

Decentralisation and Performance: Autonomy and Incentives in Local Health Economies

Research report

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Contents

Acknowledgements	5
Executive Summary.....	6
Glossary	9
1 Introduction:decentralisation in health policy..	11
1.1. <i>Setting the scene: decentralisation in contemporary public services.....</i>	<i>11</i>
1.2. <i>Decentralisation in English health policy</i>	<i>15</i>
1.2.1. <i>The classic NHS (1948-79).....</i>	<i>15</i>
1.2.2. <i>Conservative health policy (1979-1997).....</i>	<i>17</i>
1.2.3. <i>Labour health policy (1997-present).....</i>	<i>19</i>
1.3. <i>Contemporary policies on decentralisation in the English NHS..</i>	<i>21</i>
1.4. <i>Local health economy</i>	<i>29</i>
1.5. <i>Conclusion</i>	<i>33</i>
2 Literature Review.....	35
2.1. <i>Decentralisation</i>	<i>35</i>
2.1.1. <i>Decentralisation in theory</i>	<i>35</i>
2.1.2. <i>Towards a new framework of decentralisation.....</i>	<i>39</i>
2.2. <i>Autonomy</i>	<i>43</i>
2.2.1. <i>What is Autonomy and how might it be conceptualised?.</i>	<i>43</i>
2.2.2. <i>How is autonomy meant to work in practice?.....</i>	<i>52</i>
2.2.3 <i>Autonomy and performance</i>	<i>60</i>
2.3. <i>Performance.....</i>	<i>61</i>
2.3.1. <i>Decentralisation and performance.....</i>	<i>62</i>
2.3.2. <i>The centrality of performance in public management</i>	<i>64</i>
2.3.3. <i>A history of performance in the NHS.....</i>	<i>66</i>
2.3.4. <i>Performance measurement: assumptions and consequences.....</i>	<i>72</i>
2.3.5. <i>Perspectives on performance.....</i>	<i>76</i>
2.3.6. <i>Formal and informal performance explained</i>	<i>83</i>
3 Methods.	90
3.1. <i>Aims and objectives.....</i>	<i>90</i>
3.2. <i>Overall methodology.....</i>	<i>90</i>
3.2.1. <i>Comparative case-studies</i>	<i>90</i>
3.2.2. <i>Rationale for case-study selection</i>	<i>90</i>
3.2.3. <i>Case study selection criteria.....</i>	<i>91</i>
3.2.4. <i>LHE selection</i>	<i>93</i>
3.2.5. <i>Tracer selection.....</i>	<i>98</i>
3.3. <i>Methods in detail.....</i>	<i>101</i>
3.3.1. <i>Secondary data</i>	<i>101</i>
3.3.2. <i>"Policy ethnography" in LHEs.....</i>	<i>102</i>

3.3.3. Analysis	104
3.3.4. Advisory Group	105
3.4. Issues and challenges	106
3.4.1. Revisions to the methodology.....	106
3.4.2. Access	107
3.4.2. Ethics and research governance.....	110
3.4.3. Limitations of the methodology adopted.....	111
4 Findings.	113
4.1. Autonomy	113
4.1.1. Views on autonomy.....	113
4.1.2. How autonomy is shaped	119
4.2. Performance.....	134
4.2.1. The significance of "performance" in LHEs	135
4.2.2. Causes and pathways to performance:	136
4.2.3. Performance management	139
4.2.4. Formal performance.....	140
4.2.5. Informal performance.....	149
4.2.6. The interplay between formal and informal performance	155
5 Discussion and interpretation.	160
5.1 Introduction	160
5.2 Decentralisation revisited	160
5.3 Autonomy	164
5.3.1 Defining types of autonomy:	164
5.3.2 Ability and willingness to exercise autonomy:	170
5.3.3 Freedom from and freedom to:.....	172
5.3.4 Autonomy - conclusions.....	174
5.4 Performance.....	175
5.4.1 Revisiting the Decision Space Framework:.....	176
5.4.2 Formal and informal performance:	181
5.5. Concluding words.....	182
6 Conclusions.....	184
6.1. Summary of key conceptual and empirical contributions of this report	184
6.2. Implications of research for policy and practice.....	188
6.2.1. Autonomy.....	190
6.2.2. Performance	192
6.2.3. LHE	193
6.2.4. Political directions in 2009	195
6.3. Further research	198
6.3.1. The conduct of research in the current NHS.....	198
6.3.2. Autonomy: further research	199
6.3.3. Performance: further research.....	200

6.3.4. *Systems, integration and collaboration: further research*
.....201

References 203
Appendix 1. Hypothetical case-study 219
Appendix 2. Case-study profiles 223
Appendix 3. Tracer conditions 255
Appendix 4. Invitation letter to participants 284
Appendix 5. Consent form 285
Appendix 6. Interview schedule/protocol 287
Appendix 7. Interim feedback report, 2008..... 289
Appendix 8. Advisory Group 291
Appendix 9. REC approval 293
Appendix 10. Summary of issues..... 298
Appendix 11. Dissemination activities..... 300

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Executive Summary

Background

This summary presents the findings and analysis from a study commissioned by the NIHR Service Delivery and Organisation Programme (SDO).

Decentralisation remains a strong theme within English health policy, most recently focusing on autonomy for high performing local organisations. Policies such as Foundation Trusts illustrate this. The study examined the impact of national policy (especially autonomy) and local organisational collaboration in terms of the room for manoeuvre in local health economies (LHEs). It also examined the ways in which performance was measured and managed across the local health economy, and effects of measurement on behaviour and outcomes. Incentives such as Payment-by-Results (arguably a centralising measure) have, it is claimed, enabled local autonomy.

The study's methodology was a longitudinal comparative case-study of two contrasting LHEs. The study was conducted between 2006 and 2009. Within each case-study, data were collected through in-depth interviews, observation of meetings and documentation.

Aim

To investigate the relationship between decentralisation, governance, incentives and performance in LHEs.

Objectives:

- a. To examine the impact of decentralisation upon performance;
- b. To describe the local interaction of governance mechanisms;
- c. To evaluate the degree of autonomy available to local health-care organisations;
- d. To assess the incentives associated with different policy initiatives;
- e. To provide lessons for policy-makers and managers at all levels

About this study

This study was an in-depth examination of the ways in which decentralisation in the English health system was interpreted and implemented locally. It described and explained the relationship between autonomy and performance, mediated by incentives, in two contrasting LHEs. It drew on theoretical models and frameworks to provide the conceptual context within which the empirical findings are presented and interpreted. The study used a comparative case-study methodology, involving in-depth interviews, observation and documentary analysis between 2006 and 2009. It found that freedom from the centre did not always facilitate freedom to innovate or be responsive to local needs because local practitioners may have been

unable but were not always willing to exercise autonomy. The emphasis on formal performance (eg. activity or financial metrics) tended to overlook the role played by informal performance (eg. goodwill and trust). The study has implications for the design and implementation of health system reforms in England.

Key findings

1. Decentralisation:

- a. Decentralisation is evident in many English health policies, notably granting autonomy to Foundation Trusts (FTs).
- b. Decentralisation can be sub-divided into inputs, process and outcomes to clarify 'what' is being decentralised.
- c. Whilst greater local autonomy over input and process illustrates decentralisation, centralisation is also evident in terms of tighter control over outcomes through performance management and regulation.
- d. The mix of decentralisation and centralisation has created ambiguity and uncertainty for policy-makers (centrally) and practitioners (locally).

2. Autonomy:

- a. Local decision space (room for manoeuvre) is the sum of vertical (from the centre) and horizontal (from other local organisations) autonomy. Health policy has focused mainly on vertical autonomy.
- b. Without freedom to be innovative or responsive locally, freedom from the centre may be compromised. This will affect the local implementation of health system reforms because both the ability and willingness to exercise autonomy are essential to deliver these reforms.
- c. Our evidence suggests an unwillingness to exercise autonomy because of centralising tendencies, risk-averse behaviour, an uncertain policy environment and an aversion to destabilise the LHE.
- d. We also found that organisations without FT status criticised the benefits available to FTs, as an example of an 'uneven playing field.'

3. Performance:

- a. The current version of decentralisation (to organisations) has been conditional upon their 'good' performance, the measurement of which is often disputed. Moreover, official performance measures are inadequate to inform local decision-making (as data are retrospective and incomplete for all areas of responsibility).
- b. The distinction between formal and informal performance is useful. Formal performance (eg. activity or finance metrics) provides a safety net for poorly performing organisations but offers weak incentives for high performing organisations. Informal performance (eg. reputation, trust) substitutes for and/or complements formal performance, offering rich insights but lacking consistency.
- c. Where informal performance was positive (indicating high trust and goodwill), our evidence showed how some additional *de facto* autonomy was apparent (where trust underpinned inter-organisational relationships) in the absence of formally-granted autonomy.

4. Local health economy:

- a. The LHE is the setting for the local implementation of national policy reforms. So, the success of these reforms will depend on the quality of local inter-organisational relationships. The LHE is thus where national policy intersects with local organisational politics.
- b. The NHS is highly localised (eg. in terms of commissioning patterns), creating complex inter-organisational relationships within LHEs.

Organisations in LHEs are thus often highly dependent on each other (eg. PCT and NHS Trusts) even despite FT status.

Conclusions

Recent English health policy has aimed to increase local autonomy and enhance organisational performance. Decentralisation, it is often claimed, can solve multiple organisational and policy dilemmas. However, it is not be a panacea for these shortcomings. The success of this policy will depend on the impact of vertical autonomy and horizontal autonomy. The broad conclusions are as follows:

1. Decentralisation is a means to an end
 - a. Policy objectives need to be clearly defined
2. Decentralisation and centralisation usually exist together
 - a. Policy attention on decentralisation can mask the centralisation taking place at the same time
3. Clarification is required about `what' is being decentralised/centralised
 - a. Decentralisation has usually been applied in terms of inputs and processes
 - b. Centralisation has usually been applied in terms of outcomes.
4. The impact of decentralisation will depend on the nature of the local health economy
 - a. Decentralisation does not automatically lead to `improvements'
 - b. Its success will depend on the local context including the nature and quality of collaboration between local agencies
5. Decentralisation must be accompanied by regulation
 - a. Decentralisation implies more local autonomy which has the impact of fragmenting health systems
 - b. Regulation and performance management (forms of centralisation) are required to ensure that system-wide objectives are met
 - c. Regulation may stifle local autonomy, if not sensitive to local contexts.
6. Decentralisation cannot achieve specific outcomes always and everywhere
 - a. Decentralisation has mixed benefits
 - b. Policy compromises must be made (say, between equity or efficiency)
7. The study's findings have implications for implementation of the current health reform agenda and the ways in which the NHS will navigate through an era of fiscal constraint.

Glossary

A&E	Accident & Emergency
CEO	Chief Executive Officer
CHI	Commission for Health Improvement
CHAI	Commission for Health Audit and Improvement
CQC	Care Quality Commission
DH / DOH	Department of Health
DHSS	Department of Health & Social Security
DPH	Director of Public Health
EBM	Evidence-Based Medicine
FT	Foundation Trust
GP	General Practitioner
GPFH	General Practitioner Fund Holders
HC	Health Care
HOC-HSC	House of Commons-Health Select Committee
HOSC	Health Overview and Scrutiny Committee
HMC	Hospital Management Committee
HRG	Health-care Resource Group
IOW	Isle of Wight
ISTC	Independent Sector Treatment Centre
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAA	Local Area Agreement
LDP	Local Development Plan

LHE	Local Health Economy
LTC	Long Term Conditions
LSP	Local Strategic Partnership
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
NCC-SDO	National Co-ordinating Centre for NHS Service Delivery and Organisation
NICE	National Institute for Health and Clinical Excellence
NHS	National Health System
NPM	New Public Management
NSB	National Service Framework
PAF	Performance Assessment Framework
PBC	Practice Based Commissioning
PBR/PbR	Payment By Results
PC	Patient Choice
PCT	Primary Care Trust
PCG/T	Primary Care Groups/Trusts
QOF	Quality and Outcomes Framework
RHA	Regional Health Authority
REC	Research Ethics Committee
SAFF	Service Agreement and Financial Framework
SBOP	Shifting the Balance of Power
SHA	Strategic Health Authority
WCC	World Class Commissioning

The Report

1 Introduction: decentralisation in health policy.

Where should power and responsibility lie in health systems? How should different levels in the health system relate to one another? The choices about such decisions are important because they not only determine the type and nature of health services that are available but they also signify the character of the system itself. Reflecting the latest pre-occupation with decentralisation, English health policy has recently been dominated by approaches which seek to devolve power to new organizational forms and to individuals. Echoing familiar policy and organizational themes, the latest version of decentralisation has also (re-)introduced new themes, namely, autonomy and performance.

In this report, we seek to assess the role that decentralisation plays in contemporary local health systems – here, termed local health economies (LHEs). We examine the impact of decentralisation upon autonomy and upon performance, both mediated through the intersection with incentives. We do so using in-depth qualitative methods in two contrasting LHEs, conducted over 3 years (2006-2009).

The first chapter introduces decentralisation in the context of public service reform generally and health policy reform specifically. We review the history of decentralisation in the NHS, noting the recurrence of familiar policy themes and the disputed interpretation of reforms. We pay particular attention to health policy in the past decade, featuring key features which are illustrative of the policy direction. This includes an assessment of the usage and application of the term ‘local health economy’ which lies at the heart of this study.

1.1. Setting the scene: decentralisation in contemporary public services

Inquiry into decentralisation has a long and rich tradition, reflecting its role in public administration. Decentralisation concerns the relations between the centre(s) of power and sub-ordinate tiers of administration; hence it is concerned with both the

state of and process relating to inter-governmental relations and central-local relations. Decentralisation can be defined as:

“...the transfer of authority and power from higher to lower levels of government or from national to sub-national levels” (Saltman et al, 2007, p.10).

(Decentralisation definitions are discussed more fully in chapter 2). The resonance of decentralisation as an organising principle has been no less strong in recent years. It has been revived in order to address perceived shortcomings in the organisation, management and delivery of public services. Indeed, politicians, policy-makers, practitioners and, to some extent, the public have had to re-discover the perennial policy tensions and organisational dilemmas in each round of decentralisation. Given the swings of the policy pendulum (or the revolving door; Klein, 2003), the inadequacies of the former regime become increasingly apparent, so does the attractiveness of the alternative. Decentralisation (and centralisation) illustrates well this oscillation. As such, decentralisation can involve a search for greater efficiency, equity, effectiveness (or other objective) (de Vries, 2000) – though it is often claimed to achieve all of these (and more). Indeed, Saltman et al (2007) claim that

“It thus appears that decentralisation covers the full range of possible judgements, with what seem to be broadly positive outcomes to some authors or in certain contexts, becoming broadly negative to other authors or in other contexts” (p.9).

Decentralisation has multiple objectives but, as the discussion above denotes, it is also beset by controversies.

Table 1.1. Objectives, rationales and controversies of health decentralisation

Objectives	Rationale	Issues and controversies
To improve technical efficiency	<ol style="list-style-type: none"> 1 Through fewer levels of bureaucracy and greater cost consciousness at the local level. 2 Through separation of P&P functions in market-type relations 	<ol style="list-style-type: none"> 1 May require certain contextual conditions to achieve. Incentives are needed for managers. 2 Market-type relations may lead to some negative outcomes.
To increase allocative efficiency	<ol style="list-style-type: none"> 1 Through better matching of public services to local preferences. 2 Through improved patient responsiveness 	<ol style="list-style-type: none"> 1 Increased inequalities among admin units. 2 Tension between

		central and local govt
To empower local governments	Through more active local participation	Unclear concept of local participation
To increase innovation of service delivery	<ol style="list-style-type: none"> 1 Through experimentation and adaptation to local conditions. 2 Through increased autonomy of local government and institutions 	Increased inequalities
To increase accountability	<ol style="list-style-type: none"> 1 Through public participation. 2 Transformation of role of central govt 	Unclear concept of local participation
To increase quality of health services	<ol style="list-style-type: none"> 1 Through integration of health services and improved information systems. 2 Through improved access to services for vulnerable groups 	
To increase equity	<ol style="list-style-type: none"> 1 Through allocating resources to local needs 	Reduces local autonomy, decentralisation may improve some equity measures but may worsen others

Source: Saltman et al, 2007, p.16

However, in addition, decentralisation can also involve a search for new forms of legitimacy. Most recently, this search has centred on public policy and organisational change relating to:

- network-based organisations,
- governance,
- private sector involvement,
- political devolution, and
- state restructuring.

Decentralisation is an important worldwide concept in the public sector in general and the health service in particular (Atkinson, 1995; Bossert and Beauvais, 2002; Khaleghian, 2003; Levaggi and Smith, 2004; Robalino et al, 2001; Saltman et al, 2003, 2007; de Vries, 2000). Levaggi and Smith (2004, p.1) write that the most appropriate decentralisation of policy-making powers is an important unresolved policy question for most health systems. However, the trend towards decentralisation has varied over time, characterised as ongoing cycles by de Vries (2002) and as the organizational pendulum by Axelsson (2000), with recent moves to re-centralisation in some countries (Levaggi and Smith, 2004; Saltman et al, 2007; de Vries, 2000).

The UK is generally described as a 'command and control' system. However, Klein (2006) argues that the cycle of experiments with delegation quickly followed by

reversions to centralisation is one of the defining themes running through the history of the NHS. Many governments since 1948 have claimed that they wish to decentralise the British NHS, with the current Labour government stressing decentralisation and the 'new localism' in the NHS (Allen, 2006; Exworthy, 1998; Exworthy and Frosini, 2008; Exworthy and Greener, 2008; Goddard and Mannion, 2006).

Bossert (1998, p.1513) points out that 'a comparative analytical framework should provide a consistent means of defining and measuring decentralisation in different national systems.' However, many commentators agree that there are problems of defining decentralisation (eg. Atkinson, 1995; Exworthy, 1994; Gershberg, 1998; Hales, 1999; Levaggi and Smith, 2004; Saltman et al, 2003, 2007). As Gershberg (1998, p.405) put it, the concept of decentralisation is a slippery one; a term - like 'empowerment'; or 'sustainability'- empty enough on its own that one can fill it with almost anything. Likewise, Saltman et al (2007) summarise this complex nature of decentralisation thus:

"The single seemingly simple character of decentralisation, when probed more deeply, opens up into a broad array of concepts, objectives and consequences" (p.1).

The term of decentralisation has been used in a number of disciplines such as management, political science, development studies, geography and social policy, and appears in a number of conceptual literatures such as public choice theory, principal agency theory, fiscal federalism and central-local relations. It has links with many cognate terms such as autonomy and localism which themselves are problematic (Boyne, 1993; Page, 1991; Pratchett, 2004; Saltman et al, 2007; Stoker, 2004). Second, much of the literature refers to elected local government with revenue-raising powers. Application to a national health service which is appointed and receives its revenue from central grants is problematic. As Klein (2001, p.106) puts it, 'everybody paid verbal homage to the principle of decentralisation, but how was this going to be achieved in a nationally-financed service?'

A number of frameworks to understand decentralisation have been proposed (Bossert, 1998; Burns et al, 1994; Hambleton et al, 1996; Pollitt et al, 1998; Rondinelli, 1983; Saltman et al, 2007; Vancil, 1979). Though these are explored in-depth in chapter 2, a number of preliminary points can be made about these frameworks at this stage (Peckham et al, 2008). First, there is a high degree of ambiguity in definitions used, with some frameworks not defining their terms in sufficient detail, while others use the same terms with different meanings. Second, most frameworks are highly contextual in terms of time and place; transferability and generalisability are thus limited. Third, emphasis tends to be placed on decentralisation from national government to provincial/regional/local government, and tend to overlook the potential for decentralisation to individuals and/or

centralisation beyond the nation state. Finally, there is little indication of how to operationalise decentralisation. Most frameworks are typologies or lists, and do not give much assistance in comparing decentralisation beyond nominal categories.

1.2. Decentralisation in English health policy

Any assessment of the level or nature of decentralisation in the NHS is fraught with difficulty. Different Health Ministers, for example, have held conflicting views. Enoch Powell argued that the centre had almost total control. Richard Crossman maintained that the centre was weak. Barbara Castle argued that the RHAs were 'pretty subservient' (in Ham, 2004, p.174-5; cf. Lee and Mills, 1982, p.105). Similarly, commentators present different views. For example, during the Conservative period of office (1979-1997), it appeared that the NHS was moving in two different directions at once. Some commentators claimed that the *national* character of the health service was undermined (eg. Mohan, 1995) while others argued that the NHS was effectively nationalised (eg. Klein, 2006). Similarly, Labour health policy (1997 onwards) has stressed the importance of both the *national* and the *local* (Baggott, 2004; Klein, 2006; Powell, 1998). As Butler (1992, p.125) writes, it is unclear whether the NHS is a central service that is locally managed or a local service operating within central guidelines. Governments have tended to claim the latter, whilst actually willing the former.

This section examines the conventional wisdom on decentralisation in the NHS according to the main health policy and management texts (see also Peckham et al, 2005). It summarises the results of a literature review. The search strategy focused on authored (rather than edited) texts that covered a wide period of time from 1948 onwards. Although it was not a 'systematic review' of journal articles with search terms and inclusion criteria (in part because few texts have 'decentralisation' in the title), it was fairly wide-ranging. The aim was to provide a crude content analysis of decentralisation in the texts, but it quickly emerged that decentralisation (or cognate terms) rarely appeared in the indices, which meant that the texts needed to be read in full. It is clear that, while decentralisation and devolution tend to be the dominant terms, they are rarely defined or measured, or linked to the conceptual literature. Also, the terms tended to be used interchangeably. The discussion is presented by broad period.

1.2.1. The classic NHS (1948-79)

Although the NHS has often been seen as a 'command and control' model, the situation is more complex, with the first few decades more accurately described as 'exhort and influence' (Klein, 2001, p.216). Although Bevan saw local bodies as 'agents', he hoped to give members 'substantial executive powers' (Allsop, 1995,

p.44) and wished to see maximum delegation to local bodies (eg. Webster, 2002, p.19; Small, 1989, p.15-6). Brown (1979, p.11) argues that for at least half of the 1948-74 period Ministers of Health had neither the will nor the means to intervene in the work of health authorities. The early NHS was characterised by 'laissez faire' (Flynn, 1992, p.105). Baggott (2004) and Ham (2004) also see some decentralisation in the 1950s. Harrison et al (1990, p.7-8) state that the 'shared vision' of studies suggested that the centre possesses little direct operational control over the implementation of most national policies.

The 1960s saw increased central control (Allsop, 1995, p.39-40; Brown, 1979, p.13, 19), with the 1962 Hospital Plan eroding the autonomy of Hospital Management Committees (HMCs) (Small, 1989, p.20-1; Harrison et al, 1990, p.86).

Brown (1979, p.185) writes that, while greater delegation was one of the professed objectives of the 1974 Re-organisation, one of its features was tight central control, and the new planning cycle attempted to exploit the hierarchical structure of the NHS (p. 36; also Flynn, 1992, p.105). Mackenzie (1979, p.162) argues that the re-organised structure was strictly hierarchical in form, making clear the chain of command. He regards the re-organisation's claim that 'delegation downwards should be matched with accountability upwards as 'an 'utterly unintelligible proposition' (p.171; cf. Webster, 2002, p.101). Allsop (1995, p.59) argues that, despite its faults, the 1974 re-organisation began the transformation of the NHS into a national service with national standards. Harrison et al (1992, p.122) regard the 'Priorities' document (DHSS, 1976) as the 'high water mark' of the command model but, on the whole, the centre failed to constrain traditional local autonomy. Table 1.2 summarises interpretation of decentralisation in the classic NHS by leading commentators. It shows that there is broad agreement that devolution in the early NHS moved towards centralisation in the 1960s and 1970s. However, there are some gaps in our knowledge (as indicated by empty cells in the table), and the concepts and evidence on which judgment is based is often lacking.

Table 1.2. Extent of decentralisation in the "Classic NHS", as interpreted by leading commentators

	1948	1950s	1960s	1970s
Allsop	D	D	C	C
Brown	D	D	C	C
Flynn	D	D	-	C
Ham	D	D	-	
Harrison et al (1990, 1992)	D	D	C	C
Haywood and Aleszewski	-	-	-	C?

Hunter	D	D		-
Klein	D	D	C?	-
Lee and Mills	-	-	-	C?
Mackenzie	-	-	-	C
Small	D	D	C	-
Strong and Robinson	D	D	-	-
Webster	D	D	-	-

Key for tables 1.2-1.4: C=centralisation; D=decentralisation

1.2.2. Conservative health policy (1979-1997)

Most commentators agree that the 1979 consultation document, 'Patients First' (DH, 1979) and the resulting 1982 re-organisation stressed decentralisation (Allsop, 1995, p.56; Baggott, 2004, p.100; Flynn, 1992, p.61; Harrison, 1988, p.21; Harrison et al, 1990, p.79, 85-6; Pettigrew et al, 1992, p.49) or 'laissez-faire' (Harrison et al, 1990, p.86). However, this was followed soon afterwards by a dramatic move towards centralisation with a number of measures including central performance management, planning systems, 'circulars' and contracting out (Pettigrew et al, 1992, p.50; Small, 1989, p.53, p.153-5; Strong and Robinson, 1990, p.22; Flynn, 1992, p.106-8; Klein, 2001, p.121-3).

There is less consensus on the implications of the 1983 Griffiths Report (DHSS, 1983) that recommended that appointment of general managers at all levels in the NHS. On the one hand, some commentators argue that they increased centralisation (Baggott, 2004; Harrison, 1988; Klein, 2001; Small, 1989, p.53, p.155; Strong and Robinson, 1990). On the other hand, Allsop (1995, p.158) writes that the Griffiths Report was concerned with freeing managers at the centre and periphery. Harrison et al (1992, p.80) wrote that the Griffiths reforms were supposed to produce a clearly defined hierarchy of control but there was textual ambiguity, with both Fordist and post-Fordist language.

The White Paper, 'Working for Patients' (DH, 1989) and the 1990 Act proposed a purchaser / provider split, with decentralised institutions of self-governing NHS Trusts and General Practitioner Fund Holders (GPFH) (McNulty and Ferlie 2004; Robinson and Le Grand, 1994). Although much of the rhetoric was decentralist, with the exception of local pay bargaining (Klein, 2001), many of the implications were centralist (Allsop 1995: p.188; Harrison et al, 1992, p.119; Klein, 2001, p.167, p.182-3; Paton, 1998, p.151-2; Flynn, 1992, p.180). Like 'Working for Patients' and despite the decentralist rhetoric, most commentators agree that the move in

the mid-1990s from Regional Health Authorities to Regional Offices of the NHS Executive was centralist (Baggott, 2004; Ham, 2004, p.164; Webster, 2002).

In short, the Conservative period saw decentralisation rhetoric and reality in some periods and in some spheres such as devolution of actual purchasing budgets (if not of real power in determining priorities) and of local pay (Paton, 1998, p.138-9).

Table 1.3 suggests that, after the early decentralist direction of Patients First, most commentators point to varying degrees of centralization for most of the Conservative reforms, with some policies being the centralist 'wolf' in the decentralist's 'clothes.' Like Table 1.2, there are some gaps in our knowledge; concepts and evidence are often notably lacking. Unlike Table 1.2, there are some disagreements on the 'Working for Patients' and Griffiths reforms.

Table 1.3. Extent of decentralisation in Conservative health policy (1979-1997), as interpreted by leading commentators

	Patients First	Griffiths general managers	Performance indicators	Working for Patients	Regional Offices	Summary
Allsop	D	D	-	C	-	C
Baggott	D	C	-	-	C	C
Flynn	D	-	C	C	-	C
Ham	-	-	-	-	C	C
Harrison	D	C	-	-	-	-
Harrison et al (1990, 1992)	D	Both C & D	-	Both C & D	-	Both C & D
Klein	D	C	C	C	-	C
McNulty and Ferlie (2004)	-	-		D	-	C>D>C
Paton	-	-	-	C		C
Pettigrew et al	D		C	-	-	-
Small		C	C	-	-	C
Strong and		C	C	-	-	C

Robinson						
Webster	-	-	-	-	C	C

Key: PF= Patients First (DHSS 1979); Griffiths = Griffiths management reforms following DHSS (1983); PIs = performance indicators; WFP = Working for Patients (DH 1989); RO= Regional Office; > = leading to.

1.2.3. Labour health policy (1997-present)

In its first term, the Labour government's 'Third Way' approach tended to stress both centralisation and localism (decentralisation)(cf. Rawnsley, 2009). According to Paton (1998, p.177), the different agendas embraced by the Labour government led it to face both ways. In some ways, the Labour government stressed localism, an emphasis on diversity rather than national uniformity, and there has been some measure of devolution to Scotland, Wales and Northern Ireland (Klein, 2001, p.193; Ham, 2004; Webster, 2002, p.239-40). However, on the other hand, the 'New NHS' document (DH, 1997) aimed 'to renew the NHS as a genuinely national service' (emphasis added). New central institutions such as the Commission for Health Improvement (CHI, later to become the Healthcare Commission and more recently, the Care Quality Commission) and the National Institute for Health and Clinical Excellence (NICE) were set up. National Service Frameworks (NSFs) were emphasised. The Labour government aimed to achieve a 'one-nation' health service, offering 'fair access' to services irrespective of geography and to counter claims of a 'postcode lottery.' The importance of hierarchical controls was never greater than in the period after the election of the Blair government in 1997 (Ham, 2004, p.245; cf. Baggott, 2004, p.361, p.365; Klein, 2001, p.208).

The second term showed a clear rhetorical trend to decentralisation (Exworthy and Greener, 2008). This was started by the NHS Plan (DH, 2000) towards the end of the first term, with more flesh put on these bones by subsequent documents, notably 'Shifting the Balance of Power' (DH, 2001), and Secretaries of State Alan Milburn and John Reid stressing decentralisation and the 'new localism' (Greener, 2004; Stoker, 2004).

While the government stressed financial decentralisation (for example, giving more of the NHS budget to PCTs), and 'earned autonomy' (Mannion et al, 2007)), there were clear limits to this devolution (Baggott, 2004, p.121, p.174-8; Klein, 2006, p.214). Ham (2004, p.267-8) claims that it was only with the emergence of proposals to create NHS Foundation Trusts (FTs) that policy-makers showed any interest in genuinely devolving responsibility for decision-making, representing 'potentially the most radical organisational innovation in the history of the NHS since its inception' (p. 66). In particular, the traditionally available default was the reserve powers of the Secretary of State. With the advent of Monitor and FTs, the Secretary of State did not have such powers. Autonomy might thus be more genuine than before.

In 2006, PCTs were 'reconfigured' – ie. amalgamated- and reduced from 303 to 152. Similarly, the number of SHAs was reduced to 8 in "what looked remarkably like the reinvention of the regional offices that had been abolished earlier" (Klein, 2006, p.241-2). The Labour government has continued to use decentralist rhetoric, although the precise meanings are not always fully clear.

Overall, it is generally considered that the Labour government has further centralised the NHS (Baggott, 2004; Klein, 2006, p.262). McNulty and Ferlie (2004, p.355, p.357-60) regard many Labour policies (such as performance management, Commission for Health Improvement and NSFs) as top-down and target driven 'NPM mark 1.' Table 1.4 shows that, while there have been some decentralist elements within Labour's approach, policy as a whole is characterised as centralist. It also shows more gaps in our knowledge, and a mix of centralising and decentralising policies.

Table 1.4. Extent of decentralisation in Labour health policy, as interpreted by leading commentators

	PCG /Ts	NICE	CHI / CHAI	PAF	NHS Plan	EA	SBOP	FT	Dev	Summary
Baggott	C/D	-	-	C	C	-	-	-	-	C
Ham	-	-	-	C	-	-	D	D	D	C
Klein	-	C	C	C		C?	-	-	D	
McNulty & Ferlie	-	C	C	C	C?		-	-	-	C
Paton	-	-	-	-	-	-	-	-	-	C
Webster	-	-	-	-	-	-	D	-	D	-

Key: PCG/T: Primary Care Groups/Trusts; NICE: National Institute of Clinical Excellence; CHI: Commission for Health Improvement (CHAI: Commission for Health Audit and Improvement, and subsequently HC: Healthcare Commission, CQC: Care Quality Commission); PAF: Performance Assessment Framework; EA: Earned autonomy; SBOP: Shifting the Balance of Power (DH 2001); FT:= Foundation Trusts; Dev: Devolution

This section has provided a brief review of decentralisation policy drawing out key themes. In particular, the ongoing tension between centre and locality and the co-existence of both centralising and decentralising policies were identified. As Saltman et al (2007) have observed, the co-existence of centralising and decentralising processes and policy is not a unique feature of the English or even UK health system. Previous analysis of decentralisation policies in health systems has clearly demonstrated the constant shift between centre and locality both historically and by

function (Peckham et al, 2005). It is also important that in the UK discussions of decentralisation in health systems are seen within the wider context of political devolution and the development of four health systems in the UK creating different contexts for both local approaches to health care and the role of the centre(s) (Greer, 2009). The concern here though is to examine the current context of decentralisation within the English health system and how this affects autonomy and performance at the local level.

1.3. Contemporary policies on decentralisation in the English NHS.

Policy in the latter years of the Labour government has espoused to be decentralist in rhetoric and indeed, reality. However, it is notable that such policy rhetoric and organisational change have been driven much more centrally than in many other previous attempts. This is evidence of the co-existence of decentralisation and centralisation. It not only requires a centre willing to devolve power (to localities) but also to assume new regulatory and oversight powers to ensure local power is deployed 'appropriately' and does not contravene other cherished objectives (such as equity of access). Yet, questions can be raised as to whether such centralisation is effective, especially in the light of recent English health policy which, as this section argues, has been marked by organisational autonomy, Patient Choice and a performance culture of targets (inter alia).

Exworthy and Greener (2008) identified the early 2000s as a pivotal period in which English health policy shifted away from centralisation towards decentralisation. The limitations of previous centralisation and the policy shift were also observed by Harvey et al (2007):

"Neither enhanced performance targets, nor strong investment in modernisation processes, nor massive increases in funding proved sufficient to deliver the transformation the government wanted to see in the NHS. The service remained largely unresponsive to the needs and preferences of patients, with a limited ability to respond to rising consumer expectations and to secure innovation and productivity from providers (p.13)

Yet, they also noted that, like the quasi-market in the 1990s (Le Grand et al, 1998), the incentives to secure the stated policy objectives were inadequate. Harvey et al (2007) noted that the "contract [between purchaser and provider] itself and the potential for patients to transfer between practices. Neither has so far proved very effective" (p.35).

It is significant that health policy since, say, 2001 has sought to portray a “unifying narrative” (King’s Fund, 2008), one which foresees:

“...a self-improving health care system – one that is much more decentralised and much more responsive, where day-to-day ministerial involvement in its operation becomes redundant and the need for centralised performance management is much reduced” (p.x).

This “unifying narrative” has depicted the elements of reform as a coherent programme (see figure 1.1.)(Allen, 2008).

Fig.1.1. A unifying narrative of health reform?

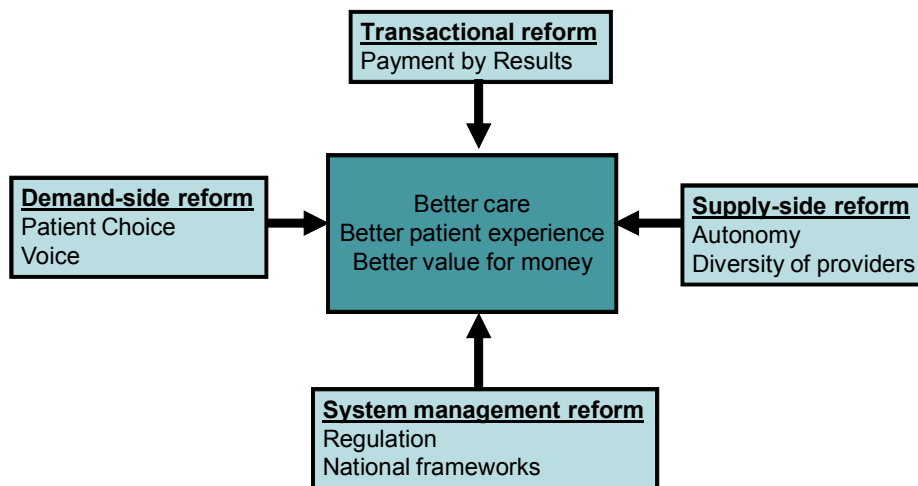


Figure 1.1. A unifying narrative of health reform?

The key features of this programme include:

- *Centralisation* in the form of a regulatory regime comprising centrally-defined standards, clinically-based frameworks, and rules about the degree of competition;
- *Decentralisation* in the form of (i) PCT commissioning decisions as a lever for local change, (ii) greater freedom to innovate in the search for services that are responsive, cost effective and of continuously improving quality” (King’s Fund, 2008, p.xi) and (iii) patients’ decisions about the location and type of treatments.

This ‘loose-tight’ structure reflects the strategic-operational division, advocated by Osborne and Gaebler (1992) and summed up by the King’s Fund (2008):

“Ministers and the Department of Health will still be responsible for setting standards, goals and priorities. But day-to-day operation, and precisely how those goals are achieved, becomes a matter for the service” (p.x).

The raft of health policies relating to such a strategic framework is increasingly inter-related but it is possible to enumerate them:

- Patient Choice
- Foundation Trusts and Monitor
- Practice-Based Commissioning
- Payment by Results
- Quality and Outcomes Framework
- Cooperation and Competition Panel
- Commission for Health Improvement / Healthcare Commission / Care Quality Commission
- National Service Frameworks
- National Institute for Health and Clinical Excellence

What follows is an illustration of one thematic policy area (organizational autonomy) and two specific policy topics (Patient Choice and Darzi `Next Stage Review`) in order to determine the extent to which the narrative is indeed unifying.

- *Organisational autonomy*

The current commitment to local autonomy has been set out in a number of DH policies over the last few years. Since the NHS Plan in 2000, there has been a move to change the structure and organisation of local health services towards a more autonomous system. At the heart of these reforms has been the sharper development of the purchaser/provider split and the designation of Foundation Trust status for health care providers. NHS Foundation Trusts have additional freedoms and governance arrangements to NHS trusts. There are, however, national monitoring arrangements and clear rules of `entry` to foundation status overseen by `Monitor` the national regulator. FT status was initially sought for all Trusts by December 2008 but, given on-going difficulties in raising performance, this goal was missed.

Since 2006, PCTs have been given freedom to define local performance targets for themselves and, recently, can designate a number of local performance targets within the Quality and Outcomes Framework for general practice. The NHS 2005/06 Planning Framework did not give prescriptive guidance on what local targets should be developed by PCTs but instead set out a framework of principles within which organisations were to consider their local needs and priorities. PCTs had to agree the local targets with Local Authorities and other partner organisations. While the DH did not monitor performance against these local targets, they were subject to assessment by the Healthcare Commission. Local targets had to be evidenced based and take into consideration NICE guidance.

Since being elected in 1997, the Labour government has supported and promoted a number of approaches to developing local partnerships for public health and health and social care delivery. A key element of these approaches has been an emphasis on increased local decision-making and the formation of formal local partnerships – between organisations and with local communities. Most recently, since April 2008, there has been a new statutory duty of partnership on local authorities and PCTs to work together with their local partners to produce a joint strategic needs assessment (JSNA). The purpose of these JSNAs is to identify the unmet health and well-being needs and inequalities of the whole local population, and to provide a sufficiently broad joint evidence base for a locality to develop its own responses to local problems (DH, 2007a). The aim was to enable increased joint working and co-operation among all local organisations leading to improved outcomes for local populations. There are a number of key objectives:

- To influence strategic planning over a range of timescales – annual, medium and long-term,
- To involve a wide range of local stakeholders other than the local authority and PCT(s),
- To engage explicitly with the public,
- To inform the sustainable community strategy and local area agreement (LAA), and
- To publish (in the public domain) and make widely available in appropriate formats.

These local arrangements are, however, overseen by a joint assessment system. In addition, the process also means that the actions of any individual organisation are restricted by the need to work collaboratively possibly limiting individual room for action (ie. autonomy). While the results of such local area agreements may produce new local approaches, the goals are, to some extent, set and monitored by central government. For example, Local Public Service Agreements included targets agreed with central government and included a common set of outcomes and indicators, targets to improve a number of these over a three-year period (Coulson, 2009). This is despite the fact that the government has placed emphasis on developing stronger local accountability through new governance arrangements for FTs and changes to the arrangements and processes for patient and public involvement. In reality, while there have been a number of structural changes to arrangements for patient and public involvement and development of new governance arrangements, there has, to date, been little extension of local accountability. As Barnes et al (2008) argue such new approaches to public engagement:

“... do not directly address issues of formal decision-making and of accountability – both of public bodies to their publics and of citizen participants to their constituencies. Nor is it clear that approaches that are at least intended to enable greater accountability can do so.” (p.67).

Autonomy is considered in more detail in chapter 2.

- *Patient Choice*

Another key policy objective has been to promote personalisation – a form of responsiveness to the individual. This reflects a level of decentralisation beyond the organisation (traditionally, the destination of decentralised powers) to the individual. The *NHS Improvement Plan* set out this framework of personalisation explicitly with the objective that the

“Patient chooses *how, when and where* they are treated” (DoH 2004: para 2.17, original emphasis).

By the mid-2000s, there was a strong emphasis on personalisation, an approach to service planning and delivery which gave stressed individual needs (DH, 2004). The theme of personalisation remains as a key component of the rhetoric of more recent policy at least. For example, in the introduction to the ‘Darzi Report’ (DH, 2008), Gordon Brown writes:

“We need a more personalised NHS, responsive to each of us as individuals, focused on prevention, better equipped to keep us healthy and capable of giving us real control and real choices over our care and our lives”.

However, Cutler et al (2007) note that, despite personalisation, professionals remain responsible for making choices in many aspects of services. Further questions about the underlying assumptions of ‘choice’ have also been raised (Exworthy and Peckham, 2006; Greener, 2007; Greener and Mannion, 2009).

Whilst personalisation is potentially a broader strategy of reform, it has its most explicit expression in the Patient Choice policy. In the English NHS, ‘Patient Choice’ policy has been a central element of recent health reform that has focused on patients being able to choose the secondary care provider (DH, 2007b). Patient Choice represents a key demand-side reform alongside a stronger voice for patients (see figure 1.1.). Policy-makers in England have promoted patient choice (including options for patients to ‘exit’ from one provider and transfer to another) as a key driver for improving quality and efficiency, and particularly for the reduction of waiting lists and lengths of wait for secondary care (Fotaki, 2007; Le Grand and Dixon, 2006). The policy was first introduced as a means of providing patients who were facing a long wait for surgery with the option to choose a provider with a shorter waiting list. Significantly, the list of (4 or 5) alternative providers also included a private provider. The policy reform objectives of Patient Choice and a competitive system were thus combined to reduce waiting lists and waiting times.

However, while the mechanisms for choice exist, there is limited evidence on widespread choice in practice (Exworthy and Peckham, 2006; Ferlie et al, 2006; Fotaki, 2007). It is still not clear, for example, what choices patients can make beyond location of care or treatments offered by the NHS or individual NHS

practitioner. In particular, patient choice seems at odds with a focus on developing clinical pathways, for example. The DH consultation on choices for people with long-term conditions (LTCs) focuses on shifting away from a "one size fits all" to one maintaining independence and providing people with more choice and control over their care with benefits for patients and the NHS. Emphasis is placed on developing choices by engaging local users and organizations for people with LTCs, rather than as individual patients, to ensure an appropriate range of services that meet people's needs (DH, 2007c). However, with regard to people with LTCs, the emphasis has been the development of clinical pathways and care management programmes (Ham, 2009), which limits explicitly the choice and which has not been influenced by service user input (McDonald et al, 2006a, 2006b). The DH has tried to reconcile choice and 'pathways' by emphasising patient and public involvement in service design. To date, there is insufficient evidence of the effectiveness of such approaches in influencing local service providers or commissioners (Lupton et al, 1998; Harrison et al, 2002; Chisholm et al, 2007).

For a number of years, some people receiving social care services have been able to manage their own funding resource as part of a formal agreement with the local social services department. Some 60,000 users of social care manage their own budgets for personal care, thereby allowing disabled and older people to buy assistance with dressing, washing or eating. The evaluation of individual budgets has been largely positive (Glendinning et al, 2009). While individual budgets can provide new approaches to care and innovative support, their operation requires complex support and development arrangements. In addition, there are concerns about how such developments influence the social care workforce. Questions also arise regarding the role of the funder in terms of their relationship with the budget holder and whether this is acting in a supportive advisory role or as a monitor and scrutineer of their budget management. In 2008-2009, there has been discussion about whether individual budgets could be extended to health care and proposals have emerged from the Darzi Review for a programme of limited 'personal budget' pilots. The DH has suggested that 'personal budgets' may be suitable for people with long-term conditions such as diabetes or asthma, and users of mental health services. It might also be extended to cover maternity services. While developing individual autonomy, this is within constraints set by local agencies. It also places constraints on local agencies as this means that they will be negotiating issues of their own and the service users' autonomy in governance arrangements for the personal budgets.

In summary, therefore, the current context for decentralisation is rather mixed. In relation to key themes of increased autonomy and greater performance, recent English health policy has been decentralist in nature but not exclusively so. Rather, aspects of health-care delivery and organisation have been decentralised – irrespective of recent organisational consolidations among PCTs and SHAs – but this has been achieved within what remains as a predominantly centralist framework that sets out the parameters of autonomy and at a local level the development of an increasingly complex set of local relationships within LHEs that may have also contributed to limits to autonomy.

- *Lord Darzi and the Next Stage Review*

The Darzi Review (DH, 2008) is probably the foremost health policy of the last two years. Professor Sir Ara Darzi, a respected cancer surgeon, was asked in 2006 to develop a health strategy for London by July 2007. In 2007, he was given peerage in recognition, and Lord Darzi joined Gordon Brown's government 'of all talents' where he was tasked with conducting a similar health review across the entire NHS (Oborn et al, 2009). The Darzi reforms have generally been welcomed (eg. <http://news.bbc.co.uk/1/hi/health/7481155.stm>). His appointment reflects the role of clinician engagement in strategic policy change as it is thought that clinical 'ownership' of policy reforms will enhance policy formulation and improve the likelihood of effective implementation. His vision is different to the "unifying narrative" (see above) but has some overlaps, notably in terms of the emphasis on autonomy and performance.

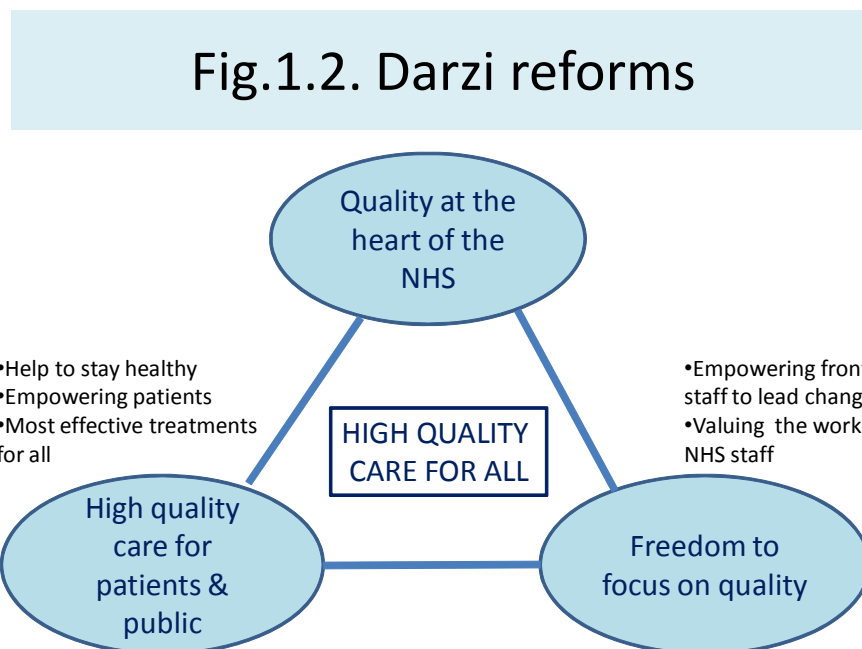


Fig.1.2. Darzi reforms

However, some concerns have been voiced. The King's Fund argues that, in order to realize the Darzi vision, there needs to be

"a decentralised health service, with less central control, leaving local organisations responsible for how they deliver care but accountable for its quality"

(http://www.kingsfund.org.uk/what_we_do/press/the_kings_fund_1.html).

Also, there is some concern that the projected annual savings of £1.4 billion may be over-optimistic (<http://www.hsj.co.uk/figures-underpinning-darzis-london-review-dodgy/311178.article> - 6.12.07).

The Darzi reviews (initially London, then an interim report and a full report) illustrate clearly the tensions inherent in recent English health policy between decentralisation and centralisation. On the one hand, Darzi reforms are offering a national strategy of "high quality care for all" through polyclinics and acute sector reconfiguration, inter alia. On the other hand, the 'Next Stage Review' is replete with references to decentralisation, autonomy and performance; for example:

"The freedom of NHS foundation trusts to innovate and invest in improved care for patients is valuable and essential... These autonomous organisations are ideally placed to respond to patient expectations of high quality care" (p.61)

"We now need to give greater freedom to those working in community services. So far, they have not had the same opportunities for more autonomy." (p.62)

Indeed, chapter 5 is titled "Freedom to focus on quality" and chapter 7 defines the scope of an NHS Constitution. Also, Darzi's interim report (published in October 2007) had a chapter entitled 'A locally accountable NHS.' Moreover, SHAs have had the flexibility (autonomy) to interpret the Darzi vision according to regional priorities. However, in the light of the economic situation in 2009, SHAs have been told by the DH to review their 'Darzi' plans

(<http://www.hsj.co.uk/news/policy/regions-told-to-re-examine-darzi-visions/5003183.article>; 25 June 2009). This resolution of this tension will be significant for the implementation of the Darzi reforms because, according to a survey of NHS managers by the Health Service Journal in 2009, the majority did not feel as if decentralisation had yet to be realised:

- "56 per cent said they felt unable to influence the way health policy was implemented locally", and
- "70 per cent said NHS managers in general had not made enough of the opportunity to look out not up"

(<http://www.hsj.co.uk/news/policy/localism-takes-flight-as-managers-seize-the-day/5003049.article>; 25 June 2009).

Clearly, implementation of Darzi reforms will require not simply the technical feasibility but also a change in attitude and perception of NHS managers. The scale of this challenge is underlined by the results of a similar Health Service Journal poll conducted in the run-up to the 2005 general election (28 April 2005).

- 58% disagreed / strongly disagreed that "A new Labour government would devolve power to local NHS organisations";
- 60% disagreed / strongly disagreed that "A new Conservative government would devolve power to local NHS organisations."

This survey also revealed that 65.8% of respondents agreed / strongly agreed that “the number of Primary Care Trusts should be significantly reduced.” The number was, of course, reduced from 303 to 152 in October 2006.

1.4. Local health economy

A prominent feature of contemporary English health policy has been the increasing reference to the ‘local health economy’ both in policy rhetoric and in the organisation of the NHS. However, there is no precise definition of what constitutes the LHE and even a brief review of how the term is used suggests that it can, on the one hand, refer to whole financial system (for example, within one SHA and with the government requiring the LHE to be in financial balance) and, on the other hand, refer to a small group of inter-connected local services. The LHE has both geographical and organisational characteristics but also refers to sets of inter-organisational relationships. In deploying the LHE as its primary unit of analysis, this study poses the notion of LHE as problematic and seeks to explore the interactions between local organisations in ‘horizontal’ networks and between the centre and those local organizations. This section provides a conceptual and empirical justification of the approach towards analysis of LHEs in this report.

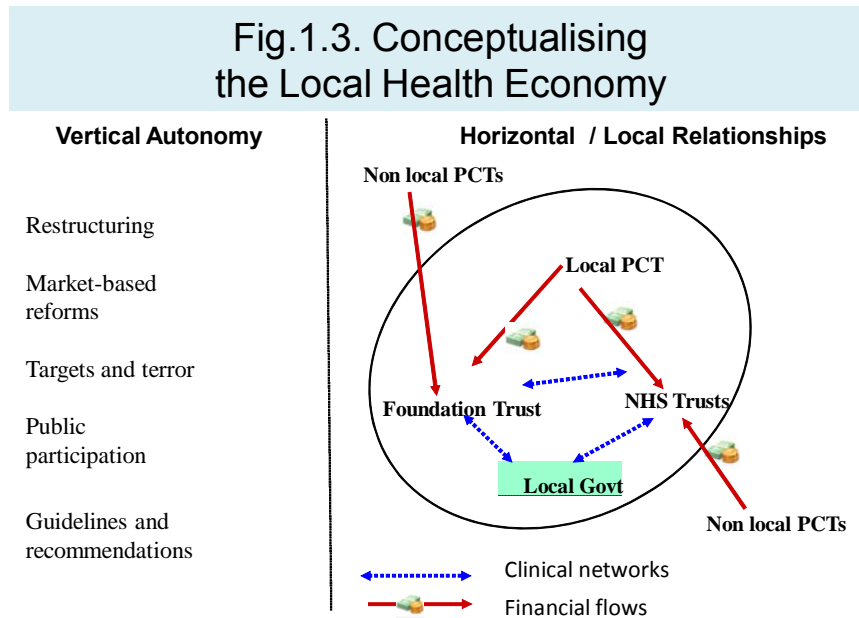
- *Defining the LHE in policy and practice:*

References to the LHE are widespread across health policy documents and local NHS papers. Few definitions, however, have been offered in these papers and policies. The definition offered by the Pan American Health Organization and World Health Organization (1990) is an equivalent:

“...a local health system [here, LHE] should be identified by its having an administrative structure responsible for managing the health activities in that particular [not specified] population. This means having the capacity for direct administration of certain resources and for coordination of all the social infrastructure assigned to health in a given geographical area, along with a structure capable of solving a significant proportion of the health problems of individuals, families, social groups, communities, and the environment and of facilitating social participation, all within the national health system, to which it gives vitality and new direction” (p.5).

In the UK, the term LHE has been increasingly used since the 1990s. However, over this period, it has rarely been clear what the reference to LHE means and whether this term is inter-changeable with terms such as ‘local health system’, ‘local health community’ or even the ‘NHS family.’ Each term implies different kinds of relationships as ‘system’, ‘community’, ‘economy’ or ‘family’ have their own

conceptual meanings. Application of the term also varies considerably in the UK with the DH referring to both PCTs and SHAs as LHEs (eg. DH, 2005; DH, 2007b). One application (which has been adopted in this study) is defining the LHE in terms of PCT financial flows with health-care providers. This is illustrated in figure 1.3.



Source: Exworthy et al, 2008

Fig.1.3. Conceptualising the Local Health Economy

The focus on the LHE provides an antidote to the organisational fixation of most health policy (and, usually by consequence, health policy research). Notwithstanding the comment by the DH (2003) that "Hospitals are no longer seen as free-standing units able to work in isolation from neighbouring health and social care providers", the organisational tier (such as the PCT or Foundation Trust) has been the level to which powers have usually been decentralised. However, it need not necessarily be thus. Alternatives include individuals (patients, as in the case of Patient Choice, or consultants, as in Enthoven's original proposal for the quasi-market). However, the LHE is an intermediate analytical level which remedies the lack of attention of inter-organisational relationships and dependencies between national policy and individual perspectives (such as clinicians' response to incentives).

It is, therefore, instructive to consider how an alternative to organisationally-based autonomy might operate across the LHE. Here, the notion of a "foundation health system" (as an LHE), with similar levels of autonomy to a Foundation Trust, might be one such alternative. The tension between autonomy and (local) partnership has been noted earlier and Davies and Stamp (2001) argued that one resolution would be

“to view foundation status as a positive opportunity to drive forward the development of integrated systems. Organisations that already have well-developed links and mutual inter-dependency within a local health economy should be allowed to apply to become NHS Foundation Systems” (p.1).

Davies and Stamp recognised that Foundation Systems would require new forms of governance but would balance “local operational autonomy” with governance which would foster integrated care (see 2.2.1.). Such systems would almost inevitably encompass current and aspirant FTs as well as poorly performing providers. The proposal has practical implications which prompt Davies and Stamp to ask:

“is the necessary improvement in the performance of a lower-rated hospital most likely to be achieved by leaving that hospital as a stand-alone organisation, albeit with increased central support?” (p.2).

The proposal was not adopted but FTs (based on single organisations) were implemented in 2004. In 2009, there are 121 FTs, over half of all NHS providers. However, this growing proportion (of all Trusts) might denote the *de facto* shift towards a different form of Foundation System. Many LHEs will be characterised by the presence of FTs to an increasingly large extent and PCT autonomy (along the lines of FT) are also mooted in 2009 (<http://www.hsj.co.uk/5002473.article>; 11 June 2009), so it may be that LHEs are dominated by autonomous organisations, rather than being autonomous itself. This pursuit of (organisational as opposed to LHE) autonomy might, however, make partnership and collaboration (such as integrated care) more problematic.

- *Conceptualising the LHE:*

Academic usage of the term LHE is similarly inter-changeable and so, there does not appear to be any consistent use of the different terms. Yet, these terms are used to describe specific aspects of health care organisation or are used to contextualise activities (such as local markets and partnerships) (Greener and Mannion, 2009). Though frequently used, this loose usage of terms is unhelpful; the term seems to obscure as much as it enlightens.

Clarity may come from disaggregating the constituent terms – local, health and economy. First, the use of ‘local’ rather than region, national, area etc. brings some meaning relating to the idea that ‘local’ refers to a geographical, sub national area but one that which has sense as a political, social, or cultural measure that emphasises and places higher value on local and small-scale political and cultural phenomena. ‘Local’ has close links with the notion of community, a term which has long held positive attributes (Bell and Newby, 1971). The term might form part of a wider approach to localism – the extent to which health-care relationships (patients, clinicians, organisations) are locally embedded and mutually-reinforcing (Exworthy, 1998). Second, ‘health’ is also a complex concept in its own right whose meaning

and definition has been widely dissected and debated (Bowling, 1997). However, here, health has more restricted application (ie. health services), focusing mainly on the NHS but increasingly on independent sector as well. Third, 'economy' has a more specific meaning relating to set of embedded institutional relationships. This would encompass the financial flows within the NHS, possibly to the neglect of inter-organisational relationships. Reference to system or community (rather than economy) provides a looser concept and implies different relationships. A community is often defined by informal and formal ties with common interest of some kind although the definition of community itself is highly complex. The use of system conjures up the notion of an interlocking whole (or an invocation of one especially if it does not exist); boundaries to such a notion are inevitably problematic (Pratt et al, 2005).

A lack of a common or shared conceptual framework is a problem both in terms of analysis and application in practice. The LHE may be observed empirically by the relationships, structures and other linkages between organisations in any one locale. A single empirical observation may not be a definitive assessment. For example, if the LHE is defined by contractual relationships between different purchasers and providers, the other dependencies between organisations will be overlooked. These might include job markets for staff, procurement of services, joint working patterns, public views on locality (eg. patients' willingness to travel and affiliations with local hospitals through, inter alia, leagues of friends)

Thus, the LHE could be viewed as a 'network' of different organisations brought together around different economic (rather than social or political) relationships (eg. contractual arrangements, financial dependence or strategic investment). However, the basis for collaboration in networks focuses on reciprocal arrangements where no single stakeholder can act alone. Reciprocity leads to notions of governance, mutually and trust. Only certain types of action require collaboration but policy statements pertaining to LHEs suggest that individual actors in the LHE need to consider the impact across the LHE as a whole. Thus we are left with a question of how to conceptualise the LHE. LHEs could be seen as the arena where organisational politics are articulated; the LHE thus becomes a microcosm of the NHS. Alternatively, LHE might be a sense-making device in constructing a meta-narrative of health-care reform which, some see, might be lacking.

The concept of governance does provide a set of concepts and theories that have applicability in trying to make sense of the LHE (Newman, 2001). Governance refers to the systems by which organisations or groups of organisations are directed and controlled. Institutional structures can be relatively durable and establish recurrent sets of working relationships between organisations. Such working relationships may be formalised by law, regulation or policy but may also develop informally between different groups (Rhodes 1997). For example, the idea of multi-level governance directly relates to the continued development of the NHS in the UK where there is a continuous interplay between national, regional, local and neighbourhood organisational levels (Exworthy and Powell, 2004). In addition the

application of different modes of governance (such as Type I (rational, evidence based, formal) and Type II (informal, stakeholder driven, negotiation)) provide useful ways of conceptualising decision making processes in health. While the more formal structures and relationships are often those that are most observable, relationships between organisations often rely on more informal negotiated processes of governance.

Though governance helps to conceptualise the LHE, it says little much about how the LHE operates. Often, the inter-actions within the LHE are missing. However, drawing on concepts from complexity theory may help to address this shortcoming. Complexity theory suggests that rather than one system with different levels we need to think about nested systems in which all levels intersect and interact (Blackman, 2006). This provides some clarity in thinking about systems as it focuses on the inter-organisational aspects (within LHE and between hierarchical levels). Thus systems are seen as emergent and developing but that as the actions undertaken within the systems reverberate throughout the system, the results that are difficult to predict.

Combining the essence of these approaches points towards a neo-institutional theory of LHEs, which would examine the patterns of economic interaction and the norms and behaviour of the actors involved. Here, the focus shifts to an examination of the ways relationships between organisations in the LHE relate to one another and how such relations are shaped by rules (both formal and informal), values and historical precedent. Such an approach has synergy with the preceding discussions of governance and complexity theory. Applying these concepts to LHEs, we would expect to them as:

- operating within an NHS that is governed by many type I and formal rules and path dependencies;
- yet being governed locally by codes of conduct and type II governance;
- demonstrating a shift from simple administrative organisational frameworks to more complex nested systems to manage changes and relationships;
- demonstrating actions within LHEs that reverberate across the LHE in unpredictable ways.

1.5. Conclusion

This introductory review of decentralisation in the NHS has shown that there are significant gaps in extant knowledge, that there are some conflicts in judgments, partly because understandings are poorly linked to coherent conceptualisations. These lacunae fail to provide policy-makers and practitioners with cogent rationales for decision-making. However, to some degree, it is not the judgments on decentralisation that are contradictory but decentralisation itself; it consists of a number of dimensions that are often in conflict.

Klein (2006, p.263) argued that the balance between centre and periphery has provided a recurring theme in the history of the NHS. It has been shown not only that the direction of change - decentralisation against centralisation - has varied over time, but so too has the content and scope of decentralisation. Many of the problems surrounding decentralisation in the NHS stem from the 'perennial question' of attempting to reconcile national priorities and uniform services with local freedoms (Paton, 1998, p.177; cf. Klein 2006). While Klein (2001, p.37) views the NHS as attempting to reconcile national accountability and local autonomy, but he concludes that 'the circle refuses to be squared'.

The remainder of this report is divided into five chapters. Chapter 2 examines the literature relating to autonomy and performance. Chapter 3 considers the methodology which was employed for conducting empirical fieldwork. The findings of such fieldwork are presented in chapter 4. These findings are discussed and interpreted in the light of the extant literature in chapter 5. The concluding chapter explores the policy implications of the new knowledge generated in this study and proposes a research agenda for the future.

2 Literature Review.

2.1. Decentralisation

2.1.1. Decentralisation in theory

Peckham et al (2005) identified the diversity of academic approaches and the problems that this diversity poses:

“There is an extensive literature on decentralisation, centralisation and devolution that covers a wide range of disciplines including politics, public administration, health services research, economics, management, sociology and organisational studies” (p.22).

Given the multi-disciplinary nature of this literature and the use of a wide range of definitions, analysis of decentralisation is inevitably problematic. Here, a selective account of the literature on decentralisation is presented, not least because (a) the authors conducted an extensive review of the literature (prior to this study; Peckham et al, 2005 and Davies et al, 2005), (b) the focus of this study goes beyond decentralisation, and (c) space does not permit an fuller examination in this report. In particular, it seeks to draw out from the decentralisation those aspects of primary relevance to the themes, *viz.* autonomy, incentives and performance.

Bossert (1998, p.1513) points out that ‘a comparative analytical framework should provide a consistent means of defining and measuring decentralisation in different national systems.’ Here, we focus only on the English health system. However, many commentators agree that there are problems of defining and measuring decentralisation (eg Atkinson 1995; Gershberg 1998; Hales 1999; Levaggi and Smith 2004; Saltman et al 2003, 2007). These problems are four-fold.

First, as Gershberg (1998: 405) put it, the concept of decentralisation is a slippery one; a term - like ‘empowerment’; or ‘sustainability’- empty enough on its own that one can fill it with almost anything. The term of decentralisation has been used in a number of disciplines such as management, political science, development studies, geography and social policy, and appears in a number of conceptual literatures such as public choice theory, principal-agent theory, fiscal federalism and central-local relations. It has links with many cognate terms such as autonomy and localism that themselves are problematic (Boyne 1993; Page 1991; Pratchett 2004; Saltman et al 2007; Stoker 2004).

Second, Bankauskaite et al (2007) summarise the literature’s deficiencies in terms of measurement. It fails to address the measurement of decentralisation (as a state and a process), the measurement of the outcomes of decentralisation in health-

care, and comparison of decentralisation between countries. (It might also be that the literature does not consider fully other spatial and temporal scales) (p.11).

Third, much of the literature refers to elected local government with revenue-raising powers. Application to a national health service which is appointed and receives its revenue from central grants is problematic. As Klein (2001: 106) puts it, 'everybody paid verbal homage to the principle of decentralisation, but how was this going to be achieved in a nationally-financed service?' Applicability of such literature to the English health system is therefore limited.

Fourth, the literature also fails to account for new political and organisational contexts. Emergent governance relations in new organisational settings provide a new context in which decentralisation is being played out. New forms of horizontal government (such as joined-up government and executive agencies at national level) and local partnerships (such as managed clinical networks) provide a radically different policy and organisation context from previous version of decentralisation.

These four analytical problems are clearly evident in the way in which different disciplines and conceptual frameworks have sought to understand and explain decentralisation. However, they have been addressed in contrasting ways. First, the case of New Public Management (NPM), for example, illustrates the evolving interpretation of organisational and policy contexts. Decentralisation has, since the 1980s, formed a key strand of NPM and its variants. For example, in a publication by the World Bank (which has heavily promoted decentralisation), Preker and Harding (2003) argue that

"Organisational reforms in hospitals include those which move "public hospitals out of the core public bureaucracies and transform them into more independent [ie. autonomous] entities responsible for performance, keeping ownership in the public sector" (p.6)

These reforms have also involved the separation of strategic and operational functions (akin to 'steering' and 'rowing'). Whilst similar to separation in other sectors and industries, the distinction by Osborne and Gaebler (1992) has been applied to executive agencies (Pollitt et al, 2004). Vrangbaek (2007) argues that the principles of 'reinventing government' (advocated by Osborne and Gaebler) promoted an entrepreneurialism with the aim of greater innovation, experimentation and responsiveness (p.56) but require the stimulation of appropriate incentives (p.67).

The strategic / operation distinction has also coincided with novel applications (and combinations) of governance forms: hierarchies, markets and networks. Exworthy et al (1999) noted the co-existence and interaction between these forms. Traditionally, hierarchy is associated with vertical (central-local) relations and networks with horizontal (local-local or central-central) relations. Attention has tended to focus on vertical relations with some seeing markets (privatization) as a form of decentralisation (Rondinelli, 1983). However, Vrangbaek's (2007) analysis has also considered networks but he notes ambiguities found elsewhere and at other times in the analysis of decentralisation:

"The issue of network-based governance form is somewhat problematic for typologies of decentralisation.... Responsibility and accountability tend to be somewhat blurred in network structures... Networks may include central and decentralised public actors as well as private actors" (p.50).

Certain features of NPM reforms were also implemented at or around the same time of successive waves of decentralisation. These reforms included:

- cadre of managers,
- competition within market-style relations,
- greater private sector involvement, and
- strategies to respond to consumerist users.

For decentralisation to be effective, it has relied on some/all of these features. For example, decentralisation – disaggregating former units into smaller ones – has been facilitated by the introduction of cadre of managers to run these 'new' units which are in competition with each other.

Ferlie et al (1996) identified four types of NPM, one of which could be termed the "Decentralisation model." Ferlie and colleagues saw this form of NPM as part of the move towards post-Fordism which has entailed a "shift for flexibility and the unbundling of vertically integrated forms of organisation" (p.12). The 'decentralisation' model of NPM is characterised by:

- Introduction of quasi-markets,
- "Move from management by hierarchy to management by contract",
- "Split between a small strategic core and a large operational periphery",
- "Delaying and downsizing",
- "Split between public funding and independent sector provision",
- "Move from the command and control form of management... to new management styles", and
- "Attempt to move away from standardised forms of service to a service system characterised by more flexibility and variety" (Ferlie et al, 1996, p.13).

Likewise, Mattei (2009) is careful to distinguish variants of NPM. She notes, however, that decentralisation reforms are distinct from those of quasi-markets:

"The strand which deals with managerialism is concerned with hands-on management, autonomy, clear objectives and performance; it is different to the strand related to new institutional economics, which is based on competition, public choice and transaction costs analysis..." (p.65).

It is such a context that decentralisation has been deployed to explain and justify such state restructuring and organisational change.

Second, a well established discussion of decentralisation distinguishes between deconcentration, devolution, delegation and privatization (Rondinelli, 1983). Deconcentration transfers authority to different jurisdictional levels within the

central government. This is the case, for example, of the creation of local or regional offices of a central government ministry. Devolution is the transfer of authority from the central government to local structures within the public administration. This type of decentralisation includes the transfer of specific powers from central government to states, provinces or municipalities. Delegation is the transfer of government authority over specific tasks to semi-autonomous agencies (e.g. arm's length bodies). Finally, privatisation, often understood as a sub-type of delegation, grants responsibilities and in some cases ownership to private organisations.

While the Rondinelli's framework is helpful in describing the institutional arrangements of decentralisation on the basis of the recipients of new powers and authority, its interpretative power is limited in several respects. First of all, it focuses on organisational recipients and therefore does not accommodate institutional arrangements that entail decentralising to individuals, being patients or professionals. Second, the classification overlooks the "what" (Mills, 1994) of decentralisation, does not explicitly address the role of the centre and the decentralisation/centralisation continuum. Furthermore, although some authors view the above categories as representing different degrees of administrative autonomy measurable through a set of indicators (e.g. Schneider, 2003), the framework does not clearly conceptualise nor operationalise the autonomy (space or freedom) available to local decision makers as a consequence of streams of decentralisation and centralization (Bossert, 1998). Therefore, the Rondinelli framework is not useful to assess the impact of decentralisation on local autonomy and ultimately on performance.

Other frameworks have been developed that (in different guises) provide descriptive accounts of the institutional arrangements of decentralisation. (See, for example, Burns et al, 1994; Hambleton et al, 1996; Pollit et al, 1998). For example, Burns et al. (1994) argued that

"It is helpful, in discussions about local government, to distinguish two types of decentralisation. On the one hand, it is used to refer to the physical dispersal of operations to local offices. In a second sense, it is used to refer to the delegation or devolution of a greater degree of decision making authority to lower levels of administration or government. In common usage, these meanings are sometimes combined." (Burns, et al., 1994: 6)

In contrast, Hambleton et al. (1996) identified four broad categories:

- geography-based: physical dispersal
- power-based: decision-making authority
- managerial: improving the quality of services
- political: enhancing local democracy.

These themes are echoed in the work by Pollitt et al. (1998) who identify three categories with binary options:

- politics (authority decentralised to elected representatives) – administration (authority decentralised to managers or appointed bodies)
- competitive (competitive tendering; non-competitive) - agency given greater authority to manage its own budget

- internal (decentralisation within an organisation) – devolution (decentralisation to a separate, legally established organisation).

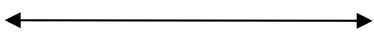
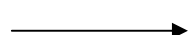
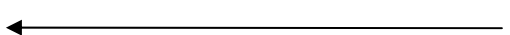
The frameworks however suffer from similar weaknesses. Similarly to the Rondinelli’s framework they are concerned with describing the institutional framework of government or administrative systems and do not provide guidance in terms of interpreting and understanding the effects of decentralisation on autonomy and performance, *inter alia*. In addition, they do not capture the co-existence of decentralisation and centralisation and the place of the individual within the health care system as clinician, health care practitioner or patient.

In summary, this decentralisation literature provides inadequate insight into the properties being decentralised, the organisational and spatial dimensions of such decentralisation (such as the extension of decentralisation to individuals, under the English ‘Patient Choice’ policy or vouchers for direct care payments) and changing role of the centre (such as the emergence / reconfiguration of multiple centres in the form of regulatory and inspection regimes). Overall, these multiple perspectives and paradigms (that have tended to dominate writing and commentaries on decentralisation) have often been conducted in parallel, rather than building on each other. Thus, relatively few attempts to operationalise notions of local autonomy within the context of decentralisation have emerged.

2.1.2. Towards a new framework of decentralisation

As previously argued, traditional decentralisation frameworks miss some of the complex shifts of decentralisation and centralisation in contemporary UK health policy. We claim that the ‘Arrows Framework’ (Peckham et al 2005, 2008; See figure 2.1) helps to examine this complexity. We claim that our framework has four main advantages. First, it is linked to wider concepts (such as personalisation of public services and internationalisation). Second, it focuses on content of decentralisation (the ‘what’ issue). Third, it identifies the scope of decentralisation (from where to where?). Fourth, it allows some progress towards very crude measurement, but accepts that simple uni-dimensional measures cannot capture the essence of a complex and multi-dimensional concept.

Figure 2.1. Arrows framework

Examples of levels Activities	Global	Europe	UK	England	Strategic Health Authority	Primary Care Trust	GP Practice /local	Individual
Input	<p>Payment by results </p> <p>Practice-based commissioning </p> <p>Professional regulations on employment </p>							

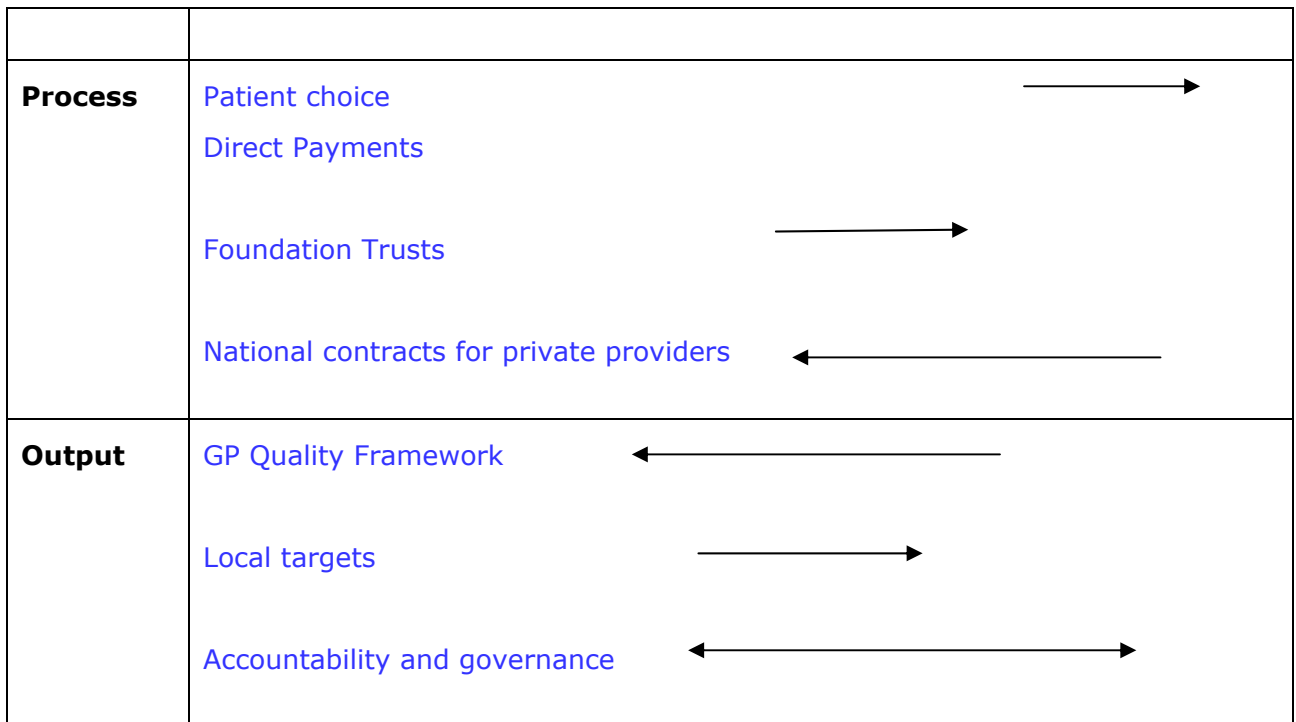


Figure 2.1 shows that decentralisation can be seen in terms of familiar concepts of inputs, process and outputs in an 'I*P*O configuration' (cf Hales 1999). Fiscal decentralisation relates to inputs such as the Government's claim that the NHS has been decentralised because PCTs spend a higher proportion of NHS money. Input decentralisation is the least radical. It gives more money, but may not devolve any power or increase autonomy. For example, if local bodies are constrained to spend their money in certain ways (earmarked or ring-fenced finance) or have to meet certain central targets (eg waiting lists) then local discretion, autonomy or 'decision space' is not increased.

Process decentralisation relates to mechanisms. For example, patient choice and 'Direct Payments' decentralise decisions about treatment to the individual. However, on the other hand, bodies such as the National Institute for Clinical Excellence and policies such as National Service Framework locate decisions at the national level.

Outcome decentralisation relates to targets. Inspection and regulation by bodies such as the Healthcare Commission and Monitor and policies such as performance management (eg the 18 week target) stress national decision making. Very broadly, recent policies suggest input decentralisation, but a mix of process and outcome *re-centralisation* (Peckham et al 2008).

Another interpretation of the Arrows framework in terms of autonomy can be seen as the balance between vertical autonomy and horizontal autonomy. Whilst governments often like to stress their policies in terms of decentralisation, this is often only in terms of vertical autonomy (from the centre). It fails to account for horizontal autonomy (in terms of the latitude from / between other local organisations). Arguably it is both vertical and horizontal autonomy that is required to maximise the decision space / room for manoeuvre locally. In preparing for this study, the team heard of one NHS manager whose three star NHS Hospital Trust


had as much autonomy as the Department of Health could offer (at the time); vertical autonomy was maximised. However, the local decision space was small because the PCT (upon which the Hospital Trust relied for funding) operated a budget deficit. Hence, horizontal autonomy was limited. According to this NHS manager, the organisation's autonomy (both vertical and horizontal) was deemed to be low.

The Arrows framework has resonance with the model proposed by Vrangbaek (2007). His model distinguishes between three activities (A-D-F):

- Arranging, planning and facilitating,
- Financing (revenue collection), and
- Delivery (in terms of ownership, distribution of risk and profit) (p.55).

These could be located along the central-local continuum, as shown by table 2.1.

Table 2.1. Governance structures: examples of institutional forms for different health service functions.

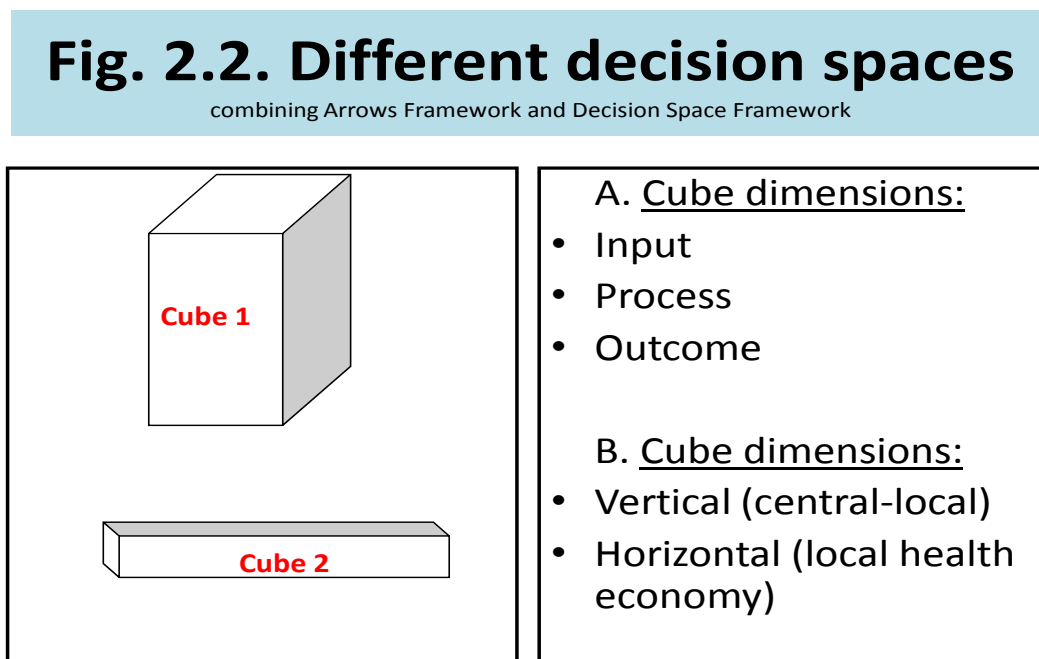
	Responsibility for arranging, planning and facilitating	Financing of health services (revenue collection)	Delivery: ownership, distribution of risk and profit
Central 	<ul style="list-style-type: none"> • National planning system • Formal national assignment of rights and obligations • Centralised agreements • Regional planning and networking • Local / municipal planning and networking • Market interaction • Individual choice of insurance or treatment facility 	<ul style="list-style-type: none"> • National taxation • Mandatory contribution to national sickness fund • Regional taxation • Mandatory contribution to regional sickness fund • Local / municipal taxation • Mandatory contribution to local sickness fund • Voluntary contribution to sickness fund / insurance company • Out-of-pocket payment to providers 	<ul style="list-style-type: none"> • National health system • State ownership and control • Regional ownership and control • Local / municipal ownership and control • Private organizations having contracts with public authorities or sickness funds • Private independent service delivery
Local			

Source: Vrangbaek, 2007, p.55

Vrangbaek's model makes a similar assumption to the Rondinelli model in that private sector involvement is considered a variant of decentralisation. It is also similar to the Arrows framework (Peckham et al, 2005) in that it seeks to address the "what" of decentralisation although it does not clearly distinguish between the "who" of decentralisation – who cedes power and who are the recipients. Significantly, Vrangbaek does note, like Peckham et al, that individuals might be such recipients.

In addition to indicating the 'what' of decentralisation, the Arrows framework (with I-P-O) can indicate- at least heuristically- the degree of autonomy or 'decision space'. While the conceptual volume of decision space is shown by $I*P*O$, it is not possible to calculate its precise volume as the 'units' of decentralisation are not clear, and it is not clear whether the three dimensions should be equally weighted. In other words, the decision space is dependent on the constraints imposed by inputs, processes and outcomes, with the shape of the cube indicating the extent of constraint. For example, there is little constraint in the vertical dimension (input) in Figure 2.2. Financial resources are not a major issue, but the decision space is constrained by tight limits on process and outcome. Conversely, there is little constraint in the horizontal dimension (process) in Figure 2.2; local health organizations are not constrained by process or how to achieve results, but there are tight limits on inputs and outcomes.

Figure 2.2. Different Decision Spaces



1

Finally, most commentators (implicitly or explicitly) view decentralisation and decision space in vertical terms through a chain of command from the centre to the periphery. For example, the local government literature focuses on the degree of autonomy that local units have from the centre (eg Page 1991). However, according to Fleurke and Willemsse (2004: 535), decentralisation or the distribution of responsibilities is organised not only vertically but also horizontally (Exworthy and Powell 2004; Pollitt 2005). In the 'congested state' (Skelcher 2000) or 'governance' (Rhodes 1997), local competitors or partners can constrain the room for manoeuvre. Organisations must increasingly compete for resources with those with whom they must also collaborate. For example, a Hospital Trust with a *de facto* local monopoly may be able to provide poor levels of service with little effective threat of exit, and so has high horizontal decision space. A local health provider may not be able to provide a good integrated service because its social care partner is of low quality or has little real interest in partnership, and so has constrained decision

decision space. Hence, using figure 2.2 again, the dimensions of these cubes could also be seen in vertical and horizontal dimension; the former denoting central-local relations (the traditional configuration of decentralisation) and the latter denoting the horizontal relations with other organisations in the LHE.

While decision making over the allocation of resources has been devolved to local commissioners (viz. PCTs and Practice Based Commissioners), their space for making decisions about the use of such inputs is constrained by local factors in terms of existing patterns of resource allocation, decisions by other local commissioners etc. Thus vertically, decisions have been decentralised but the room for manoeuvre is limited. Conversely local commissioners may not have much vertical autonomy about what they should do but local conditions mean they have more freedom to decide how they achieve this (Hoque et al, 2004). An example here might be the delivery of diabetic services where there are clear national guidelines and service frameworks but patterns of service delivery may vary considerably depending on a range of local circumstances and clinician interest.

Putting these points together, it is not possible to regard autonomy or decision space in traditional one dimensional, vertical terms. Decentralisation needs to be viewed in three dimensions of inputs, process and outcomes, which combine to give different conceptual shapes and volumes of decision space. Furthermore, decision space can be constrained by horizontal as well as vertical relationships. It follows that individual periods and individual policies may contain a mix of centralisation and decentralisation, with different shapes and volumes of decision space cube. Frameworks for understanding decision space and autonomy are explored in the next section.

2.2. Autonomy

The long-standing interest in decentralisation within public sector reform and within academic communities has, in recent years, shifted towards policies and language that emphasise the development of autonomous organisations within the public sector. Autonomy, combined with some form of regulatory oversight, may enable governments to pursue many of the policy objectives attributed to decentralisation (such as efficiency) but represents a significant movement from the earlier approaches to public sector reform, inspired by neo-classical economics,

2.2.1. What is Autonomy and how might it be conceptualised?

The term autonomy has been widely used in organisational studies literature (*eg.* Andersen, 2000; Brooke, 1984). Often, it refers to autonomy from managerial oversight in the form of goal setting or supervision over operational decisions and therefore denotes greater discretion in common tasks and functions (McGrath, 2001). Christensen (1999) defines autonomy as the formal exemption of an agency

manager from full supervision by a superior authority (possibly, political oversight in the form of a departmental minister). For example, Barber *et al* (2000) note the impact of reduced goal autonomy upon the (diminished) ability to specify the organisational objectives at the outset.

(i) Organisational autonomy

Discussions about autonomy emphasise the fact that the (English) health policy granting autonomy to PCTs and (some) Trusts has been highly specific in relation to organisational performance. First, the agents being granted autonomy are organisations rather than individuals such as managers or service users. (There are some recent developments in granting autonomy to individual service users in the form of direct payments although Patient Choice best illustrates this). Whilst it may appear problematic to grant autonomy to individual managers or clinicians in an NHS context, it is worth recalling two approaches where individual autonomy has been apparent. First, professional autonomy, which ascribes discretion to clinicians, can be defined as the entitlement to diagnose, treat and refer the clinician's patient as s/he wishes within the limits of self-perceived competence and of the clinician's perception of patient needs and available resources (Harrison, 1999, p.50). Harrison sees autonomy as pervasive through much of the history of the NHS though its dominance has come under greater attack in recent years. He argues autonomy is evident in three domains: official commitment to its preservation, in the formal organisation of the NHS and critically, in the practice of management. Second, that Enthoven (1985) originally proposed in his internal market model that contracts should be between the commissioner and individual hospital consultants. This did not come to fruition in the 1990s, but it would be feasible to introduce further decentralisation to sub-organisational levels. If one sees general practice as a sub-organisational unit rather than an organization in its own right, it could be argued that PBC is one such form of further decentralisation. Programme budgeting within PCTs might be another example; here, the proportion of the PCT budget which is spent on different areas of care is determined. It could follow that the authority and responsibility (hence, autonomy, according to Vancil (1979)) for such programme areas is allocated to dedicated managers.

Given the high degree of inter-dependency between local NHS (and other) organizations, it might be possible to extend the notion of the decentralised unit of analysis to the LHE. Davies and Stamp (2001) from Addenbrookes Hospital had proposed the notion of an autonomous LHE in its proposal to create a 'Foundation Economy' based in the Cambridge area. Whilst the proposal was not accepted, it does indicate the potential for autonomy to be granted to different units. Indeed, the recent debate on system integration partly acknowledges this (Gleave, 2009). Granting autonomy to one organisation (and not another) in a highly inter-dependent system might compromise its autonomy and/or negatively affect the non-autonomous organisations. On the one hand, it could be argued that the autonomous organisation 'benefits' directly as a result of the difference in local (organisational) autonomy; it enjoys greater decision-making freedom in the absence of competition from others. Autonomy thus becomes a zero sum game in which one agent's loss of autonomy implies another's freedom. On the other hand, it could also be argued that it cannot enjoy autonomy precisely because it is so reliant on the cooperation of others (for patient referrals funding, joint programmes in, say, service delivery or staffing). This is an argument about inter-dependence. The local context, it is thought, will determine the degree to which local inter-dependencies shape the nature of autonomy (Exworthy, 1998). Some LHEs might be highly localised, with strong inter-dependencies and (as a result) contingent autonomy. Alternatively, other LHEs might be less localised, with weaker local ties.

In short, much will depend on how the LHE is defined, the extent of local (social and institutional) embeddedness including the degree of trust, reciprocity and mutuality between local organisations (see 1.4.). Therefore, it might be disingenuous to assign autonomy to one organisation when it is reliant on others to achieve its performance.

(ii) Conditional autonomy

The second aspect of recent health policy in this area has been the emphasis on autonomy, conditional upon performance. Hence, decentralisation is not a 'blanket' approach, granting greater freedom in decision-making to all organisations; some public policy programmes have adopted this approach. However, as the performance culture in the public sector has taken hold (along the lines of the NPM (Ferlie et al, 2005)), autonomy (through decentralisation) has become much more contingent upon previous performance (according to national/central performance parameters). Thus, high performing organisations, the general policy approach posits, have demonstrated their ability to be responsible for their own governance and conduct, and are thus eligible to be granted more freedom in their decision-making. Equally, low performing organisations cannot be trusted in the same way. If good performance is not random over time but tends to persist (Mannion et al, 2005), then those organisations that exercise greater autonomy will be better performing organisations and so any simple comparisons between autonomous and non-autonomous hospitals will tend to favour the policy of autonomy (Anand, 2009).

This logic might be represented thus: performance (time period 2) is a function of the autonomy (enjoyed in time period 1) and the incentives available to the organisation.

$$P^{t2} = A^{t1} * I$$

Where P = performance, A= autonomy and I = incentives

However, such logic begs the question: if autonomy is such a panacea of organizational sclerosis and rigidity, how can poorly performing organisations acquire sufficient 'space' to improve their performance? By definition, such organisations cannot improve because their autonomy is low. However, this assumption is based on particular notions of performance and autonomy which, will be shown later, require elaboration.

(iii) Conceptual bases of autonomy

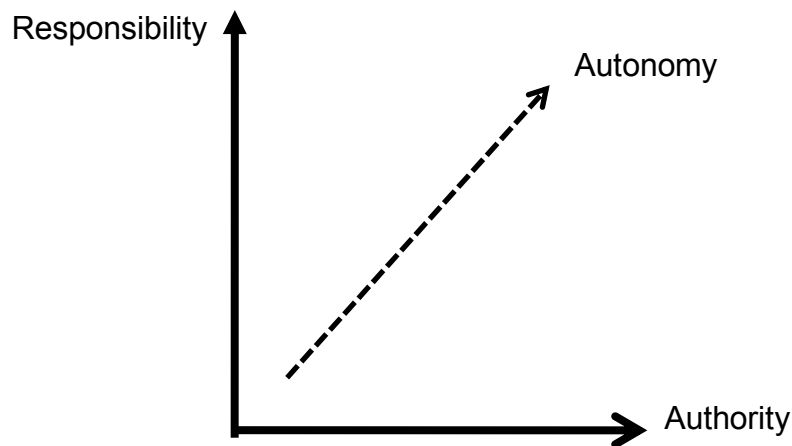
Three broad sets of theories offer conceptual justification for autonomy to organisations. First, 'political' justifications for autonomy tend to orient around the key trade-off for political actors in institutional design which is the desire to steer local agents towards the production of politically desired outcomes whilst, at the same time, withdrawing from responsibility (particularly blame) for operational issues which they cannot control in much detail. This steering / rowing distinction is the hallmark of Osbourne and Gaebler's (1992) thesis. This may be a tacit recognition that the centre never did or could 'command and control' but rather 'exhorts and encourages' (Mohan, 1995; Powell, 1998). From a political perspective, autonomy is often aimed at inputs and processes whilst offering the prospect of some outcome control. Moreover, decentralisation (linked to autonomy) offers the possibility of making more explicit tensions within policy: for example, it may enable

centralisation of credit and decentralisation of blame thereby diffusing blame of systemic issues - a policy of divided and rule.

Some explicit accounts of local autonomy in the context of decentralisation come from the literature on local government. For example, Hudson (1993) discusses the "capacity for local action" which can be "operationalised by four roles local government can play. These roles range from facilitating or accommodating local economy... and stimulating it... to activating economic activities... and interventions in the local economy..." (quoted Fleurke and Willemse, 2004, p.535). The democratic / political mandate of local government inevitably shapes the nature of how decentralised powers are exercised which Cole and Boyne (1995) conclude can lead to fragmentation and concentration. Similarly, Fleurke and Willemse (2004) refer to the "policy space left to local government's own discretion" (p.527). In his book "Decentralisation: managerial ambiguity by design", Vancil (1979) was concerned with what was being decentralised. His view was that 'real' decentralisation is marked by the degree of autonomy in organisations – the extent to which organisations have a high degree of authority over particular functions and activities with limited responsibility (or accountability) to others (see figure 2.3.).

Figure 2.3. Vancil's model of autonomy

Fig. 2.3. Vancil's model of autonomy
Vancil (1979)



Second, the 'economics' justifications for autonomy within the public sector comprise a relatively novel application of established principles. These economic theories focus on the rationality of actor behaviour and the efficiency of the resulting outcomes. The neo-classical theory of production and markets, for example, specifies conditions under which inputs are used and outputs produced in ways that are optimal with respect to preferences (x-efficiency) and it is assumed that government or other centralised interventions impose constraints which

prevent agencies from achieving optimal outcomes. A second related and widespread application (Propper, 1995) is the theoretical approach of principal-agent analysis. Here, the emphasis is on the reasons why bureaucrats might not conform to what citizens or politicians desire. This analysis has encouraged the development of proposals that often amount to the refinement of economic incentives through, *inter alia*, the introduction of performance related pay or the promotion of (market-based) competition.

The theoretical tenets of this approach lie in the fiscal federalism literature, which has its roots in economics and in particular in Oates's (1999) decentralisation theorem. It offers an account on the financial dimension of local autonomy. The main argument is that all public goods and services for which there are no economies of scale and no spillovers across jurisdictional boundaries should be provided and funded by the local level of government. The assertion is based on the assumption of highly mobile households who "vote with their feet" and local authorities that compete to attract them by making choices tailored to local tastes thus maximizing social welfare.

This framework focuses on the outcomes of decentralisation in terms of social welfare and offers a conceptualisation of how local authorities use their autonomy and of local decision making dynamics (Bossert, 1998). However this conceptualisation is only a partial account of local autonomy. First, the framework limits its analysis to the fiscal dimension of decentralisation and therefore does not allow an analysis of the range of 'choices' available to local authorities as a consequence of streams of decentralisation and centralisation in different functions. This weakness limits its applicability to context such as the NHS where the fiscal dimension (at least in terms of revenues) is not the dominant aspect of decentralisation policies. Second, by assuming rationality of local actors, it neglects the effects of local contingencies and context on the exercise of autonomy.

Drawing on Saltman and Bankauskaite (2006) and Verhoest et al (2004), four types of efficiency can be identified which can be conceptualised in terms of their impact upon different types of autonomy.

- Service Provision: providing the 'right' mix (quantity and quality) of health goods and services
- Input Mix: using an economically appropriate mix of resource inputs to produce goods and services
- Technical Efficiency: using all resources without waste
- Dynamic Efficiency: adopting new technologies

Employing three basic categories of autonomy – political, managerial and fiscal – it is possible to hypothesise the intuitive impacts of autonomy, as one form of performance (table 2.2).

Table 2.2. Autonomy-Performance Matrix

Type of efficiency	Political autonomy	Managerial autonomy	Fiscal autonomy
Service offering	Possibly substantial impact	Possibly minimal impact	Impact likely to depend on political autonomy

Input mix	Impact depends on incentives	Possibly minimal impact	Possibly substantial impact
Technical efficiency	Impact depends on incentives	Possibly minimal impact	Possibly substantial impact
Dynamic efficiency	Impact depends on incentives	Possibly minimal impact	Possibly substantial impact

Tentative conclusions can be drawn from this table. Managerial autonomy is the least likely type to have significant impact on any of the efficiencies. However, whereas political autonomy is most likely to impact on appropriate service provision, fiscal autonomy seems most scope for allowing the service offering and input mix to be determined by local level actors.

The assumptions underpinning the exercise of autonomy in practice can also be found in neo-institutionalism including principal-agent theory (Anand, 2009) and in political science which draws on notions of autonomy in the analysis of local democracy (Stoker, 2006). This theoretical approach focuses on the principal-agent analysis in which there is an emphasis on the reasons why bureaucrats might not do exactly what citizens or politicians would wish (Propper, 1995). This analysis has encouraged the development of proposals that often amount to the sharpening of economic incentives, for example by the introduction of performance related pay or the promotion of inter-organisational competition.

Third, the justification for autonomy also draws on organisational studies; the concept of autonomy is widely used in the study of public organisations. Verhoest *et al* (2004) note the problems of attribution and data quality in such research (p.102). They conclude that three studies of autonomy focus on legal aspects of autonomy, on organisational dimension and on managerial / economics aspects. Verhoest and colleagues devise a conceptual model of autonomy which distinguishes between (i) autonomy as the level of decision-making competencies, and (ii) autonomy as the exemption of constraints on the actual use of decision-making competencies (see table 2.3.).

Their first type of autonomy relates to the discretion which organisations have in determining what they believe to be important. In the classic hierarchical organisations, agents receive instructions from higher authorities but yet, will have some discretion in the ways in which they conduct and enact these roles and functions. Such discretion can be sub-divided into managerial autonomy and policy autonomy – the former concerns exemptions from rules and regulations whilst the latter refers to the decisions about how it can manage inputs and achieve outputs.

The second type of autonomy relates to the influence that governments (as superior authority) have over local agents. Christensen (1999) considers such influences in terms of

- *Structural autonomy*: “the extent to which agency is shielded from influence by the government through lines of hierarchy and accountability” (Verhoest *et al*, 2004, p.105)
- *Financial autonomy*: the reliance on government for funding
- *Legal autonomy*: the legal status of an agency as a an independent body

- *Interventional autonomy*: “the extent to which the agency is free from ex post reporting requirements, evaluation and audit provisions with respect to decisions and their outcomes” (Verhoest *et al*, 2004, p.106). If an organisation knows that its performance will be tightly controlled ‘from above’ (including the threat of sanctions if it does not perform), then it is likely that its actual and perceived sense of autonomy will be much reduced. Likewise, Hoque *et al* (2004) note that the goals externally set by central government are sufficiently numerous that autonomy may have limited bite; thus, the interventional autonomy is highly circumscribed.

Table 2.3. Taxonomy of autonomy

Autonomy as...	Type	Definition
Decision-making competencies	Managerial autonomy	“Ex ante control on inputs by rules and ex ante approval of decisions or involvement in decisions concerning management of financial, human and organisational resources.”
	Policy autonomy	“Ex ante control on processes or performance control by specifying ex ante rules, standards and norms concerning (in order of high control to low control) (1) processes, (2) policy instruments and (quantity and quality) of outputs, (3) and objectives and effects.”
Exemptions on the constraints on the actual use of decision making competencies	Structural autonomy	“Control by influencing the agencies’ decisions through hierarchical and accountability lines towards the agency head or through the supervisory board”
	Financial autonomy	“Control by influencing the agencies’ decisions by reducing or increasing the level of budget granted to the agency”
	Legal autonomy	“Control by changing the legal status of the agency”
	Interventional autonomy	“Control by influencing the agencies’ decisions by the means of reporting requirements, evaluation and auditing provisions against externally set goals and norms and by (the threat of) sanctions or direct interventions”

Source: Verhoest *et al*, 2004

In a similar vein, Mattei (2009) seeks to understand the significance for “managerial autonomy” of “accountability regimes.” She concludes that three aspects help explain the pattern of differences in such regimes (p.54-55): bureaucratic capacity, specialization and administrative coordination (see table 2.4.)

Table 2.4. Framework of accountability regimes

	Significance for managerial autonomy
Bureaucratic capacity	
Large structural capacity eg. Hospital	Strong capacity for autonomous planning, supporting managerial autonomy
Small structural capacity eg. secondary school	Fewer opportunities to initiate new strategies and to develop alternatives from central policy. Managers become agents of central control
Specialisation	
High fragmentation of tasks	Serious information deficit and conflicts over policy content. Demand for coordination pushes conflicts resolution higher up the hierarchy.
Low decoupling and de-specialisation	Weaker demand for internally centralised controls and managerial coordination
Administrative coordination	
Collegial	Decision-making occurs via negotiation and bargaining
Hierarchical	Decision-making occurs through command and control. Truncation of consultative layers.

Adapted from Mattei, 2009, pp.54-55

Analysis by Verhoest *et al* (2004) aids understanding of why the formal delegation of autonomy may not necessarily be realised in practice. They do so with reference to organisational performance. For example, organisations with similar structural autonomy (as in the case of FTs, for example) may have different levels of financial or interventional autonomy. Clearly, ambiguities, tensions and conflicts can and do arise when there are discrepancies between these different types of autonomy. As Verhoest *et al* (2004) argue,

“A lot of organisations report that they have high levels of policy autonomy but low levels of managerial autonomy” (p.111).

The work of Verhoest *et al* (2004) and Christensen (1999) provide a useful backdrop for applying notions of autonomy to the health service contexts. The previous work by the authors of this study (Peckham *et al*, 2005; Davies *et al*, 2005) also helps this process of translation. The work of Bossert (1998) and Mattei (2009) are also helpful in this regard. For example, Mattei (2009) distinguishes autonomy in terms of:

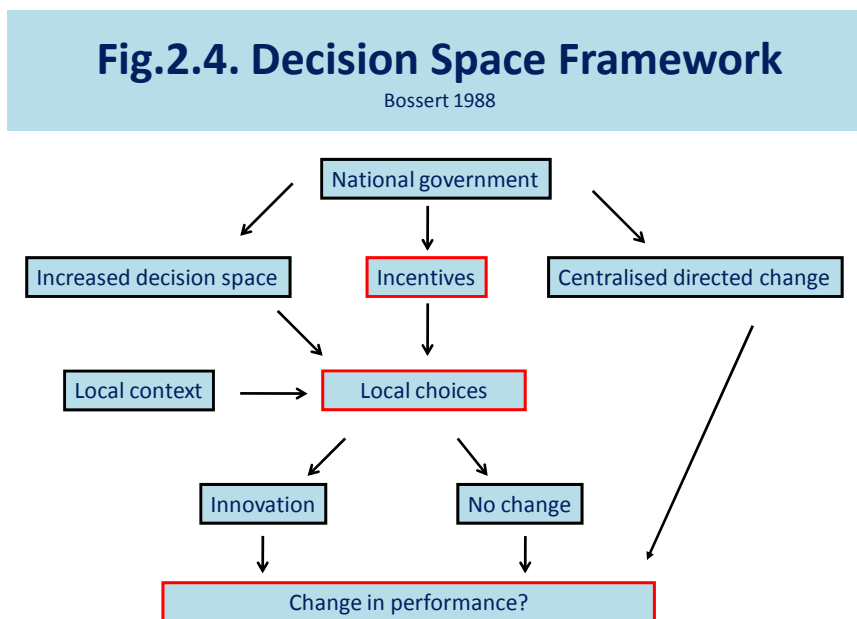
- Inputs: hiring decisions, investments and sale of assets
- Outputs: volume of services and mix of services provided
- Outcomes: public health targets
- Processes: strategic management, financial management, setting user charges, clinical management).

This distinction echoes the I-P-O configuration in the Arrows Framework (Peckham et al, 2005). In addressing the 'what' of decentralisation, the Arrows (I-P-O) framework (discussed earlier in this chapter) can indicate- at least heuristically- the degree of local autonomy or 'decision space'. While the conceptual volume of (vertical) decision space (autonomy) is shown by I*P*O, it is not possible to calculate its precise volume as the 'units' of decentralisation are not clear, and it is not clear whether the three dimensions should be equally weighted.

In the context of health-care organizations, Bossert (1998) provides a model of autonomy in terms of decentralisation. His 'Decision Space Framework' is a means to conceptualise the way in which the processes of decentralisation contribute to its apparent objectives, through the expansion of choice and hence, autonomy. Bossert's model seeks "to explain the interaction between national context and local context in shaping local decision making which, in turn, shapes the local (organisational) performance" (Exworthy and Frosini, 2008, p.206). It does so by distinguishing between three elements:

- "the amount of choice that is transferred from central institutions to institutions at the periphery of health systems,
- what choices local officials make with their increased discretion and
- what effect these choices have on the performance of the health system" (Bossert, 1998, p.1513).

Figure 2.4. Decision Space Framework



1

"Decentralisation inherently implies the expansion of choice at the local level" (Bossert, 1998, p.1518); this has particular applicability here in terms of autonomy. The (extent and type of) choices that are permitted by higher authorities (usually central government) through rules and regulations effectively determine the 'decision space' (or rules of the game) that is available to local organisations. Beside this formal local 'room for manoeuvre', there is also a *de facto* space that

arises from, for example, the “lack of enforcement of these formal definitions” (p.1518; see also Fleurke and Willemse, 2004, p.529). Clearly, the boundary between formal and informal decision space may be subject to conflict and negotiation. For example, local organisations may challenge the decision space granted by central government. Bossert (1998) applies the decision space across functional areas (such as finance or human resources) and (for simplicity) defines the decision space in each of these areas in terms of narrow, moderate or wide. The functional areas listed are those in which decisions are likely to affect the performance of the health system (loosely defined) in terms of objectives such as equity and efficiency. Arguably, Bossert’s framework “conceptualises local autonomy mainly in the context of vertical decentralisation” (Exworthy and Frosini, 2008, p.205); it does not address the local governance or organisational inter-dependencies, other than through the influence of “local context.”

Incentives are included in Bossert’s framework as a mechanism which falls outside the formal decision space. Comprising individual and institutional rewards and sanctions, these incentives might include the conditional nature of inter-governmental transfers (such as contingency funds) as well as “wide decision space itself” (p.1523) (such as professional autonomy). Sanctions might include governmental interventions. In short, the type and level of incentives affects the degree to which they contribute to shaping local decision making.

2.2.2. How is autonomy meant to work in practice?

This next part of this chapter discusses the theoretical underpinnings of the relationship between autonomy and performance. The relationships are underpinned by a set of assumptions and comprise incentives which reward or penalise local agents in pursuit of that particular objective. The following dimensions of performance are considered: technical efficiency, allocative efficiency and responsiveness, equity, accountability, and innovation.

(i) Technical efficiency

One of the assumptions is that autonomy leads to greater technical efficiency. Technical efficiency has been defined in various ways. For example, technical or productive efficiency is defined as the production of goods and services using the lower-cost combination of inputs (Hurley *et al*, 1995: 4). Kleinman *et al* (2002) state that technical efficiency refers to:

“...maximising outputs (ideally outcomes) per input. Improving technical efficiency is about reducing waste, duplication and poor management so as to maximise the productive potential of a given range of inputs.” (p.17)

Several rationales underline the relationship between autonomy and technical efficiency. Theoretically, the allocation of decision-making authority shapes constraints, demands and opportunities for “particular forms of behaviour” (Hales, 1999, p. 839). In the classical bureaucratic hierarchical command and control arrangements, an actor receives instructions about what he/she is supposed to do

or has to ask for permission and approval before making decisions. This system serves the purpose of channeling the behaviour of the local manager towards desired actions or impeding undesired ones (Hales 1999; Thompson, 1993; Verhoest, et al, 2004). The allocation of decision-making authority to local managers changes these constraints and demands, creating a more "permissive" environment (Hales, 1999) in which local managers are free to experiment and innovate. In this new environment, decisions can be made quickly because local managers do not need authorisation or approval and the organisation is thus likely to be more adaptable and responsive (Child, 1977; Mintzberg, 1979; Vancil, 1979). Also, the removal of constraints and demands releases resources previously devoted to complying with central directions. Thus, autonomy implies less waste and a more efficient use of resources. Note that autonomy cannot guarantee efficiency gains. Decentralisation can also be inefficient as local (autonomous) organisations may not enjoy economies of scale and duplicate functions (that had been previously been conducted centrally).

Furthermore, the allocation of decision-making authority defines whether there is a mismatch between information and decision rights. In a classical bureaucratic hierarchical system, those who make decisions are likely to be far removed from critical information. The implication is that information has to travel up through the layers of the hierarchy to reach those who make decisions. Yet, those who make decisions would be unlikely to have all the relevant local information. Conversely, the allocation of decision rights to local managers places decision-making authority where the information necessary to make decisions resides (Mintzberg, 1979). As a result, information processing requirements in the face of an organization's limited information processing capacity are reduced (Galbraith, 1973; Scott, 2003). Since it does not require information to travel through limited processing channels (Galbraith, 1973; 1977), autonomy helps reduce the strain on organisational information processing capacity, thus increasing the efficiency of decision-making processes. Moreover, allowing decisions to be made by those who have information may facilitate the incorporation of local knowledge and experience in the decision-making process, thus favouring decisions that are more effective and responsive to local circumstances (Child, 1977; Vancil, 1979).

Finally, autonomy is viewed as a powerful motivator (Hales, 1999; Mintzberg, 1979). Therefore, local managers are likely to have improved morale and be more satisfied about their jobs (Child, 1977; Vancil, 1979; McKnight et al. 2001). As a result local managers may have a greater commitment to the decisions they make and have greater determination to see them through (Hales, 1999). This would include pride, sense of ownership and a stronger local affiliation to individuals (eg. managers) and the organisation.

(ii) Responsiveness and allocative efficiency

Responsiveness has been identified as a key outcome indicator for health care systems by the World Health Organization (De Silva, 2000; Gostin et al., 2003). This focuses on the extent to which health care systems meet the needs of those receiving health care. There are eight dimensions to the WHO's conceptualisation of responsiveness. The following dimensions are of interest here:

- autonomy to participate in health-related decisions,
- prompt attention,
- clarity of communications to patients,

- access to social support networks and family and community involvement, and
- choice of health care provider.

Responsiveness also suggests, however, that resources are allocated in accordance with the need. In economic terms, efficient allocation of health care is when the health care system is producing exactly the quantity and type of health care that society wants – in this sense being most responsive to the distribution of needs.

Responsiveness to local needs and priorities is a key consequence attributed to greater local room for manoeuvre. The main assumptions behind this claim is that greater local autonomy means that (a) decisions are made by those closer to and with a greater understanding of local needs, and (b) there is greater flexibility to adapt to these local needs and preferences and greater innovation. Therefore decisions are more likely to reflect local needs and priorities. However, as with efficiency, local autonomy does not guarantee that local agents will be more responsive. By virtue of their reduced structural distance between decision-makers and users, it is more likely that they will respond to local needs and preferences. However, if responsiveness is the objective, then the incentives for unresponsiveness need to be more explicit. Hence, users' decisions to exit the service, voice their concerns or remain loyal (Hirschmann, 1970) must have real consequences for organisations, if responsiveness is to be realised. Local autonomy would enable to do so.

(iii) Equity

Improved equity is often presented as a positive outcome of decentralisation. The notion of equity is important in discussion of autonomy because it relates to the degree to which local agents are willing and able to exercise their newly acquired discretion to respond to local needs, and in doing so, introduce variations in the nature and type of services delivered locally. This is especially pertinent given the traditional centralised nature of the NHS and the overt 'national' dimension of British health-care.

There are two basic assumptions concerning the impact of decentralisation upon equity but which contradict each other: one suggests that decentralisation improves equity, the other the converse. The first argument claims that decentralisation reduces equity (and/or increases inequality) by enabling greater variations / differences in access, provision or use (e.g. Kleinman et al. 2002, p.28; López-Casasnovas, 2001, p.18; Rubio and Smith, 2004, p.4; Levaggi and Smith, 2004, p.6). This argument is probably the more common thesis for decentralisation. This argument relies on local agents exercising their autonomy to vary from national/central norms and practices. This therefore assumes that there is a minimal central coordinating function.

The second argument claims that decentralisation increases equity (and reduces inequality) by giving local organisations the autonomy to respond more sensitively to the needs of previously marginalised groups (e.g. Bossert, 1998). As Levaggi and Smith, 2004) argue:

"Local governments may be better placed than national governments to ensure that resources are allocated equitably within their borders" (p.5).

Decentralisation might also achieve:

"Greater equity through distribution of resources towards traditionally marginal regions and groups." (Bossert and Beauvais, 2002, p.14)

To arbitrate on which argument can be sustained, one needs to recognise two caveats. First, there are multiple definitions of equity (used in policy documents) (Powell and Exworthy, 2003). The second concerns horizontal and vertical equity. Horizontal equity aims 'to treat like cases alike' (e.g. equal access for those in equal need) and vertical equity aims to treat 'different individuals differently' (e.g. allocating more resources to particular areas or groups; Powell and Exworthy, 2003, p.59). Third, much the debate hinges on where the goal of equity is pursued – at national or local levels. The impact of decentralisation upon equity depends on where equity is sought. It might deteriorate equity at the inter-group/area level but improve it at the intra-group/area level (Peckham et al, 2005). Fourth, the ability to exercise the autonomy generated by decentralisation may not be enacted. Local agents may be socialised into centralised norms of behaviour, be inclined to conform to national equity principles and/or be risk-averse.

Overall, Bossert's (2000) conclusion that 'decentralisation improves some equity measures but worsens others' is commonly cited. Likewise, Janovsky (1997) found 'no clear evidence' that decentralisation has increased equity. These conclusions hamper definitive conclusions about the equity consequences of decentralisation (Bossert and Beauvais, 2002, p.26).

(iv) Accountability:

Mattei (2009) argues that the NPM reforms which placed a central emphasis on "autonomisation" (p.35) also entailed a change in the political accountability of public services. She argues that this shift in accountability is highly patterned between sectors (say, health and education) and between countries. Traditional forms of public accountability had rested upon notions of elected representatives and/or a hierarchical line of (managerial) authority from the periphery to the centre. However, NPM reforms have tilted the balance of power away from such forms of accountability to a new regime in which local agents have greater autonomy (in certain domains) (Pollitt and Bouckaert, 2000).

Yet, new forms of centralisation are apparent which seems to replace one form of accountability for another. The rise of performance management has been a central plank of the NPM and transforms the role of the centre. Indeed, new organisations have been created to 'regulate the new relationships between the centre and the locality. In health-care, these include the Care Quality Commission (formerly, Healthcare Commission and prior to that, the Commission for Health Improvement and Audit) and the National Institute for Health and Clinical Excellence (NICE). These new central institutions have mostly focused on the control of performance (through the definition of what 'counts' as good/poor performance and the ability to institute corrective action, should it be needed). Significantly, the re-centralisation of power to the centre can, it might be argued, re-locate power away from elected

representatives to a managerial notion of performance, enforced by a regulatory regime and informed by expertise (in the form of research evidence). In order for health policy based around performance and autonomy to be effective, it might require the combination of local managerial ability and willingness together with "institutionalised bureaucratic systems" and incentives (Mattei, 2009, p.53). In short, decentralisation cannot work effectively without (some degree of) centralisation. In the absence of the former, decentralisation can become a mode of control by the centre – a system of 'divide and rule' among disconnected local agents.

The re-emphasis on centralisation is perhaps even more subtle than the re-formation of central institutions. The decentralisation of authority and responsibility to disaggregated units, as part of the NPM programme, has, to a larger degree, fragmented the coordination and collaboration that previously existed between local organisations. Hence, the 're-discovery' of the need for partnership, joined-up working, inter-agency cooperation and networks has occurred at around the same time that NPM reforms have taken effect. Whilst the ostensible aim of such local partnership working might be to improve "responsiveness" to service users and their needs, it does not necessarily follow that autonomy (acquired through decentralisation) would automatically generate such public responsiveness. Indeed, stronger partnerships could form a stronger institutional alliance to the detriment of service users. For example, the potential for 'surveillance' of individuals would be enhanced by such partnership. However, the reformed regime may not grant service users with sufficient 'resources' (eg. information) to hold autonomous agencies to account. Alternatively, autonomy could be used purely for organisational interests such as to maximise revenue, to protect their interests or to gain strategic advantage. To illustrate these points, Mannion et al (2007) found that chief executives of NHS organisations which were eligible for 'earned autonomy' did not seek autonomy necessarily for improving responsiveness to patients or the public. Rather, they sought much greater separation from the centre (in the form of performance monitoring and management) but also better access to policy-making machinery (presumably to influence it). There was some evidence that 'earned autonomy' would enable these chief executives to retain surplus to be reinvested for service developments. One opportunity of earned autonomy had been to 'take over' failing / poorly performing Trusts. This opportunity has become a possibility in 2009 with the East of England SHA allowing the take over of the Bedfordshire and Luton Health and Social Care Partnership Trust (<http://www.hsj.co.uk/comment/leader/takeover-is-a-test-run-for-nervous-bidders/5002017.article>; 28 May 2009) and with the announcement that the "Top primary care trusts will be able to take over poor performing PCTs as franchises" (<http://www.hsj.co.uk/news/primary-care/commissioning/best-primary-care-trusts-to-get-franchise-on-rest/5002615.article>; 11 June 2009) (see chapter 6). However, Mannion *et al* (2007) note that this aspect of autonomy has not previously been highly valued by managers.

Furthermore, greater autonomy can lead to exactly the types of decisions which might not be tolerated by the centre. Allowing for the potential for difference (under claims of 'responding to local need' or 'allowing managers to manage') creates the possibility that these variations may run counter to the ethos of the wider institution. For example, whilst the "post-code lottery" may be seen as an unfair approach to determining priorities in the NHS, it can also be seen as a logical outcome of a system where decisions are taken locally, to reflect local needs and preferences. Such discretion in local decision-making is, however, becoming increasingly circumscribed by national guidelines based on (apparently) sound evidence. For example, FTs have a list of 'regulated services' which it must provide

to NHS patients. Other limits of FT autonomy include a cap on the income from private patients, borrowing limits (security can only be given over unregulated assets), and close financial scrutiny (Allen et al, 2009). Moreover, managers may not wish to exercise their autonomy for various reasons including a lack of capability or capacity (to run their own affairs), a fear of the negative impacts upon partner agents/agencies, or an unwillingness to take the risks associated with greater autonomy (Hales, 1999; Exworthy et al, 2008). Hence, autonomy may assuage critics of unresponsive, bureaucratic organisations but it may (on its own) do little to enhance organizational accountability (Peters, 1992). Emergent evidence from Foundation Trusts seems to support this thesis. Aspects of public involvement, for example, have not been at the forefront of FT activity whilst most attention has been devoted by FTs' governance of financial and organisational matters (House of Commons, 2008)

(v) Innovation

Both decentralisation and innovation defy easy definition, being complex concepts with multiple categorisations (Hartley, 2008). Mattei (2009) argues that autonomy is an essential component of innovation which has the potential to improve the performance of health-care organisations. Indeed, this notion has much support in the academic literature. Decentralisation, it is claimed, creates incentives for innovation and experimentation (Hales, 1999; Levaggi and Smith, 2004, p.5, p.10; Malcolm et al, 1994; Oates, 1972). Osborne and Gaebler (1992) describe colourfully this opportunity for innovation:

"Innovation happens because good ideas bubble up from employees, who actually do the work and deal with the customers" (p.253).

However, the evidence in support of the connection between decentralisation and innovation is somewhat weak (Levaggi and Smith, 2004; Oates, 1999). Indeed, innovation, stimulated by decentralisation, might have adverse effects, as discovered by Moran (1994). Across the USA, UK, Scandinavia and Germany, institutional structures which encouraged innovation also generated health-care cost inflation. Moreover, as a publicly-funded health system, it might be seen as important to enable the lessons of innovation from (semi-)autonomous agencies to be shared with other publicly-funded organisations. This places a key role for the centre in fostering widespread adoption of innovation; indeed, Walker (2004) argues that many innovations are centrally-driven. This might also contradict a version of autonomy in which the benefits of autonomy accrue solely to the autonomous organisation; otherwise, there is a strong incentive to free-ride by poorly performing organisations.

Innovation is often sought to pursue a strategic advantage over competitors. However, organisations should be able to reap the rewards for such innovation if this aspect of autonomy is to be realised. (Equally, the logic follows that organisations which are not innovative should suffer the disadvantage). The case of recruitment and retention of staff is one example of such how autonomy may affect innovation. Staff turnover can also hamper efforts to introduce and sustain innovation as it disrupts patterns of social and organisational knowledge. Recent re-organisations in the English NHS have affected organisational memory. This problem is especially prevalent when "up to half of senior executives are likely to spend less than two years in the same post"

(<http://www.hsj.co.uk/news/workforce/startling-senior-executive-turnover-stifles-nhs-innovation/5002834.article>; 18 June 2009).

One way in which the notions of autonomy and innovations may be conceptualised is through Pettigrew and colleagues (1996) notion of 'receptive context.' Innovations, it is claimed, cannot prosper unless there is a conducive environment. Context, Pettigrew *et al* argue, refers to both the inner and outer context which concerns the internal organisational systems and the external environment. In this sense, innovation can be seen as an incentive by which autonomy can be translated into improved performance Walker and Damanpour (2008) claim that "the adoption of innovation is intended to contribute to the organisation's effectiveness [performance] by changing the adopting organisation so that it can respond to new conditions in its external environment" (p.220).

(v) The role of context

The discussion of autonomy and its relationships with performance so far views decision space mainly in vertical terms – the relationship between the centre and the locality. Though this dimension undoubtedly remains crucial, other scholars argue that decentralisation also needs to be viewed horizontally. As Fleurke and Willemsse (2004) state

"...decentralisation or the distribution of responsibilities is organized not only vertically but also horizontally" (p.535)

Putting these points together, it is not possible to regard autonomy or decision space in the traditional one dimensional, vertical terms. In terms of decision space, this is a function of the amount of autonomy allowed vertically. However, whatever the amount of vertical autonomy available, organisations are embedded in a local context where other organisations operate and are therefore faced with inter-organisational complexity (Exworthy and Frosini, 2008). The implication of this is that the characteristics of the local environment is likely to shape both the incentives an organisation faces and its effective room for manoeuvre, in turn influencing the outcomes of decentralisation. In other words, the ability and willingness to exercise autonomy and act upon incentives must take account of the local context and the degree of inter-dependencies in the locality. Ability to exercise autonomy may be derived from formal granting of this freedom but it may equally be derived from informal sources relating to trust. 'Lighter touch' performance management of a provider by an SHA exemplifies this. An unwillingness to exercise autonomy might be indicative of senior officials'

"view of risk (aversion to it) given their greater degree of financial exposure, the uncertainty associated with the new policy environment (including on-going features of centralisation) and the impact that their decisions might have upon other local organisations" (Exworthy et al, 2008).

In the context of decentralised health-care, Atkinson *et al* (2000) explicitly discuss the horizontal dimension of local autonomy in accounting for the "different spaces for autonomy" (p.626) in Brazil and the ability of local groups and individuals to

exercise their 'voice' in health planning and policy. In the context of health-care in Brazil, they argue that increased autonomy over decision-making plus participation from the local population will generate greater responsiveness to local needs, accountability and ultimately quality of care and social development.

In addition, the authors recognise that the local context, in terms of "social organisation and political culture" (p.626) influences the actual space available locally and the processes through which this space influences responsiveness, accountability and quality of care. In accounting for the "different spaces for autonomy" (p.626) in Brazil, Atkinson *et al* (2000) found three different aspects of local context that affect autonomy: sources of income, local government decisions, and capacity for information to inform planning. The processes through which autonomy works are in turn shaped by "personal and institutional influences", *viz.* management style, personalised leadership, individual and collective behaviour patterns, degrees of personal involvement, and commitment and continuity.

The horizontal dimension in analysis of decentralisation is further reinforced by two distinct perspectives: (a) governance and networks, and (b) inter-organisational dependencies. Both have implications for local autonomy and decision space. The governance literature refers the dynamic interaction between and co-existence of collaboration and competition (Exworthy *et al*, 1999; Newman, 2001; Rhodes, 1997). For example, to achieve their objectives, organisations must increasingly collaborate with other agencies, over whom they have no direct or immediate authority. Yet, at the same time, they must also compete with these other agencies for resources (eg. financial resources from government and human resources from the labour market).

The inter-organisational literature emphasises the influencing effects of (other) local organisations upon one organisation's autonomy. The main tenet of this literature is that organisations are embedded in systems of inter-dependencies that are generated by an organisation's need to achieve its objectives and survive (Pfeffer and Salancik, 1978; Thomson, 1967). These inter-dependencies vary in nature and intensity, including institutional linkages, financial flows, patient flows, and collaborative and cooperative initiatives (Oliver, 1991; Goes and Ho Park, 1997) and may be more or less intense, temporary or longstanding. Inevitably, to a greater or less extent, an organisation's autonomy is affected by these dependencies (Oliver, 1991; Pfeffer and Salancik, 1978; Milward and Provan, 1988).

Notwithstanding the inquiry into the interaction between human agency and wider structural forces, there is a growing literature on the role that context plays in shaping local decisions. For example, Pawson and Tilley (1997) identify outcomes (eg. performance) as the interaction between context (organisational and spatial) and mechanisms (such as decisions or policies). The configuration of context, mechanisms and outcomes are dynamic, interactive and specific. By contrast, Pettigrew *et al* (1992) describe the interaction between context, content and process. They distinguish between inner (local) and outer (national, structural) context. In terms of local autonomy, the decision space afforded vertically by government and horizontally by local organisations shapes both the context within which local agents make decisions and the content/mechanisms which are implemented (ie. the properties being decentralised or centralised). The resulting performance of local organisations can be seen as a function of both the formal metrics (eg. performance indicators) and the informal aspects (such as reputation).

In summary, decentralisation viewed in this way reinforces its conception as a process, not simply as a product. The processes of vertical and horizontal decentralisation and other local context dimensions define the “room to manoeuvre” available to local managers

The factors that comprise this local dimension of autonomy include the spatial and organisational characteristics of the LHE, financial status, embeddedness of social and institutional relationships, organizational capacity and centralised legacy (Exworthy and Frosini, 2008).

- *Spatial and organisational characteristics of the LHE:* The geographical context of organisations will shape their willingness and ability to exercise autonomy. For example, the 152 PCTs cover very different geographical areas. Some will cover urban areas with multiple local NHS and independent providers, often with more deprived populations.
- *Financial status:* The financial performance of local organisations, in a centrally-funded system with strong political involvement, might affect the decision space enjoyed by these organisations. Also, local organisations will vary in terms of their dependency on others for funding (through commissioning). Exworthy and Frosini identified “in one LHE in southern England (fiscal year 2005–2006)” that “one hospital provider received 38% of its revenues from the local PCT whereas the other two providers received over 80%” (p.209).
- *Embeddedness of social and institutional relationships:* Networks of individuals and organisations build up in LHEs over time to such an extent that they accumulate a high level of tacit knowledge that supports their decision-making, especially in areas which lack full or detailed information (Exworthy, 1998). Such networks can build trust, reciprocity and mutuality which may prevent departures from the status quo. Thus, despite autonomy, individuals and organisations may be unwilling to exercise such autonomy.
- *Organisational capacity:* Decentralisation creates a flatter organisational hierarchy with fewer tiers. As the centre ‘loses’ control (in some respects), it must reform itself by changing its systems of processes of control. Equally, the newly autonomous local organisations must develop the skills and competencies to exercise new decision-making powers. Often, these are lacking. Decentralisation could replicate small scale management arrangements in each autonomous unit, with a loss of overall coordination and higher transaction costs.
- *Centralised legacy:* Though many claim that decentralisation frees local managers from central control, many such managers remain beholden to the centre, either because they have become inured to centralisation, are risk-averse (in a new autonomous climate) and/or anticipate on-going centralisation (despite ostensible decentralisation). They may also reject the entrepreneurial spirit of decentralisation (not least because it has been closely associated with marketisation and other NPM principles). Local managers may thus feel that they are a bastion of bureaucratic rule and consistency in an increasingly variegated and diverse system. Such ideas have close conceptual and practical connections with convergence theories, path dependency and coercive isomorphism (Greener, 2002).

2.2.3 Autonomy and performance

Much of the literature that focuses on autonomy or decentralisation has demonstrated that there are a number of dimensions on which autonomy can be

measured and these generate different kinds (and levels) of autonomy. Some of the literature has deployed taxonomies of autonomy and/or decentralisation to illustrate this. These dimensions can interact in ways that give rise to a complexity that defies simple descriptive conclusions about the extent of autonomy or degree of decentralisation. Additionally, some of the literature has sought to determine the outcomes (and their determinants) of decentralisation and autonomy. The next section to this chapter explores the 'performance' dimension in detail.

The alignment of autonomy with performance is significant because it is founded on an apparently unambiguous definition and measurement of performance. The development of earned (conditional) autonomy and Foundation Trust status in the NHS are variants of the traditional justifications of decentralisation generally and autonomy specifically. The policy initially began (DH, 2000) in terms of earned autonomy for 3 star Trusts but since June 2004, has expanded into Foundation Trust policy. In time, this is expected to cover all NHS Trusts. As of June 2009, 121 Trusts had acquired FT status, over 50% of all NHS Trusts. Acute Trust account for 52 of the 120 FTs and the SHA with the most FTs is the North-West (24) whilst South-East Coast only has 6 FTs. (<http://www.monitor-nhsft.gov.uk/>).

By offering NHS Trusts that perform "well" the opportunity to become more autonomous, central government (in theory) allows 'room' for growth as autonomous Trusts are allowed to expand their activities more freely. In practice, a regulatory regime (in the form of Monitor and Competition Panel) has been introduced which effectively limits this scenario. Equally important, the finance and organisational relationships within the LHE might inhibit such entrepreneurialism. The 'autonomy' policy also comprises an inherent selection bias; high performing Trusts have tended to be more likely to apply for FT status (not least because prior performance was one of the selection criteria). This bias complicates comparisons between FTs and non-FTs. This issue is very similar to the 1990s policy of Self-Governing Trusts and GP-fund holding according to which better performing group practices were in effect selected to be fund-holders thereby encouraging a conclusion that funding-holding was itself desirable (Anand, 2009). There may also be a political benefit in that the earning of autonomy could place more responsibility for autonomous status on Trusts themselves, thereby giving rise to fewer objections from the service itself; blame is thus effectively decentralised to autonomous agents. However, if all Trusts become FT, the concern with performance still remains (see above) unless the government is satisfied that overall performance is above a threshold/minimum.

2.3. Performance

This section considers the significance of performance in managing the relationships within LHEs. It outlines the way in which notions of performance have become central to the management of the NHS, locally and nationally. It presents a distinction between formal and informal influences upon performance. The conceptual analysis provides a more nuanced understanding of the ways in which local agents understand and act upon information relating to the performance of their and other organisations. These issues are explored in relation to empirical evidence in chapter 4.

2.3.1. Decentralisation and performance

Bankauskaite and Saltman (2007) argue that “the evidence regarding the ability of decentralisation to achieve its objectives is complex and ambiguous” (p.15). The ‘performance’ of decentralisation is not straightforward, not least because decentralisation itself is a complex concept, and is heavily influenced by contextual factors.

Peckham et al (2005) examined decentralisation in terms of its performance of the following nine dimensions: outcomes, process, humanity, equity, staff morale and satisfaction, allocative efficiency (responsiveness), adherence (to guidelines), technical (productive) efficiency, and accountability. The assumptions underpinning the association between each measure and decentralisation, the theoretical propositions and the quality of evidence is enumerated in table 2.5.

Table 2.5. Decentralisation and performance in health services: assumptions, theoretical propositions and quality of evidence

Performance measures	Assumptions			Theoretical propositions			Quality of evidence		
	I	P	O	I	P	O	I	P	O
Outcome measures	+	-	+	✓	✓	✓	+	+	+
Process measures	+	+	+	?	✓	?	/	+	?
Staff morale	+	+	+	?	✓	✓	/	?	-
Humanity	?	+	?	/	/	/	?	?	-
Equity	-/+	-/+	-/+	✓	✓	✓	+	+	+
Alloc. efficiency	+	+	+	✓	✓	✓	?	?	++
Tech. efficiency	+	+	+	✓	✓	✓	++	+	+
Adherence	-	-	-	?	?	✓	?	?	+
Accountability	+	+	+	✓	✓	✓	?	/	++

I/P/O: Input / Process/ Outcome

Assumptions: +, Improved organisational performance; -, worsened organisational performance; ?, unclear.

Theoretical propositions: ✓, Support the assumptions in previous column; ?, no clear link between theory and assumption; /, no theoretical proposition.

Quality of evidence: Evidence: ++, strong; +, moderately strong; -, moderately weak; ?, mixed quality; /, insufficient.

Source: Peckham et al, 2005, p.78

Vrangbaek (2007) presents “performance-related arguments for decentralisation” (p.64). He divides these into (dis-)advantages of centralisation and decentralisation (p.68) and input / throughput / output (p.64) (tables 2.6. and 2.7.).

Table 2.6. Performance of centralisation and decentralisation compared

Centralisation advantages	<ul style="list-style-type: none"> • Provides clear steering signals • Facilitate standardisation of process and products • Improves predictability in organisational practice
Decentralisation disadvantages	<ul style="list-style-type: none"> • Risk of sub-optimality as decision entities focus on their own performance • Lack of coordinated steering impulses • Inappropriate diversity in practice and standards • Reduce comparability and predictability at system level

Source: Vrangbaek (2007)

Table 2.7. Performance-related arguments for decentralisation

Input-related	Clear link between decision-makers and user
	Differentiated services
Throughput-related / process-related	Efficiency: coordination problems occur with increasing size; facilitates use of knowledge and experience of local staff; improves flexibility; motivate employees
	Experimentation
Output-related	Empowerment: counter-balance to central power and decision-making

Source: Vrangbaek (2007)

In this section, the notion of 'performance' is not used at a macro level in terms of the effectiveness of decentralisation. Rather, the notion is considered problematic in itself. The focus is on the ways in which the performance of (semi-)autonomous organisations is managed and affected by incentives.

2.3.2. The centrality of performance in public management

It has become axiomatic that new public management (NPM) introduced new notions of performance which elevated the concept of efficiency to a pre-eminent position. Talbot (2005) argues that the "performance tide" is intimately linked with the trends of NPM in the latter half of the 20th century. Exworthy and Halford (1999) describe the aspects of NPM reforms which related to new parameters of performance:

"Significant changes have included the imposition of new arrangements of financial accountability and the measurement of effectiveness (Exworthy and Halford, 1999, p.3).

The evolution of NPM has, according to some commentators, evolved into a post-bureaucratic position whereby new forms of control are exercised (Hoggett, 1996). Such control has, it is claimed, been marked by more remote / distal agents, greater use of IT (transmitting the performance information) and the inculcation of behaviour and norms (by local staff) which effectively provide self-enforcement (Newman, 2005). Performance measurement and management can also be seen in terms of the wider group of strategies used by government to improve services. These include the use of competition, citizen / user engagement and organisational development (Hartley and Skelcher, 2008, p.12). Of these, only organisational development may be seen as internal, the others being external (Hodgson *et al*, 2007)

Notions of performance have been seen as critical to the NPM emphasis on improvement. NPM was accorded a revolutionary zeal by many politicians, policy-makers and some practitioners in being able to transform public services through a greater focus on managing performance. The professionalisation of many public services inevitably posed a challenge to the introduction of the NPM performance regime (Exworthy, 1994). Traditionally, professionals (individually and collectively) had been responsible for setting standards of acceptable performance, monitoring those standards and taking (remedial) action, where necessary. On all three counts, though to varying degrees, NPM challenged professions in managing 'their' performance. For example, by changing notions of what performance meant, public managers were also able to challenge professions. That said, professions have sought to re-present their practice in the light of public research evidence, largely as a counter-balance to managerial notions (Exworthy *et al*, 2003).

The NPM focus on performance in the last 20 (or so) years has involved the creation of new organisations and new processes (such as OFSTED in schools, QAA in Higher Education and Healthcare Commission (now Care Quality Commission) in health) (Hodgson *et al*, 2007). As a result of these, new institutions and processes, a series of "adaptive expectations" have been generated. For example, notions of 'quality' in general practice have become re-defined in terms of the Quality and Outcomes Framework (QOF). Whilst it could be argued that such performance systems open the possibility of 'gaming' (deliberate manipulation of data for ulterior purposes), it might equally be claimed that this behaviour illustrates the importance which practitioners place on such systems (Wilson *et al*, 2006).

Despite the on-going focus on performance as a tool of service improvement and managerial control, there have been significant shifts in the role that performance has played in most public services and notably health-care (Harrison, 2008):

- *Formative to summative*: Initially many performance schemes (such as medical audit) were developmental and educational. Such schemes have been more summative in becoming regulatory and managerial. The shift has thus been from 'teacher to cop.' Allied to this shift, the focus has moved from voluntary to compulsory schemes which have become more judgemental. This shift has been manifest since around 2000 when, for example, the star ratings were introduced.
- *Managerial motivation*: There has been a shift from intrinsic motivation to extrinsic motivation whereby the value of performance has ostensibly been for improving services. However, more recently, the extrinsic focus introduces more (possibly, nefarious) motives related to competition and income generation, for example.
- *Extensiveness*: Whereas performance measures were initially confined to administrative and organisational measures, there has been a growing reach of performance into more clinical domains. This has been most apparent with the introduction of the QOF in 2004 and more recently, by the publication of mortality data on the Healthcare Commission website (<http://2008ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance.cfm>) and NHS Choices (<http://www.nhs.uk/Pages/HomePage.aspx>). Similarly, in education, Wilson *et al* (2006) identify three types of performance measures: (i) level (the traditional "raw" data of output scores), (ii) changes (improvements of successive cohorts") and (iii) gains ("measure of progress in one cohort"). The third of these has measured "context value added." Alongside this development, there has been a shift from organisational to individual level data. Significantly, much of these data is no longer anonymised, but named. This extensiveness has been accompanied by greater ability to compare organisations.

- *Plurality*: Professional groups have largely lost the ability to retain control of their performance data not simply to managerial and regulatory groups but to the wider world in terms of patents and the media. Much of this plurality has been aided by Freedom of Information.

In defining the scope of “performance”, it is worth noting that attention has also been given to “conformance” – changes in performance against pre-defined standards. (Conformance might also refer to expectations and norms). Whilst this approach may have some appeal, it overlooks whether the standard itself is appropriate, whether current performance levels can be sustained and neglects the role of systemic / environmental factors (Hartley and Skelcher, 2008, p.10). Freeman and Peck (2007) identify tensions between, on the one hand, conformance (“careful stewardship of resources”) and performance (“strategic value through risk taking”), and on the other hand, between monitoring and control (vertical) and developing partnerships (horizontal)(p.911).

2.3.3. A history of performance in the NHS

The Labour government’s use of both performance measurement and performance management have now become a ubiquitous feature of the NHS (Greener, 2008a; Johnson, 2006). However, the idea of ‘performance’ has a much longer history and needs to be set in the context of understanding relationships between professional groups in healthcare and the state, as well as in terms of the changing role of administrators and managers in healthcare.

- *The creation and establishment of the NHS*

At the creation of the NHS, performance was not a concept that was considered as being of particular importance. Policy-makers, health-care professionals and health-care administrators were far more concerned with getting the newly created NHS to work than to deal with the finer points of how well it was being run (Honigsbaum, 1989). Klein’s analysis of the relationship between the state and the medical profession is of particular importance in understanding how the health-care system worked at this time. Klein (1990) uses the metaphor of the ‘double bed’ to show the mutual dependence of the state on the medical profession, which it required to run the health service operationally, and of the medical profession on the state, which had become with the creation of the NHS the *de facto* monopoly employer of the medical profession in the UK. This relationship came with a ‘concordat’, that the state would effectively leave the doctors to run health services as they saw fit, in return for accepting that the state be left to set the overall budget for the service. This does not mean that the relationship between the medical profession and the government of the day was a harmonious one (see for example, Ross, 1952), but it does capture the flavour of the prevailing dynamic of the NHS at the time of its creation.

The mutually dependent relationship between the state and the medical profession meant that the state effectively decentralised the running of health-care to the doctors left to run health services in their own specific organisation. Present day accounts of the history of health services (Ruggie, 1996; Secretary of State for

Health, 1997, 2000) have sometimes suggested that the NHS represented a 'command and control' system at its founding, but this view is entirely mistaken. Central policy-makers took responsibility for the results of the NHS – hence Bevan's aphorism about every dropped bedpan in the NHS ringing in the corridors of Whitehall – but they had very little idea what was going on in the hundreds of health-care organisations that represented the NHS, and very little practical means of control over them. The early years of the NHS were largely a case of the DH attempting to govern (by exhortation) via the use of circulars sent to health-care organisations, with very little idea of whether its requests were being carried out or not (Klein, 2006).

Within a decade of the creation of the NHS, the Conservatives had instigated an inquiry into the costs of health-care, prompted by the difficulties the NHS had encountered in remaining within budget in its early years. The resulting report of the Guillebaud inquiry (Ministry of Health, 1956) absolved the NHS of being profligate, but did make observations about the lack of information the government appeared to be receiving about the everyday activities of the NHS. It suggested that the Department needed to employ specialist health economists to begin to collect and analyse information, a recommendation that was acted upon, but still with remarkably little effect.

By the end of the 1950s, with the Conservatives still in power, Enoch Powell became Minister of Health. Powell's tenure is best remembered for his Hospital Plan (Minister of Health, 1962), but Powell also wrote a book about his experiences as health minister where he expressed considerable frustration at the difficulties of attempting to find out what was actually going on in the NHS:

"The attempts to find satisfactory measurements of yardsticks of performance have been persistently baffled. Enormous effort has been lavished during the twenty years of the National Health Service on the collection of statistics of hospital activity, and on the search among them for the means making valid comparisons, within the service itself and between the service and other systems. It is a search I myself engaged in with the freshness of hopefulness of inexperience only to be driven into recognising reluctantly that the search itself was inherently futile. The most carefully constructed parallels between one hospital and or hospital group and another dissolved on closer examination into a baffling complex of dissimilarities. Every attempt to apply a common standard had the effect of disclosing a deeper level of individual differences and incommensurables." (Powell, 1966, p.52-3)

Powell's frustration was not simply a function of his individual experience as Minister, but also represented the orthodoxy in terms of the way that academics considered public organisations at that time (Dunsire, 1999). Public organisations were regarded as having outputs that were too difficult to measure to make any attempt worthwhile. Was the output of the NHS to be measured in terms of how many patients it treated, how long its waiting list was, or how healthy the population of the UK appeared to be? Given the inherent difficulties in measuring health-care organisations, performance measurement was regarded as being a task that required the careful tacit judgement of doctors rather than the use of hard (quantifiable, comparable) performance measures (Carter, Klein & Day, 1992). The lack of easy performance measures also tended to reinforce the organisational logic

that the state leave the doctors to run health services, despite increasing concerns in the 1960s about the sums being spent on health-care, especially as the medical profession became more militant in demanding increased pay awards (Rivett, 1998).

- *NHS reform*

The first organisational reform of the NHS took place in 1974 after over a decade of debate as to how health services could be better organised (Greener, 2008). It was important in the story of performance because of its attempt to begin to introduce performance measures into health-care. In the wake of the reforms, steering groups were set up to examine how health-care information might be better managed and statistics generated from it. The 'Korner group', named after its chair Edith Korner, reported in 1982 (Steering Group on Health Services Information (Korner Report), 1982). The resulting performance indicators were introduced through the 1980s, and were picked up as a potentially important area of the future by prescient commentators. Pollitt (1985) noted that the measures had the potential to challenge clinical practice even though little impact had been made so far, and Bloomfield (1991; Bloomfield & Coombs, 1992) examined how coding systems had the potential to become sites of conflict between managers and clinicians over definitions of care, but also noted that the introduction of the performance indicators, in themselves, appeared to have been accepted by clinicians. This meant that doctors appeared to accept the legitimacy of performance indicators, and even that they might be co-opted to improve clinical practice. This appeared to represent a potentially centralising inroad into the very localised approach to clinical practice that had previously dominated through the possibility of greater monitoring and evaluation of NHS information.

As the 1980s wore on, the 'Griffiths' NHS reforms (Department of Health and Social Security, 1983) came into effect, directly challenging the right of doctors to run their local health organisations by upgrading the formerly administrative roles in the NHS to those of managers. The Griffiths' report suggested that health-care managers had to become accountable for the running of health services as Griffiths claimed he could presently find no-one 'in charge.' The new managers were analysed as terms of being corporate 'rationalisers' (Alford, 1972, 1975), challenging doctors, and with the new performance indicators as a means by which they might hold doctors to account (Gabe, Kelleher & Williams, 1994). As such, the combination of Griffiths and performance indicators gave an appearance of the potential of greater centralisation and control as the DH would be able to not only access more information about the NHS's activities, particular seeking outliers in the indicators, but also be able to hold managers accountable for these differences. At the same time, however, the logic of the Griffiths reforms was very much decentralising – of making local managers accountable to local people and arguing that the Department should have much more of a general overseeing role than getting involved in the day-to-day operations of health-care. Perhaps it was this tension that meant that, by the end of the decade, the reforms appeared not to have led to a transformation in the way the health service operated (Harrison, 1988). By the end of the decade, the NHS internal market was retrospectively explained by its creators as being a series of reforms not primarily about markets, but about giving NHS managers greater legitimacy in their challenge to the medical profession (Ham, 2000).

The 1980s were also the decade in which information technology became more widespread, so creating the possibility for information to be gathered in a more

systematic and widespread manner than before. Whereas, in the 1960s, it was impossible to gather and analyse the vast amount of information health services produce, the availability of cheap personal computers made both feasible. The NHS was very slow at working out the potential of information technology (Scrivens, 1985), but as personal computers became more widespread by the end of the 1980s, the role of Director of Information was created in many hospitals, and, alongside the need to gather increasing amounts of information for the contracting process in the internal market, it became more and more possible to assemble comparative performance information about health services.

In the 1990s, however, data from performance indicator were perhaps more significant outside of health-care organisations than in them. After the uproar over the NHS internal market, health-care went through something of a becalming (Wainwright, 1998) with the effects of the market becoming tempered by the Conservative government becoming concerned not to antagonise the still respected and vocal doctors further (Ham, 2000). What the government did do, however, is attempt to move performance measures into a more consumerist mode by publishing them in leaflets that were available to the public (such as the Patients' Charter) (NHS Executive, 1994). However, the incentives on poorly performing health organisations as a result of their publication were often weak, with stories often being run in local newspapers as results appeared, but with little sanction for poorly performing health organisations as a result.

In short, performance management techniques increased through the latter periods of the NHS (in common with wider NPM trends). "Performance targets and the linking of such targets to the resources allocated by Treasury to government departments" had become common by the time a Labour government was elected in 1997 (Wilson et al, 2006, p.154; see also Hartley and Skelcher, 2008).

- *Labour government and performance*

Labour were elected in 1997 with a promise to reduce NHS waiting lists by 100,000 as one of their pledges designed to restore trust between the public and politicians (Labour Party, 1997). Their first policy document was designed to increase quality in the NHS through a more partnership-driven approach, with claims that the market of their predecessors had been divisive and expensive (Secretary of State for Health, 1997). There appeared therefore to be no particular emphasis on centralising health services, and a rhetoric suggesting that it was the front-line staff of the NHS that knew how to run health services best.

By 2000, and with the government apparently frustrated with a lack of progress towards the waiting list target and with health reform more generally (Giddens, 2002), a very different focus on policy appeared (Exworthy and Greener, 2008). The publication of the NHS Plan (Secretary of State for Health, 2000) instigated performance management in UK health-care for the first time. Performance was not simply being measured now, but actively managed. The Performance Assessment Framework was originally designed around a traffic light system (red, amber, green), with poor performers to be publicly sanctioned, but also potentially facing their management teams being removed. High performing organisations, in contrast, were promised a lighter touch inspection regime and access to additional funds. By the time the first round of performance league tables were published a year later (Department of Health, 2001), the measurement system had changed to one of 'star ratings', and resulted in considerable media discussion and debate.

Either way, performance management was being used in a way that centralised policy, putting in place standards with which local managers and clinicians now had to conform (Baggott, 2004).

In terms of star ratings, Mannion *et al* (2005) noted the “general view” that the ratings did not represent a “rounded or balanced” picture of an organisation’s activities (p.18). This was despite the inclusion of a variety of dimensions such as government targets, clinical focus, and patient focus. This was explained by the partial information used to construct such measures. The ratings did have some value to local managers in the efforts to introduce organisational change. However, much of the attention devoted to them concerned their “mechanical application” (p.20) and/or

“unintended and dysfunctional consequences, including tunnel vision and a distortion of clinical priorities, bullying and intimidation, erosion of public trust and reduced staff morale, and ghettoisation.” (Mannion *et al*, 2005, p.18)

The new performance measures achieved wider publicity not only because of the government’s determination to make them meaningful, and potentially to remove managers in ‘failing’ organisations, but also because they were now widely available not only through the government’s web-site, but also with widely-read websites such as the BBC picking them up and making them extensively available to their readers. As such, the broader use of information technology increased external scrutiny for the NHS as well as making it possible to produce performance league tables. Health managers found they had less space to make local decisions than before, that they were ‘free to do as they were told’ (Hoque *et al*, 2004).

The more focused approach to performance management in the NHS was a manifestation of the government’s concern with ensuring ‘delivery’ – that is, the implementation of policy ‘on the ground’. A ‘delivery unit’ was set up by the Prime Minister and it was made clear, not only in health-care but also in other areas such as education, that the targets put in place were not simply going to be sources of information as they were in the 1990s, but were meant to be a means of leveraging improvement (Barber, 2007).

The new focus on delivery was not without its critics. Performance management was viewed by many commentators as leading to a focus on targets rather than care (Smith, 2005), and with claims that the government was ‘target mad’ (Economist, 2000) and to extensive ‘gaming’ in which managers tried to find ways of working within the performance management system rather than trying to drive improvement (Hood, 2006). Large scale surveys were drawn up to attempt to assess whether particular organisational cultures appeared to achieve better performance than others (Mannion *et al*, 2004; Scott *et al*, 2003). The performance management system was presented by policy-makers in subsequent years as becoming more ‘light touch’ (Timmins, 2002), but this shift did not appear particularly apparent to managers within the NHS itself (Greener, 2005).

Further criticisms led to further changes to the performance management system, but not before it had been extended to cover not only hospitals, but also PCTs. Star

ratings were abolished to be replaced by a rating system that ranked a range of performance factors including new areas such as 'use of resources', and with many organisations that were previously highly-ranked in the star-rating system finding themselves appearing as poorly performing in the new assessment. This rather confusing tendency created doubt that the rating systems were consistently or reliably capturing the performance of health organisations. To create greater independence and trustworthiness for the rating systems their control passed from the DH to the Healthcare Commission, before that organisation was itself re-named to include its new social responsibilities. PCT mergers and the renaming of organisations overseeing performance management made it difficult for anyone but the most careful researcher to track the progress of particular trusts over time.

Also significant was that, as the 2000s went on, Labour became increasingly more serious about re-inventing a marketplace for health-care. Unlike the Conservative internal market of the 1990s, prices were not a factor in competition as care carried a set price or tariff. Instead, patients (as patient choice became a key policy) were meant to choose between potential providers of care on the basis of their quality, with performance indicators providing an important basis for assessing their quality (see Easington Primary Care Trust, 2006). Performance data, as well as being used by policy-makers, and later care regulators, to make decisions about the quality of NHS managers, were also becoming a market signal by which patients were meant to decide between potential providers of care. Such performance data have enabled specific rewards (and penalties) to be linked to organisations. In health-care, the high performing Trust gain 'earned autonomy' (notably through FT status) and in education, schools that perform well attract more students and hence more resources (Wilson et al, 2006). If this logic is followed through, it would have profoundly decentralising tendencies within health-care as the allocation of local resources would be made on an individual level. However, it remains extremely unlikely that this will be the case given the considerable difficulties attached to the patient choice policy (Clarke *et al*, 2007; Greener and Mannion, 2009).

- *Assessment*

As such, the history of performance in the NHS represents a move from being largely ignored at its creation because of political considerations, to being a central part of the organisation of the NHS under Labour. Along with this change, there have been remarkable shifts in the relationships between doctors, the government and health-care administrators and managers. At the creation of the NHS, performance was absent in the rhetoric of health-care, and largely decided by groups of local doctors – an extremely decentralised system of delivering care. This was the 'double bed' relationship suggested by Klein. By the 1980s, managers were being introduced to challenge the doctors' authority, and by the 2000s, performance management systems put in place that challenged clinicians in providing comparative information about the activities of health organisations. The possibility of centralising health-care on this basis, however, did not arrive until the 2000s when a fully-fledged performance management system was introduced which demanded health-care managers improve their organisations or face potentially losing their jobs. This shift was aided significantly by the widespread use of information technology (Greener and Powell, 2008). There was a move from the relatively informal use of performance indicators in the 1980s and 1990s, to performance management in the 2000s as the indicators were used to judge the success (or otherwise) of health organisations. However, even in a performance-led NHS, it would be problematic to rely solely on a formal system of performance measurement (Goddard *et al*, 1999).

The effects of the NHS performance culture can be seen at two levels. At a micro level, there is considerable evidence that the use of performance indicators in this way has led to managers attempting to 'game' systems rather than necessarily improve health organisations, and a concern that target focus has led to clinical priorities getting subsumed in the need to meet particular indicators (see next section). At a macro level, the UK's system centralised government (despite political devolution) shapes the use and impact of performance management regimes, either for the acquisition of resources and/or to gain reputation and influence (Hartley and Skelcher, 2008, p.18). Moreover, it is debatable whether the emphasis on performance especially in the latter years of the NHS has yielded the outcomes which its supporters claim. For example, Hartley and Skelcher (2008) suggest that

"There may be a danger that performance targets emphasise conformance to standards at the expense of organisational learning, thereby reducing the capacity of organisations to address future challenges or to innovate" (p.19).

This is further underlined by the dubiety of many performance measures. If, as Greener (2003) argues, it is difficult (if not impossible) to reach a consensus about a definition, the centralising effects of recent performance management regimes pose serious questions about veracity, validity and value of such measures.

2.3.4. Performance measurement: assumptions and consequences

The 'model' by which performance measurement is supposed to improve the organisational and individual effectiveness relies on a number of assumptions.

- *Perfect information*: Information about the performance of a particular unit of analysis (service or individual) is supposed to be freely available, in a format that can be readily digested. The form of dissemination (increasingly, the internet) of such data is not assumed to be significant; simply its production and dissemination is sufficient. Moreover, it is supposed to capture the entirety of the measured unit in a way that aids the 'user' of the information to make informed decisions.
- *Rational producers*: The individual and organisations whose 'performance' is being measured are assumed to act as rational actors. Evidence of 'poor' performance is supposed to stimulate them, as trustworthy professionals, to take action to improve. Whilst intrinsic motivation is often seen as emblematic of clinicians, their motivation is increasingly shaped by external incentives. When the organisation (school, hospital) is the unit of analysis, managers are supposed to be able to act upon performance data to the benefit of the organisation. It also assumed that the performance which is being measured is discrete and able to be defined (making units of 'work' measurable). Harrison (2008) refers to the 'abstract reductionism.'
- *Rational users*: Those for whom performance information is intended, it is assumed, face rational choices in receiving, understanding and using the

information. The multiplicity of users is acknowledged; users include the general public (citizenry), clients (such as patients), regulators, politicians, and the hierarchical tiers of authority (including civil servants and managers).

- *Implementation impediments:* It is assumed that no barriers exist to implementation of initiatives designed to improve performance, including flows of information and organisational change. Individuals, it is assumed, would not face organisational or systemic barriers to improve their own performance. Decentralisation complicates this as it introduces more inter-relationships and often separates control (hierarchically and spatially) from operational agents.

Clearly, the perfect expression of the model can never be realised (Anand, 1988). That said, it is useful to identify how a/any performance measurement system is 'supposed' to work (in theory). Its use in practice is fraught, as discussed next.

The factors modifying the ideal type of performance measurement' can be grouped in the following ways:

- Performance in the public sector

Public sector organisations face similar contextual imperatives in terms of measuring and managing performance. First, the public sector comprises multiple stakeholders. Discussion of the 'rational users' (above) is effectively redundant as performance measures vary in their importance, relevance and attention of any stakeholder (Dixit, 2000). Since public services are indeed "services, (rather than products), there is an inevitable impact upon performance measurement since the outcome of these services is effectively the interaction (dynamic) between the user and the public sector worker (Stewart and Walsh, 1994). There is an inherent unpredictability since two apparently identical users may perceive and receive different quality of services, the measurement of which would thus be further complicated.

Second, the public sector operates in areas of market failure. Traditional market mechanisms are not feasible or appropriate for most public sector organisations. Hence, the role of exit, voice and loyalty (Hirschmann, 1970) does not readily apply in the same ways as commercial organisations. Moreover, these organisations do not 'choose' their markets.

Third, given these multiple audiences, public sector agencies will have to meet the competing and often contradictory goals of these multiple audiences. Moreover, these goals may be vague and/or difficult to define in ways which facilitate measurement and management. In such cases when values conflict between stakeholders, Stewart and Walsh (1994) argue, the measurement and assessment of performance are "necessarily a matter of judgement" (p.45).

Fourth, Wilson *et al* (2006) note the intrinsic motivation of many public sector workers, many of whom are professionally trained which tends to suggest greater intrinsic motivation. This has implications for the ways in which they respond to the incentives associated with performance measurement regimes/systems (Behn, 2003). If the activity is the reward itself (the notion of 'doing good', vocational

work etc), then extrinsic motivation is unlikely to be effective; it may even have a negative impact (Frey, 2000). Any performance management system will comprise both intrinsic and extrinsic incentives (Wilson *et al*, 2006, p.168)

- Limits to performance measurement

The limits can be summarised into technical and normative issues. First, Freeman (2006) notes the technical difficulties in performance measures: imprecision, data availability and reliability, data validity and indicators robustness. As such, it is unlikely that "full satisfactory" performance measures will ever be found (Stewart and Walsh, 1994). Greener (2003) identified:

"...an even more important fallacy. That fallacy is the assumption that we can work out, and measure, exactly what we mean by performance in the NHS" (p.243).

Wilson *et al* (2006) note the complexity of most public services and the consequential problems in measuring their performance. They argue that no single performance measure would be sufficient to capture the multiple functions and tasks, some of which are ineffable (Exworthy *et al*, 2003). As a result, publishing multiple measures seeks to overcome this dilemma. However, they note a "trade off between comprehensiveness and transparency" (p.156).

Secondly, performance measures denote claims to objectivity. This authenticity is supposed to engender trust in such measurement but this may be displaced (Davies and Lampel, 1998). The existence of performance measures does not remove the "need for trust but relocates it from the internal control systems of professional to audit systems" (Freeman, 2006, p.311). Tsoukas (1997) also notes that the continual refinement of performance measures leads to the creation of in-groups and out-groups; the former implying knowledge and ability to interpret the measures, the latter implying ignorance. As such, performance measures can never be fully transparent. Indeed, efforts to 'improve' the measures are doomed and lead to further erosion of trust.

Third, performance measures may not necessarily achieve the desired or anticipated results or outcomes. In other words, the value of performance as a measure of public service improvement may be over-stated. Hartley and Skelcher (2008) conclude that the

"UK central government emphasis on public management has not resulted in the scope, scale or sustainability of change that had been anticipated by policy-makers. In particular, there may be a danger that performance targets emphasise conformance to standards at the expense of organisational learning, thereby reducing the capacity of organisations to address future challenges or to innovate" (p.19).

This implementation gap between expectations and experience of performance measures might point to the rhetorical importance of notions of performance as well as organisational barriers which might hamper their use in practice.

- Unintended consequences of performance measurement

Whether as a macro or micro scale, the impact of performance measures appears to be rather inconclusive. For example, it is significant that there appears to be no direct link between the type of governance structure (basically, hierarchy, market and network) and organisational performance (Allen, 2006; also Braithwaite et al 2005). At a more micro-level analysis, Scott *et al* (2003) argue that their review of evidence does not provide "clear answers" as to whether there is a link between organisational culture and performance. At either level, the focus on performance measurement is likely to generate unintended consequences. Moreover, it is inevitable that systems and processes (introduced to measure performance) will continue to pose performance as a "problem" (Harrison, 2008). Performance is thus perpetuated and reproduced as a legitimate focus for managers and other actors. Rather than addressing systemic concerns, performance measures focus on disaggregated units of analysis (the school, the hospital etc). This regime both implies and guarantees that "poor" performance will always be found. A normal distribution curve of 'measured' performance will highlight some "high" performers and some "poor" performers; indeed, the performance of half of all schools/hospitals is below average.

In a seminal paper, Smith (1995) identified the unintended consequences of publishing performance data (such as in school, hospitals or local government) (p.314). First, there is an "emphasis on the phenomena quantified in the measurement scheme" to the detriment of areas/aspects not measured. Second, objectives and strategies are pursued which enhance the measured but do little to address wider objectives (even those of the organisation). Possibly, as a result, short-term objectives tend to dominate. Third, there is the potential to deliberately manipulate the performance data and to adjust behaviour (of those being measured or those responsible for delivering organisational performance). Such manipulation might be for "strategic advantage" or for more prosaic purposes. The potential for such 'gaming' may arise from "the imperfect picture of a complex process" (Wilson *et al*, 2006, p.154). Fourth, it is feasible that "misleading inferences" could be drawn from "raw performance data." However, data adjustment (for example, in terms of social deprivation or "value added") might lead to claims of manipulation. Fifth, Smith (1995) notes that organisational inertia might result from an overly "rigid performance evaluation" in which analysis creates paralysis.

Talbot (2005) draws similar conclusions. He notes that, despite a series of arguments advancing notions of 'performance', there are a series of counter-arguments. These highlight the deficiencies of performance measurement

1. *Incompleteness*: information is only ever able to glean a partial picture of public activities, leading to distortion and bias
2. *Over-complexity*: in seeking completeness (see 1), performance systems often result in information over-load
3. *High transaction costs*: Such costs refer not simply to data collection but also to the time spent on anticipating and responding to them by those whose performance is being measured.
4. *Attribution difficulties*: It is commonly difficult to attribute variations in inputs or outputs to outcome. Causation is often implied from correlation or association
5. *Imbalances between quantity and quality*: Performance measures are usually quantitative (given the need for comparisons) but this can lead to claims that what is measured becomes important, because it is being measured.
6. *Manipulation and deception*: Some performance measures can, Talbot claims, encourage a "culture of cynicism and amoral behaviour" (p.504).

7. *Distorted behaviours and unintended consequences*: Given ever stronger incentives to comply with the performance regime, the “narrow” focus on outputs for one organisation can be sought to detriment of wider objectives or concerns.
8. *Cyclical incompatibility*: Sustaining improved performance over a period of time may not be achieved through a short-term focus, responding to the political and organisational dynamics. Hartley and Skelcher (2008) note the “limited shelf-life” of some improvement strategies proposed by government (p.12).
9. *Measurement degradation*; Talbot notes the effectiveness of performance measurement declines over time, thereby undermining the “long-term stability in performance measurement which is important for public accountability”(p.504)
10. *Tension between politics and rationality*: Public sector is fraught with “instability incrementalism and muddling through, messy compromises and value judgements which fatally undermine all attempts at rational decision making” (p.504).

Stewart and Walsh (1994) conclude, like others, that an ideal measure of performance is unachievable. Thus, they argue, “There is a need to recognise the imperfections and limitations of measures, and to use them as a means of supporting politically informed judgement” (p.45)

2.3.5. Perspectives on performance

Theoretical perspectives on performance have proliferated in recent years as the significance of performance has become more critical to public sector organisations. There are multiple notions of performance. For example, Skelcher (2008) suggest three conceptions of performance.

Table 2.8. Concepts and definition

Concepts	Definition
Organisational performance	Substantive outputs and outcomes of a public organisation
Democratic performance	Extent to which a public organisation is able to demonstrate mechanisms for legitimacy, consent and accountability
System performance	Extent to which a system of public organisations is integrated

Source: Skelcher, 2008, p.29

A second approach is offered by Talbot (2005) who presented “emerging arguments for performance” (p.496-501). These were “performance” as: accountability, as user choice, as customer service, as efficiency, as results, effectiveness and ‘what works’, as resource allocation, and as creating public value.

Clearly, such multiple interpretations of performance offer a conundrum for its analysis; it would be virtually impossible to offer a comprehensive synthesis of them. No review of this myriad of perspectives can do justice to the breadth or depth; rather, an analysis of performance is feasible in relation to key dimensions pertinent to decentralisation, autonomy and local health economies. Such dimensions thus include governmentality, the role of incentives in improving performance and accounting logic.

- *Governmentality*

Governmentality has not commonly been associated with notions of autonomy and performance. However, it does potentially offer some intriguing insights which are sketched in this section. The notions that comprise 'governmentality' refer to a sweep of changes to governance relations within and between organisations. Commonly, these changes have been summarised in notable phrases such as 'steering at a distance', 'external gaze' and 'remote surveillance'. However, they also denote a broader shift in inter/intra-organisational relations, which have been described by Reed (1999), Courpasson (2000) (among others) and adapted from the work of Foucault. In particular, governmentality refers to new and emerging modes of institutional control (as traditional forms have waned). In turn, disciplinary institutions, practices, discourses and knowledge bases have emerged within a new social order (Flynn, 2004; Freeman, 2006).

Governmentality also encompasses changes in power relations associated with expertise and knowledge. Governmentality theories interpret the rise of invisible and often opaque apparatus of elite professionals that create what Stehr (1994) termed a 'technical state.' Power, for Foucault, was a diffuse property, produced and reproduced in everyday practice and techniques, not simply through observable use of authority. The rise of evidence-based medicine and the ways in which this evidence has been used by commissioners (in particular) illustrates the advent of this new discourse which has made alternative perspectives difficult to establish and challenge. Appeals to 'evidence' thus become superior to other competing claims.

For the focus here on autonomy and performance, governmentality is also associated with changes in the normative behaviour of individuals who have become self-regulating. Rather than introducing coercive change, governmentality shifts norms and customs such that individuals become obedient and compliant. Individuals thus become the object and subject of performance control. Performance measurement makes the individual (clinician, teacher, etc) the *object* of inquiry and also *subject* to the exigencies of such a regime (Miller, 1992). The impacts of such control also entail:

- i. *Continuous, remote observation*, the effects of which are continuous even though such surveillance may (or may not) be continuous
- ii. *Spatial separation* of the observer and observed, aided increasingly by information technology which allows data collection, interpretation and comparison. No longer need the supervisor be in close proximity to the supervisee. As a result, local knowledge might be de-valued.
- iii. *Segregation* of those observed is enabled not only by remote surveillance (which implies that alternative meanings and resistance can be easily thwarted; but see (v) below). Further, surveillance facilitates performance categories such as those requiring 'remedial' action (so-called 'poor' performers) or 'high' performers (eligible for initiatives such as earned autonomy).
- iv. *Hierarchical ranking* in the form of comparative 'league tables', based on categories of measured 'performance.' (The consequence is that ineffable

practice is unmeasured). This ranking is aided by the use of standardised units of performance and again aided by the collection and analysis of large volumes of data by IT. Such ranking privileges one form of performance assessment above others.

- v. A process of *normalisation* whereby the customary norms of behaviour and what counts as 'good' or 'poor' performance are internalised within individuals and within professions.

According to the 'governmentality' thesis, performance management (such as audit or accreditation) shifts attention from first order control (control of professional activity) to second order control (control of systems supervising / overseeing the quality of services). Reed (1999) thus refers to the 'conduct of conduct' – affecting how individuals behave and act. This echoes Power's (1997) reference to 'control of control.' Hence, whilst some see the self-surveillance of governmentality as replacing programmes such as (clinical) audit (Flynn, 2004), it might also be seen as duplicative of it. Audit (and related) activities (such as hospital morbidity and mortality meetings) are largely organised and run by clinicians (usually doctors) which may be becoming oriented around reformed notions of performance – what counts as good / poor performance, whose notions of performance are ascendant.

A widely applied concept associated with governmentality is that of panoptic control. Drawing on Bentham's notion of the panopticon, the notion of control is extended to various techniques of surveillance with the aim of creating obedient individuals in a reformed social system. The notion of panopticon includes physical systems as well as discourses and practices (which underpin Foucault's notion of power). Specifically, panoptic control entails micro-control of fragmented subjects whose resistance (to control) is quelled. As such, Reed (1999) sees a critical shift from the 'cage' (prison-like structures) to the 'gaze', implying more remote surveillance and less tied to structural apparatus. However, whilst he notes this development, he is cautious as to whether a significant degree of change has taken place.

A related concept associated with governmentality is 'soft bureaucracy' (Courpasson, 2000; Flynn, 2004). It also focuses on managerial systems within organisations which combine decentralisation (flexibility) and centralisation (control). This concept has been most widely applied in cases where managers have sought to 'manage' professionals; the former seeking to exert control whilst the latter seek to retain flexibility (their autonomy). Managers' adopt "soft practices" within an existing framework of hierarchical control. Control is applied but in subtle ways which do not involve coercion and may not be readily evident. For example, managers may co-opt senior professionals into the management of clinical colleagues but using standard management techniques. Senior professional involvement creates a legitimacy of such practices, among colleagues. Goddard and Mannion (2006) note the complexity of performance measurement in the NHS and the consequent reliance on the "myriad of informal networks and "soft-intelligence" channels of communication, formal accountability arrangements [which] will always be supplemented by "softer" processes of control." It can also be hypothesised that soft bureaucracy can be applied to managerial systems between organisations.

Whilst the notions of governmentality have an intuitive appeal, it is far from certain that they have been widely or deeply implemented or adopted in health-care settings (clinically or organisationally). At both the level of discourse and practice, notions of governmentality suffer from conceptual and practical shortcomings.

Whilst challenges to clinical (especially medicine) professions have been many and manifest in recent years, it is far from clear that their power has been seriously eroded. Indeed, their power may not have been eroded but rather re-constituted in different forms. For example, the re-articulation of what counts as good/poor performance has been done so within the rubric of evidence-based medicine (EBM), a development largely owned by the profession. EBM has perhaps, however, instigated a re-ordering of the profession, internally. Freidson (1994) suggests a re-stratification between the rank-and-file professionals, the knowledge elite (such as researchers generating the evidence base) and the administrative elite (such as medical directors). It is far from clear that the evidence generated is being used systematically to exert greater control over all professionals. Some have become more subject to surveillance, such as GPs under the QOF (Doran *et al*, 2006; Downing *et al*, 2007). Most recently, there have been signs that surveillance – the gaze – is increasing through the transparency offered by the publication of mortality (and other) data on the internet. Emerging evidence suggests that such disclosure is not widely used by the public, managers or others and that clinicians resist such disclosure, claiming it fails to capture an authentic picture of their activity (Exworthy *et al*, 2003; Smith *et al*, 2009).

However, it is notable that senior managers in health-care organisations have been increasingly subject to the performance culture. Given their hierarchical position, it may be more difficult for them to offer overt resistance to the performance culture. However, the parameters by which (local) performance is measured and managed may be poorly transmitted through hierarchical / supervisory arrangements to an apparently omnipotent observer. Performance also remains highly contingent upon local (social and institutional) relationships (Fleurke and Willemse, 2004). This local contingency is examined later in this chapter.

In summary, governmentality does provide a broad perspective on performance which is useful in the context of decentralisation, autonomy and inter-organisational relationships.

- *The role of incentives in improving performance*

Incentives are important concepts in relation to performance because they comprise the mechanisms by which performance is supposed to be improved. They rely heavily on adjusting the behaviour and motivation of individuals within organisations (Greener, 2003). Any performance indicator is socially constructed and should not be seen as a “neutral or objective measure” (p.242). As such, they seek to foster specific behaviour, often at the expense of others.

The mechanisms of change / improvement comprise a set of incentives which might reward “good” performance and penalise “poor” performance. These mechanisms and incentives consist of a series of assumptions about human motivation and behaviour (Le Grand, 2003; Davies *et al*, 2005). Le Grand’s (2003) work on the motivation and agency in public services focuses on the tensions between two types of behaviour, principally between knightly and knavish behaviour. Essentially, this is a distinction between altruistic and self-interested behaviour, encouraged/discouraged by incentives; knights represent the former, whilst knaves represent the latter. (He also discusses whether citizens/users should be disempowered ‘pawns’ or ‘queens’ able to choose between competing providers).

For the purposes of the analysis here, it is instructive to note that Le Grand also considered the role of performance measures in the shift towards market-based public services. As such, performance information was a vital ingredient to affect the motivation and behaviour of producers and consumers. He concluded that NHS incentives should be sufficiently robust to invoke both knightly and knavish behaviour (rather than one or the other). Wilson *et al* (2006) regard the need to align these approaches within providers incentives in order to reconcile the objectives of users and government as (potentially opposing) stakeholders (p.154).

The ways in which autonomy motivates individuals and their organisations clearly falls within the remit of this study. Le Grand *et al* (1998) found that the incentives in the 1990s internal market were probably insufficient to generate significant improvement across the NHS. In short, the incentives were too weak to alter motivation and behaviour. By contrast, Goddard and Mannion (2006) found that autonomy was valued by NHS and that, in itself, it was a sufficient incentive to improve performance (see also Hoque *et al*, 2004). Whilst such autonomy may be granted from 'above' (hierarchically), it may also be seen as instrumental in fostering a particular organisational culture (Scott *et al*, 2003)

Boyne (2003) concludes the variables most likely to affect performance are resources, regulation, market structure, organisation and management. This structural conclusion places little overt emphasis on incentives, other than the way in which regulation or market operates will, in consequence, shape the incentives for local agents. Kaiser Permanente (2008) offer a different set of criteria for health system performance: governance, strong physician leadership, organisational culture, clear/shared aims, accountability and transparency, patient centredness, and team-work. The Kaiser criteria require some 'translation' to a UK context but do address health systems (which might be akin to LHEs).

English health policy comprises a set of incentives which may complement or contradict each other. Ideally, incentives should be aligned but public policy inevitably involves trade-offs and compromises. For example, Wilson *et al* (2006) conclude that any performance management regime must strike "a balance between measured and unmeasured performance, between extrinsic and intrinsic reward" (p.168). Among many other impacts, it is possible to hypothesise the intuitive impacts upon the autonomy of organisation in a LHE; see table 2.9.

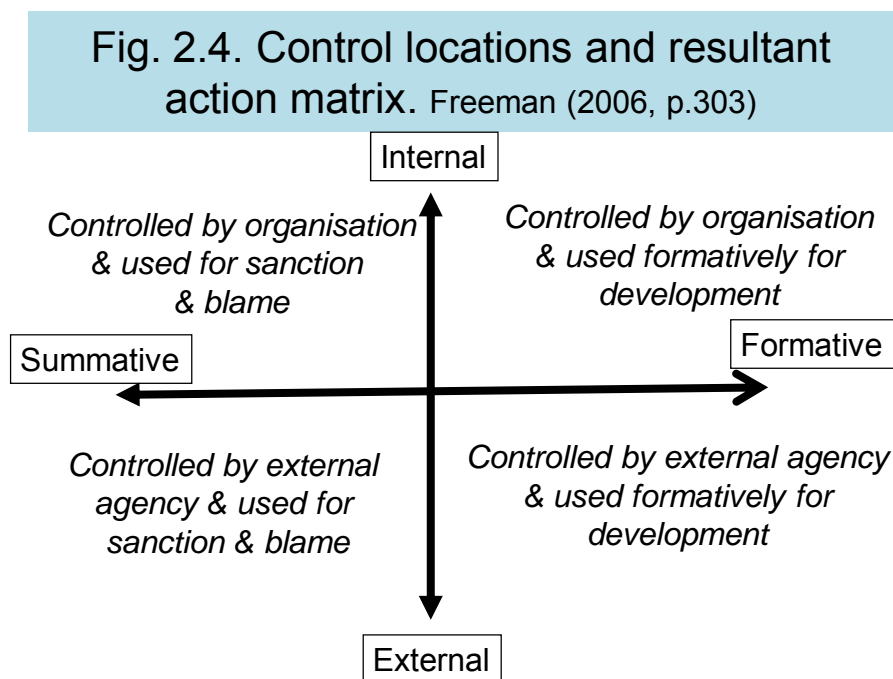
Table 2.9. Health policy: incentives and hypothesised autonomy

`Policy`	Incentive (based on hierarchy, market, network)	Potential impact on autonomy of LHE organisations
Payment by Results	↑ competition	↑ autonomy
Patient Choice	↑ competition	↑ autonomy
Practice Based Commissioning	↑ competition	↑ autonomy
National Service Frameworks	↑ hierarchical control	↓ autonomy
Market stimulation (WCC)	↑ competition	↑ autonomy

Clinical networks	↑ coordination	↓ autonomy
Performance management	↑ hierarchical control	↓ autonomy

In addition, Freeman (2006) presents a conceptual framework which seeks to identify the locus of performance control (also see Exworthy et al, 2003) (see fig.2.4.). It consists of two dimensions: location of control and nature of resultant action. The former lies on a spectrum from internal to external whilst the latter lies between formative and summative. In recent years, the locus has moved from internal to external and from formative to summative, though each performance regime has a specific configuration of these dimensions.

Figure 2.4. Control locations and resultant action matrix



- *Accounting logic:*

Ferlie and Geraghty (2005) distinguish between two types of NPM – hard and soft. The latter draws on the principles and practice of the “Human Resource school of private sector management” which place an accent on “user orientation, quality improvement, organizational and individual development and learning” (p.431). The former is associated with the accounting logic.

The group of perspectives that address the social construction of accounting systems are relevant here as they challenge the notion that performance measures, as key elements in the accounting logic, are neutral and objective. Broadbent and Laughlin (2002) argue that accounting measures create an “aura of factual

representation, promoting a general perception that such measures generate neutral objective, independent and fair information" (p.102). This "aura" relies on standardisation to produce comparable units of assessment through quantification. This reductionism is aided by techniques and technologies such as Health-care Resource Groups (HRGs).

In some ways, the accounting logic has strong connections with governmentality in the sense that logic makes visible aspects of local performance to central agents (Broadbent and Laughlin, 2002). By implication, it also makes invisible those aspects which are not included in such logic because they are ineffable or non-standard. Similarly, the logic provides the mechanism by which local agents become the subject and object of surveillance. Individuals can become the object of performance assessments and subject to its exigencies; they thus become calculating selves (Miller, 1992).

Many see this accounting logic (especially as it applies to performance management) as being a crucial element in hierarchical control. It would be hard to see, by contrast, how such logic would be consistent with network forms of governance. Yet, governance forms (principally, market, hierarchies and networks) compete and co-exist (Exworthy *et al*, 1999; Rhodes, 1997). Hence, whilst accounting logic is an essential component of the market and facilitates hierarchy, the individualisation of accounting logics might corrode collaboration and cohesion.

- *Public choice and other theories*

A number of other theories might shed light on the nature and scope of performance. These are largely oriented around disciplinary perspectives.

Rather than one specific theoretical construct, the disciplinary approach taken by Public Choice and Institutional Economics are, according to Talbot (2005) "strong candidates" for the analysis of performance (p.509). Public choice theories posit that competition and market-style relations are critical to improving performance. Hence, monopolies, producer capture and lack of user choice are seen as inimical to competition. Policies that remedy such deficits include greater reliance on contracts and better user information (about performance). Indeed, information becomes vital in managing the contracts and enabling users to make more informed decisions. However, such a perspective overlooks the relational dimensions of markets (Flynn *et al*, 1996) which entail notions of mutuality, reputation and legacy effects of previous transactions (Greener, 2008). Neo-institutional theories might also be expected to offer perspectives on performance but relatively little has been written (Talbot, 2005).

Fordist and post-Fordist theories might also be expected to offer some insightful critiques on performance. Fordist theories place emphasis on the routinised, standardised nature of the production process and the outputs. Post-Fordist theories stress the socially-constructed nature and contested of such processes and outputs. It could be argued that current performance management systems are Fordist in character, seeking to measure performance in a standardised and comparative format, irrespective of local contextual factors. Talbot (2005) argues that performance management is redolent of the Taylorist approaches of Fordism that then the cultural management of the 'excellence' school (Peters and Waterman, 1982). By contrast, post-Fordist approaches might highlight the ways in which

notions of performance and even the specific measures are socially constructed and subjective.

The next section draws on different aspects of these theories to present a heuristic device for considering the inter-relationship between different domains– formal and informal performance.

2.3.6. Formal and informal performance explained

Conceptually, notions of performance can be divided into formal and informal. The former refers to official and (apparently) objective accounts and measures of organisational / individual activities whilst the latter refers to subjective perspectives on such activities (which might include `soft' information such as reputation or credibility, for example). The division between the two categories is not fixed or permanent but contextual and contingent. Both categories address the structure, process and outcome of organisational activities. For example, processual aspects of performance might include both the measurement mechanisms of formal performance metrics as well as the ways in soft information is produced and disseminated. This reflects a similar distinction between governance type I and type II (Marks and Hoogh, 2005). Without privileging one form of performance over another, it is important to recognise the interaction and reaction between the two in making assessments about the ways in which performance is conceived, constructed and reproduced in local and national health systems. Performance can thus be seen as a disputed term which is socially constructed and contested by different stakeholders. Given the volume which have been written on `formal' performance, the emphasis in this paper is towards `informal' performance.

- *Formal performance:*

Most research attention has been paid to aspects of performance which may be described as `formal' or `hard' information. `Formal performance' relies on the assumption that such information is an objective account of an organisation's activities and presumes a degree of precision in measurement mechanisms and measures. Such performance systems are largely based on quantitative measures. Indeed, Goddard *et al* (1999) argue that

“the success of formal performance measurement systems depends in part on the degree to which they can capture adequately relevant information within a quantitative framework” (p.119).

Formal performance measures have been widely adopted in all areas of public services as a result of advances in information technology coupled with the adoption of the tenets of new public management (NPM) (Ferlie *et al*, 2005; Hartley *et al*, 2008). Together, such performance information is used to make comparisons between units (such as rankings (such as stars) or league tables) with a view to (a) improving the organisation's performance and/or (b) managing contracts between such units (agent) and a purchaser/commissioner (principal) in a quasi-competitive market. Much of the effort by public managers and researchers has been to find ways of improving the reliability and validity of formal performance systems and

measures, often without questioning the assumptions upon which those systems and measures are founded (Mannion *et al*, 2007).

However, formal performance suffers from a number of drawbacks. Formal approaches to performance (especially quantitative ones) cannot measure what (all) multiple stakeholders consider important about a particular service. Goddard *et al* (1999) highlight this point thus:

“The ability of Trusts to deliver on their contracts was seen by both regional offices and health authorities as a hard measure of performance, but again, the fulfilment of these targets does not appear to signal ‘good’ performance to the external organisations” (p.127).

Moreover, any performance system cannot capture all the information (in meaningful and practical ways) which might be considered relevant to an organisation and its stakeholders (Sheaff *et al*, 2004). Whilst offering apparent precision, formal metrics are founded on a series of subjective judgements about which organisational activities should be measured, what standards should be adopted, what actions might follow ‘poor’ or ‘good’ performance. Street (2000) argued that the performance system (used to measure efficiency) was as significant as the performance of the organisation (hospital) itself. As a result, he concluded that

“no significance can be attached to the differences observed among trusts” (p.50).

Finally, there is a danger that formal metrics can displace trust by claiming to offer a credible account whilst inevitably overlooking some (‘unmeasured’ or ineffable) aspects (Davies and Lampel, 1998; Exworthy *et al*, 2003; Power, 1997). The danger is that unmeasured aspects of performance become relegated or neglected by providers since there is no incentive to address them (Sheaff *et al*, 2004).

Despite its shortcomings, formal performance has been the dominant mode by which organisations have been assessed in the last 20 years. Given the ability to align incentives to formal performance (in the form of government targets), there has been some evidence to suggest that formal metrics have improved performance (Gravelle *et al*, 2003). However, some side-effects have also become apparent (Greener, 2003; Propper *et al*, 2007). Sheaff *et al* (2004) identify ten such negative consequences in health-care settings:

1. “Tunnel vision, i.e. concentration on areas that are included in the outcome scheme to the exclusion of other important areas.
2. Sub-optimisation, i.e. managers (and clinicians) pursue their own narrow objectives at the expensive of strategic co-ordination.
3. Myopia, i.e. concentration on short-term to the exclusion of long-term issues which may not show up in (clinical) outcome indicators for some time.
4. Convergence, i.e. having a stronger preference not to be exposed as an outlier in an indicator scheme than to be outstanding.

5. Ossification, i.e. organisational paralysis due to an excessively rigid system of measurement and the disinclination to experiment with new and innovative methods.
6. Gaming, i.e. altering behaviour so as to obtain strategic advantage.
7. Misrepresentation, including creative accounting and fraud.
8. Complacency, i.e. lack of ambition for improvement brought about by an adequate comparative performance.
9. Misinterpretation, i.e. incorrect inferences about performance brought about by the difficulty of accounting for the full range of potential influences on a performance measurement.
10. Ghettoisation, i.e. polarisation in provision and quality of provider staff exacerbated by a poor performance ranking" (p.66-67).

Also, its value in improving performance has been questioned (Hartley *et al*, 2008). Some claim that formal performance approaches have been most widely applied in identifying 'poor' performing organisations rather than stimulating further improvements; hence Goddard and Mannion (2006) conclude that formal ('hard') performance information is most commonly used as a 'safety net', as a way of identifying 'poor' performers (see below).

- Informal performance:

The notion of informal performance rests on the assumption that the ways in which performance is conceived, constructed and managed are founded on a series of subjective judgements, mainly by senior individuals responsible for managing organisations (directly or through contracts). Such judgements might, for example, relate to perceptions of trust, reputation, credibility and competence. Commonly, such aspects of performance include the professional norms, and conventions, habits and informal codes of conduct. They are particularly apparent in terms used by senior individuals to describe others; these include 'a safe pair of hands' or 'we need to keep an eye on them.' This informal performance might also be evidenced in "clashes and where people do not keep their side of the 'bargain' are labelled as 'problem' Trusts" (Goddard *et al*, 1999). Atkinson (2000) described these factors as the "informal influences on local health system performance" (p.117). In short, informal performance data can generate a "picture of what is 'really' happening within Trusts" though dangers of bias are present (Goddard *et al*, 1999).

Informal performance draws attention to relationships and networks to transmit information. This 'informal' dimension presumes that notions of performance are inevitably contested and thereby might reveal the lack of consensus among stakeholders about the quality or effectiveness of activities of individuals or organisations, and also the remedies to ameliorate (supposedly) 'poor' performance. It is thus a social constructionist approach to understanding and explaining performance (Talbot, 2005, p.510). Using notions of informal performance, better understandings might offer explanations as to why similar formal performance metrics and even similar organisational contexts might still elicit different accounts or perspectives (according to stakeholders) on such 'performance' (Braithwaite *et al*, 2005).

Notions of informal performance may also play a part in explaining the intersection and interplay between markets, hierarchies and networks. In each of these coordinating mechanisms or governance modes (Exworthy *et al*, 1999), the mechanisms which allow each to operate may be classified thus

- Markets ~ Price
- Hierarchy ~ Authority
- Network ~ Trust

To some extent, notions of informal performance help explain the 'mix' between each of these co-existent modes (Rhodes, 1997). This interplay between price, authority and trust may be especially significant in (sub-)systems (or local health economies) which exhibit few options for 'exit' but rather involve greater emphasis on 'voice' and/or 'loyalty' (Hirschmann, 1970).

Recognition of the role of informal influence on performance points towards a greater understanding of the wider context within which organisations operate. Here, particular attention is paid to the LHE. This accords with neo-institutional theories which see institutions as integral within societal networks and therefore a determinant of the organisational, structure, process and outcome/performance (Sheaff *et al*, 2004, p.67). Such information enriches any assessment of organisations; indeed, Goddard *et al* (1999) argue that it is important that the formal performance does not suppress informal performance data.

The ways and extent to which informal influences have influenced the (formal) performance of organisations has been assessed through analysed of concepts such as trust (Zaheer *et al*, 1998; Dyer and Chu, 2003) and dramaturgy (Freeman and Peck, 2007), and the interplay between 'hard' and 'soft' information (Goddard *et al*, 1999). Together, these two themes offer contrasting perspectives on the informal aspects of performance.

Trust: Trust is a notoriously slippery concept to define and operationalise. However, one definition refers to confidence between agencies; trust is

"one party's confidence that the other party in the exchange relationship will not exploit its vulnerabilities" (Dyer and Chu, 2003, p.58; see also Gambetta, 2000; Zaheer *et al*, 1998).

Some assume that trust can help improve organisational efficiency by eliminating (or at least, minimising) the need for formal, extensive contracts. Health-care is a sector which fulfils Williamson's (1975) criteria for a weak applicability of markets: bounded rationality, asset specificity and opportunism. Bounded rationality posits that it is difficult / impossible to specify or anticipate every eventuality in a contract, not least because many of the outcomes of interventions can never be fully known – the indeterminacy of health care (Klein, 2000).

Similarly, trust helps to ensure that agents do not take "excessive advantage" of another even when the opportunity is available (Mayer *et al*, 1995); this again may be likely in health-care when complete monitoring of a contract is almost impossible. In such cases, it is logical to rely on 'soft' information (such as trust or reputation) to complete the picture about an organisation's performance. In doing so, trust may help to reduce or minimise transaction costs (which are often high when contracts are written, implemented and enforced).

Dyer and Chu (2003) conclude that, in their study of private sector companies, trust was linked to lower transaction costs and, in turn, lower transaction costs were

associated with 'better' performance (primarily financial). They also found that trust was most valuable when it was not based on contractual mechanisms but reinforced reciprocity and mutuality between agencies. These conclusions advanced by Zaheer *et al* (1998) take this argument a little further by surmising that

"The basis for performance enhancement does not appear to be based on efficiencies gained from eased negotiation processes. Rather, we speculate that the enhancement of transaction value (Zajac and Olsen 1993)—such as cooperation in the exploration of new information and coordination technologies, new market opportunities, and product and process innovation—may account for the link between inter-organizational trust and exchange performance" (p.67)

Hence, here, trust is seen as instrumental to improved "transaction value" rather than being an end on itself (*cf.* Boyne, 2003).

Vakkuri and Meklin (2006) recognise the ambiguity in performance management which, they claim, gives rise to a search for more sophisticated measurement systems. It follows that this search will be fruitless as important aspects remain unmeasured or fail to capture its full impact. As a result, trust in the measurement system might decline.

Dramaturgy: A hitherto neglected aspect of (informal) performance has been the notion of performance as drama – the symbolic and ritualistic aspects of giving a performance in an organisational setting. Rather than 'performance' being something that is measured, the notion of dramaturgy presents 'performance' as a dramatic composition and representation of the organisation. This might include approaches such as the enactment of impression management. Performance can thus be defined as

'The deliberate, self-conscious 'doing' of highly symbolic actions in public' (Bell, 1997, p.160).

Dramaturgy may help, for example, to understand and explain the processes whereby agents

- "Create and maintain identities as charismatic leaders" (Gardner and Avolio, 1998, p.32);
- Manipulate organisational symbols in order to build narratives about the organisation (Ritto and Silver, 1986);
- Deploy ritual in meetings to create and maintain a sense of organisational identity (Peck *et al*, 2004)

Dramaturgical analyses tend to examine organisational 'outputs' such as board meetings or public documents in order to search for meaning. Gardner and Avolio (1998) identify framing, scripting, staging and performing as ways of explaining "the situated interaction itself constructs new knowledge/understandings/ power relationships" (Freeman and Peck, 2007). Such step-wise analysis aids identification of the ways in which ritual and ceremony are deployed. For example, Freeman and Peck (2007) claim that meetings have dual purposes; firstly, instrumental, palpable and explicit and secondly, social, symbolic and implicit. Dramaturgy focuses especially on the latter. So, the purposes of a PCT board meeting might comprise both the formal action of holding the PCT to account and also the building of solidarity and cohesion within the senior management. This latter claim can be supported by the fact that often, board meetings do not make decisions but overtly

or covertly, seek ratification of decisions already made. Meetings thus become the venue for rites of affirmation or initiation. Freeman and Peck (2007) offer another example: participatory governance practices. They examine the "setting(s) in which deliberation takes place and the norms expressed during the process."

- Interplay between hard and soft information:

Given the significance of formal performance and the mediating role of informal performance, it is important to examine the interplay between them. Indeed, the interplay is implicitly recognised by the way in which, for example, the Healthcare Commission's annual check is summarised in its two headline measures (clinical quality and use of resources). Beneath these headlines lie a series of narrative accounts which rely heavily on subjective assessments. This has overtones of the inspection system (OFSTED) in English schools which also comprise (quantitative) summary measures and a narrative (<http://www.ofsted.gov.uk/Ofsted-home/Forms-and-guidance/Browse-all-by/Education-and-skills/Schools/How-we-inspect/School-self-evaluation>). Indeed, Schools are now required to complete a self-evaluation form to self-diagnose their 'own' performance.

Huang and Provan (2007) discuss the interplay between what might be termed formal and informal performance. They argue that the balance between past performance (formal) and perceptions (informal) is "fragile" and "uncertain", especially when organisations have contradictory objectives and measurement is problematic. If the "social outcomes" of this interplay are valued by the organisation and its stakeholders, then, Huang and Provan argue, legitimacy will be enhanced.

Often, there appear to be shortcomings of formal performance systems in that they fail to convince local agents. This can breed further doubts about the value of initiatives such as 'earned autonomy' (Goddard and Mannion, 2006). A reliance on both formal and informal approaches might thus appear a sensible strategy. However, this can also risk the erosion of incentives for formal performance measures, especially if a degree of autonomy is already available to organisations (often through informal approaches)

Goddard *et al* (1999) identify three ways in which "hard" and "soft" information on performance is employed. (Here, hard and soft equates well with formal and informal measures). First, soft information can be seen as a substitute for hard information.

"Hard data are not available on all of the areas which are seen as important factors in forming a judgement on Trust performance" (Goddard *et al*, 1999, p.126).

No performance system would ever be able to comprise sufficient information to capture all aspects of performance which might be of interest. Soft information, it is claimed, might replace such hard information in offering a summation of performance. Indeed, before the relatively recent introduction of formal performance metrics, it is arguable that only soft information existed. Alternatively, formal/hard performance information may not be in a format that is desired; for example, the unit of analysis is often the organisation (rather than divisions within it or individuals). Hence, as Talbot (2005) asks, "Where does performance take place – with programs, organisations or people?" (p.493)

Second, soft information can be seen as a complement to the deficiencies of hard information. Alone, the latter can be misleading or inadequate to enable others (such as a PCT) to judge the performance of another (such as a provider). Combined, hard and soft information can complement each other, offering a more rounded picture of an organisation's activities. Goddard *et al* (1999) suggest that neither approach was able to determine what is "really" happening:

"Health authority staff also indicated that whilst the hard indicators provide an overview of Trust performance, they need to supplement this with softer information in order to get a fuller picture of what is 'really' happening within Trusts" (p.125).

Third, hard information may act as a safety net, providing a degree of re-assurance most especially in cases of 'poor' performance. As such, hard information can be seen as a "screening device" which helps identify 'poor' performance (see also Greener, 2003).

In judging the balance between formal and informal performance (and the interplay between them), it should be noted that other factors might also determine organisational performance. For example, Appleby and Mulligan (2000) estimate that over 40% of health performance in a given area might be explained by socio-economic factors which lie beyond managerial or organizational control.

"New strategic health authorities should have a coordinating role for performance measurement, and still collect hard data about performance in health-care organisations, but also recognise the need to use soft information and not forget the socioeconomic context within which health organisations are working." (Greener, 2003, p.247)

In summary, performance management regimes have acquired a growing scope and remit within the NHS. However, this focus on formal aspects has not excluded informal aspects; indeed, both seem to have been incorporated, relying on each other to provide both important insights into organisational activities and as levers for service improvement (especially among poorly performing organisations). Indeed, neither formal nor informal performance measures can fully capture the entirety of the organisation's activity. In order to strike a judicious balance, central and local agents must exercise politically-informed judgement (Stewart and Walsh, 1994).

3 Methods.

This chapter describes the research design and the methodology that has been adopted in this study, based on the original aim and objectives. It considers the methodological challenges and problems which were encountered during this study.

3.1. Aims and objectives

The original aim of this study was to investigate the inter-relationship between decentralisation and performance in LHEs. Five objectives flowed from this aim:

- a. To examine the impact of decentralisation upon performance through analysis of selected 'tracers' (as examples of current priorities) in local health economy (LHE) case-studies;
- b. To describe the local interaction of governance mechanisms;
- c. To evaluate the degree of autonomy available to local health-care organisations;
- d. To assess the (financial and non-financial) incentives associated with different policy initiatives;
- e. To provide lessons for policy-makers and managers at all levels in implementing decentralisation, managing the implications of autonomy and incentives, and addressing performance management through incentives.

3.2. Overall methodology

3.2.1. Comparative case-studies

In order to achieve the aims and objectives of the study, the plan of investigation was to adopt a longitudinal, comparative case-study methodology of LHEs in England. To capture the nature of change and interaction within LHEs as complex adaptive systems, it was felt that a primarily qualitative study would be appropriate. With this in mind, the LHE would be considered as the case-study and the unit of analysis. Comparative case-studies were thought to reveal the apparent differences in motives, patterns and outputs/outcomes. However, case-studies are open systems which complicate data collection. This methodology has become widely applied in policy and organisational studies in recent years (for example, Buchanan *et al*, 2007; Greenaway *et al*, 2007).

3.2.2. Rationale for case-study selection

The purpose of the research project was to investigate the inter-relationship between decentralisation, governance mechanisms (hierarchy, market and networks), incentives and performance in LHEs in England. In particular the research sought to understand the pathways that link the above factors to performance as well as the conditions for their optimal balance.

On the basis of the stated objectives, the research adopted a comparative case study design and identified the LHE as its unit of analysis. A Local Health Economy is commonly defined as a community of local (NHS and non-NHS) organisations that offer health care and other welfare-based services. Furthermore, to provide greater focus, the study identified specific policy priorities or areas of service (tracers). These tracers were relevant to all local communities in England and had been used to variously capture the local interaction of market forces, incentives, autonomy, decentralisation and inter-organisational relationships and also to improve understanding about their impact on performance. In order to gain an in-depth portrayal of these dynamics, more than one tracer was selected. This approach allowed comparisons within tracers (across LHEs) as well as across tracers (within a LHE). The intention had been to provide depth and breadth to these issues,

3.2.3. Case study selection criteria

A main design issue was the selection of the case studies, which involved the choice of LHEs. Secondly, the selection also involved the choice of tracers. Case study selection required a number of methodological choices in terms of the logic of selection, the criteria for selection, and the number of cases. These are examined in turn.

Drawing on Yin's (2002, p.47) concepts and rationale for the selection of case studies, the research used a replication logic according to which contrasting LHEs (and tracers) are selected for analysis. This theoretical replication approach was based on the development of a conceptual model that draws on Pawson and Tilley's (1997) work. Pawson and Tilley, in the context of programme evaluation, argue that the mechanisms (M) through which a programme is expected to function are shaped by the context (C) in which the programme is implemented. The interaction between context and mechanism generated outcomes (O). Therefore, a "realistic evaluation" of the programme should be guided by the development of a theory that links contextual characteristics, mechanisms and outcomes, which are called "context/mechanisms/outcomes configurations." The configuration of the C-M-O was essential to discern effectiveness and evaluate programme impact. The identification of the relevant contextual factors and their linkages to mechanism and outcomes can be based on academic theory and previous research as well as on practical/folk theory.

In the context of this study, adopting Pawson and Tilley's framework implied that LHEs should be selected on the basis that they vary in terms of their local contextual frames. Context is assumed to shape local dynamics in terms of functioning of market, hierarchy, networks and incentives (the mechanisms) and in turn organizational and LHE outcomes. This also reflected the national policies that are being implemented (by and large) across all NHS organizations; hence, 'mechanisms' can be seen as a constant between LHEs, whereas 'context' varies between them.

However, following the same logic, tracers could be selected that present different characteristics in terms of degree of autonomy, degree of competition, requirement for inter-organisational collaboration, because of their nature (Propper and Soderlund, 1998; Thomson, 1967), and of a differential national context (e.g. NSF,

NICE guidelines etc.). Consequently, the study design aimed to provide in depth understanding of differential local dynamics and their effects as they are shaped by contextual characteristics.

The team developed a general model of alternative “context / mechanisms / outcomes” configurations. Various streams of literature have provided a theoretical basis for identification of relevant contextual criteria, their linkages with mechanisms and the linkages of the latter with outcomes. This model could then be applied to specific tracers to hypothesise how local dynamics for the tracers change depending on the contextual frame (the LHE).

Two clarifications are, however, necessary. First, for the sake of clarity and simplicity, the conceptual model has been developed as linear relationships, where for each contextual characteristic, corresponding mechanisms and potential outcomes are hypothesised. However it is evident that complex causal pathways (which are made up of multiple influences) are likely to be a more accurate representation of local dynamics. It was hoped that empirical analysis would help identify some of these complex interactions and their implications for the LHE. Second, the model set out to conceptualise outcomes both in terms of behaviours and performance. However, behavioural changes have proved more immediate to trace than performance changes and are therefore the main focus of the conceptual model.

Tracers were selected to achieve variation in terms of the degree of command and control exercised from the centre through NSFs, NICE guidelines and programmes and guidelines for change, the degree of competition to which the tracer is subject, the requirement of inter-organisational collaboration, and the extent to which the tracer is subject to national programmes such as patient choice, and PBR. As previously mentioned, hypotheses on the behavioural and performance consequences of these mechanisms are based on a number of theories and literature strands including public choice and principal agent theory, public policy implementation theory, decentralisation literature, inter-organisational relations literature and institutional theory. For example, the incentive effects of competition in terms of innovation and change are strongly advocated by public choice theory (see for example Tullock *et al*, 2002). By the same token, the decentralisation literature argues that autonomy increases flexibility in designing services and releases managerial entrepreneurship, thereby facilitating innovation and ultimately performance improvement (as discussed in the literature review by Davies *et al*, 2005; Peckham *et al*, 2005; Peckham *et al*, 2008). Alternative paths to outcomes are proposed by other scholars. For example, in the context of educational reforms, evidence has shown that schools respond to increased competition by engaging in symbolic change (Lubienski, 2005) rather than changing processes.

In order to determine the LHE selection, a number of contextual criteria were identified for their relevance on influencing mechanisms and outcomes. These criteria included:

1. location: regional spread across England,
2. level of PCT funding: above and below parity,
3. comparative performance of the LHE (individual and collectively), according to formal performance metrics (such as the former star ratings), and
4. presence of Foundation Trusts.

The framework traced the linkages of these contextual factors to mechanisms and outcomes drawing on the cited theories, as well as practical theories. For example, geographical location was considered as a proxy of the number and types of local service providers. The number and type of providers shape at least two mechanisms. First, they shape the characteristic of the local market in terms of degree of competition and contestability actually operating in the market. Therefore, for tracers subject to competition (e.g. elective procedures), it was expected that different behavioural outcomes would be evident in different LHEs. Second, the number and types of providers shape the degree of inter-organisational complexity. For services where inter-dependences are strong (such as urgent care), inter-organisational complexity influences coordination of these inter-dependencies and collaboration. (Coordination is expected to be facilitated when inter-organisational complexity is lower). Moreover, inter-organisational complexity impacts the ability of an organisation to act autonomously within the LHE (Bossert, 1998; Fleurke and Willemse, 2004).

A final design issue refers to the choice of the number of LHEs and tracers. This choice entails a trade-off between breadth and depth. More LHEs would allow greater breadth in terms of contextual factors and would strengthen theoretical replication. However, having an in depth understanding of a LHE dynamics is fundamental to the research objectives. This requires having more than one tracer, and the inclusion of as many organisations as possible that are relevant to the tracers.

In order to anticipate the type of data that might be gleaned from fieldwork in case-studies and to acclimatise the researchers to the *a priori* themes, a hypothetical case-study was constructed (Appendix 1). It was developed, using extracts from quotes of NHS managers, clinicians and policy-makers. Whilst not designed as a comprehensive exercise (data was only gathered for 3 months in 2006), it did prove helpful in appreciating the saliency of different policy and practice issues.

As a consequence, a study of several LHEs would have been extremely complex and resource-consuming. Given these considerations the research team decided to have two LHEs and three tracers. This decision was vindicated by subsequent logistical difficulties that were to arise in securing access to and ethical approval from the potential case-study sites.

3.2.4. LHE selection

The research team conducted a process of LHE selection. For practical reasons, the team narrowed the selection to 8 candidate areas. It also decided to exclude London on the basis of features which would made LHE boundary issues more problematic. As such, London was considered an outlier. To initially identify candidate LHEs in the 8 areas, PCTs and their main providers were listed. Preliminary data collection was undertaken for each of these candidate LHEs. This classification was based on currently existing PCTs, as of summer 2006. However, PCTs underwent re-organisation in October 2006. Thus, it was important to take into account the then-imminent reconfiguration of PCTs by considering likely re-configured PCT and eventually, by grouping merged 'old' PCTs under the 'new' PCT. This provided a picture of the comparative characteristics of the PCTs that were supposed to merge

in October 2006. Candidate LHEs were profiled using different data sources. Office of National Statistics Bands classification and rural/urban classification provide the source against which candidate PCTs have been profiled in terms of location. Other data included formal performance ratings of the PCT and main Providers (according to the Healthcare Commission), main providers' FT status, funding level of the PCT (above / below parity) and coterminosity with Local Authorities. Table 3.1 provides the profile of LHEs against these criteria.

Table 3.1. Candidate case-study LHEs

Candidate LHE	Performance (2006-07) PCT & main 'local' provider*	Geography DH categories	Complexity
A	PCT: (i) Fair (ii) Fair Provider: (i) Excellent (ii) Fair	"Regional centre"	Low
B	PCT: (i) Fair (ii) Weak Provider: (i) Good (ii) Weak	"City with industry"	Low
C	PCT: (i) Fair (ii) Fair Provider: (i) Excellent (ii) Excellent	"Prospering towns"	High
D	PCT: (i) Fair (ii) Fair Provider: (i) Fair (ii) Fair	"Prospering towns"	High
E	PCT: (i) Weak (ii) Fair Provider (i) Excellent (ii) Good	"City with industry" & "Prospering towns"	Mixed
F	PCT: (i) Good (ii) Good Provider: (i) Good (ii) Weak	"City with industry" & "Prospering towns"	Mixed
G	PCT: (i) Fair (ii) Fair Provider: (i) Fair (ii) Weak	"Prospering towns"	High
H	PCT: (i) Weak (ii) Weak Provider (i) Excellent	"Mining and manufacturing"	Low

	(ii) Excellent		
I	PCT: (i) Weak (ii) Weak Provider: (i) Fair (ii) Fair	"Prospering south England"	High
J	PCT: (i) Weak (ii) Fair Provider: (i) Good (ii) Fair	"Prospering towns" & "Regional centres"	High

*Comparative performance is based on the assessment of how the performance of the old PCTs (pre-2006) comprising the new PCT (post-2006) compared with the performance of their main providers

Healthcare Commission annual health check scores relating to (i) Quality of services and (ii) Use of resources

The team decided that characteristics of location would be the initial criteria of selection. There would then be a consideration of the other criteria as well as of knowledge that the team has developed through preliminary documentary analysis, collection of current information (e.g. from Health Service Journal, the Guardian etc.) and preliminary informative interviews with key stakeholders in the system (e.g. managers from NHS organizations, and individuals from key entities such as, DH, Healthcare Commission and NHS Confederation). Overall, case selection was based on an informed judgement taking a number of factors into account.

A total of three case-studies was originally thought to represent sufficient breadth of LHEs. On advice of the Advisory Group, two were selected to ensure sufficient depth rather than breadth. The two case-studies represented contrasting LHEs in terms of performance, geographical location and LHE complexity:

- *Performance*: as no single measure of LHE performance exists, it was necessary to judge overall performance. Using the former star ratings, the two LHE case-study exhibited the performance dimensions (table 3.2. and 3.3).
- *Geographical location*: the LHEs comprised a major urban area and a semi-urban/semi-rural area. Also, the LHEs were located in the north and the south of England.
- *Complexity*: one LHE was a 'closed', highly dependent LHE (involving few NHS organizations) whilst the other was an 'open', highly inter-dependent LHE (involving multiple NHS organisations).

The two LHEs were termed Northern and Southern to preserve their anonymity. (A detailed case-study profile of the two LHEs is presented in Appendix 2)

Table 3.2. Northern LHE performance

Organisation	Year	Star ratings	HC Annual health check	
			Clinical quality	Use of resources
"Northern" PCT	2005-06	-	n/a	n/a
	2006-07	-	Weak	Weak
	2007-08	-	Fair	Fair
"Northern" Hospital 1	2003-04	3*	-	-
	2004-05	3*	-	-
	2005-06	-	Good	Excellent
	2006-07	-	Good	Excellent
	2007-08	-	Excellent	Excellent
"Northern" Hospital 2	2003-04	3*	-	-
	2004-05	3*	-	-
	2005-06	-	Good	Fair
	2006-07	-	Excellent	Excellent
	2007-08	-	Excellent	Excellent

Table 3.3. Southern LHE performance.

Organisation	Year	Star rating	HC Annual health check	
			Clinical quality	Use of resources
"Southern" PCT	2005-06	-	N/a	N/a
	2006-07	-	Weak	Weak
	2007-08	-	Fair	Fair
"Southern" Hospital 1	2003-04	2*	-	-
	2004-05	3*	-	-
	2005-06	-	Good	Weak
	2006-07	-	Fair	Weak
	2007-08	-	Good	Fair
"Southern" Hospital 2)	2003-04	3*	-	-
	2004-05	3*	-	-
	2005-06	-	Good	Excellent
	2006-07	-	Excellent	Excellent
	2007-08	-	Excellent	Excellent
"Southern" Hospital 3	2003-04	0	-	-
	2004-05	2*	-	-
	2005-06	-	Good	Weak
	2006-07	-	Fair	Fair
	2007-08	-	Excellent	Good
"Southern" Hospital 4	2003-04	0	-	-
	2004-05	0	-	-
	2005-06	-	Weak	Weak
	2006-07	-	Weak	Weak
	2007-08	-	Fair	Fair
"Southern" Hospital 5	2003-04	2*	-	-
	2004-05	1*	-	-
	2005-06	-	Fair	Fair
	2006-07	-	Good	Weak
	2007-08	-	Good	Fair

The case-study profiles (appendix 1) also illustrate the contrasting nature of the two LHE case-studies in terms of the financial flows between the PCT and local providers. In the Northern LHE, the 4 former PCTs spent between 95% and 97.4% of their (hospital and community health services) budget with providers located within their boundaries. Similarly, in the Southern LHE, two Trusts received as much as 93% of their budget from the local former PCTs.

3.2.5. Tracer selection

To direct the attention of inquiry within each case-study, it was thought that a focus on selected tracers would be appropriate. To ensure some consistency across LHE case-study sites, the tracers needed to be national priorities. These tracers were selected to illustrate the potential and the pitfalls of local governance mechanisms and the decision space which may enable/constrain, say, commissioning or service developments. The criteria for such tracers include:

1. *Governance regime* (the mix of market, hierarchy and network); for example, market concentration indices may be applicable in day case surgery whereas forms of hierarchical control will influence organisations' financial balance;
2. Number and type of *local organisations* involved (for example, Chronic Disease Management may involve more organisations than others, posing problems of coordination; similarly, others (such as day case surgery) will have a stronger presence of private health-care providers);
3. *Tracer type* (for example, some tracers focus on organisational processes, some on service delivery and others on social determinants of health);
4. *Autonomy* (for example, some tracers (such as Coronary Heart Disease) are more centrally prescribed than others (say, tackling health inequalities) because of central policy guidelines and framework and/or clinical effectiveness evidence).

The purpose of the tracer was to provide insight into these themes, rather than a specific focus on the services themselves. The tracers were also useful in applying the components of the Arrows Framework (Peckham *et al*, 2005): inputs, process and outcomes.

The candidate tracers originally included

1. Emergency admissions,
2. Tackling health inequalities,
3. Chronic disease management,
4. Coronary heart disease (CHD),
5. Day case surgery and
6. Financial balance.

On the advice of NCC-SDO and the project's Advisory Group and in the light of current English health policy, three tracers were selected across all case-studies (appendix 3). Three tracers across three case-studies were thought to be a manageable workload given the size and scope of the proposed project. These were urgent care, elderly care and orthopaedics. The rationale for each tracer is summarized in tables 3.4 to 3.6.

Table 3.4. Urgent care tracer

Control from the centre/autonomy	<ul style="list-style-type: none"> • Identified as a national priority in the NHS Plan 2000. • Autonomy over outcomes is limited by specific targets incorporated in the performance management framework. Both NHS Trusts and PCTs are evaluated on Urgent Care related targets • There are no NSF frameworks specific to urgent care. However several NSFs influence the way patients should be treated during their journey through the urgent care system (ambulance, A&E) • Autonomy over processes is greater but within the framework of a 10 year national strategy and several guidelines and national-led improvement programmes
Degree of competition	By nature, urgent care is not subject to competition
Service Interdependencies	<p>Urgent care entails a great deal of interdependencies among different actors of a local urgent care system. Interdependencies require collaboration and coordination between them and flexibility in the utilization of staff. PCTs are likely to serve as the leading organisation in the re-design of urgent care pathways to assure a smooth and seamless journey of the patient from first contact with until exit of the system.</p>
Influence of national policies	<ul style="list-style-type: none"> • Patient choice not likely to influence urgent care • PBC - limited • PBR – limited

Table 3.5. Elderly care tracer

Control from the centre/autonomy	<ul style="list-style-type: none"> ▪ Became a national priority in the NHS Plan 2000 ▪ Autonomy over outcomes: a specific National Service Framework has been produced in 2001 and recently reviewed. The NSF sets the targets for elderly care inside and outside the hospital setting ▪ Autonomy over processes: moderate
Degree of competition	The degree of competition depends on the aspect of elderly care that is looked at. For example, orthopaedic and cataract procedures are likely to be elective. Conversely emergency admissions for elderly patients are not subject to competition
Service Interdependencies	Elderly care entails a great deal of organisational inter-dependencies. It involves both health-care providers and social care providers. It also cuts across the other two tracers as both urgent care and orthopaedics are two services frequently utilized by elderly. Achieving the targets set out by the NSF requires joint working and collaboration, which involves PCTs, NHS providers and Local Authorities, as well as the Independent Sector
Influence of national policies	<ul style="list-style-type: none"> • Patient choice is likely to be relevant for those procedures that are elective, not on urgent care procedures. However given the characteristics of the population, the exercise of choice by elderly patients may be even more limited than for other categories of individuals • PBR also is likely to influence where elective procedures are involved

Table 3.6. Orthopaedics tracer

Control from the centre/autonomy	Targets have been set out for orthopaedics to tackle waiting times for elective procedures. However there has been a great deal of freedom left on the processes of service redesign
Degree of competition	Procedures tend to be elective, therefore this tracer is subject to competition and contestability
Service Interdependencies	Service redesign in orthopaedics is likely to be mostly a provider's internal issue without involving complex inter-dependencies with other actors. However, inter-dependencies may arise with rehabilitative care and home support once an individual has been discharged. Also it is likely that providers search for collaboration with other local providers as a strategy to service redesign.
Influence of national policies	Waiting time targets and Patient Choice are likely to affect orthopaedics significantly given the traditional waiting times for such services. As a consequence, policies such as PBR and PBC will also impact upon Orthopaedics.

3.3. Methods in detail

The study comprised mixed methods, with particular emphasis on qualitative components. The methodology was sequential and cumulative in that later stages were dependent on previous ones to inform the questions and topics to be addressed. In practice, this proved much more complicated than we had imagined because of the complex nature of the LHEs and organisational restructuring in our selected case-study sites. These specific factors are addressed in the sub-sections that follow and later in section 3.4.

3.3.1. Secondary data

● National perspective:

As this NCC-SDO funded project had followed two previous NCC-SDO funded literature review (conducted by some of this research team, led by Stephen Peckham and Celia Davies), it was felt that a detailed review of evidence would be unnecessary. However, the previous studies had not examined decentralisation in terms of the impacts upon organisational performance, and of the ways in which organizational autonomy was shaped by local and national incentives. Given this gap in knowledge, it seemed sensible to undertake a national review of LHEs.

A review of routinely collected data, independent reports and research evidence was undertaken which identified broad patterns of organisational performance across England. Data included independent reports such as Leatherman and Sutherland (2005) and the Healthcare Commission's annual health checks. These broad patterns were analysed by location, organisational size and type. In particular, the patterns also helped to identify case-studies. These data and advice from NCC-SDO and Advisory Group members helped to determine the final selection of case-studies.

● Mapping the LHE

A detailed assessment of each (potential) LHE was made using local performance data (mainly financial and activity data), reports (such as NHS Local Development Plans (LDPs) and those from the District Auditor and Healthcare Commission). The start of the project (2006) acted as a baseline year but such evidence was gathered continually during the study. This mapping exercise helped keep an on-going appraisal of the (inner) contextual factors and the extent of local (LHE and organisational) autonomy. Other local data collected included:

- Recent or planned changes to service provision: eg. commissioning confederations (as conducted in Manchester, Merseyside, Cheshire), vertical acute/PCT mergers (as in IOW, Cheshire, Winchester), PCT devolution contract administration and management, or PCT divestment of provision function (dependent on current DH review of PCTs).
- Structure and pattern of local authority commissioning and provision (eg. unitary *versus* two-tier structure; extent of private sector involvement);
- Emerging local effects of policies such payment-by-results; patient choice

- Evidence from patient / public surveys (eg. local results drawn from national studies).

Data from previous years were also collected which helped to identify evolving patterns and to provide a more informed baseline (for subsequent analysis in this study) up to the start of the 2006-2007 NHS planning cycle (year 1).

3.3.2. "Policy ethnography" in LHEs

In-depth case-studies of local decision-making have been termed "policy ethnography", signifying the ethnographic approach in policy and organizational settings (Flynn *et al*, 1996; Griffiths and Hughes, 2000; Oborn *et al*, 2009). The aim of such ethnography is to glean the repeated action, interaction and reaction of different stakeholders to an on-going / unfolding series of events and decisions. It is the continual nature of such relationships which poses challenges for the researcher but also makes such inquiry so insightful. It is thus not simply a matter of discerning individuals' motives and behaviour but the interactivity between individuals. Such interaction might be apparent during formal settings (such as meetings) but equally, during chance encounters on corridors, over lunch or coffee. In effect, the policy ethnography is the organisational equivalent of Whyte's (1943) "street corner society." The researcher needs to "hang around" (proverbially) in formal and informal settings. This proved very difficult to achieve in the number of organisations involved over the extended period of fieldwork.

Given the constraints within which most funded research operates, a genuine policy ethnography is highly challenging. For example, dividing time between two (or more) case-studies inevitably dilutes the ability of the researcher to glean information. The presence of the researcher might inhibit the conversations of stakeholders, thereby imparting a bias. Moreover, it is impossible to be everywhere to capture all interactions between multiple stakeholders. A judicious choice needs to be made in terms of coverage and depth; coverage ensures all relevant arenas of interaction are included whilst depth provides sufficient knowledge of the repeated interaction in these settings.

The policy ethnography that was adopted for this study was circumscribed in the following ways. First, two case-study LHEs were selected, comprising a total of 10 (NHS) organisations. Given this number, it was not feasible to explore every organization within the two LHEs. The local authority was included. However, despite their role in Practice-Based Commissioning, GP practices were not included. Second, the initial idea of tracking the Local Development Plan (LDP) was not feasible, not least because of the PCT reconfiguration in 2006. During the first and second years of the study, PCTs were almost entirely engaged with reconfiguration linked to systems and processes.

• In-depth interviews

Semi-structured interviews generate detailed information directly from informants. These interviews were held at two levels: national and local.

National level interviews were held with two DH civil servants and two representatives from national organisations. Though the focus of the study was on

decentralisation in LHEs, evidence from the preceding literature review (Peckham *et al*, 2005) and others (eg. Saltman *et al*, 2007) demonstrate the significance of the centre in determining the parameters of decentralisation, notably in terms of the strategic objectives of the system and its performance measures. Such perspectives offer a counterpoint to local level views. It was, therefore, appropriate to interview individuals with a national overview. Interviews addressed the logic, implementation and consequences of decentralisation policies (including PBR, PBC, FT). In addition, individual discussions were held with Advisory Group members who were unable to attend meetings. Such discussion tended to provide a more in-depth insight into current policy tensions and challenges than Advisory Group meetings (where discussions were more wide ranging). Health policy analysis through interviews at this level tend to be less common, partly due to difficulties in accessing this group of civil servants and policy-makers (see Greer and Jarman, 2007), hence the value of these interviews in informing the overall study.

Interviews at the local level were conducted in two rounds in the two case-study LHEs. An initial interview sample was drawn up by virtue of individuals' organisational position (for example, chief executive or medical director), their role in the LHE (eg. PCT Director of Commissioning) or in one of the tracers (eg. clinical director for A and E). Additional individuals were identified from analysis of secondary sources (such as annual reports and strategy plans) or word of mouth. Their organisations included the PCT, local acute Trusts, the SHA and the local authority. Moreover, it was important to interview more than one individual from each organisation (wherever possible). This was to ensure triangulation between and within organisations and professional groups (primarily clinicians and managers). Finally, it was also important to conduct repeat interviews so as to gauge the extent of change over time. The longitudinal perspective was important because of the dynamic nature of LHE and organisational change could not easily be captured in a single data collection. All interviews were recorded (with permission, for transcription and analytical purposes) and were conducted in accordance with the approval from the Research Ethics Committee.

A total of 52 interviews were conducted in phase 1 and phase 2 in both case-studies (appendix 4 and 5). The number of interviewees in the second round was lower than the first because the content and number of phase 2 interviews were largely dictated by the findings of the first round. It was concluded that repeat interviews were not required from each participant in phase 1. Whilst 34 interviews were conducted in phase 1, 18 were undertaken in phase 2. The volume of data was weighted towards one case-study for two reasons. First, the Southern case-study was more complex in terms of the number of organisations. Second, access to the Northern case-study had proved especially problematic (see 3.4.2.). Difficulties of access there curtailed the number of interviews that could be undertaken especially with one organization. As numbers are not meaningful in qualitative studies (for generalisability or power calculations), it was possible to vary the number of interviews in both case-studies and in both phases whilst being confident with the quality of the data. For example, in both phases, there was a reasonable confidence that saturation (of interview topic and respondent coverage) had been reached, largely due to other data sources.

Interview topics in both phases included the effects of governance mechanisms, local contextual influences, perceived organisational/LHE autonomy, incentives, and sources/reasons for organisational/LHE performance, especially relating to the tracer examples (appendix 6). Additional topics included the role of commissioning in the LHE, development of LHE-wide objectives, performance management by the

SHA and clinician involvement. The repeat interviews were informed by the first round of data collection (including the interview, documentation and observation of meetings). Interviews were conducted by four members of the research team.

● Observation

Observation of formal and informal settings is an essential component of policy ethnography. The interactions over time across a community of organisations (the LHE) shape the character of local networks and inter-dependencies and denote the decision space within which local actors operate. This is especially significant in describing and explaining the ways in which local actors negotiate vertical imperatives from the centre and horizontal pressures from within the LHE.

Observation of 14 meetings was undertaken across the two LHEs. These meetings consisted mainly of board meetings (open to the public) but also of 'private' strategy and executive meetings. Both public and private observations corroborated data from other sources, especially interviews. Informants were, for example, observed in meetings and their comments could therefore be contrasted with interview accounts. Detailed field notes taken from each observation were compiled and contrasted with formal records (such as the agenda, minutes and papers for discussion) and communications (phone conversations and emails).

The observations were undertaken by four team members, fostering triangulation between case-studies (including individual organisations) and between researchers. These data were forthcoming from the participating Trusts.

● Documentary analysis

An extensive array of documentation was collated from the two LHE case-studies and from national sources. Documents such as annual reports, strategy plans, board meeting minutes and public consultation documents were gathered on the basis that they informed the a priori and emerging themes of the study. Hence, for example, papers concerning reconfiguration across the LHE were specifically sought. The information gathered in these documents helped to corroborate the interview and observational fieldwork. Such triangulation is common in case-study methodologies (Abbott *et al*, 2004; Elston and Fulop, 2002).

Due to problems of access (see below) in one organization (a Foundation Trust), a request under the Freedom of Information Act was submitted. The request was to see the minutes of the Board of Directors, which are normally private.

3.3.3. Analysis

Comparative case-study analysis seeks to identify and explain patterns across and within organizations and case-study LHEs. Analysis sought to achieve insights in four areas:

1. The interaction of (different) governance regimes, autonomy and incentives (implicit within national policies and local inter-organisational relationships) in forming / shaping performance across the LHE
2. The patterns of performance by organisation and by LHE

3. The relative influence of vertical (hierarchical) and horizontal (networks and market) factors in determining the local decision space (room for manoeuvre)
4. The impact of decisions (including non-decisions) over time.

Given the longitudinal nature of the study (including observations), it was possible to begin analysis at an early stage (soon after data collection began in 2006) in order to inform subsequent phases. The iterative process of analysis involved all members of the team through periodic team meetings and more frequently, among the researchers. The members of the Advisory Group also received and commented on interim findings.

Interview transcripts and observational field-notes were analysed by at least two researchers and their content was organised into *a priori* and emergent themes. Differences in interpretation were discussed among the researchers and later at team meetings. This process helped to identify a common thematic approach.

NVivo software (version 7.0) was used to interrogate these qualitative data. This structured / hierarchical coding framework allowed comparisons to be drawn between and within the key parameters

- LHE (north and south),
- Purchaser (PCT) and providers (eg. acute Trust),
- Organisation (such as Foundation Trust / non-FT, 'poorly' performing Trust), and
- Professional (eg. clinician and manager).

The complexity of multiple interviewees and multiple data sites (organisations and LHEs) were made easier by use of NVivo.

Secondary data (such as documentary reports and quantitative evidence) was analysed through the identification of patterns and trends, consistent with the *a priori* and emergent themes from the qualitative data.

As a way of offering feedback to those who had given their time in the first phase of data collection and so as to corroborate our emergent findings, an interim feedback was sent to all participants in the summer of 2008. This one page report summarised two primary areas of findings: autonomy and organizational relationship (see Appendix 7). The interim feedback summary generated relatively little response from study participants. However, the Health Select Committee did request written and oral evidence from the research team in 2008 (Exworthy *et al*, 2008).

3.3.4. Advisory Group

The Advisory Group was formed to advise the project team on current policy developments and emerging findings. The Group was chaired by a former civil servant and professor at Warwick University. The group comprised 10 individuals, with a mix of academics and policy-makers (appendix 8).

The Advisory group met on 3 occasions. Attendance was generally good. However, on occasion, participants withdrew from a meeting, usually at short notice, making

discussions somewhat truncated. Given their stated on-going interest in the project, the researchers arranged meetings with non-attenders to seek their advice and comment. This proved especially useful as it allowed more in-depth discussion (though at the expense of interaction within other Advisory Group members).

3.4. Issues and challenges

As in any other major study, numerous challenges were encountered in the execution of the research proposal. These fall into three broad categories.

3.4.1. Revisions to the methodology

The original research proposal was written before a major structural change in the NHS had taken place (October 2006, with the reduction on the number of PCTs) and with a certain level of knowledge about LHEs. The re-organisation and a greater appreciation of the dynamics of LHEs demanded certain revisions to the proposed methodology.

- Survey data

Having identified the candidate case-study LHEs and secured access, the first part of the case-study fieldwork was to conduct a self-administered questionnaire. Using an electronic survey facility (Survey Monkey: <http://www.surveymonkey.com/>), the survey was to be sent to:

- a. *SHA* (n=1): CEO, chair and directors (including finance, commissioning/planning and clinical (eg. DPH/medical director))
- b. *PCT* (n=2-3): CEO, chair and directors (including finance, commissioning/planning and clinical (eg. DPH))
- c. *NHS providers* (n=3-4 in each LHE): CEO, chair and directors (including finance, commissioning/planning and clinical (eg. medical director))
- d. *Local authority* (social services department)(n=2) and
- e. *Independent sector* (n=3).

This sample of approx. 60 per LHE (total=180) was to be larger than the later interview sample. (It contrasts with a similar (postal) survey by Mannion *et al* (2007) who surveyed Chief Executives of all 173 NHS Trusts in England). Respondents were to be asked to identify the perceived degree of local autonomy, local service and policy dilemmas. A mix of open and closed questions would, it was thought, confirm the documentary assessment (identified earlier) and ascertain the current organisational issues to provide an up-to-date picture across the LHE. This would also provide a baseline for subsequent qualitative methods.

However, the intention to conduct this survey questionnaire was hampered by the logistical and bureaucratic concerns. First, the logistical issues of operationalising the LHE soon became apparent. Whilst it was relatively easy to identify the key organizations and some individuals within them, it became less clear which individuals within were most suitable recipients of the questionnaire. This raised questions of comparability between organisations and LHEs. Second, at the time of questionnaire construction (summer 2006), PCTs across England were in a period of re-configuration. This created a 'shadow' effect of several months before and many

months after the formal reconfiguration which took place in October 2006. For example, at this time (summer 2006), in both LHE case-study sites, the PCT consisted only of a handful of executive officers (at senior or junior level). Former PCT managers had left or been re-located. There was little organizational memory and even less appetite to undertake a research study, let alone a questionnaire. (Further discussion of Access is presented below).

As a result of these deliberations and other data (see 3.3.1), the aim of the survey – to glean an in-depth picture of LHE issues – was achieved through other means, primarily the collection of documentary evidence and discussions with LHE staff and relevant external individuals (such as the SHA and DH).

- Case-studies and tracers

It had originally been proposed to conduct three case-studies in contrasting LHEs. As initial exploration of the fieldwork was undertaken and taking advice from the Advisory Group (June 2006 meeting), it was decided to reduce the number to two. The complexity of the LHEs (the number of organisations and the inter-relationships between them) and conducting research in them (over two phases and across three tracers) within the available resources were critical factors in this decision. Dividing these resources (primarily researcher time) between three LHEs was thought to dilute the ability to conduct an effective policy ethnography. Two LHE case-studies would still provide sufficient depth within LHEs and also breadth across contrasting networks of organisations.

The reduction of case-study numbers also allowed a more detailed ethnographic approach within the remaining two. For example, the original proposal had stated that the meetings to discuss the Local Development Plan (LDPs) would be observed. In fact, a wider range of meetings were observed, adding to the richness of data collected.

The background analysis relating to the tracers, nationally and locally (appendix 3) shaped the thematic approach to data collection. However, it became apparent from initial fieldwork that it would be problematic to isolate individual tracers. Rather, the study took a wider approach but one informed by the tracers. For example, we conducted interviews with lead clinicians in the respective service areas but did not restrict the questions to the tracers alone.

3.4.2. Access

The research team was experienced in conducting applied research, in conjunction with NHS organisations. However, the project proved extremely challenging to secure access to NHS sites. This seemed to stem from a combination of three inter-related factors.

First, the start of the project (spring 2006) was in the shadow of the imminent re-organisation of PCTs. As the PCT had been taken as the core of the LHE for the purposes of this study, it was essential that access to these organizations was

secured. Initial contact proved hard to establish as both sites only had a skeleton staff in the summer of 2006. For example,

"The PCT only has "8 substantive people" in post, the last one joining on 1 April. The CEO's management team of 9 is still 2 short." (From researcher field-notes of phone conversation with Northern PCT Chief Executive, 26 April 2007).

Despite an expressed interest in the project, senior managers had multiple and competing issues, not least to establish the infrastructure and effective governance of their organizations. The PCT Chief Executive in the Northern case-study was sympathetic to the project and said that "natural urge to snap hands off" that offer support (like this project) but feels he must resist (from researcher field-notes from phone conversation, 26 April 2007). However, given the process of PCT re-organisation, the decisions following our initial requests in early 2007 was deferred until the autumn of 2007, as indicated in the following emails:

"Have double checked again with [the Chief Executive] and he is not yet in a position for a meeting with you. Maybe give it a few months and contact us again to see if the situation has changed. The organisation might be a little more structured then because as you know he has only been in post since Dec [2006] and his Directors are just taking up their posts." (Email from Chief Executive's secretary, 14 March 2007).

"...the Senior Management Team [of the PCT] agreed that a 2 year research project looking at the PCT's success... would be valuable. We would, therefore, wish to proceed on this basis... [but] particularly bearing in mind the need to minimise any PCT involvement before October [2007]." (Email from Chief Executive, 16 July 2007).

Second, access proved not simply to be a one-off decision but an on-going negotiation between the team and the organisation but significantly, between local organisations the team. Seeking initial interest in the project from senior NHS managers prompted the response that their organisation would participate if others did so too. In many instances, this relied on securing the agreement of the PCT (see above). Having secured an agreement in principle, access was not always or necessarily secured from participants. Across the two LHE case-studies, three organisations (all providers) refused to participate. One of these refusals was later to reverse its decision in phase 2 when interviews and observations were undertaken. Of those who did participate, most respondents were generally supportive of the project but some required persuasion to participate (eg. to be interviewed). Across the two LHE case-studies, only a couple refused to take part. Access was such a problem that, having sites to agree to a questionnaire survey as well as to two rounds of interviews, the former become unfeasible. A related dilemma here was how to approach access in relation to ethical approval; this is explored in more detail below.

Third, the challenge of securing access from one provider, in particular, illustrated many of the wider issues for the research community in conducting such research. The initial approach to the Trust was through its Research Governance committee. This application (which was submitted in October 2006) was rejected in late 2006 on grounds that it was not relevant to the Trust. The response in this rejection seemed to indicate a misunderstanding of the nature of the project. Therefore, one

of its Directors was approached (in November 2006) to seek the provider's (a Foundation Trust) participation in the study. Although the Director was not supportive of the request, the PCT Chief Executive had suggested in discussions about the PCT's participation (October 2006 – March 2007) that another Director at this provider Trust might be sympathetic. The second Director was contacted in May 2007 and he indicated that

"I have gained clearance with my colleague Directors subject to a discussion with [PCT Chief Executive]. I will arrange this as quickly as possible and get back to you." (Email, 20 July 2007)

Agreement to participate had already been secured from the PCT Chief Executive. This was indicated by the research team to the provider Director (in a phone conversation and email, 4 December 2007) and by the PCT Chief Executive (email, 4 December 2007):

"I have indicated that it [the project] should not interfere too much or be too onerous and the history to date is good on this." (PCT Chief Executive email to provider Director, 4 December 2007).

(The reference of "history to date" refers to a previous research project led by the PI which had involved the Chief Executive when he occupied a different managerial position elsewhere. It had been fortuitous that the LHE was being chosen at around the same time that the new PCT Chief Executive was being appointed in 2006). The reactions to this email from the provider Director were positive:

I will seek support from colleagues and assuming they are up for it I suggest we agree a start date and some sort of joint sponsorship. Will confirm later this month." (Email from Director to PCT Chief Executive 14 January 2008).

However, by early February 2008, the provider Director reported that the Trust was not sympathetic, not least because of wider policy developments.

"We discussed the proposed project at some length at our Executive meeting last week and unfortunately the consensus view was that we could not support the project at the moment. The Trust is managing a number of vital challenges over the next 6 months and the focus necessary to do justice to your research just would not be sufficient in terms of the availability of key staff to follow your methodology. Also the work needed to pilot the project through the local ethics committee would be considerable taking into account the current long lead times for research projects of our own to be considered. Inherently the subject matter was of interest but there was an almost fatalistic view that no matter what the study revealed the headroom for local determination (despite what is said and published) will be small whilst ever the NHS is the subject of national direction through an executive that is essentially driven by Political preference." (Provider Director email to Principal Investigator, 4 February 2008).

(The reference to the 'local ethics committee' was slightly disingenuous because the research governance process had already been undertaken and, though the initial response was negative, the majority of paperwork was already in place. This workload would largely fall on the research team). The comments towards the end of the list email are highly significant since the provider – a Foundation Trust – did not enjoy sufficient "headroom", free from "political preference." The PCT Chief Executive's reaction to this email was sought; he explained:

"I don't think [Director] was ever keen and I know he was feeling pretty disgruntled on that day." (PCT Chief Executive email to Principal Investigator, 15 February 2008)

The research team asked the Director to reconsider (now, with even more minimal Trust involvement, ie. a fewer number of interviews) and the subject was tabled at the Trust's Executive meeting (25 June 2008). However, the Director explained: "unfortunately time ran out and I had to leave the meeting early" (email to Principal Investigator, 7 July 2008). With a month, the topic had been discussed but the outcome was negative.

"We discussed again your request that we be involved in your research project together with [Northern] PCT. However, having explained to my colleagues your revised proposal to limit the contact with this Trust, the prevailing view was we would still prefer not to participate in your project. I am sorry that this is the outcome and I feel that further appeals would be fruitless. I wish you well with your project and hope that you can produce some useful work, albeit without the co-operation of this Trust" (Email to PI, 29 July 2008)

Given the PCT's support and the cost (primarily time) of pursuing a replacement case-study, it was decided to continue seeking access across this Northern LHE case-study. Though this Trust had decided not to cooperate in direct data collection, it was possible to observe some of their meetings, and collate documents. Given the limited access to some FT documents, it was decided to make a request for Board of Directors' meeting minutes under the Freedom of Information Act.

The implication of these specific factors was to increase the "transaction cost" of conducting the research. A tremendous amount of time throughout the life of the project was spent in simply securing the access of organizations. The research team kept on "Contact Diary" (kept on a password-protected internet file sharing website) to monitor the contact with case-study sites. This proved extremely helpful. It showed that, in the first 15 months of the study (to July 2007), 37 contacts and 131 contacts (by phone, email or visit in person) were made with individuals in the Northern and Southern case-studies respectively. These contacts were simply to secure access and did not include arrangements to collect data (in terms of interview or observation, for example).

Participation in this study was entirely voluntary. It is significant therefore that, despite stressing the funding of the research team came from the NHS, some organizations still refused to take part. In our correspondence with this Trust (and others), we had stressed the commitment of participating in the study, as follows: minimal organizational involvement (comprising 1 hour interviews with about 8-10 Trust staff), unobtrusive observation of meetings, and access to relevant documentation. The organisational imperative to be involved in evaluations was overlaid too with an emphasis on accountability for public funds and on the need to share lessons and good practice across the NHS. The rights and responsibilities of developing an evidence-based approach to health services, their management and policy seemed to be weighted against the researchers. In sum, it was significant that the project, which was examining the impact of autonomy, was to encounter organisations' autonomy in deciding not to participate.

3.4.2. Ethics and research governance

The research team sought ethical approval from London and Surrey Borders Research Ethics Committee (REC). Approval was secured following their meeting on 12 July 2006. In the REC's letter (13 July 2006) (appendix 9), it stated that

“You should arrange for the R&D Department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter. All researchers and research collaborators who will be participating in the research at a NHS site must obtain final research governance approval before commencing any research procedures. ”

Subsequently, the R&D department of each Trust in the two LHEs was approached. Most required the completion of local research governance approval but significantly, not all did.

The “transaction costs” (preparation time and attendance at the REC meeting) was substantial, possibly amounting to 4-6 months (elapsed time). This heavy commitment for a study which was interviewing only senior managers and clinicians, and observing meetings (some of which were public anyway) seemed disproportionate to the ethical issues at stake.

From the outset of the study in 2006, the bureaucratic issues concerned access and ethical approval were problematic. It had been debatable whether the LHE case-study sites should be approached first (to garner their initial support) or whether ethical approval should be sought first (in order to ensure a smooth introduction once access had been agreed). The former option would involve an initial contact and agreement to participate in principle, then some period of time (probably months) to secure ethical approval from the Research Ethics Committee and local Research Governance approval. The latter option would, assuming a favourable REC approval, run the risk that access might later be denied and implying that research governance process had been pointless. In the end, initial soundings were sought from key parties ahead of the ethical approval and research governance processes.

3.4.3. Limitations of the methodology adopted

The study has been primarily qualitative in its methodology. Whilst this approach offers some strengths which have enabled rich data to be garnered, it also presented some limitations. Qualitative methods are limited in that interviews consider the perceptions of respondents and observations only reveal actions at that time. Reliance on these data can also introduce bias or be misleading. We sought to maximise triangulation (of the same participants in different settings) which would enable more robust interpretations to be drawn from these data. However, triangulation cannot be comprehensive in two case-studies, involving several organisations, over an extended period of time. It is impossible, for example, to capture the web of networks operating between organisations. We have thus sought to portray an authentic picture of the case-studies and believe that we have achieved this from feedback (in the second round interviews and other case-study contact).

We did not consider quantitative methods to be useful in this study because they would be ill-suited to examining the actual effect of decentralisation on performance, not least because we have defined performance in a broader sense than simply official measured outcomes (some of which are outlined in the case-

study profiles; see Appendix 2) or quantified responses from participants. These data would, for example, be unable, for example, to reveal how patterns of performance were achieved. We were thus not interested formal performance metrics per se but rather how ideas about performance were enacted and managed.

4 Findings.

The empirical findings are divided into two broad categories: autonomy and performance. These two comprise the primary themes which framed the literature review and shaped the *a priori* and emergent themes revealed through fieldwork. NVivo coding did reveal a breadth to both these themes which tended to subsume other, seemingly less significant themes.

4.1. *Autonomy*

4.1.1. Views on autonomy

This section of the chapter reports on respondents' views on the benefits and value of autonomy. This focus on benefits and value develops the earlier work by Russell Mannion *et al* (2007) on the perceived value of 'earned autonomy.' Given our focus on the intersection between vertical and horizontal pressures, a binary categorization of autonomy became readily apparent. Autonomy can thus be seen as both '*freedom from*' (eg the centre or local inter-dependencies) and '*freedom to*' (eg innovate, be responsive etc). This tension reflects a balance between constraining and liberating effects. These terms might appear pejorative and tendentious. A third benefit – autonomy as a 'gold standard' – was also identified. It refers to the notion that autonomy is valuable in itself, an organizing principle that is redolent of subsidiarity. The concepts have not been previously identified in the literature in this way. These three aspects will be discussed in turn, looking at both the views of respondents from the Foundation Trust (FT) in our case study and from organisations aspiring to become an FT or in inter-dependent relations with them. FTs played powerful roles in shaping the terms of the debate in both LHEs, despite their contrasting inter-dependencies. Nonetheless, FTs are the embodiment of English health policies designed to foster autonomy in the local NHS. It is, therefore, appropriate that attention is devoted to perceptions of them, both by those 'possessing' autonomy (as an FT) and those working in apparently non-autonomous organizations.

- *Autonomy as "freedom from":*

The benefits of autonomy in terms of "freedom from" emerged in the respondents' narratives mainly in relation to the performance management approach of the Strategic Health Authority (SHA). For example, senior staff at a non-FT provider in the Southern case study felt that the space that had been created when performance management shifted from the SHA to the PCT had enabled them to improve their performance. Importantly there was a change in the 'tone' of performance management. In place of the 'big stick' approach the trust was able to develop collaborative relationships, with other organisations in the LHE, and with clinicians within the organisation. The shift in performance management "freed" the provider from the apparently constraining approach of the SHA towards a more

collaborative approach at the PCT level. The PCT also found this approach valuable as one of its senior managers explained:

"I think the other positive thing is the work across [Southern LHE] with the ...HR Directors because I think that because they see me as a colleague, I'm in a much better position to get them to work with me than the SHA I'm afraid because the SHA was always 'bad'... I do think that I've managed to build the relationships with my colleagues that are much more on a- 'you know, we need to help each other out, I really do need you to do this' and we understand each other..." (HR manager, Southern PCT)

The view from providers on the Southern PCT's efforts were appreciated

"The PCT is working hard to develop a more substantial and structured relationship with the acute Trusts. I think it's paying dividends" (Manager, non-FT provider, Southern LHE)

FTs are not performance managed by the PCT or the SHA in the same way as before their autonomous status. However, a slightly more tempered view was given by senior staff at the Foundation Trust as to the benefits of autonomy in terms of freedom from SHA performance management.

"The second thing, there were some short term gains to be coming out of financial trusts inasmuch as financial gains were really quite important but those have all been equalised down. I think there is a small amount of freedom from local control, from SHA control, but it is not anywhere near what I had envisaged it should be, would be, and I don't think it's anywhere near what our counsel of governors believed it should be or would be ..."

(Senior manager, Foundation Trust, Southern LHE).

The shift towards more local autonomy in terms of performance management was evident from the SHA perspective too. This was notable in the Northern LHE where the PCT and the Northern Hospital 1 were both highly regarded.

"The main thing is we don't ask for anywhere near the same amount of information that we would of places that we're worried about. We tend to trust them [the organizations in the Northern LHE] when they're going to do something. If they say they're going to do something, we tend not to then check have they done it" (Director, SHA, Northern case-study).

This view was corroborated by the Director Finance at the Northern PCT who complimented the SHA on its strategy of allowing more local autonomy:

"So the SHA is naturally being rather hands-on to start with because we were one of their red-risk patches and we had to be seen to be delivering but now we've shown that we're into being able to deliver and we've come back to

financial balance. They've, in my book quite rightly, stepped back and we're not on the fortnightly monitoring, we're on much more light-touch review because we've gained their confidence, we know what we're doing and we are able perceive, so that's good."

However, there appeared to be a persistence of centralisation in relation to SHA-PCT relations, as indicated by the Chair of the Northern PCT

"The PCT has not yet shaken off the old constraints of the SHA wanting to hammer us" (Field-notes, Northern PCT board meeting, October 2007).

The 'Northern' approach contrasts markedly with the 'Southern' approach to performance management by the SHA. The degree of autonomy ceded by the 'Southern' SHA appears more limited.

"Now ideally, it would be preferable for Primary Care Trusts to performance manage all of their commissioned responsibilities but it just doesn't work so we separate mental health. The PCTs chair part two but we are always in attendance and we reserve the right to resume chairing if we don't think they're doing a good enough job of it." (SHA Director, Southern case-study)

A senior director of a provider, aspiring to become an FT, seemed to support the value of freedom from performance management by the 'Southern' SHA, as judged by this quote:

"I would say we won't, in formal terms, be performance-managed by the SHA and that may make some things easier and simpler to achieve."

Similar views on autonomy emerged in a provider which was aspiring to become a Foundation Trust. Senior managers at this Trust viewed Foundation Trust status as liberating the Trust from much of existing external pressure (both vertically and horizontally). With FT status, more space for change could be created:

"We feel that we've got to make that space, we don't actually feel that we have space at the moment as an organisation. We're still very pushed, very drained. At this meeting I had just before, I was talking about the fact that ward sisters are absolutely at their wits' end, you know. But we feel that one way out of this is to become a Foundation Trust" (Senior Manager, non-FT provider).

These comments were echoed by another senior manager in a Trust hoping to become an FT in the near future.

"We've got some quite ambitious capital plans which will require significant investment and we need to be a Foundation Trust in order to deliver on those and I think the reputational benefits both in terms of patient choice but also in terms of attracting the right workforce will be very, very helpful to us" (Chief Executive on an aspirant FT).

The lack of autonomy felt by poorly performing Trust was also notable. The Southern LHE comprised one Trust which, one respondent described as “we were the worst performing Trust as far as A&E was concerned in the country as well as having one of the largest deficits, this organisation for the last five years has not achieved any performance targets whatsoever.” The national targets around certain clinical priorities were interpreted as a lack of autonomy, as manifest by one Director’s comments.

Interviewer: did you feel along the way that there was any particular barriers?

Director of Operations: “Um, pressure of time so there was a huge barrier. Well for example, in November last year, we received a David Nicholson [NHS Chief Executive] letter saying 'these are the top three things that you've got to hit, finance, improve quality of service and you're A&E target and if you don't do it within 12 weeks then...' potentially, well, unsaid but potentially we're moved out and a new system moved in. I think there is that kind of still, one of the barriers is still a culture of blame that exists within the NHS, there is a big culture of national, Government policy that's introduced that goes bad because of *bad management*, not necessarily bad policy-making or planning at a Central level”

This manager viewed the national targets and their incentives as negative in terms of the autonomy that it gave the Trust. Such minimal vertical autonomy did, in this manager’s view, hinder efforts to improve.

“When you're on the receiving end, you certainly realise that quite a big barrier is the enormous amount of pressure, negative pressure, if you don't- if you don't achieve within a certain time scale. It is quite difficult to stand up and be counted and say, 'Either- either we just apply another Elastoplast to this wound or you give us the head space to apply the appropriate treatment so that we treat the underlying problem and we have sustainable change over a longer period of time.’ (Director of Operations)

However, in another Trust, previous poor performance had been improved. In the next quote, for example, a provider manager describes how the Trust was able to move from being one of the lowest performing trusts in the country in A&E to the highest.

“The consultants were kind of regularly hauled in and just told to do better but just, you know. Calling people in and haranguing them about poor performance doesn't really achieve anything so what happened was that a very detailed piece of work to understand the medical pathway, what happened coming through A&E, how were they assessed, who assessed them, where were they admitted to? (Senior manager, provider Trust, Southern LHE)

The freedom from the centre was claimed, in some cases, to be illusory. FTs (in both case-studies) most clearly felt this since the expected freedom from the DH was not being realized. It was claimed that national policy was still being applied uniformly rather than recognizing local variations (including FTs), highlighting the

need for the centre to adjust its relationship with an increasingly variegated locality. This loss of "freedom from" precipitated a pessimism which was evident in one of the Northern FTs. (The reference to the NHS Council refers to the debate, at that time, about the possibility of an 'independent NHS' with its own constitution).

"The headroom for local determination (despite what is said and published) will be small whilst ever the NHS is the subject of national direction through an executive that is essentially driven by political preference. If the long awaited NHS Council free of party political interference is ever a substantive option then there may be a chance for local determination to flourish." (Email from Director, FT, Northern LHE, April 2008)

A similar concern was expressed by the Chair of a Southern Trust who argued that:

"The NHS has been centralised and prescriptive for 60 years. Can the NHS let go without imposing extra bureaucracy. What does local mean? Is it the end of a national health service? Is there one now" (field-notes, Trust board meeting, July 2008; original emphasis).

A non-executive director at the same meeting commented in a similar fashion:

"We shouldn't underestimate the challenge of moving from command and control to distributed leadership. Middle management will be confused - 'What will be expected of me.'" (field-notes)

- *Autonomy as "freedom to":*

Freedom from performance management was seen as a benefit in itself which amounted to a 'control over one's destiny.' However, it was also seen as a derived benefit which enabled Trusts to develop their own strategies and provide more responsive services to patients. In this sense, autonomy also represented "freedom to" forge new ways of working.

In the following account, for example, a senior manager from a non-FT illustrates how, in his view, an FT environment will be more conducive to the development of market expansion strategies.

"What I want to get to personally in terms of my role is that we become more entrepreneurial, we have a much better sense of what patients and GPs think of us, and of our services, we use that feedback to improve and we actually go out there and actually promote our services externally so [another Trust] is just down the road, is a Foundation Trust but a specialist service but there are a number of services where they are looking to expand and grow their market share and that's what I want to, you know, our market share to increase because patients choose to come here and you don't need to be a Foundation Trust to do that but I think by being a Foundation Trust in a sense it will indicate that we're at that point where we can do more of that" (Senior manager, non-FT)

In a similar fashion, the financial freedoms derived from Foundation Trust status were valued so as to enable better patient care. A direct link was claimed between

financial freedom and improvements, not least staff morale, according to this FT manager.

"I suppose we've had the income that the Trust have generated whether it be through surgery or emergency or whatever; we've seen massive investment in equipment and resources for things like theatre whereas before the Trust did its best in trying to supply us with additional bits of kit. We've been able to actually replace broken items, just basic instrumentation has been replaced; we've spent a lot of money on infrastructure and equipment and that's been noticed and really appreciated by the clinical staff and the nursing staff. So they've seen a real benefit." (Business manager, Foundation Trust)

However, the longitudinal nature of this study revealed how initial enthusiasms about FT freedoms (freedom to) were, in some cases, not being realized. The effect of enduring centralisation seemed to dominate (well-publicised) aspects of autonomy. Such effects were more insidious and were evident in FTs in both case-studies. For example, in one FT, the Chief Executive had initially been optimistic about the FT's freedom to (*inter alia*) improve infrastructure, to develop services and to improve staff morale.

"Well we're on our own. So if we get it wrong, there's no one to bale us out. We have got a number of freedoms so you know, if we can make tariff work for us and provide services for low tariff we keep the difference and that generates our surplus and the more surplus we make, the more we can invest in the hospital for the future. So people here think they work hard to deliver an efficient service and a quality service to the local public, if we can, you know, generate a surplus, they can see some fruits for their hard work and we can say, yes, we're going to spend, I don't know, 5 million quid on reinvesting you know, money in the A&E infrastructure or building another operating theatre or whatever." (Chief Executive, FT; phase 1 interview, October 2007)

However, he had become rather more pessimistic in the second interview, citing the retention of powers by the DH.

"It's the way the Department of Health and the NHS works so, you know, everyone kind of levels down to the lowest common denominator over time and you know, the NHS doesn't like winners and losers. It likes everyone to be neutral [*laughs*] and that's where you know, I think we're going to end... at some point with you know, changes to the funding model and the new tariff coming out now. We'll see some of our surplus disappear along with other FTs." (Chief Executive, FT; phase 2 interview, December 2008).

- *The gold standard*

For Trusts aspiring to become FTs, perhaps the main attraction was in being awarded a status which was seen as a 'gold standard' or 'charter mark'. As one senior manager in a Trust aspiring to become an FT put it:

"There is that perception both within the wider NHS community and now from the patient perspective, that in order to be of the highest quality, you must be a Foundation Trust."

This comment implies an inevitability to health policy - that FT option is the only route to autonomy, among other objectives, and not valuable in and of itself. However, achieving the 'gold standard' was also seen as improving the internal image the Trust had of itself, which then fostered staff motivation and recruitment, which in turn improved the quality of patient care:

"Our clinicians are very keen for us to become a Foundation Trust. I think there's an element of kudos and status that comes along with the Foundation Trust. There's an element from workforce perspective that we've exceeded and particularly for an organisation like ours that has come from an incredibly low base and I don't mean that in terms of clinical delivery of care because I think our workforce provides very good care. They've just been told that they've been crap for a very long time so I think the aspiration to be a Foundation status sends a very clear message to the workforce that we feel that we're succeeding and I think when we get there, the workforce will feel that it's achieved a huge amount. So there's a lot of- from a workforce point of view- issues around them wanting to prove a point that they provide good quality care and they want recognition for it" (Director of Finance, non-FT)

The award of the FT 'badge' was seen as the primary benefit by the FTs in the case studies. Here, the impact upon staff pride and sense of ownership was stressed:

"I think it enabled the continuation of a successful philosophy in the Trust to be demonstrated. It's hard working in an acute Trust, it's hard working for the Government and you need something to puff your chest out so that you can try and be 3-star. You can try and win the charter mark in the old days. I think you have to have something that can, if you're good enough to get there, demonstrate to your staff that you're different." (Senior manager, Foundation Trust)

4.1.2. How autonomy is shaped

The empirical evidence underscores how both vertical (e.g. central policy) and horizontal (e.g. inter-organisational relationships) factors shape local decision space and organisational change. To some extent, the distinction "freedom from" and "freedom to" recognises the vertical / horizontal tension but this next section delves further into the impact of national policy upon local autonomy (vertical factors) and the impact of the LHE upon an organisation's autonomy (horizontal factors).

- *Vertical factors– How autonomy is shaped by national policy mechanisms*
We found that, despite the rhetoric of decentralisation, national policy continues to influence local autonomy in several ways. Local autonomy should thus be seen as contingent upon the nature of the central policies.

First, national policy imperatives directly influenced local priorities and the focus of attention of local organisations. This direct mechanism of influence chiefly operates through targets and standards, as part of system management reforms. In the majority of the interviews across organisations, the main priorities were related to the achievement of targets, in particular financial balance, waiting times and infection rates. This was also true for the Foundation Trust – for example, in our Northern case study.

“I [have] just learned that there is an SHA instruction about to hit the PCTs and hence the Trust that, no matter the substance of the case or the background context, we are to be instructed to have more Matrons associated with infection control because that is what the DoH has told the SHA to do. This is an example of the antithesis of local determination even in an economy that comprises Foundation Trust providers and reasonably free-thinking PCTs” (Director, Foundation Trust, Northern case-study)

It is significant that this Director also pointed to the importance of the (“free-thinking”) PCT – an illustration of horizontal autonomy that will be explored later. In a similar vein, a PCT senior manager indicated:

Interviewer: Yes and how do you decide what to implement and what not to implement or what to prioritise?

Respondent: “...the absolute priorities are the Healthcare Commission standards and the targets within those standards and the ...requirements that go alongside them and so on and so to try and make it clear what the priorities were we then sort of went through all the targets, especially the targets anyway. We've been having two or three of the targets that were at red or amber, the people who were leading on them coming to Exec team and us discussing and seeing how we could how we could improve on things” (Senior manager, PCT)

Whilst recognising the role of central priorities, we observed some participants who expressed “the feeling that centrally defined policies and directions are detached from the local reality and that this creates tension for the organisation” (Field-notes, Trust board meeting, May 2007).

In addition, around the time the second phase of fieldwork began, Lord Darzi’s review had been released and the World Class Commissioning document had been finalised. These two documents represented two examples of how (new) national policy was shaping the focus of attention locally, irrespective of the degree of local autonomy. However, there was a notable difference between the Northern and Southern case studies. In the Southern LHE case-study, the accounts suggested that these two documents were starting to channel attention and resources locally with a feeling that this would be, once again, generating a climate of uncertainty.

In contrast, in the Northern case study, the Chief Executive of the PCT (who had actively participated in development work on world class commissioning) claimed that the PCT had been able to anticipate World Class Commissioning requirements quite proactively rather than simply being a recipient of an additional national programme. This view was reiterated and strengthened in our second phase of interviews.

“It's [WCC] really just enabled us to carry on the way we're going, it hasn't really forced us to change our direction of travel, but it's obviously enabled us to focus

on one or two areas... it's reaffirmed if you like, confirmed where we thought we needed to work ... There was the usual exercise of external validation but you know, ultimately it's not such a... different course, it's just confirmed we need to carry on the way we're going" (Chief Executive, Northern PCT; phase 2 interview, March 2009).

As a fellow senior manager in the Northern PCT clarified, the high performing Northern PCT had the ability to align national and local policy, often in ways which implied that the latter was the driving force with the former precipitating on-going adjustments.

"The five-year strategy, of course you need to refresh these things from time to time, as you'll know the NHS operating framework for this year said, 'Well Darzi will be out in June and the Darzi Report is going to say that every PCT... should have a strategy by the autumn but we've already got one. It's not entirely accidental because the boss is well connected and made sure he knew what was coming and did exactly what a Chief Exec should do, but essentially what, you know, what we will do is we'll refresh the strategy in the light of the Darzi Report" (Director, Northern PCT).

An interesting aspect, and perhaps not surprising, that emerged from the narratives around national policy, was a concern about the extent to which local agents were able to game the national targets. For example, on the A&E targets, at least one manager suggested that this could be achieved by careful, but honest, work on the data. Another manager noted that the improving patient care was the underlying motivation of targets:

Trust has good cancer performance and "whether you agree with the 2 week target or not, it about standards of patient treatment." (Field-notes, Trust executive meeting, September 2007).

Associated with the direct influence of the national policy on local organisations' autonomy was the perception of the distance between 'directed change' and the characteristics of the local context, which often resulted in the implementation of models of care inappropriate for the local population.

"So that's one of the problems with planning of emergency services. There's this idea one size fits all and it really doesn't, so there was never a huge primary care need in this department so that's one of the reasons why the walk-in centre never ended up seeing the number of patients that they were originally designed to. But at the planning stage, my colleagues had to push the PCT to even look at a few of the A&E cuts but the planning stage when they were contemplating spending millions on this project. There was no audit done as to what actually was coming in here and what they might see. They just assumed that there would be lots of patients they could see and there weren't and they employed nurses with a primary care background, not a minor injuries background and they've had to sort of try and get themselves up to speed dealing with the most minor of the minor injuries... you know, so they had the wrong skills for what they were need to do." (A&E lead clinician, Southern case-study).

In the Northern case-study, one PCT Director commented on the inappropriateness of central policy approaches to managing the new version of LHE emerging from national policy:

"World Class Commissioning I mean, you just know that the assurance framework is going to turn into, for us, what *Monitor* is for FTs and what they've also got no doubt about is that it will be done in a deeply unimaginative and heavy-handed manner by the Strategic Health Authority because actually what other role have they got other than performance-managing us."

There was also a perception among clinicians of how directed (central) change distorts clinical priorities and is often made at a level and by people who, it is claimed, have little sense of how things work in reality. Clinicians referred to central policies, especially waiting time targets, as influencing clinical practice in a way that is not guided by patient needs and with a weak clinical justification.

"...the pressure on my operating list in two weeks' if there's a spare slot would be to get the person who has waited thirteen weeks in... and so to a degree, that was why targets were always not approved of, is that pressure would always be to just meet the target rather than determine the wait on clinical grounds. I mean that thirteen week patient, if they can wait thirteen weeks they can wait sixteen weeks, it's not going to kill them, yes it's a bore for anyone to have to wait that long but it's not going to adversely affect their outcome." (Consultant, Hospital).

A second pathway through which national policy constrains local room for manoeuvre works through distracting from good patient care and crowding out of motivation. Interviewees highlighted how multiple and occasionally contradictory policies were being implemented simultaneously and delivered and disseminated in a non-user friendly way. They claimed that this led to a dilution of management energy and resources. As a result, efforts, energies and attention were focused on ticking boxes, leading to demoralisation and discouragement. For example, in the Southern case study, multiple and at times contradictory policies and a rapid pace of change resulted in a dilution of management energy and resources. This was expressed both by managers and clinicians.

"I don't know what the master plan is but sometimes... I guess as with anything, people just add bits on and then work out that actually they don't fit together very well. It's no wonder that we confuse the population if you think about it; we've got so many initiatives running on so many things that we call terms that people don't even understand..." (Senior Manager).

"Inundated with pieces of paper, guidelines, questionnaires, you know, can't remember all... frameworks, you know. Have you got posters up telling people what to do if they need alcohol rehabilitation, this kind of thing and it takes up vast amounts of my time, NICE guidelines on this that and the other. I really think they ought to do a NICE guidance on NICE guidance and actually there may be other areas of medicine where it's made a big difference from an A&E perspective. I can't think of a single piece of NICE guidance for example that really has improved patient care. They produce these 50-page documents

that you know, waffle on for ages and you know, you want to just pick out the important facts. I do. So there's tons of that going on, box-ticking exercises and I don't think it translates into good patient care. (Consultant, Hospital).

"I've just spent over a year and a half with a completely demoralised and extremely worried set of staff in there who don't know if they've got a job. To be honest, politically, no one in the Health Service wants to play politics and it looks like it's a whole political thing around here. The Trust that is the most overspent is not the Trust that's to be involved in the public consultation and so everybody thinks well 'what's that about?' And then someone twigs, it's in a Labour seat – oh fine – so, everybody loses faith somewhat in these scenarios. It's very difficult and everybody has felt very threatened and that's been very difficult and you cannot talk about change and you cannot talk about moving things forward with a set of people who are just worried about whether they've got a job or not, you can't go there, so that's difficult" (Manager, Hospital, Southern case-study).

In addition to demoralisation, there were also concerns around the shifting agenda and decisions from government. For example, the Chair of a Trust (hoping to become an FT) spoke of the value of autonomy as a way of controlling their own 'destiny', a view which had been shaped by the Trust's experience with another aspect of national policy – Independent Sector Treatment Centres (ISTCs). The ISTC policy had been given a great deal of emphasis locally and, although it was not implemented locally, its deliberations had created a planning blight for the Trust.

"Becoming master of our own destiny actually that means the Department of Health can't impose things on us. One of the things that we did suffer from for many years, was we were going to have an ISTC. This wasn't our initiative, it was imposed on us, huge amounts of money spent on legal fees. It was all going to go ahead but it was stopped. It was orthopaedic work so it stopped us developing our orthopaedic service because we- because you know, we were going to lose all this work and the contract was signed with the supplier and then all went quiet for months and months and months and in the end the Department of Health quietly decided to drop it."

Furthermore, managers complained that as a result of national decisions they are often held responsible for things not entirely under their control, which is clearly detrimental to their autonomy - their 'room for manoeuvre' as this managers describes it.

"I think sometimes the big decisions set the risk in the wrong place. I think the risk around eighteen weeks sits with the acute trust. If the PCT haven't commissioned accordingly, you get anomalies down the line which then make you feel as though your room to manoeuvre is being completely kyboshed" (Senior Manager, Hospital)

(The 18 week target should be shared across the patient journey, with responsibility divided between the Trust, GPs and PCT). However, this view was not shared by managers in the Northern case study, who offered a much more tempered account on responsibility over national targets. In particular, it appears that there was a

more shared ownership for the achievement of targets, such as A&E and waiting times, between the PCT, the main hospital provider and other partner organizations. This shared ownership appeared to have mitigated the issue of a divergence between responsibility and control over actions. This might reflect a perception that the target was instrumental to a wider objective, as one senior manager in the Northern PCT explained:

“You obviously need to be seen quickly and safely but it's [targets] seen as a means to an end reducing of waiting times as opposed to the be all and end all and it- it's cost us a lot of money.”

Another way in which national policy shapes local decision space is by setting/defining the parameters through which organisations evaluate and are evaluated by other organisations, which is embodied for example in a local highly structured approach to performance management. This theme is explored in detail in the next section of this chapter.

“The formal structure is that we have a Monthly Performance Management cycle which has a part one performance management meeting which is the SHA Performance Managing Primary Care Trusts so it's just the SHA and the PCTs present. Part two is the PCTs chairing the meeting, undertaking their responsibilities of performance management of the acute providers or the mental health providers. We separate the acute and mental health because otherwise what tended to happen was that mental health got about five minutes at the end of the agenda.” (Director, SHA, Southern case-study).

This contrasts with the approach of the SHA in the Northern case-study which had a more remote approach to local performance management

“We think of it as a high-performing health economy that also has quite significant challenges and um, and I guess from our perspective, we tend to think that they're pretty good. If anybody's going to deal with some of the things they have to deal with, it will be them, um, and I think one of the things that probably really happened over the last couple of years has been, I think, seeing the PCT take on the mantle of kind of leading the NHS.” (Director, SHA, Northern case-study).

However, interestingly, the data also indicated that formal metrics, although dominating local mindset, alone did not provide adequate information. Informal relations were crucial, especially when the FT is but one of several players, as in the Southern LHE case-study.

“In addition to that formal meeting structure, the Director has one-to-one meetings with all Chief Executives on a monthly cycle ...then on a two-monthly basis, they meet our Chief Executive and on a quarterly basis our Chair and Chief Executive meet the Chair and Chief Executive of each organisation because we have responsibility for management of both the executive and the

non-executive function. So we have our Chair doing performance reviews with Chairs of PCTs and Trusts.... So that's the formal structure. Informally, we have very regular contact through the weekly performance reports which come in, which would cover A&E performance, or some come in weekly, some are monthly, A&Es on a weekly basis, activity returns are on a weekly basis, breaches we pick up on a daily basis when they happen" (Director, SHA, Southern case-study).

Two narratives of autonomy were often juxtaposed. The first suggested that local organisations' autonomy continued to be jeopardised by considerable pressures from the centre and by the multiple and at times contradictory policies. For example, the annual plan (2008-2009) of a Northern hospital referred to:

"The cumulative impact of the many current NHS policies and initiatives creates great risk and uncertainty for this and other Foundation Trusts. It is in this context that the Board will again commit itself to improving services, governance and links to the membership whilst making a step change in productivity and efficiency to maintain financial health and enable additional investment" (para.1.4).

The second narrative centred on how national policy occasionally had facilitated local change. The mechanism through which national policy operates as a lever for change is the removal of constraints, especially in terms of resource allocation and competing arguments and interests on the necessity of change. In so doing, national policy actually created 'room for manoeuvre' within which it had been possible to instigate organisational and clinical change. For example, several interviews with clinicians and managers indicated how the A&E target was essential to marshal resources towards the restructuring of the A&E department and how the national collaborative further supported this change.

"I really think that there's been a lot of benefits from these targets; I don't think we would have probably ever cracked the A&E problem if we hadn't had the four-hour target around it" (Senior Manager, Hospital).

Similarly, the NSF on Stroke was viewed as key to silence disagreements and focus resources on a service improvement which was needed "*years ago*".

"Well, a stroke (service) was easy to set up, relatively speaking because of the National Service Framework. We were required to do it. I wanted to set up a stroke unit years ago and nobody would have it, the hospital clinicians were against it, my colleagues in medicine, the GPs weren't. There was a debate in the postgraduate centre you know, are stroke units worthwhile... and I think it was unanimous that they were, so the general physician that spoke against them ... [laughs] didn't quite know what to say afterwards but I think he sort of half believed they were as well, so, the hospital, our colleagues were against it and the management and the PCT weren't interested because, like most new services and improvements cost money and, if it costs money, it can't be done" (Consultant, Hospital).

In addition, it was found that local organisations used national policy as a lever to bring forward their agenda and implement change. The alignment of national policies and local priorities was a strategic decision to enhance the interest of key

local agents. For example, in the Southern case study, the PCT used national standards published by the Royal Colleges as the basis of their commissioning intentions (see 4.2.4). However, in some cases, this alignment was as much coincidental as a strategic choice. On occasion, this prompted critical (and cynical) comments from others.

- *Horizontal factors – How autonomy is shaped by the local health economy*

In contrast to the influence of national policy on autonomy, the following section looks at how 'room for manoeuvre' is shaped by local context characteristics, including relational dynamics between organisations and professional groups, by attitudes towards autonomy, and by leadership and competence.

Relational dynamics:

LHEs are shaped and defined by organisational inter-dependencies which are generated by collegial relationships (eg between general practitioners and specialists) and organizational / institutional relationships (eg the purchasers and providers of health-care and between providers). The existence and continuous nature of such social and institutional relationships develops a deep knowledge of people and processes that are underpinned by informal aspects such as reputation, trust, and reciprocity. This embeddedness shapes how clinical and managerial staff in organisations make decisions and act / react to others. Thus, these relational dynamics are a key factor in understanding local organisation's uptake of autonomy and the scope for organisational change. The data provide several interesting leads into the role of relationships.

"I suppose in [the Northern] case is I think that really comes down to the way that personal relationships are managed between the Chair and the Chief Executive and um, the reputation of the Chief Executive at the PCT is such that the Chief Executive [at one of the Northern FTs], even if he wanted to, you know, I'm sure he wouldn't want to but kind of can't take him out, you know. So there has to be a bit more respect there" (Director, SHA, Northern case-study).

This perspective was corroborated by observations of the Northern PCT board meeting (October 2007). During the Chief Executive's verbal report, he referred to the 18 week waiting limit and indicated that the orthopaedic waiting times in the local FT (Northern Hospital 1) was 20 weeks. This had prompted him to have "a number of conversations with the other local PCTs and the chief executive of [Northern Hospital 1] about orthopaedics" (field-notes). The PCT chief executive also reported similar conversations with the chief executives from the FT and local authority were also held regarding the 'healthy' financial position.

One manager explained that the Southern PCT had sought to develop a LHE-wide strategy to foster the type of inter-organisational relationship which would facilitate subsequent organisational change.

"We'll also have the [Southern LHE]- Team [Southern LHE] - a Chief Execs meeting where we have the opportunity to reflect on some of the sort of higher level stuff as well but I think it's... the way in which we establish our own personal relationships is what will make [the LHE] work or not" (Senior manager, Southern PCT).

This LHE-wide approach was also adopted in the Northern case-study where the PCT had made it central to its strategy.

"We've got a document which I'm sure... proper document called the "[Northern LHE] Way" which- which we produced last summer in response to the national competition rules... We said, 'OK so where does this leave us in terms of...but also getting a bit of grit in the oyster?' So we produced a document signed up by the providers. It's been through all their Boards and the consortia and local authority and other bits of the system to sort of say how we're going to navigate, how we're going to keep the system going, at the same time deliver change" (Director, Northern PCT).

This local approach seemed to be mirrored in the Trusts, one of whose annual plan (2008-2009) stated that

"The Trust Board of Directors is aware of the very challenging time which lies ahead in terms of new commissioning arrangements, developing market dynamics, the general economic environment, very challenging national targets and growing public and patient expectations. It is at all times mindful of its role in ensuring stability and excellence but is also very clear that it is part of an NHS system which needs to be equitable and facilitative as well as challenging" (para.1.3; emphasis added).

Persistence of social relationships:

Embeddedness can limit 'room for manoeuvre' in two ways. A first pathway highlighted by the findings of this study relates to the constraints that embeddedness poses in moving from the *status quo*, where this shift requires the alteration of established patterns and loyalties. We found that entrenched social and institutional relationships moderated the incentives set by national policies such as patient choice. As a result, embeddedness minimised the impact of central and local organisational changes. For example, patients and GPs appeared to be loyal to local providers and unwilling to receive treatment and move referrals away from their local hospital. Such patterns were evident in both our case studies and explain why national policies such as patient choice aimed at enhancing autonomy appear to have less local significance.

"We will offer a patient five places to go and appointment times at those five places. That's what it says. It doesn't mean it's going to be within your county, or within your district, it's anywhere within the country. So all [the GP seeking to refer a patient] does is she logs out of the Choose & Book screen and writes me a letter and sends it in, so I mean, so that's all that's happening. There is no choice. Patients don't want choice, patients want to be treated in their local hospital" (Clinical director, Hospital).

This comment about Patient Choice also highlights the implementation gap in the sense that local agents deal with the impracticality and shortcomings of centrally

developed policies. In the case of Patient Choice, the impracticalities related to the public's tendency to prefer a local hospital and the shortcomings related to some of the IT problems.

Similarly, the evidence indicates that PCTs are prompted not to change patterns of commissioning as they do not want to destabilize local providers. (Previous patterns of PCT expenditure are illustrated in the Case-study profiles; appendix 2). In the Northern case study, for example, this collegiality is reflected in the PCT negotiating with the main local provider what was needed for the provider to maintain its current risk rating and refraining from moving activity elsewhere.

[Northern FT] has an incentive to keep going. Monitor's risk scoring rates [it] as "4." [Chief Executive of Northern PCT] told [Northern FT] "tell us how much you need to score 4." "There need to be some trust." This helps to shift the agenda from finance to quality. (Field-notes, October 2007).

Equally, in the Southern case study, where there is a multiplicity of providers, they appeared more willing to negotiate services rather than competing with one another, including the FT. This pattern was reinforced by the persistence of clinical networks that span organisational boundaries. Contrary to expectations, the clinical networks/collaborations have persisted even after one of the main local providers became a Foundation Trust.

[Trust manager] said that he believed that "more and more that networking is the thing. More consultants are visiting local hospitals" [A clinician] explained that [another local Trust] was "offering the hand of friendship to consultants", to which the Trust manager said "good God." (Field-notes, Trust executive meeting, September 2007]

However, there are signs that the stability of patterns may be altered over time. Our second round of interviews in the Northern case study at least, suggested that as the PCT has become a more mature and consolidated organisation, it might turn into looking outwards its LHE to commission services, including the private sector. However, the Chief Executive of the Northern PCT pointed out that market stimulation (one of the WCC criteria) should not simply be seen as an end in itself.

Disruption of social relations:

A second way in which embeddedness shaped room for manoeuvre and organisational change, is where relationships were disrupted, for example because of constant re-organisations, with new staff being appointed. This was particularly evident in our Southern case study where ongoing reconfigurations and reorganisations disrupted relations and distracted staff from other imperatives. For example, a few months before the beginning of our fieldwork (October 2006), the PCT had undergone a major re-organisation with five former PCTs brought into one. This reorganisation was accompanied by a major LHE-wide reconfiguration programme and the proposal of a merger between two Trusts in the economy, which then was withdrawn few months into the process. (The financial aspects of this re-organisation are explored in the next section of this chapter). These multiple exercises, and changes in the direction of local policy without any particular

transparent reason, generated lots of uncertainty in the economy and led to tensions which ended up creating conflicts and lack of trust.

“Well, it’s difficult because, you know, new people come and you end up with a different set of relationships. Sometimes that’s been helpful, sometimes it’s been less helpful but you know, it has caused some difficulties where you develop some strategic alliances and new people come in and want to change those alliances for all sorts of reasons. That can disrupt continuity” (Managers, Hospital, Southern case-study).

“I think that situation often brings out the worst in people and sours relationships which then take a long time to recover. So I think it’s been very detrimental to the area and probably the reason why we’re now thinking about joining with [the other hospital] as opposed to- some might say the more logical thing is for us to join with [Southern] hospital first and then go east towards [another hospital] is that the relationships between us and [Southern] hospital have been soured by the whole process, so it wasn’t a particularly constructive or useful thing to go through” (Consultant, Hospital).

“The premise was that this was a financial problem that the PCT had, now the other thing, and if you read the local papers, the trust the public have now is completely shot to bits because it would appear magically, the PCT have got money from somewhere! Well how dare you threaten us all that time and then suddenly find the money! How dare the NHS make £500,000 or whatever it made, half a million pounds nationally and we have just been to hell and back for a year and a half thinking, you know, everything was going to be ghastly. So I think there’s a great deal of mistrust out there as to what’s really going on.” (Manager, Hospital).

The LHE-wide re-configuration did not take place as planned as it attracted a large amount of local criticism (from clinicians and the public) and was also overtaken by the Darzi ‘Next Stage Review’. However, social and institutional embeddedness had inevitably been disrupted by the merger of the former PCTs into one (in both case-studies), and of the legacy effect of previous re-organisations. In the Southern case-study, a new senior manager at the PCT observed the historical impression that had been left by previous attempts to re-organise services across the LHE

“Although I’m obviously still relatively new to [the LHE], I think there has been a history of threatening one organisation or another for you know, I’m led to believe ten to fifteen years. So I think my diagnosis of some [of the LHE’s] problems is probably different from where other people have come from and I think the first thing really was to analyse just what is the problem to start off with rather than start it with a solution” (Senior manager, Southern PCT).

In addition, in the Southern case study, differential levels of autonomy brought about by the phased-in introduction of Foundation status and PBR (only one provider was a Foundation Trust at the time of fieldwork) had also led to perceptions of an uneven ‘playing field’ locally and had exacerbated existing historical rivalries among providers. There were also perceptions by managers and clinicians in other non-FT providers of a favoured relationship between the

Foundation Trust and the PCT, whereby the FT was seen as having “*the PCTs ear*” in the major reconfiguration exercise the LHE was embarking at the beginning of fieldwork.

“The [FT] contract is better than the standard FT contract that was around at the time. [The FT] had become an FT and so they clearly were very successful at negotiating clauses into the contract that have been beneficial over and above what they would have had through the standard contract at the time” (Director, Southern PCT).

Relationships as enhancing room for manoeuvre:

There is also evidence of how embeddedness can actually enhance room for manoeuvre. Where relational dynamics are underpinned by shared understanding, reciprocal trust, and transparency, embeddedness can actually create autonomy - space for change. Under these conditions, role and background differences appeared to become less relevant. Actors were thus bound together in mutual endeavour and as a result, lengthy negotiations were avoided and change was facilitated, even in the absence of autonomy from the centre. As such, it may be possible to describe this situation as *de facto* horizontal autonomy in the absence of *de jure* vertical autonomy. Both the relationships between managers and between clinicians and managers appeared to be important in shaping the ability to implement local change (through horizontal autonomy), although sound relationships between clinicians and managers were certainly paramount in each organisation.

Good relationships were particularly evident within organisations, both between managers in different hierarchical positions and between managers and clinicians. Middle managers felt positive about relationships where the top management was giving them freedom and trusting their competence and decisions. The autonomy that these middle managers enjoyed was especially noticeable in FTs, suggesting that decentralisation need not simply stop at the organisational level.

Interviewer: ...how's that developed in terms of the freedom that you're been given within the Trust?

Respondent: The same as [business manager in another directorate]. We both report in to the Chief Exec... He gives us a lot of freedom as well as, you know. If I said to him there was a problem and this was the solution, he'd say 'fine go ahead and do it.' So we're given a lot of autonomy to make those decisions and also as far as the investment and saying what services we need and what we need to develop, you know, he's very reliant upon you know, what we think” (Directorate business manager, Foundation Trust).

The fostering of autonomy within the organisation also concerned another FT. In a discussion about organisational development, the minutes of the Board of Directors (November 2008) note that the following questions were posed by OD consultants:

- “Do managers and leaders have sufficient time to think or are they weighed down by immediate operational pressures?”

- We want leadership and culture which supports people in 'doing the right thing for the patient' whatever the implications. How do we develop the courage for this?
- What about more delegation to create some space? Do things come 'back to Trust Executive Group' too easily, creating a bottleneck?"

Clinical engagement appeared strong within the providers and was mostly grounded on clear communication and shared goals. Engagement was further reinforced where hybrid managers (especially medical and clinical directors in executive-style boards) were involved, as in those cases the relational dynamics were strengthened by a shared professional identity. For example, at one hospital executive board meeting (September 2007), the chief executive spoke of the centrality of clinical involvement in Trust decision-making.

'The chief executive emphasised that "we can only spend the money once." If money is spent but value for money is not secured, auditors can write off the difference. He stressed that "there is no GO button until you guys [clinicians] support it. But we [the Trust] need to decide what we want to see as an organisation and what the priorities are.' (field-notes)

There were several examples of how these healthy relationships were conducive to space for change. Good internal relationships were, it was claimed, at the base of one local provider in the Southern case study moving from being one of the worst performers in emergency care to being one of the best in the country. The process through which this happened was underpinned by transparency and communication within and outside the department. Similarly, another local hospital, which at the beginning of our fieldwork was recognised as the longstanding poorest performer in the LHE, managed to considerably turn around its performance by the time of our second phase of fieldwork

"The pressure got to a point where we couldn't stave it [organisational change] off any further and we were given a very tight time scale to turn around our A&E performance.... So from January this year, for six months, I stopped all my clinical work and did full-time Medical Director role to implement what we called the new medical model care processes... I spent hours and hours and hours down in A&E pushing trolleys and talk. It was that sort of engagement and being on the ground and really supporting the whole process to get the new sort of model in place and along with me, the A&E lead who was at that time the Clinical Director for Medicine also took three months off clinical work to really get that embedded. So we started at the beginning of January and it was just horrendous. I mean I can remember two Monday nights being in A&E and thinking 'God, how are we ever going to do this?' it was just unbelievable, it was just chaos, complete chaos." (Medical Director, Trust).

Again, good relationships between the various stakeholders were grounded on shared goals and transparency, was one of the key drivers for this shift in performance.

Functioning relationships were generally evident also between clinicians across organisations as "*clinicians just get on with it*", perhaps not surprisingly given the shared goal of patient care and a shared professional identity. However, these clinical relationships were threatened either in the presence of a particularly strong

willed consultant or when organisational identities were endangered and therefore became dominant compared to professional identities. This, for example, happened in the Southern case study at the beginning of our fieldwork when the LHE-wide plan for reconfiguration entailed the potential closure of one A&E department. Meanwhile, in the Northern case study, the presence of trust between the main players and transparency in the development of a LHE strategy has contributed to moving forward the LHE-wide plans.

The Northern case-study was commended in the World Class Commissioning panel assessment (2008) because the PCT's "Joint needs assessment and performance management arrangements with the local authority are strongly embedded"

Attitudes towards autonomy:

The evidence on respondents' views of the benefits and value of autonomy suggests that overall autonomy is valued both per se and as a vehicle/means to change. However, the evidence from the FT in the Southern case study found managers to be rather risk averse and unwilling to take up the risks that would result from expanding existing services or venturing out into the development of new service initiatives. This aversion appeared to be the result of a greater degree of financial exposure and the uncertainties in the policy and local environment.

"...no. I'd say we've been very conservative about being bold as yet, so most FTs you know, they've all got borrowing limits, we have and we can borrow 32 million. But you know, no one's borrowed very much so far and I think you know, we're naturally cautious because everyone doesn't want to press the wrong kind of investment buttons" (Senior Manager, FT).

This cautiousness was also mentioned in a meeting (September 2007). Likewise, in a meeting in an FT, a senior manager was concerned that financial autonomy meant little given the scale of expenditure that capital projects, for example, incurred.

It's a question of what we will do with the money [savings]. FTs want to spend it on capital projects – there is a need to save to invest. FTs do not get money to replace their asset base. [This FT] has £28million in the bank but that's not much for a capital project" (field-notes).

It also appeared that Monitor's regime contributes to this cautiousness as Monitor's degree of intervention was linked to the performance (especially financial) of the organization

"The Monitor regime that we have to comply with is quite pernicious if performance isn't going well. So you're in a- quite a high-risk business so I think as a consequence, people are a bit more reticent about whether you know, they should borrow 30 million and stick up you know, a XYZ facility." (Senior manager, FT).

However, there was a sense that things might change in the future as an organization becomes more mature and consolidated as an FT. In particular vertical integration into primary or community care was mentioned as one potential area of interest.

Some uncertainty about autonomy prevailed in Foundation Trusts. In a similar vein to the cautiousness (above), another FT wondered how to spend their retained savings. The minutes of the Board of Governors (January 2009) reveal the internal debate about how to recognise the "Trust's success in the Healthcare Commission Ratings":

"The Chief Executive explained that a number of neighbouring organizations had given their staff either a cash bonus (£50) or vouchers to recognise their success in the Healthcare Commission Ratings. The Trust Executive Group had been giving some consideration on how best to do likewise within [the FT] and following discussions with staff and staff of neighbouring organisations, a decision had been taken not to go down the route of cash bonuses but to invest the money in improving patient care. Therefore, it had been decided to give each Matron / Departmental Manager an allocation of £5000 to spend on patients within their areas of responsibility before the end of this financial year. The Deputy Chief Nurse would hold the central budget of £200k"

This dilemma contrasts with the Trust's response to its award as the Large Trust of the Year 2008 by the Dr Foster Good Hospital Guide (minutes, Board of Director, November 2008). Press releases, congratulatory letters to staff and GPs, website redesign, banners in hospital entrances and redesigned hospital stationery aimed to disseminate the positive news. In addition, "further consideration was being given to how to recognise the staff's contribution" (minutes).

Leadership and competence:

Leadership and competence within the organisation emerged as key components shaping room for manoeuvre and ability to change. The Southern and Northern PCTs represent two contrasting examples of these dynamics. Both case studies had undergone reconfiguration in October 2006, therefore starting from a potentially destabilising and challenging baseline. In both cases, reconfiguration meant staff turnaround and internal reorganisation. However, the two PCTs clearly took two different approaches. In the North, the PCT spent the first year after reconfiguration building up a new top management team and putting a new structure in place. The PCT also invested in building up relationships and partnerships, assessing and diagnosing problems in the LHE, and building up public consensus and engagement. An LHE-wide strategy was produced as a result of these processes, which was viewed as an "LHE strategy (not just a PCT one)" (field notes, meeting with Chief Executive, Northern PCT, October 2007). The implementation of this strategy over the subsequent year has been made possible by agreement of all the stakeholders and the competence and leadership the PCT had built during its first year of life as a reconfigured PCT.

"At the end of '06/07, we were classified as a weak organisation in terms of our Healthcare Commission ratings... If you go on any of the websites they, you know, they usually come up with, 'but how was your organisation doing?'... Last October, for the year '07/08, we got Fair and Fair so a tangible impact that we're starting to use our money more wisely and put in systems in place to get better delivery" (Director, Northern PCT)

Conversely, the Southern PCT launched a major LHE-wide reconfiguration programme immediately after reconfiguration. The PCT embarked in this programme before having replaced the necessary infrastructure and developed its leadership and competence. The common view emerging from the fieldwork was that there was no clear vision behind this programme

"...the [Southern] PCT weren't in a position to handle all this. They were completely, you know, in a turmoil all of their own so I mean, we have some sympathy with them because they couldn't sit down and get the pieces of work done and they still don't know what an urgent care centre is" (Manager, Southern Hospital)

"I think they're struggling to really work out what their remit is, and rather than being able to bed down as a new organisation in a sort of a constant situation, what you refer to is also an issue which is the political demands are changing so fast that the PCT isn't just able to actually sort itself out, set itself up. They're having to change before they've even recruited people." (Manager, Southern Hospital)

Equally, the lack of leadership within the PCT was regarded as a major constraint, an aspect that was also implicit in respondents' referring to the PCT as "the PCT" or "They", rarely to named individuals within the PCT.

"So in relation to the PCT it is difficult, they have difficulties in knowing who's now in charge of which area, which director's responsible for this, who in the structure is this. So that's been very difficult because there five PCTs gone into one big one for [the LHE] and I suspect the [Southern PCT] one is one of the biggest PCTs in the country now" (Manager, Southern Hospital)

Ultimately, the programme was not implement as planned with numerous changes in the direction of travel adopted in the year following its first launch and strong criticisms within the LHE. This contrasts with examples of strong leadership which enhanced an organisation's autonomy. FTs clearly illustrated this but equally, poorer performing Trusts had, over the course of the fieldwork, begun to demonstrate this capability (albeit in different ways). Leadership in the latter case had often been associated with new senior management appointments and/or new roles of existing staff. Yet, this was not universal, according to our fieldwork. For example, observing a Trust board meeting (July 2008), one non-executive director argued that "We have to decide as a Trust that we are going to do it and not wait for someone to tell us we can do it." In return, the Chair wondered whether the Trust had "the leaders [who are] going to be able to deliver Darzi [reforms]?" as, he argued, previously people were 'told what to do.'

4.2. Performance

Here, performance is viewed as a contested concept, with rival versions disputed by stakeholders. This contestation needs to be set against the general thrust of recent policy which has placed a heavy emphasis on (quantified) performance measures, associated with incentives (for 'good' and 'poor' performance); see chapter 2. This section of the chapter considers respondents' views on this performance culture, and their perceptions of how good / poor performance is achieved (the causal pathways). It also examines the distinction between formal and informal performance, as contrasting (though not necessarily competing) ways of describing, explaining and acting upon organisational functions and activities.

4.2.1. The significance of "performance" in LHEs

Respondents were commonly attuned to the needs of a 'performance culture' in which activity needed to be demonstrated (primarily) through quantitative data, notably for the purpose of accounting to higher authorities (such as the SHA). Few questioned the need or the value of such a performance culture; it was taken as a *sine qua non* of NHS organisations. Indeed, most sought ways in which it could be enhanced.

Measured activity was central to securing revenue for services commissioned from the PCT and to meeting government targets.

"Before PbR, clinical coding was kind of, you know, ...if you were clinical coder you could be stuck in a broom cupboard somewhere you know, given a biscuit once... But then all of a sudden, you know... at the sort of outset of PbR, the Trust actually started to improve the clinical coding, improve the depth of clinical coding, then there's a financial benefit" (Director, Southern PCT)

"The message of the CEO is that the Trust has to deliver. Even though the targets of DH are demanding and probably unachievable (he was referring to infection control mainly), the Trust has to show that it is going in the right direction" (field-notes; Chief Executive, Trust board meeting, May 2007).

The PCT Director of Commissioning reported that it is difficult to get data from [hospital X] in a form that the PCT can use. The main performance issue for the PCT is [hospital Y] A&E performance. (Field-notes; PCT Board meeting, June 2007).

Interviewer: what areas would you say that this Trust is performing particularly well and what areas this Trust is not?

Respondent: I think we're very high performers, I think that we achieve all of our targets so, all the waiting time targets, numbers on waiting lists, all those sort of you know, very numerical measurements, we are home and dry on constantly and I think there's a real culture here that people want to achieve those. (Director of Nursing, Southern Hospital)

Though the performance culture has been embedded within social and institutional practices, there was a widespread use of competing notions of performance across the two LHE case-studies. Often, formal performance metrics were cited and yet, at other times, it was respondents' impressions of key organisational leaders or the collective impression of an organisation which predominated. This seems to denote a tacit recognition and understanding of the role of formal and informal performance measures and processes. It may also significantly point towards the interplay between them.

However, a crucial omission in these notions of performance across LHEs was consideration of or accounts by the public and/or patients. There was little or no evidence in observations, interviews or documentation of such user-defined

performance measures. This perspective was not apparent in interviews but it did surface on rare occasions in observations of board or other meetings. Yet, even when public / patients' views were recalled, it was done in a rather cursory and perfunctory manner.

One Trust board meeting held a discussion about plans to become a FT. A manager said the Trust "needs to start working on a membership strategy. We are claiming a catchment of 450,000. We have to know what it is we want to say to people about what we are about and why people would want to become members." (Field-notes from Board meeting, July 2008).

In other meetings, anecdotes from Board members (for example about a neighbour's experience of care at the Trust) were common. Public protests in or outside some board meetings were clearly indications that (some) people felt strongly about organisational and clinical issues under discussion. Also, the Southern PCT had undertaken a 'public involvement' exercise regarding a proposed reconfiguration in the LHE. The approach involved a bus touring local towns and villages, with information leaflets and staffed by PCT managers.

"I think what happens is, whenever you try and engage with the public you get the sort of small core of people that actually probably recognise their faces anyway. So I think the idea of the bus going out was to try and get some people who happened to be walking by whereas the questions and answer sessions you do tend to get the people that you would normally be engaging with anyway" (Director, Southern PCT)

Reference to the National Patient Survey results might have illustrated this perspective. Whilst these data are nationally aggregated, they might have prompted local debate and managerial attention. <http://www.pickereurope.org/page.php?id=45>). We found few examples of where these data were used; such as

"The assessment of 2006 patient survey shows a number of positive achievements. Trust is on top 20% for not changing admission dates and top 20% for ward quality (noise, sharing of sleeping area and bathroom). These are all huge improvements from past" (field-notes; Director of Nursing, Trust board meeting, May 2007)

Generally, these findings imply a predominance of formal metrics over informal notions based on organisational networks.

4.2.2. Causes and pathways to performance:

Respondents offered multiple interpretations for the causes of 'good' and 'poor' performance: why such-and-such a Trust was performing the way it was, according to formal metrics or their own subjective assessment. This focus on causes and pathways has implications for the conceptualisation of the association between autonomy and performance. Their comments also included the barriers and opportunities which culminated in such levels of performance – perceived or otherwise.

Respondents questioned and offered interpretations for the apparently differing 'performance' of local organisations.

"I suppose I was looking at the comparison between [three Southern hospitals], who aren't a Foundation Trust who are serving broadly similar population and their kind of, you know, broadly similar hospitals. I mean there are features that are different, but their performance is completely different" (Director, Southern PCT)

Interviewees were asked how their own organisations had reached a particular level of performance. Their answers were insightful, not least because it prompted individuals to reflect on how their own organisation (or others) had developed and might develop into the future. One of the case-study organisations had 'improved' the performance in their A&E department through a combination of analysis of formal performance metrics – "real analysis" – and challenging perceptions and attitudes – changing "hearts and minds." As a result, performance had "improved" and was gauged by a ranking position of "one of the top performing" departments in England.

"That was certainly the case here four years ago when our A&E was not performing well and we were not performing well on the waiting lists... Now what's happened is, is you know, real analysis, real getting I think, the hearts and minds of the medical staff in A&E such that we are now- have become one of the top performing areas in the country. I think a methodical approach to waiting list management as well has made that improvement" (Director of Finance; emphasis added).

A contrasting perspective from the same Trust was observed at a Board meeting (May 2007): "Not many areas have improved. The trust is in the bottom quartile nationally in areas. Every area comes down to communication. The question was 'how do we engage with every member of staff?'... The only attendee was a senior member of medical staff. He felt the trust could do more to ensure that staff represent the community it serves (in terms of ethnic make up of workforce, especially in senior posts). He also stated that the Board needed to 'come out of the Ivory Tower to see the issues.'"

Another illustration of this understanding about pathways to performance might be apparent in one PCT, one of whose directors commented on a local provider's strategies. He continued to offer further insight on the causes of performance in this provider Trust.

"I think some of those things are as much about the providers that you're working with and historical accidents as always as necessarily about the competencies or not of the commissioners." (Director, PCT).

In the case of the Southern PCT's own performance, the financial situation was seen as the fundamental cause of its 'performance.' Indeed financial deficits were critical factors, a situation (it was claimed) directly affected by the financial competence of the providers from which it commissioned services. The centrality of financial

performance, it was claimed, hampered (PCT) efforts to rectify the financial imbalance.

“[Southern Hospital] is a very efficient organisation and they are one or two steps ahead of the commissioners [the Southern PCT] all the time and so the PCT gets into deficit, once you get into that then you know, it’s a struggle to get out of it” (Director, Southern PCT; emphasis added).

This comment reflects the often-cited power imbalance between PCT commissioners and providers (in terms of prestige, executive pay, influence etc). He added that provider strategies complicated the PCT’s ability to ensure financial balance.

“I think there were benefits to the PCT by having a Trust that wasn’t particularly aggressively pursuing maximum income” (Director, Southern PCT).

The logic of this statement is that the PCT can only remain solvent so long as the providers do not pursue self-interested strategies of revenue maximisation. This recognises a tacit recognition that the fortunes of the PCT and providers are bound together and it would seem to follow that a LHE-wide approach of shared objectives would be mutually beneficial. By contrast, in the second phase of the fieldwork (2008-2009) and in the light of World Class Commissioning (WCC) panel reviews (2009), both PCTs seemed to be taking more assertive action in their LHE. Both had ‘performed’ at or above their expectation in this WCC process (according to interviews conducted after the WCC panel had reported in January 2009). As such, it seemed as if their causes of their own performance lay increasingly within their own strategy and implementation.

“I think we have got traction... contractors are our Foundation Trusts and our community services and the local authority and the SHA would say that [Northern] PCT is now in charge of the system and obviously the first thing is we’ve made sure that people know that we have the money and we’re not going to hand over the cash without some return” (Chief Executive, Northern PCT; phase 2 interview).

Equally, this Chief Executive also felt that the causes of provider performance were also increasingly within the PCT’s remit

“We are moving the money around a little bit to incentivise and penalise where performances prove positive so you know, it’s supported by some hard-edged, you know, shifting activity” (Northern PCT Chief executive; phase 2 interview).

If this is the case (viz. that the PCTs’ fortunes were increasingly within their own hands), it might signal that autonomy (for the PCT at least) was connected with their (improved) performance. However, these comments need to be contrasted with the case-study of formal performance (see 4.2.4.).

4.2.3. Performance management

The dominant form of managing the relationships between organisations was performance management primarily through the contracting / commissioning process. This was a layered process in which health-care providers were accountable to the PCT and (for non-FTs) to the SHA. For some (and not necessarily those who were classed as 'poor' performers), this was seen as a heavy-handed process. The process might reflect a lag effect between formal performance metrics (inevitably retrospective) and SHA perceptions. However, it might also reflect a sense in which the Trusts felt that their performance had improved sufficiently to be given more autonomy from SHA performance management. For example, one Trust in the Southern case-study had scored "fair" (use of resources) and "good" (quality of services) on the Healthcare Commission's annual health check (2007/08). A more reflective assessment of the SHA role was offered by another respondent from a local authority in the Southern case-study:

"They [SHA] basically play the role of life that has to be for central Government in the local area. A lot of people don't know what they do except represent the DoH values at a regional level. They ensure that targets set by Government are being reached or have an understanding of why they are not being reached and what the recovery strategy is. So you see their role more as, I shouldn't probably use this word really but not passive but not as like steering role into the [local health] economy."

Even in the case of high performing organisations, PCTs often felt unable to exercise control through commissioning. For example, in the Northern case-study, the discussion at the Northern PCT board meeting (October 2007) focused on available penalties for high infection rates at an FT. One non-executive director asked if there was a financial penalty. The PCT director of strategy said that there was no penalty, other than "asking them to comply with the infection control team." The non-executive director observed that "Non-financial penalties are "embedded in NHS thinking" (filed-notes). (The 2008-2009 model contract for PCT did allow some penalty for breaches of 18 week waiting times but unilateral contract variations were not permissible before then).

In contrast to this regulatory (policing) role, others saw performance management as much more developmental. This approach involved an evolution of a relationship between commissioner and provider, which had been "messy" but was becoming more "standardised."

"We'll pick up individual performance issues with the Trusts. It's been messy, the kind of PCT-to-organisation detailed meetings that we have in different ways, they're now coming into a sort of fairly standardised approach." (Director, Southern PCT).

Clearly, there was a strong link between the performance management approach and the formal metrics (previously, star ratings and more recently, the annual

health check and key government targets). This reflects the primacy of formal performance (see next section) and is evident from the comments of a senior PCT manager:

“We left some of the qualitative aspects of it [performance management] to continue the way they have been before. So we’ve been trying to move again, towards a sort of standard approach which we’re now building in so in terms of having a standard, kind of routine, monthly process that you would be able to read across from one Trust to another so that my team you know, have one set of reports that look the same although we tell them different things.” (Director, Southern PCT).

These approaches are being increasingly tested in the PbR regime whereby Trusts will be paid for activity. FTs, in particular, saw PbR as a route to increasing revenue but were aware of PCT constraints. This was evident, for example, in the Annual Plan of one FT (2008-2009) which stated that

“Elective activity in 2007/08 was close to the Trust plan overall, with significant over performance on new outpatient attendances. Referrals were 4% higher than in 2006/07, and consequently there was significant over performance in all categories compared to commissioner contract targets.”

4.2.4. Formal performance

As noted above, formal metrics dominate the performance management system. The annual health check by the Healthcare Commission, government targets relating to national priorities (such as 18 week waiting, 4 hour wait in A&E, infection control and financial balance) were the principle metrics by which such formal performance was calculated in the LHEs.

The ‘performance’ tables (see appendix 2) provide a summary of some formal performance metrics of the NHS organisations in the two case-studies. Whilst, in general, some managers may not agree with the impression that such (formal) metrics provide (Mannion *et al*, 2005), they serve to illustrate the diversity of ‘performance’ within the two LHE case-studies.

In both LHEs, the (formal) performance of individual organisations appears relatively consistent over time. However, over the three years in question, Southern Hospital 3 has managed to record all four possible scores on the Healthcare Commission’s annual health check. In general, the direction has been an improvement of scores / ratings. Those who had reached the highest ratings had largely managed to maintain their position. Equally, ‘poor’ performers still tended to remain weak or fair. Although the two LHEs represent a small sample, this picture of two LHEs largely corresponds with a national picture gleaned by Mannion *et al* (2005).

One aspect of the reliance on formal performance was the need to record activity and financial data, in relation to government and local targets. Without such data,

organisations would be unable to confirm or deny the formal performance metrics. This was, for example, manifest in the move to FT status that many Trusts sought. Trusts needed to ascertain a baseline for their activity and financial performance but this was not a straightforward exercise, as one director of a provider Trust noted:

"None of us can even really begin to get our head round the concept of what the baseline truly is but for sure the baseline for the amount of work that we need to do, in elective work and outpatient work, not emergency work, is significantly less than what we've been doing and tremendously less than what we're doing for this last push to eighteen weeks [the government's waiting target]." (Director, non-FT)

A second aspect concerned the performance against targets that were set. Trusts needed to "perform" across a whole range of measures. However, target setting did not always appear to take local organisational factors into account (see Mannion *et al*, 2005). For example:

"We don't achieve our MRSA target and probably never will. Our target was set... the year that we had an abnormally low number of MRSA, ...we probably never will achieve it which is very sad because we do work very hard towards it." (Director, provider, Southern LHE)

Targets did catch the attention of managers in the ways in which their organisational performance was managed (Bevan and Hood, 2006; Propper *et al*, 2007). This underlines the centrality of formal performance measures, set by central government, and the incentives that they comprised. Effectively, this 'crowded out' other measures of performance and unmeasured aspects as well as promoting a 'tick box' mentality in service improvement (McGivern and Ferlie, 2007). That said, the 'performance' tables in appendix 2 reveal a general upward trend on formal (measured) performance. What the tables do not reveal, however, is the unintended consequences and distorted behaviours that resulted.

"The four hour wait target [for A&E] is such a big one, and it's just constantly there, I mean, the SHA can't talk to us about anything else really, and it's a bit like our Chief Exec says, you know, unless you can tick off those targets you can't get on with other things" (Director, Southern PCT).

Targets were the shared responsibility across the LHE, so for example, the 18 week target had to be divided between GPs/PCT and providers. Yet, the PCT (claimed that it) did not have the authority of that Trust whose performance was considered poor. The incentives associated with national policies had some leverage but so did other 'softer' techniques and tactics.

"Here's something that's about how you collectively deliver the bottom line, deliver the targets, because some of the measures of performance of the PCT are completely reliant on what's happening within [Southern Hospital] - so for example, [Southern Hospital's] A&E performance." (Director, Southern PCT)

In one Trust in the Southern LHE, discussion at a Board meeting focused on Trust performance against national targets.

“The Trust is also doing well against most national targets.... Some problems and confusions are created by the way targets are measured and set. For example waiting time targets generate confusion as to where the responsibility of the Trust starts, “where the clock starts ticking” (versus PCT and other providers)”. (Field-notes of Board meeting, May 2007)

Clearly, determining when the “clock starts ticking” can create the possibility for conflict, gaming and other opportunistic behaviour (Mannion *et al*, 2005).

In addition, the use of formal performance metrics to determine the ‘actual’ performance of Trusts was problematic for PCTs. It was often claimed that it was hard to discern pre-existing ‘high’ performers as opposed to those who were ‘adding value.’ The example of Foundation Trusts was illustrative here.

“It’s an association which is a function of the fact that Trusts that we’d had in Foundation Trusts were bloody good Trusts. They were well-managed and efficient units.” (Director, Southern PCT).

Generally, despite their previous high performance, FTs had been willing to use only some of their ‘freedoms’ despite their apparent ability to do (Exworthy *et al*, 2008). Such high performance did not always match individuals’ perception of them. For example,

“[I know] a [nursing] sister at [a nearby FT] which is quite interesting and it is quite interesting... [she] and I talk quite regularly, and they have similar problems to what we do... They’re in the better position that they are a Foundation Trust and... well they seem to have more money than we do” (Clinical lead, Southern PCT)

The chief executive of the FT in the Southern case-study was worried about the weak incentive that FTs, especially in terms of retained savings. He spoke at one Trust Executive meeting (September 2007):

“Number one is not a good position to be in! FTs have about £1billion in the bank accounts. Gordon Brown might take back that money as a ‘windfall tax.’ [the chief executive] and other Ft chief executives recently had dinner with the DH policy adviser and tried to persuade him that nothing will come if this idea” (field-notes).

● ***Financial deficit and accounting: a case-study from the Southern LHE***

Financial assessments were a central component of formal metric approach, not least of the need to maintain financial balance. The case-study fieldwork took place during a change in financial fortunes, nationally. At the outset of fieldwork, the NHS

was reporting large deficits - £512 million, according to the BBC (<http://news.bbc.co.uk/2/hi/health/5055602.stm>), more than double the previous year. In the Southern LHE, the Audit Commission (January 2006) was reporting an estimated deficit in 2005-2006 on £75 million in the (former) SHA area. Nationally and locally, the size of deficits prompted severe managerial action.

The financial strategies had apparently brought the NHS back into balance by 2008. In August 2008, the Department of Health was predicting that the NHS would report a surplus of £1.75 billion (equivalent to 2% of the entire NHS budget) for 2008-2009. (<http://www.nelm.nhs.uk/en/NeLM-Area/News/2008---August/28/NHS-finance-report-at-quarter-1-2008-2009/>).

The Southern LHE offers a compelling case-study of how the centrality of formal (here, financial) performance prompted organisational initiatives to remedy an apparent PCT deficit. In a short space of time (less than 1 year), this local deficit was seen to be much less than first thought, which bred a high degree of resentment and cynicism across clinicians and managers in the LHE

Having merged several PCTs into one in October 2006, a financial deficit of approximately £120 million in the Southern LHE was revealed. Such a scale (approx. 10% of the PCT annual turnover of £1.3 billion) necessitated, the PCT argued, wholesale re-configuration. This was approached through an organisational restructuring which focused on seven clinical areas including A&E and maternity services.

An early proposal was the closure of an entire Trust, as one manager revealed:

“There was some work done around the future financial viability of this... health system and a conclusion was reached that the only solution was a whole site closure of one of the Trusts in [the LHE]” (*Director*).

By March 2007, the proposal had been to replace the current three district general hospitals with two 'hot' sites (with major A&E departments) and one 'cold site' (with an urgent care centre) (Jones et al, 2008). A key management strategy for implementing the reconfiguration was to involve local doctors in order that they could 'sell' the model of provision to the wider public. This strategy focused mainly on medical and clinical directors.

The three affected hospitals 'signed off' the document drafted by management consultants. However, interviews with those who had attended the planning meeting highlighted dissatisfaction with the process and with the final document which, they claimed, did not reflect the discussion. Comments from two consultants (at different hospitals) reveal the reaction of clinicians generally.

“We were all very, very cross about that because... it was only a short workshop, when you think of the scale of what's discussed, to achieve some sort of meaningful outcome after two half days is pretty ambitious. It was one afternoon and the next morning and the session was supposedly fairly broad

discussion without any specifics and then in the next, we focussed on what would happen if you reduced sites or services at sites. But, the participants from here felt that our input was effectively ignored and certainly, we said quite a lot things and almost none of it was recorded. You felt that whoever wrote it had decided it all beforehand and the consultation was not really intended to accurately reflect what the consultants felt." (Hospital consultant).

"Closing a hospital in this kind of area is not going to be easy and I mean, that's why they tried to sort of shift it towards us clinicians... So trying to make it look like the clinicians were suggesting it which was quite a crafty move and caused a lot of resentment. A lot of my colleagues were saying 'no, no don't take part in the process because otherwise you'll be blamed when it happens'" (Hospital consultant).

However, the proposal that was advanced by the PCT comprised a wider re-organisation of existing services. The PCT Director of Finance presented the financial case for reconfiguration at a PCT Board meeting (June 2007). The Director explained that incorrect assumptions had meant that the PCT's projected deficit of £118 million was revised to a likely surplus of £20 million. During this PCT Board meeting, the rationale for LHE re-configuration seemed to shift away from financial pressures to an emphasis on evidence-based standards and national guidelines (field-notes). Indeed, in referring to the plans for re-configuration, the PCT Chair claimed that: 'this is what the doctors have told us we have to do' (field-notes).

A clinical director of an 'affected' provider Trust confirmed this and discussed its implications:

"At the initial spending review and can't remember which accountant's firm it was that did it, it said it was going to be this 120 million deficit and the only way they felt that they could recoup that was by shutting the acute services at one hospital. We went through lots of scenarios looking at the best clinical scenario and what the financial implications of that would be so us staying as an acute hospital, [...] being downgraded or [Southern Hospital] being downgraded and that was going to be closing ICUs, closing A&E departments at one hospital so that there would be more an elective centre which makes more money than it costs sort of thing. So that's where it was up until reasonably recently..." (Clinical Director).

However, the scale of the financial deficit was hotly disputed, not least because of the changing assessments over the course of several months.

"...basically I think for a variety of reasons including the fact that the providers and the PCT have managed to turn round a number of financial issues and problems. The picture changed significantly so it went from one really where finances were the main motivation for making the... change [ie the re-configuration], and alongside that we wanted to make clinical best practice changes as well to one where it completely flipped so that it was almost entirely about clinical best practice, Royal College guidelines etc. etc. That was quite a rocky road because obviously you know, it was almost like

going from one end of the scale to the other end of the scale..." (Director, Southern PCT).

Many questioned the assumptions upon which such financial calculations could change so radically and so quickly. Brokering of financial deficit (traditionally undertaken by the SHA, on behalf of the DH) was viewed as manipulation of figures, rather than pointing to fundamental organisational concerns. The dramatic and significant shifts in accounting assumptions and conclusions raised doubts about the entire process, as the quotes (below) illustrate. Two are from 'affected' provider Trusts and the other from a local authority.

"Then they got a different accounting firm to look at the books and he said 'ooh actually, you won't have any deficit at all, you're all fine!' So it's a complete and utter mess. We all felt very pissed off and used really by the whole thing, because we'd gone through this huge exercise and we've given up a lot of time and effort to go through all this and then find that actually we're scrapping all the ideas we came up with" (Clinical director, FT hospital)

"...then suddenly [the] PCT announced that they had re-audited their figures and that was no longer the case. So they weren't going to lose all this money, therefore all the pressure to shut an A&E and shut a hospital have gone" (Clinical Director, non-FT hospital)

Respondent: Well I'll give you one example. [Southern Hospital] - largest deficit in the whole of the country, all of a sudden, ah! 43 million [pounds] comes flying out of the ether -

Interviewer: How do you think that

Respondent: I have no idea, conjuring trick? [pause, laughs] It was a decision I would think that this was taken definitely at DoH level to ensure that vast amounts of money which had been spent on very expensive consultants did not blow up in the Governments face." (Local authority officer, Southern LHE).

However, tacit knowledge supplemented this perceived weaknesses in formal performance data), as will be shown later in this chapter in discussion of 'informal performance.'

The financial situation also prompted widespread public concern

"In parallel with that, clearly we had an awful lot of publicity going on 'Save' you know, '[Southern Hospital]' and the like with banners because they'd picked up on the earlier message and we weren't, for a number of months, in a position really to share anything else with them because it was still very much under discussion..." (Director, Southern PCT)

This public interest and engagement was later promoted by the Southern PCT as a positive benefit of this process.

"We've learnt a lot from the... exercise. I suppose some of the really good learning lessons and some of our strengths now as a result of that has been our patient and public engagement around the changes." (Chief Executive, Southern PCT).

As a footnote to this case-study, the `Southern' PCT Director of Finance reported to the PCT Board meeting (July 2008) that the PCT deficit was £1.6 million in the first quarter 2008-2009. The scale of this deficit largely depended on Trust activity as there was an overspending of £6 million in acute commissioning (mainly due to waiting time target) (field-notes). By 2009, the financial position was more delicate, as reported by the Director of Finance to the PCT:

"The forecast outturn position for the year remains a surplus of £200k after the return of the PCT's contingency from the SHA, full use of the PCT's contingency reserve and the delay in discretionary spending. The forecast out-turn continues to be extremely finely balanced with no scope for further movements over the last month of the financial year" (Finance report, Executive summary, Southern PCT Board meeting, April 2009).

- *Formal performance as a safety net*

Goddard *et al* (1999) note that formal performance information is often used as a `safety net.' They argued that the `safety net' was mostly applied in cases of poor performance, rather than being used to stimulate further improved performance of already `high' performing organisations. In this study, PCT commissioners and other managers also tended to rely on formal performance metrics, possibly because the saliency of `failing' organisations has been consistently high across the NHS – poor performance initiated external interventions and observation in the form of media interest, `turnaround teams', highly structured performance reporting etc.. One Chief Executive described one local `poorly' performing Trust thus:

"They have some very interesting challenges and I think they've had just about everybody in to assist them, so far and I think there's something about it's not one- what that work is showing it's quite a systematic change that needs to take place around."

Formal performance metrics thus provided reassurance for commissioners and other stakeholders. However, often, such formal performance also set (or limited) the terms of debate between the poorly performing organisations and those who oversaw its performance management. Negotiations only seemed to take place about managing the quantitative measures such that they were above the `safety net' (for example, having met a particular target) and no longer attracted such negative attention.

This study thus confirms this `safety net' approach. However, the qualitative data that were gathered in this study, demonstrated a more subtle picture. According to one SHA Director, `poorly' performing organisations had (already) prompted a

significant amount of managerial activity including secondments, SHA interventions and challenge as well as traditional performance management. Indeed, given the social and institutional embeddedness of both LHEs, many of the problems of poor performance had been known for some time, irrespective of recent or the latest performance metrics. Hence, a reliance on formal performance data alone for poorly performing organisations was less relevant. Information relating to informal performance was used in conjunction with the formal performance metrics (see below).

Furthermore, the 'safety net' role of formal performance applied poorly to 'high performing' organisations such as Foundation Trusts. It did not seem to offer the stimulus for such organisations to improve further. Clearly, 'high' performing Trusts faced different challenges, often linked to the risk posed by greater autonomy and especially Foundation Trust status. The incentive to maintain their 'high' performance was especially relevant in terms of retaining FT status. Two illustrations from the same FT bear out this point. In January 2009, the minutes from the Board of Directors meeting recorded that

"If the Trust was to retain its HCC [Healthcare Commission] score of "Excellent/Excellent". it would need to achieve 98.23% for the next 10 weeks to achieve 98.01% for the year overall. It was hoped that the recent pressures on the department would ease over the coming weeks. Elective surgery had also been cancelled during January which would affect the 18 week position. Therefore, it was essential to carry out as much elective work as possible during February and March. It was noted that the PCT had served a Performance Notice on the Trust concerning the 98% target. This was routine procedure

The on-going concern with hard performance measure was also evident in the Board of Directors meeting of this FT (March 2009). The minutes note that the Chief Executive:

"explained that the Trust had now failed to achieve the [emergency services target] target for two quarters in a row and, if it was to fail for a third quarter, [the FT] would automatically receive an Amber rating which would be extremely serious for the Trust. However, he emphasised that this did not mean that the Trust could not be "excellent" for quality of services next year."

Yet, the Chief Executive of the 'Northern' PCT (which had 'performed' well in the World Class Commissioning panel assessment (2009)) spoke of the continued focus on meeting "hard targets." For him, these targets were not so much a safety net as a baseline which prompted further improvements.

"For me, it's about being very clear about what our vision is and our strategy – [getting] everyone to galvanise and to deliver what we want in our strategy so it's about dialogue and it's about vision and it's about performance management and hard targets"

This PCT Chief Executive claimed that the WCC had proved positive because

"We were reassured by the process because it confirmed where we thought we were."

Nonetheless, for such high performing organisations generally, it was unclear whether formal performance metrics alone achieved this. Formal performance metrics were increasingly less relevant despite their fundamental importance (linked to incentives to comply). They had become the minimum standards that were largely taken for granted.

The Chief Executive reported that the Trust has good cancer performance but "whether you agree with the 2 week target or not, it about standards of patient treatment." (Field-notes of Trust Executive meeting, September 2007)

The Chief Executive of the Northern PCT illustrated the declining relevance of the safety net function of formal performance metrics by recalling an anecdote.

"Eighteen weeks [target] has been there for ages but it hasn't driven... I had somebody come from the hospital, she's a director of a very large [Trust] that I know and she spent the day with me, she said, 'I've been with you all day including executive team meeting and a meeting with the commissions, through our PEC', she said, 'not one person has mentioned eighteen weeks all day', I said, 'Yes that's right, it's not- it just happens' ...and we expect the Provider to ... it's not a big issue for us, what drives us is tackling health and inequality and driving up the standard of care"

The 'safety net' role of formal performance had other limitations. Reliance of formal performance metrics was only sufficient if supported by an appropriate set of incentives. Hence, if a Trust was "under-performing", what options were available to the PCT? This question became the topic of one (Northern) PCT Board meeting (October 2007) in relation to the MRSA targets of one local Trust. The conversation developed as follows:

Board member: "It's always disappointing to see [Northern Hospital, an FT] being too high. Is there any financial penalty?"

PCT Director #1: "No. PCT can ask them to comply fully with the infection control team."

Board member: "Non-financial penalties are "embedded in NHS thinking."

PCT Director #1: "That's not entirely true. The "new model contract" [with effect from 2008-2009] allows some penalty in terms of 18 week. Before then, a variation of contract cannot be unilaterally implemented. "

PCT Director #2: "MRSA is a very tight target that has been benchmarked nationally."

PCT Director #1: "18 weeks will be the total wait time by 2008. But [Northern] SHA is the worst SHA area. So there is high anxiety as [the Northern LHE] is one of the worst in the SHA. The PCT can't sort this out on its own. It's reliant on its providers." (Field-notes).

Another perspective on the role of formal performance and the 'safety net' function relates to time, both in terms of the periodic performance assessment and the

legacy / template of former performance regimes (Pollitt, 2008). Performance targets are often defined in temporal dimensions: 18 week target for elective admissions, 4 hour A&E target, health inequalities target (of life expectancy and infant mortality) by 2010, for example. A PCT would receive weekly updates on its performance against the 18 week target but would only receive an annual report on its progress in addressing life expectancy. Clearly, the volume of performance data for the former tends to imply a greater priority than the latter. The temporal dimension of formal performance metrics ('hard targets') was illustrated during one PCT Board meeting.

The main performance issue for the PCT was [Southern Hospital] A&E performance. The Trust has extended the walk-in opening hours. They are putting greater and more senior resources into issue. The PCT Chief Executive and Director are getting daily text message updates." (Field-notes, Southern PCT Board meeting, June 2007).

The immediacy of A&E (as a service and a target) is illustrated in contrast to the target for tackling health inequalities which operates over a much longer timescale.

"Where the data comes in, so say A&E on Mondays mornings we can see the data for the previous week. For life expectancy, we see it a year after- a year later we see the life expectancy changes and we only get it once a year so it's not that we don't, you know, we- we care about both - but actually one, the amount of attention you can give it just by fact that the data isn't there and it doesn't move quickly in a way that A&E moves on an hourly basis" (Director, Northern SHA; emphasis added).

Nonetheless, in both cases cited by this respondent, performance data were retrospective. By contrast, one SHA director suggested that one of their primary roles was to provide "time and cover" for poor performers. The health system - centrally and locally - tended to exert pressure to improve performance but, this director noted, time might be needed to introduce and sustain new processes and practices. Hence, the SHA was able to provide "cover" (*de facto* autonomy) for Trusts to develop improvement strategies. In this sense, autonomy might be seen as a route to improved performance but this autonomy was granted by the SHA. On the other hand, good / high performers required less time by the SHA in terms of checking. In one SHA area, 80% of senior management time was spent, according to one Director, on three "poorly" performing PCTs.

4.2.5. Informal performance

Notions of informal performance were commonly used by interview respondents and employed in meetings which were observed. Notions such as trust, reputation and credibility were often deployed but were not always explicit. The information gleaned from the deployment of such 'informal' notions generated vital intelligence in managing relations between organisations, especially between the PCT and its

provider(s). For example, a Director of one Trust in the Southern LHE identified that:

“There are old prejudices from when we were a non performing trust that we need to turn around” (Field-notes, Trust board meeting, July 2008).

The role of informal performance is, according to Goddard and Mannion (2006) twofold; first, to act as a complement to formal (hard) performance information and second, to act as a substitute for it. We apply this typology to the case-studies.

- *Informal performance as a complement*

Some respondents contrasted their formal and informal aspects of performance in complementary ways. In particular, aspects of performance which were not easily measurable or were ineffable, were described in “softer” or “touchy-feely” terms. By contrast, formal performance aspects were deemed more precise, hard and sometimes ‘real’. Respondents offered a clearer association between cause and effect in terms of formal performance; hence, there were more “black and white” measurable issues. In the quote below, it is interesting that the Trust Director does not seek to evaluate one form of performance over another but recognises that both offer important insights into the overall performance – recognising the complementarity of performance information. Yet, despite a claim to be a “very high” performing organisation, this respondent was able to identify shortcomings in performance.

“I think we're very high performers. I think that we achieve all of our targets so, all the waiting time targets, numbers on waiting lists, all those sort of you know, very numerical measurements, we are home and dry on constantly... The area that I think we are very weak on is a softer area which is actually involving patients listening to patients ...but on the black and white measurables I think we're strong. On the softer, more touchy-feeling stuff, we're not particularly good, so staff morale we're not particularly good so the more soft stuff we're poor, the hard stuff we're good.” (Director, Southern Hospital).

The internal/external perspective was also offered by a Non-Executive Director of a Northern Hospital:

“His impression was that the organisation had made significant achievements since 2004 and was viewed much better as an organisation from the inside rather than the outside. He felt staff morale was high” (Minutes of Board of Directors meeting, November 2008).

Complementary aspects of informal performance were also manifest in other regards. For example, the ‘official’ performance management process (which might be considered a formal aspect of performance) was increasingly seen as limited in offering insights into provider performance.

“Creating performance management frameworks and control mechanisms is not sufficient if the organisation does not respond” (field-notes, Southern Hospital board meeting, April 2007).

Official meetings to discuss performance were often seen in ritualistic ways or were part of the dramaturgy of performance (where individuals might orchestrate events or use the forum for 'playing games'). Other processes had been instituted to complement the official/formal approaches. In particular, this involved developing a corporate / cross-organisation approach.

"That's called a Part One Review, performance review monthly with the [Strategic] Health Authority where they look at us and also our kind of management of this system and then we have another one which the acute Trusts with the exception of [Southern Hospital A, an FT], come to and that's, to my feeling, that's never been a particularly helpful or effective meeting generally speaking, Chief Exec from the [Southern Hospital B] says something stupid and everyone jumps on him and then we all go home and sort of talk about [Southern Hospital C] and how difficult things are there. But we're beginning to move away from that and what [Chief Executive of the Southern PCT] has done is set up a- I'm not sure what he's calling it but that's on a monthly basis where he's going to sit down with the Chief Execs from across [the LHE], and not just the acutes, so mental health will be there and also ...from the local authority will be there and our own provider side as well so a sort of much more Health and Social Care Community ...officers meeting. He hasn't yet but we'll build in some elements of performance management into that." (Director, Southern PCT).

This complementary role of formal and informal performance was also manifested in the strategic development of PCTs. Following their re-organisation in 2006, PCTs initially focused on establishing the organisational infrastructure for commissioning all services and providing community-based services. In the phase two interview with the Chief Executive of the Northern PCT, he noted a shift in the implementation of the PCT strategy over time, from a formal approach to an informal one.

"I think in those three years [coinciding with the life of the PCT and the period of fieldwork] it was 'sort out the money and get our house in order' ...putting new things in place, structures and processes as you say, and then year three was starting to see the returns on our efforts and I think we're starting to generate a whole stock of stories, narratives and evidence of where we have an impact on patients and the public and commissioners will see a difference. I guess the big question for PCTs and you will have a view - that's the effort of two to three year's of investment."

A second example is the tacit knowledge (based on experience) which was seen as vital. In both case-studies, the Chief Executives of the two PCTs were new appointments (since or as a result of the October 2006 reorganisation). Some provider Chief Executives had been in post a while but, in the Southern LHE case-study, all but one provider had appointed new Chief Executives in the two years prior to the start of our fieldwork. In some cases, this provided the opportunity for a strategic re-design of the PCT's approach or in other cases, it stifled development since other infrastructural and relational issues had yet to be resolved.

"I think they [PCT] were very slow to start and I'm not quite sure why they were so slow. I think part of the reason was that when [the Chief Executive]

was appointed, he took the view that the [...] former PCTs coming together into one new one was such a confusion, such a mess, that he didn't quite know who he wanted or what he wanted or how. So they took a long time getting their structures in place. I think the board was slow to get together so they were much slower in appointing their new Executive Directors and getting their new structures in place than the other PCTs from [the region]" (Director, SHA).

We also recorded the `reverse' perspective (of the SHA by the Trusts). For example, we noted the observation that

"the role of the SHA is fundamental in facilitating collaboration and setting the expectations. The old [metropolitan] SHA had created a quite adversarial relationship. The new one, instead has created a culture of transparency which has help to move things forward. The same cannot be said of the [regional] SHA." (field-notes, Trust board meeting, April 2007)

Informal performance was evident in external perceptions of other Trusts. For example, at one Trust board meeting (April 2007), it was noted that the local FT "presents a contrasting example. The Trust is a mature organisation which has self-awareness and control internally" (field-notes).

- *Informal performance as a substitute:*

Informal performance as a substitute was evident at all levels – inside the organisation, between organisations and across the LHE. Firstly, within the organisation, one Trust provider manager used an `informal' approach as part of their management `style.'

"It's about communication regularly on a regular basis and obviously monitoring is through the data you get and discussing 'this looks like this is happening, what's happening here?' It is about constant regular communication and my door is actually never shut. It is always open because what you pick up out and about and around, the sort of intelligence that you work to is probably the best thing that you can do by being out and about picking up on the issues and you'll trip over something and someone will say 'well you know, I can't actually do that because this, this and this.' And...there's no point being very important if you can't sort things out, so I use my importance to sort out lots of things often and to be the place where people can escalate" (Medical manager)

Secondly, between organisations, the management of inter-organisational relationships (even for FTs) was an important role for managers and clinicians. In some cases, this was to remedy apparent misconceptions or to ensure harmonious working relationships, say, with the PCT. In the case of the former, the following quote illustrates how GPs were led to believe rather outlandish claims. These examples are hopefully hyberbolic but may have been fostered by previous attitudes and approaches by this FT or FTs in general.

"So we're building up liaison with GPs more now, you know, we're trying go out and see them, we're trying to build up relationships and trying to dispel some of the myths that are you know, 'we've been told that you're all, you know, operating on dead people, you know, admitting people unnecessarily, charging your private patients to us.'" (Director, FT).

Such negative perceptions were reinforced by comments of senior managers at a Trust meeting (September 2007). The Director of Human Resources said that there was a "common theme from GPs that [the Trust] is ripping them off in terms of coding. The Medical Director argued that "We need to keep in with GPs. One meeting he attended led to a row between GPs and the PCT" and a consultant claimed that the "PCT is painting us as a pariah." To these comments, the chief executive replied

"There seems to be a `ring of hatred" around [the Trust] but some respect that, organisationally, we deliver good quality services. It seems that the NHS doesn't like success"

An example of the latter relates to the mutual inter-dependence evident in the Northern case-study. The Chief Executive of the PCT spoke of the "trust" that he had in Chief Executive of a local FT, a trust which the PCT manager recognised as essential in developing a strategy in a mutually dependent LHE. The SHA confirmed the high degree of respect that the PCT and FT held for each other; they thus avoided exploiting the opportunism that might be feasible.

Thirdly, across the LHE, inter-organisational relationships impacted upon others. Perceptions about services and organisational decisions were often formed in the absence of formal performance (usually because it would be impossible to capture such data or do so in a timely manner).

The PCT chair explained that there is a "perception of poor mental health services" in [the LHE] and that the PCT is going to "take money away from services" (Field-notes, Northern PCT Board meeting, October 2007)

In a different way, though at the same meeting, the Director of Public Health pointed out a common view across many patients and the public at large. The solutions, according to the DPH, was to hold "conversations" with the public.

"The public don't appreciate the organisational differences between the PCT and providers. How do we cope with that? We need to have a realistic conversation with the public." (Field-notes, Northern PCT Board meeting, October 2007)

In another example, performance management by the SHA or PCT affected perceptions and shaped attitudes. An interview with a Northern SHA director revealed how informal performance operates in the performance management of the PCT. The director explained that, whilst the SHA offered challenge and support to the PCT, it also adjusted its approach according to the "performance" of the PCT and LHE. In the case-study, the PCT was perceived as a high performer and so the SHA could "trust" the PCT and hence, needed to "check" less. Specifically, the time that senior SHA management would spend per PCT indicated the perceived level of "trust." However, the SHA director believed that granting autonomy did not generate improved performance *per se*.

The opposite end of the performance management regime presents different insights. For example, a discussion on infection control was held at a Trust Board meeting (field-notes, July 2008). It was reported that

“The SHA are still on our back and they are ringing us up once a week to see what has happened in the last week.”

In a similar vein, one Board member commented that “the visibility of Matron is improving patient perceptions of how well the hospital is being run.”

Whilst informal performance was often seen as a substitute for formal performance, there were differing levels of the former. It was thus not always evident that managers could access, use or interpret the information about informal performance emanating from providers. This differential became especially critical when a PCT was commissioning services from several different Trusts, with contrasting levels of formal performance. It is instructive to note the “longer conversation” in terms of relationships as well as the commissioner’s response to levels of performance - a wealth of “informal knowledge” in situation where there had been a history of “poor” performance and “informal networking” creating a collegial approach. However, it was the Trust which had performed moderately well that had been a “closed book” to the PCT.

“Again we’d have to have a longer conversation perhaps about kind of, relationships and perceptions between PCTs and Trusts from both aspects. We’ve got a wealth of informal knowledge about [Southern Hospital X] because there are a number of people in the team who’ve been there before and the nature of [Southern Hospital X] is it’s been very open to it because they’ve been so desperate for help. [Southern Hospital Y] is much more of a closed book to us. There are people that have come into different roles in the PCT who may have known something about it but it always feels quite antagonistic that relationship and the GPs are pretty disenfranchised lot as well. So there’s not a lot that has a kind of root of understanding and influencing this... isn’t there either. [Southern Hospital Z] was a fairly sort of collegiate comfortable sort of relationship and there’s a fair amount of sort of, traffic, you know, informal networking stuff through that, for a lot of people in the PCT or- there are in the Exec Team of the legacy PCTs” (Director, Southern PCT).

(Note the organisations in this and subsequent quotes have been given additional anonymity). Commonly, informal performance was used as a substitute for formal performance when the latter was deemed inadequate, inappropriate or insufficient. Despite the volume of formal performance data, its inadequacy in managing relationships within the LHE was widely acknowledged. In its place, an array of informal performance ‘mechanisms’ was deployed. When asked how the competencies of WCC, one PCT Chief Executive explained

“It’s a whole range of things that I think are in lots of ways tied up to be World Class Commission... It starts off with ‘Well, do we know what’s going on?’ you know, ‘Can we get to the bottom of the activity flows and what patients are saying about their experience, is there enough information out

there that can give us an evidence-based decision making' and the answer is 'we're getting there' and some things are very good, some things are woefully inadequate in telling us about what's actually happening and why and what the patients are saying about it."

The WCC panel (2009) assessed this PCT's strategy positively: "The PCT has built strong foundations, which have already made an impact in both developing the strategic vision for the health of the [LHE] population, and in ensuring a robust grip on financial performance."

In a different way, an example from the Northern LHE illustrates the importance of securing effective / productive informal performance 'mechanisms' in support of wider organisational and policy goals. At a PCT Board meeting (October 2007), the Chair of the Professional Executive explained the relations between the PEC and the PBC 'clusters.'

There is some leading edge work but others are looking for lessons to improve themselves. PEC "feels healthy." We are getting a good relationship between the PEC and the (practice-based commissioning) consortia. The two balance each other quite well to deliver on action to reduce health inequalities across the city. (Field-notes)

A different example from the Southern LHE seemed to highlight a similar use of informal performance. At a Trust Board meeting, there was a debate about the options facing in the Trust in the light of LHE discussions about possible merger with a neighbouring Trust.

The Chairman reported that the Trust had considered several alternatives and had discarded the hypothesis of becoming an FT or merging with [Southern Hospital L], because of "cultural" divergences. They had have considered [neighbouring hospital M] but it is an aspirant FT. [Southern Hospital N] turns out as the best option (though it was already an FT) because there is a "strong cultural compatibility." It would be the merger of two "high performing" trusts, which would allow financial stability and more investments. The PCT and SHA agree. From a clinical viewpoint, this would allow the Trust to have safe and high quality services in accordance with Royal College guidelines. Furthermore, there would be opportunity for vertical integration in the community. Also as [Southern Hospital N] is an FT, there is the opportunity to learn from their experience on how to best engage with the community. (Field-notes, September 2007)

4.2.6. The interplay between formal and informal performance

Rather than viewing informal performance as complementary to formal performance, it is also possible to view the two in conjunction with each other, as they facilitated the interplay between different mechanisms and notions of

performance. This interplay was played out in various settings and in different arenas. Three are prominent: (i) defining the LHE, (ii) the inter-twining of formal and informal performance, and (iii) the mismatch between formal and informal performance.

- *Defining the LHE?*

As noted earlier in chapter 1, the definition of the LHE is not an objective matter. At a fundamental level, decisions about which organisations comprised the LHE (or system) seemed, on occasion, quite subjective. In some cases, the decision was to include them within LHE decisions whilst in others, to exclude them, and others still to include and then exclude them.

Throughout the field-work, there were frequent debates about the size and scope of the LHEs, especially in the Southern case-study. In June 2007, the PCT Chief Executive gave a verbal report to the PCT Board meeting.

The Chief Executive had attended the Board meeting at [Southern Hospital R]. It is now considered to be a [neighbouring SHA] trust even though [one half of the Trust] is in [the Southern LHE]. London is bringing out guidance to accelerate to the standard on consultant cover at [Southern Hospital R] (field-notes)

Similarly, in July 2008, the Chief Executive gave his verbal report in which he mentioned again the responsibility for the border Trust (mentioned in June 2007) being shared with a neighbouring PCT in a different SHA area. In addition, he referred to the re-naming of the PCT.

"[Southern] PCT will become NHS [Southern]. The DH recognises the separation between provision and commissioning and becoming NHS [Southern] is the expected step to take. Concerns were raised of the costs that changing name will generate and of the implications on reputation when [Southern] PCT is withdrawing services because of financial issues. (Field-notes of Southern PCT Board meeting, July 2008)

- *Formal and informal performance inter-twined:*

Quite often, it was difficult to distinguish notions of performance between formal and informal aspects. Rather, they seemed to be so inter-twined as to become inter-twined with each other.

Respondents' discussed the mechanisms and techniques available to them to improve 'performance' ranged across formal and informal aspects. It seemed that managers (as opposed to clinicians) valued their ability to deploy a judicious blend of formal and informal notions, as demonstrated by this manager:

"So you've got a whole range of tools in the tool-bag [to improve performance] starting with soft stuff, ending up with quite hard stuff and we spend a lot of time thinking about... whether we're going to use a hammer

or we're going to use a nut, ...to crack a nut, we're going to use a scalpel, we're going to use a load of hammers. That is the nature of our business, trying to keep all that going over a sustainable period where ultimately you want a sustainable system is what the [name of the PCT's strategy] is trying to describe even though it may be a bit tricky along the way." (Manager, Northern PCT)

The blend of "soft and hard stuff" to implement the PCT strategy seemed to vary over time according to local contingencies, that could not necessarily be determined centrally. This careful use of "hard and soft stuff" might be easier in a more "closed" LHE where social and institutional relationships are more embedded. For example, at the Southern PCT board meeting (June 2007), the PCT Chair described his recent meeting with the Health Overview and Scrutiny Committee. They were, he said, 'not quite on the same wave length'. There was a lot of information that, although available in the public domain, the committee expected to have shared with them more formally. They want to hear from us about performance across [the LHE], not just the PCT. The Chair added "let's hope we quickly get onto the right wave length." (field-notes).

This inter-dependence also became obvious in observations of meetings. For example, at a Trust Executive meeting (Southern Hospital, September 2007), a discussion was held about the Trust's performance and the associated financial implications. One consultant claimed that "there is a fear that the PCT is stealing our money", to which a Trust Director replied that "there is agreement that [Trust's] coding is generally accurate and where it is not, there is no financial gain." The consultant has presented performance in an informal perspective and yet the reply has been within a formal perspective. A similar illustration also came from observation at a Trust Board meeting. A Board member asked: "How do you think we [the Trust] are perceived?" A clinical director replied that: "We need to go out and tell people what we are going to do." This prompted the Trust's medical director to comment that "We had a 24% increase in new medical referrals so somebody knows we are here."

The inter-dependence of formal and informal performance was especially evident in 'performance management.' As this function seeks to capture all aspects of performance, it is perhaps unsurprising that respondents drew on both types of performance notions. Comments by the WCC assessment of PCTs illustrate the inter-dependence in performance management; for example, in the Northern PCT, the 2008 assessment panel concluded that:

"The PCT has built strong foundations, which have already made an impact in both developing the strategic vision for the health of the [Northern] population, and in ensuring a robust grip on financial performance."

- *Mismatch between formal and informal performance*

Much of the time, there appeared to be a reasonable consistency between formal and informal notions of performance across the two LHEs. However, on occasion, a mismatch was evident. The mismatch became apparent when informal performance notions tended to be more responsive to events than formal performance metrics (which are inevitably retrospective; see above). That said, reputations and goodwill (key aspects of an informal performance perspective) might, arguably, take a longer time to develop and, equally, be lost in a short time too. For example, it might be

expected that newly appointed and newly formed organisations might rely more heavily on formal performance (and vice versa). Since "up to half of senior executives are likely to spend less than two years in the same post" (<http://www.hsj.co.uk/news/workforce/startling-senior-executive-turnover-stifles-nhs-innovation/5002834.article>; 18 June 2009), there might also be a mismatch in terms of their ability to "deliver performance improvements" in, say, less than 1½ - 2 years. The legacy of former informal performance notions might thus be expected to provide a basis for current assessment of individuals and organisations. As such, informal performance seemed to be less volatile or fluid than formal performance. This accords with findings that many formal performance metrics are liable to significant changes through small variations.

One newly appointed Chief Executive spoke about his focus on the formal performance of the organisation and the LHE:

"I just encourage people to look at, if you like, what we do know as facts, that our audited accounts, our projections were assessed independently." (Southern LHE)

By contrast, a long-serving senior manager seemed to emphasise more informal performance aspects of his job. His length of service seemed to offer some advantages though later in the interview he also noted some disadvantages.

"I think longevity gives you an opportunity to have or build up a successful team, it gives you the opportunity of having a degree of credibility you know, the organisation is successful and you- you know a lot more about the organisation because you are the organisational memory"

In the case of a third organisation which had a tradition of 'poor' (formal and informal) performance, a new Chief Executive had been appointed shortly before fieldwork began. One senior manager at this Trust noted that

He has a reputation for strong leadership and presence on the 'shop floor'. He has imposed a culture of 'non-tolerance of non-delivery.' (Field-notes, April 2007)

It is important to note that the previous poor performance had precipitated the appointment of this new Chief Executive. As hypothesised above, new senior managers thus tend to rely on formal performance at the outset and might focus on the aspects of performance that had prompted their demise of their predecessor in the first place.

Respondents spoke about the 'organisational' correspondence between formal and informal performance. One senior manager noted that the public may rely more heavily on personal experience (informal performance) than national measures (formal performance). Yet, he also felt that Foundation Trust status does carry recognition of high performance amongst the public.

"I'm not sure whether the health-care standards are that understood by the wider public. I think certainly the old star system was and I think the label of Foundation Trust is. But you know quite a lot of it is probably more to do with what people's own experience is. I live within 10 miles of the hospital, I mean, there's hardly anything you'd go to where somebody doesn't say 'Ah well, you know, I was admitted to the hospital, I had a great experience of going to A&E there' or 'I know so-and-so and-' or 'my elderly mother went in' or whatever." (Director of Finance, Southern LHE).

He later than explained that reputation of clinicians does become associated with the Trust as a whole.

Public perceptions might become increasingly significant in a era of "Patient Choice." This policy imperative did not feature very strongly in either LHE case-study. However, it provided a rhetorical back-drop to some discussions. For example, at the Board meeting of one Trust which regularly performed 'poorly' according to formal metrics and was widely perceived to be in 'difficulty', it was reported that:

The Trust Board wants to be 'a trust of choice' and are primarily concerned with meeting performance indicators that are published and are of most concern to patients and most likely to influence commissioners. (Field-notes, Trust board meeting, May 2007).

This was also illustrated in documentary evidence. One example is the mismatch between 'improving results' and the public's "poor" perception of services.

"Members commended the [Southern LHE] Trusts on their improving results with the Healthcare Commission, however, concerns were raised that patient and user surveys were poor. Members were informed that this was an area that the Trust was looking at improving." (Southern LHE, Health Overview and Scrutiny Committee minutes, January 2009, p.4).

5 Discussion and interpretation.

5.1 Introduction

This chapter revisits the conceptual frameworks (introduced in chapter 2) in the light of the empirical evidence gathered through fieldwork (whose findings are outlined in chapter 4). This is done through three primary themes: decentralisation, autonomy and performance. It is also important to consider the contribution that this study makes to extant knowledge about such themes in terms of the original aims and objectives.

Aim:

- To investigate the inter-relationship between decentralisation, governance, incentives and performance in LHEs.

Objectives:

- f. To examine the impact of decentralisation upon performance;
- g. To describe the local interaction of governance mechanisms;
- h. To evaluate the degree of autonomy ('decision space') available to local health-care organisations;
- i. To assess the incentives associated with different policy initiatives;
- j. To provide lessons for policy-makers and managers at all levels

5.2 Decentralisation revisited

Decentralisation has long been analysed in a variety of academic disciplines. It has also been popular among policy-makers and politicians for (apparently) resolving organisational and structural failings. Nonetheless, its appeal has waxed and waned in response to shortcomings of the previous 'regime.' It is fair to say that over the last 10-20 years, decentralisation has been in the ascendancy among Western/OECD-type countries. Developments towards centralisation have, however, also been apparent during this time, underlining the dual / oscillating process of reform that is inherent within central-local relations.

Although previous 'rounds' of decentralisation / centralisation have been well covered in various academic literatures (Peckham *et al*, 2005; Saltman *et al*, 2007), there has been a need to examine this latest version for two principal reasons. First, extant knowledge about decentralisation has been unable to account for recent policy and organisational developments. Governance reforms (such as the rise of network-based organisations and quasi-markets) have fundamentally altered the landscape in which health policy reforms now take place (Davies *et al*, 2005). Yet, decentralisation models and frameworks have been unable to accommodate such

reforms, not least because they were constructed beforehand. Secondly, extant knowledge has also been limited in being able to differentiate both what is being decentralised and which agents are involved – the ‘what and who/where’ questions of decentralisation.

A previous study (written by some of the authors of this report; Peckham *et al*, 2005) sought to advance extant knowledge by proposing the Arrows framework which clarified the ‘what and who’ questions. The traditional model of decentralisation had usually located the continuum from central to local. The Arrows framework extended both ends such that international / supra-national organisations and the individual (patient / practitioner) were now included within this ‘new’ framework. It also sought to distinguish more clearly between what properties / domains were being decentralised. Primarily for analytical clarity, the Arrows framework distinguished between inputs, process and outputs/outcomes (I*P*O). This distinction helped demonstrate the ambiguity inherent in decentralisation (Vancil, 1979) because it allowed for the possibility that decentralisation and centralisation might take place at the same time. Hence, control over inputs (I) and process (P) may be decentralised whilst control over outputs/outcomes (O) may be centralised. Moreover, an organisation (at one level within the central-local continuum) may experience the loss of power (upwards and/or downwards) and power by-passing them (say, from central authority to a more local agency). All three possibilities make decentralisation highly problematic as a strategy for evaluation and assessment.

However, this Arrows framework, though an ‘improvement’ on previous models, remained focused on the vertical dimension. As we had noted earlier, frameworks had not adapted to the changing governance landscape. Hence, it was important to recognise the networks and dependencies within which organisations (newly in receipt of decentralised powers) operated. Inter-organisational dependencies and relationships, it was hypothesised, were crucial to the ways in which decentralised powers might be exercised and ultimately, to the performance of the initiative itself and also the organisations. These dependencies and relationships were situated within the LHE which was thought to shape and be shaped by decentralisation (see below). Though a nebulous concept, the LHE was thought to be the context in which the vertical dimension would intersect with the horizontal dimension. This contextual dimension helped to explain (in two ways) why decentralisation might have differential effects. Firstly, national policy (vertical dimension) has increasingly sought to differentiate local organisations (most clearly related to performance; note, star ratings, earned autonomy and Foundation Trusts). This can be seen as a ‘divide-and-rule’ strategy, evident in many versions of decentralisation. The sub-national interpretation of national policy might also have had an effect; note, for example, the variation in Foundation Trusts by SHA (<http://www.monitor-nhsft.gov.uk/>) or geographical variations in the uptake of Patient Choice. Secondly, given the uniformity of many (though clearly not all) national policies, local context (horizontal dimension) has an explanatory contribution.

In short, the evolution of decentralisation frameworks can be seen as the development of multi-dimensional perspectives. The first, and traditional, approach was oriented around the central-local axis. The second involved the extension of the central-local continuum from supra-national to individual. The third involved the expansion from a purely vertical analysis to one which also included a horizontal (local) dimension. We might also add a fourth development – time – involving the oscillation (ebb and flow, wax and wane) of decentralisation and centralisation. By virtue of the length of this study (3 years) and the methodology adopted (including

repeat interviews and extended observation), this study has been able to incorporate a temporal dimension. However, it may be arguable that a longer time frame (such as a decade) is required to appreciate the wider ramifications of decentralisation.

In terms of the conceptual contributions relating to decentralisation, this study has shown the value of the new multi-dimensional perspective even though the study did not extend its inquiry to individuals or to supra-national organisations. (This latter point was beyond the scope and remit of the study). Attention remained focused at the organisational level, not simply in terms of atomistic agencies but rather in terms of the inter-relationships between them, each of which were implicated in and affected by decentralisation in differing ways. All were affected by the implementation of national policies (such as Patient Choice), but some became FTs and others were subject to greater scrutiny and control (due to previous "poor" performance). Yet, how did these vertical imperatives have horizontal ramifications within the LHE?

It was found that several national policies had little impact upon local inter-organisational dynamics. Structurally and financially oriented policies (such as FTs and PBR) seemed to gain greater traction locally than others (eg. PBC). This may have been partly due to the focus of the study on structural and financial concerns (among others) but PCT budget devolution did not seem to figure prominently in accounts about new decentralised powers. Yet, this specific policy (a form of 'input decentralisation', in the Arrows framework) had been prominently advanced as one of the key ways in which PCTs were able to be free from government and be free to respond to local concerns/needs. However, it may also reflect the relatively slow / problematic implementation of other policies such as Patient Choice and PBC (Fotaki, 2007). The Audit Commission (2008) confirms this impression:

"The incentives and infrastructure to support practice-based commissioning are not currently sufficient to engage most GPs in commissioning" (p.4). In short, these policies were the 'dogs that did not bark in the night.'

We found that central control had either been retained (ie. not decentralised) or re-centralised almost wholly within the 'output/outcome' domain (in the Arrows framework) (or interventional autonomy, according to Verhoest *et al* (2004)). This was closely related to the performance culture which placed heavy emphasis on a centralised approach to measuring and managing performance. Such 'centralisation' was apparent in terms of targets (relating to A&E 4 hour target, 18 week elective surgery target and financial balance etc.). Whilst there has been much comment on the deficiencies of the performance culture generally and the targets specifically (eg. Bevan and Hood, 2006), we found that the 'centralisation of outputs' was largely accepted by respondents in all agencies in both case-studies. Clearly, some questioned their value and accuracy but in general, they were mostly accepted as a 'fact-of-life.' It might have been expected that such centralisation would have been more strongly resisted. However, much time and effort was expended in dealing with the data and their implications. This might lead to the conclusion that, whilst input and process decentralisation offered local organisations some new powers, attention was dominated by 'output centralisation.' It might also be argued that all local organisations were (for the most part) equally affected by this 'output centralisation' even though it had been policy sought to differentiate local organisations through input and process decentralisation.

The permission to apply for and the granting of FT status was a notable example whereby differential patterns did emerge in the 'Inputs' and 'Outputs' of decentralisation. This was noticeably apparent in the Southern case-study. Here, there was a distinction between FTs and non-FTs, and in particular aspirant FTs. The aspirant FTs perceived an uneven 'playing field' in competing with the FT in terms of the alleged preferential financial regime. The transitional PBR applied to FTs did indeed offer them a financial advantage over non-FTs. However, some aspirant FTs went further to claim that their applications were held back in order that the LHE might be better established given recent reconfigurations (such as the PCT). This differential decentralisation was not simply a variant of conditional decentralisation associated with 'earned autonomy', an approach linking decentralisation and performance. Rather, differential decentralisation sought to exploit an apparently uniform policy (the possibility of FTs status) into a deliberate market-shaping strategy. This is where evidence from a wider range of case-studies would be especially illuminating.

We found degrees of ambiguity as some powers were devolved to sub-organisational levels (eg. to individual patients through Patient Choice, and to practices through PBC). Some powers (mostly relating to outputs) were also centralised but many of these were not contested because it was possible to deploy them beneficially. For example, NSFs and clinical evidence were used to justify local (often controversial) decisions.

An alternative reading of the findings gleaned from this study can be cast in terms of legitimacy (Vrangbaek, 2007). It can be argued that decentralisation (and equally, centralisation) is not so much an initiative to improve the performance of local (and possibly, central) organisations, though this may be a beneficial by-product. Rather, decentralisation is a strategy design to restore legitimacy in central and local organisations. Vrangbaek identified three types of legitimacy: input, process and output – categories which offer a close correspondence to the Arrows framework and enable a deeper analysis. Decentralisation may thus be as much about the search for new forms of legitimacy in re-structured public services as specific performance objectives.

'Input legitimacy' refers to the ability of the public to influence decision-making; decentralisation is often presented as a chance to reduce the structural distance between decision-makers and citizens. We found little evidence that input legitimacy had been enhanced by decentralisation. The Southern PCT had claimed that its approach had enhanced public involvement. Under competency 3 of World Class Commissioning ("Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health"), the PCT had assessed its 'influence on local health opinions and aspirations' at level 3 but the WCC panel rated this level 1. Likewise, the PCT rated 'public and patient engagement' at level 3 but the WCC panel at level 2. This evidence supports a wider pattern, reported by the Health Service Journal (4 June 2009; <http://www.hsj.co.uk/5002146.article>). The FTs in the study claimed that more needed to be done to engage better with the public and patients, a conclusion also reached by the Health Select Committee report on Foundation Trusts (2008). One FT in the Northern LHE has begun to use the Picker Institute 'Frequent Feedback' service (from 2009 for 3 years) (<http://www.pickereurope.org/frequentfeedback>).

'Process legitimacy' offers the prospect of greater control, trust accountability and transparency. This is thought to be achieved by decentralisation creating smaller,

leaner organisations which are better able to respond to local needs. We found limited evidence of this, especially among those organisations with greater autonomy (such as FTs). However, this moderately favourable conclusion is tempered by three factors. First, local needs are mediated through assessment by PCTs (ie. joint service needs assessment); responsiveness may thus be evidence in the light of Patient Choice. Second, although the Audit Commission (2008) noted some improvement in services delivered by to FTs, they concluded that "FT status does not yet seem to be empowering organisations to deliver innovative models of patient care" (p.4). Third, some signs of centralisation still persisted.

'Output legitimacy' concerns the acceptance of results by relevant actors. Decentralisation is thus a "way to shift attention... and signal responsiveness" (Vrangbaek, 2007, p.72). Whilst the focus in this form of legitimacy is on the performance of organisations, there was evidence in this study of 'blame decentralisation', the tendency to present a performance 'failure' as the responsibility of only that organisation, rather than analysing the systemic problems across the LHE or wider. This study began to demonstrate how improvement (and indeed, failures) in one organisation had consequential effects elsewhere in the LHE, underlining the need for further attention to local health systems.

5.3 Autonomy

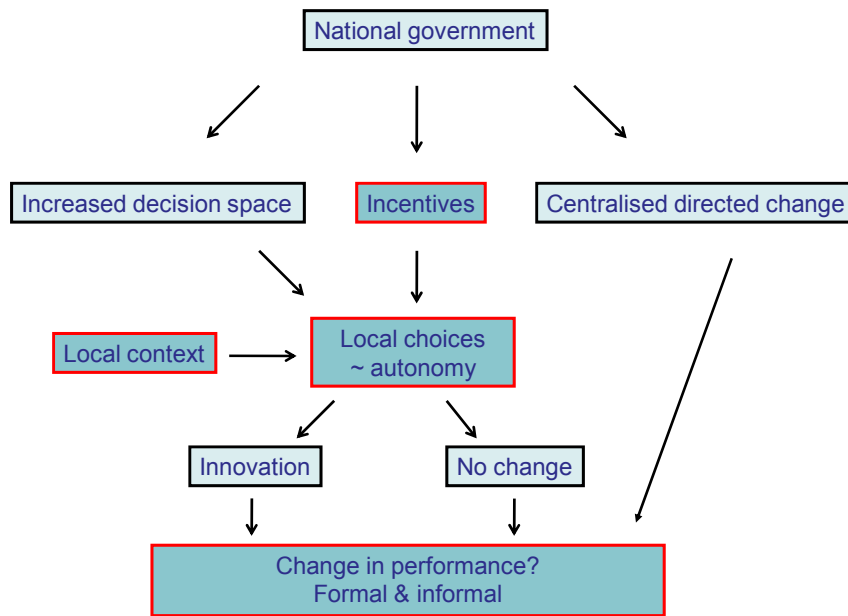
5.3.1 Defining types of autonomy:

The notion of 'autonomy' is foremost in analyses of decentralisation. By decentralising powers to lower / local levels, the autonomy of such local agencies / agents is supposedly augmented. This, of course assumes that all properties have been decentralised. Using the I*P*O properties of the Arrows framework, it can be argued that 'full' autonomy is only achieved if each of the I*P*O properties are decentralised to the same level. As, in many cases, this does not happen, it can be argued that there have been few instances of decentralisation in which autonomy has been fully or properly 'enabled.' This is especially pertinent in tax-funded health systems where centralisation denotes notions of political accountability.

Verhoest *et al* (2004) have delineated two basic forms of autonomy (and sub-types): (i) decision-making competencies (managerial and policy autonomy), and (ii) exemptions on the constraints on the actual use of decision making competencies (structural, financial, legal and interventional autonomy) (see table 2.3.). In addition, this study has sought to add another dimension to the useful framework by Verhoest *et al*. Previously, emphasis in decentralisation had been on vertical aspects of autonomy. Here, vertical autonomy created the opportunity for local implementation. It also conveyed a shift in the explicit norms and standards which were expected of organisations. However, the local 'room for manoeuvre' available to organizations (with newly-acquired vertical autonomy) might also play a part in how vertical autonomy was deployed. Horizontal autonomy thus implies opportunity for innovation and a political space (for argumentation and engagement). Innovation has been particularly stressed as part of the new structural options emerging from Lord Darzi's Next Stage Review (NHS Confederation, 2009).

An equally useful framework is offered by Bossert (1998) whose decision space framework incorporates the horizontal dimensions, in explaining performance (figure 5.1.).

Figure 5.1. Decision space framework: a revised version.



8

Note: The boxes with darker shading denote particular relevance to this study

This model presents three possibilities for central government in terms of autonomy: increased decision space, the creation of incentives and centralized directed change. 'Increased decision space' might result from the relaxation of central controls (say, in terms of performance management) or devolution of previously centralised functions (such as budgetary decisions). PCT budget devolution might fall into this latter category. Equally, 'centralised directed change' has been apparent in recent re-organisations such as the creation of the NHS quasi-market in the 1990s and the re-configuration of PCTs in October 2006. The framework implies (though does not make explicit) the possibility that national policy might also constrain decision space (say, through 'national' frameworks and targets). The third possibility – creation of incentives – is a more conditional approach than the other two as it influences local decisions through differing levels of rewards and sanctions, both financial and non-financial. Most national policies created incentives for local agents though often, these were contradictory or at least, not synchronous. For example, PBR created the incentive for Trusts to increase their activity, knowing that they would be paid for each item of activity. Yet, for PCTs, PBR could be a strategy to introduce demand management, restricting the rise in costs. Likewise, Patient Choice was a way in which PCTs might seek to exert leverage over Trusts but the latter could equally employ the localised nature of health-care to reinforce existing patterns of service delivery. This study found examples of these tensions in both case-studies.

Arguably, the key component of the DSF is the local choices relating to the exercise of autonomy. This concerns the ways in which local decisions are made about how and where new areas of discretion might be deployed. This study was able to explore how individual organisations and the LHEs as a whole, made (or did not make) these local choices. Bossert argues that these local choices are influenced by the local context. We found the local context to be critical in explaining the ways in which autonomy was exercised (or not) locally. Here, context is taken to mean the LHE. In selecting a sample of two contrasting case-studies, we were able to observe marked differences in the ways in which autonomy was used and the ways in which other organisations responded to such autonomy. It is this latter point which distinguishes this study (from those which might focus more centrally on autonomy *per se*). Critical aspects of the LHE context included:

- Spatial and organisational characteristics,
- Financial status,
- Embedded social and institutional relations,
- Centralised legacy, and
- Organisational capacity

Such factors were hypothesised *a priori* (Exworthy and Frosini, 2008) and have been confirmed by empirical evidence. The study found examples of 'innovation' and 'no change' which were largely the interaction between vertical and horizontal factors.

Recognising that autonomy can be viewed in both vertical and horizontal dimensions is a crucial component for understanding and explaining autonomy in LHEs. Note, however, that autonomy, like power, is not necessarily a zero sum game, in which one agent's 'loss' of autonomy automatically implies another's 'gain.' Thus, the I*P*O configuration and the Verhoest taxonomy (chapter 2) help explain why autonomy may be seized by local agents in the hope of 'breaking free' from the centre, only to find their new powers are illusory (Hoque *et al*, 2004). Autonomy, in Verhoest's terms, may be granted, for example, in a managerial or financial sense but not in a policy or interventional sense. The ambiguity of decentralisation (and autonomy) is, once again, apparent.

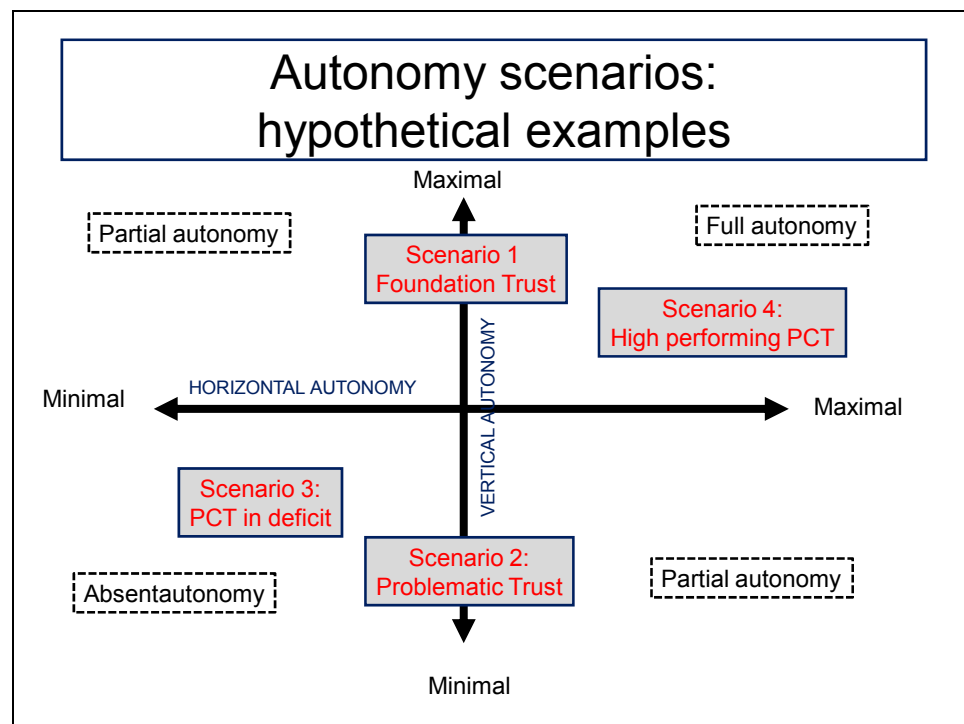
Combining the horizontal and vertical, and distinguishing between types of autonomy, it is possible to construct a series of scenarios to illustrate the consequences for organisations and LHEs. Here, four scenarios are presented as a heuristic device to improve understanding. However, the content of these scenarios is based on the empirical data, gleaned from fieldwork in this study. They are composite pictures, rather than a portrayal of one LHE or organisation. The four quadrants of the figure below denote contrasting levels of autonomy: full, partial or absent. Whilst the consequences of full and absent autonomy may be relatively easy to decipher, it is not necessarily clear which state of autonomy might be preferable: (i) "maximal vertical and minimal horizontal" or (ii) "minimal vertical and maximal horizontal." They each offer different advantages and disadvantages. However, this study has begun to reveal such consequences.

It is apparent that horizontal autonomy exists through the inter-organisational and inter-personal relationships between managers and clinicians in LHEs. This might include the 'loose rein' of performance management by the SHA regarding a well-performing (non-FT) Trust. Equally, it refers to the good working partnerships between a PCT and local Trusts. From this study, maximal horizontal autonomy (implied in option (ii) (above)) is a vital to a well-functioning LHE, though 'process autonomy' may still be problematic. By contrast, vertical autonomy certainly offers

freedom from constraints that have traditionally been associated with the centralised policy-making and finance of the NHS. Structural autonomy has been most apparent in this vertical dimension whilst interventional autonomy has largely remained (or been reinforced). This conclusion is supported by Verhoest *et al* (2004) who argue that;

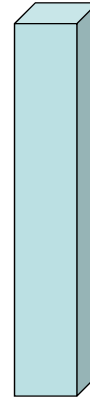
“A public organisation with extensive decision making competencies could be less good than expected because the organisation faces constraints on the actual use of the competencies.... When organisations have high level of managerial autonomy but low levels of interventional autonomy, the organisation could be inhibited in the full use of the managerial autonomy due to the strong reporting, evaluation, audit and sanction provisions issued by the oversight authorities” (p.112).

It does not follow, therefore, that full autonomy is necessarily a positive situation. It may be beneficial for the organisation (by fostering innovation, greater pride and sense of ownership) but have negative consequences for the LHE (if the organisation acts upon its freedom to accrue more activity at the expense of others). Much will depend on the specific configuration of the LHE in balancing the types of autonomy and, crucially, the motivation of the agents involved (see 5.3.2.).



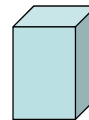
Scenario 1: Foundation Trust

- Vertical autonomy from centre
 - Autonomy re. input and process
 - Little autonomy re. outputs
- Horizontal autonomy limited
 - LHE in financial deficit
 - High level of competition with other Local provider
- Autonomy cube:
 - Tall and thin



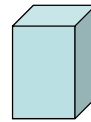
Scenario 2: Problematic Trust

- Vertical autonomy from centre:
 - Limited
 - Close performance management
 - Limited autonomy in I-P-O
- Horizontal autonomy:
 - Little collaboration from local partners
 - Some assistance through PCT assistance (eg. secondments) and informal support from other local Trusts



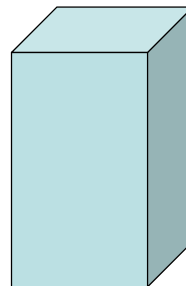
Scenario 3: PCT in deficit

- Vertical autonomy from centre:
 - Close scrutiny from DH
 - Close performance management by SHA
 - Some autonomy in 'I', little in 'P' and none in 'O'
- Horizontal autonomy:
 - Limited
 - Few options to develop local strategy



Scenario 4: High performing PCT

- Vertical autonomy from centre
 - Significant freedom from DH and SHA
 - PCT well regarded
- Horizontal autonomy
 - Senior PCT managers well regarded
 - Cooperative Trusts enable Implementation of PCT strategy



The overall volume of the autonomy 'cuboids' in these scenarios is indicative of the *organisation's* overall 'decision space.' Whilst it is difficult to create a single 'cube' for the LHE, the room for manoeuvre afforded by the LHE is incorporated within organisational cubes through the horizontal dimension. In addition, the 'cubes' need to be sub-divided into types of autonomy, discussed earlier in this section.

Autonomy can, in theory, also be withdrawn. Since autonomy was granted on the basis of (good) performance in previous periods, it could follow that failure to perform might also precipitate a loss or withdrawal of autonomy. This equates to 'interventional autonomy', as described by Verhoest *et al* (2004). Although the legislation enacting FTs was significant because it removed many of the former powers of the Secretary of State and introduced a new regulatory function (Monitor), it would be possible to envisage circumstances whereby (some or all of) the powers of FTs were withdrawn. Evidence of this re-centralisation might be emerging from the experience of events at the Mid-Staffordshire NHS Trust. Though an FT, clinical performance was apparently well below expectations at this Trust. The then Health Minister Ben Bradshaw has indicated that legislation might be amended to allow the de-authorisation of FTs (4 June 2009; <http://www.hsj.co.uk/news/policy/government-may-take-further-powers-over-foundation-trusts/5002370.article>). In addition, the possibility (pressure) to 'take-over' failing Trusts may become significant as about 20 Trusts are thought to be unable to become FT. Yet, earlier studies on 'earned autonomy' found that this aspect of autonomy was not valued highly by managers (Mannion *et al*, 2007). Similar take-over plans are mooted for PCTs (11 June 2009; <http://www.hsj.co.uk/news/primary-care/commissioning/best-primary-care-trusts-to-get-franchise-on-rest/5002615.article>). Given the number of FTs now exceed 120 (<http://www.monitor-nhsft.gov.uk/>), it is unlikely that a major reversal of this policy would be feasible or desirable. Moreover, given their ability to generate surpluses, such financial abundance might be seen as a luxury in times of economic restraint. Once again, this possibility highlights the oscillation between centralisation and decentralisation. Yet, significantly, it further emphasises the differential impact as some organisations will maintain autonomy whilst others will lose (or be unable to gain) it by virtue of performance.

5.3.2 Ability and willingness to exercise autonomy:

The act of granting autonomy, it has been noted by several commentators, does not necessarily guarantee that it will be exercised. In short, there is a fundamental distinction between the ability to exercise autonomy and a willingness to do so. The technical possession of autonomy (through formal granting of FT status or budgetary devolution) does provide the opportunity for the benefits of decentralisation to be enjoyed. However, unless these new opportunities are exploited, the autonomy will remain illusory, a situation which may foster claims that this form of decentralisation is superficial and impotent. This can be accounted for in a parallel explanation to the Arrows framework. If it is assumed that autonomy is only realisable if each of the I*P*O properties is controlled by the same agent, then it follows that autonomy can not be fully enjoyed when the locus of control of any of these is not co-located with the others. Likewise, it could also be argued that it is not simply the technical possession of these properties at that level which realises autonomy but in addition, the willingness of agents to exercise them.

In the light of the preceding text on vertical and horizontal autonomy, it is possible to map the salient differences between these approaches in terms of the ability and willingness to exercise autonomy. Table 5.1. shows that ability to exercise autonomy may be compromised by unwillingness to do so. Here, ability is taken to imply not just a technical / formal ability (derived from the receipt of formerly centralised powers) but the managerial / organisational capability. Hence, it is possible to envisage a trade-off between the granting of autonomy to an

organisation whilst there is a lack of managerial capacity to enact such autonomy. A similar pattern emerges from 'willingness.'

Table 5.1. A comparison between vertical and horizontal autonomy in terms of ability and willingness to exercise autonomy

	(In)ability to exercise autonomy	(Un)willingness to exercise autonomy
Vertical autonomy	<ul style="list-style-type: none"> • PCT budget devolved (✓) • FT (✓) • Savings required before capital investment in FTs (X) • Low management capacity locally as talent is spread thinly (X) 	<ul style="list-style-type: none"> • Inured to centralisation (X) • Greater exposure to risk (X) • PBR rewards more activity (✓)
Horizontal autonomy	<ul style="list-style-type: none"> • Higher inter-dependency in LHE (X) • Competitive environment (✓) 	<ul style="list-style-type: none"> • Fear of destabilising LHE (X) • Harm local relationships (X) • Opportunity to develop new services / new markets via Patient Choice (✓)

(✓) implies ability / willingness. (X) implies inability / unwillingness.

The contents of each of the cells in table 5.1. were, to a greater or lesser extent, found in this study. Certainly, there had been a heavy emphasis on the creating in the ability to exercise vertical autonomy (top left cell). In part because of Monitor's authorisation process of FTs, there were few concerns about managerial capability in these organisations. However, by contrast, the WCC panels had identified managerial capability to be deficient, notably in the Southern PCT. The case-study organisations did welcome the policy emphasis on autonomy and saw that some (though certainly not all) policies were aligned (top right cell). However, certain factors made them less willing to exercise autonomy. The FTs were exposed to greater (financial and organisational) risk than before and this made them cautious in certain decision areas. The two PCTs seemed to demonstrate contrasting approaches, largely because of the nature of the LHE within which they were situated. The Northern PCT has forged a strategy which potentially threatened the existing pattern of services, primarily delivered by an FT, its main provider. The Southern PCT was faced with a more challenging environment and, though it had tried to develop a similar health strategy, there were signs that the legacy of centralisation was still felt in some areas (such as challenging existing financial flows). That said, it may not be so much that PCTs were acting in the context of centralisation but rather the sense in which they (PCT managers) felt and acted as part of a wider institutional framework (namely, the NHS). Hence, there is significant value in exploring the role that senior leaders in the NHS play in organisational change; they have the 'room for manoeuvre' to interpret and adapt national policy in the light of the local context. Managers in both PCTs seemed to be very cognisant of their responsibility and accountability to the broader NHS as were some FT managers.

Given the potential for positive and negative aspects in table 5.1., it is possible to draw up a set of types which see the intersection of ability and willingness to exercise autonomy; table 5.2.

Table 5.2. Potential impacts of differences between ability and willingness to exercise autonomy

Type	Exercise of autonomy	Potential impact?
I	Able but unwilling	Unused / under-used powers
II	Unable but willing	Frustration; disempowerment
III	Unable and unwilling	Acceptance of centralisation
IV	Able and willing	Genuine local freedom

Table 5.2 begs the question whether vertical autonomy is a necessary condition to facilitate horizontal autonomy, and hence release the full performance potential of local agencies. (Ability could be seen as the formal authorisation of autonomy whereas willingness could be the perceptions and motivations of such 'freedom'). This study did not reach this conclusion. Given the degree of informal performance (that exists or existed), there was some horizontal autonomy already within the system. For sure, vertical autonomy did enhance and even build on extant autonomy. This occurred in catalytic effects whereby, for example, FTs were seen as doubly advantaged – already being high performing Trusts but being given additional, preferential freedoms by virtue of their status. This was referred to as an 'uneven playing field' by non-FTs. The Audit Commission (2008) make a similar point in concluding that "Foundation Trusts are becoming even stronger organisations when compared with other acute trusts" (p.5). However, as noted earlier, FTs were selected specifically because they were "high" performing organisations; evidence from this study and the Audit Commission suggest potentially widening of performance between organisations. With reference to the above table, this study found a combination of all four types of ability/willingness. There was evidence that type IV (able and willing) was generating improvements in innovation and efficiency. In sum, neither is sufficient to enable full autonomy and neither prevents some degree of autonomy to be exercised.

5.3.3 Freedom from and freedom to:

The distinction between two types of freedom – from and to – offers a slightly different analysis of the preceding discussion and of the empirical evidence. 'Freedom from' equates with autonomy from the centre and is associated with the technical ability to exercise autonomy. Freedom refers to the apparent constraints of centralisation – stifling bureaucracy, rigidity and unresponsiveness to variations in local needs. Also, 'freedom to' equates with horizontal autonomy, implying the potential to be responsive and to innovate. Though it does not necessarily imply a willingness to exercise autonomy, the motivation to exploit 'freedom to' does include horizontal aspects of autonomy.

However, this binary division of freedom (from/to) has an intuitive appeal but alone is unsatisfactory. First, the term 'freedom' is itself rather pejorative in that it implies the former regime was restrictive and oppressive. Whilst this may have been the case, it also overlooks the possibility that it may have had other advantages such as being more equitable, rational and efficient (in terms of scale economies). Equally, autonomous local agencies might be as unresponsive or lack capacity to innovate as the centre; decentralisation *per se* does not guarantee such outcomes.

Second, we need to understand that freedom (whether `from' or `to') carries responsibilities, whether exercised centrally or locally. Freedom is this viewed as instrumental to wider organisational / policy purposes; it is a means to an end. Third, as much of the preceding discussion has shown, we need to examine different types of freedom and autonomy. For sure, freedom `from' and `to' offer some further insight but possibly not as much as `ability' and `willingness.' Fourth, the binary distinction overlooks the possibility that freedom within a central framework may be possible through informal autonomy associated with local discretion.

In this study, it was often not easy to distinguish between `freedom from' the centre and `freedom to' be responsive or to innovate. Whilst one agency might have greater freedom from the centre, this did not always translate into a freedom to be responsive, for example, because the other agencies with whom collaboration took place, did not always enjoy similar levels of freedom. The putative freedoms of FTs (from the centre) did not necessarily translate (yet) into responsive services. Freedom to innovate did, however, appear more promising. In other cases, differing levels of freedom (between agencies or between `from' and `to') did not appear to hamper collaborative efforts; this was apparent in shared services and clinical networks.

It is notable that autonomy has been granted in the English NHS on the basis of (past) performance. Though consistent with the heavy emphasis of a performance culture, it has precluded other imperatives and reasons for autonomy. Two alternatives might be envisaged: subsidiarity and public involvement.

First, subsidiarity involves the delegation of functions to smallest, lowest or least centralised competent authority. Significantly, this competent authority has, in some cases, become the individual patient, though it could equally apply to individual clinicians. Subsidiarity (especially to individual patient level) raises further questions about the complexities of information and knowledge asymmetries, increased transaction costs and the limits to assumed `competence' of the individual patient (or inequalities between patients in this regard). By implication, more central levels of authority only have subsidiary roles where they cannot be performed at the local level. This is inevitably problematic in centrally-funded health systems and yet, the UK has devolved health as a competency to Wales and Scotland.

Second, in line with a more democratic version of decentralisation, autonomy could be granted on the basis of greater public (and patient) involvement in decision-making (Greener and Powell, 2008). Public involvement is facilitated by such reduced structural distance between those governing and those governed. This accords with one of decentralisation's positive virtues which aids improved responsiveness to needs which were previously ignored or overlooked. In terms of current decentralisation strategies, this `democratic' impulse might be evident in a range of recent initiatives such as `parent-run' schools (and academies with private sector input) or vouchers for social care and potential initiatives such as elected police commissioners or local referenda. This could be accompanied by a greater emphasis on health service "rights" or "entitlements", the logic of this shift being "to create public services that are accountable to the public rather than Whitehall" (Lucas and Taylor, 2009). Mandatory services (through entitlements) could be a form of centralisation, restricting local freedom but, if allied to a reformed

relationship with users and the public, it could represent (outcome) decentralisation beyond the organisation to individuals.

These versions of local autonomy seem to go further than previous efforts to reinvigorate local government between the 1970s and 1990s. It was argued (by both ends of the political spectrum) that some local governments were "virtually powerless in the face of wider social and economic forces" (Burns *et al*, 1994, p.10). However, Burns and colleagues also noted that "different localities [here, we could substitute LHEs] have different degrees of local autonomy in responding to social and economic processes" (p.12). In noting that 'context does matter', they argue that "local governments can choose to ignore the space that may be available to them" (pp.11-12). Such local government decentralisation retained power over decision-making, consistent with Arnstein's (1971) ladder of participation.

5.3.4 Autonomy - conclusions

By way of conclusion to this section on autonomy, we consider the extent to which agencies can ever be fully autonomous in a publicly-funded health system. Whilst the principles of strategic and operational separation (steering and rowing) may be desirable (even though they are predominant in virtually all organisations nowadays), this study has shown the importance of assessing the context within which the operational activities are conducted. The boundary between strategy and operation is invariably blurred in the public sector (Pollitt and Talbot, 2003), not least because of professional autonomy and discretion (Lipsky, 1980). The local context inevitably conjures up notions of inter-dependency which have shaped, to a considerable degree, the extent of horizontal autonomy. In some senses, vertical autonomy simply offers a formal supplement to some of the (semi-)autonomous activity that was taking place anyway at the local level. This is especially apt if the vertical autonomy is granted on the basis of 'good' / 'high' performance. That said, vertical autonomy may provide an additive or catalytic effect to horizontal autonomy whereby 'high' performing organisations are enabled to perform even better (than before, than counterparts). In the English NHS, the establishment of Monitor (FT regulator) has institutionalised, to a far greater extent than ever before, a commitment to decentralisation. Yet, as of June 2009, there are suggestions that "the Department of Health is moving to weaken the power of foundation trust regulator Monitor" (Health Service Journal, 2009, p.3; <http://www.hsj.co.uk/comment/leader/limits-on-monitor-should-not-threaten-foundation-trusts/5002903.article>).

Notwithstanding the potential that certain forms of autonomy (eg. interventional autonomy) may undermine or counteract other forms, the combination of vertical and horizontal autonomy across all types (I*P*O; managerial/policy, structural/financial/legal/interventional) offers the most extensive decision space to local agents.

One way in which vertical and horizontal autonomy may be 'reconciled' is through the notion of 'responsible autonomy' (Fairtlough, 2005). As a variation of the market-hierarchy-network trilogy, Fairtlough offers "three ways of getting things done": hierarchy, heterarchy and responsible autonomy. The latter of these types implies much of the foregoing analysis of autonomy but specific reference is made to the autonomy within a wider framework of accountability. The analysis thus gives

greater acknowledgement to the role of the centre in retaining interventional autonomy, namely the centralization of outputs (O). As Fairtlough (2005) argues:

“For autonomy to become responsible autonomy, the absence of external rule must not mean there is no accountability for the outcome of self-organisation. With responsible autonomy, the ways in which outcomes are achieved are not externally controlled, but the outcomes are monitored and poor outcomes are sanctioned.”

We might argue that the outcomes which are achieved may not be externally controlled (by the centre) but rather heavily influenced by local partners in the LHE. The monitoring and sanctioning of poor outcomes is consistent with the (centralised) performance culture of the NHS in recent years. In addition, the notion of heterarchy – with its stress on dispersed and multiple nodes of power – may also be equally valid in these circumstances.

5.4 Performance

Decentralisation has long been claimed as a solution to various organisational problems. The evidence that decentralisation is positively associated with improved performance is, however, rather equivocal (Peckham *et al*, 2005; Saltman *et al*, 2007). There are indications that decentralisation is positively associated with intra-area/group equity, innovation and allocative efficiency, among other performance criteria. However, whilst it not always or even often stated in policy pronouncements or academic assessments, the context into which decentralised powers are located appears to be crucial in determining the impact that such powers have upon organisational performance. One might also claim that autonomy (as a consequence of decentralisation) might have a similar impact though the evidence for such claim is decidedly weak at the moment (López-Casasnovas *et al*, 2006). Moreover, both decentralisation and autonomy might, it could be argued, have objectives which go beyond improvement in organisational performance; these might include the search for greater legitimacy, for example (Saltman *et al*, 2007). Indeed, autonomy has been a primary focus of this study as illustrative of the decentralisation policies of recent years.

Performance is often defined in rather reductionist terms (as simply, one particular performance criterion such as efficiency), neglecting:

- a. the wider socio-political climate and / or
- b. the local administrative / organisational context in which semi-autonomous agents (individuals and organisations) operate.

This contextual dimension might help explain apparent paradoxes in practice when, for example, the effect of (apparently uniform) policies (such as FT) might vary between different localities. For, as Verhoest *et al* (2004) argue,

“The link between autonomy and performance may appear blurred or unclear in seemingly similar cases just because the focus of the analysis is only on

decision making competencies of the agency. Agencies with similar decision making competencies may have totally different financial or structural links with government which may affect the extent to which these agencies can actually decide freely within these competencies" (p.109).

We would argue that it is not just "structural links with government" that might affect agencies' room for manoeuvre but also local / horizontal links with other agencies in the LHE. For sure, "links with government" affect the decision space of agencies but it is the interaction between vertical relations and horizontal relations which effectively determine the autonomy of local agencies. Moreover, as we have sought to demonstrate in this project, the degree of autonomy over different aspects of these agencies' activities are crucial to explaining patterns of ability and willingness to exercise such autonomy. Hence, we saw contrasting (rather than radically different) strategies by the FTs in both LHE case-studies. The catalytic effect between vertical and horizontal autonomy implies that autonomy is not a static property but ever-changing in the light of national and local decision-making in each of the facets of autonomy (however defined – whether Peckham *et al* (2005) or Verhoest *et al* (2004)). The two dimensions of autonomy are not necessarily co-dependent because, as table 5.1 shows, it is feasible to have an ability to exercise autonomy without willingness (and *vice versa*).

5.4.1 Revisiting the Decision Space Framework:

The theoretical constructs that have been applied (and modified) in this study offer some insight into these catalytic effects, in terms of performance. Bossert's 'decision space framework' posits performance as an outcome of the interaction between national policy, incentives, local choices and context. Such performance might include innovation and also 'no change' (or inertia). We can apply and interpret the framework to this empirical study in each of Bossert's components. First, national policy has been relatively consistent in stressing conditional autonomy, 'earned' through 'good' performance. (It is, of course, debatable how far some organisations actually 'earned' this through their own efforts). Although it is questionable whether these policies are necessarily consistent or offer contradictory messages (note, for example PbR), recent policy statements such as Darzi's (2008) Next Stage Review is replete with references to autonomy being the catalyst for improved performance; for example:

- "We try to improve our practice but we need the freedom and opportunity to do so" (p.59)
- "The freedom of NHS foundation trusts to innovate and invest in improved care for patients is valuable and essential" (p.61)

It will be a strong test of this commitment to local autonomy as public spending tightens in the coming years. There may be a tendency to revert to greater centralisation, ensuring stronger control over key aspects of inputs, process and (as now) outcomes. FT surpluses might be seen, for example, as excessive given wider spending restraint. Mergers between smaller, possibly below-average performing Trusts might also be seen as attractive to policy-makers in search of savings.

Second, the incentives in these national policies (focusing on autonomy) have been both financial and non-financial. Davies *et al* (2005) found that most attention has been devoted to financial incentives and called for a more finely-grained analysis. The rewards for autonomy have been greater (provider) revenue (financial) and the ability to shape ones own destiny, foster local pride and ownership (non-financial).

This study found that both these sets of rewards had strong-to-moderate effects in both LHE case-studies. By implication, the sanctions were largely the opposite of these – loss of revenue and financial penalties (financial) and loss of job (especially for chief executives and directors) and damaged reputations (non-financial).

Moreover, we found that the incentives were less effective when:

- a. *Autonomy of organisations was lower.* With little decision space, organisations were less able to respond positively to the incentives.
- b. *Complexity weakened the transmission of incentives.* The effectiveness of incentives was diminished when there was organisational complexity which meant that the incentives were poorly transmitted through the LHE.

However, the balance between rewards (positive) and sanctions (negative) is a matter of interpretation. The King's Fund (2008), for example, concluded that

"Their [PCTs'] main incentives are negative ones: performance management from above allied to the ultimate threat of removal of their chairs or chief executives. That only encourages a risk-averse approach. They need other, more positive incentives....There need to be stronger incentives for PCT performance: for example, publication of performance against metrics that the PCT can influence" (pp.7 and 10).

Based on our empirical study, we would not necessarily concur entirely with the King's Fund conclusions although we recognise that the influence of performance management is pervasive. We found evidence that the incentives facing PCTs did indeed relate strongly to their (formal) performance but also a desire to become legitimate organisations in their LHE. In both LHEs the PCTs were striving to forge a health strategy which shifted the balance of power between the PCT and provider, and shifted care away from the hospital and 'closer to home.' Since PbR created an incentive for greater provider activity, we could agree with the King's Fund that more positive incentives for PCTs are required. The King's Fund outlines such possibilities:

- "Performance-linked flexibility to manage surpluses and deficits over longer time scales, of up to five years,
- Performance-linked access to innovation funds for new service development (formula-based to avoid bureaucratic application processes),
- Performance-linked flexibility around existing staffing levels – do well and you can appoint more staff to do better" (p.10).

The prospect of health policy which affords greater autonomy for 'high-performing' PCTs has been outlined in the summer of 2009 (Crump, 2009).

The proposed freedoms for PCTs

1. Lighter touch performance management
2. Franchising (taking on some of the commissioning functions of poorer performing PCTs)
3. Direct access to the DH to influence national policy
4. Setting budgets across multiple years
5. Being highlighted as a top PCT
6. Preferential access to the innovation fund
7. DH commitment to consider pay flexibilities

Source: Crump, 2009

Though the notion of taking over a failing PCT may not be appealing to PCT managers, other aspects such performance management and budget flexibility may be welcomed. The 'freedoms' (described in this study and outlined by the DH) are performance-based (derived from WCC assessments) and relate mainly to inputs and process. Whilst PCTs are rightly responsible for the spending of NHS money locally, there might be some potential to relax PCT performance management, consistent with World Class Commissioning and consistent with existing practice, in some areas. A major criticism of the 1990s internal market was that the incentives were not strong enough to elicit significant organisational change (Le Grand *et al*, 1998). The reforms in recent years may suffer the same fate if, according to this study, the embedded social and institutional relations still heavily influence the horizontal autonomy of LHEs (Exworthy, 1998; Granovetter, 1992). This may compromise the incentives of the reforms which are associated with vertical autonomy. Furthermore, the "best" performing PCTs and Trusts could plateau in performance and become less innovative if their 'autonomy' was associated with a lack of new incentives to achieve continuous improvement beyond centrally-determined targets.

Third, Bossert's framework hinges around the choices that local agents make. In reconciling the incentives associated with national policy and local context, performance outcomes are generated. As Bossert (1998) argues, "Decentralisation inherently implies the expansion of choice at the local level" (p.1518) but much rests on local agents' willingness to make such choices. (They may, of course, make a non-decision by choosing not to choose). However, whilst the general tenor of health policy has been decentralist, increased choice for PCTs has not always been apparent, as table 5.3 shows. (Further analyses could be applied to other local organisations). Indeed, it reinforces the Arrows framework which shows that, often, decentralisation by-passes particular organizations, adding to further ambiguity. Thus, choice (for organizations as much for patients) is highly structured and contextualized (Exworthy and Peckham, 2006).

Table 5.3. Assessment of decision space for PCTs

Policy	Degree of choice	Argument
Patient Choice	Less choice	Power is ceded to patients. PCTs are required to provide conditions (e.g. capacity) for such choice to be exercised
Foundation Trusts	Less choice	At least in theory, power is ceded to providers and PCTs are required to implement contracts with them
Practice-based commissioning	Less choice	Power is ceded to family doctors' groups rather than the PCT
Payment by Results	Mixed	PCT has a mechanism to control costs (if they improve commissioning capacity and demand management strategies). However, providers have incentives to increase activity level, particularly critical with respect to FTs
Budget devolution	More choice	At least in theory, PCTs have greater freedom to allocate resources based on local priorities and needs
Regulation regime by Healthcare Commission	Less choice	Former bureaucratic hierarchies are replaced with surveillance and control strategies of inspection regimes
National Service Frameworks	Less choice	PCTs are more or less constrained to follow national 'guidance', as deviating from them would need to be justified more robustly

Source: Exworthy and Frosini, 2008, p.208

Fourth, choices thus interact with the local context in ways that focus on ability / willingness and freedom from / to (see earlier in this chapter). Exworthy and Frosini (2008) conclude that:

"Whatever level/amount of decision space vertically available to local organisations, the process of horizontal decentralisation implies that the exercise of choice by managers in such organisations is shaped by and interdependent with other actors in the locality" (p.206).

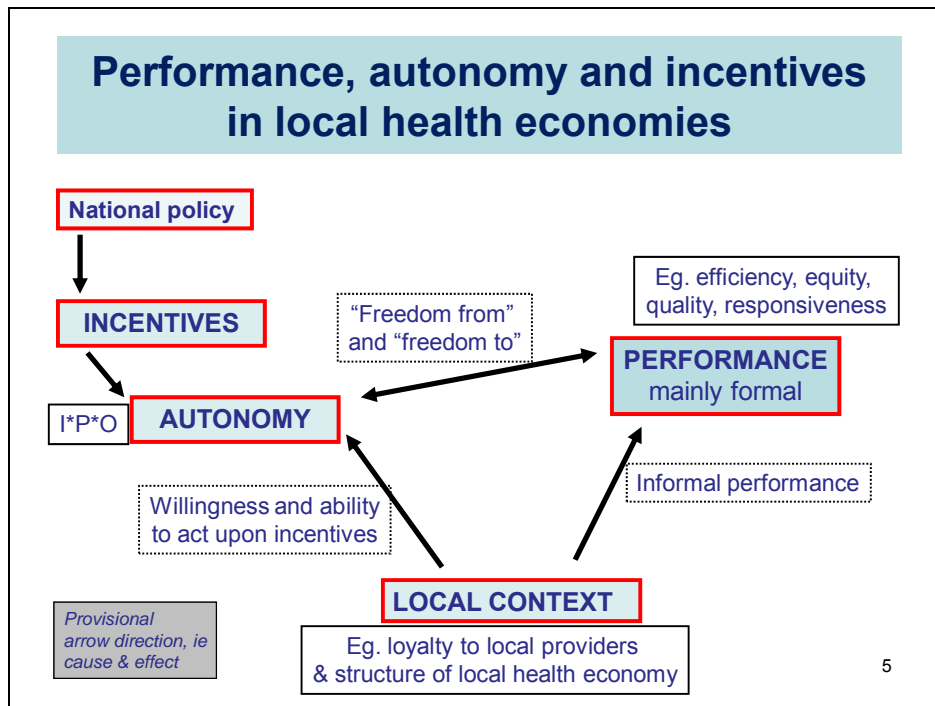
This is echoed by Fleurke and Willemse (2004) who argue that "...decentralisation or the distribution of responsibilities is organized not only vertically but also horizontally" (p. 535). In order to understand better the vertical / horizontal interaction, it is useful to draw on the notion of 'realistic evaluation' which posits a pivotal role for 'context' in mediating mechanisms (M) and outcomes (O) (Pawson and Tilley, 1997; Pettigrew *et al*, 1992; Greenhalgh *et al*, 2009). Often this is summarised as $C+M=O$, generating C-M-O configurations. Here, adapting Bossert's model, we can observe the relationship as " $I+C+A=P$ " (where I=incentives, A=autonomy, C=context, P= performance). Rather than the relationship being additive, we see it as a configuration in which the constituents are interactive and

co-dependent. Hence, in understanding the relationship between autonomy and performance, we need to understand the "ICAP" configurations in each locality (here, LHE).

Fifth, Bossert identified two performance outcomes – innovation and no change – in the decision space framework. Here, we may interpret 'innovation' not simply as new service developments but also strategies to 'defend' an organisation's autonomous position and/or implement an entrepreneurial strategy within the LHE. Equally, 'no change' may imply an active decision not to change (a freedom not to choose). Though recognising the value of this binary approach (change / no change), this study offers a finer distinction in terms of performance outcomes, relating to formal and informal performance (see next section). For example, this study helps explain why there may be differences between the *de jure* formal performance (as measured by 'official' metrics) and the *de facto* informal performance (as manifest in reputation and perceptions). Clearly, the LHE shapes the receptivity of the local context for innovation, mediating between vertical and horizontal imperatives and between formal and informal performance.

In addition, the decision space framework poses the possibility that national policy creates greater decision space (say, through greater budget devolution to PCTs) and/or centralised directed change (say, through PCT mergers). The former directly increases decision space but this approach has been less in favour in recent years, as policy has tended to work through incentive mechanisms. The latter illustrates coercive, directed change, and has remained as an option in the policy 'toolkit.' Again, it illustrates the tension between decentralisation (here, autonomy) and centralisation, as both have usually been implemented at the same time.

This study has sought to emphasise the interactivity between policy, incentives, autonomy, context and performance. In the light of the empirical evidence and preceding analysis, we are able to offer a revised version of Bossert's 'decision space framework', drawing on the conceptual analysis in Exworthy and Frosini (2008). Bossert identified a causal pathway from incentives, local choices to performance. The framework that we present (figure 5.2.) suggests a more co-dependent / co-constitutive process between autonomy, context and performance; hence, the causal pathway is not linear. Rather, performance shapes and is shaped by autonomy. We suggest that incentives have a direct relationship on autonomy. In this relationship, autonomy would expand and contract as incentives increase and decrease.

Figure 5.2. Performance, autonomy and incentives in LHEs

5.4.2 Formal and informal performance:

The focus on different aspects of performance has enabled a more critical perspective, one which offers insights into the ways in which `formal' performance interacts with `informal' performance. Traditionally, health policy towards performance improvement has focused almost exclusively on formal performance – improving the metrics, meeting targets, keeping financial balance etc. This study has demonstrated how notions of informal performance are co-constructed with approaches to formal performance. The example of the financial deficits in the Southern LHE illustrated this well.

The study found the categorisation by Goddard *et al* (1999) to be useful. Formal performance still had a key role in acting as a safety net, most notably for `poor' performers. Yet, the incentives of such an approach to high performers seemed to be quite weak. Recent debate about further `freedoms' to high performing Trusts and PCTs illustrates the weakness of formal performance as a single strategy. In addition, informal performance offered both substitute and complimentary effects. These informal notions were widely deployed to explain patterns of performance when formal notions were deficient. These notions were found to shape the culture of the LHE and the character of inter-organisational relationships. These affected how organisations made decisions and reacted upon one another. These notions were drawn from the embedded relations within the LHE and enhanced the knowledge derived from formal performance notions, effectively influencing the local `room for manoeuvre' (autonomy).

The notion of performativity – performance as a dramatic gesture – has not been explored in detail in this study. It represents a strand of inquiry which future

research should examine. The field of the 'anthropology of policy' (such as the work of Shore and Wright (1997)) provides a useful entry into these debates. Such inquiry could examine:

- The ways in which performance is portrayed to various audiences including the public. This might include content analysis of Trust websites;
- The deployment of performance narratives in board meetings and other 'public' settings;
- The construction of debates justifying 'poor' or 'good' performance.

5.5. Concluding words

The shortcomings of extant evidence have been identified. Existing frameworks and models of decentralisation autonomy and performance has traditionally provided some value in descriptions and explanations in health policy and elsewhere. However, to date, they have not been integrated into a coherent framework. This study has sought to remedy the individual deficiencies of such models by undertaking detailed fieldwork in LHEs.

It has been noteworthy that, to date, English health policy has sought to decentralise power to an organisational tier (such as Self-Governing Trusts in the 1990s and Foundation Trusts in this decade). Moreover, most research in health policy and management (and health services research) has tended to focus exclusively on individual organisations. Little attention has been paid to inter-organisational relationships that are prevalent in the new governance regimes. The increasing inter-dependence of organisations in (a) public sector settings and (b) health-care settings demand a re-appraisal of our understandings of such inter-organisational relationships. The reforms of the public sector have had the effect of creating a tension between competition and collaboration. Public service organisations must both collaborate and compete with other agencies. Health-care is increasingly organised around patient pathways and clinical guidelines which cut across traditional organisational boundaries. This is most clearly manifest in (managed) clinical networks (Ferlie *et al*, 2009). This project has provided an antidote to the prevailing policy and research paradigm by examining LHEs.

The contribution of empirical evidence has been made through a longitudinal, comparative case-study method. Using interviews from a range of managerial and clinical staff at middle and senior levels from across two LHEs, it has been possible to trace the actions, reactions and interactions of key stakeholders implementing national policies and taking local decisions. The focus of attention has focused on autonomy and performance and on the incentives which pertain to both. We have been fortunate to undertake such fieldwork over an extended period of time. Not only does this allow a focus on the 'reaction' and 'interaction', but also to monitor the influence over external policy imperatives (here, government policy) upon LHEs.

The key models and frameworks we have sought to test and refine have included:

- Arrows Framework,

- Decision Space Framework,
- Autonomy (‘freedom from’ and ‘freedom to’), and
- Formal and informal performance.

The Arrows Framework has had limited value in analysis of autonomy and performance in LHEs because its primary analytical contribution is on the vertical axis. Its structure does not permit an assessment of horizontal (inter-dependent) relationships. However, it has been useful in separating the properties of decentralisation into inputs, process and outcomes. In the light of autonomy to FTs, it is also able to capture the emergence of multiple centres, *viz.* the way in which Monitor has provided a counter-balance to the DH at the centre (see chapter 2).

The Decision Space Framework introduces the association between autonomy (choice) and performance, between central policy and local decision-making, both through the mediation of incentives. This study modifies the Decision Space Framework, through expanded and more nuanced notions of autonomy and performance. For example, the Framework says little about how local choice is exercised and what forms of performance might be generated.

Notions of autonomy have been explored through the framework offered by Verhoest *et al* (2004) and by the distinction between ‘freedom from’ and ‘freedom to.’ The former has been useful in distinguishing between different types of autonomy (firstly, managerial and policy, and secondly, structural, financial, legal and interventional). However, the distinction between the ability and willingness to exercise autonomy has been particularly powerful in accounting for the tension between formal acquisition of autonomy and its practical expression as an agent of responsiveness, innovation etc. It also underlines the contextual nature within which autonomy can be exercised, structured in terms of the constraints and opportunities presented in/by the LHE.

The assumption that performance is contested has also been helpful as it leads to a recognition that the formal metrics of performance measurement and assessment only offer a partial analysis of the ways in which agents understand and act upon organisational activities. The attention of formal performance has tended to eclipse other forms and notions of performance. Here, informal performance is examined as it offers a contrasting and more rounded perspective than one based solely on formal metrics. The notion of ‘dramatic performance’ might equally be addressed.

These conclusions provide the link to the next chapter where the implications of this study are examined for policy-makers and research agendas.

6 Conclusions.

6.1. Summary of key conceptual and empirical contributions of this report

This report is an in-depth examination of the ways in which decentralisation in the English health system is being interpreted and implemented. It has sought to describe and explain the relationship between autonomy and performance, mediated by incentives, in two LHEs. It has drawn on a variety of theoretical models and frameworks to provide the conceptual context within which the empirical findings can be presented and interpreted.

Decentralisation remains a focal theme within international health policy and is still highly salient within England. However, given the evolution of governance of public services and the observed limitations of most conceptual frameworks, the need to revisit and update theoretical and empirical knowledge relating to decentralisation has become pressing. To date, analysis of decentralisation has predominantly focused on vertical (central – local) relations. Debates have become entangled in definitions of decentralisation and its measurement. This study has refined earlier conceptualisations of decentralisation, extending the vertical perspective and combining this with the horizontal perspective within LHEs. The conceptualisation has also distinguished more clearly what is being decentralised from where and to where.

One of the recent developments which has prompted the renewed interest in and application of decentralisation has been the notion of health systems. Hence, the study took the LHE as its primary unit of analysis. Hitherto, the organisation (the hospital, the FT) or the individual (the clinician, the manager) has dominated analysis in health policy research (and other fields of inquiry). However, the LHE represents an important perspective since it addresses inter-organisational dimensions such as power, dependency, autonomy and relationships. The project has also sought to delineate differences and similarity in terms of:

- Organisations (mainly PCTs, FTs and other Trusts),
- Function (purchaser / commissioner and provider), and
- Professional (clinical and managerial groups).

A second recent development has been the use of autonomy as a lever for improvement in the quality of health services. Whilst decentralisation necessarily expands choice for local agents, the circumstances within which such autonomy is exercised, are invariably contingent upon local context. Using Bossert's (1998) 'decision space framework', the study has provided a more finely grained analysis of the ways in which autonomy has been interpreted and deployed in LHEs. This has involved analysis of the catalytic effects of one organisation's autonomy upon the rest of the LHE (including the PCT and providers). The empirical analysis has

focused attention on local agents' views of autonomy (their perceptions of freedom from the centre and of freedom to innovate or be responsive to local needs) and their resulting behaviour. We were also able to examine how autonomy was shaped by vertical and horizontal factors (such as relational dynamics, persistent social relationships, disrupted social relationships and local leadership).

The third development concerns performance. Whilst the 'performance culture' has become ever more prevalent recently, it has been given greater weight by its association with autonomy. Claims for autonomy have not been universally applied; rather, there has been a form of decentralisation contingent upon certain levels of performance. Such an association has implications for those with autonomy and those who aspire to it. Interest in this study has, therefore, focused on respondents' views on the causes and pathways to performance. However, we have considered performance to be a contested concept. Clearly, there are many views on what constitutes effective or successful performance which may have a direct bearing on how organisations are measured and managed, especially by external agencies. Here, the distinction between formal and informal performance is relevant. Across both LHEs, formal performance was relevant to 'safety net' functions, ensuring that performance did not drop below a minimum threshold. Informal performance, by contrast, acted as a substitute or complement to formal performance.

The issues of autonomy and performance have been mediated by incentives which are both implicit and explicit, financial and non-financial, rewards and sanctions. The overlapping and often contradictory incentives are, however, "frequently implicated in the success, or otherwise, of reforms" (Davies et al, 2005, p.21). The broad association can be sustained in this study but it is difficult to make clear association and pathways between incentives and improved performance. Hence, analysis of how incentives shaped autonomy and performance has been particularly instructive. However, the effect of single incentives has been difficult to disentangle from the 'noise' of multiple national and local policy imperatives, each with their own set of incentives. The study found that some incentives had substitution effects whereby attention was diverted to some areas (such as FT, PbR, and targets for A&E and waiting times) to the neglect of others (such as Patient Choice and patient involvement). The study also found that the consequences of responding to incentives rippled throughout the LHE. Adopting the LHE as the unit of analysis showed the inter-dependent effects of health reforms; for example, a PCT's or an FT's decisions had consequences for others, sometimes in negative ways. Promoting collective responses (in the form of LHE-wide health strategies) recognised this inter-dependency but also emphasised entrenched local interests. Equally, the lack of autonomy (or the threat of loss of it) also blunted the incentive regime. In short, the benefit of intrinsic and non-financial rewards was often eroded at the expense of extrinsic, financial sanctions. Viewing such incentive effects across LHEs helped to understand better the role of agency within LHEs.

- *Decentralisation, autonomy and performance: a programme theory?*

So, what does interpretation of our findings say about 'what works for whom, where and in what context'? Building on the work of Pawson (for example, Pawson, 2002; Pawson et al, 2005), it is possible to devise some tentative 'programme theories' which could be empirically tested in subsequent research (see below). Programme theories and theory-based evaluations are increasingly widespread in health and social research as ways to generate empirically-based recommendations for policy and practice. In particular, they can help to identify the linkages in the

"causal chain" which require "repair" and to offer a contingent assessment, qualifying outcomes measures (Dahler-Larsen, 2005, p.629).

Walshe (2007) argues for the need to "unpick the complex relationship between context, content, application and outcomes" (p.58). Here, we might assume that each of these is highly variable (table 6.1.). First, 'context' varies between LHEs, as the contrasting complexity of the two case-studies demonstrated. The LHE was established as the primary focus of this study which generated an inherent variability according to spatial, institutional and social characteristics. It appeared as if these starting points had a significant bearing upon the findings. Second, the 'content' of (national) policy might be assumed to show little variation but a performance-based approach to autonomy (ie. FTs), for example, belies the notion of uniformity; national policy was thus mediated by the local context (Pawson *et al*, 2005). Third, attention in this study has addressed the local 'application' of national policy (Exworthy *et al*, 2002). Factors such as the behaviour of individuals in each LHE, their tacit knowledge, their reputation and local organisational politics have been powerful in explaining differences between the two LHEs. The active involvement of key individuals (with varying levels of power), we found, had a significant bearing on the application of policy. Fourth, the multiple 'outcomes' were diffuse and less measurable than other results of policy interventions, largely because they are contested (often between formal and informal performance). The outcomes also have a synergistic effect so autonomy and performance are co-dependent (see figure 5.2.): the willingness to exercise autonomy, for example, was shaped by an organisation's previous (formal and informal) performance and also by the anticipated impact on the LHE.

Table 6.1. Summary of LHE differences in response to policy according to context, content, application and outcome

	Southern LHE	Northern LHE
Context	Complex and `open` LHE; multiple providers; only 1 FT provider; mixed organisational performance	Highly inter-dependent but largely `closed` LHE; only FT providers
Content	<i>National:</i> broadly decentralist, including autonomy conditional upon performance, increasingly strong central incentives (such as national targets) but weak incentives for responsiveness and innovation.	
	<i>Local:</i> PCT financial deficit; plans for reconfiguration; some market competition attempted	Local: LHE-wide strategy with wide ownership; some market competition attempted
Application	Weak PCT (eg. capability) though improving situation; variable organisational responses to policy content; inter-organisational tensions; limited PBC development	Collaborative approach underlined by PCT with strong leadership; strong reputation of local organisations; PBC clusters developed
Outcome	Moderate but variable performance, as PCT faces transition issues. Stalled re-configuration.	Strong, sustained performance across the LHE. Some progress towards service re-configuration.

Understandings and explanations of the inter-relationship between autonomy and performance must be situated within LHEs which intersect vertical (national policy) and horizontal (local inter-dependencies) dimensions. Hence, there is an inherent limitation as to how generalisable these findings can be to any other LHE. By definition, any LHE is a highly complex open system which offers a unique configuration of factors. However, empirical generalisability was not the purpose of the study. By drawing on conceptual frameworks, the study can, however, offer theoretical generalisability, defined as "the ability to transfer theories from the research setting and bring them to bear in often quite different combinations of context, content and application" (Walshe, 2007, p.58). The study did, for example, demonstrate the ways the actions, reactions and interactions within LHEs were nested within a hierarchy of (national) infrastructure, local institutional configuration, inter-personal relationships and individual behaviour (Pawson *et al*, 2005, p.23).

It is, nonetheless, challenging to provide a generalisable theory based on the empirical evidence presented in this study. Whilst programme theories offer some insight into what works, for whom and in what circumstances, the complexity that arises from examining the content and application of multiple national policies and from assessing multiple outcomes is a weakness. Policy interventions comprise an

assumed theory (of underlying assumptions) but rarely do they address the synergistic effects with other policies (vertically) and with inter-organisational relationships (horizontally). For example, national targets, the presence of FTs (and their regulatory regime) and the implementation of PbR (among many other policies) interacted in the two LHEs such that performance (shaped by formal and informal notions) dominated inter-organisational relationships. These findings echo the conclusions of the Health Select Committee report on patient safety (2009), the chair of which is reported as saying: "Government policy has often given the impression that there are other priorities for hospitals, such as hitting targets, reaching financial balance and maintaining foundation status, which seem to have become more important than maintaining safety."

Disentangling the multiple underlying assumptions and tracing their application over time in LHEs has been challenging. For example, in spite of the emphasis on partnership working with local government and the voluntary sector to deliver improved public health, it has only been feasible to study NHS parts of the LHE. However, the focus on the LHE – as context – does provide the arena within which policy content, its applications and outcomes are articulated and displayed (table 6.1.). Yet, the LHE is not passive; it is malleable to organisational politics, local leadership as well as shifting definitions about its very nature. Such a shifting arena of change complicates the analysis further; context shapes and is shaped by autonomy, performance and policy.

There is also a need to appreciate the limits of such analysis. Pawson *et al* (2005) suggest that such programme theories are akin to the highway in that the latter does not instruct the driver but gives indications to survive the journey (p.33). Here, we suggest that this study's assessment is a brief insight into an on-going story in both LHEs; we have only taken glimpses at a random point in time. Hence a longer time frame can help fill in gaps in knowledge though inevitably this extended perspective can lose sight of the finer detail available through our methods. It seems likely that the three year period of this study was an appropriate compromise.

6.2. Implications of research for policy and practice

Since the research brief and the research questions were informed by practical concerns of health policy-makers and NHS managers, it is appropriate that the concluding chapter of this report considered the implications of this extensive study for health policy and practice in England. Before policy themes are addressed, it is important to note that assessments of decentralisation are problematic "cover the full range of possible judgements" (Saltman *et al*, 2007, p.9). The implications, therefore, for policy and practice will depend, to a large degree, on the perception of existing systemic shortcomings and the starting point of analysis. Framing policy 'problems' as public services which are (apparently) unresponsive to local needs, fail to innovate, suffer from a lack of meaningful competition and lack appropriate incentives to improve, can lead to a conclusion in which decentralisation is the answer. Bearing these points in minds, Saltman and Vrangbaek's (2007) interpretation of evidence provides useful pointers for policy and practice (see table 6.2.).

Table 6.2. Summation of evidence in terms of claims made for decentralisation

Claim: Decentralisation ...	Evidence: Decentralisation...
Is a panacea	"is not a magic bullet, capable of solving all... dilemmas"
Implies a uniform model	Has "not set model, no perfect or permanent solution." Instead, "there are multiple models of decentralisation, each developed to fit the particular context"
Requires a universal approach	Is "neither unitary nor consistent" across health systems. Decisions about mix of decentralisation and centralisation are critical
Is a static concept	Is "not a static organizational attribute" but reflects oscillation between decentralisation and centralisation
Is straightforward to implement	Is "labour-intensive..., hard to introduce, hard to maintain and requires continual adjustment if it is to be successfully maintained over time"
Is a superior mechanism for delivery	May affect legitimacy of local organisations if decentralisation "impedes the delivery of those services"
Improves outcomes	"Few, if any, links between decentralisation and the evidence for specific policy outcomes"

Adapted from Saltman and Vrangbaek, 2007, p.79

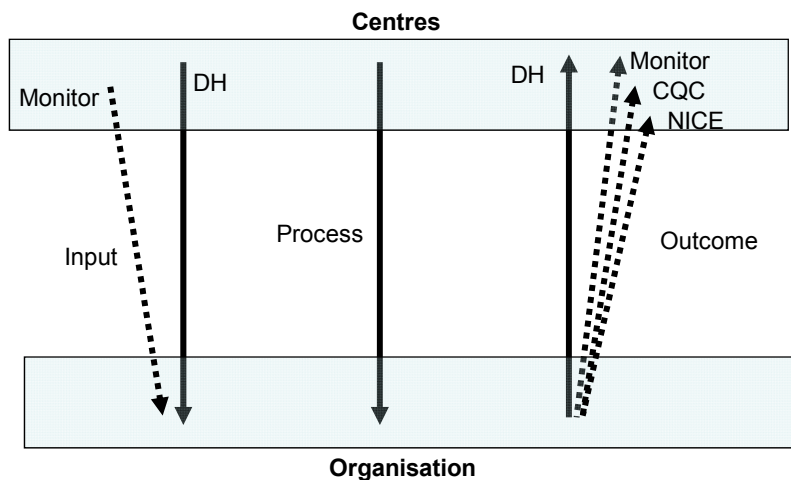
They conclude that decentralisation is based upon the values, objectives and preferences of the decision-makers, which will necessarily be context-dependent (p.80). This study concurs with their conclusions. The key policy lessons may therefore be summarised as:

1. Decentralisation is a means to an end which needs to be clearly defined;
2. Decentralisation (and centralisation) can be applied in multiple ways and approaches - most commonly, to inputs, processes and outcomes;
3. Decentralisation needs to be constantly adjusted according to on-going decisions about system and organisational performance;
4. Decentralisation strategies must reflect the variety of contexts where they are implemented;
5. Decentralisation underlines the need for more effective regulation to ensure system goals;
6. Decentralisation cannot achieve specific outcomes always and everywhere, and so, policy compromises need to be made.

6.2.1. Autonomy

FTs now cover more than 50% of hospital and community health service Trusts which changes the balance of power *vis-a-vis* the DH and the PCTs. With Monitor established as the FT regulator, the centre has become bifurcated, shifting the centre of gravity away from the DH alone (as recently discussed; for example, <http://www.hsj.co.uk/comment/leader/limits-on-monitor-should-not-threaten-foundation-trusts/5002903.article> 18 June 2009). Proposals that Monitor might extend its remit to cover 'quality' (as currently measured the Care Quality Commission) would exacerbate this. The Care Quality Commission (and to a lesser extent, the NICE) has also deflected attention away from the DH. As a result, the centre is no longer unitary. However, these 'alternative' centres related largely to 'outcome decentralisation', as in a modified version of the Arrows framework (figure 6.1. where the dotted lines represent new forms of decentralisation/centralisation). The centre(s) will need to adjust their relationships with an increasingly diverse locality (Exworthy et al, 2008). No longer can policy be applied uniformly.

Fig.6.1. Arrows Framework with 'multiple centres', applied to FTs



Equally, the distinction between the rhetoric and reality of autonomy needs to be addressed by policy-makers (Hoque *et al*, 2004). No longer will it be possible to exhort most local organisations to deliver better services; incentives must be sufficient to drive such change. Whilst there is some evidence that the incentive regime of (performance-based) autonomy is driving change (eg. PbR), it remains in contradiction to other aspects of the policy reform programme (such as Patient Choice and integrated care)(Audit Commission, 2008). Greater autonomy for PCTs is currently proposed but it is unclear how far they can deviate from the (national) norm since local variations will become ever more evident. Above all, centralisation is possible (or even likely) if/when performance drops. This approach is in contrast to 'failing schools' which risk being handed over to private sector sponsors to run as relatively more autonomous 'Academies.' This may be because schools are less

politically sensitive than hospitals. This scenario may also become more apparent in an era of economic constraint on public services since (semi-) autonomous organisations are likely to challenge some long-established customs and norms of the NHS (such as equity of access). This potential re-centralisation would mirror the experience of other semi-autonomous agencies (such as Non-Departmental Public Bodies and 'quangos') where the boundary between politically-defined strategy and operational management has, notwithstanding regulatory regimes, become ever more blurred (Pollitt and Talbot, 2003). Finally, the proposed NHS Constitution (contained in the 2009 Health Bill) may formalise a centralised definition of entitlements to NHS services. This may centralise the control over what can be delivered locally and implies that targets are re-branded as entitlements.

The motivation of managers and clinicians in these autonomous organisations are shaped not only by national policy but also by the local context (including legacy effects and reputation within the LHE, *inter alia*). For example, the possibility that FT managers would wish to take over a 'failing' Trust (as in the 2009 case of the Bedfordshire and Luton Mental Health and Social Care Partnership Trust) may be over-optimistic. Mannion *et al* (2007) found little appetite for this opportunity among managers. Hence, their willingness to exercise autonomy may be a more significant explanatory factor than their technical ability to do so (Exworthy *et al*, 2008). Though FT status is increasingly the norm in England, policy will need to address their attitudes and perceptions of autonomy if it is to be exercised in the way that the DH intends.

Two further aspects are worth considering here. First, autonomy remains focused on the organisation (*cf.* LHE). The shift towards integrated care, for example, will increasingly challenge the tension between collaboration (relying on trust and goodwill) and competition (relying on autonomous agencies). These tensions will be played out most acutely in LHEs, with some areas becoming highly contentious. Complex, open LHEs may find this especially problematic (table 6.1). Autonomous organisations embody the policy focus on localisation which, in the current policy climate, suggests further devolution to PCTs (and emphasis on innovation), locally-determined targets and a reduced role for SHAs. As PCTs devolve decision-making further to PBC and FTs become the norm, the PCT can take on some of the former SHA roles (such as performance management)

Second, the growing emphasis on personalisation (and the even more recent developments on 'entitlements' to public services) underlines the shift of decentralisation beyond the organisation to the individual. Whether such personalised services can be maintained in an era of fiscal constraint remains to be seen but, together with Patient Choice and market stimulation, personalisation might put further strain on public services. Such policies rely on an element of spare capacity such that (autonomous) organisations can respond and attract more patients. Organisational slack is normally the first casualty of fiscal constraint, illustrated by recruitment freezes, high vacancy factors and reductions in training budgets.'

6.2.2. Performance

The performance culture in the NHS has become so pervasive that often its tenets are unquestioned. However, this study has sought to question the assumptions of (formal) performance metrics and to explore the informal aspects. There was clear and widespread use of informal performance notions which complement formal performance. Formal performance was seen as inadequate and/or unresponsive to manage performance across the LHE. New forms of formal performance (that move away from dysfunctional targets) will be required. The development of Patient Reported Outcome Measures (PROMs) may be one such enhancement but its impact will inevitably be limited without informal performance measurement and management. Where formal performance is incomplete or inadequate, informal performance offered a complementary role. It, therefore, appears from this study as if NHS staff need to be more aware of the use and abuse of informal performance measurement, and how it can enhance their assessment and management functions.

The interplay between formal and informal performance was found to be vital in both LHEs which involved, more or less, inter-dependent relationships. Such relationships were socially and institutionally embedded, meaning that relational aspects of commissioning (for example) may be as important as formal techniques. As yet, analysis of (formal and informal) performance across LHEs remains nascent. Harvey *et al* (2007) underline the need to move away from solely an organisational focus to one which recognises the inter-dependent relationships across LHEs:

“An important question for them is whether the assessment of health care performance can be adequately undertaken solely with an organisational focus. Increasingly, patients will be cared for by competing ‘supply chains’ of providers, and it may be necessary for regulators to take a more ‘horizontal’ service view rather than a vertical institutional perspective in order to assess safety and quality” (p.21).

Given the policy direction towards health system performance (DH, 2009), it is increasingly important to undertake analysis of formal and informal performance across LHEs. Performance is increasingly a shared concern and, in cases such as public health and waiting times, assigning responsibility across organisations has been challenging but constructive in fostering greater integration. Other performance measures do require inter-organisational collaboration either as a mandate (eg. joint targets and inspection across health and social services) or implicitly such as measuring PCTs on the performance of hospitals (A&E waiting time targets were constructed on this basis). Local performance frameworks that take account of local context and inter-organisational approaches to performance are, according to this study, worth further development. However, in doing so, questions are raised about giving autonomy to one organisation when others do not enjoy such freedom from the centre. (‘Freedom to’ may not always be apparent irrespective of whether autonomy is granted or not). As a result, sustaining autonomy over the long-term (as a stimulus to improved performance) and reconciling competing policies remain key issues for the DH to address in this regard. There is a strong danger that centrally-determined standards and targets may ossify as an incentive and/or that the dysfunctional effects of targets remain potent barriers to local reform. This potential has been identified as the ‘dead hand’ of best practice (a situation which relates to coercive isomorphism (DiMaggio and Powell, 1983)).

Given the focus of this study – the intersection of vertical and horizontal dimensions - the performance of the LHE may be viewed as the result as a balance between `integration' within the LHE and `domination' by the centre. Integration would imply local, cooperative relationships whilst domination would imply little scope of local autonomy. Drawing on work of `cultures for performance' by Mannion *et al* (2005), this balance can be portrayed as one of four potential `outcomes': synergy, segregation, domination and breakdown (table 6.3.). According to this scenario, `breakdown' in the LHE would occur when there is no integration between organisations within the LHE and the centre retains a dominant control. `Domination' would occur when the centre allows little autonomy despite local integration within the LHE. `Segregation' would occur without integration in the LHE or domination by the centre. Such a situation would not necessarily imply local autonomy but rather a disjointed system that achieves the benefits of neither centralisation nor local collaboration. Finally, `synergy' is seen as the result of integration within the LHE without the domination by the centre. As this model is oriented around the LHE, it is weighted against the notion that strong central involvement in the LHE is a positive attribute.

Table 6.3. Performance outcomes for LHE (as the unit of analysis)

Integration <i>versus</i> domination		Integration within the LHE?	
		Yes	No
Domination by the centre?	No	Synergy	Segregation
	Yes	Domination	Breakdown

Adapted from Mannion *et al* (2005) p.33

This table has some heuristic value but also some practical value in the sense that it raises questions as to whether local organisations are sufficiently integrated to accommodate central policy reforms and whether those reforms have sufficient incentives to achieve their objectives. If not, the `unifying narrative' of reforms may mean little locally. There may be a synergistic effect between `domination' and `integration' since, as we found in this study, the vertical context shapes and is shaped by horizontal contingencies.

6.2.3. LHE

Although this study has examined the interpretation and application of the notion of the LHE, what is its value for policy and practice? Is it just a useful general descriptive term that is used imprecisely to describe various sets of relationships? Is there any value in trying to be more precise about the term? If the main use is descriptive, does a precise definition or contribution to policy matter? At one level, the answer is negative except that it is widely used at all levels of the NHS.

There appears to be a strong assumption in policy and practice that the LHE is tangible, underpinned by shared conceptions. The emphasis on `economy' suggests that inter-organisational relationships within the NHS are primarily economic. The focus is thus on a set of economic relationships – ties of finance, performance, contract etc. This study has sought to demonstrate that additional social, political

and clinical connections overlies economic relationships. All these tend to be highly localised within the LHEs. Organisational relationships thus denote the extent of inter-organisational dependency.

So, is it possible to develop a definition of the LHE or is it merely a portmanteau concept to be used with various meanings by policy makers? The definitive use of LHE may remain elusive and be of little use in health policy analysis. However, by exploring the nature of the LHE, a number of key features emerge. This process might help to understand better the different types of LHEs and to determine the strength of horizontal ties (*cf.* vertical). The continua would apply within LHEs. Such a process might be aided by a typology of LHEs (table 6.4.).

Table 6.4. Typology of LHEs

Features	Continuum
LHE	Open – Closed
Inter-organisational relationships	Collaborative – Competitive
Inter-organisational dependency	High – Low
System complexity	High – Low
Embeddedness (institutional and social)	Strong – Weak
Power (organisations within the LHE)	Strong – Weak
Autonomy (organisational)	Larger – Small
Spatiality (geographical coverage)	Large – Small
Performance – formal	High – Poor
Performance – informal	Strong – Weak
Trust	High – Low

Without doubt, the LHE is a (localised) system but it is also a number of interlocking systems, the boundaries of which are defined by how people define the purpose of the systems. The LHE may thus be defined in terms of different services. For example, the three tracers in this study (urgent care, care of the elderly and orthopaedics) would each have different LHEs. LHEs for these and others would overlap and may not necessarily be connected by any formal institutional structure but have meaning for individuals and inter-personal relationships. One approach to examining the LHE may be through the lens of governance. Rather than examining formal structures, attention would focus on the rules, activities and structures that define its 'boundaries.' In this way, analysis could help explain how autonomy is exercised or restrained and how central control is brought to bear within LHEs.

A final consideration in the implications of the analysis for policy and practice is the role of LHE leadership. We noted that rapid turnover of senior managers was detrimental to building a strong 'informal performance' across the LHEs. It appeared significant that only the FT chief executives in the two LHEs had not moved position in the three years of fieldwork. Whilst the leadership in Northern LHE was noted inside and outside the LHE, it appeared remarkably absent in the

Southern LHE. Such leadership relates clearly to both transactional and (perhaps more importantly here) transformational qualities of leadership (Denis *et al*, 2005; Newman, 2005).

Leadership needs to be considered in terms of autonomy and performance. Local leaders' willingness and ability to exercise autonomy will be crucial to the impact of health reforms. Local leaders should therefore be 'empowered' if reform objectives are to be realised (Newman, 2005). Also, it may be that senior leaders in the LHE value informal performance; if so, how do they nurture and sustain their networks of informal relations and how do leaders reconcile differences between formal and informal performance? Yet, moreover, LHE leadership will also be required to drive locally-inspired and owned change through contested processes of re-configuration. For PCT leaders, this might be increasingly problematic given the growing presence of FTs.

There is a danger, however, that discussions about the role of leadership in the context of decentralisation become self-reinforcing. As Newman (2005) states, the discourses of leadership are often portrayed as a series of binary divisions such as failing/successful organisations, forces of conservatism/proactive leadership (p.720). Decentralisation too is often portrayed as only beneficial and the antithesis of the current (centralised) regime. Leadership can thus help to magnify the diversity that is enabled by decentralisation.

6.2.4. Political directions in 2009

Over the past decade, there has been a general rhetorical consensus that decentralisation is a positive direction and greater autonomy a positive attribute for the NHS. Despite this, there have also been significant features of centralisation. As a general election looms before May 2010, it is timely to review the political and policy directions related to decentralisation. Retrospective and prospective analysis is therefore opportune.

Rawnsley (2009) identified five "phases" of the Labour government's public policy which has striking applicability to ebb and flow of decentralisation and centralisation in health policy. The fifth phase, he argues, began in June 2009 with the proposal of public service "entitlements."

- Phase 1 (1997-2000; Blair): the objective was "to drive public services through centrally imposed diktat"
- Phase 2 (2001-2005; Blair): recognition of the limitations of the "dirigiste approach"
- Phase 3 (2005-2007; Blair): approach which aimed to make reform "self-fuelling" (or self-sustaining)
- Phase 4 (2007-2009; Brown: reform process stalled though rhetoric of choice and competition remained
- Phase 5 (June 2009-onwards; Brown): revival of citizen-led reforms; Brown's "new concept is to make a big shift away from the Whitehall command and control" and "there weren't really any meaningful penalties for those who didn't hit the targets. Their latest answer is to give 'entitlements' to parents, pupils, patients... The idea is that this creates pressure to perform from the bottom up

rather than vainly trying to drive everything from the top down." (see also House of Commons Public Administration Select Committee, 2008)

It is far too early to tell whether Rawnsley's fifth phase is indeed a "big shift" but this study provides the apparatus by which such claims could be assessed. At a superficial level, the focus on the individual is the extension of a recent trend. Whether this shift can be institutionalised and whether it applies across input, process and outcome decentralisation will denote the degree of this "big shift." With Rawnsley's assessment in mind, it is worth highlighting salient sections from recent statements relating to political parties' views on decentralisation (table 6.5.).

Each of the three main parties in England is emphasising decentralisation and autonomy. A particular accent is placed in institutionalising autonomy in the form of entitlements (Labour) or a statutory framework (Conservative). This accords with the previously identified version of (process) decentralisation to the individual. As the Liberal Democrats suggest, there may be greater scope for considering the possibility of institutionalising democratic accountability, an issue also raised by Ben Bradshaw (former health minister) who claimed that:

"PCTs that increasingly will be responsible for spending vast sums of money and commissioning services don't have any direct democratic accountability" (quote in Health Service Journal, 13 September 2007. <http://www.hsj.co.uk/news/bradshaw.html>).

Accountability might take the form of petitions, directly elected boards, elected board members, wider application of FT-style governance arrangements. However, some may be wary of further re-organisations and others might suspect that these moves would only further marketisation in the NHS. Still further, others will be reminded of the public opposition to 're-configure' services in Kidderminster (which led to the election of an independent MP in 2001) and Sussex (where plans were "suspended" in 2008; <http://www.hsj.co.uk/west-sussex-puts-hospital-plan-on-ice-after-backlash/1894010.article>).

Table 6.5. Political indications of future health policy relating to decentralisation

Political party	Policy statements (2009)
Labour	<p>Existing targets would either be converted into minimum standards for services or "removed", he [Burnham] said. "We have got to make sure that minimum standards are fairer and more focused on local context than the targets that preceded them." He gave the example of the MRSA target, saying it was important that standards were high, but a national target was "no comfort" to patients in areas where their local hospital was not up to standard. (Evans, R. 'Andy Burnham promises to overhaul NHS targets' HSJ, 11 June 2009 http://www.hsj.co.uk/news/policy/andy-burnham-promises-to-overhaul-nhs-targets/5002708.article)</p> <p>"We are committed to an enabling government that, wherever possible, wants national targets turned into individual entitlements in service delivery" (Foreword by Gordon Brown in HM Government, 2009, p.8)</p>
Conservative	<p>In November 2007 we published our draft NHS Autonomy and Accountability Bill, which outlined a strong statutory framework to set the NHS free from constant political meddling. (Conservative Party (2008) Renewal: plan for a new NHS. p.16)</p> <p>"The government must... allow more decentralised, open systems where people and professionals, not politicians, take the lead on how our public services are run." (ditto, p.20)</p> <p>"Mr Lansley also criticised the "command and control" structure that he said had led to leadership becoming confused with control. More power needed to rest with patients, he said, which would be helped by expanding practice based commissioning. (Santry, C. 'Tories will increase NHS budget' Andrew Lansley says.' http://www.hsj.co.uk/news/finance/tories-will-increase-nhs-budget-andrew-lansley-says/5002659.article 10 June 2009)</p>
Liberal Democrats	<p>Health spokesman Norman Lamb has called for further devolution and local accountability in the NHS. Speaking at the NHS Confederation conference today, Mr Lamb said: "There needs to be a fundamental change from the situation at the moment where the only person accountable is the secretary of state to a situation where there is local democratic accountability for the commissioners. (West, D. (2009) 'Devolve NHS power, urges Norman Lamb.' HSJ, 11 June 2009 http://www.hsj.co.uk/news/policy/devolve-nhs-power-urges-norman-lamb/5002720.article).</p>

6.3. Further research

Whilst three years of research has answered many questions, new and outstanding questions remain to be addressed. Indeed, one could argue that the institutional frameworks within which the research design was constructed, have altered so markedly, that the research may have little relevance. Whilst this may be so up to a point, the conceptual models provide an enduring framework within which on-going policy and structural modifications can be accommodated. This is a value of long-term funding that research can (hopefully) move beyond the purely descriptive, evaluative approaches to offer some deeper, more meaningful interpretations of long-term trends and on-going developments. Such an approach ensures that programme theories are necessarily grounded in robust empirical findings. The recommendations for future research (6.3.2., 6.3.3. and 6.3.4.) are not placed in priority order as the topics they cover are sufficiently distinct as to be considered in their own right and/or in conjunction with findings from other studies.

6.3.1. The conduct of research in the current NHS

Future research needs to pay more attention to the context in which it is conducted. There are many concerns that the feasibility of conducting organisationally-based research has rarely been more difficult than now. This difficulty might stem from three sources.

First, procedures for ethical approval and research governance are out of proportion to the risk of the research. Like many other studies funded by NCC-SDO, this project only involved managers and clinicians in interviews about organisational change, strategy and implementation.

Second, whilst this study was bound to involve many organisations in two LHEs, access has proved more problematic than anticipated. Several organisations initially refused to participate. This was despite assurances that participation would:

- Comprise minimal active involvement (involving 6-10 one hour interviews),
- Foster accountability (as it was funded by the NHS)
- Provide lessons and good practice across the NHS, and
- Be relevant (to current policy and organisational concerns).

The reasons for such initial refusal relates to the third point: re-configuration. Many who declined cited poor timing due to re-configuration (especially in 2006/07). This reason was perplexing since the study sought to examine how LHEs navigated through re-configurations.

The (ir)-relevance of research has often been cited and indeed the potential futility of research in an ever-changing organisational/policy environment is still present. Research often reports its findings after the `problem' has apparently been solved and the topic becomes less relevant. Alternatively, research is used symbolically in decision-making, to justify a decision `already' made. These dangers remain. This study encouraged a dialogue with participants and feedback results to various policy and academic audiences.

These concerns point towards the need for a new 'contract' between research communities and policy and practice. Both parties have a role to play and so need to be aware of their responsibilities towards producing the evidence with the support of practitioners (on the one hand) and acting upon findings which are disseminated in a timely and appropriate manner (on the other).

6.3.2. Autonomy: further research

- *Intra-organisational autonomy:*
 1. Do autonomous organisations (such as FTs) delegate responsibility within their organisations to middle managers and clinicians?
 - 4.1.2. sub-section "Relationships as enhancing room for manoeuvre"
 2. How do middle managers and clinicians deal with their new ability and what is their willingness to do so?
 - 4.1.2. sub-section "Relationships as enhancing room for manoeuvre"
 3. Are there differences in the nature of autonomy between 'freedom from' and 'freedom to'?
 - 4.1.1. sub-section on 'freedom from' and 'freedom to'
 4. How far does organisational autonomy limit the incentives for local collaboration?
 - 4.1.2. sub-section 'Horizontal factors: how autonomy is shaped by the LHE'
- *Ability and willingness to exercise autonomy:*
 5. How does local autonomy vary between different types of LHE?
 - 4.1.2. sub-section 'Horizontal factors: how autonomy is shaped by the LHE'
 6. How does local autonomy vary in response to evolving national policy imperatives?
 - 4.1.2. sub-section 'Vertical factors: how autonomy is shaped by national policy mechanisms'
 7. What are the attitudes and perceptions of managers and clinicians who 'enjoy' autonomy, those who aspire it / are about to receive it, and those unlikely to get it (due to poor organisational performance)?
 - 4.1. Autonomy
- *New frontiers of autonomy:*
 8. How do organisational actors respond to incentives which allow the franchise of poorly performing organisations?
 - 2.2.2. (iv) Accountability
 - 4.1.1. View on autonomy
 9. How do private sector providers view autonomy?
 - 4.1.2. Sub-section 'Horizontal factors: how autonomy is shaped by the LHE' (including 'Persistence of social relationships')
 10. What lessons can be learned from other health systems in the UK and elsewhere about the use of autonomy to improve organisational and system performance?
- *Leadership and autonomy:*
 11. What role do senior leaders play in organisational change?
 - 4.1.2. Sub-section 'Horizontal factors: how autonomy is shaped by the LHE' (including 'Leadership and competence')
 - 4.2.5. Informal performance ('as complement' and 'as substitute')

12. How do senior leaders 'adapt' national policy to meet local exigencies?
 - o 4.1.2. Sub-section 'Horizontal factors: how autonomy is shaped by the LHE' (including 'Relational dynamics')

6.3.3. Performance: further research

- *Formal performance:*
 1. What are the unintended consequences for autonomy of the emphasis on formal performance?
 - o 4.1. Autonomy
 - o 4.2.4. Formal performance
 2. How can formal performance provide a sufficient incentive for high performing organisations to continue to improve?
 - o 4.2.4. Formal performance
 - o 4.2.6. Interplay between formal and informal performance (sub-sections 'inter-twined' and 'mismatch')
- *Informal performance:*
 3. What measures or markers of informal performance are most relevant to managing the LHE?
 - o 4.2.5. Informal performance
 4. What factors affect the ways in which informal performance evolves over time?
 - o 4.2.5. Informal performance
 5. How strong is informal performance across different managerial and clinical grades and how could it be 'measured'?
 - o 4.1.2. Sub-section 'Horizontal factors: how autonomy is shaped by the LHE' (including 'Leadership and competence')
 - o 4.2.5. Informal performance
- *Interplay between formal and informal performance:*
 6. What are the effects of dissonance between formal and informal performance? (That is, how do local actors reconcile good formal performance with poor informal performance, and vice versa?).
 - o 4.2.6. Interplay between formal and informal performance (especially sub-section 'mismatch')
 7. How resistant is informal performance over time? (That is, in the face of contrary evidence, how strong is informal performance?)
 - o 4.2.5. Informal performance
 8. In what ways do the public and patients reconcile formal and informal performance in making decisions about health-care?
 - o 4.2.6. Interplay between formal and informal performance (especially sub-sections 'defining the LHE' and 'mismatch')
 9. How can formal performance (via remote monitoring by DH, SHA) incorporate informal performance?
 - o 4.2.5. Informal performance (especially sub-section 'complement')
- *Performativity and dramaturgy:*
 10. What forms of performativity are evident in different settings (board meetings, public meetings, private meetings, interviews)? How are they constructed and displayed?
 - o 2.3.6. Formal and informal performance explained (sub-section 'Informal performance')
 - o 5.4.2. Formal and informal performance

11. How does the 'ritualistic' collection of performance data for the purposes of the centre affect local managers?
 - o 2.3.6. Formal and informal performance explained (sub-section 'Informal performance')
 - o 4.1.2. How autonomy is shaped (sub-section 'Vertical factors: how autonomy is shaped by national policy mechanisms')

6.3.4. Systems, integration and collaboration: further research

- *System integration:*
 1. What factors are most effective in managing different types of nested health systems? What is the respective role of infrastructure, institutions, inter-personal relationships and individuals?
 - o 1.4. Local health economy
 - o 4.2.6. Interplay between formal and informal performance (sub-section 'defining the LHE')
 2. How do PCTs manage across an increasingly diverse range of local organisations?
 - o 4.1.2. How autonomy is shaped (sub-section 'Horizontal factors: how autonomy is shaped by the LHE')
- *Collaboration:*
 3. Under what conditions is collaboration a strategy that promotes autonomy and performance?
 - o 4.2.6. Interplay between formal and informal performance
 4. Are there aspects of health systems (eg. structures or processes) where collaboration is vital and aspects where it is not?
 - o 4.2.6. Interplay between formal and informal performance
 5. Can high performing, autonomous organisations ignore collaboration with other agencies? What effects does this have upon the system?
 - o 4.2.6. Interplay between formal and informal performance
- *System performance:*
 6. In what ways does LHE performance differ from the sum of individual organisational performance?
 - o 1.4. Local health economy
 - o 4.2.6. Interplay between formal and informal performance (sub-section 'defining the LHE')
 7. How do regulators and performance managers (Monitor, SHAs, DH and CQC) facilitate improved performance and secure compliance?
 - o 4.2.1. Significant of 'performance in LHEs
 - o 4.2.2. Causes and pathways to performance
 - o 4.2.3. Performance management
 8. How can the regulatory regime foster improved performance?
 - o 4.2.2. Causes and pathways to performance
 - o 4.2.3. Performance management
 9. How do local performance managers (PCTs, SHA) manage system fragmentation?
 - o 4.2.3. Performance management
 - o 4.2.6. Interplay between formal and informal performance (sub-section 'defining the LHE')
- *LHE:*
 10. How is the LHE defined and operationalised in policy and practice?
 - o 1.4. Local health economy

- 4.2.6. Interplay between formal and informal performance (sub-section `defining the LHE')
- 11. Is there an optimal size and structure to LHEs (for the purposes of system management, among others)?
 - 1.4. Local health economy
 - 4.2.6. Interplay between formal and informal performance (sub-section `defining the LHE')
- 12. How is a new language and practice of health systems (involving organisational learning, knowledge sharing and long-term commitment) incorporated into a competitive environment of semi-autonomous organisations?
 - 4.2.6. Interplay between formal and informal performance
- 13. What role does leadership play in LHE / system integration?
 - 4.2.6. Interplay between formal and informal performance
- 14. How do PCTs legitimate themselves as leaders of the LHE in the facing of FT membership? Does place affiliation counteract membership of FTs?
 - 1.4. Local health economy
 - 4.1.2. Sub-section ``Horizontal factors: how autonomy is shaped by the LHE' (including `Leadership and competence')
 - 4.2.6. Interplay between formal and informal performance (sub-section `defining the LHE')
- *Legacy effect on health systems:*
 - 15. How do LHEs / local health systems deal with different legacy effects (such as "years of heavy command, control and performance management from the centre." (King's Fund, 2008, p.3)?
 - 4.1.2. How autonomy is shaped (sub-section `Vertical factors – how autonomy is shaped by national policy mechanisms')

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Appendix 1. Hypothetical case-study

To inform the selection of case-study LHEs and to draw on contemporary debates in health policy and practices, extracts from commentaries and articles in practitioner / trade journals (such as the Health Service Journal and British Medical Journal) and newspapers (such as the Guardian) were collated between April and June 2006. The extracts were grouped into the primary themes of the study. The questions and issues which were of relevance to the study are included (in italics) after some of the extracts. The hypothetical case-study was useful in anticipating the type of data that would be gleaned from fieldwork, anticipating the type of analysis that might be possible. The extracts have been anonymised because some of them referred to case-studies that were eventually chosen for further inquiry as part of the fieldwork

a. Vertical autonomy:

- “The government has put too many changes in place at the same time without considering the impact on services. Targets are set nationally, locally we try and meet these and then get the blame when the targets and funding don’t balance” (Chief Executive)

How does the locality try to meet the targets? What is the impact on services? Why do targets and funding not balance? What are the conditions for balancing?

- “There are certainly some trusts where the finances have been mismanaged but there are a significant number where the situation has been caused by structural changes” (Chief Executive)

How are finances being mismanaged? What are the factors that generate mismanagement? How do structural changes affect Trusts that would otherwise be well managed? Why do some trusts thrive while others do not?

- “An utter disgrace. Taking my own trust as a barometer, our financial difficulties are almost exclusively a function of things imposed upon us. We would not be in this position but for centrally-driven initiatives. (Chief Executive)

What is it about centrally driven initiatives that cause problems? How would things be done differently? What factors other than central initiatives are responsible for the situation?

- “The government has failed to examine their own part in the problem. We have undoubtedly been given a huge increase in revenue, but it has been more than swallowed up by too many ill thought-out targets and changes” (CE)

Why are targets ill thought out? Would better targets make a difference?

- "Sending in turnaround teams will not resolve the problem. If there is a hint that an external body is taking the lead, then it is less clear where accountability lies. There is a risk that over-reliance on external intervention dilutes board responsibility" (NHS finance director).
- "Local managers need to have choice over what they can do"
- "[XYZ] Hospital Trust had already asked for independent help and its finance director is not too proud to take advice along the way." (Financial director)
- " We do not need turnaround teams. What we need is support for implementing the unpalatable" (CE)

Why are turnaround teams not effective? What would be a valuable support?

b. Capacity and skills

- "The DoH underestimated the fact that a change in culture and behaviour takes a long time in some organizations and the senior leadership is not sufficiently skilled. Some providers are slow to accept financial realities and most commissioners lack the capacity and skills to effectively manage demands" (Chief Executive)

c. Horizontal autonomy and dependency

- "A top performing Trust in [...], which has been balancing its books for years is having to make savings to help out its neighbouring NHS services. The cuts will harm patient care at a time where services need more investment not less."

How can an organization balance its books and maintain the balance over time? What are the conditions for this? Who decides that the "sacrifice" has to be done? Does the type of organization influence the extent of sacrifice?

d. Priority policy areas

- "The economy has continued to struggle to meet and sustain delivery of emergency access targets (County, LDP)
- "The narrow range covered by the targets within the proforma does not reflect the needs of children and priority service areas, particularly with the forthcoming NSF. There is a danger that the whole service area will be neglected as it is not high profile within the national targets. We will be re-focusing on the provision of community-based services to enable children with more complex needs to be supported at home." (County, LDP)
- "[ABC and DEF] PCTs have yet to meet the two month GP urgent referral target for cancer care."

e. Relationships between PCT and NHS providers

- “The role of the new PCT will be to become a commissioning organisation with the scale and greater capability to commission services that are affordable from the major providing organisations, in particular the [...] NHS Trust.”

How will affordability will be achieved? Which are the major providing organizations? How can greater capability be reached?

f. Relationships between PCT and private providers

- “The policy that has introduced the private sector has destabilized the NHS”

How has the private sector destabilised the NHS?

g. Collaboration and partnership

- “Hospitals will have to collaborate to ensure some services are provided in a locality. We need to combine the benefits of contestability with the need for integration in certain services” (Chief Executive, NHSTrust)

How is partnership going to be created and managed? How will the independent sector be involved? How are trust and confidence created? Are there differences based on the constituent parts of the survey?

h. Reconfiguration

- “Many of the issues like clinical engagement, public involvement, health inequalities and partnership, all fit much better with smaller PCTs who are accountable to their communities” (Chair, PCT)
- “Obviously if you’ve got fewer organisations you may be able to save money at PCT level, but then you’re devolving a lot of the activities and you’ve got to fund that. So whether overall you’re going to save money is at best questionable.”
- In the [city] area, the local strategy devised by the PCTs together with the SHA had delivered service improvements. This strategy included merging the existing PCTs into three. However, the DoH’s requirement of creating a single [city-wide] PCT, against the wishes and strategy of the local health community, generates the risk of stopping the reform and shunt the road.
- There are currently five PCTs in [county] with five Boards and Chairs. There is a shared management structure for two PCTs in the South and the North, resulting in three Chief Executives and management teams covering the five PCTs. These 5 PCTs will be streamlined into 1 PCT from October 2006.
- The [county] PCTs’ approach is to grow a new streamlined organisation

out of the current five PCTs . A single management team has already been set up in anticipation of one PCT for [county] which will ensure that services to patients are not disrupted during the transition period and that we lay the best foundations for a successful single PCT. The role of the new [county] PCT will be to support GPs as budgets are devolved to primary care practitioners and to become a commissioning organisation with the scale and greater capability to commission services that are affordable from the major providing organisations”
How is capacity to manage the change created? How is scale going to make things better? How is the commissioning function going to be carried out?

i. Financial balance

- “We recognize that the financial position differs for individual NHS bodies, with some managing their finances well. We need to focus on what the good trusts are getting right, so that we can spread good practice across the whole area” (Chief Executive, SHA).
- “Services have been the victim of weaknesses in financial management.”

What are the elements of good management? What are the conditions for good management (why are some trusts able to be in balance while others are not?). How does this disparity affect the economy? (This is linked to the horizontal dimension of autonomy; from this excerpt emerges an attitude where disparity is good for learning; while, from the other cases, it seems to emerge that disparity is detrimental for the successful cases). How can good practice be spread? How can learning for organizational change be nurtured and fostered?

Appendix 2. Case-study profiles

Given the guarantees of anonymity that the research team gave to the participants in both LHE case-studies, it is somewhat problematic to provide a profile of these case-studies in sufficient depth to enable an informed assessment. However, it is important to provide a degree of contextual information relating to the nature of each LHE so as to triangulate empirical data which is described elsewhere in the report. These profiles thus offer an abbreviated version which presents the key information.

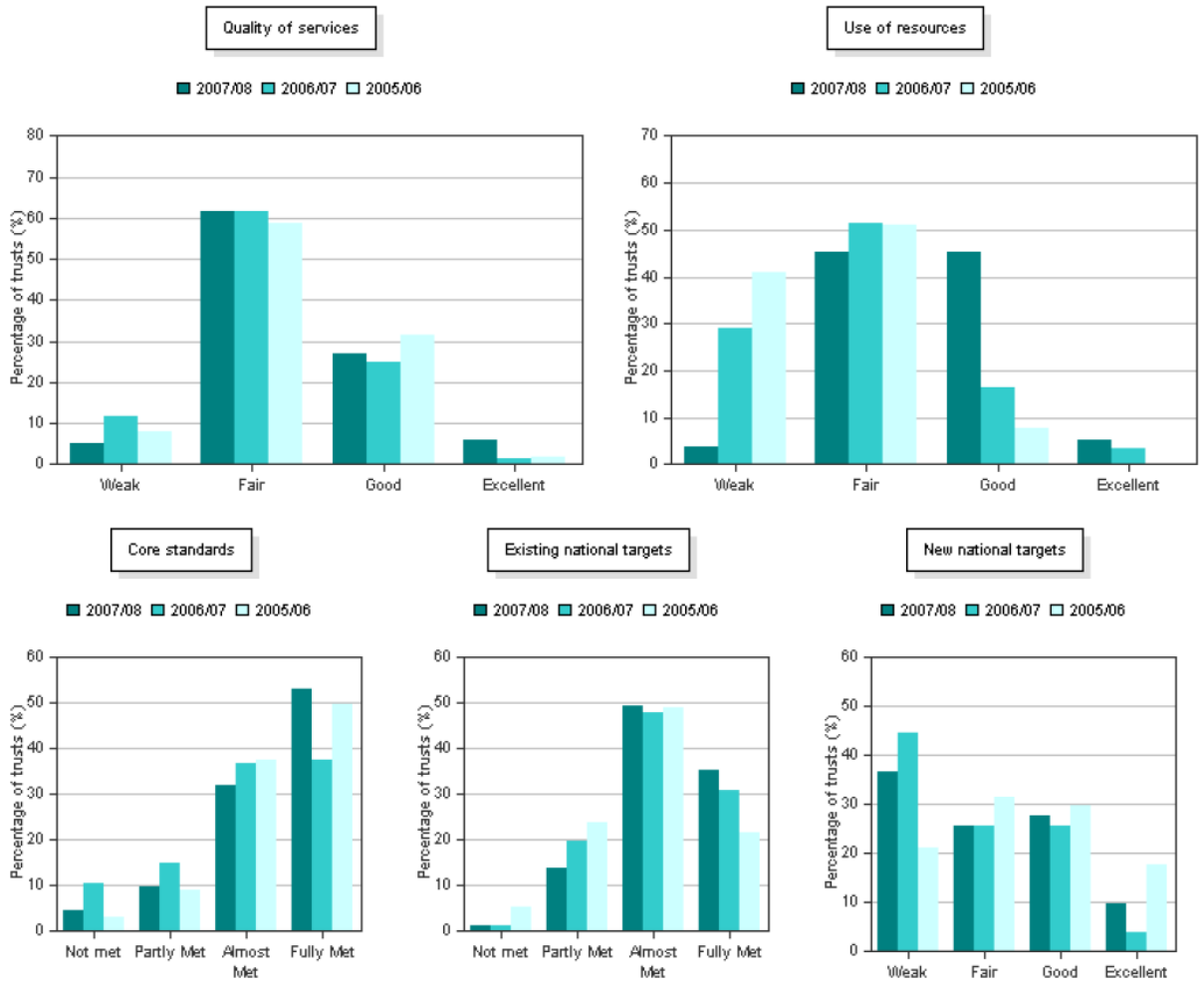
A similar pattern of description is presented in each case-study but differences are apparent in terms of the degree to which the data might reveal the identity and location of the LHE and its constituent organisations. The methodological justification for the inclusion of these case-study profiles is not to imply that they are generalisable or representative of other or any LHEs; rather, the conceptual and empirical themes (which are outlined in chapter 2 and form the basis of the case-study profiles) are designed to be illustrative and heuristic.

These themes include:

1. Organisational configuration of the LHE
2. Financial position and performance
3. Organisational performance
4. Organisational inter-dependence (based on financial flows between PCTs and principal providers)
5. Organisational issues which were contemporary (during the fieldwork) and oriented around:
6. Clinical tracers of urgent care, orthopaedics and care of the elderly, in order to illustrate:
 - a. Service re-design
 - b. Integration and collaboration
 - c. Access to care

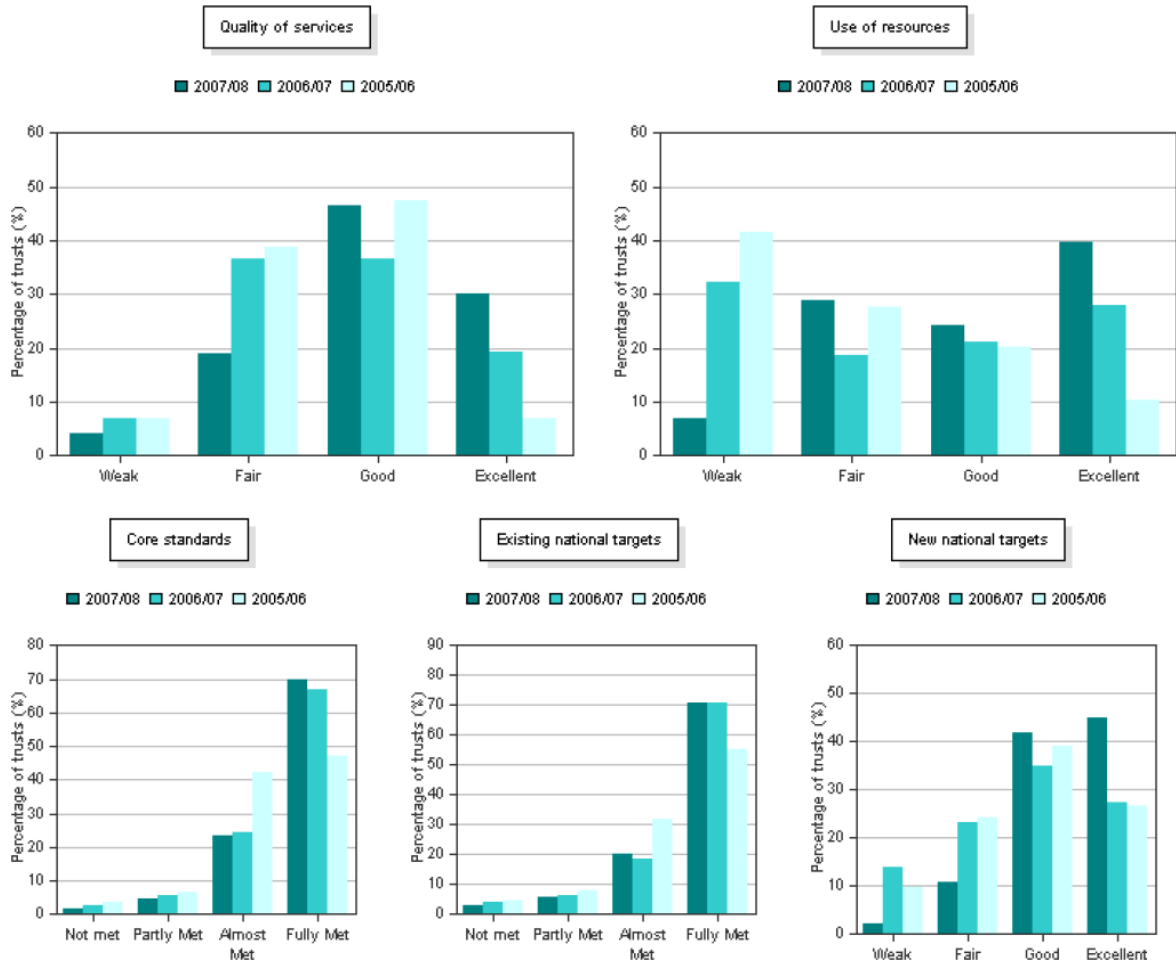
Before details of the two case-studies are examined, it is worth setting them in a national context. Information from the Healthcare Commission achieves this (see figures 1 and 2). The case-studies comprise organisations which represent the range of performance evident across all PCTs; the case-studies comprised among the best and worst performing Trusts in England.

Fig. 1. Healthcare Commission (2008) Overall performance of primary care trusts



Our 2007/08 assessment rated 391 trusts, down from 394 trusts in 2006/7, and 570 trusts in 2005/6. Graphs and tables presented here relate to performance in the relevant assessment year i.e the spread of performance in 2005/6 is based on how the 570 trusts that were assessed that year performed.

Fig. 2. Healthcare Commission (2008) Overall performance of acute and specialist trusts



Case-study: Northern LHE

•Organisational configuration

The Northern LHE comprises three NHS provider-based organisations which are Foundation Trusts and one PCT (which was formed from the merger of four former PCTs in 2006). .

Table 1. NHS organisations in Northern LHE

SHA	<ul style="list-style-type: none"> • Formed July 2006 from the merger of 3 former SHAs
Northern PCT	<ul style="list-style-type: none"> • Formed in October 2006 from the merger of 4 PCTs • Catchment population >500,000 • Coterminous with City Council
Northern Hospital 1	<ul style="list-style-type: none"> • Formed in April 2001 from the merger of 2 former Trusts • FT since 1 April 2004 • Primary site with >1000 beds plus 4 other sites • 12,000 staff • Annual turnover (2007/08) £ 673 million
Northern Hospital 2	<ul style="list-style-type: none"> • FT since 1 August 2006 • Annual turnover (2007/08) £87 million • >150 beds • >1,500 staff
Northern Trust 3	<ul style="list-style-type: none"> • FT since 1 July 2008 • 570 beds • 2,300 staff • Annual turnover (2007/08) £99 million

- Financial position and performance

The Northern LHE presents a positive trend in terms of financial position of its constituent NHS organisations. In both 2004-2005 and 2005-2006 each NHS organization in the Northern HE (pre-merger PCTs and NHS Trusts) ended the fiscal year with a surplus, although this represented a small percentage of overall organizational turnover across the LHE. In 2005-2006, "Northern Hospital 1" had achieved financial balance for the fifth year in a row.

Despite these successes financial pressures within the LHE have been increasing and in February 2006 the pre-merger PCTs appointed a turnaround team. The financial position of the new PCT in 2006/2007 highlighted some issues, although by December 2006 the forecast year end over spend had improved. Commissioning expenditures had been an area of concern, due to an increase in activities at the "Northern Hospital 1" over the budget level. However, "the PCT remains in negotiation with [the Trust] with the objective of returning expenditure as close to plan as possible" (Finance Director's Report, February 2007). A second reason for the forecast is a lower than planned income, which savings from the PCT turnaround plan should help to offset.

A turnaround plan has been agreed with the SHA and the Department of Health with the aim to return the PCT to financial balance. Although to date there have been some progresses, "the PCT continues to face a significant challenge to deliver financial balance in 2006-2007" (Finance Director's Report, February 2007).

According to the Audit Commission's (2008) analysis, the Northern PCT's total spending per head (unified, weighted; £ 2006/07) was marginally above the national average (median) of £1,336. However, its reference cost index 2006/07 (inc MFF) was 86.9, significantly below the average (median) of 101.5.

One of the FTs in the Northern case-study recorded an Income and Expenditure Account surplus for 2007/08 of £6.9million but its annual report (2007-2008) noted that this represented "just less than 1 per cent of turnover for the year, and equivalent to just 3.7 days' worth of expenditure, the surplus can be reasonably described as modest and beneficial" (p.39).

- Financial flows

Table 2 and table 3 report on the relationships between the pre-merger PCTs and Acute Trusts based on financial flows in the Northern LHE. They also include NHS organizations outside the immediate boundaries of the LHE with which Northern NHS organizations have financial relationships. Table 2 shows that all NHS Trusts draw most of their activity from the LHE, especially Northern Hospital 1 and Northern Care Trust. Table 3 shows that most of the resources from pre-merger PCTs stayed within the LHE. The Northern LHE appears therefore as a 'closed' LHE. In addition, before PCT reconfiguration there was quite an asymmetry in terms of financial flows between each pre-merger PCT and local NHS providers, with the latter presenting a diversified portfolio of commissioners while the former almost exclusively depending on 'Northern Hospital 1' as single adult care provider. However reconfiguration is at least in terms of financial flows going to rebalance this dependency situation.

Table 2. Northern LHE: Proportion of the (former) PCT contract expenditure to the Acute Trust

Acute Trusts ↓	PCT →	Ex-PCT 1	Ex-PCT 2	Ex-PCT 3	Ex=PCT 4
"Northern" Hospital 1		8.2%	7.1%	7.5%	8.0%
"Northern" Hospital 2		88.1%	86.9%	88.7%	86.8%
"Northern" Trust 3		1.1%	1.1%	0.8%	0.6%
Total		97.4%	95.1%	97%	95.4%

Note: PCT expenditure is disbursed to other providers

In other words, each of the former PCTs in the LHE spent the vast majority (over 95%) of their expenditure of hospital and community health services budget with thee providers within the Northern LHE

Table 3. Northern LHE: Proportion of the local NHS Trusts budget received from the former Northern LHE PCTs

Acute Trusts ↓	PCT →	Ex-PCT 1	Ex-PCT 2	Ex-PCT 3	Ex=PCT 4	Total
"Northern" Hospital 1		15.3%	11.3%	11.2%	19.7%	57.5%
"Northern" Hospital 2		18.1%	15.2%	14.5%	23.3%	71.1%
"Northern" Trust 3		30.6%	26.7%	17.9%	21.2%	96.4%

In other words, the three providers within the LHE were differentially dependent upon the (former) PCTs of the Northern LHE for funding. Yet, for even 'Northern Hospital 1', it received over half its funding from the local PCTs. By contrast, 'Northern Trust 3' was almost totally reliant on these local PCTs.

Table 4. Northern LHE Proportion of the NHS Trusts budget received from non-local PCTs

Acute Trusts ↓	PCT →	PCT [i]	PCT [ii]	PCT [iii]	PCT [iv]	Total
"Northern" Hospital 1		7.0%	7.3%	3.4%	-	17.7%
"Northern" Hospital 2		5.9%	5.6%	3.0%	-	14.6%
"Northern" Trust 3		-	-	-	2.4%	0%

Source for all three figures: DH Purchaser-provider matrix

In other words, the local providers also received expenditure from non-local PCTs. Apart from PCT [iv], these were neighbouring PCTs. For Northern Hospital 1 and 2, the expenditure amounted to around one sixth of their total budget.

In summary, therefore, the observation that Northern LHE was a closed economy is validated by these figures on financial flows between the PCT(s) and local providers. This has implications for the ways in which inter-organisational relationships were conducted and, it is hypothesised, for the room for manoeuvre available to all organisations.

- Organisational performance

In February 2006, at the outset of the project, the Northern PCT assessed the position of the LHE in terms of performance targets as follows:

Table 5: Northern PCT self-assessment

Areas on target to be achieved	<ul style="list-style-type: none"> • Key waiting time targets • Health inequalities: cancer, heart disease, stroke • Older people's mental health • Delayed transfers of care • Reducing emergency bed days
Areas requiring support	<ul style="list-style-type: none"> • Cancer waiting times • Infant mortality • A&E waiting times: "[Northern Hospital 1] performance has been fluctuating to below the target 98%" (Performance Report, 6 February 2007)
Areas not expected to achieve	<ul style="list-style-type: none"> • Patient choice • Community equipment for long-term conditions (older people) • Community matrons • Financial balance)

Subsequently, two sets of performance assessment have been made – World Class Commissioning applicable to the PCT and the Healthcare Commission annual health check (applicable to the PCT and NHS Trusts). The performance measured in these assessments are summarised below.

- World Class Commissioning assessment:

The WCC Panel (2008) declared that the Northern PCT was "an ambitious organisation with big plans" and concluded that

- "The panel believes the scale of risk and provider management that the PCT faces to deliver its strategy is significant"
- "The panel recommend that the PCT give thought to: (a) how they work with their main providers to manage this transition"
- "The PCT has a long history of joint needs assessment"
- "The panel recognises the work to be done on building the PCT's capabilities in order to execute its vision"
- "The panel observed strong aligned leadership at the top" of the PCT

In terms of the 10 WCC competencies in the PCT self-assessment and panel assessment, the PCT rated themselves at level 3 (out of 4, with 4 being the 'best') on 2 measures ("locally lead the NHS" and "work with community partners"), only one of which was confirmed by the WCC panel (the latter). All the other measures were rated level 2 except "stimulate market" which was rated by both at level 1.

However, the PCT did under-perform in terms of Patient Choice:

"The PCT performs below national and SHA averages for offering and providing choice to patients (Patient Choice Survey). The strategic plan does not fully set out how the market can be developed to extend patient choice

- Audit Commission (2008)

In November 2008, the Audit Commission conducted an audit of the PCT's "use of resources." As part of this assessment, it reported on the 2007 survey of patient perceptions (p.11). It also reported that the PCT's reference costs were 86.9 compared to an average of 101.5 (median)(index 2006-2007 including MFF).

Table 6: Northern PCT - selected performance

	Northern PCT	Average (median)
Offered choice of provider	95.0%	93.4%
Phone access	81.0%	84.5%
Able to get appointment within 48 hours	81.0%	84.3%
Opening hours	83.6%	84.6%

Whilst choice of provider is above the average, the other 3 measures (cited here) were below average.

The findings from the Healthcare Commission's Annual health check are reported in 2.3.6. (see also 3.2.4. and 3.3.1). However, it is worth noting that the Healthcare Commission provides a more detailed analysis of each organisation's performance according to the national performance targets. This offers a more detailed assessment of performance compared to the 'headlines' in the table above.

Northern PCT:

In the Healthcare Commission's annual health check (2006/07), a total of 32 indicators were used to measure performance of the organisation against the (new and existing) national targets. In 2006/2007, the Northern PCT "failed" on 8 indicators:

1. Commissioning of crisis resolution services
2. PCT facilities in place to support choice
3. PCT booking
4. Teenage conception rates
5. Community matrons and additional case managers
6. Practice-based registers
7. Community equipment delivery
8. Four week smoking quitters

By 2007/2008, the PCT "failed" on 7 indicators

1. Access to a GP
2. Commissioning of crisis resolution services

3. PCT facilities in place to support choice
4. PCT booking
5. Teenage conception rates
6. Community matrons and additional case managers
7. Four week smoking quitters

Whilst the PCT was compliant in all but 5 of its core performance standards (and a further 4 has "insufficient assurance") in 2006/2007, it was fully compliant in 2007/2008.

Northern Hospital 1:

In 2006/2007, the Trust achieved all of its 24 (new and existing) performance targets though 3 of which were "not applicable" and they achieved 1 score as "satisfactory" and 1 "under-achieved" in that year. The following year (2007/2008), three targets were "under-achieved" (though they had been the previous year). One target was deemed "satisfactory" (the same score as the previous year). No target was deemed "not applicable" in 2007/2008. The Trust was compliant in all its core performance standards in 2006/2007 and 2007/2008

Northern Hospital 2:

In 2006/2007 and 2007/2008, the Trust achieved all (new and existing) national performance targets although 8 (of the 24) were applicable in neither year.

Northern Care Trust:

As of spring 2009, there are no 'formal interventions' in this Trust, according to Monitor. Its risk rating is level 3 which indicates "regulatory concerns in one or more components" but that a "serious breach is unlikely."

- Stated policy goals and approaches to key research themes (including tracer conditions)

Research themes

This section cites extracts from local documentation in the Northern LHE which address initiatives that are related to the core themes of the study: central-local relationships, national policies and local relationships in general. They are cited here to illustrate the broader themes which are explored in further detail in the empirical fieldwork (see chapter 4)

a) Central-Local Relationships

Quotes/Actions	Organisation	Source
"we will focus on specific targets for reducing health inequalities which take account of national priorities and local needs"	Ex-PCT 1	Delivery Plan 2003-2006, p.9

b) National Policies

Quotes/Actions	Organisation	Source
"we aim to meet and exceed the standards of the NSFs and will implement NICE guidelines"	Ex-PCT 1	Delivery Plan 2003-2006: 9
"Work is ongoing to reconcile and merge the different management systems that were in place in the 4 former PCTs"	Northern PCT (post-2006)	Performance Report February 2007, p.3
"PBC has given us an opportunity to work with our GPs and other NHS staff and give them greater say in how services can be delivered around the needs of the patients" "Our practices have formed into two groups led by GPs and practice managers"	Ex-PCT 4	Annual Report 2005-06 (pp a)
"we are working with our colleagues across the four [...] PCTs to develop an organizational framework for the future"	Ex-PCT 4	Annual Report 2004-05 (pp a)

c) Local relationships

Quotes/Actions	Organisation	Source
"we will work with NHS trusts, Social services and other providers to deliver improvements to capacity and efficiency for emergency care, chronic disease and elective care"	Ex-PCT 1	Delivery Plan 2003-2006, p.10
"We will develop with other NHS organizations in [the Northern LHE] and [Northern] City Council a three year financial plan for health and social care"	Ex- PCT 1	Delivery Plan 2003-2006, p.10
"[Northern] Partnership arrangements are very strong"	Ex- PCT 1	Delivery Plan 2003-2006, p.15
It is in the joint interest of the Trust and its commissioners to plan capacity for secondary care services as a collective effort. This will	Northern Hospital 1	Strategic plan 2004-2009

provide advantages of simplifying the capacity modelling and liberating scarce management time for focus on the delivery of strategic changes (p. 15)		
"It is our intention to pursue greater collaboration in joint provision to maximise the collective capacity of all secondary care and give no threat to organisational integrity the inclusion of independent sector organizations" page 15	Northern Hospital 1	Strategic plan 2004-2009
"Since October 2005 the PCT has been working in partnership with Northern Hospital 1 to improve appropriate admissions to hospital. PCT nurses have been working in the hospital"	Ex-PCT 4 and Northern Hospital 1	Ex-PCT 4 Annual Report 2005-2006 (pp a)
"The four PCTs in [the LHE] have reciprocal working arrangements...[the PCT]set out a suite of service redesign initiatives alongside a neighbourhood approach to service planning"	Ex-PCT 4	Annual Report 2004-2005

d) Local context: an illustration

Area	Characteristics	Source
Ex-PCT 1	<ul style="list-style-type: none"> • Health: High level of premature death and illness • Socioeconomic situation Poverty and social exclusion (six of the seven wards are amongst the 10% most deprived areas in England) Poor environment • Social capital Strong communities, many voluntary and community organizations • Organisational ethos Flat, open and accessible organization Seeks out for participation of the public in decision making 	<p>Delivery Plan 2003-2006</p> <p>Public health report 2004-2005</p>

e) *Performance Management and Planning*

Organisation	Quotes/Actions	Source
Ex-PCT 1	" We will continue to improve our internal performance management framework through which we monitor and review all aspects of our performance"	Delivery Plan 2003-2006, p.10

Tracers in the Northern LHE

This section reports on issues that relate specifically to each tracer, including performance, organization of the service and local initiatives. These local initiatives have been categorised based on the themes of service redesign and access and integration. Where the documents reported a clear time range for the initiative, this is also reported together with the organization(s) involved and the documentary source.

a) *Urgent care*• *Performance against targets*

Organisation	Target
Northern Hospital 1	Performance fluctuating below target 98% A&E waiting times (as reported in the[Northern] PCT performance report 2006)
Northern Hospital 1	In the A&E department survey high score in most areas with waiting times improved and high level of confidence in doctors and nurses (as reported in the 2004-2005 annual report)
Northern Hospital 1	2004-2005 A&E target achieved. in January 2004 the figure was less than 90%
Ex-PCT 1	Since February 2005 the target of 98% of patients who attend A&E has been achieved

- *Service re-design (A&E) and access to urgent care*

Action	Status	Organisation	Source
<ul style="list-style-type: none"> • Clinical Unit for A&E department for patients needing non urgent tests • Medical Assessment Unit for Bed bureau patients 	Created	Northern Hospital 1	Annual report and accounts 2005-2006
<p>"In A&E we have radically improved the services by ensuring 98% of our patients get the treatment they need and a hospital bed within four hours of their arrival...only two years ago patients often waited on trolleys for hours in the corridors of the A&E department"</p> <ul style="list-style-type: none"> • Pit stop scheme introduced • Patient tracking system • Temporary clinical decision unit (not sure it is the same as the clinical unit mentioned above) • Work has involved the entire hospital: • A&E work with new specialist assessment areas to fast track patients to appropriate specialty • Imaging, lab and the hospital discharge Lounge supported A&E <p>Improvements of emergency admissions and minor injuries unit at the [Northern] Hospital</p>	Changes implemented in 2004	Northern Hospital 1	Annual report 2004-2005
Resident Consultant Emergency Physician in the A&E		Northern Hospital 1	Strategic Plan 2004-2009

- *Integration*

Change	Status	Organisation	Source
"Partnership between [Ex-PCT 4 and Northern Hospital 1] to reduce number of patients using A&E as principal access to care"	Implemented since October 2005	Ex-PCT 4 and Northern Hospital 1	Ex-PCT 4 Annual report 2005-2006

b) Care of the elderly

- *Integration*

In 2005, Northern LHE developed [Northern] Health Agreement 2005-2008 which consists of three areas among which older people. Below is a summary of the main aspects of the document:

i) Vision: The vision of the document is to ensure local older people independence and well being (reduction in unnecessary admissions and increase in the number of elderly able to live in their homes). This entails covering all the range of services older people need, beyond health and social care.

ii) Goals: Provide a fully integrated and coordinated care for older people through innovative ways of working and partnership approach

iii) Actions:

- Development of a strategy for an ageing population
- Reengineering services for older people
- Using Local Government Act (empowering LAs)
- Assessing needs in the community
- Developing the workforce

The Agreement requires additional local flexibility (especially in terms of workforce) to be able to achieve these goals. There is an Older People's partnership Board responsible for the delivery of these goals and an Older People Service Executive Group linked to it with responsibilities on strategic development of health and social care and resource coordination.

Action	Status	Organisation	Source
City-wide panel to address offer of services to over 65 and access to Stroke Service	Declared/ not specific initiative reported	Ex-PCT 1	Local Plan 2003-2006
Work with social services to achieve national targets on hospital discharge and at home care for elderly people	Declared by 2005	Ex-PCT 1	Local Plan 2003-2006
Strategic intention to prevent avoidable admission for elderly: <ul style="list-style-type: none"> • Collaboration for primary care service and support to residential and nursing homes • Rapid access to outpatient clinics 	Declared in 2004	Northern Hospital 1	Strategic Plan 2004- 2009
Hospital discharge team		Ex-PCT 4	Annual Report 2005-2006
"We have started to develop integrated services...We have used the Health Act 2000 to pool budgets...this early experience has helped us to understand how different pays between health and social care staff are presenting barriers to recruitment and retention"		[Northern] First Agreement 2005-2008	

- *Service redesign and community care*

Action	Status	Organisation	Source
Case management system has been introduced in some wards to ensure patients are discharged in a timely manner. It also involves older people with orthopaedics problems.	Ongoing	Northern Hospital 1	Annual report and accounts 2005/2006
"The vision of the PCT is to transform health care services for older people....by providing consistent support avoiding unnecessary admission to hospital...The PCT has piloted a number of approaches and made investment in community nursing and established an older people care team"	No specifics about the projects	Ex-PCT 4	Annual Report 2005-2006
The PCT has activated a number of services: <ul style="list-style-type: none"> • The Tissue Viability Service supports community service to prevent ulcers • Intensive Case Management to provide individual support • Physiotherapy rehabilitation • Intermediate Care Unit (including staff at hospital and community team • There is a city-wide project to redesign services for older people including: <ul style="list-style-type: none"> • Additional beds for discharged patients <ul style="list-style-type: none"> ▪ Day care facilities ▪ Primary Health Centre to be opened in 2007 • Services for older people with Parkinson's disease 		Ex-PCT 3	Annual Report 2004-2005

c) Orthopaedics

- *Service Redesign*

Action	Status	Organisation	Source
Refurbishment of a orthopaedic ward in the [Northern Hospital 1] to help reduce the number of cancelled operations	Completed	Northern Hospital 1	Annual Report and Accounts 2005-2006

Case-study: Southern LHE• Organisational configuration

The LHE is a large geographical areas, with the PCT covering one of the largest populations in England. The LHE relates mainly to 5 NHS Trusts, some of which operate across the border into other LHEs. Indeed, the LHE is an "open" system with a high degree of (patient and financial) flow and influence across its borders.

Table 7. NHS Organisations in Southern LHE

Southern SHA	<ul style="list-style-type: none"> • Formed July 2006 from the merger of 2 former SHAs
Southern PCT	<ul style="list-style-type: none"> • Formed in October 2006 from the merger of 5 PCTs • Catchment population 1.2 million • New PCT initially works in localities of former PCTs
Southern Hospital 1	<ul style="list-style-type: none"> • Catchment population 450,000 • Provides services from 2 hospitals:250 beds and 400 beds • Higher proportion of older people • Trust undertaking public consultation to become FT, June 2009
Southern Hospital 2	<ul style="list-style-type: none"> • Foundation Trust since April 2005 • 700 beds • Catchment population 365,000 • 2,500 staff • Annual turnover £100 million
Southern Hospital 3	<ul style="list-style-type: none"> • Formed in 1991 • 570 beds • 2,300 staff • Permission from SHA to apply to become FT, March 2009
Southern Hospital 4	<ul style="list-style-type: none"> • Formed in 1998 • Catchment population 350,000 • Over 2,500 staff
Southern Hospital 5	<ul style="list-style-type: none"> • Established in 1999 • Catchment population 500,000 • 1,000 beds • Provides services from two hospitals • 4,000 staff

• Financial position and performance

Southern LHE has faced longstanding financial difficulties. Several sources report on such difficulties. For example, according to the Audit Commission (2005), as of October 2005, NHS trusts and (pre-merger) PCTs in the Southern LHE were predicting a collective deficit of £75 million by 31 March 2006. The report also indicated an increasing number of organizations in deficit and some where the financial position had deteriorated. The LHE has proved short of capacity to deliver change, and the Audit Commission expressed concerns about the future "without a more effective and comprehensive performance culture" (p.5).

In the 2005-2006, Healthcare Commission Annual Health Check, three of the acute Trusts in the LHE were rated as weak in their use of resources with only "Southern Hospital 2" rated as excellent. Similarly none of the pre-merger PCTs were rated as excellent. Two PCTs presented particular concerns in terms of their financial position. Among the Acute Trusts, "Southern Hospital 4" showed a longstanding challenging situation. The size of the Trust's financial difficulties and its recurrent problems have been the object of several reviews including a Public Interest report (in March 2005). In March 2006, the Trust had published a new turnaround plan. In its 2006 Annual Report, "Southern Hospital 4" anticipated to reach break even by June 2007. The "Southern Hospital 4" did report a financial break-even in 2007-2008 but an underlying deficit of £2.6 million. By 2008-2009, it was forecasting a surplus of £7.0 million (both net and underlying). Yet, its financial difficulties remain problematic given the historic deficit that had been accumulated. The Trust itself reported that it was "one of 17 trusts formally described in 2007/08 as 'financially challenged' by the Department of Health because of its past deficits and the amount of debt it owed (Trust Annual report, 2007-2008, p.25).

The Chief Executive of the new Southern PCT reported that

"One of the first things the new PCT has sought to do is improve on the performance of those localities where their situation is a cause for concern and regular meetings have been established" (Chief Executive Report, November 2006, p.4).

This assessment was corroborated by the finance report of the PCT which indicated that

"...the financial pressures facing the new PCT are considerable.....the plans that are being developed by the Locality Management Teams and the work of the Programme Management Offices....will be crucial to the PCT delivering the best financial position" (Conclusions, PCT Finance Report,, October 2006).

In its annual audit letter (2007-2008), the Audit Commission reported that the Southern PCT had a surplus of £425,000 against the Revenue Resource limit of £1.4 billion (p.5).

- Financial flows

Table 8 and table 9 reports on the relationships between the pre-merger PCTs and Acute Trusts based on financial flows. From table 8, it is apparent that while Southern Hospital 1" and Southern Hospital 3" draws most of their activity from the LHE (81% and 83%), the catchment area of Southern Hospitals "2" and "4" go beyond the LHE (table 10). Table 9 shows that most of the resources from the pre-merge PCTs of the LHE are spent with providers within the LHE borders.

Table 8. Southern LHE: proportion of the Acute Trust budget received from the 'local' PCT

<i>Acute Trusts</i> ↓	<i>PCT</i> →	<i>Ex-PCT 1</i>	<i>Ex-PCT 2</i>	<i>Ex-PCT 3</i>	<i>Ex-PCT 4</i>	<i>Ex-PCT 5</i>	<i>Total</i>
Southern Hospital 1		57%	24%				81%
Southern Hospital 2			27%	11%			38%
Southern Hospital 3		3%	9%	69%	3%		84%
Southern Hospital 4					8%	32%	40%

Table 9. Southern LHE: Proportion of the former local PCTs contract spent in local providers

<i>Acute Trusts</i> ↓	<i>PCT</i> →	<i>Ex-PCT 1</i>	<i>Ex-PCT 2</i>	<i>Ex-PCT 3</i>	<i>Ex-PCT 4</i>	<i>Ex-PCT 5</i>
Southern Hospital 1		78%	36%	-	-	-
Southern Hospital 2		3%	8%	62%	2%	-
Southern Hospital 3		-	-	-	7%	66%
Southern Hospital 4		-	40%	15%		-
Southern Hospital 5		-	-	-	50%	3%
Total		81%	84%	77%	59%	69%

Table 10. Southern LHE: Proportion of local NHS Trusts budget received from non-local PCTs

Acute Trusts ↓	PCT →	PCT [i]	PCT [ii]	PCT [iii]	PCT [iv]	PCT [v]	Total
Southern Hospital 1		-	-	12%	-	-	12%
Southern Hospital 2		45%	8%	-	-	-	53%
Southern Hospital 3		-	-	-	-	-	-
Southern Hospital 4		-	-	-	16%	35%	51%

Source for all three figures: DH Purchaser-provider matrix

- Organisational performance

World Class Commissioning

The PCT Trust Board received a paper in March 2009 which summarised its own view of the WCC Panel's assessment. The paper stated that

"The outcome is broadly in line with other PCTs both nationally and in [Southern SHA] with the majority of competencies at level 1 and 2."

Critically however the panel felt that [Southern PCT]

"has strong potential for improvement, and would expect the PCT to continue to build on achievements to date over the next year."

The WCC Panel (2008) recognised that the Southern PCT had faced significant challenges across the LHE, notably in terms of achieving financial balance and organizational change. The Panel also noted that "Over the past 12 months the PCT have moved into a position of balance."

As for the future, the Panel recognised that, in the two years since the PCT was formed, it had been pre-occupied with financial balance and organizational change. However, it recommended that the PCT "move from a turnaround mindset to one which allows for strategic investment and delegation." The challenges of this shift require moving more activity out of the acute sector, ensuring appropriate governance structures, and securing competent leadership.

The PCT's work in developing "relationships with acute provision" (focusing on performance management) was recognised as a positive development but this contrasted with the need for similar development in primary care.

In terms of the 10 WCC competencies, the PCT assessed itself as level 2 in 7 competencies, level 3 in 1 area ("collaborate with clinicians") and level 1 in 2 areas ("prioritise investment" and "stimulate market"). Whilst the Panel agreed with the PCT in 5 of the 10 competencies, it rated the PCT lower than the PCT's own assessment. In one competency ("collaborate with clinicians"), the difference was between level 3 (PCT) and level 1 (Panel). Overall, the Panel agreed with 11 of the PCT's 30 self-assessment ratings.

- *Audit Commission:*

In November 2008, the Audit Commission conducted an audit of the PCT's "use of resources." As part of this assessment, it reported on the 2007 survey of patient perceptions (p.11). Only the last measure rated lower than the average.

Table 11. Patient perceptions

	Southern PCT	Average (median)
Offered choice of provider	96.9%	93.4%
Phone access	86.4%	84.5%
Able to get appointment within 48 hours	88.5%	84.3%
Opening hours	80.6%	84.6%

It also reported that the PCT's reference costs were 87.2 compared to an average of 101.5 (median)(index 2006-2007 including MFF).

- *Healthcare Commission annual health check*

The performance (according to the Healthcare Commission annual health check) of these organisations is summarised earlier and in 2.3.6. However, here, the Healthcare Commission data can also provide a more detailed analysis of each organisation's performance according to the national performance targets. This provides a more detailed assessment of performance compared to the 'headlines' in the table above.

Southern PCT:

Of the (new and existing) national targets in 2006-2007, the Southern PCT "failed" to meet 8 targets and "under-achieved" in a further 9 targets. However, by 2007-2008, the PCT had failed to meet 7 targets and under-achieved on a further 8 targets. Three of the 'failed' targets in 2006-2007 also failed in 2007-2008. Four of the previous 'failed' targets improved on this period by becoming 'under-achieving' whereas another 4 had gone in the opposite direction (previously 'under-achieving' and most recently, rated as 'failed').

Southern Hospital 1:

In 2006-2007, the Healthcare Commission assessed this Trust as having "failed" only one target ('Rapid access chest pain clinic: two week wait'), recorded one as "satisfactory" ('experience of patients') and two as "under-achieved" ('Cancelled operations and those not admitted within 28 days' and 'Thrombolysis - 60 minute call to needle time'). Data were not available in three targets and one target had "data not returned." By 2007-2008, the Trust still only recorded one failed target and under-achievement in 2 targets. With the exception of "experience of patients," all other targets were "achieved." In addition, in January 2008, the Healthcare Commission found that the maternity services at "Southern Hospital 1" were deemed among the 20% which were "least well performing."

Southern Hospital 2:

In 2006-2007, the Trust had performed well, as the Healthcare Commission rated all (new and existing targets) as achieved. Only the "experience of patients" was rated as satisfactory

six targets were either not applicable or data were not available. By 2007-2008, the experience of patients was still deemed satisfactory but the target "Information in place to support choice" was rated as "under-achieved." All other targets had been achieved. In addition, the Healthcare Commission rated this Trust's maternity services as among the 25% deemed "best performing."

Southern Hospital 3:

In 2006-2007, the Trust was deemed to have failed on 1 target (MRSA bacteraemia) and under-achieved on two targets ('Thrombolysis - 60 minute call to needle time' and 'data quality on ethnic group'). All other targets were achieved (with the exception of 1 target deemed satisfactory and 6 for which data was not returned or the target was not applicable). By 2007-2008, the Trust had improved its performance such that only 1 target was under-achieved, and 1 was satisfactory. (Two targets were deemed not applicable). In addition, the Healthcare Commission rated this Trust's maternity services as among the 21% deemed "fair performing."

Southern Hospital 4:

In 2006-2007, the Trust failed to meet the following targets: (i) Total time in A&E: four hours or less, (ii) waiting times for diagnostic tests, and (iii) Information, screening and referral for drug misusers. It also under-achieved or was below average for: (i) Cancelled operations and those not admitted within 28 days, (ii) Inpatients waiting longer than 26 weeks, (iii) Participation in audits, and (iv) Experience of patients. A further 5 targets were not applicable.

In 2007-2008, the Trust was deemed to have still failed 3 targets (Total time in A&E: four hours or less; Inpatients waiting longer than 26 weeks; Referral to treatment time milestones) and under-achieved on 2 targets (Cancelled operations and Participation in audits).

Its maternity services were rated the lowest category - "least well performing" - in January 2008 by the Healthcare Commission.

Southern Hospital 5:

In 2006-007, this Trust did not fail any of the (new or existing) national targets although four targets were scored as "under-achieved." One target (Experience of patients) was rated satisfactory and a further four were not applicable. In 2007-2008, the Trust failed on its "MRSA bacteraemia" target and under-achieved or were below average on another three targets (Cancelled operations and those not admitted within 28 days; Experience of patients; Referral to treatment time milestones). Its maternity services were rated the lowest category - "least well performing" - in January 2008 by the Healthcare Commission.

- Stated policy goals and approaches to key research themes (including tracer conditions)

Research themes:

This section cites extracts from local documentation in the Southern LHE which address initiatives that related to the core themes of the study: central-local relationships, national policies and local relationships in general. They are cited here to illustrate the broader themes which are explored in further detailed in the empirical fieldwork (see chapter 4)

(a) Central-Local Relationships

Quotes/Actions	Organisation	Source
"Of course we are driven by national priorities but we are also heavily influenced by the needs and views of the local population" (page 2; emphasis added)	Ex-PCT 1	Annual Report 2004-2005

(b) National Policies

Quotes/Actions	Organisation	Source
Practice Based Commissioning introduced during 2004, high level of interest from practices	Ex-PCT 1	Annual Report 2004-2005
Established a PBC local Board to oversee development of PBC in four clusters (2006)	Ex-PCT 5	Annual Report 2005-2006
First wave applicants for the National Primary Care Collaborative in the former SHA area to help the development of PBC	Ex-PCT 2	Annual Report 05-06
"We are sure that the new PCT will want to maintain and strengthen the local partnerships that have been developed so effectively over the past four years" (Page 4)	Ex-PCT 2	Annual report 2005-06
"Although the reorganisation of the PCTs had merged five PCTs... into one PCT, the previous PCTs would remain as localities of the main PCT in order to keep the business running." (Page 4)	Southern PCT	Chief Executive report, Southern PCT, November 2006
The PCT has also been working closely with local GPs to support Practice-Based Commissioning arrangements	Ex-PCT 4	Annual Report 2005-2006

(c) Local relationships

Quotes/Actions	Organisation	Source
<ul style="list-style-type: none"> • "We are strongly supported by our partnerships with [the County Council], and the borough councils" (page 24) • "We work closely with local hospitals, especially [Southern Hospital 1] to re-design patient pathways and provide as many treatments outside hospital as possible" (page 23) 	Ex-PCT 1	Annual Report 2004-2005
<ul style="list-style-type: none"> • "At the heart of all our improvements are the strong partnerships developed with our partners in social care, children services, local authorities, the voluntary and community sector and clinical and commissioning colleagues across the local NHS" (page 4) 	Ex-PCT 5	Annual Report 2005-2006
<ul style="list-style-type: none"> • Integrated Adult and Social Care Services (2002): "Such fully integrated approach is unique in this part of the country and has brought remarkable improvements (virtually eliminated bed blocking and reduced emergency bed days) (page 6) 	Ex-PCT 5 and [Southern] County Council	Annual Report 2005-2006
"PCT and [County Council] are considering a number of opportunities to jointly commission services with the portion of pooling budgets where there are benefits in doing so"	Ex-PCT 2 and County Council	Local Health and Social Care Plan 2006
Better Healthcare closer to home programme	Ex-PCT 4, Southern Ambulance Trust, Southern Hospital 5 and former SHA	Mid Southern PCT Annual Report 2005-2006
Collaboration between Southern Hospital 1 and Southern Hospital 2 and with the private sector	Declared in the strategic directions in 2001	Strategic Directions 2001-2006
The Trust has strong links with Ex-PCT 1 and Ex-PCT 4, being the main commissioners	Southern Hospital 5	Annual Report 2005-2006
The western area of the Southern LHE (including the three main providers) is working to develop sustainable models of care and reconfigure services around these models. A consultation of clinical leaders (which emerged in a number of recommendations but no formal decision making capacity) suggested that the goals for this part of the LHE should be to treat locally as many LHE patients as possible, integrate services across these providers and so avoid duplication and improve quality through specialization and	Southern PCT, Southern Hospital 1, 2, 3,	Clinical options workshop, March 2007

over time to have a single organizational entity. An area of focus in the discussion was urgent care (see below)		
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The five PCTs in the Southern LHE had been working together through the reconfiguration programme (2006-2008) with the aim of creating a local NHS that was sustainable and provided the appropriate care. A case-study of the reconfiguration finances are included in Chapter 4.

- *Tracers*

This section reports on issues that relate specifically to each tracer, including performance, organization of the service and local initiatives. These local initiatives have been categorised based on the themes of service re-design and access and integration. Where the documents reported a clear time range for the initiative, this is also reported together with the organization(s) involved and the documentary source.

(a) *Urgent care*

- *Performance against targets*

Organisation	Target
Southern Hospital 4	In 2006, the Trust met the 4 hour waiting target
Southern Hospital 3	In 2005, the Trust moved from being in the bottom three hospital for waiting time to be continually in the top five
Southern Hospital 5	In 2005-2006, 96.5 per cent of patients were assessed, treated and either admitted or discharged from Accident and Emergency (A&E) in less than four hours. Although still short of the 98 per cent target for all NHS Trusts, achievements this year demonstrate progress was made over a short period of time. A number of factors, including a steep rise in the number of attendances at both A&E departments during the winter months, contributed to the Trust failing to meet the target of 98 per cent during 2005-06.

- *Service re-design (A&E) and access to urgent care*

Action	Status	Organisation	Source
Reconfiguration of services: <ul style="list-style-type: none"> • Closed the A&E department on one site and on the same date opened a Walk-in Centre at the same facility for minor injuries • The reconfiguration will be facilitated by a number of PCT-led schemes to reduce inappropriate admissions 	February 2006	Southern Hospital 1	Business Plan 2005-2006
<ul style="list-style-type: none"> • See and Treat • Assessment and Treatment pilot project 	2004 ongoing	Southern Hospital 1	Ex-PCT 2: Local Health and Social Care Plan 2006
Trauma Services centralised on one site	Actual	Southern Hospital 1	Trust website
Participation to the 3 rd wave of a national initiative to review emergency services→ Rapid Assessment and treatment area (together with Ex-PCT 2)	2005-6	Southern Hospital 2	Ex-PCT 2: Local Health and Social Care Plan 2006
Redesign of emergency services: <ul style="list-style-type: none"> • Medical Assessment Unit • Emergency Nurse Practitioners • Close work relationships among specialties across the hospital (no additional specification) • Fast track protocols 	2002-ongoing	Southern Hospital 2	Ex-PCT 2: Local Health and Social Care Plan 2006. Southern Hospital 2: 2006 Annual Report
Based on the principles behind Better Healthcare Closer to Home, the PCT's Community Assessment Unit at [local] Hospital is providing a fast and effective alternative for patients who would have attended A&E. As a result of the initiative, more patients are being treated within the community and at home	Ongoing	Ex-PCT 4	Annual Report 2005-2006
Trauma Centre	Planned	Southern Hospital 2	Annual Report 2006
Trauma Services	Actual	Southern Hospital 4	Strategic directions 2006-2011
A Surgical Assessment Unit has been established which has improved the emergency care pathway for surgical patients and reduced waiting times in	2004-1005	Southern Hospital 3	Annual Report 2004-2005

Accident and Emergency			
Service redesign: "Meet and greet" nurse	2005-2006	Southern Hospital 5	Annual Report 2005-2006
Centralisation of trauma and emergency services on one site	Planned as part the "safe and sustainable service review"	Southern Hospital 5	Report 2005-2006
Emergency access plan: <ul style="list-style-type: none"> ▪ Planned date of discharge ▪ Clinical leadership Improve Epsom emergency be capacity <ul style="list-style-type: none"> ▪ Capital funding ▪ New emergency beds Close balancing beds		Southern Hospital 5	Business Plan 2006-2009

- *Integration - change across the whole Southern LHE:*

The DH Emergency Care modernisation agenda has been developed in the Southern LHE into the Southern Emergency Care system programme, an IT- based integrated model of urgent care involving the whole LHE (Acute Trusts, Ambulance Trust, Social Care and PCT). As part of this programme, the Ambulance Trust (now merged into the regional Ambulance Service) has been managing a capacity management system aimed at continuously monitoring the number of patients in acute units within hospitals in the county. However, while the programme has been planned for years and received full support by all the key players in the LHE, it is still not fully implemented. The main barriers appeared to be lack of financial resources, and difficulty in joint planning and resource sharing across the whole LHE (Navein and McNeil, 2003). It is envisaged that the "Shifting the Balance of power" agenda will resolve some of these issues by providing PCTs with the capacity to facilitate change.

- *Specific initiatives from Southern LHE organizations - pre-merger period*

Change	Status	Organisation	Source
"Work closely with Southern Hospital 1 to improve way patients are seen once they reach A&E" (page 12) → Part time GP on A&E of one site as part of urgent care system re-design	Pilot/ongoing	Ex-PCT 1	Annual Report 2004-2005
New Walk In Centre at Southern Hospital 3	2005	Ex-PCT 3 and Southern Hospital 3	Ex-PCT 3: Annual Report 2004-2005
Work to reduce waiting times in A&E and delayed discharges	2005 - no initiative	Ex-PCT 3, Southern	Ex-PCT 3: Annual

	specified	Hospital 3 and County Council	Report 2004-2005
Collaboration to provide out of hours services (no specification of what specific initiatives)		Ex-PCT 1, 2 and Southern PCT	Local Health and Social Care Plan 2006
Western area of Southern LHE is discussing how to define models of care for urgent care and reconfigure services accordingly. From a workshop of clinical leaders (March 2007), the following suggestions emerged: <ul style="list-style-type: none"> • Stronger demand management and better access to community care • Closure of one A&E department (FPH won't be closed as [Southern] is not main commissioners and the main commissioners have intention to keep it open) • Develop local emergency centres with clear clinical protocols and linkages of A&E departments to a trauma centre • Make sure the ambulance service work as a mobile clinical service 		Southern PCT, Southern Hospitals 1, 2 and 3	Clinical options workshop, March 2007

(b)Elderly care

- *Organisation of elderly patient care in the Southern County Council*
 - In 2002, the County Council was re-organised into 5 departments
 - The Social Service Department was separated into two services: Adult and Community Care and Children's Services (A&CC)
 - There are five local A&CC teams whose boundaries roughly coincided with those of the pre-merger PCTs
 - The medium term strategy of A&CC sets out how services will develop in the medium term. It includes objective of producing seamless services across health and social care and working closely with partners
 - Local Implementation Teams to oversee implementation of NSFs

- *Performance assessment of Social Care Services*

Overall, the performance regime (overseen by the (then) Commission for Social Care Inspection PAF) included 46 indicators across 5 domains (National priorities, cost and efficiency, effectiveness of service delivery and outcomes, quality of services, and fair access). The performance on older people care in the 2005-2006 performance assessment can be summarised as follows:

- Problems in moving older people to live at home
- Assessment of older people timeliness still to improve
- Rate of delayed transfers for 65+ for which the Council is responsible is dropping and better than national average

- *Integration*

Action	Status	Organisation	Source
Together with Southern Hospital 1 and Adults and Community Care progresses made against the NSF standards	Declared/no specific initiative reported	Ex-PCT 1	Annual Report 2004-2005
Coordination for stroke services improved → patients referred to community teams once discharged	Ongoing	Ex-PCT 1	Annual Report 2004-2005
Joint funding budgets	Ongoing-no specific aspects reported	Ex-PCT 1 and A&CC	Annual Report 2004-2005
Joint planning (social support, falls, mental health, stroke, delayed discharges) on health and social care. The plan jointly identifies main issues in elderly care in the Ex-PCT 1 area and provides a number of actions to meet them that involve the different actors in the community	Ongoing	Ex-PCT 1, A&CC and three local Borough Councils	Health and Social Care Improvement Plan 2004-2006
Developed service pathway for older people with complex needs for rehabilitation	Ongoing	Ex-PCT 3, Community and Adults Care, clinical staff and therapist	Annual Report 2005-2006
New Key Care Service (older people receive appropriate care)	Launched 2004-ongoing	Ex-PCT 3 and County Council	
Appointment of a joint services director for older people	2002-ongoing (?)	Ex-PCT 5 and A&CC	CSCI 2004 Report on elderly care in Southern LHE
Fully integrated management team leading to operational integration of front line services: "We were particularly impressed by the level of partnership and mutual respect in [Ex-PCT 5 area] amongst key partners" (page 22)	2004-ongoing (?)	Ex-PCT 5 and A&CC	CSCI 2004 Report on elderly care in Southern LHE
Co-location of A&CC area management team and health colleagues	2004-ongoing	Ex-PCT 1 and A&CC. Ex-PCT 4 and A&CC	CSCI 2004 Report on elderly care in Southern LHE

Improvement of care for older people who experience falls (overlapping between elderly and emergency care; no specific initiative reported)	Ongoing	Ex-PCT 2 and Southern Ambulance Trust	Annual Report 2005-2006
Joint Planning on health and social care (page 17): <ul style="list-style-type: none"> Created a multi agency Health & Social Care Planning Group Quality of life and independence Mental health Stroke → joint stroke coordinator with Ex-PCT 1 from Southern Hospital 1; similar approach explored for Ex-PCT 2 	2006 – 3 years	Ex-PCT 2 and A&CC and 4 Borough Councils	Health and Social Care plan, March 2006
Single Assessment process	From 2004	Ex-PCT 2 and A&CC	
Specialist rapid response service for falls (aim to provide right service in the right place and avoid unnecessary visit to A&E)	2004	Ex-PCT 2 and Southern Ambulance Service	
Working partnership with Social Services → number of delayed transfers of care reduced from 50 plus at its worst to single figures.	Ongoing	Southern Hospital 3 and Social Care	Annual Report 2004-2005
Jointly funded a falls coordinator	Ongoing	Ex-PCTs and Borough Council	Southern PAF 2005-2006
Joint strategy for older people with mental health problems		All Ex-PCTs	Southern PAF 2005-2006
Partnership for Demential Collaborative	Ongoing	All Ex-PCTs and A&CC	Southern PAF 2005-2006
The Annual Report 2004-2005 declares : "The Trust has developed links with local authorities through the overview and scrutiny committee and through specific projects such as std 1 NSF older people – rooting out age discrimination" ..." The Service Improvement Plan for older people's services has also seen some beneficial multi-organisational working" (page 8)		Southern Hospital 5	Annual Report 2004-2005

- *Service redesign and community care*

Action	Status	Organisation	Source
<ul style="list-style-type: none"> • Community Matrons • Intermediate Care team for older people rehabilitation at home • Stroke services • Community Hospital expanded to become a rehab centre 	ongoing	Ex-PCT 1	Annual Report 2004-2005
<ul style="list-style-type: none"> • Falls prevention strategy • Orthopaedic patients suitable to be transferred to community 	Planned	Ex-PCT 1	
Commissioning of beds to reduce emergency bed days	Actual-2005	Ex-PCT 5	Annual Report 2005-2006
Community matrons team	Ongoing	Ex-PCT 2	Annual Report 2005-06
Rapid Access Clinic opened on one site to provide (mainly older) patients with speedy assessment and treatment in one place, aimed at preventing unnecessary hospital admissions. The clinic is staffed with specialist geriatricians	November 2005	Southern Hospital 1	Annual Review 2005-2006

(c) *Orthopaedics*

- *Service re-design*

Action	Status	Organisation	Source
Reconfiguration of services: <ul style="list-style-type: none"> • negotiation with Capio for an orthopaedic independent treatment centre at Southern Hospital 1 which should be opening during 2006 • One site of Southern Hospital 1 is set to become a centre for Day Surgery and elective Orthopaedic care (along with a new rehabilitation centre) with the majority of planned orthopaedic joint replacement surgery 	No further specification on timing and change	Ex-PCT 1 and 2	Ex-PCT 1: Annual Report 2004-2005. Southern Hospital Business Case for Service Reconfiguration 2005 and Business Plan 2005-2006
Agreement with BUPA to establish a dedicated diagnosis and treatment	December 2002	Southern Hospital 4	Trust web-site

centre (DTC) for NHS patients using the BUPA unit co-located with local hospital.			
Expansion of a Multi-professional Orthopaedic Triage team, a community-based service	Actual	Ex-PCT 3	
Scheme for discharges in orthopaedics adopted by all orthopaedic consultant	2005-ongoing	Ex-PCT 5	Annual Report 2005-2006
As part of the development of PBC, one practice is reviewing ways of providing orthopaedic treatments in primary care settings and redesign it (no other indication on actions actually taken)	2005-ongoing	Ex-PCT 2	Annual Report 2005-2006
The regional Elective Orthopaedic Centre is based on one site of Southern Hospital 5 and currently provides services for four acute Trusts.	March 2004	Southern Hospital 5	Annual Report 2005-2006

Appendix 3. Tracer conditions

Tracer: Care of the elderly

Policy framework, guidance and main issues

1. Introduction

As in many Western countries, in England the number of people over 65 has been steadily increasing over time posing a tremendous challenge to the NHS and social care in terms of addressing their needs and demands. However there has been mounting evidence of widespread problems in elderly care including age discrimination, lack of dignity and respect, inappropriate hospital admissions, delayed discharges due to lack of alternative service arrangements and early and unnecessary institutionalization of elderly.

These concerns have progressively brought elderly care to the centre stage culminating with the NHS Plan 2000 that started a period of intense reform and investment characterised by a focus on the whole system (i.e. the complexity of services and actors, NHS and non-NHS, involved in the care of older people). The ethos of the reform agenda was centred on promotion of dignity and respect, access to services, promotion of independence and well-being, responsiveness to older-people prevalent conditions (e.g. stroke, falls, mental health etc) and appropriate treatment of the elderly in hospitals and institutionalised settings. The focus on the whole system implied that joint working and coordination among the different actors involved was to become the model of delivering services.

The National Service Framework for older people care (2001) is the centre of this programme of reform. Nationally, the implementation of this programme has been supported by a consistent investment, and the production of guidance, and monitored through the incorporation of elderly care in the performance management system, to be integrated with the performance framework for local governments.

This review looks at the policy context for elderly care, in terms of its policy framework, and national guidance. It also describes current issues and challenges in elderly care and the way these challenges are dealt with nationally.

2. Policy framework

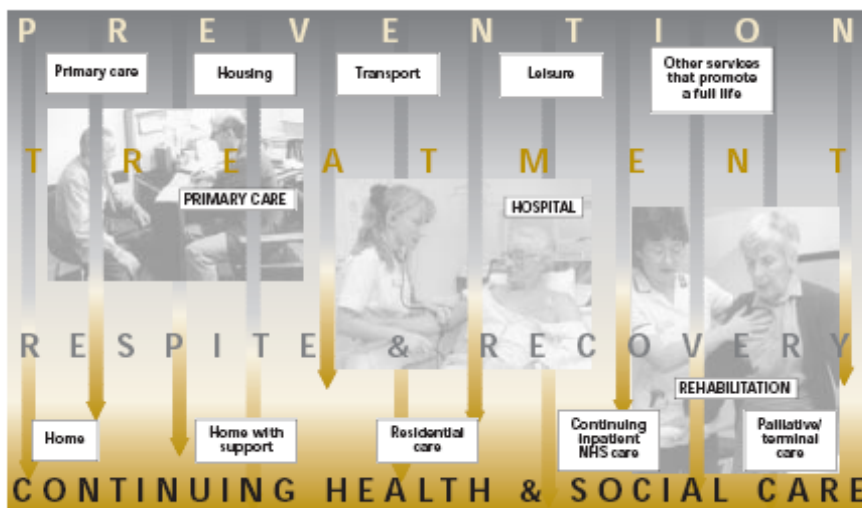
2a. Policy planning and priorities

The vulnerability and complex needs of older people necessitate access to a broad range of social and health-care services. These services encompass prevention, treatment, recovery and continuing care for those with disabilities impeding independent living (see figure 1). Furthermore many of these services interact requiring the coordination of different agencies responsible for their provision, including the NHS, local authorities and increasingly the independent sector (Audit Commission, 1997).

In the 1990s, reports suggested that the status of elderly care was not prepared for the challenges presented by a steadily aging population. Common problems involved age discrimination in both health and social care, considerable variation in access to services (by geographical area and other factors such as race), lack of dignity and respect, poor assessment systems, poor specialist services for age-related needs (such as falls, stroke and mental health) and lack of services between hospital and the community causing unnecessary hospital admissions, delays in discharge from hospitals and premature admissions to residential facilities. For example in a 1997 report on the status of elderly care services, the Audit Commission concluded that the provision of healthcare and social services was "locked in a vicious cycle" (p.39) characterised by the lack of community services (e.g. rehabilitation services and other intermediate care) and an increasing focus on acute care and residential settings, which would further impede the release of resources to be invested in the development of these local alternative services. The main result of this cycle being inappropriate hospitalizations, delays in discharges and premature placement in residential homes.

This conclusion was subsequently reinforced by the National Bed Inquiry (DH, 2000) suggesting that a significant number of elderly stayed in hospital longer than necessary, with a wide geographical variation in the use of acute beds and availability of alternative services.

Together, all these services provide a wide range of support.



Source: Audit Commission

Fig 1. Services to help older people

The longstanding lack of clarity in the distribution of responsibility between NHS and local government, the differences in funding systems (the first organised and paid nationally and mostly free at the point of use, the second funded according to local decisions and means-tested in most areas), and in planning and budgeting cycles greatly contributed to the aforementioned problems, and significantly hampered integration and coordination across health and social services.

Several policy initiatives have attempted to tackle the various issues related to the provision of care to older people. For example, in 1998 the documents *Modernizing Health and Social Services* (DH), and the White paper *Modernising Social Services: promoting Independence, improving protection, raising standards* affirmed the commitment towards promotion of independence, including maintenance of independence for the healthy elderly, through prevention and rehabilitation centred in community-based care. Emphasis was given to partnership working across health and social care. To facilitate collaboration between NHS and local governments, changes to the legal frameworks were introduced with the Health Act 1999, where provisions were made under Section 37 that allow for pooled budgets, lead commissioning and integrated provision.

Building on these ongoing efforts, the NHS Plan (2000) made elderly care a top priority and set the foundation for a major plan of reform cutting across health and social care services. The goal of such reform was to radically shift existing attitudes towards the elderly and to change and improve the system of service provision to older people. The reform program was grounded around a number of key elements: (i) standards of care; (ii) access to services; (iii) promotion of independence; (iv) prevention and promotion of older people health; and (iv) fairness in funding.

“In future older people must not be left to find their own way around the system or left in a hospital bed when rehabilitation or supported care is what they need. They must receive the right care at the right time in the right place.” (NHS Plan, 2000, p.71)

The plan identified joint working and integration between health and social care as a paramount instrument to deliver the reform agenda. For example access to services had to be improved through a single assessment process for health and social care aimed at defining a comprehensive package of health and social services for older people. Joint working was to be built on the legal flexibilities provided by the Health Act (1999), using Local Strategic Partnerships as the umbrella framework. Two additional key aspects of this strategy were investments in health and social services, especially towards the enhancement of intermediate care and the building of capacity at the local level. Furthermore, indirectly, elderly care was to be

improved by tackling other issues addressed in the Plan, such as waiting times and clinical priorities (e.g. cancer and coronary heart disease).

In 2001, the National Service Framework for older people operationalised the programme of reform set out by the NHS Plan (2000). This operationalisation revolves around three aspects: (a) standards of care to be achieved locally by health and social services; (b) definition of the performance management framework aimed at monitoring the delivery of the standards; and (c) national programmes to support the delivery of the standards.

In line with the NHS Plan, the standards are around four major themes: (i) Respect of the individual; (ii) Intermediate care; (iii) Provision of evidence-based treatment in hospital settings and for stroke, falls and mental health; and (iv) Promotion of health and active life (see table 1). For the sake of clarity standards, aims, key areas (when applicable) and key interventions are summarised in table 1.

Standard	Aim	Key areas	Key Interventions
Respect of the individual			
Std. 1. Rooting out discrimination → health and social services provided regardless age	Ensure elderly are not discriminated		<ul style="list-style-type: none"> ▪ Joint working ▪ Managerial and clinical leadership ▪ Policy review and rolling program of action ▪ Workforce development ▪ Communication
Std. 2. Person-centred care → NHS and social services treat elderly as individuals and enable choice	Older people are treated as individuals receive appropriate and timely packages regardless of health and social services boundaries.		<ul style="list-style-type: none"> ▪ Personal and professional behavior ▪ Provision of information to service users ▪ Joint commissioning arrangements ▪ Integrated approach to service provision: <ul style="list-style-type: none"> ○Single assesment process ○Integrated community equipment services ○Integrated

			continence services
Intermediate care			
Std. 3. Intermediate care → access to a new range of intermediate services from NHS and local councils for preventative care, rehabilitation and continuing care	to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living	<ul style="list-style-type: none"> ▪ Response to crisis ▪ Active rehabilitation ▪ Continuing care 	<ul style="list-style-type: none"> ▪ Integration across the whole system ▪ Clear clinical and managerial accountability ▪ Joint commissioning and pooled budgets ▪ Community equipment and housing improvements
Evidence-based treatment			
Std. 4. General hospital care → elderly care delivered through appropriate specialist care and by staff with the right set of skills	Ensure elderly receive specialist help in hospital and maximum benefit		<ul style="list-style-type: none"> ▪ Develop emergency response for elderly ▪ Early assessment ▪ Ongoing care in hospital wards (guidance for good management) ▪ Discharge planning ▪ Specialist old age team and definition of an effective service model
Std. 5. Stroke → NHS take action to prevent strokes working with other agencies; people who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist and participate to programmes of rehabilitation and secondary prevention	Reduce the incidence of stroke and ensure access to integrated stroke services	<ul style="list-style-type: none"> ▪ Prevention ▪ Immediate care ▪ Early and continuing rehabilitation ▪ Long-term support 	<ul style="list-style-type: none"> ▪ Reducing risk factors: <ul style="list-style-type: none"> ○ Population approaches (e.g healthy eating) (std. 8) ○ Individuals at greater risk ▪ Specialist stroke services within stroke unit (to coordinate with community professionals and primary care) ▪ rehabilitation in hospital and coordinated care

			planning after discharge <ul style="list-style-type: none"> ▪ Continuing care (std 2)
Std. 6. Falls → The NHS with councils takes action to prevent falls; older people who have fallen receive treatment, rehabilitation and advice on prevention through a specialised falls service		<ul style="list-style-type: none"> ▪ Prevention ▪ Diagnosis, care and treatment ▪ Rehabilitation and long-term support 	<ul style="list-style-type: none"> ▪ Reducing risk factors: <ul style="list-style-type: none"> ○ Population approaches (e.g safe pavements) (std. 8) ○ Individuals at greater risk ▪ Specialist fall service ▪ Staff development ▪ Coordination
Std. 7. Mental health → Older people with mental health problems have access to integrated mental health problems by NHS and councils to ensure effective diagnosis treatment and support	Promote good mental health and support those with dementia and depression	<ul style="list-style-type: none"> ▪ promotion ▪ early recognition and management ▪ access to specialist care 	<ul style="list-style-type: none"> ▪ coordination and integration ▪ specialist service ▪ care pathways for depression and dementia

To reiterate, the NSF for older care people focuses attention on the priority areas of prevention, promotion of health and independence, intermediate care, and specialist care for prevalent conditions (i.e. stroke, falls, dementia and depression). Underpinning these priorities are the following themes:

- working across organizational and professional boundaries through the implementation of new procedures (joint commissioning, SAP, multi-disciplinary teams),
- definition of clear accountability and responsibilities,
- development of a new range of services in the community,
- leadership, and
- workforce development.

The integration agenda across health and social care envisaged by the NHS Plan and operationalised in the NSF for older care has been further promoted in subsequent policy documents. The 2005 *Green Paper Independence, Well-being and Choice* and the White Paper (2006) *Our Health, Our Care Our Say* bring forward the agenda with further attention on four key areas: i) choice; ii) prevention; and iii) promotion of health. The White paper also addresses issues of access to community

services and support for people with long-term needs. Each of these areas involves older people.

Partnership working and integration are confirmed as paramount instruments to deliver the change agenda. To support the achievement of good partnership working, the document sets out a revision of the framework within which local services work, including the development of LAAs, the alignment of planning and performance management for NHS and local government, and a strong role for the Director of Adult Social Care in terms of inter-agency coordination. The reconfiguration of PCTs, by creating coterminosity with local governments, is also envisaged to facilitate joint working. Furthermore the document points to direct payments and individual budgets as the mechanisms to empower choice and control for people who need social care services.

The different funding regimes for health and social services still represent a significant barrier to integrated services. The 2007 Comprehensive Spending Review will address the funding of social care informed by the final report of the local government inquiry (carried out by Sir Michael Lyons). Also the independent report from the Wanless *Social Care review, Securing good care for older people: taking a long term view* (2006) provides some foundation for the forthcoming spending review.

2b. Regulation and performance management

The achievement of the standards set out in the NSF for the care of the elderly is assessed through the identification of specific performance measures within the performance assessment frameworks (PAFs) of social services and healthcare services respectively. The Health Care Commission has responsibilities over monitoring the implementation of the NSF. Its reviews involve both health and social care organizations. The Social Service Inspectorate (the Commission for Social Care Inspection since 2004) has responsibilities over the monitoring and inspection of social services. Since April 2002 the National Care Standard Commission inspects private and voluntary care homes, private health care sector and domiciliary care agencies. National oversight is carried out through the task force for older people within the NHS Modernisation Board, both established in 2000.

As the differences in funding system, the operation of parallel performance management systems for health and social services represents a relevant barrier to joint working and integration. The White paper *Our Health Our Care our Say* (2006) addresses this issue and envisages the alignment of the performance management systems for health and social care as the necessary step to reinforce and enable joint working and the delivery of common outcomes. This alignment is to be

facilitated by a proposal to merge the Commission for Social Care Inspection with the Health Care Commission by 2008.

“If we want services to work together to deliver common outcomes, we need to ensure that performance measures for services reinforce and help deliver health and well-being outcomes”. We will therefore take forward the development of performance assessment regimes to achieve this, reinforced through inspection.” (pag 42)

The White Paper sets out additional revisions to the performance management framework aimed at strengthening the incentives to joint working and to investment in areas such as prevention and community care. These revisions include the development of performance measures on joint working activities of local governments and NHS organizations as well as on preventive spending. For example, the document proposes the inclusion of commissioning functions within the performance assessment framework to make sure joint commissioning becomes a major part of the commissioning work of PCTs and local government.

“we will make commissioning more important in performance assessment.CSCI and the Healthcare Commission will inspect local commissioners to ensure joint commissioning becomes a major part of commissioning” (White paper, 2006, pag 168)

By the same token, Primary Care Trusts are to be scrutinised against preventive spending targets from 2008 onwards in order to promote spending on prevention.

2c. Incentives

The performance management system within which the delivery of the standards for older people care is incorporated is backed up by explicit financial incentives to strengthen joint working and collaboration across health and social services. As the NHS Plan 2000 states:

“Local authorities, health authorities, primary care groups and primary care trusts will receive incentive payments to encourage and reward joint working. In the case of health organisations it will be through the National Performance Fund (see chapter 6). In social services £50 million a year will be available from April 2002 to reward improved social services joint working arrangements based on measuring performance from 2001. From April 2003 the fund will rise to £100 million. It will operate as a ring fenced grant and will be focused initially on intermediate care performance. There will be common criteria between the funds” (p.72).

As an additional incentive to partnership working with the specific aim of tackling the issue of delayed discharges, since 2004 local authorities have been charged for avoidable discharge delays, where it is clear that they bear a responsibility (Community Care Act, 2003).

Additional incentives to partnership working, development of community services and quality improvement of services are likely to be generated by a number of mechanisms introduced with the White Paper *Our health, our care, our say* (2006). First individual budgets and direct payments are aimed at empowering people and increasing choice. Second, PBC should provide the necessary incentives to commissioner to develop new models of care outside the hospital settings and strengthen prevention and early intervention. Third the introduction of PBR should support such development by making clear the cost of inefficiencies.

“Payment by Results (PBR) makes real to commissioners the benefits of improving care for people with long-term needs, by making clear the costs of preventable illnesses, avoidable emergency admissions, poor medication prescription and use, and lack of preventative investment in social care. The combination of PBC and PBR will encourage commissioners to seek out providers who offer better quality care, particularly for those that are the most intensive users of health care” (p.121).

Refinements to the current tariff system with the aim of unbundling tariffs to reward PCTs for moving rehabilitation services outside the acute hospital setting are under consideration (Health Service Journal 19 October 2006). These refinements, if implemented, are likely to strengthen PBR-related incentives to change the system of care to older people.

3. Policy guidance

3a. Clinical guidance

In line with the service models envisaged by the NSF for older people, NICE has published a number of guidelines. For example, in November 2004, NICE has published guidelines on the assessment and prevention of falls in older people living in the community. Guidelines for Dementia have been published in 2006 and further reviewed in January 2007. Other National Service Frameworks (e.g. NSF for coronary disease and mental health) includes standards that affect practice for the care of older people.

3b. Guidelines, programmes and support

Local delivery of the reform agenda for elderly care and the standards set up in the NSF (2001) have been variously supported by DH over time. The NSF itself provided for the establishment of a national work group to guide the implementation of the single assessment process, one of the pillars in which collaboration and integration across services was to be grounded. The work of this group resulted in the publication of guidance in 2002 with the aim of standardizing the approaches to assessment across agencies. Further guidance have been produced in the form of checklists to support particularly challenged localities.

Other aspects of elderly care addressed in the NSF have been object of guidance from DH. For example, guidance documents were produced to support the improvement of care for older people in hospital settings according to Standard 4 of the NSF (General guidance on implementing standard 4 of the NSF and General Hospital Care – CE Check List, January 2004). Guidance have been produced to support the achievement of standards on falls through improved commissioning processes (*How can we help older people not fall again?* 2003), as well as standards on mental health.

Mental health improvements are further supported by the programme Care Services Improvement Partnership's older people's mental health, that works through a range of projects to support mental health services across organizational boundaries. Everybody's business, launched in November 2005 is an example of the Partnership work and has been identified by the HCC and the CSCI as the benchmark to be used for inspection of services.

4. Current reflections on elderly care

Since the publication of the NSF for older care in 2001, much progress has been made to change and improve health and social services to older people as reported by various source of assessments (HCC, Audit Commission and CSCI, 2006; Philp, 2004, Wanless Review, 2006; Royal College of Physicians, 2004). However there is still room for improvement in many areas and several challenges remains to be faced. Table 2 summarises progresses, challenges and next steps looking at a number of areas that have been identified as key issues to ensure improved services to older people.

Table 2. Achievements and challenges in delivering change in services for older people

Areas	Achievements	Challenges
1. Dignity, discrimination and equality	Improved access to key elective procedures (e.g. cardiac surgery)	<p>Still evidence of ageist practice or behaviour</p> <p>Access issues in mental health still relevant</p> <p>Issues of equality and diversity and geographical variation (rural versus urban)</p> <p>Still poor experiences in hospitals</p>
2. Service care systems redesign		
2a. Involvement, choice and control	Uptake of direct payments is starting to grow	<p>Still little systematic involvement of older people in service planning and no shared vision based on their views</p> <p>Room for improvement in choice and control</p>
2b. Integration and joint working	<p>Shared vision starting to emerge</p> <p>Leadership stronger in local authorities</p>	<ul style="list-style-type: none"> • SAP across social and health care still not operational • Development of explicit strategies and plans • Joint commissioning strategies • Governance and accountability in partnerships • Partnership working at the operational level • System to monitor progresses • Usage of pooled budget • Leadership in the NHS • Joint workforce development strategies

		<ul style="list-style-type: none"> • Involvement of the independent sector • Problems in large counties where also districts operate • Learning and sharing of good practices
2c. Investment in community/intermediate care	<ul style="list-style-type: none"> • Increase in intermediate care services • Increase in the number of people cared for at home • Increased capacity and choice for long-term care needs • Reduction in delayed discharges 	<ul style="list-style-type: none"> • Variation in the level of services • Leadership and coordination in the development of services
3. Stroke	<ul style="list-style-type: none"> • Development of integrated networks • Development of both acute and community services • Stronger leadership • Development of acute specialist stroke service and stroke unit • Development of agreed joint protocols for referral and management of people with a mini stroke • Joint workforce training and development 	<ul style="list-style-type: none"> • More work on awareness and prevention by working on agreed protocols for prevention and management
4. Mental health	Limited progresses in the provision of integrated service	<ul style="list-style-type: none"> • Challenges in the creation of integrated services • Lack of shared visions and planning (fragmentation of services) • Lack of joint commissioning • Underfunding • Lack of skills to deal with mental health problems • Lack of intermediate services • Lack of services to promote mental health • Inconsistent use of agreed protocols for

		depression and dementia
5. Falls	74% of Trust have part of a coordinated integrated and multi agency service for falls (Audit from the Royal College of Physicians, 2006)	<ul style="list-style-type: none"> • Further need to develop shared strategies identification of a fall coordinator and clear lines of accountability • Review of agreed protocols and monitoring of usage and impact • Coordinated interventions to prevent falls • Collection and use of data to inform commissioning and provision of services
Prevention and promotion of health	<p>Increasing uptake of cancer screening, flu vaccination and smoking cessation</p> <p>Increasing attention to promote well-being and independence of older people</p>	Widespread lack of explicit and coordinated approach to prevention and promotion

The document *A new ambition for old age: next steps in implementing the national service framework for older people* (2006) takes up these challenges and defines the next phase for the implementation of the NSF for older people. The next phase involves ten programmes under three areas: (i) Dignity in care; (ii) Joined up care; (iii) healthy ageing. The recent document *Our Health, our care, our say: making it happen* (2006) provides further guidance and support to local actions for the implementation of the integration agenda. Table 3 summarises the aforementioned programmes:

Table 3. Next steps in the implementation of the NSF for older people

Programme	Main aims
1. Dignity	
Dignity in care	<ul style="list-style-type: none"> • Nutrition and clinical environment • Workforce competence and skills • Mental health • Quality • End of life • Human rights • Information and awareness
Dignity at the end of life	<ul style="list-style-type: none"> • Spread of best practice models • Best practices in commissioning, delivery and education in end of life in home care
2. Integration	
Stroke services	<ul style="list-style-type: none"> • Raising awareness • Rapid access to treatment for TIA • Emergency response to stroke • Recommend ways of working in the acute phase of stroke • Support survivors • Workforce development
Falls and bone health	<ul style="list-style-type: none"> • Extend local initiatives to improve falls prevention • improve emergency response to falls • develop fall assessment services in every economy • increase osteoporosis services • improve rehabilitation
Mental health	<ul style="list-style-type: none"> • Equality • Workforce development • Comprehensive specialist services • Promote mental health
Complex needs	<ul style="list-style-type: none"> • Coordination of care • Strengthen commissioning arrangements • Develop managed networks • To build on development in intermediate care
Urgent care	<ul style="list-style-type: none"> • Redesign urgent care response to falls, mobilizing intermediate care to avoid inappropriate attendance of A&E • Redesign urgent care for people with mental health problems • Redesign urgent care response to TIA and stroke
Care records	<ul style="list-style-type: none"> • Fit SAP in the work of developing personalised and integrated record systems

3. Healthy ageing	
Healthy ageing	<ul style="list-style-type: none"> • Promote prevention • Improve access to services for older people socially isolated • Overcome barriers to active life • Improve physical fitness
Independence, Well-being and choice	<ul style="list-style-type: none"> • Increase use of assistive technology • Strengthen leadership and collaboration • Increase use of direct payments and individual budgets • Increase uptake of response to carer's needs

5. Discussion

The review of the policy context for elderly care allows a preliminary assessment of the formal decision space available to local managers in this area. Not only has government made elderly care a priority of its health reform agenda, but also it has explicitly indicated the directions of this reform at the local level. The policy context for elderly care dictates a shift along the continuum of care towards prevention, promotion of health and recovery. This shift has been guided in a number of ways: first, through the definition of standards that encompass both expected outputs and the implementation of specific processes, for example specific instruments of collaboration such as SAP; second, through the incorporation of these standards in the performance management framework; and third, by setting a system of incentives towards the implementation of such processes (e.g. integration). The production of NICE guidelines adds a further element to the treatment of elderly people with specific conditions. Overall, one could argue that the space local managers have available from the top with regard to elderly care issues is quite constrained in terms of targets as well as routes to reach those targets. However, some room for local creativity remains in the way specific instruments are implemented and managed and collaborative initiatives are initiated.

The review also highlights the relevance of service interdependences in elderly care as well as their complexities in spanning across the boundaries of health and social care, and the voluntary and independent sector (mainly for continuing care), which has at least two consequences. First, these inter-dependencies imply that the LHE for elderly care is likely to be particularly dense and to involve several actors, although its shape will vary greatly across different areas. For example it will be different in areas with unitary councils versus areas with district councils. Second, they imply that individual and collective performance in elderly care will strongly depend on how these interdependencies are managed locally. Managing these inter-dependencies is particularly challenging in the face of the historical structural and cultural divides across the different organizations involved. While some structural barriers can be addressed through policy changes (such as PCT reconfiguration to

make PCTs coterminous with local governments; same PAF), other structural barriers (the way different councils have organised their social care services) and cultural barriers (between social and healthcare professionals) will require local adaptation.

Tracer: Emergency care

Policy framework, guidance and main issues

1. Introduction

The problem of long waits and poor experiences of patients at each stage within the emergency care system was evident since the mid 1990s. As a consequence, emergency care became a priority in the modernization agenda set out by the NHS Plan in 2000. The ethos of the modernization agenda demanded a radical reform covering hospital care and A&E departments as well as ambulance services, primary care, community and social care. The approach has been that of increasing the resources available (to A&E departments, ambulance and community care), fully integrating emergency care in the NHS performance management framework and providing financial incentives. In addition, emergency care targets have been set in the context of a 10 year strategy and their achievement supported and facilitated by a number of initiatives by the Department of Health (DH).

This review looks at the policy context of emergency care, in terms of policy planning and priority, incentives and DH guidance and facilitation. This helps to identify the "outer" context. (Pettigrew et al , 1992) for emergency care. It also describes current issues and challenges in emergency care. Finally, the paper re-discusses emergency care in terms of the theoretical concepts of "decision space" (Bossert, 1998) and LHE/inter-organizational collaboration.

The paper is organised into five further sections:

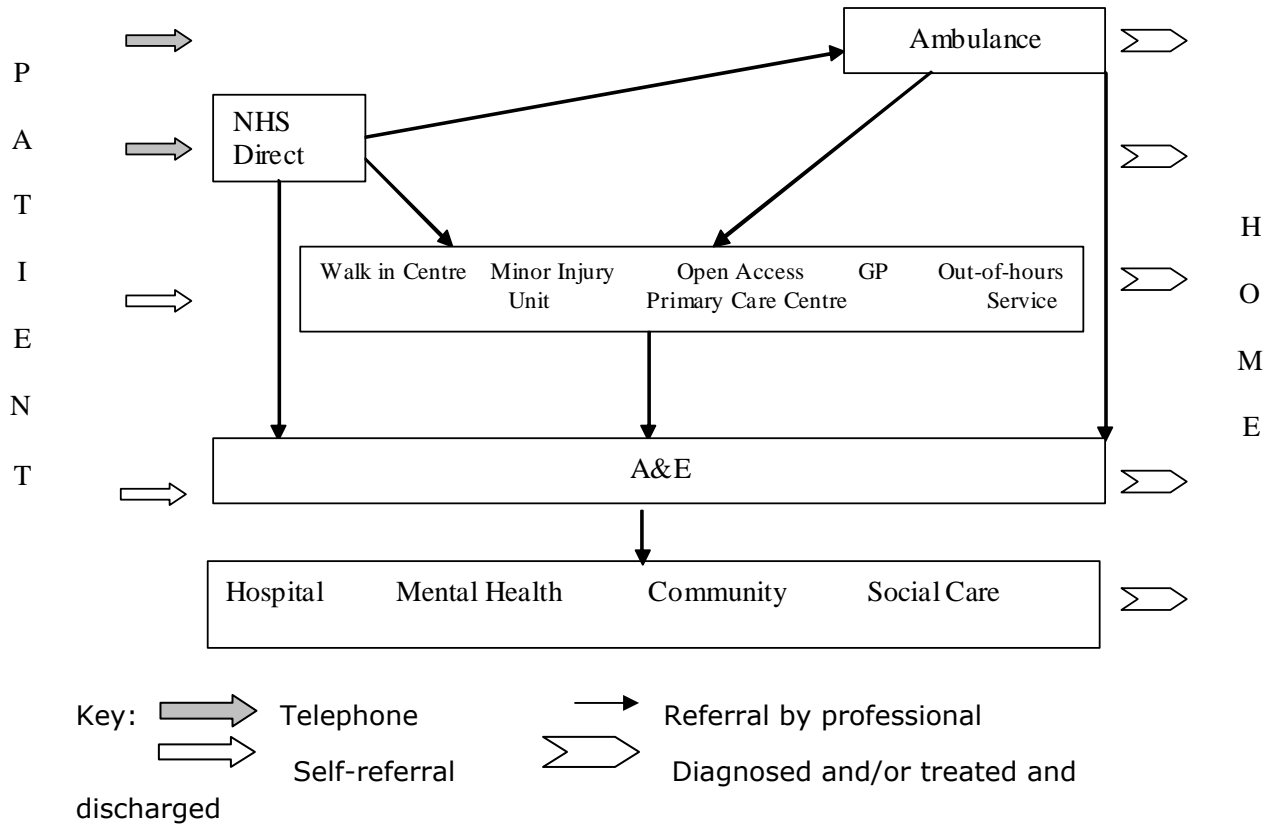
- The emergency care system
- Policy framework
- DH guidance on emergency care
- Current issues in emergency care
- Discussion

2. The emergency care system

Emergency care depends on a complex system of services of which A&E department is only a component. The experience of the patient in his/her journey through this system depends therefore on the functioning of the different components as well as

their coordination. Figure 1 describes the flow of patients through the emergency care system and highlights the components of the system.

Figure 1: The Emergency Care System



Source: National Audit Office

The A&E department can be seen as the centre of this system. There are some components that sit before the A&E department. These components are comprised of services that function as alternatives to A&E (e.g. walk in centres etc.) and/or as channels through which a patient accesses A&E departments.

These components are:

- NHS direct
- Other health-care professionals (walk-in centres etc.)
- Ambulance services
- GPs

Of course, patients may refer themselves to A&E department or to other health care professionals.

The functioning of and the ease of access to these services will determine whether patients go to the right place (where their needs can be appropriately attended to)

and how many of them arrive to the A&E departments, thus constituting a first element of potential influence on waiting times (Matthew Cook, 2004 SDO report).

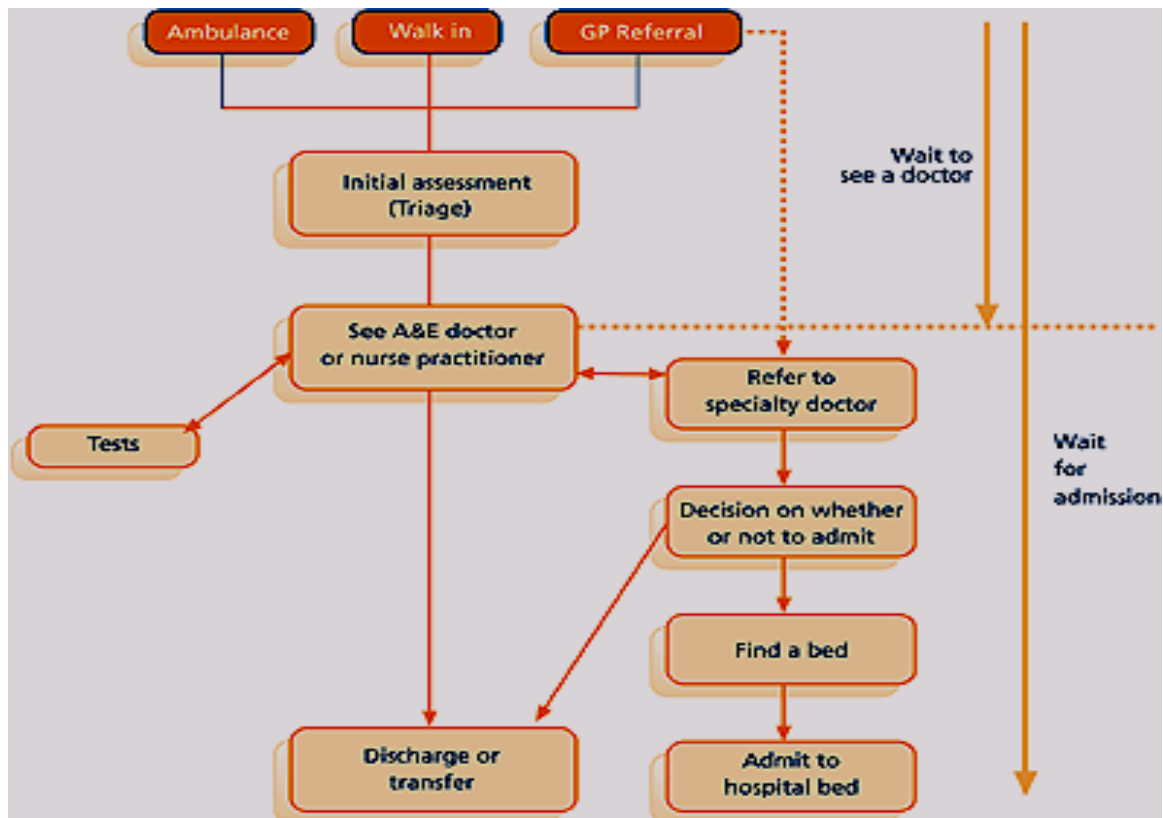


Figure 2: Patient Journey through A&E Department

Source: Audit Commission, Accident and Emergency Acute Portfolio, 2001

Figure 2 shows the pathway of patients within A&E. Patients are initially assessed and then seen by a doctor or a nurse who can diagnose and treat or refer to a specialist. Depending on the condition, patients can be discharged, admitted or kept for further observation in A&E. Specific categories of patients will need the intervention of specialists outside the hospital (e.g. mental health and social care

Within the A&E departments, delays are determined by an imbalance between resources, typically staff availability, and workload, as well as working practices of the department

The outflow of patients from the A&E department (discharge or admission) depends on an additional cluster of services which involves the rest of the hospital (e.g. tests, specialists and beds) as well as actors outside the hospital such as mental care and social care providers. Bottlenecks at these levels of care can cause obstruction of these outflows and are therefore responsible for further delays and waiting (Cook et al., 2004). For example, lack of bed availability due to "bed

blocking" phenomena (for example linked to deficiencies/gaps in social care services) will affect waiting time of those requiring hospital admission from A&E. It will also affect space availability in the A&E which in turn will influence the experience of other patients that do not need admission (Cook et al. 2004).

3. Policy framework

3a. Policy planning and priorities

The problem of emergency care delays was apparent since the mid 90s. The Audit Commission examined the service in 1996 and 1998 finding increasing length of waiting times for both treatments and admissions to hospital from A&E. By 2000 "there was well documented evidence of lengthy waits for treatment in A&E" (NAO, 2004, page 10). For example, the Audit Commission's Acute Hospital Portfolio (2000) concluded that waiting times, for both treatment and admission, varied greatly and had been deteriorating since 1996 (with an increase of the rate of deterioration since 1998).

Along with this evidence, reducing waiting times in A&E was indicated as the second most important factor for improvement in NHS services by the general public and the first by patients actually using A&E (NAO, 2004).

As a consequence of the evidence and given the public concerns, emergency care became a national priority in the *NHS Plan (2000)* to be incorporated into the national performance management framework. The range of targets relating to emergency care in the Plan (2000) is showed in Table 1.

Table 1: NHS Plan Emergency Care Targets

Area	Targets
<i>Primary care (p.105)</i>	"By 2004, patients will be able to see a primary care professional within 24 hours, and a GP within 48 hours".
<i>A&E departments (p.106)</i>	"By 2004 no-one should be waiting more than four hours in accident and emergency from arrival to admission, transfer or discharge".
<i>Coronary Heart Disease (p.120)</i>	<ul style="list-style-type: none"> • "By 2001 the ambulance service should achieve a first response to 75% of Category A calls within 8 minutes" • "By 2003, 75% of eligible people will receive thrombolysis within 20 minutes of hospital arrival as services are redesigned"

A combination of investment and reform was identified as the way of progressing on this front. The NHS Plan (2000) indicated that change would require new money to recruit additional staff and increase capacity, new organizational arrangements

(both in primary care and within hospitals) and new working practices (through role redesign).

In 2001 *Reforming Emergency Care*, (DH, 2001) set the NHS Plan (2000) targets in the context of a ten year strategy of modernization that specifies the steps to drive "local" change. The strategy recognised that the reduction of waits depended on the functioning of A&E departments as well as on functioning of and coordination within and across different parts of the local emergency care system. Accordingly, the plan identified a number of problems and solutions that revolved around four areas as illustrated in Table 2:

Table 2: Reforming Emergency Care

Area	Problems	Solutions
<i>A&E departments' streaming</i>	<ul style="list-style-type: none"> • lack of staff and hospital capacity • competition between emergency patients and those with elective needs • delays in discharging patients • diagnostic and other services availability • single queuing • demarcation of work practices 	<ul style="list-style-type: none"> • New investments: <ul style="list-style-type: none"> - staff (emergency consultants and nurses) - hospital capacity - social care services (freeing hospital beds) - specialised centres for elective care (e.g. for cardiac care) • Organizational change: <ul style="list-style-type: none"> - separation of elective and emergency workloads -role redesign and expansion -integration within the hospital, -out-of-hours diagnostics services
<i>Assessment and Prioritization of emergency requests</i>	<ul style="list-style-type: none"> • inconsistent assessments • wrong place of care 	<ul style="list-style-type: none"> • standard assessment system • redirection of patient according to his/her needs.
<i>Integration and coordination</i>	<ul style="list-style-type: none"> • Fragmentation 	<ul style="list-style-type: none"> • emergency care leads (within hospital coord.) • Emergency Care Networks (across organizational boundaries coord.)

		<ul style="list-style-type: none"> • Collaborative (to spread knowledge)
<i>Standards and monitoring for emergency care</i>	<ul style="list-style-type: none"> • Variation in quality standards 	<ul style="list-style-type: none"> • Creation of quality framework <ul style="list-style-type: none"> - definition and uniform application of standards for emergency care - definition and uniform application of standards for emergency care - care pathways from NICE - monitoring by the Commission for Health Improvement (CHI)

Throughout the document, it was recognised that different localities may need different solutions and may need to adapt strategies to their own circumstances. It was also recognised the importance of “working across traditional organizational boundaries”. This was reflected in the strategy of creating networks and collaborative projects to favour the spreading of best practices as well as in the necessity of improving staff flexibility to allow working across the whole system and in different environments.

Over time “there has been a significant and sustained improvement in waiting times. These changes have come largely through improved working practices and local investment within A&E [.....]. [However] further major improvements [.....] will depend on further improving the way the whole hospital and other health and social care providers work to manage the flow of patients” (NAO, 2004, p.1).

Accordingly, in 2006, urgent care was confirmed a policy priority in the white paper *Our Care Our Health Our Say* (NHS, 2006, Section 4.48 – 4.52). Attention was particularly placed on community care and integration across different providers. The document brought forward the notion that urgent care can be delivered in different settings depending of the patient’s needs and envisions a system that integrates the main actors in the community to ensure simpler access, consistent assessment and appropriate response to the patient. To this end, an urgent care strategy was under development to provide a “framework within which PCTs and local authorities can work” (para. 4.51).

From April 2005, the DH no longer considered the four-hour-maximum total time in A&E a national target. However, “existing commitments on access to ambulances, primary care professionals and GPs, [and] A&E” are to be maintained (*National Standards, Local Action: Health and Social Care Standards Planning Framework 2005-2006 2007/2008* (DH, 2004d). In addition, among the new core standards in

the domain "accessible and responsive care" the standard C19 states that "Health care organizations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services". Existing and new standards fed into the Health Care Commission (HCC) annual health check assessment 2006-2007, demonstrating continued strong performance management over emergency care issues. (<http://ratings2007.healthcarecommission.org.uk/>).

3b. Incentives

The strong performance management framework for emergency care has been backed up by financial incentives established by DH. In terms of A&E, DH ran a capital incentive scheme between March 2004 and March 2005 which awarded payments up to £500,000 to Acute Trusts meeting specific thresholds within a certain time range. A similar scheme was established for Ambulance Trusts that rewarded those making progress in achieving the 75% life threatening standard. Since April 2004, Primary Care Trusts are responsible for the provision of out-of-hours care as GPs have opted out in accordance to the new contract. Provision of out-of-hours care has been incorporated in the NHS performance management framework and accompanied by a capital incentive schemes to PCTs.

Additional incentives are likely to be generated by the recent provision of the White Paper (NHS, 2006) that indicates that changes are being made to the Payment by Results tariff "to create appropriate financial incentives and financial stability to better support delivery of urgent care in the NHS[.....]:

- In the longer term we will develop a single tariff that applies to similar attendances in A&E, minor injuries units and Walk-in Centres, so that funding is governed by the type of treatment and not where it is delivered. As a first step, in 2006//07 there will be one tariff for minor attendances at A&E and attendance at minor injuries units.
- A reduced rate tariff will apply to emergency admissions above and below a threshold. This will help manage the overall level of risk of inappropriate growth in emergency admissions and share the financial risk between providers and commissioners.
- The short-stay tariff (which results in a reduction for stays of less than two days for defined Healthcare Resource Groups within tariff) has been revised to more closely align the tariff with the actual cost of short stays. " (para. 4.52)

4. Policy guidance

4a. Clinical Guidance

The patients pathways for emergency care that were envisaged in Reforming Emergency Care (2001) are still to be published by NICE. In terms of standards for emergency care, there are no specific National Service Frameworks. However, existing National Service Frameworks for coronary disease, elderly and children and mental health patients include some requirements that affect clinical practice in emergency care. Some examples are illustrated in Table 3

National Service Framework	Provision
Coronary Heart Disease	<ul style="list-style-type: none"> • “Door to needle” for trombolysis drug
Children	<ul style="list-style-type: none"> • Pain killers • At least one registered children’s nurse available 24 hours a day to advise each A&E department

4b. Service Improvement in Emergency Care

The policy framework set the foundations for a number of initiatives aimed at delivering the strategy laid out in Reforming Emergency Care (2001) and improving emergency care services locally on the basis of the national targets (NHS Plan, 2000). The approach endorsed by the DH has focussed on developing national initiatives to support change as well as producing checklists and toolkits to serve as guidance to Trusts in implementing change.

Two national initiatives were managed by the Modernization Agency (formed in 2001) and involved a series of structured programmes. The *Ideal Design of Emergency Access* (IDEA) program was initiated in April 2001. The ethos of the programme was to work across the whole spectrum of emergency care including primary care, ambulance services and social services and use successful manufacturing improvement methods such as ‘lean thinking’ and ‘supply chain analysis’ to improve the flow of patients through the emergency care system (Modernization Agency, 2001). The Modernization Agency started to work with two pilot communities and then extended the programme to nine additional communities. The second program, *Emergency Services Collaborative* (ESC), started in October 2002. The sites participating to IDEA were merged with ESC in spring 2003. Similarly to IDEA, the aim of the ESC was to support local teams in making improvements across the emergency care system by focusing on the whole system of emergency care, rather than individual departments. This time, however, the program endorsed a method of collaborative working among staff of different organizations to allow reciprocal learning and knowledge sharing (Modernization Agency, 2002). The programme ran between October 2002 and September 2004 and involved every Trust in England with a 24-hour A&E department in six waves or learning sets. Participation from across the health and social care community was a main component to the success of the ESC. Each site was required to work on four groups:

- *Group 1* Patients who can be treated and discharged relatively quickly, often following a simple diagnostic assessment. These patients will often have minor injuries or illnesses.
- *Group 2* Patients who require a longer assessment and observation, in addition to diagnosis and treatment. These patients are often treated in a Medical Assessment Unit or equivalent.
- *Group 3* Medical patients who require an admission to an acute hospital with significant lengths of stay.
- *Group 4* Patients who are admitted for emergency surgical procedures.

For each group, a number of potential themes were looked at. For example, "See and Treat" was one of the principles introduced by ESC entailing assessing and treating patients with relatively minor problems as soon as they enter A&E departments.

Over time, the Department of Health has also issued several guidance documents in the form of checklists and toolkits covering specific problem areas in A&E departments and Ambulance Service as well as specific target populations (e.g. elderly and mental health patients). These documents were based on local analyses of main problems affecting the emergency care system. They were not meant as prescriptive indications to Trusts and mainly expressed in the form of recommendation and "should do". For example, a second version of the *4-hour checklist: Reducing Delays for A&E patients* (DH, 2004a) was published in 2004 and provided indications and recommendations on priority actions, analysis, discharge, bed management, community action, emergency department activity and admissions. Additional guidelines to streamlining A&E departments specified the areas of bed management and specialists (DH, 2004bc) where a set of actions were suggested to reduce delays in access to beds and specialist for patients waiting A&E departments.

5. Current reflections in Emergency Care

5a. Achievements and challenges in waiting times

Since 2000, there have been significant and consistent improvements in emergency care waiting times as reported by various sources of assessment (NAO, 2004; Healthcare Commission, 2005, Alberti, 2004; Committee of Public Accounts, 2005). However, general improvements mask differences that still exist across different groups of patients. Table 5 shows differences by relevant groups of patients (NAO, 2004; Committee of Public Accounts, 2005):

Table 5: Achievement and Challenges in Waiting Time

Groups	Current Status
Minor injuries or illness	great majority dealt with in less than 4 hours
Serious conditions	Still delays
Patients requiring admission (surgical or intermediate care)	Still delays
Mental health and elderly patients (partially included among patients requiring admissions)	Still delays

5b. Key themes

Cutting across the issues of waiting times for the different groups of patients are a number of key themes. One of these themes entails streaming in A&E and the broader hospital, a second theme looks at the emergency system outside the A&E department and the last refers to inter-organizational relations (across organisational boundaries). For the sake of clarity the themes, achievement and challenges and examples of methods/strategies of improvement are summarised in Table 6. The table also reports on the sources of assessment.

Table 6: Key themes in emergency care

Area	Assessment	Methods	Source
Service redesign within A&E and Hospital <ul style="list-style-type: none"> • Working practices • Diagnostics • Access to specialists • Bed Management 	<ul style="list-style-type: none"> • Still working practices issues • Still delays in diagnostics (11% of all stays longer than four hours bc of diagnostics), • Still delays in access to specialists (24% of all stays and 27% of those admitted were caused by delays in obtaining a specialist) • Still issues in bed management 	<ul style="list-style-type: none"> • Process redesign: <ul style="list-style-type: none"> - See&Treat - Observation Units - Creation of special units for diagnostics - Discharge lounges • Job redesign <ul style="list-style-type: none"> - Expansion of roles for nurses in A&E - Expansion of roles of radiologist and A&E staff 	<ul style="list-style-type: none"> • NAO Report 2004 • Transforming Emergency Care, 2004 • HCC, 2005 • Committee of Public Accounts, 2005

		<ul style="list-style-type: none"> • Coordination <ul style="list-style-type: none"> - Coordination with radiology department and specialists 	
<p>Augmenting alternative sources of care:</p> <ul style="list-style-type: none"> • New services • Job roles/skills • Ambulance service 	<p>Good progresses:</p> <ul style="list-style-type: none"> • Increased number of Walk-in Centers and minor injury units • emergency care practitioners 	<ul style="list-style-type: none"> • Ambulance paramedics • Walking centers 	NAO, 2004
<p>Integration/joint working</p> <ul style="list-style-type: none"> • Managing the interdependences in patients flows: (e.g. transfer to intermediate care, patients' return home, social care and mental health assessment) • Consistency of services through coordination of different providers (e.g. A&E and walk in centers, NHS direct and out-of hours care, Rerouting of patients) 	<ul style="list-style-type: none"> • Obstacles due to organizational boundaries: <ul style="list-style-type: none"> - org work as separate entities - Lack of whole system indicators • Networks: <ul style="list-style-type: none"> - Lack of participation of relevant stakeholders - Lack of clarity in objectives and responsibility - Not all the issues identified for them have been addressed - Lack of power and influence - Few resources 	<p>Existing networks</p> <p>Joint projects PCT/Acute care Trusts and local authorities</p> <p>Coordination Ambulance services and A&E</p>	<ul style="list-style-type: none"> • NAO, 2004 • Committee of Public Accounts, 2005

6. Discussion

6a. Decision Space

The policy background for emergency care defines its "outer context" (Pettigrew et al., 1992) and allows assessing the degree of formal decision space available to local managers in this area (Bossert, 1998). Between 2000 and 2005, emergency care has been explicitly identified as a priority at the national level and "imposed" to local managers as a "must do" area. This imposition has been signaled by the definition of specific targets and their incorporation in the national performance management framework thus minimizing the decision space in terms of the outputs of emergency care (Peckham et al. 2004; Bossert, 1998). Although, since April 2005 emergency care is no longer considered a national target, existing commitments need to be maintained and are still part of Trusts' performance assessment by the Healthcare Commission. Furthermore, emergency care reappears as a priority in the new White Paper (2006) and is included in the new core standards for 2006-2007 (DH, 2004d). Therefore, hierarchical authority over emergency care seems to be consistently quite strong.

In terms of the processes (Peckham et al. 2004) by which localities are supposed to reach those targets and meet the standards, the degree of decision space localities have been allowed is less clear and seems to vary over time, by organization and by area of intervention. Between 2000 and 2004, the DH has appeared to be active in providing guidance and direction in terms of the means necessary to achieve the targets. For example, although the strategy set in 2001 has recognised the need for local adaptation, thus leaving at least some space for localities to devise "locally suitable" actions, it has reinforced the hierarchical authority already exerted over targets by identifying specific areas and potential solutions to be tackled. It has also indicated the necessity of appointing Emergency Care Leads in each organization. Furthermore, the strategy has been accompanied by national initiatives such as the ESC. This programme was set with the intention of supporting and steering local change through knowledge sharing. However, each Trust with A&E departments had to participate, with no choice available, and it seems that at least for some innovations (e.g. See&Treat) the Modernization Agency has exerted quite a central role in their development and diffusion.

In terms of the Checklists and Toolkits produced over that period, they are not prescriptive and are mostly presented in the form of recommendations "to help health care organizations streamline emergency care for patients" (DH, 2004), p.1). However, they endorse the DH approach to tackle specific problems (e.g. bed management, and access to specialists) and represent the strategies DH adopts for challenged organizations through the action of an Intensive Support Team (Alberti, 2004).

Future directions will depend on the tones of the strategy under development as a result of the new White paper. Also, further constraints to the decision space of local managers might come if NICE will develop standards for emergency care pathways as envisaged by the 2001 strategy and these will be incorporated in the performance inspection by Healthcare Commission.

Finally, at the moment, localities seem to have some "room of manoeuvre" in the way joint working can be organised and managed, having DH only provided some general guidelines in terms of how emergency care networks should be organised and being these not managed as other examples in the NHS (e.g. cancer networks) (NAO, 2004). However, evidence shows that joint working is often constrained by limits to decision space imposed over individual organizations through performance targets (NAO, 2004).

6b. Local Health Economy

The decision space discussed in the previous section refers to the formal freedoms for action left from the centre to local managers. However, key to the notion of local autonomy is the inter-dependency among health-care organizations. Where this inter-dependency exists, there is a need to consider the LHE and its nature in explaining individual and collective action and performance

In terms of emergency care, the shape and relevance of the LHE depends on the aspects one looks at. One of the themes, service redesign in A&E, is more internal to individual organizations. Each organization, given the terms of national policies, will take specific course of actions. The local context (e.g. performance, location, funds availability) in which the organizations is embedded will be relevant in shaping organizational responses (Bossert, 1998). In some respects, these responses are likely to be influenced by relational dynamics but these will be mainly linked to certain types of dependencies (e.g. financial) (Pfeffer and Salancik, 1978). Therefore, the LHE involved is likely to be restricted to few organizations (e.g. PCT and Hospital) and less complex.

However, for some of the issues highlighted above (emergency admission, mental health patients and elderly), the theme of joint working and collaboration is as important as service redesign. These issues are clearly inter-organizational and involve strong service inter-dependencies (Thomson, 1967). For example, emergency admissions are influenced by internal service redesign (e.g. bed management) but also require strong collaboration among different actors (e.g. hospital and social care). Consequently, the LHE involved includes more organizations and the nature of the relationships and how they are managed

becomes a fundamental ingredient of the resulting individual and collective performance.

Appendix 4. Invitation letter to participants

Dear <insert name of potential participant>

New research into the impact of decentralisation upon the performance of 'local health economies' (LHEs) is being conducted by a multidisciplinary team coordinated by the School of Management of Royal Holloway - University of London. This research has been awarded a grant for a three-year project by the National Coordinating Centre for Service Delivery and Organization Research, part of the NHS's research and development programme and has received ethical approval from the London-Surrey Border Research Ethics Committee.

In a period of further substantial change for the health service, the study is focusing on issues critical to the NHS. It aims to analyze the links between organizations in LHEs to determine how their "room for manoeuvre", the incentives they face and the local context affects the performance of the local NHS. The findings will generate practical lessons for study participants as well as policy makers, managers and practitioners at all levels in implementing decentralisation, managing the implications of autonomy and incentives, and addressing performance management through incentives.

Researchers are comparing **two** LHEs in England and involving constituent organizations (NHS and others) comprising the LHE. <insert organisation> has been identified as one of the constituent organisations in the <insert name of associated LHE> and I would appreciate the opportunity to learn about the relationships between local organizations and how this affects health service delivery.

Please review the enclosed information regarding the study and what your involvement would entail, should you chose to participate. If you agree to participate in this research please contact <insert name of researcher> on <insert telephone number and e-mail address>.

Alternatively, if you have any queries or require further information about this project, please contact the chief investigator, Dr. Mark Exworthy, whose contact details are provided on the attached information sheet.

I look forward to hearing from you at your earliest convenience.

Yours sincerely,

<insert name/signature of researcher>

Appendix 5. Consent form



Decentralisation and Performance Autonomy and Incentives in Local Health Economies

Research Participant Consent Form

Please read this form in conjunction with our Research Participant Information Sheet.

**Please Initial
Box**

1. I have read and understood the Participant Information Sheet dated 25 October 2006, and I have had the opportunity to discuss details with a member of the research team, and to ask any questions. The nature and purpose of this study have been explained to me, and I understand what will be required if I take part in this study.
2. I understand that my participation is voluntary, and that I may withdraw from this study at any time without justifying my decision and without affecting my normal working.
3. I consent to the interviews being recorded, and I understand that the transcript of the record will only be seen by members of the research team.
4. I agree to take part in this study as described in the Participant Information Sheet.

Signature of participant

Name in BLOCK LETTERS

Date ____/____/____

I confirm that I have explained the nature of the study as detailed in the Participant Information Sheet, in terms which in my judgement are suited to the understanding of the participant.

Signature of research team member

Name in BLOCK LETTERS

Date ____/____/____

Appendix 6. Interview schedule/protocol

Interview Protocol

1. Context – personal and organizational

- a. What is your job title?
- b. How long have you been in this post at (name of the Trust)?
- c. Which responsibilities/role are part of your position within the Trust?
- d. How long have you been working in the LHE (considering previous jobs) and where were you before?

2. Strategic change (influences on decision making and organizational development)

- a. What are the current issues in (name of the organization) with respect to organisational change?
- b. Probe

Are there major service redesign initiatives going on?

Are there major change programmes going on?

- c. What do you see as the key factors influencing decision making and the implementation of change in this organization?
- d. Probe

What are the key drivers behind change programmes and initiatives

What are the key factors influencing the implementation of change

- a. external influences
 - i. central control/ directions/guidelines
 - ii. local context including local culture and historical links
- b. internal influences
 - i. leadership
 - ii. clinical engagement
 - iii. organization history/memory

3. LHE

- a. What are the current issues with respect to LHE-wide change?
- b. Probe
 - a. Re-configuration
 - b. Tracers: urgent care, orthopaedic and care of the elderly
- c. What role has been / should be played (by the manager/Trust) in LHE-wide change initiatives?
- d. What are the key factors that influence LHE-wide change (FFF)?
- e. Probe
 - a. Problems/issues in the process
 - b. Success factors in the process
- f. How existing/historical relationships influence LHE-wide change (including sharing of best practices and inter-organizational learning)
 - a. Stakeholders involvement?

- g. How is / has recent local re-organisations (eg. PCT merger) affect the LHE? How do you think it will impact on the LHE?
- h. Probe
 - a. What are the implications for your organisation? How is the Trust affected and how is the Trust responding?
- i. What do you see as the role of an effective SHA (including managing the reorganization process)?
- j. What do you see as the role of an effective PCT (including managing the reorganization process)?
- k. Probe
 - a. How do the SHA and the PCT shape the room for manoeuvre locally?
- l. How does the Trust approach collaboration with other organizations in the LHE?
- m. Probe
 - a. How does the Trust initiate collaboration?
 - b. What are the drivers to collaboration?
- n. What are the main factors influencing collaboration?
- o. Probe
 - a. What are the main barriers/success factors in collaboration?

4. System reforms (inspired by central government)

- a. How are (national) system reforms (e.g. PbR, patient choice, reconfiguration, Foundation Trusts, PbC) impacting on existing relationships in the LHE?
- b. Probe
 - a. What does the presence of and FT mean for the LHE?
 - b. How is the Trust affected by the (national) reorganisation processes?
- c. How is the PCT reconfiguration (including change in leadership) influencing on commissioning relationships and performance management?
- d. How does your organisation learn how to manage new systems and processes?
- e. How does staff turnover affect this process?
 - a. Informal processes
 - b. External support
 - c. Past experience

5. Performance

- a. In what areas is the Trust performing well and in what areas is performing less well?
- b. Probe
 - i. Tracers
- c. Which are in your opinion the key factors accounting for this performance?
- d. How is the performance of the Trust affected by issues in the LHE?
- e. How is it affected by internal issues?
- f. How does this affect Trust's activities and position in the LHE (including relationship with PCT and SHA)

Appendix 7. Interim feedback report, 2008

Decentralisation and performance: autonomy and incentives in local health economies

Interim feedback: July 2008

Research funded by the NHS R&D programme:

<http://www.sdo.lshtm.ac.uk/sdo1252006.html>

AIMS

- k. To investigate the inter-relationship between decentralisation, governance, incentives and performance in local health economies (LHEs)
- l. To provide lessons for policy-makers & managers in implementing decentralisation, managing the implications of autonomy & incentives, and addressing performance management through incentives.

METHODS

Qualitative, three-year study using a comparative case-study design of 2 contrasting LHEs – one in the “North” and one in the “South.” Fieldwork in the “South” case-study has involved:

- Interviews: 23 interviews including chief executives, directors, clinical directors & service leads
- Observation: Board meetings, executive meetings
- Documentary analysis: reports, strategy & policy documents, annual reports

MAIN MESSAGES

1. **Room for manoeuvre:** Autonomy can be seen as “freedom from” (eg) the ‘centre’ and “freedom to” (eg) innovate, be responsive etc.
 - a. *Freedom from* government has been hampered by the multiple and occasionally contradictory policies being implemented simultaneously. This leads to a dilution of management energy and resources, and diverts energy and resources to most pressing issues (eg. 18 week target). However, in some instances, targets and central initiatives have aided implementation of long-needed changes (eg. in A&E)
 - b. *Freedom to* innovate and to respond depends on incentives and the willingness and ability of organisations to exercise their autonomy. There are signs that some incentives are still weak and that differing levels of autonomy amongst organisations and effect of other reforms have led to perceptions of an uneven ‘playing field’ locally. Some organisations used their autonomy to respond to incentives to improve patient experience and service delivery.

The combination of incentives and willingness/ability of organisations to exercise their autonomy suggests a pragmatic approach to implementing reform locally. For example, organisations have been cautious in the face of uncertain rules of the game Innovation and responsiveness also required changed mindsets, attitudes and leadership skills.

2. Organisational relationships:

- a. On-going social and institutional networks have minimised the impact of central and local organisational changes. For example, loyalty (by patients and GPs to local providers) implies some resistance to reforms. However, new staff (especially at senior levels) have yet to be fully integrated within local networks. Also, (organisational and service) reconfiguration and lack of transparency in decision-making have disrupted relationships and trust and created some tensions There is therefore a need to build further the mutual trust and shared ownership that underpins the presumed benefits of wider reform.
- b. In the context of policy turbulence and upheaval, good organisational performance is associated with long-standing relationships that engender trust and shared ownership. There is therefore a need to understand and nurture the existence of these long-standing relationships

Further information:

Dr. Mark Exworthy. Email: M.Exworthy@rhul.ac.uk. Tel: 01784-414186

Appendix 8. Advisory Group

Research team:

Dr. Mark Exworthy (PI): School of Management, Royal Holloway-University of London

Stephen Peckham: London School of Hygiene & Tropical Medicine

Professor Martin Powell: Health Services Management Centre, University of Birmingham

Dr. Ian Greener: Durham University

Dr. Jacky Holloway: Business School, Open University

Professor Paul Anand: Business School, Open University

Researchers

Francesca Frosini: School of Management, Royal Holloway-University of London

Lorelei Jones: London School of Hygiene & Tropical Medicine

Advisory Group members (in alphabetical order):

Professor Perri 6: Nottingham Trent University

Miguel Castro: Institute for Public Policy Research

Dr. Pauline Allen: London School of Hygiene & Tropical Medicine

Professor Celia Davies: Open University / LSE

Dr. Stephen Dunn: Strategy Unit, Department of Health / East of England SHA

Dr. Mary Edwards: Chief Executive, North Hampshire Hospitals NHS Foundation Trust

Nigel Edwards: Director of Policy, NHS Confederation

Professor Ewan Ferlie: School of Management, Royal Holloway-University of London / Kings College London

Professor Geoff Meads: Medical School, Warwick University

Dr. Dan Murphy: Head of Research and Evaluation, Healthcare Commission

Meetings

- 26 June 2006, London School of Hygiene and Tropical Medicine
- 14 June 2007, Royal Holloway (offices on Gower Street, London. WC1)
- 19 June 2008, Royal Holloway (offices on Gower Street, London. WC1)

We found that attendance at these meetings was patchy despite members' willingness to participate. We therefore decided to contact Advisory Group members who could not attend meetings. Progress in the project and interpretation of emerging findings were discussed with these members.

Appendix 9. REC approval

London - Surrey Borders Research Ethics Committee
St George's University of London
South London REC office 1
Room 1.13,
1st Floor, Jenner Wing
Tooting
London
SW17 0QT

Telephone: 020 8725 0262
Facsimile: 020 8725 1897
13 July 2006

Dear Dr Exworthy

Full title of study: Decentralisation and performance: autonomy and incentives in local health economies
REC reference number: 06/Q0806/60

The Research Ethics Committee reviewed the above application at the meeting held on 12 July 2006.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to complete Part C of the application form or to inform Local Research Ethics Committees (LRECs) about the research. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	5.1	22 June 2006
Investigator CV	1	26 June 2006
Protocol	2	26 January 2006
Covering Letter	1	26 June 2006
Summary/Synopsis	2	06 June 2006
Peer Review	1	04 November 2005
Letter of invitation to participant	2	06 June 2006
Participant Information Sheet	2	06 June 2006
Participant Consent Form	1	06 June 2006
Letter from funder	1	12 January 2006
Indemnity Arrangements	1	04 November 2005

Research governance approval

You should arrange for the R&D Department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research at a NHS site must obtain final research governance approval before

commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q0806/60 correspondence

Please quote this number on all

With the Committee's best wishes for the success of this project

Yours sincerely

Mrs Sheree Manson
Committee Co-ordinator

Email: sheree.manson@stgeorges.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

Standard approval conditions

Copy to: *National Coordinating Centre - SDO Programme
London School of Hygiene and Tropical Medicine
99 Gower Street
London*

London - Surrey Borders Research Ethics Committee

Attendance at Committee meeting on 12 July 2006

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present?</i>	<i>Notes</i>
Dr Hervey Wilcox	Consultant Chemical Pathologist	Yes	
Dr Steve Hyer	Consultant Physician	Yes	
Canon Christopher Vallins	Head of Pastoral Care	Yes	
Mrs Sylvia Aslangul	Lay Member	Yes	
Mrs Wendy Brooks	Stroke Nurse Consultant	Yes	
Mr Derek Cock	Chief Pharmacist	Yes	
Mrs Anne Davies	Chief Pharmacist	Yes	
Mr Eddy Digman	Lay Member	Yes	
Dr Rim El-Rifai	Consultant Paediatrician	Yes	
Mr Christopher John	ENT Surgeon	Yes	
Mrs Louise Kedroff	Physiotherapist	No	
Mrs Sally Kerry	Senior Lecturer in Medical Statistics	No	
Mrs Rita Lewis	Lay Member	Yes	
Dr Lawrence Webber	GP	No	
Mrs Nikki Evans	Cancer Research Nurse	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Ms Amanda Jackson	REC Assistant
Mrs Sheree Manson	Committee Co-ordinator

Appendix 10. Summary of issues

For the attention of the Health Select Committee regarding their inquiry into NHS Foundation Trusts (2008)

Dr. Mark Exworthy¹, Francesca Frosini¹, Lorelei Jones² and Stephen Peckham²

1-School of Management, Royal Holloway-University of London

2-London School of Hygiene and Tropical Medicine

1. Summary

Foundation Trusts (FTs) represent a significant phase in the decentralisation of the NHS. Allied to other reforms, FT status offers (high performing) Trusts the opportunity for greater autonomy in various functions from the Department of Health (DH)/centre. Here, autonomy can be seen (i) as "freedom from" the centre as well as "freedom to" be innovative and responsive, and (ii) as a key factor with incentives in promoting further improved performance (crudely, autonomy+incentives=higher performance).

The willingness and ability of FTs to exercise their autonomy will determine the impact they have both within their organisations and the wider NHS. Currently, the evidence suggests that they have yet to exercise fully this autonomy but have the potential to do (given their current evolutionary path and supporting policy developments).

2. Lack of evidence

In general, there is a lack of (research) evidence on the work and impact of FTs, given their significance to English health policy. The reports by the Health Select Committee (2003), Day and Klein (2005), Healthcare Commission (2005) and the Audit Commission (2008) are the major sources of evidence. Some studies have been conducted into specific aspects which relate to FTs, such as Payment by Results (PbR). Anecdotal evidence is much more prevalent.

3. Synthesis of evidence

This synthesis is informed by the provisional findings from our research (see 5).

2a. Macro-level: Autonomy from the Centre:

Recent reforms have transformed by the role of the 'centre' in that the DH is no longer the sole agency. For example, the Secretary of State no longer retains residual powers. Instead, Monitor (as regulator) has a key role in ensuring performance standards of FTs and acting as a buffer between DH and FTs. Generally, Monitor is well regarded by FTs. The role of the Strategic Health Authorities (SHAs) in relation to FTs has also changed given the removal of performance management function. The number of FTs by SHA area varies considerably and may imply a key role for SHAs in fostering FT development.

However, the DH and SHA also require a change in attitude and behaviour to reflect the changed landscape of FTs and their activities.

2b. Meso-level: FTs in the local health economy: Despite autonomy, FTs' actions are constrained to varying degrees by the context of the local health economy (or community). For example, PCT deficits or 'competition' from other providers might constrain service developments of or related to FTs. Provisional evidence suggests that FTs are 'picking and choosing' the issues on which they are cooperating (especially if it is in their self-interest). There are some perceptions that FTs have secured an unfair advantage in the LHE (for example, as a result transitional relief arrangements associated with PbR). PCTs still remain generally weak (in capability and intelligence) compared to FTs, comprising the strategic perspective of PCTs,

2b. Micro-level: FT attitudes and behavior

FTs have been the 'high performing Trusts'; this was the criteria for their approval. This biased sample indicates that their performance might also be strong as FTs but initial evidence suggests no significant improvements as a result of FT status. The willingness and ability of FTs to exercise their autonomy is debatable. Generally, they are able to exercise autonomy (under their new status as public benefit corporations) although FT status demands that senior staff change their skills and attitudes. Equally, FTs appear less willing to exercise autonomy to a great extent, as they are still acquiring legitimacy as organizations in their LHE and internally. This unwillingness might reflect their view of risk (aversion to it) given their greater degree of financial exposure, the uncertainty associated with the new policy environment (including on-going features of centralisation) and the impact that their decisions might have upon other local organizations. New governance arrangements are seen as an important development but have yet to translate into meaningful change. The relationship between the FT Governors and the Board still require further development.

4. Contact:

Dr. Mark Exworthy: M.Exworthy@rhul.ac.uk

5. Funding:

Our current research is funded by the National Institute of Health Research (Service, Delivery and Organisation R&D programme): "Decentralisation and performance: autonomy and incentives in local health economies" (2006-2009) <http://www.sdo.nihr.ac.uk/sdo1252006.html> (Lay and scientific summaries are available on this web address).

The research project involves a collaboration between Dr. Mark Exworthy (Royal Holloway, University of London; principal investigator), Francesca Frosini (RHUL), Lorelei Jones (London School of Hygiene and Tropical Medicine) Stephen Peckham (LSHTM), Prof. Martin Powell (Birmingham University), Dr Ian Greener (Durham University), Dr. Jacky Holloway (Open University) and Dr Paul Anand (Open University)

June 2008

Appendix 11. Dissemination activities

Dissemination **(2006-2009)**

Presentations

1. Exworthy, M. and Frosini, F. (2006) 'Room to manoeuvre? Explaining the impact of English health policies upon local autonomy. Paper presented to the Health Politics (Political Studies Association) conference, Oxford, September 2006.
2. Jones, L., Exworthy, M. and Frosini, F. (2008) 'Discourse and power: Health service reconfiguration in England.' Paper presented to the Organisational Behaviour in Health Care conference, Sydney, April 2008
3. Exworthy, M., Frosini, F. and Jones, L. 'Autonomy and collaboration: managing local organizational relationships in the English NHS.' Paper presented to the European Health Management Association conference, Athens, June 2008
4. Exworthy, M., Frosini, F. and Jones, L. 'Decentralisation and Performance.' Paper presented HSRN/SDO conference, Manchester, June 2008
5. Exworthy, M., Frosini, F. and Jones, L. 'Assessing performance in local health economies: going beyond the metrics?' Paper presented HSRN/SDO conference, Birmingham, June 2009
6. Holloway, J., Exworthy, M., Frosini, F. and Jones, L. 'Freedom to perform? Exploring policy responses in local health economies.' Paper accepted for the OHBC conference, Birmingham, April 2010.

Papers published in peer review journals and edited collections

1. Peckham S, Exworthy M, Greener I and Powell M. (2007) 'Decentralisation and health care services in England.' Chapter 3 (pp.27-40) in Hann A (ed) *Health Policy and Politics*. Ashgate.
2. Peckham, S., Exworthy, M., Powell, M. and Greener, I. (2008) 'Decentralizing health services in the UK: a new conceptual framework.' *Public Administration*, 86, 2, pp.559-580
3. Exworthy, M. and Frosini, F. (2008) 'Room to manoeuvre? Explaining local autonomy in the English National Health Service.' *Health Policy*, 81, 2-3, pp.204-212
4. Exworthy, M. and Greener, I. (2008) 'Decentralisation as a means to re-organise health-care in England: from theory to practice.' Chapter 4 (pp.46-58) in McKee, L., Ferlie, E. and Hyde, P. (eds) *Organising and re-organising: power and change in health-care organisations..* Basingstoke; Palgrave
5. Greener, I., Exworthy, M., Peckham, S. and Powell, M. 'New Labour and decentralisation.' *Policy Studies*, 30, 4, pp.439-454
6. Powell, M., Exworthy, M., Greener, I and Peckham, S. 'Going down the local (again): decentralisation and centralisation in sixty years of the British National Health Service.' *Financial Accounting and Management*, forthcoming.

In preparation

1. Jones, L., Exworthy, M. and Frosini, F. (2008) 'Discourse and power: Health service reconfiguration in England.' Submitted to *Journal of Health Services Research and Policy*. Peer review (in 2008) indicated major revisions. Currently undergoing such revisions.
2. Peckham, S., Exworthy, M. Frosini, F. and Jones, L. 'Local health economy: fact or fiction?' Journal to be determined.
3. Anand, P., Exworthy, M., Frosini, F. and Jones, L. 'Autonomy and performance.' Journal to be determined
4. Exworthy, M., Frosini, F. and Jones, L. 'Assessing performance in local health economies: distinguishing between formal and informal performance.' Journal to be determined

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Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.