involved in this dialogue?**

  are these confident/competent in this area?
  if not, why? what needs to be done about this?

- **What is currently happening - ie is the level of clinical involvement in commissioning between you and your major provider**

  (a) poor/inadequate?

  why? identify major barriers? professional or managerial?
  is there agreement that this needs to be increased?
  if so, whose responsibility is this?
  what processes/mechanisms/levers will help achieve this?
  what are the workload implications?

  (b) satisfactory/working well?

  explore influencing factors - eg who were the major players? what processes/levers did they have/use? what interventions were effective? what have the implications been for workload etc?

- **Are there any concerns about increasing levels of clinical involvement in commissioning?**

  perceived risks
  perverse incentives?

- **What kinds of contract are you currently using with your major providers?**

  explore whether whole hospital/specialty-based - are case mix, service-specific quality standards, outcomes, incentives/sanctions etc. included?

- **Any other issues identified and felt to be important not covered so far**

  (eg how does this relate to issues such as involving GPs and local communities? any lessons to be learnt or areas of conflict)

ygc/intsched.com/12oct94

South East
Institute of Public Health

INVOLVING CLINICIANS IN THE COMMISSIONING PROCESS

SURVEY OF CLINICAL DIRECTORS AND CLINICAL MANAGERS IN SOUTH THAMES (EAST)

This survey has been commissioned by the South Thames (East) Commissioning Network, to explore the current level of clinical involvement in the commissioning process, and to find out your views on how this might be improved. It is being sent to all clinical directors and clinical managers in trusts located in the east of the South Thames Region.

For some questions you will need only to tick the relevant box or boxes. For others, space has been left for you to write your answer. If you require more space, or have any other comments you would like to add, please continue on a separate sheet if necessary. Please complete all sections as fully as possible, and return the completed questionnaire to us in the envelope provided. Thank you so much for your cooperation.

All information will be treated in strict confidence

Ref No:

Section 1

LINKS WITH YOUR MAJOR COMMISSIONERS

In this section, we would like to find out about your current relationships with your major commissioners. This includes all health authorities with whom your trust holds a substantial contract for your service. (Please do not include GP fundholders or those commissioners/purchasers from whom you only accept extra-contractual referrals.)

1. **Do you have *direct* contact with your major commissioners:**

Frequently ☐ Sometimes ☐ Rarely ☐ Never ☐

2. **Would you describe this contact as:**

Very Useful ☐ Quite Useful ☐ Not Very Useful ☐ Useless ☐

3. **Is this contact:**

Mainly Formal ☐ Mainly Informal ☐ Mixture Of Both ☐

4. **Do your major commissioners visit your services?**

Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐

5. **Do you welcome these visits?**

Yes ☐ No ☐ Not applicable ☐

6. **Which members of the commissioning authority do you have most frequent contact with?**

Finance ☐ Contracts ☐ Public Health ☐ Other ☐ None ☐

7. **Which members of the commissioning authority would you like to see**

More Often _____

Less Often _____

8. **Do you feel you understand the commissioners agenda?**

Yes ☐ No ☐ Not Sure ☐

9. **Do you feel the commissioners understand the clinical agenda?**

Yes ☐ No ☐ Not Sure ☐

If no, please outline what you perceive to be the major gaps in their understanding.

10. **Would you describe your vision for the future of your services as shared with major commissioners?**

Yes ☐ No ☐ Not Sure ☐

11. **Do you think the relationship with commissioners could be improved?**

Yes ☐ No ☐ Don't Know ☐

How?

Who should take responsibility for ensuring this?

Section 2

INVOLVEMENT IN THE COMMISSIONING PROCESS

In this section, we would like to find out about any joint work you currently undertake with your major commissioners on the broader commissioning agenda.

12. **Does your major commissioner have a local health strategy?**

Yes ☐ No ☐ Don't Know ☐

If yes, did you have any involvement in the development of this?

Yes ☐ No ☐ Don't know ☐

If yes, please describe briefly

13. **Have you (or members of your team) been involved in any work with commissioners on population health needs assessment?**

Yes ☐ No ☐ Don't know ☐

If yes, please describe briefly

14. **Have you (or members of your team) been involved in with the development of local purchasing plans?**

Yes ☐ No ☐ Don't Know ☐

If yes, please describe briefly

15. **Have you (or members of your team) worked jointly with commissioners to review your services?**

Yes ☐ No ☐ Don't know ☐

16. **Have you agreed future development in your services with your major commissioner?**

Yes ☐ No ☐ Don't know ☐

17. **Has your major commissioner discussed any strategic changes in service with you?**

Yes ☐ No ☐ Don't Know ☐

18. **Do you feel commissioners communicate their requirements/expectations to you effectively?**

Yes ☐ No ☐ Don't Know ☐

19. **Who do you feel is currently driving the commissioning process?**

Commissioners ☐ Trust Management ☐ Clinical Staff ☐ Other (please specify) ☐

Section 3

INVOLVEMENT IN THE CONTRACTING PROCESS

In this section, we would like to find out about your involvement in contract negotiation, contract management and contract monitoring.

20. **What type of contract do you have with your major commissioner?**

Simple Block ☐ Block with Triggers ☐ Cost & Volume ☐ Other (please describe) ☐

Don't Know ☐

21. **Is this contract**

Whole Hospital ☐ Specialty-based ☐ Other (please describe)_____

22. **Which of the following are included in the contract (√ all which apply)**

Case-mix ☐ Service-specific Quality Standards ☐ Contract Exclusions ☐

Incentives ☐ Sanctions ☐ Base-line Activity ☐ Waiting List Targets ☐

23. **Who writes the contract specification?**

Commissioner ☐ Provider ☐ Both ☐ Other ☐

24. **Please describe any involvement you have in the contracting process**

Please outline briefly

25. **Does the outcome of clinical audit influence the contract specification?**

Yes ☐ No ☐ Don't Know ☐

26. **Does information on clinical effectiveness influence the contract specification?**

Yes ☐ No ☐ Don't Know ☐

27. **Overall, would you describe your feeling about the contracting process as**

Positive ☐ Neutral ☐ Negative ☐

Why?

Please outline briefly

Section 4

BENEFITS AND BARRIERS

In this section, we would like to find out a little more about the barriers to further clinical involvement in commissioning (including contracting), how you think some of these barriers might be overcome, and what you think the benefits of increased clinical involvement might be.

28. How important do you think it is for commissioners to involve clinicians in the following areas?

	Very Important	Quite Important	Not Very Important
Developing local health strategies	☐	☐	☐
Developing individual service strategies	☐	☐	☐
Agreeing strategic changes in service	☐	☐	☐
Agreeing service development (including new technologies)	☐	☐	☐
Population health needs assessment	☐	☐	☐
Needs assessment for individual specialties	☐	☐	☐
Developing purchasing plans	☐	☐	☐
Agreeing purchasing priorities	☐	☐	☐
Contract negotiation - service specifications	☐	☐	☐
Contract setting - volumes and case-mix	☐	☐	☐
Contact monitoring - agreeing performance target	☐	☐	☐
Developing clinical audit	☐	☐	☐
Agreeing ECRs	☐	☐	☐
Agreeing referral criteria	☐	☐	☐
Introducing work on effective clinical care	☐	☐	☐

29. **Which clinicians do you think should be involved?**

Medical Directors ☐
Clinical Directors ☐
All Consultants ☐
Other (please specify) ☐

All Doctors ☐
Nurse Managers ☐
All Clinical Staff ☐

30. **What do you think would be the major benefits of increasing clinical involvement in the areas you have identified as very important?**

Please outline briefly

31. **What other sources of professional advice do you think commissioners should have access to?**

Please outline briefly

32. **What do you think is the appropriate balance between the involvement of local clinicians in commissioning and other (independent) sources of professional advice?**

Please outline briefly

33. **Overall, would you describe your own involvement in the commissioning process as**

Less than you would like ☐ (go to Q 34)

More than you would like ☐ (go to Q 37)

About right ☐

If you would like to be *more* involved in commissioning,

34. **Which aspects of commissioning would you like to become more involved in?**

Please outline briefly

35. **What do you think are the main barriers to fuller clinical involvement in the commissioning process? (Please tick all which apply)**

type of contract	☐
problems with information systems	☐
no appropriate organisational mechanism	☐
purchasers not sufficiently informed about clinical issues	☐
clinicians not sufficiently informed about commissioning issues	☐
insufficient time for this work	☐
not enough support within your department	☐
resistance from trust mangers	☐
resistance from commissioners	☐
no incentive for you to get more involved	☐
other (please list any other factors not included above)	☐

36. **What factors do you think would help to increase your involvement?**

Please outline briefly

If you would like to be *less* involved in commissioning,

37. Which aspects of the commissioning/contracting process would you like to do less of?

Please outline briefly

38. Why?

Not relevant to patient care	☐
Not a cost-effective use of clinical time	☐
Someone else should be responsible for this	☐
Other (please give details)_____	

Section 5

BACKGROUND INFORMATION

In this section, we would like to find out a little about your role, the type of provider organisation you work in and the level of management support you have available to you.

39. **Would you describe your role as**

Clinical Director ☐ Clinical Manager ☐ Clinical Coordinator ☐
Clinical Chair ☐ Other (please specify)_____

40. **Is the clinical grouping you lead based on**

Specialty/Sub Specialty ☐ Care Group ☐ Locality ☐

Service Group ☐ Other (please describe)_____

41. **How many sessions per week do you have allocated for this Management work?**

_____

42. **How many sessions do you actually spend on this work?**_____

43. **How many session per week do you spend on your clinical practice?**_____

44. **Who are you managerially accountable to in your role as clinical director/clinical manager (or equivalent)?**

_____

45. **What is your clinical background?**

Profession_____ Specialty_____ Grade_____

46. **Are you**

Male ☐ Female ☐

47. **Which age band are you in**

25 - 34 ☐ 35 - 44 ☐ 45 - 54 ☐ 55 and over ☐

48. **Is the Trust you work in**

1st Wave ☐ 2nd Wave ☐ 3rd Wave ☐ 4th Wave ☐

49. **Are the Trust services**

Acute only ☐ Community only ☐ Mixed service ☐ Other ☐

50. **Is the Trust in the London Implementation Group?**

Yes ☐ No ☐

Please use this space for any further comments you wish to make. (Continue on a separate sheet if necessary).

END OF QUESTIONNAIRE

Thank you for your cooperation