Policy as discursive practice: an ethnographic study of hospital planning in England

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DECLARATION

I, Lorelei Jones, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

ABSTRACT

This thesis considers how policy 'works' as an instrument of governance. I report an ethnographic study of health care policy in the contested field of hospital planning. In this study I explored how a controversial policy to centralise hospital services was presented in national policy documents and implemented in one locality in England. I identified a shift in the framing of the policy, from one that presented centralisation as a means of improving access and making services more responsive to patients, to one of clinical necessity. In the new framing plans to close hospital services were presented as clinical decisions that were based on the evidence and necessary to ensure safety. I have interpreted this framing as a rhetorical strategy deployed at both national and local levels with the aim of realising change in the face of community resistance to closing local hospitals and a concomitant policy rhetoric emphasising the need to involve the public in decisions about how services are provided. Although the persuasive power of the framing was limited, a more insidious form of power was identified in the way the framing disguised the political nature of the issue by defining it as a clinical problem. The framing had the effect of restricting the extent to which alternative courses of action could be considered, and undermined public participation in decisions about the delivery and organisation of services.

My thesis is that, beyond the often quite obvious use of rhetoric, power operates in policy practices in ways that are often difficult to see. Central to these processes are medical knowledge and expertise which serve to frame the debate, shaping how the problem is understood, which solutions are considered (and which are not) and who is included in decision making. To the extent that health services research is orientated to problems as defined by policy makers and service managers, and in our adoption of the scientific paradigm, we are implicated in these processes. The knowledge and analytic techniques of health services research constitute an indirect control technology, shaping how an issue is understood, creating subjectivities and assigning authority, constructing versions of health care, and influencing the practice of health care professionals. I conclude by proposing a reorientation from 'science' to 'scholarship'. Unlike the scientific paradigm which abstracts policy issues from their social and cultural context, scholarship assumes that policy issues can only be understood in their relational settings. Scholarship supports public deliberation of policy issues and is of practical benefit to decision-makers, opening up policy options and illuminating the different perspectives on policy issues and thereby contributing to more creative, more acceptable, and more effective policies.

ACKNOWLEDGEMENTS

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INTRODUCTION

In this thesis I ask 'how does policy 'work' as an instrument of governance?'. By this I mean 'what does it do?' And 'how does it do it'? My focus is on the discursive origins and properties of policies and how these relate to the intentions in, responses to, and effects of policies. My approach is of 'studying through', that is, following a policy through relations between actors, institutions and discourses across space and time (Wright and Reinhold 2011). Drawing from an ethnographic study of hospital planning in England, I describe how a policy to centralise services was espoused in national policy documents, how this shifted over time, and how it was enacted in practice. I found that power operated through policy texts, and in the practices of policy formulation and implementation, in ways that were often difficult to see. Central to these processes were medical knowledge and expertise which served to frame the debate and undermine public involvement in decision making.

The topic of my study emerged while I was doing fieldwork for another study, from what Agar (1999) calls a 'rich point'. A rich point is something that happens in the field that the ethnographer notices. This may be due to repetition, or contradiction, or it may be something that the ethnographer simply finds unsettling. In this case what caught my attention was the way that local health service managers would refer to the 'clinical case for change' when presenting plans to close hospital services. This rationale presented the decision to close a department, or a hospital, as a clinical decision that was based on the evidence and necessary to ensure safety. I noticed it, because it was something I kept hearing, and because it contradicted earlier planning documents that I had read that contained a financial rationale for change. I was also struck by the rhetorical force of this rationale. It appeared to me to have the effect of 'shutting down debate', which I thought was significant given the emphasis in national policy of involving the public in decisions about service delivery. The extent and implications of this observation then became the focus of my study.

My thesis is that the 'clinical case for change' is a rhetorical strategy for implementing organisational change in the context of community resistance to service closure, and a concomitant policy emphasising the importance of patient and public involvement in the planning of health care services. I argue that while the persuasive power of the framing is limited,

a more insidious form of power is apparent in the way that the framing channels thinking in a particular direction and disguises the political nature of the issue by defining it as 'clinical'. This framing restricts the extent to which alternative courses of action can be considered and undermines public participation in decisions about the delivery and organisation of health care.

An anthropology of policy

My approach draws from the anthropology of policy (Donnan and McFarlane 1989, Shore and Wright 1997, Wedel and Feldman 2005, Shore, Wright and Pero 2011), parallel developments in sociology (Ball 1997, 1993, 1990) and cognate fields such as interpretive policy analysis (Fischer and Forester 1993, Fischer 2003, Hajer and Wagenaar 2003). The anthropology of policy locates policy processes in the social and cultural context of the interaction of different groups with conflicting values, beliefs and views of the world. My focus is on how, in this context, members of society use cultural resources to create meaning and to accomplish activities.

Anthropology relates specific local practices to broader social processes. For Shore and Wright (1997) the interest in policy for anthropologists stems from the role of policy as a form of governance in modern times. Policies are key instruments through which governments classify and regulate the spaces and subjects they seek to govern and are central to how society is organised (Shore and Wright 2011, p 2). Policy constructs social relations and fundamentally shapes the way people live their lives and understand the world. The reach of policy is such that there is no part of the globe where the lives of inhabitants are not shaped by the policies of governments. In England policy shapes every aspect of citizens' lives, from the location of birth to who can bury the dead. It is the way that policy influences local practices that is the key concern of this thesis. Following Shore and Wright (1997) I ask 'how does policy 'work' as an instrument of governance?

In many anthropological accounts there is an explicit attempt to unsettle the perceived fixedness and inevitability of the present. Shore and Wright, for example, state that the task of an anthropology of policy is to 'unsettle the certainties and orthodoxies that govern the present' (Shore and Wright 1997, p17). Similarly, Wedel and Feldman suggest that anthropology can destabilise the taken-for granted assumptions that underpin the formulation of policy and

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thereby 'help to create room for alternative policy options' (Wedel and Feldman 2005, p2). This is different, however, to the 'emancipatory' project of fields such as critical management studies, or critical discourse analysis, which seeks to expose, with a view to alleviating, oppression, and where the source of oppression, is often identified a priori, in terms of class, race or gender. I adopt a position, more aligned with Foucault's stance, that an awareness of the operation of power is a necessary precursor for freedom:

> It's true that certain people, such as those who work in the institutional setting of the prison...are not likely to find advice or instructions in my books to tell them 'what is to be done'. But my project is precisely to bring it about that they no longer know what to do, so that the acts, gestures, discourses that up until then had seemed to go without saying become problematic, difficult, dangerous. (In Flyvberg 2001, p103)

An anthropological perspective has a number of practical benefits. Firstly, studying policy processes in their broader social and cultural context can illuminate why policies may not have their intended effect and can identify unintended consequences. Secondly, by questioning the taken-for granted assumptions that underlie policy it can help create room for alternatives. Thirdly, the insights and understanding that are generated by studying policy practices in ethnographic context can contribute to the development of more acceptable and effective policies.

Hospital planning in England

In England hospital planning is an enduring and seemingly intractable issue on the agenda of local health services managers. Efforts on the part of regional planners to rationalise services have been in place since the publication of the Hospital Plan for England in 1962 (Ministry of Health, 1962). This agenda coincides with that of the medical profession which, over the same period, has sought to centralise acute services (i.e. concentrate in fewer, larger departments) in order to facilitate medical staffing and training (Joint Working Party of the British Medical Association, Royal College of Physicians of London and the Royal College of Surgeons of England, 1998; Senate of Surgery of Great Britain and Ireland, 1997, 2004; Royal College of Obstetricians and Gynaecologists 2012; Academy of Medical Royal Colleges, 2012). In both

managerial and professional narratives arguments for the centralisation of hospital services are couched in the language of rational analysis whereby centralisation is presented as the means to some desired ends ('efficiency' say or 'effectiveness'). These claims are highly contested in the research community. Criticisms have addressed the methods of studies investigating the relationship between volume and outcome, the interpretation of findings and, of particular relevance to my study, *the choice of policy response* (Nuffield Institute of Health, 1996; Shahian and Normand, 2003; Bryne and Yang, 2008; Shapiro, 2008; Harrison, 2012). Plans to close hospitals or hospital departments also face significant community resistance. One of the best known examples of community resistance to hospital closure in England is that of Kidderminster, where in 2001 a Member of Parliament lost his seat in a general election to a single-issue candidate on a platform to save the local hospital. At the same time national policy rhetoric emphasises the importance of involving the public in decisions about health care delivery (Secretary of State for Health, 2010, 2006).

Hospital planning exemplifies what Schön and Rein call an 'intractable policy controversy'. Intractable policy controversies are 'marked by contention, more or less acrimonious, more or less enduring' (Schön and Rein 1994, p3). A feature of policy controversies is that they are resistant to resolution by appeal to evidence, research, or reasoned argument. Opposing parties either differ in their view of what facts are important, or give the same facts different interpretations. The reason why the controversy over hospital planning cannot be resolved by an appeal to 'the evidence' is because it is political. In this study I adopt a conception of politics as involving not just a conflict in interests but in frameworks of meaning (Geertz 1973). So, for example, for health service managers the overriding concern is with the efficiency and operational effectiveness of the service. However, from the perspective of community groups, hospitals are about more than just health services, they are places of social, symbolic and emotional significance. My concern in this thesis is not with how hospital services should be provided but with how, in this context of political contestation, policy 'works' as an instrument of governance. I use Foucault's theory of discourse and governmentality to consider how power operates in policy processes – how, in this sense, policy works, what it does, how it does it.

Despite the inherently political nature of hospital planning, within the health services research literature it is assumed, for the most part, to be a technical issue (Spurgeon et al 2010). The majority of research is instrumental in focus, orientated to solving the problem of how best to

organise hospital services so as to maximise effectiveness whilst minimising cost. It is also largely normative, in that it presupposes the need for change and is concerned with judging the 'success' of changes that have been introduced. Where hospital planning is acknowledged to have a political dimension, the tendency has been to see this in terms of a simple trade-off between service 'effectiveness' and patient 'access'. Alternative value systems are either excluded from analysis entirely, or treated as an implementation issue. So, for example, public resistance to closing services is classified as a 'barrier to change'. This technocratic view of hospital planning is ill-suited to the needs of decision-makers because it assumes that policies are the *outcome* of politics, which can then be handed over to local administrators for implementation. It fails to recognise the way that policies *produce* politics. Indeed Hajer (2003) has argued that the point at which policies are made public has become more important as a site of politics than party politics. It is when policies are made public that people reflect on who they are and what their values are.

The term 'hospital planning' is an etic rather than an emic category. The term was never, in my recollection, used by any actors in my study. Politicians, local health services managers, and policy think tanks, instead used the term 'reconfiguration'. Academics involved in producing research for policy also adopted this term (see for example Fulop et al 2012, Spurgeon et al 2010). Fulop et al, for example, provide the following definition:

> A deliberately induced change of some significance in the distribution of medical, surgical, diagnostic and ancillary specialties that are available in each hospital or other secondary or tertiary acute care unit in locality, region or health care administrative area. (Fulop et al 2012, p129)

The emic terminology is not stable but rather changes over time. In the 1980s managers talked of 'rationalisation' (Pettigrew et al 1992) whilst at the time of writing it is my impression that 'service change' seems to be the favoured parlance. I have chosen hospital planning as a way to refer to the specific area of health care policy that is the focus of my study, although settling on 'hospital planning' was not unproblematic, reflecting the discursive, socially constructed and politically contested nature of policy domains. I wanted to choose a single term that could be used for the multiple descriptions and explanations of actors, without simply repeating the analysis of one particular group (Callon 1986). In the end I settled on hospital planning because

it seemed to capture more of the contested nature of the issue than more seemingly neutral terms such as 'service change', even though it might seem to some to be a politically loaded term.

Within what is therefore intended as a generic classification of an area of healthcare policy, my particular focus is on a policy to centralise services, sometimes referred to as 'concentration' (Dawson et al 2004, Posnett 1997). Centralisation of hospital services is continuous in nature, thus policy might be for more or less centralisation. Changing the distribution of services is also only one possible course of action, and different parties may advocate alternative courses of action (or no action). My use of the term 'centralisation' is thus a descriptive term that I have employed to refer to a policy to redistribute hospital services into fewer, larger units. Whilst 'centralisation' is sometimes used by academics, and can be found in the national policy documents analysed as part of this study, it was rarely used by local actors, who used instead the broader term 'reconfiguration'. This possibly reflects the fact that centralisation often refers to the *regional* distribution of hospital services. In such instances it would not make sense at the local level where the impact would be the loss (or retention) of a hospital or hospital department (A&E say, or obstetrics), although a single NHS trust with services distributed over multiple sites might also seek to 'centralise' services onto a single site. It might also reflect the extent to which centralisation has become orthodoxy in the NHS (Harrison and Ahmad 2000, Fulop et al 2005) so that centralisation and reconfiguration come to be used by local managers interchangeably.

Democracy and expertise

My study is important because of the contemporary importance placed on public involvement in decisions about the delivery of health care in national policy. This emphasis on public involvement reflects the dominance of this motif in policy discourse in the UK more generally. At the level of practice, 'consultation' has become an imperative for public service managers. However the notion of 'consultation' is ambiguous and can have different meanings to different actors. One notion of consultation is as necessary complement to the democratic process (Beetham 1996). In this view consultation allows citizens to play a creative political role between elections, indicating priorities, contributing expertise and providing an assessment of needs. An alternative view of consultation sees it as a method that mimics commercial market research (Needham 2003). This approach to consultation asks citizens to report their experience as

service users without considering wider community, policy or budgetary implication. It is the latter which Needham sees as characteristic of consultation on policy under New Labour, reflecting a more general construction of citizens as consumers. Needham argues that under New Labour there emerged 'a style of political communication which treats the voter more as a consumer to be pleased than as a citizen to be enlightened or engaged in debate' (Needham 2003, p52). Meanwhile empirical research has found that community groups are dissatisfied with the constraints of the top-down format of consultation and have rejected these formats in favour of self-organised forms of participation (Crompton 2015).

Beyond policy rhetoric, there is a substantial debate in the academic literature concerned with the public involvement in collective decision making. This can be seen in the scholarship of Fischer and Forrester (1993), Dryzek (1987, 1989, 1990) and Hajer and Wagenaar (2003), among others, and in their calls for more democratic policy forums and deliberative policy processes. Drawing on Habermas (1987), these scholars argue that application of the principles of communicative rationality would improve public involvement in collective decision making by removing forms of coercion and facilitating consensus. This argument is countered by those, many of whom are inspired by the work of Foucault, who argue that communication is always permeated by power, often in ways that are hidden from view.

This debate plays out in a broader social and cultural context in which professional knowledge and expertise has become central to policy processes. This regime privileges abstract knowledge over experiential-based knowledge and manifests a positivist, rational and technocratic ideology that excludes non-expert opinions (Bell 1976). This ideology exists in constant tension with demands for public participation in collective decision making and a value system that denies expert knowledge any privileged position whilst calling for a widening of access to policy processes. Recently scholars have expressed considerable concern at what they have identified as a widespread and growing public distrust of democratic political processes, political institutions and politicians (Pharr and Putnam 2000, Hay 2014, Norris 2011). Hay (2014) for example, states that:

I am of the view that the disdain in which citizens seem increasingly to hold political elites is perhaps the single greatest political pathology of our age – and one that, unless held in check, may in time threaten the very legitimacy of our democratic political culture. (Hay 2014, p301)

Health services research is intricately involved in these processes. It is part of an industry that supplies the 'evidence' for 'evidence-based policy' and is thus central to the tension between expertise and democracy in policy making. As it is currently practiced much health services research manifests what Russell et al (2008) term a 'naïve rationalism' in assuming that more and more knowledge will be able to tell policy makers what to do. The error of the 'evidence-based policy' paradigm is that it conflates the separate questions of 'what do we know' with 'what should we do'? Whilst the former might be informed by health service research, the latter, for advocates of participatory democracy, must be subject to public deliberation. I conclude this thesis by considering how health services research can 'bring the politics back in' and support the public deliberation of policy issues.

My thesis makes a theoretical contribution by developing a theory of policy as discursive practice. I argue that knowledge, expertise, rationality, and versions of truth are cultural resources that are mobilised in policy. Thus policy is not so much rational decision making as the *mobilisation* of rational decision making, as a cultural resource. Rational-decision making is both the prevailing lens to view the world and a 'sacred value' in society, to such an extent that it has become naturalised as 'common sense'. It is this very 'taken-for-grantedness' that gives it potency when mobilised, through policy, in political contests. The way it works is rhetorical, in that it is impossible to argue against the proper order of things. But it is also, in a broader sense, discursive, in that it constitutes the subjectivities of policy actors, and constructs a world that privileges certain values as it excludes others. My approach is novel in using the concepts of 'frames' and 'framing' (Rein and Schön 1993, Schön and Rein 1994) to link agency, rhetoric and discourse.

Using the case of hospital planning in the NHS in England, I show how, beyond the often visible use of rhetoric by agents, power operated through policy texts, and in the practices of policy formulation and implementation, in ways that were often difficult to see. Central to these processes were medical knowledge and expertise which served to frame the debate and

undermine public involvement in decision making. Medical and knowledge and expertise were mobilised through the co-optation of doctors occupying hybrid roles, what Waring (2014) has termed political and managerial elites. At the national level this involved enrolling political elites in the development of policy, whilst at the local level this involved enrolling managerial elites in the process of implementation.

Returning to broader debates about the potential of deliberative forums my research supports the conclusion that communication is *always* permeated by power. I show how in the case of hospital planning power operated before and during deliberative forums, shaping how the problem was understood, which solutions were considered (and which were not) and who was included in decision making. Moreover, I show how deliberative forums themselves were used as co-optive devices in the interests of service leaders and policy makers. Turning to current developments in policy, I propose that Foucault's theory of governmentality remains a potent theoretical resource for understanding the discourse of 'clinical leadership' and 'co-production'.

I conclude by discussing the implications of my research for health services research. Here I extend Foucault's theory of governmentality, arguing that the knowledge and analytic techniques of health services research constitute an indirect control technology, shaping how an issue is understood, creating subjectivities and assigning authority, constructing versions of health care, and influencing the practice of health care professionals. I argue that in our orientation to problems as defined by policy makers and services managers, and in our adoption of the scientific paradigm, we are enrolled in the strategic framing of policy issues, and implicated in the technicalisation of politics. In response I propose a reorientation from 'science' to 'scholarship'. Whilst science abstracts problems from their relational settings, scholarship seeks to show how issues are constituted and shaped by their social and cultural context. Scholarship supports public deliberation of policy issues and is of practical benefit to decision makings, opening up policy options and illuminating the different perspectives on policy issues thereby contributing to more creative, more acceptable, and more effective policies.

Organisation of this thesis

This thesis is arranged into 7 chapters. In chapter 1 I provide the background to my study by introducing the topic of hospital planning in England and the broader policy context of public and patient involvement in health care decision making. In chapter 2 I locate my study in the theoretical literature. I contrast the prevailing representation of policy as rational decision making with my own theoretical stance whereby, drawing on Foucault, I view policy as discursive practice. I outline my methodological approach in chapter 3.

In chapters 4 and 5 I present my empirical findings. I explore first how a policy for centralising hospital services was presented in national policy documents over the period of fieldwork (2007-2009). I identify a shift in the framing of the issue, from one of patient responsiveness to one of clinical necessity, and show how this framing was reinforced by the enrolment of political elites. I then explore how the policy travelled from the national level of government policy to the level of practice. Looking at how local managers introduced changes to hospital services, I focus on how managers sought to persuade other stakeholders of the nature of the problem and enrol them in the process of implementation. I show how the rhetoric of local health service managers mirrored that of national policy documents. At the local level a framing of 'clinical necessity' was reinforced by using local medical-managers in the process of implementation. For example, local doctors were invited to participate in 'co-design' forums. These gave the impression that the plans for changing services were produced by local doctors. However, participants saw their involvement as superficial and strategic, designed to convince the public of the need for change. Medical-managers were also used to 'front' public meetings to explain to the public why change was needed. Despite these measures, as a rhetorical strategy, the framing had limited success in that local staff and community groups were unconvinced of the need for change. The discursive power of policy, however, goes beyond rhetorical force. It takes the form of the power to both define the nature of a problem and the solution. The framing of centralisation of hospital services as a 'clinical necessity' defines the nature of the problem as 'clinical' and thus the proper business of the medical profession. One of the more tangible consequences of this framing was that it enabled local NHS organisations to avoid public consultation.

In chapter 6 I discuss my findings, returning to my original research question, 'how does policy 'work' as an instrument of governance?' I begin by considering the 'clinical case for change' as a 'rhetorical strategy of legitimacy' exploring the central role of medical expertise and the co-optation of professional elites. I reiterate the limited persuasive power of this framing of the issue before considering the adverse consequences, in terms of the erosion of trust that results from public recognition of strategic communication. I then turn to the less visible forms of discursive power. I show how the framing works by channelling thinking in a particular direction, presenting some dimensions of a policy issue as fixed whilst others are open to change, making a particular solution appear inevitable whilst marginalising alternatives, and disguising the political nature of the issue by defining it as technical. I then discus my findings in terms of broader debates concerning the potential for more democratic policy forums.

In chapter 7 I draw out the implications of my research for health services research. I conclude by outlining a future research agenda that considers current developments in Health Services Research, particularly the nascent fields of implementation and improvement science which seek an explicitly 'closer' relationship between researcher and health service managers, what academic 'independence' may mean in this context and what is the uniquely *academic* contribution to be made to policy and practice in health care.

1. BACKGROUND

In taking an anthropological approach to policy I am presupposing that hospital planning is a political, rather than simply a technical, issue. Therefore in this chapter I outline the political context of health care delivery in the NHS in England before focusing specifically on the politics of hospital planning.

Health care politics in England

The rise of managerialism
In the 1980s the dominant position of the medical profession in health care politics in England was challenged by the emergence of managerialism, an ideology that remains pervasive in the NHS today. Managerialism is here taken to be a not entirely stable ideology but one that can be broadly characterised by an interest in controlling public expenditure and a concern for efficiency achieved through standardization of work practices (Pollit 1990). The emergence of managerialism in the NHS is generally associated with the publication under the Conservative government of the Griffiths Report in 1983 (Griffiths 1983). Initially focusing on professional management and measuring performance, managerialism later embraced neoliberal beliefs about competition and markets, embodied in the NHS in the introduction of an 'internal market' in 1990 (Department of Health 1989). New Labour introduced a third strand to managerialism with its service delivery agenda (Rhodes 2013).

Changes in the nature and extent of professional influence following the emergence of managerialism is a key subject of debate in the sociological literature. One analysis is that as managers have ascended as a power group in health care politics the relative influence of the medical profession has declined. This decline in influence is evidenced by the exclusion of the profession, by the end of the 1980s, from major policy decisions, such as the introduction of the internal market (Salter 2003).

Osborne (1993) argued that it was not simply that managers were empowered at the expense of doctors, rather doctors were enrolled alongside managers 'as something of administrators and

economists themselves' (Osborne 1993, p353). Even in the Griffiths Report the idea was to bring about an alignment between clinical decisions and administrative decisions. This alignment of clinical rationalities and economico-administrative rationalities can be seen, for example, in the introduction of budget holding and self-governing trusts. According to Osborne:

> in each case what is at stake is an attempt to make truth administratively and economically efficient; to make, as it were, an economic rationality function as close as possible to the point of clinical decision itself. (Osborne 1993, p353)

This attempt at alignment of clinical and administrative rationalities can be contrasted with the earlier NHS reorganisation of 1974 where clinicians and administrators were to work in parallel, i.e. as separate forms of expertise developing policy by negotiation. What managerialism put in place were not financial incentives for the medical profession to provide better, more efficient care, but a 'vocabulary and a rationality for being governed and simultaneously governing itself' (Osborne 1993, p354).

Another sophisticated analysis of changes in professional influence is provided by Harrison and Ahmad (2000). They nuance the relationship between managerialism and professional autonomy by considering changes in professional autonomy at the micro, meso and macro level between 1975 and 2000. In their analysis the micro level corresponds to clinical decision making; the meso level corresponds to the institutionalised relationships between the medical profession and the state (as embodied in the BMA and medical Royal Colleges, and the government Health Departments) and the macro level corresponds to the prevailing system of ideas, that exists within society more generally, in relation to health and illness.

At the micro level Harrison and Ahmad document the increasing managerialisation of professional work, embodied, for example, in the introduction of work plans and new forms of external regulation. Similarly, at the meso level, Harrison and Ahmad observe a significant decline in professional influence, concluding that:

> the ostensible corporatist bargain between medicine and the state is rather one-sided, in favour of the latter. Specifically, it seems that the relationship can be downgraded when no longer deemed convenient. (Harrison and Ahmad 2000, p141)

At the macro level, however, they find that the biomedical model of illness remains pervasive. They conclude that 'medicine is no longer the dominant structural interest in the NHS' despite there being no significant weakening of the macro-level biomedical model. Indeed they argue that the biomedical model serves the interests of managers as much as medicine suggesting, for example, that because doctors' clinical decisions are made within the boundaries of a biomedical model that assumes that ill-health equates to individual pathology, and that health care therefore consists of individual medical interventions, they do not threaten the dominant capitalist order and are a politically invisible medium for health-care rationing.

Other analyses have considered the way that the managerial state has changed the character of the profession. The most influential of these has been by Freidson (1985) who proposed that professions have responded to managerialism by becoming more hierarchical. Freidson identifies the emergence of new internal strata made up of 'elites' and the larger 'rank and file'. Elites are professionals who take up new academic and managerial positions (what he calls 'knowledge elites' and 'administrative elites'). Freidson argues that professions are able to use these positions strategically, to maintain autonomy over the content of work and to ensure working practices reflect professional interests. Freidson's restratification thesis has recently been extended by Waring (2014). Waring argues that while restratification enables professional elites to protect their collective interests and autonomy, it has the potential to fracture norms of collegiality, equality and solidarity:

> Elites become increasingly proactive in managing and governing their colleagues in non-collegial and more bureaucratic ways, leading to new internal hierarchies, disputes and divisions of power (Waring 2014, p4).

Empirical research among doctors has questioned the extent to which elites retain professional power, suggesting that while elites have retained control in day-to-day aspects of clinical work, they have lost influence in wider service planning (Annandale 1989) and that they have been 'co-opted' by policy makers to extend external control within professional work (Coburn et al 1997). In England the medical profession has always been characterised by internal differentiation and hierarchy, most notably the subordination of general practice to hospital medicine that followed the establishment of the NHS (Johnson 1995). Since the managerial reforms of the 1980s, a

range of hybrid medical-manager roles have developed within the NHS management hierarchy (Kitchener 2000, Waring 2014). Waring and Currie (2009) show that it is not simply that professional elites are co-opted into management roles, it is also the case that management practices are co-opted into medical roles. The co-optation of management practices into medical roles enables professionals to avoid unwanted management interference in work, and to extend their influence over management. While this strategy serves to maintain professional autonomy, it also illustrates the 'managerialisation' of professional work:

> As professionals internalize management techniques in an endeavour to starve off management encroachment, they become increasingly managerial in terms of their practice and identity- the implication being that it negates the need for top-down management controls *over* professionals, as it fosters conformity from *within* professional work. Managerialization may give the impression of self-control and autonomy but it may also signify an important reconstruction of professionalism that potentially leads to enhanced compliance to managerial intent (Waring and Currie 2009, p 775).

Waring and Currie's (2009) analysis highlights how professionalism is transformed through the mediation of both 'top down' intentions to reorder work and occupational resistance from below. This focus on the way that professionalism is transformed through the dynamic interplay between the state and the profession echoes Johnson's (1993) attention to the symbiotic nature of the formation of professionalism and the state. In other words, both the state and the profession emerge from an interplay between changing government policies and occupational strategies.

More recently there has been a shift in policy rhetoric that has emphasised 'clinical leadership' as an alternative to health care management (Martin and Learmonth 2012, Waring 2014). Martin and Learmonth (2012) highlight how doctors are increasingly represented not just as the objects of policy interventions, but as subjects implicated in policy design. They suggest that:

> claims made by health policy about the engagement of professionals as leaders in the design and delivery of reform are best understood as efforts to reconstitute these actors' subjectivities: a co-optive means of 'governing at a distance' that complements more

coercive models of rule such as performance management and associated surveillance regimes. (Martin and Learmonth 2012, p282)

What is important for my study from the literature on the macro politics of health care in the NHS is the dominance of the imperatives and ideology of managerialism, even as doctors seek to maintain autonomy over working practices. Moreover, health care politics involves not simply managers and doctors vying for resources but, it has been argued, the co-optation of doctors in the interests of policy makers. I will seek to elaborate on the role doctors in policy processes with empirical data from my study. Specifically I will explore how doctors are enrolled strategically, as a cultural resource, in the political contest over hospital planning.

Public and patient involvement in health care
The position afforded to the public in decisions about how health care is provided has also changed over time. Until the 1990s the public were largely excluded from such decisions. This reflected the centralised and highly planned nature of publicly provided health care combined with the influence of the medical profession and, later, health care managers. As Milewa et al (1998) describe, in the post war NHS citizens and local communities 'were, implicitly, merely recipients of technocratic and medical expertise delivered in accordance with central planning and clinical judgement' (Milewa et al 1998, p508).

NHS policy now champions the involvement of the public in decisions about service delivery. 'Public involvement' has become a mainstay of national policy rhetoric, beginning with 'Working for patients', published under the conservative government in 1989 (Department of Health 1989), and, at the time this study was undertaken, in New Labour's policies for public and patient involvement. The goal of patient and public involvement in decisions about service delivery was reiterated under the coalition government:

> Patients and carers want to be equal partners with health care professionals in discussions and decisions about their health and care. Citizens want their involvement in decisions about the design of their local health services to be genuine, authentic and meaningful. There can be no place for tokenism or paternalism. The declaration of 'no decision about me, without me' must become a reality, supported by stronger and clearer duties of involvement written

into the Bill focused on the principles of shared decision-making. (NHS Future Forum 2011, p10)

At the time my study was undertaken, strengthening public and patient involvement in health care was a key motif of national policy documents. For example, the White Paper *Our Health, Our Care, Our Say* (Secretary of State for Health 2006) promised 'a stronger local voice' and 'more rigorous fulfilment of existing duties to involve and consult the public in how services are provided' (Secretary of State for Health 2006, p159). However, although public involvement was mandated in national policy, there was no guidance provided to localities on how this should be done (Martin 2008). There was also no central guidance on to what extent local organisations were expected to 'act on' as opposed to merely 'listen to' the views of the community groups, or on how public agendas were to reconciled with national and local bureaucratic agendas when these conflicted (Williams 2002).

In addition to policy pronouncements, there were also statutory changes to way that the NHS was expected to involve and consult communities in the planning and development of services. The 2007 Local Government and Public Involvement in Health Act introduced a new duty for NHS organisations to involve and consult patients and the public in the planning of the provision of services; the development and consideration of proposals for changes in the way those services are provided; and decisions to be made by the NHS organisation affecting the operation of services. This duty applied if implementation of the proposal, or a decision (if made) would have impact on (a) the manner in which the services are delivered to users of those services, or (b) the range of health services available for those users. Previous legislation on the functions of local government Overview and Scrutiny Committees is also contained within the Act. These regulations required NHS organisations to consult the Overview and Scrutiny Committee of the relevant local authorities on any proposal for a substantial development or variation to health services.

The Overview and Scrutiny committee was given the statutory right to refer the decision the Independent Reconfiguration Panel. The Local Government and Public Involvement in Health Act followed the 2006 NHS Act which introduced Local Involvement Networks (LINKS). LINKS were 'set up in every area of England to help people influence the way their local NHS and social care services are delivered' (Department of Health 2008). Membership of LINKS was

open to individuals and groups such as charities and other community organisations. The law allowed for LINKS to ask health and social care commissioners for information about their services and expect a response; make recommendations and expect a response from commissioners; refer matters to the local council's OSC; and make inspections of care providers.

An enquiry by the House of Commons Health Committee found considerable confusion as to the scope and purpose of patient and public involvement (House of Commons Health Committee 2007). This is illustrated in the following excerpt from the evidence to the committee of Ed Mayo, co-Chair of the Department of Health's expert panel on patient and public involvement:

> …it is difficult to know what kind of accountability people want in relation to the NHS. Is it the accountability of a service provider, like Tesco or someone, that is just responsive to what people want? Is it accountability that is in some way mutual and engages them as partners in health, or is it some democratic process that has parliamentary of local councillor scrutiny? Those are very different notions of accountability and I have never heard very clear answers either from the patients we talk to or others in this field. (House of Commons Health Committee 2007, p14)

In terms of the *scope* of patient and public involvement, Forde-Roberts (1998) distinguish between public and private participation where private participation refers to the involvement of patients in decisions about their own treatment and public participation refers to taking part in decisions about service planning and delivery. In relation to public participation, Arnstein (1969) describes a spectrum of involvement depending on the extent to which power is transferred. Thus public involvement ranges from professionals giving information to the public on planned changes to services, to a complete transfer of power and decision making. Other models of this continuum of participation have reduced the number of categories. Feingold (1977), for example, proposed five degrees of participation (informing, consultation, partnership, delegated power and citizen control) whilst Charles and DeMaio (1993) revised this to three (consultation, partnership and lay domination).

In an empirical study, Litva et al (2002) investigated what type of participation the public wanted at different levels of decision making in health care. They used focus groups to explore public views on participation in decision making at the following levels:

(i) At the health system level, determining the location of services within the authority, and exemplified by the placement of emergency services in either one specialist centre or more basic care in two local hospitals;

(ii) At the programme level, determining the funding of particular types of specialist services, represented by the choice between funding a new cancer or mental health ward;

(iii) At the individual level, determining the particular patient who should receive a treatment, exemplified by a choice of which of two patients should receive an expensive and effective drug treatment.

Litva et al found that the majority of informants felt that the public should be involved in decision making at the health system level. The authors report that 'there was a strong view in all groups, however, that the public should be consulted to provide creative solutions and apply 'common sense' to particular problems'. Such consultation 'should also be 'real' with decision makers being open to incorporating ideas from the public that might change their minds about the decision. Otherwise the public may become cynical about the process' (Litva et al 2002, p1831).

There was less consensus about public involvement at the other two levels with only a minority (20%) indicating that the public should be involved in decision making concerning choices between patients (53% indicated that they should not, 12% were unsure and 14% did not respond). According to the authors, the impulse for involvement had both instrumentalist and communitarian aspects. That is the public wanted decisions that more appropriately met their needs: 'Their perception was that this could be achieved by taking account of their practical knowledge and personal experience' (Litva et al 2002, p1834). An 'expressive' impulse was also present which 'may have been reflected through the public's desire to be involved in the NHS which, as a publicly funded institution is perceived to be owned by the citizenry as a whole (Litva et al 2002, p1834).

The participants in the Litva et al study believed they could contribute to decision making and wanted some guarantee that they would be heard. Importantly, 'they also wanted the decisions that were made following consultation to be explained'. The authors note that this empirical meaning of 'consultation' does not relate well to the theoretical models. Charles and DeMaio (1993) for example describe consultations as 'an opportunity for individuals to express their views, but offer no guarantee that individuals views will be taken into account'. The next level of participation is 'partnership' with responsibility for decision making shared between professionals and the public. In other words, what Litva et al found was that there was a 'gap' between degrees of participation and the informants in this study wanted their involvement located in this gap. What members of the public wanted was something like 'accountable consultation'. That is they wanted to contribute to decisions by expressing views, a guarantee that this contribution will be heard, and an explanation of the rationale for the decision ultimately made.

There are two findings from the Litva et al research which are pertinent to my study. The first is that while members of the public noted that they needed information if they were to be involved in decision making, there was a concern that this information would be biased. As one participant observed:

> Any member of the public will never know if they've been given all the information or the information has been slanted to a particular way.

The other was the belief that, contrary to the precepts of rational planning, that people's experiences and emotions were relevant to decision making. This is illustrated by the following quote from a participant in the study:

> There is a lot of emotion from the public because it's an emotional topic. But sometimes emotion does have to come into decision making. It can't just be all straight forward, non-emotional and ...you can't put money to everything. There must be some emotion somewhere to make people realise how the decision making does affect people.

With regards to the *purpose* of patient and public involvement, a number of different perspectives can also be identified. Allen (2006) for example, describes two understandings of the purpose of

public involvement. The first views public involvement as a means of achieving more responsive services. That is, by seeking the views of patients and the public services can be provided that are more likely to reflect patient preferences and community priorities. The second understanding views the process of participation as an end in itself. In this notion of 'active citizenship' citizenship is a 'concept of both *being* and *doing*' (Prior et al 1995, p2).

The first of these understandings is the one most commonly found in Government policy documents. For example, the policy documents introducing Foundation Trusts state that their enhanced autonomy, combined with new governance arrangements that focus on involving patients and the public, will enable them 'to innovate and develop services tailored to the particular needs of their patients and local communities' (Department of Health 2003a, p 2). However, notions of active citizenship have also been articulated by ministers. For example, while minister for public health Hazel Blears published a pamphlet for the Fabian society that argued that 'citizenship must be an active not a passive condition':

> …A democratic view of citizenship must include more than voting in elections, but also the right to be informed, engaged, and involved in a range of state activities and functions and a right to a meaningful stake in the public realm. (Blears 2003, p29)

In the wider social science literature it has been suggested that it is more accurate to speak of 'publics' rather than a singular public. These multiple identities have been variously described as patients, users, communities, taxpayers and citizens (Martin 2008). These relations imply different and sometimes conflicting preferences (to control public expenditure, to retain local hospitals, to improve the quality of care and so forth) (Parker 2004). Martin (2008) found that national policy documents contained ambiguous and multiple rationales for public participation. And whilst public participation in service change was centrally mandated, there was little in the way of guidance for localities on how this should be done, or central monitoring of outcomes. The existence of divergent notions of the role of public participation were also apparent in real-life situations of user involvement. For example, in Martin's (2008) case study of user involvement in pilot cancer-genetics services, he found that staff valued the identities of users as biomedical and lay subjects whilst users themselves described the legitimacy of their contribution in terms of knowledge and citizenship.

Many commentators have been critical of attempts by NHS organisations to involve patients and the public in the planning and delivery of services arguing that service-led initiatives are 'little more than mechanisms by which state agencies give their decision making legitimacy' (Hodge 2005, p164). Similarly, Harrison and Mort (1998) have described public consultation as a 'technology of legitimation'. Reporting on a study of public consultation by local health service managers, Harrison and Mort found that local managers saw their role as making decisions in an essentially pluralistic environment, where the views of patients must be balanced against those of other stakeholders such as doctors and politicians. User groups were a recognised feature of the organisational landscape, 'but not one to which any superior degree of legitimacy was accorded' (Harrison and Mort 1998, p66). Managers often spontaneously described the way they used public involvement as a tactic. For example, they would use the phrase 'playing the user card' to refer to the use of user group opinion to buttress their preferred course of action against that of another professional or institution. The authors suggest that one way of reading the actions of local agents is as officials engaged in strategic micropolitics:

> Thus 'playing the user card' is a concrete manifestation of a situation where a particular set of officials happens to be in agreement with a user group but in disagreement with other officials. In such circumstances it makes sense to build up the legitimacy of the user group. Conversely, in circumstances where officials do not agree with users it makes sense to challenge their legitimacy by means of various criticisms. Thus, for instance, they may be dismissed as extremists, unrepresentative of some unspecified broader social group…(Harrison and Mort 1998, p66)

Other empirical studies have found local public participation initiatives to be beset by frequent challenges to the representativeness of users involved in these initiatives. These challenges have been interpreted as an effort on the part of staff to marginalise public participation and maintain control over decision making processes (Crawford et al 2003). In contrast to the conclusion that managers manipulate public participation to ensure that it advances their own interests, or that staff employ tactics to retain control over decision making processes, Martin illuminates a somewhat more subtle and diffuse form of power. He describes how 'users found themselves isolated in professionally dominated meetings' and that the professional construction of public participation structured the way users were involved, for example by confining their involvement to bounded questions of patient satisfaction and information (Martin 2008, p1763). What Martin

exposes is the less visible operation of power through the professional 'framing' of public participation, which nonetheless had the effect of directing and limiting the input from users in the decision making process.

Public consultation on plans for changes to hospital services has been criticised from a number of sources, including academics, policy think tanks and community groups (Boyle and Steer, 2008; House of Commons Health Committee, 2007; Farrington-Douglas and Brooks, 2007). For example, the Health Committee concluded that 'too often NHS bodies seek to avoid consultation' and that 'consultation is or is thought to be insincere or dishonest' (House of Commons Health Committee 2007, p75). An example of a consultation over plans to change hospital services is included in the Health Committee's report. This example involved plans to close services at Hemel Hempstead Hospital. The public consultation presented two options: Option 1 was for day surgery to be provided at St Albans Hospital, Option 2 was for it to be provided at Hemel Hempstead Hospital. The consultation received 4,200 responses, of which 4% voted for Option 1, 82% voted for Option 2, and 14% favoured other options or stated they were unsure. Despite the result of the consultation the Trust chose Option 1.

A similar conclusion was drawn from a case study of plans to close hospital services undertaken by the Institute of Public Policy Research (Farrington-Douglas and Brooks, 2007). This study found that the decision making process was not transparent, leading to widespread distrust by the public and other stakeholders in the fairness of the outcome:

> Local stakeholders expected to influence the outcome of consultations. Several options, including 'doing nothing' were presented for public feedback. Yet in practice change was unavoidable, even if it was unpopular with consultees. This led to a perception that consultation was a 'sham'. (Farrington-Douglas and Brooks 2007, p 6)

While public involvement has become a mainstay of policy rhetoric, the actual mechanisms for public involvement are either limited or have been weakened. The government has shown little interest in strengthening public involvement through democratization (such as direct elections for PCT members and transferring health commissioning functions to local government). And while government attention to public and patient involvement has seemingly increased, the role played by *independent* patient groups has diminished (Mold 2010, Hodge 2005).

In summary, improving patient and public involvement in decisions about the delivery of health services has become a mainstay of policy discourse, although the existing literature on public participation shows that the concept has multiple meanings and it is not always clear in policy texts whether it is referring to involvement of the public as citizens, as local communities, as service users, or some other identity. While empirical research suggests that the public do want a say in how local services are delivered, efforts of local managers to involve the public have been interpreted by some scholars as primarily geared to establishing legitimacy. Empirical studies have also concluded that staff have sought to marginalise public participation to maintain control over decision making processes. Martin (2008) reveals how users were also marginalised through the way the issue was constructed on the ground by professionals.

It has been suggested that the point at which a policy is made public is now a more important site for politics than party politics. It is at the point when a policy is made public when people reflect on who they are and what their values are (Hajer 2003). Proposed changes to hospital services generate significant concerns from the community, and are often the focus of organised protest, yet, as the Health Committee (2007) concluded, NHS organisations frequently either seek to avoid public consultation, or do it in a way that is, or is viewed as, 'insincere or dishonest'. Other scholars have argued that whilst public involvement has achieved a prominent place in policy rhetoric, the mechanisms for involving the public in decisions about service delivery have weakened. Thus the existing literature raises questions as to the extent to which there has been any substantial shift in health service governance, and to what extent this is even an intention of government (as opposed to rhetoric).

The national policy of public participation forms an important context for my study. Regardless of whether the stated aim of increasing public participation has substance beyond rhetoric, it is nonetheless an important imperative to which local managers must respond, and I argue that this policy helps to account for the emergence of the framing of 'clinical case for change' in the field of hospital planning. The discourse of public participation is also a cultural resource that becomes mobilised in micro (and, as I will show, macro) political contests. In this study I consider the way this discourse is enacted in the practices of deliberative forums and how such forums serve as co-optive devices in the interests of service managers and policy makers. Beyond

the stated objectives of national government policy in the UK, my findings have relevance for broader scholarly debates concerning the potential for more democratic policy processes.

The politics of hospital planning

What we know about hospitals - their location, size, the services they provide, and the way they dominate the organisational landscape of the NHS, stems largely from the 1962 Hospital Plan for England and Wales. When the NHS was created in 1948 it inherited a haphazard distribution of hospitals made up of a mix of voluntary and local authority provision. The aim of the Hospital Plan was to rationalise and modernise the existing hospital stock and to better match the geographical distribution of acute services to apparent need. Problems identified in the Plan included obsolete buildings and a lack of investment in maintenance during the war. The intention was to use the opportunity provided by a rapid increase in capital funding to 'take a comprehensive view of hospital needs and to formulate a long-term national plan for meeting them' (Ministry of Health 1962, p2).

The Plan itself was a collection of regional intentions for hospitals based on a centrally dictated norm of 3.3 beds per 1000 population. These regional plans were published alongside an overriding framework, the centrepiece of which was the 'District General Hospital'. Comprising between 600-800 beds and serving a population of 100,000 to 150,000, the Distinct General Hospital would provide, with a few exceptions, the full complement of specialist services. A smaller number of specialties that were considered to require a greater catchment area, such as neurosurgery, would only be provided at certain hospitals. The underlying assumption of the Plan was that rationalising hospitals onto fewer sites would increase efficiency. Although some smaller hospitals would be retained to provide a more limited range of services, such as care for the elderly, the plan anticipated the closure of some 700 hospitals over the next ten years.

According to the political scientist Rudolf Klein (2001), the publication of the Hospital Plan reflected a nascent 'ideology of rationality' in national health care policy. At the time the Plan was published there was an increasing concern with efficiency in public spending; economists were, for the first time, recruited to key posts in the Department of Health; and civil servants were beginning to use techniques such as cost-benefit analysis. Enoch Powell himself once described

the Hospital Plan as 'ruthlessly breaking with habit and tradition where they conflict with reason and common-sense' (in Mohan 2002, p125).

From this perspective the focus is on the services that are provided in hospitals and the overriding concern is with the efficiency of those services. However, like any organisation, a hospital is not just a technical system but has social and symbolic dimensions (Scott 1987). These broader dimensions are excluded in the rational paradigm. This is illustrated in the following excerpt from Enoch Power's 1962 'Water Tower' speech, which followed the publication of the hospital plan:

> We have to get the idea into our heads that a hospital is a shell, a framework, however complex, to contain certain processes, and when those processes change or are superseded, then the shell must be probably scrapped and the framework dismantled.

The Plan also represented an alliance between the State and the medical profession which then, as now, advocated the rationalisation of hospitals onto fewer sites to concentrate consultant expertise and equipment. The Plan thus represented a medical vision of health care quality. This vision excluded other possible considerations for hospital planning, such as access for patients and their families, and for other health care staff who must travel to and from the hospital at all hours of the day and night.

From the outset, hospital closures faced significant resistance from community groups, a political contest that has endured to this day. The following is from a letter to the Times from 1962:

> The ideological centralisation proposed in the Hospital Plan is about as realistic as would be a plan to scrap all the ships in the fleet except the aircraft carriers, and about as moral as would be a plan to close all the parish churches on the grounds that the work done in them could be more efficiently organised in cathedrals.(In Mohan 2002, p151)

The correspondent is here rejecting the assumption that service efficiency should be the overriding concern in hospital planning, but there is something more. It seems to be an attempt to articulate a sense that hospitals have meaning beyond 'capital stock'. The analogy with the parish church suggests that hospitals have symbolic and social significance within their localities.

In addition to public resistance to hospital closure, implementation of the Hospital Plan was also constrained by the economic situation of the 1970s, which led to cutbacks in the hospital building programme (Harrison and Prentice 1996). In some areas services continued to be provided from existing facilities, spread over a number of sites. According to Harrison and Prentice, 'in this way, the district general hospital became, and in some way remains, an organisational concept applied over separate sites rather than a cluster of related clinical activity'(Harrison and Prentice 1996, p4).

Following the publication of the Hospital Plan an advisory committee (staffed mostly by doctors) published the Bonham-Carter Report (Department of Health and Social Security 1969). This report recommended even greater centralisation of hospital services, with the implication that such hospitals may have as many as 15, 000 beds. This report was never endorsed by the government and official statements published since then have tended to counter the centralising tendency of professional reports by reaffirming a role for smaller hospitals, and suggesting that there may be disadvantages to centralising services (Department of Health and Social Security 1975, 1980, Department of Health 2003b). For example, the following excerpts are from a consultation document, published in 1980:

> Experience has shown that a large degree of concentration on a single site may have serious disadvantages. Communications of all kinds within the hospital become more complex and difficult, as does management. Patients and relatives, as well as staff, find the hospital too impersonal. It often suffers from physical disadvantages and the need to provide air conditioning, with high energy requirements. (Department of Health and Social Security, 1980, p10).

> Steep rises in motoring costs mean that travel to hospital is more expensive for patients, staff and visitors. Ambulances and other forms of hospital transport all cost more to run. Public transport costs more. And in rural districts it is not as comprehensive, nor as frequent, as it used to be – an important factor for many elderly patients and mothers with young children. (Department of Health and Social Security 1980, p11)

Between 1980 and 2003 there was no national policy on the form and content of hospitals, instead responsibility for planning hospital services was left to regional-level planners. For other

national policy elites, such as national organisations representing managers, national bodies representing the medical profession, and policy think tanks, the issue of 'the future hospital' remained a perennial topic for debate. The position papers published by these organisations have all tended to advocate further centralisation, although the details of the organisational models that have been suggested have varied and shifted over time. For example, at one point the national association representing health authorities and trusts (what is now the NHS confederation), published a policy document that recommended that services should be concentrated in very large 'super hospitals' serving a population of 2 million people (National Association of Health Authorities and Trusts 1993). The report, unsurprisingly, contains a managerial narrative whereby concentration is proposed as a means of achieving greater system efficiency:

> There is too much under- utilised capital in the system. Many people now believe that there is also in some areas of service significant under-utilisation of scarce staff resource. (National Association of Health Authorities and Trusts 1993, p14)

The national professional associations representing doctors have also continued to advocate further centralisation in order to facilitate medical staffing and training (Joint Working Party of the British Medical Association, Royal College of Physicians of London and the Royal College of Surgeons of England 1998, Senate of Surgery of Great Britain and Ireland 1997, 2004). In addition to publishing policy documents that explicitly promote a policy of centralisation, centralisation is also implicit in the standards set by the Royal Colleges for staffing and training. Given the influence of these bodies on the distribution of clinical services their role is worth setting out at some length.

The influence of the Royal Colleges on hospital planning
The Royal Colleges are national bodies representing the different medical specialties. Royal Colleges are responsible for approving staffing and training arrangements and setting standards and as such have a considerable influence on hospital planning. As West (1998) has observed:

> Hospital planning in the UK, both within hospitals and across geographical areas is effectively dominated not by purchasers but by the professional bodies, the medical and

surgical Royal Colleges, responsible for the oversight of junior doctor training and approval of consultant posts. (West 1998, p171)

A substantial proportion of the medical care received in hospitals is provided by doctors in training. However, before a trust can employ a medical trainee they must have the post approved by the relevant Royal College. Royal Colleges set criteria for training posts that specify the size of the clinical team and/or volume of procedures. For example, at the time of writing, the Royal College requirements for training in accident and emergency (A&E) were at least two full-time consultants and an annual throughput of 25, 000 new patients. For the post to be approved for the paediatric component of A&E training it must have an annual input of 18, 000 new patients who are children (College of Emergency Medicine 2006). A trust that is unable to meet the criteria will not only be unable to employ medical trainees but will be unlikely to attract senior doctors, who will be more likely to be attracted to a position with a full clinical team (West 1998).

The Royal Colleges also publish recommendations for how services should be provided. These specify catchment populations, staffing patterns, workload and inter-professional linkages. For example, at the time of commencing fieldwork, the recommendation from the Royal College of Obstetricians and Gynaecologists for Maternity Services was as follows:

> Consultant cover should be available in a supervisory capacity for a minimum of 40 hours during the working week, unless the unit is small and where the majority of women who give birth have had a normal pregnancy. (Royal College of Obstetricians and Gynaecologists 2002)

Unlike standards for training, clinical standards cannot be enforced in any formal sense but have an influence on the configuration of services in so far as they are used by purchasers in drafting contracts with providers (Dowie and Gravelle 1997). Royal College recommendations may also specify that one specialty cannot be present without another, for example, maternity and paediatrics. This means that if the caseload for paediatrics falls below that required by Royal College standards, the hospital will not be able to provide obstetrics. Without obstetrics the hospital cannot provide gynaecology, as consultants work across the two specialties. Without paediatrics the hospital will also find it difficult to attract trainees in surgery or anaesthetics as

they will not be able to complete the necessary training in the paediatric component of their specialty. Thus there is a potential 'domino effect' whereby the loss of a single specialty could threaten the viability of the entire hospital. Over time there has been increasing specialisation within medicine (e.g. recent surgical subspecialties include vascular surgery and urology). Increasing specialisation has meant an increase in the number of different clinical teams in hospitals and, as a consequence, a push for hospitals to serve larger catchment populations to ensure sufficient caseload.

The evidence supporting Royal College recommendations for training and service provision is limited and recommendations are often made on the basis of expert opinion. Given the significant impact these recommendations have for service provision, concerns have been expressed that there is little coordination between Colleges and that recommendations are often published without discussion with managers of the effect on service provision (Ferguson, Sheldon and Posnett 1997).

In summary, since the publication of hospital plan for England and Wales, responsibility for hospital services has been left to regional-level planners, although the issue has remained a key topic of national policy debate. In both managerial and professional narratives a policy of centralisation has been presented, although the preferred model has shifted over time.

Hospital planning in local health economies
By way of context, there is a key feature of the NHS I wish to highlight at this point because it relates to the description in the following chapters. This is the distinction between the central and local levels. Brown (2003) describes the tension between the central and local levels as the 'key axis that shapes the geography of the NHS' (2003, p294). As a *National* Health Service funded from general taxation the NHS has a uniform character, at the same time is has been described as comprising a series of local health services (Exworthy 1998). Whilst the policy rhetoric of successive governments has often promulgated localism and decentralisation as a means of increasing flexibility and making services more responsive to local needs (see for example Secretary of State for Health 1989, Department of Health 2000) most have simultaneously put in place measures designed to increase the control of the centre over the periphery (Klein 2001). At the time of fieldwork one of these measures was the presence of 'outposts' of central government in the regions in the form of Strategic Health Authorities

(figure 1). Strategic Health Authorities (SHAs) were responsible for managing the performance of health services and ensuring that national priorities were integrated into local plans.

At the time of fieldwork the local organisations responsible for commissioning care from providers on behalf of their population were known as Primary Care Trusts (PCTs). The official relationship between the centre and localities in relation to hospital planning was set out in guidance sent from the Department of Health to Strategic Health Authorities. This states that local commissioners are 'responsible for assessing the needs of their local population and identifying suitable services to meet those needs' but in such a way as to be 'consistent with national policy direction' (Carruthers 2008, p 10).

Figure 1. The organisation of the NHS in 2007
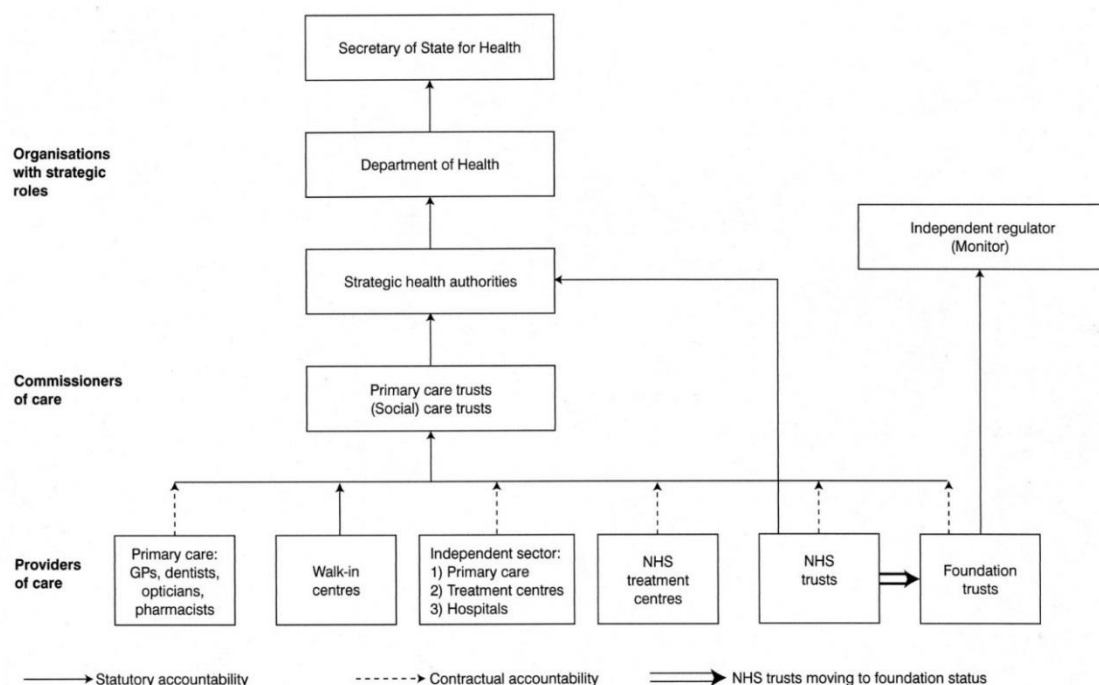
Since the publication of the Hospital Plan in 1962 regional and local-level planners have sought to centralise hospital services, despite limited evidence of either financial or clinical gains. When I began this study plans to either close hospital departments or entire hospitals were widespread. For example, in February 2007 the BBC reported that 60 NHS trusts in England were involved

in plans to centralise services (BBC, 28 February 2007). In one of the few empirical studies of efforts by local NHS organisations to centralise services, Fulop et al (2002) report a range of 'drivers' for the plans, some of which were not publicly stated. Local managers reported in interviews that the strongest driver was the need to comply with the European Working Time Directive (legislation that places limits on the working hours of medical staff) and with staffing and training requirements prescribed by the Royal Colleges. Other stated drivers for change included the need to respond to national policy on moving services out of hospital, closer to where people live, and changing the way cancer services are provided. Unstated drivers also became apparent during interviews with key stakeholders. These were concerned with specific local issues about one of more constituent trusts:

> These included a need to impose new management regimes on trusts perceived by health authorities or regional office as 'undermanaged' or 'lacking control', to negotiate reductions in accumulated deficits of one of the constituent trusts (because new organisations could not be expected to carry the burden of deficit from the start). (Fulop et al 2002, p326)

Criticisms of centralisation

In both professional and managerial narratives policy arguments are couched in the language of rational analysis whereby centralisation is presented as a means to some desired ends, usually improved 'efficiency' or 'effectiveness'. These arguments are highly contested in the academic literature. Taking, for instance, the argument that centralisation improves patient outcomes, there have been a number of critiques of the methods of studies, the interpretation of findings and the choice of policy response (Nuffield Institute of Health 1996, Shahian and Normand 2003, Bryne and Yang 2008, Shapiro 2008).

For example, a number of criticisms have been made in relation to the methods and interpretation of the volume-outcome literature. One of these relates to the dichotomisation of the continuous variable 'volume' into 'high' and 'low'. According to Bryne and Yang (2008) there is considerable overlap between studies in where the line is drawn so that what is considered 'high volume' in some studies is 'low volume' in others. Another problem relates to the direction of causality. Much of the research assumes that outcome is result of volume. However, volume could equally be a product of outcome if, for example, a skilled clinician attracted patients. A skilled clinician may also be attracted to, or more likely to be employed by, a large volume

provider. One early systematic review (Nuffield Institute of Health 1996) concluded that there appeared to be an association between volume and outcome for some procedures but not for others. Elsewhere, research has shown that centralising services may impact negatively on health outcomes. Nicholl et al (2007), for example, found that increased distance in ambulance journey to accident and emergency was associated with an increased risk of death.

Researchers have also argued that clinical effectiveness is not the only consideration in hospital planning. Centralising services will inevitably reduce access for some patients and can shift the cost from the NHS to patients and their carers. The review by the Nuffield Institute of Health found this particularly impacts on more disadvantaged groups. Issues of access concern staff as well as patients. Boyle and Steer (2008), for example, argue that:

> Although accessibility is often one of the public's main concerns, it is also an issue that concerns staff and it will impact on staff recruitment and retention. Often consultations take little account of the transport needs of staff, who may be required to work unsocial hours, particularly when the reduced availability is of public transport at night is considered (Boyle and Steer 2008, p8).

More broadly, hospital closures have been found to have damaging effects on local and regional economies, including unemployment and lower incomes (Holmes et al 2006).

A final contested issue is the choice of policy response. A failure to establish causal direction means that there is no evidence that increasing volume will result in an increase in health care outcomes. And optimal thresholds might be reached through specialisation of tasks within a hospital rather than an increase in the size of the provider. In the systematic review by the Nuffield Institute of Health the authors concluded:

> If service concentration, justified on the basis of clinical outcomes, is proposed there is a need to understand the source of expected benefits. For example, if the main driver of improved outcome is the experience of clinicians, this may justify specialisation of tasks within a clinical team, it may justify larger units, or it may simply suggest that clinicians need to work across sites. Each case must be examined to see if a solution can be found

that reaps any volume-related quality gains in excess of financial, access or equity costs (Nuffield Institute of Health 1996, p6).

Similar conclusions were reached more recently by Harrison (2012). Harrison showed how a policy of centralisation may involve the closure of some high performing units. He gives the example of a recent study of paediatric surgery which found that the goal to reduce the overall number of units from 11 to 7 would mean that some high performing units would need to close:

> This policy was based on volume and outcome evidence that was taken to mean that units should treat at least 400 patients a year. In addition, the study assumed that a geographical spread of units was desirable on the grounds of access. Together these two principles led inexorably to proposals for closing one or more high performing units. (Harrison 2012, p4)

Harrison argues that the apparent advantages of larger units may not be intrinsic but can be matched in other circumstances. For example skilled clinical staff, knowledge transfer and well-defined care processes can all be made available in hospitals with lower levels of activity. Harrison suggests that alternatives to centralisation include moving the doctor to the patient; using telemedicine to allow local clinicians to seek advice from specialised units on the basis of electronic transfer of imaging; or linking the smaller units into networks with agreed referral to ensure that the most difficult cases are transferred to better equipped units (Harrison 2012, p4).

This thesis is not concerned with how best to provide hospital services. Rather, it is concerned with the role of policy in political contests. The purpose of this section is to establish some of the starting assumptions of this thesis, which is that policy arguments for centralisation are contested and that, as with all policy issues, there are alternative courses of action. What I will show in my empirical chapter is how a framing of the issue as clinical constrains which courses of action are considered, and who is involved in decision making.

Community resistance to hospital closures

Plans to close hospital departments or entire hospitals are highly contested by other local stakeholders. Hospitals targeted for service closure may resist plans because they face a loss of income and private practice. And because of inter-specialty linkages, even plans to close a single

department may be perceived as threatening the viability of the organisation (Ferlie, McGivern and FitzGerald 2012). Plans are also contested by community groups, typically comprising patients, staff employed in the hospital and other members of the local community. This resistance has taken the form of public demonstrations and campaigns to save the local hospital that have involved both local and national politicians. Just prior to starting this study, in 2006, the Guardian newspaper reported 50 areas where there were public protests at plans to close hospital services (Guardian, 26 October 2006).

Community resistance to hospital closures has been a feature of local politics since the publication of the Hospital Plan in 1962. The following is a description of a public protest from 1968 which differed in no way from what I encountered in the field:

> When (the decision to close the hospital) became known local residents organised to oppose the proposal: an action committee was formed: the support of the MP for the area was enlisted; and the local authorities concerned expressed their opposition to the closure. Following a packed public meeting in Kirkbymoorside in 1968 attended by senior Board officials and members, the Board reaffirmed its policy, and the Secretary of State subsequently agreed to the hospital being closed (Ham 1980, p68).

Attempts in the 1990s to close hospitals in London, notably St Bartholomew's ('Barts') provoked enormous public protest (Moon and Brown 2001). In 1996 the Conservative MP Sir John Gorst withdrew support for the government following the closure of an A&E department in his constituency, resulting in a minority government (Mohan 2002). One of the best known examples of community resistance to plans to close hospital services is the protest against plans to close all acute inpatient services and the accident and emergency department at Kidderminster General Hospital. According to a local newspaper report, the first public consultation meeting was attended by 1,350 people (Kidderminster Times, 19 March 1998) and one public rally was attended by an estimated 12, 000 people (Kidderminster Times 26 March 1998). But perhaps the best illustration of the strength of local feeling is the victory in the 2001 general election of Dr Richard Taylor who defeated a sitting government minister after campaigning on a single issue - saving the local hospital.

Oborn's (2008) analysis of the controversy over Kidderminister hospital focuses on the rhetorical strategies of different parties. She argues that the rhetoric of community groups constructed a notion of 'the local' that contrasted with the 'regional' level at which health services were understood and planned by NHS organisations. The national policy response to the events of Kidderminster was the publication in 2003 of the White Paper *Keeping the NHS Local* (Department of Health 2003b). As with previous guidance published by the Department of Health on hospital planning, this policy sought to temper the centralising tendencies within the NHS. It does this, firstly, by maintaining a role for smaller hospitals. In so doing it mobilises a community narrative that mimicked the construction of the local found in the rhetoric of community groups opposed to the Kidderminster closure. This community narrative touched on the value of local hospitals to communities and advocated a process of joint planning with communities:

> The mindset that 'biggest is best' that has underpinned many of the changes in the NHS in the last few decades, needs to change. The continued concentration of acute hospitals without sustaining local access to acute care runs the danger of making services increasingly remote from many local communities. With new resources now available, new evidence emerging that 'small can work' and new models of care being developed, it is time to challenge the biggest is best philosophy. (Department of Health 2003b, p4)

> The guidance proposes sustainable solutions for smaller hospitals to secure their valued role at the heart of local communities. Service and workforce redesign offer the potential for a wider range of safe, effective, high-quality care to be offered in smaller hospitals than has previously been thought possible. Modernisation and improving the quality of care should not be seen as synonymous with or inevitably involve a move to centralise services into fewer, larger 'super hospitals'. It is instead working with local communities and staff to rebuild local services around local needs. (Department of Health 2003b, p4)

A key referent in *Keeping the NHS Local* is the recently established statutory duties to involve the public in decision making. In referring to these duties the government makes it clear that local organisations are expected to involve the public *prior* to a decision being made:

The key message from the new duties is that open discussion with patients and the public, and with staff, needs to begin right at the outset- before minds have been made up about how services could or should change. And this discussion needs to continue right through the process – all stakeholders need to feel that they have had the opportunity to influence the debate at key stages, and have been kept properly informed throughout. (Department of Health 2003b, p12)

Secondly, *Keeping the NHS Local* adopts a critical stance in relation to the volume-outcome literature and explicitly places findings from research alongside other, equally important considerations for hospital planning:

The link between volume and outcome is one aspect of quality that has been hotly debated. There are few instances where clear links have been made, for example in upper gastro-intestinal tract surgery, but generally the links are less frequent than is often assumed. Outcomes may be equally linked to the organisation and approach of the service – for example, outcomes for stroke patients are greatly improved if they are admitted promptly to a hospital based stroke unit and receive care from a specialist multi-disciplinary stroke team. (Department of Health 2003b, p15)

Thirdly, the White Paper takes a tentative, non-directive tone (there are, for example, frequent uses of the words 'might' and 'may') and suggests a wide range of alternatives to centralisation. Rather than promulgating a single, universal service model, the emphasis is on local innovation, flexibility, and services that are 'tailored to local priorities' (Department of Health 2003b, p17):

In this guidance we have set out how service improvement strategies, coupled with a better and more detailed understanding of patient needs, can open up possibilities for service development. Options need to be developed openly in discussion with all stakeholders – local people, staff, the local council and others, starting from a clear understanding of the opportunities and constraints. (Department of Health 2003b, p29)

This document has discussed in more detail the potential that service and workforce redesign have to offer new solutions, built in partnership with local populations. The ideas it contains may be useful in suggesting ways of doing this – or you may wish to feedback

on other local solutions which have been found and which others could learn from.

(Department of Health 2003b, p40)

In the following chapters I will contrast this policy with subsequent national policy to show a shift in the framing of centralisation in national policy. I show that at the time of my study national policy came to increasingly frame centralisation as a clinical necessity. I argue that this shift in framing can be understood as a rhetorical strategy intended to convince other stakeholders of the need for change. I show that while the rhetorical effects of this framing were limited a more insidious operation of power can be found in the way the framing channels thinking in a particular direction and subjugates the voice of the public.

Summary

Hospital planning is an enduring and seemingly intractable issue on the agenda of local health services managers. Efforts on the part of regional planners to rationalise hospital services have been in place since the publication of the Hospital Plan for England in 1962. This agenda has coincided with that of the national professional associations representing doctors that have sought to concentrate acute services in fewer larger units in order to facilitate medical staffing and training. In both managerial and professional narratives policy arguments are couched in the language of rational analysis whereby the centralisation of hospital services is presented as the means to some desired ends ('efficiency' say or 'effectiveness'). These claims are highly contested in the research community. Criticisms have concerned the methods of studies investigating the relationship between volume and outcome, the interpretation of findings and, of particular relevance to this paper, the choice of policy response. Plans to close hospitals or hospital departments also face significant community resistance. At the same time national policy rhetoric emphasises the importance of involving the public in decisions about health care delivery. My question is, how, in this context of political contestation, does policy 'work' as an instrument of governance?

2. THEORETICAL FRAMEWORK

This chapter locates my study in the theoretical literature. I begin by exploring the way that policy shapes practice. I then problematize the concept of policy by turning first to the prevailing notion of policy as the application of rational decision making to social problems. Drawing on empirical studies I show that policy processes do not, in practice, exhibit instrumental rationality, but have significant habitual and political dimensions. Nonetheless, I argue that the idea that policy making represents rational decision making remains an important mythology, reinforcing the sacred values of rational choice. I then contrast the concept of policy as the application of rational decision making with my own theoretical stance which views policy as discursive practice. This approach is concerned with the way people use cultural resources to create meaning and accomplish activities. From this perspective policy is not so much the application of rational decision making, but the *mobilisation* of rational decision making, as a cultural resource. Drawing on Foucault, I argue that rational-decision making has become naturalised as 'common sense' and it is this very 'taken-for-grantedness' that gives it potency when mobilised, through policy, in political contests. The way it works is rhetorical, in that it is impossible to argue against the proper order of things. But it is also, in a broader sense, discursive, in that it constitutes the subjectivities of policy actors, and constructs a world that privileges certain values as it excludes others. In this thesis I apply this theory to hospital planning in the NHS and in the remainder of this chapter I introduce the specific concepts I use in my analysis, namely Rein and Schön's (1993, 1994) concepts of 'frames' and 'framing'.

Policy and practice

Policy matters (as the sociologist Stephen Ball remarked) because it is acted on (1993, p12). Policy has the ability to both stimulate and channel action. This is not to say that the relationship between policy and action is straightforward. The effects of policy cannot be simply 'read off' a policy text but are the result of complex dynamics of constraint and agency. Responses to policy vary between different contexts and a policy text is subject to different readings and reactions of actors (Ball 1993). In practice the 'room for manoeuvre' created by the intervention of policy will differ for different actors. For example, Waring (2015) has shown how a policy to involve the

private sector in the provision of public health care in the NHS had significantly different interpretations and implications for staff depending on individual attributes, such as expertise and status. So, for example, some doctors felt that transferring from a public provider to a private provider had 'restored' their professionalism. They felt that they had been freed from NHS bureaucracy and had more autonomy. The effect of the policy on perceptions of professionalism and morale was contingent on various factors, such as whether the individual had a financial interest in the organisation, whether they had particular expertise or knowledge that was valued by the organisation, and whether they had alternative employment options available to them.

Policy shapes but does not determine the action of practitioners. Government policy is only one, and not necessarily the most important, influence on local actors. Conversely, policy may itself be shaped by the action of practitioners. Weatherly and Lipsky (1977), for example, showed how the coping strategies adopted by teachers and other school staff to manage the demands of their job distorted the implementation of special education policy. For instance, the policy required uniform treatment of children with special needs, but with no explicitly mandated system of prioritising children, and faced with an increase in workload, staff biased the scheduling of assessments in favour of children whose behaviour was disruptive, who were not likely to cost the system money, or who matched the specialty interests of individual members of staff. Weatherly and Lipsky showed how the patterns of responses developed by local staff to the multiple demands placed upon them effectively *became* the policy.

Policies are also, as Miller and Rose (1993) observe, in many ways destined to fail. The reality of social life always escapes the theories that inform policy, it is too 'unruly' to be captured by abstract knowledge. Policies are 'heterogeneous and rivalrous' so that solutions for one issue tend to be the problems for another. And unintended consequences emerge from the intersection of one policy with another, or in the process of implementation:

> Policies produce unexpected problems, are utilised to their own ends by those who are supposed to merely implement them, and are hampered by underfunding and professional rivalries. And the technical conditions required to make them work – reliable statistics, efficient communications systems, clear lines of command etc – are invariably absent (Miller and Rose 1993, p85)

A distinction can also be made between the effects of a single policy, and the general effects of policies as they accumulate over time. While the effects of a single policy may be limited, the effects of a series of polices over time may be considerable (Ball 1993). Nonetheless, although the effects of policies cannot be assumed, they do have effects in the material world.

So far my discussion has assumed a definition of policy along the lines of 'a decision as to a course of action'. In the next section I problematize the concept of policy by considering, firstly, the notion of policy as the application of rational decision making to social problems. I then introduce my own theoretical stance of policy as discursive practice. From this perspective policy is not so much the application of rational decision making but the *mobilisation* of rational decision making, as a cultural resource.

Policy as rational decision making

In the speeches of government ministers, and in policy documents published by government agencies, policy is presented as the application of rational decision making to social problems. In a broad sense, to refer to something as 'rational' is to say that it is based somehow on reason, where reason is defined as the process of drawing logical inferences. In a more narrow sense it is used to describe effectiveness in instrumental problem solving (Dryzek 1987, p673). It is this notion of instrumental rationality that is the dominant paradigm in public policy (Dryzek 1987, Stone 1988, Tenbensel 2000, Torgerson 2003). In this paradigm government and its agents are assumed to be purposive, goal-oriented problem solvers seeking optimal solutions. Rational decisions are based on comprehensive information about alternative courses of action and can objectively demonstrate that they maximise benefits and minimising costs (Tenbensel 2000). The process proceeds in a linear fashion through the following steps (Stone 1988, p5):

i Identify objectives
ii Identify alternative course of action for achieving objectives
iii Predict and evaluate the possible consequences of each alternative
iv Select the alternative that maximises the attainment of objectives

Scholars have argued that is not how actual decision making occurs, nor would it be possible in real-life situations. Lindblom (1959), for example, describes actual decision making as involving a small number of alternatives, none of which vary much from the status quo. Policy thus proceeds incrementally and as a result of decision makers 'muddling through'. Similarly, Simon (1997), describes real-life decision making as exhibiting 'bounded' rather than comprehensive rationality. So, for example, rather than considering all options and choosing the action with the best consequences, decision makers instead seek a course of action that is 'good enough', in Simon's words they 'satisfice'.

One of the best-known studies of real-life decision making is Allison's (1971) analysis of the Cuban Missile Crisis, the 1962 confrontation between the US and the Soviet Union that brought the two nations to the brink of nuclear conflict. The events known as the Cuban Missile Crisis were described by the then prime minister, Harold Macmillan, as a 'strange and scarcely explicable affair'. Macmillan's statement reflects the widespread assumption at that time that no country would start a nuclear war because it would be an irrational decision - the consequence would be 'mutually assured destruction'. The perception of these events as 'inexplicable' also reflects the dominance of 'rational decision making' as a conceptual lens to view the world, and the fact that the rational decision-maker model of action cannot account for these events.

Allison proposes two alternative conceptual models of action. The first is the organisational process model whereby action is not the outcome of rational choice but of organisational behaviour. In this model action results from the enactment of established routines and the adoption of standard operating procedures. Analysis using this model is attuned to the problems that occur when an existing programme is introduced into a new context and when policy makers attempt to force organisations to act contrary to their goals. So, for example, in the case of the Cuban Missile Crisis, the Soviet government assigned the task of establishing nuclear missile bases in Cuba to established departments which followed their own established procedures. Responsibility for placing the missiles in Cuba was given to the Soviet Ground Forces whose objectives and standard operating procedures were all orientated to warfare in Europe. As a consequence it continued to rely on Medium Range Ballistic Missiles, capable of hitting targets in Europe, rather than Intercontinental Ballistic Missiles.

The second model of action proposed by Allison is the governmental politics model whereby action is the result of bargaining between individuals and groups with different interests and perspectives. This model recognises that 'decision makers' who sit atop organisations are not a monolithic group, rather, each is a 'player' in a central competitive 'game'. Overlapping interests constitute the 'stakes' for which games are played. The use of the word 'game' here follows Wittgenstein's theory of the 'language game' and is similar to the way the term is used in game theory (e.g. Shelling 1967), rather than intending to suggest nonserious play. In the governmental politics model action is a result of bargaining among players positioned hierarchically within government. Because power is shared, and because individuals differ in their view of what needs to be done, government decisions must result from a political process. Sometimes one group committed to a course of action will prevail, other times different groups pulling in different directions produce policy that is a result of different, conflicting preferences and unequal power, and is different from what any group intended. What is influential is not simply the reasons for a course of action, or the routines of organisations, but the power and skill of proponents and opponents of the course of action in question. The impact a player has is influenced by formal authority, charisma, and control over resources, including control over expertise and information which enables a player to define the problem and identify options. The peculiar preferences of individual players may also have a significant effect on action.

In this model of action 'players' do not act in terms of a consistent set of strategic objectives but rather according to various conceptions of national, organization and personal goals. The results of minor games (negotiation among lower-level players, such as the wording of a memo) central games (bargaining among central players) and what Allison calls 'foul-ups' (e.g. misunderstandings, reticence on the part of players etc.) form a *collage* that constitutes government action on an issue. Drawing on Neustadt (1960) Allison argues that in this context 'presidential power is the power to persuade' (1971, p154). Policy is thus the result of bargaining, accommodation, compromise and 'logrolling' (trading off subordinate interests for major interests).

In the governmental politics model government action does not presuppose intention. The sum of action relevant to a policy issue is rarely intended by any individual or group, nonetheless the resultant policy can be roughly consistent with a group's preference. 'Solutions' to problems are not discovered by detached analysts focusing disinterestedly on a problem. Each player focuses

not on the total strategic problem but on 'the decision that must be made today'. Thus there is a gap between the problem the player is focusing on and the problem that the policy analyst is focusing on. Allison argues that while formal decision makers (such as heads of organisations) might focus on an issue and look for a solution, other players, such as government officials who have become committed to a solution developed for an earlier, somewhat different, problem, seek a problem. Allison illustrates the governmental politics model again using the Cuban Missile Crisis. He argues that following the failure of the Bay of Pigs invasion the republicans had made Cuban policy a major issue. As a result, Kennedy decided immediately upon a strong response rather than a diplomatic one. What was at stake for Kennedy was his presidential authority and the possibility of impeachment. Thus other options, such as diplomacy, were irrelevant to *his* problem.

Allison argues that the rational actor model, when used in analysis to support policy, leads to unreliable assumptions about reality which could have significant consequences. He uses the example of the attack on Pearl Harbour which, he argues, was able to happen in part because it was assumed Japan would not attack the US because this would be 'irrational' (because Japan did not have the military capacity to win a war against the US).

March and Olsen (1989) also argue that the model of rational decision making cannot account for decision making in real-life situations. They argue that from the lens of instrumental rationality most actual collective decision making, as recorded in empirical case studies, appears chaotic, like 'bedlam' (March and Olsen 1989, p12). As with Allison's organisational process model, March and Olsen argue that much behaviour is driven by rules, routines, duties and obligations. In contrast to the 'logic of consequentiality' of 'anticipatory action' (i.e. rational decision making) 'obligatory action' displays a 'logic of appropriateness'. So, for example, a hospital manager does not ask 'what should I do in this situation' but '*what would a hospital manager do in situation such as this?*' The difference between the 'logic of consequentiality' and the 'logic of appropriateness' can be characterised as follows:

Anticipatory action:	Obligatory action:
i. What are my alternatives?	i. What kind of situation is this?
ii. What are my values?	ii. Who am I?
iii. What are the consequences of my alternatives for my values?	iii. How appropriate are different actions for me in this situation?
iv. Choose the alternative that has the best consequences	iv. Do what is most appropriate

Like Allison, March and Olsen argue that much behaviour is driven by routines that constrain the field of action:

> Routines embody collective and individual identities, interests, values, and worldviews, thus constraining the allocation of attention, standards of evaluation, priorities, perceptions and resources (March and Olsen 1989, p24).

However, to say that most behaviour is driven by routine is not to say that most behaviour is routine. Rules and their applicability to particular situations are often ambiguous, individuals have multiple identities and situations can be defined in different ways that call forth different rules.

March and Olsen go on to suggest that to understand real-life decision making what is needed is a conceptual lens that takes account of the non-instrumental construction of meaning. From this perspective, the process of decision making is not just instrumental but symbolic, not only in the strategic sense of 'window dressing', but in the sense of contributing to the interpretation of life. Politics, they contend, is not just about achieving outcomes, it is about creating, confirming and modifying interpretations of life. It is a way by which people establish conceptions of experience, values and the nature of existence. The symbolism of the decision process sustains broader social visions and affirms 'sacred values'. One of these sacred values is 'rational decision making':

> The idea of intelligent choice is a central idea of modern ideology, and political institutions are dedicated to that vision of life. Consequently, activities within political institutions, and particularly decision activities, are part of a set of rituals by which a society assures itself that human existence is built around choice. Such rituals confirm that human institutions

are manifestations of the intelligent control of human destiny through intentional action. (March and Olsen 1989, p50)

Thus, according to March and Olsen, the idea of intentionally choosing a course of action is a 'well-elaborated and reinforced myth' (March and Olsen 1989, p 52). In reality change is often driven less by problems than by solutions. And both changes, and the intentions behind changes, are transformed by the process of change so that 'it is difficult to describe a decision, problem solution or innovation with precision, to say when it was adopted and to treat the process as having an ending' (March and Olsen 1989, p63).

Kitchener (2002) contends that managers do choose a course of action, but from a restricted menu of options that are legitimised within the prevailing institutional logic. In a study of strategic decision making in Academic Health Centres in the US, Kitchener found that managers adopted 'merger' as a course of action not because of any evidence that it was effective, but because it was legitimised within the prevailing institutional logic of managerialism that valued 'business-like' practices. Kitchener's study provides an empirical example of the way that organisations may decide to adopt a course of action not as a rational response to apparent need, but in order to signify legitimacy (DiMaggio and Powell 1983, Meyer and Rowan 1977). Kitchener describes how executives presented merger as a necessary response to external conditions (in this case market pressures). Legitimacy was then attached to the decision by employing management consultants and business school professors, to give the impression of thoughtful deliberation. Finally, executives claimed that merger was commonplace and successful in the business world (the source of legitimate managerial innovations).

Thus numerous empirical accounts have explored how actual decision making deviates from the ideal of rational decision making. One area where this is particularly apparent is in the use of evidence as the basis for action. As March and Olsen put it 'decision makers ignore information they have, ask for more information, and then ignore the new information when it is available' (March and Olsen 1989, p11). Feldman and March (1981) again highlight the symbolic role of decision making procedures, arguing that the collection and use of information symbolises and signals legitimacy. Information is not simply a basis for action, it is a representation of competence and social virtue:

The gathering and use of information in an organization is part of the performance of a decision maker or an organization trying to make decisions intelligently in a situation in which the verification of intelligence is heavily procedural and normative. A good decision maker is one who makes decisions in the way a good decision maker does, and decision makers and organizations establish their legitimacy by their use of information (Feldman and March 1981, p178).

This is evident in a range of empirical contexts. Flyvberg (2001, 1998), for example, showed how urban planners used findings from research, not as the basis of decision making, but, selectively, to support decisions that had already been taken. In an ethnographic study of ministers and civil servants in Westminster, Rhodes (2013) argued that 'rational analysis' was used to justify decisions already taken 'by other means and for other reasons' (Rhodes 2013, p 485). He describes the real rationality at work among ministers and civil servants as a political rationality concerned primarily with the appearance of rule, in 'keeping things going' and 'still being here tomorrow'. Nonetheless, rational decision making continues to function as a normative ideal among policy makers (Fischer 2003, Alexander 1986, Gordon, Lewis and Young 1977). Its enduring influence can be seen in the ideal of 'evidence-based policy' currently advocated by government, think tanks and others in the research community. It also underlies the other key characteristics of public sector reform in the UK over the last decade, namely managerialism and 'choice' as the organising principle for the delivery of services.

The dominance of rational decision making as a normative paradigm in the field of public policy reflects the pervasiveness of instrumental rationality in contemporary society more generally. Weber (1968) saw this as the defining feature of modern capitalist society embodied in the spread of bureaucratic organisation. As a form of organisation, bureaucracies are geared to maximising efficiency and operational effectiveness. Features of bureaucracy include a focus on calculability through the division of labour into quantifiable tasks and exerting control over activity through rules and regulations. Employees of bureaucracies are typically required to perform well-defined tasks in the manner prescribed by the organisation. Importantly, for this study, bureaucracies are carriers of a set of values and behavioural norms that exclude subjective, moral, or otherwise 'irrational' considerations. Weber considered bureaucratic organisation to be essential to the modern state. He argued that it was technically superior to any other form of organisation for dealing with the sheer quantity and complexity of administrative tasks of social

welfare policies and the public administration of transport, communication and so on. At the same time he was concerned that instrumental rationality would overwhelm individuals, trapping them in amoral cultural systems. These concerns continue to be voiced by scholars. Illich (1997), for example, has argued that organisations are no longer a tool for social improvement of individuals or communities, instead instrumental rationality had become an end in itself.

Bureaucratic organisation was not the only carrier of instrumental rationality in the development of the modern state. Professional knowledge and expertise, which have become key resources for public administration, are also based on rational assumptions. Giddens (1991) has argued that all social life has become permeated by expert systems that supply knowledge and practices geared to problem solving.

Like Weber, Habermas was also concerned with the pervasiveness of instrumental rationality. He sensed that the preoccupation with rational decision making excluded many moral and aesthetic guides for action. Habermas (1987) made a distinction between the instrumental rationality of 'the system' (the sphere of government and economy) and the values and norms of the 'lifeworld'. The lifeworld is what people draw on to interpret events and share them with others. It is made up of personal experiences, the shared beliefs and values that develop in social groups, such as families and communities, and the interpretations of events by previous generations. Habermas was concerned that the lifeworld was being invaded, or 'colonised' by the instrumental rationality of the system. These concerns are shared by other academic traditions, such as postmodernism, where scholars have argued that the emphasis on efficiency in the rational paradigm crowds out other values, such as those based on morality or aesthetics.

As discussed above, empirical studies suggest that policy processes do not, in practice, exhibit instrumental rationality, but have significant habitual and political dimensions. What is important for my study is the extent to which instrumental rationality remains a cognitive lens and a normative paradigm in society, and the way this is then used by members of society, post hoc, as a reason for action and as a façade to attract legitimacy. The way that members of a society use cultural resources, such as instrumental rationality, is central to my theoretical approach. In this approach I view policy not as rational decision making but as discursive practice. This approach, which is elaborated below, focuses on actual, situated activity to establish the way members of society use cultural resources to create meaning and to accomplish activities.

Policy as discursive practice

Policies are written down and talked about. They are 'codified and publicised' (Shore and Wright 1997, p5). Or as Deborah Stone observed, 'we talk about policy with words' (1988, p109). In this thesis I view policy as a cultural practice but one that is essentially linguistic. As the focus of my analysis is on the operation of power it must therefore be attuned to the relationship between language and power. The centrality of the concept of 'power' in my approach requires some consideration of the different ways the concept has been understood.

Dahl (1957) argues that an intuitive idea of power can be expressed along the lines of 'A has power over B to the extent that he can get B to do something that B would not otherwise do'. Power can thus be identified empirically by seeing who prevails in decision making when there is a conflict. Bachrach and Baratz (1962) argue that in addition to power exercised during decision making, power may also be exercised through 'non decision making'. Here power is exercised by confining the scope of decision making to particular issues. In other words power is exercised by controlling the agenda. According to Bachrach and Baratz, non-decision making is:

> A means by which demands for change in the existing allocation of benefits and privileges
> in the community can be suffocated before they are even voiced; or kept covert; or killed
> before they gain access to the relevant decision making arena; or, failing all these things,
> maimed or destroyed in the decision-implementing stage of the policy process. (Bachrach
> and Baratz 1962, p 44)

To these two 'faces' of power (i.e. decision making and non-decision making) Lukes (1974) adds another, less visible, dimension. According to Lukes, power is exercised when people are in effect prevented from having grievances in the first place because their perceptions and preferences are shaped so that they accept their role in the existing order of things which they see as being natural, unchangeable and without alternative. While the earlier notions of power developed by Dahl (1957) and Bachrach and Baratz (1962) focus on situations of conflict, Lukes considers the exercise of power in situations where there is no observable conflict. Thus 'A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping or determining his very wants' (Lukes 1974, p23). This is the most effective, and insidious use of power, in that it prevents conflict from arising in the first

place. Lukes suggests this occurs through the mass media and through socialisation. This conception of power departs from the focus, in earlier notions of power, on the intentional acts of individuals. Instead Lukes draws attention to situations where the exercise of power may be unconscious. He also raises the possibility of the exercise of power by collectivities, such as a class, or an institution. Here the exercise of power cannot be attributed to the decisions or behaviour of individuals.

Foucault, discourse and governmentality

My theoretical stance draws on the work of Foucault (1974, 1979, 1990, 1991), which also departs from a focus on the intentional acts of individuals. Foucault was interested in how power worked in particular settings. He developed a decentred concept of power where power is something that is *exercised* (by everyone) rather than *held*. For Foucault the question of interest was '*how* is power exercised?' rather than '*who*' holds power or '*why*'. As Dreyfus and Rabinow put it, Foucault was concerned with 'how power works, what it does and how it does it' (Dreyfus and Rabinow 1982, p10). From a Foucauldian perspective power is relational in that it is located in the relationships between individuals and groups throughout society. It is also anonymous in that although there is intentionality in the plans and decisions that individuals take, the combined effect of these decisions are not coordinated or foreseen. As Foucault once described it 'people know what they do; they frequently know why they do what they do; but what they don't know is what what they do does' (personal communication reported in Dreyfus and Rabinow 1982, p187).

For a study of public policy, there are two observations of Foucault, on the way power operates in contemporary society, that are particularly salient. The first is the immanence of knowledge and power. Power and knowledge, Foucault argued, 'imply one another':

> there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. (Foucault 1979, p27)

The second, related, observation is the way that the operation of power is hidden from view. It is this ability of power to hide its own operation that makes it so effective. Both these features of power are involved in the operation of discourse.

Foucault used the term 'discourse' to designate the conjunction of knowledge and power (1990, p100). For Foucault discourses are constitutive of social reality. They are 'practices that systematically form the objects of which they speak' (Foucualt 1974, p49) and in doing so conceal their own invention. Discourses embody meaning and social relationships, they constitute subjectivity and power relations. As Stephen Ball put it 'discourses are about what can be said and thought, but also about who can speak, when and with what authority' (Ball 1990, p2).

Discourses are both an instrument and an effect of power. Importantly, discourses are an instrument of *power*, not necessarily *domination*. They transmit, produce and reinforce power, but they also expose and undermine it. In this way discourse can also be 'a hindrance, a stumbling block, a point of resistance' (Foucualt 1990, p101). Discourses are embodied in speech and writing, but also in the social practices of everyday life and even the physical layout of social institutions, such as the home, schools, churches and hospitals. According to Foucault it is not the case that there is a single dominant discourse, rather he refers to discourses as 'tactical elements' operating in force relations, indeed there can be different and even contradictory discourses within the same strategy (Foucualt 1990, p102).

Foucault's insights on the operation of power have been applied in studies of policy by scholars such as Shore and Wright (1997), Ball (1990), Edelman (1988) and Stone (1988). Ball, for example, describes policies as 'power/knowledge configurations par excellence' (1990, p22):

> Policies embody claims to speak with authority, they legitimate and initiate practices in the world, and they privilege certain visions and interests (Ball 1990, p22).

Similarly, Shore and Wright (1997) observe that while policies are inherently political phenomena, it is a feature of policies that their political nature is disguised by the objective, neutral and rational idioms in which they are portrayed, so that they appear to be mere instruments for promoting efficiency and effectiveness.

Edelman (1988), also acknowledges a debt to Foucault in his analysis of how policy problems are 'constructed' in discourse, rather than existing 'out there', waiting for government action. He observes that a course of action that is offered as a solution to a problem will typically preceed

the problem. In other words, supporters of a particular course of action will seek out a problem to which to attach it. Edelman states that 'this process is not necessarily self-conscious or deliberately deceptive' and that supporters of a course of action can easily persuade themselves of its rationality and morality in the course of persuading others (Edelman 1988, p22). Edelman's work is important to my study because it addresses the key question of how power works in the language used to discuss policy issues. Edelman argues that the discursive construction of a problem reduces an issue to a particular perspective that eliminates or minimises other perspectives. The origin that is attributed to a problem reflects an ideology and rationalises a course of action. In the process of constructing a link between a problem and a solution an ideology is transformed into rational government action. Moreover, every construction of a problem vests authority in particular group of people. For example, if the 'problem' of mental illness stems from individual pathology then doctors will have authority. A problem construction will also generate benefits to certain claimants (authority, a particular status, financial support) whilst denying these benefits to others.

Like Edelman, Stone (1988) also draws attention to the material effects of policies. Stone views policies as a political process of establishing definitions. The classifications and categories used in policy not only reflect a particular view of the world, they have consequences for people's lives. They 'confer advantages and disadvantages, rewards and penalties, permissions and restrictions, or power and powerlessness' (Stone 1988, p309). In this thesis I also adopt a Foucauldian view of policy. From this perspective policy is a cultural practice that combines knowledge and power so that truth itself becomes central to the operation of power.

The notion of discourse is one component of Foucault's broader theory of governmentality. Foucault saw the exercise of power as action that does not act directly and immediately on others, but acts on their actions. Thus when he refers to 'government' he is referring to the way that the conduct of individuals is directed. Foucault describes government as 'the right disposition of things' (1991). By 'governmentality' he means 'the ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics' that enables this form of power (Foucault 1991, p102).

Foucault argues that in the development of the modern liberal democratic state the legitimacy of political power shifted from a divine to a popular basis. In other words, in modern societies the

legitimacy of political power resides in the obedient subject (Johnson 1993). The obedient subject is therefore the focus of political power. In this regime the knowledge (discourse) and activities (practice) that create the obedient subject are supplied by professionals.

Foucault contrasts government with other forms of power, namely sovereign and disciplinary power. He uses the examples of responses to leprosy, the plague, and small pox, to illustrate sovereign power, disciplinary power and government respectively (Foucault 1979, 2007). Whilst the leper was expelled from the community (sovereign power) the response to the plague involved careful surveillance of the community (disciplinary power). This was achieved through the strict partitioning of the town into distinct areas, creating an enclosed, segmented space. There were strict regulations concerning such things as when people could go out and what they could eat, and people had to present themselves for inspection. All individuals were registered and all movements were observed and recorded. The work of writing down observations served to link the periphery to the centre. Inoculation campaigns for small pox, in contrast, involved new techniques of calculation and knew forms of *knowledge* based on statistics (government).

These different forms of power co-exist and interact in contemporary society (Foucault 1991, 2007) and recent scholarship has explored their interaction in healthcare settings (Martin et al 2013, Waring and Martin in press). Nonetheless, governmentality is a particularly powerful lens through which to understand the operation of power in neoliberal regimes (Dean 2010). The term neoliberalism 'denotes new forms of political-economic governance premised on the extension of market relations' (Larner 2000, p5). The term has been applied to the economic principles that underpin contemporary global capitalism (Crouch 2011) and to the political ideologies of many contemporary governments, including those of Reagan, Thatcher and, of relevance to this study, New Labour.

As economic principles and as political ideology neoliberalism recognises that the unfettered pursuit of individual interests (liberalism) can threaten the security of the wider social and economic system. Thus neoliberal regimes characteristically involve regulated markets and mechanisms for steering personal liberty so as to ensure the security of the wider social order. From a governmentality lens, these mechanisms work *through* the freedom of individuals by acting on their very subjectivities (Dean 2010). From this perspective neoliberalism is 'both a political discourse about the nature of rule and a set of practices that facilitate the governing of individuals at a distance' (Larner 2000, p6). Or as Foucault described it, neoliberalism is 'a way of

doing things' (2010, p318). Thus a governmentality perspective on public policy is attuned to the way that neoliberalism rejects state intervention in welfare but nonetheless requires 'government'. This is achieved through a complex assemblage of rationalities and technologies that enable 'action at a distance' (Rose 1993). Although it is argued here that governmentality is a particularly valuable lens for understanding the operation of power in neoliberal regimes, its applicability is not restricted to neoliberal regimes. And although neoliberalism is arguably the dominant political ideology in contemporary society, it exists in constant tension with alternatives such as communitarianism (Dean 2010).

Whilst Foucault focused primarily on the obedient subject, Johnson (1993) extends Foucault's theory of governmentality by further developing the role of professionals in governing. Johnson rejects the idea of a dichotomy between the state and the profession, arguing that from a governmentality standpoint the state is not a pre-constituted calculating subject but an ensemble of institutions, procedures, tactics, calculations, knowledges and technologies that are the 'residue' or outcome of governing. The institutionalisation of expertise in professionals is also an outcome of governing. As both the state and professionals are outcomes of governmentality, they are 'always in a process of becoming' (Johnson 1993, p 139).

Johnson argues that professionalization is produced both by the strategies of professionals as a social group and by government policies. He uses Foucault's study of the asylum to illustrate. Foucault shows that asylums were not a necessary response to individual pathologies, nor were medical professionals the only possible choice to staff these institutions. Rather, classifications of mental illness were a product of government policy directed at the problem of pauperism in the context of an increasingly urban, industrial society. The official recognition of the medical profession as having jurisdiction was the outcome of a political struggle between different social groups.

Thus in contemporary society professionals are simultaneously incorporated into and autonomous from the state and are a key resource in governing. Expertise, the practical activities of professionals, and the perceived neutrality and social authority of professionals, are essential to rendering the complexities of modern social life knowable and amenable to governing. This is accomplished through both forms of thought and procedures of documentation and evaluation.

For example, professionals help to identify new social problems, they supply the rationalities and means for solving them, and staff the organizations created to address them (Johnson 1993). Miller and Rose (1993) also extend Foucault's theory of governmentality by showing how it can be applied to the study of government policy. Miller and Rose locate policy in a broader discursive field comprising 'political rationalities' that define issues, goals and values, and prescribe action, and 'technologies' comprising programmes, calculations, techniques, documents and procedures through which 'authorities seek to embody and give effect to governmental ambitions' (Rose and Miller 1992, p175). Rose and Miller describe governmentality as about achieving 'action at a distance' so that actors come to perceive problems in a particular way and accept responsibility for findings ways of transforming their position themselves. 'Action at a distance' is accomplished through professionals who are mobilised within policy. Authoritative norms, calculative technologies and forms of evaluation are translated into the values, decisions and judgements of citizens in the professional and personal capacities (Miller and Rose 1993, p 92). Professionals make it possible for self-regulation to operate in a way that minimises the need for direct political intervention. They act as:

> Powerful translation devices between 'authorities' and 'individuals' shaping conduct not through compulsion but through the power of truth, the potency of rationality, and the alluring promises of effectivity (Miller and Rose 1993, p93)

The above statement by Miller and Rose is central to my thesis. I argue that knowledge, expertise, rationality, and versions of truth are cultural resources that are mobilised in policy. From this stance policy is not so much rational decision making as the *mobilisation* of rational decision making, as a cultural resource. What I am concerned with is the operation of power. So, for example, as discussed above, instrumental rationality is both the prevailing lens to view the world and a 'sacred value' in society, to such an extent that it has become naturalised as 'common sense'. It is this very 'taken-for-grantedness' that gives it potency when mobilised, through policy, in political contests. The way it works is rhetorical, in that it is impossible to argue against the proper order of things. But it is also, in a broader sense, discursive, in that it constitutes the subjectivities of policy actors, and constructs a world that privileges certain values as it excludes others. In this thesis I will demonstrate these processes with my ethnographic study of hospital planning but first I must further explain how I am approaching 'rhetoric' and 'discourse'.

Rhetoric and discourse

Beyond the work of Foucault, the term 'discourse' has been used in many different ways in the literature on public policy. The different uses of the term reflect the different disciplines (such as anthropology, sociology and psychology) that have adopted the concept. It also reflects the range of theoretical traditions that underpin the study of public policy. These include post structuralism, social constructionism, critical theory and postmodernism. In some instances 'discourse' is used to refer simply to 'what is said' or to 'conversation' (Grillo 1989, p9), whereas in others it is 'the place where language and ideology meet' (Wodak 2004, p192). Van Dijk (1997) uses it to refer to a mode of thinking. In this vein Seidel and Vidal (1997) define discourses as 'a particular way of thinking and arguing that excludes other ways of thinking'. For them 'discourses involve naming and classifying. This is a political activity. As such it is not merely symbolic, but has material outcomes that impinge on people's lives' (Seidel and Vidal 1997, p59).

Hepburn and Potter (2004) identify two broad approaches to discourse. The first approach can be found in studies that identify discourses as a 'thing'. For example, in an ethnographic study of a hospital oncology ward Hansen (1997) identified three discourses: a patient discourse that centred on the lived experience; a nursing discourse of caring; and a medical discourse that centred on a sick body, visible to the professional but invisible to the patient (Hansen 1997, p 100). The second broad approach is to use the term to denote the active nature of language. Discursive practices 'do not just describe things; they *do* things. And being active they have social and political implications' (Potter and Wetherell 1987, p6). Potter (2003) goes on to distil three features of discourses:

i.   Action orientation: Discourse is the primary medium of human action and interaction. Actions are not free-standing but embedded in broader practices.

ii.   Situation: Discourses are situated institutionally such that institutional identities are relevant to what takes place.

iii. Construction: Discourse is constructed and constructive. It is constructed in the sense that is it built from various resources (words, but also categories, ideas, broader explanatory systems). It is constructive in that versions of the world are built and stabilized in talk.

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Studies of rhetoric are specifically concerned with the persuasive use of language. In classic Aristotelian rhetoric the primary forms of persuasive appeals are 'logos' or appeals to logic, 'pathos', appeals to emotion, and 'ethos', or appeals made on the basis of character. The art of persuasion also involves the mastery of 'rhetorical devices' such as metaphor, metonym (referring to something not by its name but by the name of something with which it is associated, as in 'Fleet Street) and 'enthymeme' (truncating an argument and leaving things unsaid, as is commonly used in political slogans) (Paine 1981). In this study I am primarily concerned with the use of rhetorical strategies in decision making and organisational change. Rhetorical strategies are the deliberate use of persuasive language as a means of initiating and directing change (Suddabury and Greenwood, 2005). Rhetorical strategies work by manipulating underlying worldviews (Heracleous and Barrett 2001). The aim is to convince other actors of the legitimacy of a course of action by using language to connect it to broader social values (Suddabury and Greenwood, 2005).

Scholars who use discourse theory to illuminate the operation of power in policy texts differ on the extent to which they see the operation of power as intentional. Some focus on the *uses* of discourse, emphasising agency and the mobilization of discourses for political purposes. Bacchi (2000), for example, attempts to capture this in her notion of 'category politics' which refers to the deployment of categories for political purposes. Others focus more on the *effects* of discourse, emphasising the way underlying assumptions and presuppositions of policies constrain what can be said or done. In my study I adopt a Foucauldian perspective that sees the operation of discourse as *exceeding* the intentions of individuals (Shapiro 1992, p38). This perspective sees the constraints imposed by discourse as arising from institutional practices and power relations. From this perspective the effects of discourse 'cannot simply be reduced to the intentions and ambitions of a few key actors' (Ball 1990, p155). Nor can discourses be reduced to language and speech, they are, 'more' than that (Focualt 1974, p49). As Ball observes:

> We do not speak a discourse, it speaks us. We are the subjectivities, the voices, the knowledge, the power relations that a discourse constructs and allows. (Ball 1993, p14)

Similarly, Shapiro argues that when people speak they participate, often unreflectingly, in an existing discursive practice that 'constructs worlds of submission and domination'. So for

example, doctors dominate patients not so much through the strategic use of language, but through the fact that discursive practices construct 'doctors' and 'patients'.

Frames and framing in policy processes

To explore the operation of power in policy processes I employ, as a point of departure, Rein and Schön's (1993) concepts of 'frames' and 'framing'. The concept of interpretive frames stems from the work of Goffman (1974) who defined frames as organizing principles that govern the meaning we assign to social events (1974, p10). Rein and Schön have applied the notion of frames to the study of public policy, using the term to refer to 'a perspective from which an amorphous, ill-defined, problematic situation can be made sense of and acted on' (Rein and Schön 1993, p146). Rein and Schön argue that policy actors have different frames that lead them to see things differently and support different courses of action concerning 'what is to be done, by whom, and how to do it' (1993, p147).

Schön and Rein locate their theory firmly in the social constructionist tradition. For them

> There is no possibility of falsifying a frame; no data can be produced that would conclusively disconfirm in the eyes of all qualified, objective observers. The reason for this is that if objective means frame-neutral, there are no objective observers. There is no way of perceiving and making sense of social reality except through a frame. (Schön and Rein 1994, p30)

Rein and Schön's concepts of 'frames' and 'framing' (1993, 1994) were chosen as a point of departure because they allow the exploration of the multiple ways that power operates in policy processes. They also allow for the consideration of the operation of power both with and without intention. Rein and Schön describe 'frames' as 'part of the natural, taken-for-granted world' so that 'we are often unaware of their role in organizing our perceptions, thoughts and actions' (1993, p151). Elsewhere they speak of the strategic act of 'framing' in policy processes. Indeed they suggest that 'reframing' may be a way out of a situation where conflicting frames have produced policy paralysis.

The discursive act of 'framing' focuses attention on certain elements of an issue and leads to the neglect of others. As with Edelman, Rein and Schön argue that framing socially constructs the

problem and suggests what courses of action are appropriate. The effects of framing are illustrated by Shapiro's (1981) analysis of an Australian government report on high infant mortality in aboriginal populations. The report concluded high infant mortality was due to the semi nomadic lifestyle of the Aborigines. By constructing the problem as 'Aborigine's way of life' the solution becomes Aborigines changing their lifestyle. An alternative course of action would be for the health care system to change the way it delivered care. Here the problem becomes the mode of delivery of the health care system, and the solution changing the way services are delivered. Shapiro suggests that the framing might be explained by the fact that one of these options is more expensive than the other. The language of the report, however, made the conclusion appear self-evident. Thus the language hid the underlying politics of funding.

Schön and Rein (1994) distinguish between action frames and rhetorical frames. Action frames are those implicit in the content of policies while rhetorical frames are those that underlie the persuasive use of argument. Sometimes the same frame serves both functions but more often they are different. Where a different rhetorical frame is deployed it may obscure the underlying action frame:

> Frames are about action, and the desire to do something usually leads to a commitment to make the action we seek realizable. We often do so by 'hitching on' to a dominant frame and its conventional metaphors, hoping to purchase legitimacy for a course of action actually inspired by different intentions (Rein and Schön 1993, p151).

The same course of action may be consistent with different frames. And the same frame can lead to different courses of action. Framing can also occur at different levels, i.e. at the level of both espoused and enacted policy. In policy discourse members of the social science community may act as 'sponsors' of frames, developing frames, establishing arguments and explicating the implications for action.

Politics as 'frame conflict'
The focus of my study is on the role of policy in political contests which I explore in an ethnographic study of hospital planning. Arguably one of the most influential theoretical approaches to health care politics, and one developed from an empirical study of hospital planning, is Alford's (1975) theory of competing structural interests. By 'structural interests' he

means those groups who could be considered to gain or lose from the way health services were organised. In Alford's study the dominant interest group is the medical profession ('professional monopolists') whose interests are served by the existing organisation of health care. The profession is challenged by planners and administrators (the 'corporate rationalisers') whose ideology is of a 'rational, efficient, cost-conscious, coordinated health care delivery system' (Alford 1975, p204). There are also 'repressed' interests in the form of patient and community groups. The views of patient and community groups are often co-opted by either the profession or planners and administrators (or both) as a source of legitimacy in their struggle for power. The government does not sit above interest groups but 'represents changing coalitions of elements drawn from various structural interests' (1979, p251).

According to Alford, to say that the profession's interests are served by the existing organisation of health care is not to say that they may not also be served by reforms driven by corporate rationalisers:

> Professional monopoly may thus be furthered by certain bureaucratic reforms, particularly those aspects of planning and coordination which safeguard professional interests, or administrative rules in hospitals which guarantee continued professional dominance of medical practice (Alford 1975, p194).

Alford's study was undertaken in the US, although Ham (1980) demonstrated the applicability of this model in the NHS in England. Looking at hospital planning by a regional board in England between 1948 and 1974, Ham found that attempts by regional planners to rationalise the distribution of hospital services largely excluded the views of the public and were at times frustrated by local professional interests. Like Alford, Ham argued that the interests of different groups could sometimes dovetail. He considered the example of the 1969 Bonham-Carter report (published by an advisory committee dominated by representatives of the medical profession) that recommended greater service concentration across England and Wales (fewer, larger hospitals). Ham argued that the Bonham-Carter report could be viewed as an alliance between the interests of the professional monopolisers and corporate rationalisers against community interests. The decision by the government not to endorse the recommendations of the report could be seen, in this instance, as the ability of policy-makers within the government to successfully defend community interests.

Another, similar, theory of health care politics was developed by Light (1991, 1995, 1997). Light conceptualises health care politics in terms of what he calls 'countervailing powers'. This theory views health care as 'an arena in which contending parties vie for resources, territory and control to carry out their goals and vision of how health care should be' (Light 1997, p107). Using Weber's concept of the ideal type, Light sought to identify some enduring features of the interests of countervailing powers. For example, he suggests that the State has a primary concern for a strong society, a healthy and productive labour force, for instilling loyalty and in pursuing these goals at minimal cost. The profession, on the other hand, is concerned with developing and providing the finest clinical care to every sick patient which it sees as key to enhancing autonomy, prestige, power and wealth. In a given country during a given era, one party may dominate, such as the state in the former Soviet Union, or the medical profession in the United States. The power of the state can be democratic, or autocratic, depending on the case in question. According to Light, professional dominance in health care systems arose when the profession parlayed its expertise into legal, institutional and economic forms of power. Extrinsic forces, such as technological advances and macro changes in resources, influence the balance of power. In these circumstances:

> legitimation becomes more problematic because the model is ideological rather than hegemonic; the dominant powers have to justify their prominence and incorporate the interests and concerns of other parties in order to preserve or strengthen their position. (Light 1997, p108)

Culture and popular sympathies or hostilities are important sources of legitimacy or non-legitimacy that can be aroused by either party. Expertise and knowledge claims become important weapons because they seem universal and independent of power. Set against these countervailing powers is 'participatory power' that is exercised when patients take action. Participatory power is in tension with countervailing powers as patients do not always act as desired or expected but are motivated by complex and subtle reasoning:

> For, ultimately, limitations of countervailing powers stem from the many ways that individuals exercise participatory power in their daily lives, which powerful parties cannot control and do not often understand. The most sophisticated programs in health care, based on a party's rational assumptions about how the world works, do not work very well

when people do not trust, or use bribes, or have different models of illness behaviour, or do not care, or care intensely, or act on their own, or fight among themselves (Light 1997, p108).

Both Alford and Light have a conception of politics that extends beyond material interests to include ideological differences between interested parties, although this is more explicit in Light's theory. Light also introduces the central role of rhetoric in efforts to impose a particular vision of the way health care should be and underlines the importance of expertise and knowledge claims as a source of legitimacy.

What I take from the work of Alford and Light is a model of health care politics as a conflict between different groups, not just in terms of 'interests' but in 'frameworks of meaning' (Geertz 1973). This focus on meaning has previously been employed by Edelman (1988) who emphasised that policy issues mean different things to different groups. Indeed Edelman argued that an issue becomes political precisely because the meanings an issue holds for one group are excluded in the way another group defines the issue. According to Edelman, 'if there are no conflicts over meaning the issue is not political, by definition' (1988, p104).

This conceptualisation of politics as a conflict in meaning is captured in Schön and Rein's concept of 'intractable policy controversies'. Hospital planning exemplifies an intractable policy controversy which is 'marked by contention, more or less acrimonious, more or less enduring' (Schön and Rein 1994, p3). Another feature of intractable policy controversies is that they are resistant to resolution by appeal to evidence, research, or reasoned argument. Opposing parties either differ in their view of what facts are important or give the same facts different interpretations. In intractable policy controversies opposing parties contend with each other over the definition of the problem. These are symbolic contests over the social meaning of an issue, 'where meaning implies not only what is at issue but what is to be done' (Schön and Rein 1994, p29). In other words, intractable policy controversies are disputes in which conflicting parties hold different *frames*. According Rein and Schön:

Interest groups and policy constituencies, scholars working in different disciplines, and individuals in different contexts of everyday life have different frames that lead them to see different things, make different interpretations of the way things are, and support different

courses of action concerning what is to be done, by whom, and how to do it. (Rein and Schön 1993, p147)

There is a reciprocal but nondeterministic relationship between the actors' interests and their frames. Interests are shaped by meaning and meanings may be used to promote interests. So, for example, real estate developers may define an urban planning issue as 'blight' because this term is linked to a frame that prescribes actions favourable to increases in real estate profits. On the other hand, how actors understand their interests is shaped by their frames. So, for example, groups may have an interest in neighbourhood preservation because they see neighbourhoods as natural communities (Schön and Rein 1994, p29).

The concepts of frames and framing were chosen as a point of departure early on because of the way they seemed to capture some of what I first noticed in the field. That is, the shift in the rationale for hospital closure and the effects of this shift (in terms of shutting down debate). The concepts also resonated with my experience in the field of hospital planning as a highly contested issue, and the policy of centralisation as highly controversial, and offered a means of generating insight and understanding (politics as 'frame conflict'). Thus the concepts seemed to have a good 'fit' with my data (I could say that what I had observed was a shift in the 'framing' of the issue). I also saw potential in the concepts to get analytical purchase on my data in terms of the relationship between meaning and action. The concepts capture both meaning shaping action (action frames) and meaning strategically mobilised by actors (rhetorical frames).

The concepts of frames and framing are consistent with my Foucauldian theoretical orientation, offering a link between my data and theories of discourse and governmentality. Significantly, by allowing a consideration of both the *uses* and *effects* of discourse they offer me a way to make a novel link between rhetoric and discourse, agency and governmentality. As Foucault put it, 'people know what they do; they frequently know why they do what they do; but what they don't know is what what they do does' (in Dreyfus and Rabinow 1982, p10). The concepts of frames and framing enable me to consider both what people do (they frame) and what framing does (aligns people and ideas, assembles practices, knowledge's, institutions and morality). They enable me to explore the intentions in, and responses to, policy, relate these to the discursive origins and properties of policies, and, in turn, to the effects in the material world.

3. METHODOLOGY

The topic of my thesis emerged while I was doing fieldwork in local healthcare organisations for a study funded by the English Department of Health (Exworthy et al, 2010). I was employed full-time as a research fellow on this study which was being undertaken by an academic team. The topic of this study (which, for clarity, I will refer to as 'the primary study') was health system decentralisation and the aim was to investigate whether organisational autonomy improved the performance of the overall local health economy. The concept of the 'local health economy' has geographical and organisational characteristics but is also used to refer to the relationships in which local NHS organisations are embedded (Jones et al 2012). The geographical boundary of the local health economy was defined in terms of the financial flows of the local health care commissioner (at that time the PCT). Therefore the organisations that were included in the primary study were the local PCT and surrounding hospitals. The study received ethical approval from London and Surrey Borders Research Ethics Committee (REC) (appended).

The research design of the primary study was of longitudinal comparative case studies. Research was undertaken in two counties in England, one in The North and one in The South. Fieldwork began in the southern case study as there were difficulties gaining access in the other locality. It was this county which was the setting for my PhD research (I have given it the pseudonym of 'The Shire'). The primary study followed a 'policy ethnography' approach (Flynn et al 1996, Hughes 1996) with the aim of gleaning the repeated action, interaction and reaction of different stakeholders to an on-going series of events and decisions. Data comprised interview accounts, observations and documents. Fieldwork for the primary study was undertaken at the local and national level. At the national level it involved interviews with staff from the Department of Health and other policy makers and reading national-level policy documents. At the local level it involved attending the board meetings of NHS organisations (NHS 'Trusts' responsible for providing hospital services, the PCT and the Strategic Health Authority), interviewing staff from these organisations, as well as local politicians, and reading documents such as Board meeting papers and annual reports. Fieldwork for the primary study was undertaken by myself, the principal investigator Mark Exworthy, (a professor from an academic management school) and Francesca Frosini, who, like me, was a research fellow. Mark and Francesca began fieldwork with initial discussions with key individuals in the Autumn of 2006. I commenced fieldwork after

being employed on the project in the Spring of 2007. I attended all interviews and observations, sometimes on my own (in which case I conducted the interview) sometimes with either Mark or Francesca (in which case we took turns conducting interviews).

National level interviews were held with two Department of Health civil servants and two representatives from national organisations. Interviews at the local level were conducted in two rounds. An initial interview sample was drawn up by virtue of individuals' organisational position (for example, chief executive or medical director), or their role in the LHE (eg. PCT Director of Commissioning). 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 Strategic Health Authority and the local authority. Several individuals were selected from each organisation so as to triangulate between and within organisations and professional groups (primarily clinicians and managers). Repeat interviews were held so as to gauge the extent of change over time. The longitudinal perspective was important because of the dynamic nature of the local health economy 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 45 interviews were conducted in phase 1 and phase 2 in the southern case study (the setting for my doctoral research). 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. Interview topics in both phases included the effects of governance mechanisms, local contextual influences, perceived organisational/local health economy autonomy, incentives, and reasons for organisational/local health economy performance. The topic guide for the primary study in appended.

Data collection for the primary study also involved observation of 14 meetings. 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).

An extensive array of documentation was collated from the local health economy 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 primary study. Hence, for example, papers concerning reconfiguration across the local health economy were specifically sought. The data-set from the primary study (interviews and observations) that I drew on for my PhD is detailed in table 1 below.

Table 1. Summary of data (interviews and observations) from the primary study

National level interviews (n=4)	
Department of Health	Policy maker 1 Policy maker 2
NHS Confederation	Policy maker 1 Policy maker 2
Local level interviews (n=41)	
Strategic Health Authority	Director of Performance and System Reform (2) Head of Organisational Development
The Shire PCT	CEO (2) Director of Commissioning (2) Director of Human Resources and Organisational Development (2) Director of Finance Director of Public Health Deputy CEO
Forest NHS Foundation Trust	CEO (2) Medical Director (2) Director of Nursing Director of Finance Clinical Director orthopaedics General manager surgery General manager medicine
Warton and Judford NHS Trust	CEO Chair Medical Director
Shire General NHS Trust	Director of Organisational Development

	Director of Nursing Director Finance Matron elderly care Matron orthopaedics Lead clinician A&E (consultant) Clinical Director medicine Manager medicine Manager surgery
South Shire NHSTrust	Medical Director Director of Organisational Development Director of Operations Clinical Director surgery
Smithton and Wildbridge NHS Trust	Director of Organisational Development
Local authority overview and scrutiny committee	Executive director
MP	MP
PCT of neighbouring locality	CEO
Observations n=13	
The Shire PCT	Board June 2007 Board July 2007
Forest NHS Foundation Trust	Board September 2009 Board March 2008
Warton and Judford NHS Trust	Board September 2007 Board July 2008
Shire General NHS Trust	Board May 2007
South Shire NHS Trust	Board May 2007 Board July 2008
Smithton and Wildbridge NHS Trust	Board June 2007 Board July 2008 Annual public meeting
The OSC	Board

Relationship between the primary study and my doctoral study

I had hoped, on taking the job as a research fellow on the primary study, that there would be an opportunity to undertake a PhD, and asked about this at the interview. The principal investigator agreed that it would be possible to use data collected from the primary study for a PhD. Thus I began fieldwork for the primary study with the intention of pursuing a PhD part-time but without a specific topic. I had an interest in the medical profession, having completed a masters dissertation on professionalism among medical school graduates, and had a long standing interest in managerialism. I also had an enduring fascination with hospitals. This stemmed, in part, from my experience of emergency surgery for peritonitis as a teenager, followed by a long in-patient stay, and other formative experiences, including television dramas such as 'Quincy'. Since kindergarten (I grew up in Australia) I had wanted to be a nurse and spent a year in training before switching to an undergraduate degree in Anthropology. On commencing fieldwork I very quickly (the first day) became interested in the political contest over hospital planning that was apparent in the Shire.

In the Shire, as in many parts of England at the time, health service managers were in the process of implementing plans to 'reconfigure' health services in the area. 'Reconfiguration' was the term that was used by local managers and in national policy documents to refer to a strategic change in the distribution of health services. In the west of the county this involved plans to close an accident and emergency department in one of the local hospitals. Separate plans in the east of the county involved closing a maternity unit. In both cases, as has historically been the case in the NHS, these plans were vehemently opposed by the local community.

The starting point for my study was what Agar (1999) calls a 'rich point'. A rich point is something that happens that makes a particular impression on the researcher. This might be something the researcher notices because of repetition, or it might be something the researcher simply can't make sense of, or something that arouses anger or anxiety in the researcher, that is not present in the source group. What I noticed were repeated appeals to the 'clinical case for change' when managers presented plans to close hospital services to other stakeholders (the public, or front-line staff). This contradicted earlier planning documents that I had seen, where a financial rationale had been given. I was also struck by the rhetorical force of these appeals which felt, to me, to have the effect of shutting down debate. This seemed significant given the

stated policy objective of involving patients and the public in decision making. The extent and implications of this observation then became the focus of my study.

In attempting to produce an account that made sense of my rich point, I tested my ideas against data collected from a range of sources including observations, documents, interviews and informal conversations. Opportunities to do this were provided by the primary study, although there were occasions when I instigated additional opportunities to collect data, such as when I decided to attend a public meeting of one of the hospitals because I thought it would be an opportunity to observe the interaction between hospital staff and members of the public. Another time I made field notes at a health service research conference that I happened to be attending during the period of fieldwork and which caused me to reflect on my topic. Thus the research for my PhD was undertaken at the same time as fieldwork for the primary study in an ethnographic tradition that I describe in more detail in the remainder of this chapter. Briefly, when I noticed patterns that I thought were significant or interesting I recorded these in my notebook together with my emerging ideas. During fieldwork I also conducted searches of potentially relevant scholarly literature and critically reviewed theoretical perspectives for their ability to make sense of the cultural phenomena I had identified and was seeking to describe and explain. Later, after the fieldwork for the primary study had been completed, I continued to test and refine my ideas against the data that had been collected (interview transcripts, observations of board meetings, and documents). I continued to develop and refine my ideas whilst writing up.

There are debates is the methods literature concerning the use of data collected for one purpose being used for another. Some of these concerns relate to the use of an existing data set by a different research team, or for a *subsequent* analysis, and therefore do not apply in this instance - I was a member of the research team for the primary study and fieldwork for my PhD was undertaken *concurrently* with fieldwork for the primary study. One concern which might apply, however, concerns what Hinds et al (1997) call 'missing data'. According to Hinds et al, in a qualitative study missing data results when a topic is not explored in all interviews. This might result in a 'false conclusion'. This could happen in a concurrent secondary analysis, such as mine, where the topic emerges spontaneously during fieldwork and was not pursued in previous interviews. Hinds et al argue that the extent to which missing data is a concern for a secondary study is contingent on features of the primary study. The risk of the secondary study being

affected by missing data will be minimised when the primary study uses methods that involve asking the same open-ended interview questions for all study participants, and when the topics of the two studies are closely aligned. In such cases the primary study is likely to produce data of sufficient depth and detail to enable a secondary analysis.

In my case the topic for my PhD emerged very early on. Indeed my interest in the politics of hospital planning was piqued on the first day of fieldwork for the primary study. My first interview generated a large amount of talk about the commissioner's plans for hospital services in the Shire. There was, I thought, clearly 'something going on'. In total, the primary study involved 45 in-depth interviews with individuals across the different organisations in the local health economy, and in national organisations, and all of these I used for my thesis. All interviewees were asked about local health economy-wide change (see topic guide appended). As all organisations were involved in the plans to reconfigure services these plans were invariably brought up spontaneously by interviewees. Thus the primary study generated data of sufficient depth and appropriate detail for my thesis.

My approach

Agar (1996) uses the funnel metaphor to describe the way that ethnographic investigation is initially broad, open and flexible but then, gradually, the focus narrows and a more specific topic of investigation emerges. In this way ethnography differs from other research traditions that proceed from a tightly defined hypothesis. This is not to say that the process is entirely inductive. It is inevitable that researchers bring some prior theoretical concepts to the field. Kelle (1997) describes these as forming a loosely connected 'heuristic framework' of concepts which helps the researcher to focus his or her attention on certain phenomena in the empirical field.

A characteristic feature of an ethnographic approach is an extended period of time spent undertaking fieldwork. In other words, time spent in a research setting collecting and analysing data. The conventional notion of ethnographic fieldwork is of time spent living in a local community in a particular setting. As ethnographic approaches have been taken to the study of organisations, elites, and policy, it has come to encompass more varied forms of involvement in the field. Rhodes (2011) who studied British government, describes his approach as 'yo-yo'

fieldwork, as he repeatedly went back and forth, in and out of the field. In studies of organisations, 'multi-site' ethnography has become the norm as researchers follow actors, actions, artefacts and the ideas they embody and reflect (Yanow et al 2012). The approach I have adopted is one which has been found to be particularly well suited to a focus on policy and which Wright and Rheinhold (2011) have called 'studying through'. 'Studying through' involves following a policy through relations between actors, institutions and discourses across space and time. In my study I have sought to capture policy processes at both the national and local level and the connections between the two. To do this I spent two years conducting fieldwork in a local health economy (an English county) as well as studying developments in national policy over the same period (March 2007 to March 2009).

In an ethnographic approach methods, questions, and the proclivities of the researcher are intertwined so that Pader (2006) speaks of an ethnographic 'sensibility', rather than a method that one chooses, as one would choose a tool from a toolbox. This ethnographic sensibility is captured by Ybema et al (2009):

> …ethnographers bring with them to the field, as well as to their texts, an attitude of wonder, an openness to the potential for the unfolding of surprises there, a talent for improvising as observational or interview circumstances demand and for being less reliant on interview schedules and closed-end questions, and a theoretical imagination that links observations to interpretations (Ybema et al 2009, p15).

Similarly Agar suggests that 'some of it involves creative use of the imagination, mixed with empathy, rather than 'method' in any traditional sense of the term (1996, p xi)'. In an ethnographic approach methods *precede* questions, in that questions arise in the course of the research itself, from what the researcher notices in the field. And the sorts of things that the researcher notices in the field are not just influenced by their research interests but by their lived experiences and ways of seeing and knowing (Yanow et al 2012).

An ethnographic approach employs a variety of research methods, both qualitative and quantitative. In addition to more formal methods, such as interviews, a researcher may use any encounter, experience or object to reflect on the phenomenon of interest. The general character of this approach is captured by Hammersley and Atkinson:

watching what happens, listening to what is being said, asking questions; in fact collecting whatever data are available to throw light on the issues with which he or she is concerned (Hammersley and Atkinson 1983, p2).

The aim is to understand some aspect of the human situation. Analysis takes the form of a description of particular events but done in such a way as to illuminate more general features of social life. From what I have said so far there is little to distinguish an ethnographic approach from other endeavours that generate insight into culture and society, such as literature or journalism. Indeed the anthropologists Donnan and McFarlane (1997) claim to be unconcerned by the association between anthropology and journalism, 'when the association is with *good* journalism' (Donnan and McFarlane 1997, p276). One way an ethnographic approach differs from other endeavours is in a more explicit engagement with theory. This is done throughout the research process as the researcher reflects simultaneously on the empirical evidence and on theory. The aim is to generate ideas and then refine these ideas into a theory that explains 'what is going on' (Goffman 1974). According to Hammersley (1992) what distinguishes ethnography from other, similar, forms of social analysis is the explicitness and coherence of the theory that is being applied and developed and the rigour of the data collection and analysis.

Conducting fieldwork

In this section I give an account of my own fieldwork practice which I see as reflecting a combination of influences. Firstly there is the 'training' in research methods that I received as an anthropology and sociology undergraduate in the early 1990s, and, later, as a masters student in health service research in 2004. I also amassed a collection of tips and techniques for doing interviews when, following my masters degree, I taught for a time short courses on qualitative research methods. This training had less influence on my practice than my sense that I was somehow intuitively, instinctively, an ethnographer. Over time I have also learnt from experience and from trying things out.

Interviews were 'conversations with a purpose' (Burgess [])My goal in interviewing was to generate talk that could be used for analysis but in such a way that captured the interviewees'

own priorities. The topic guide (appended) included some initial ice breakers (what is your role in the organisation? how long have you worked here?). I would then introduce a fairly broad, open-ended question, such as 'what is the big thing for you at the moment'. I would encourage the interviewee to elaborate, but in a non-directive way. This took the form of nodding or making otherwise encouraging gestures and noises to convey the impression that I would like the interviewee to say more on a subject, with the occasional use of a direct prompt such as 'can you tell me more about that'. Follow-up questions would pick up on something the respondent had mentioned. If, toward the end of the interview there were topics that had not been covered in the course of the conversation I would introduce them. Or that, at least, was the plan. Just as often I would do what felt 'natural' for conversations with people I did not know very well, colluding with their own assessment of a situation (for example, by laughing when they laughed) rather than attempting a 'neutral' stance. Sometimes I self-disclosed, if it felt right. Toward the end of fieldwork I was heavily pregnant so sometimes I talked about that. Or, if asked, I would give my own opinion on the topic we were discussing. In doing this I may have been influenced by long-forgotten feminist texts that I read as an undergraduate (Oakley 1991 or Douglas 1985). I was aware that there were other ways my practice drew on my internalised norms for everyday social interaction. My manner was more deferential with CEOs, more collegiate with middle managers. At times it felt like rapport was facilitated by biographical or cultural allegiances (middle aged women, clinicians).

Some interviews were easier than others. I liked the ones with managers who 'held the floor', by using 'the rush through' and by telling stories. In these interviews I didn't have to do very much at all. One interview didn't go very well. Despite my best efforts the interviewee, a male CEO, responded with short answers and seemed grumpy. The interview didn't last very long. I noted in my field notes that he seemed a bit annoyed and I wondered why, but I wasn't overly concerned. Perhaps he was pushed for time. He may have assessed the relative merits of a research interview with the other demands on his time that day and was agitated about being kept from other, more pressing concerns. (In one interview the digital recorder failed. I tried to make notes but it wasn't the same. It was an interview with a senior analyst in the Department of Health. The narrative that was produced was of the purest technocratic form, so valuable in my eyes to my burgeoning interest in the rational paradigm in policy making, I feel its loss to this day).

There are debates in the research methods literature concerning the status of interview data (for example Silverman 1998). To summarise, researchers adopting a more positivist stance view interview data as a mirror on a stable external reality, whereas researchers adopting a more social constructionist stance (as I do) see interview data as an account created as part of the interaction between interviewee and interviewer. The critique of the positivist stance is that it cannot be assumed that interview data provides access to any entity, such as 'real' feelings or ideas, beliefs and behaviour, beyond the interview. From a social constructivist stance, interviews are not simply occasions where information is being communicated in an unproblematic way. Rather, they are instances of social interaction where participants are providing an account of themselves as morally adequate (Goffman 1959). The implication for the researcher is that the story they are being told might be different if there was a different listener (Reissman 1993).

When I was undertaking fieldwork I didn't give that much thought to the status of my data. I was adopting a broadly discursive approach so it was accounts I was interested in. I assumed that interviews with policy actors about a policy controversy would elicit accounts of themselves, their allies and their adversaries (Callon 1986). It only remained to acknowledge that these were identities in formation, and that they were identities constructed for me, a researcher from an academic management school. But I had cause to reflect at greater depth upon my practice when I came to writing up. What occasioned me to reflect on my practice was a paper I read by Tim Rapley (2001). I had been inspired by an earlier engagement with Tim Rapley's work, a chapter on interviews from a textbook on qualitative research practice, which I felt at the time resonated with and articulated (validated?) my own practice. Rapley argues that 'contra most of the current literature on 'how to' interview, interviewers don't need massive amounts of detailed technical (and moral) instruction on how to conduct qualitative interviews' (2004, p16). Rapley's position is that as interview data is the product of the local interaction of the speakers, it does not produce knowledge that exists in any 'pure' form, vulnerable to contamination. I was reassured by his admonishment that interviewers don't need to worry excessively about whether their questions and gestures are 'too leading' or 'not empathetic enough' and by his advice that 'they should just get on with interacting with that specific person' (Rapley 2004, p16).

On returning to Rapley's work whilst writing up I was challenged to reflect on my practice by his observation that interviews are social interactions where talk is locally produced by *both* interviewer and interviewee. In other words, the performance of the interviewer 'doing an open-

ended interview' also shapes the talk that is produced. This made me think that my 'broad and open-ended' question was more directive than I had initially thought. I had asked interviewees 'what was the big thing for them at the moment'. This had worked well for me, producing lots of talk about the local plans for hospital services, whilst still feeling this had been brought up spontaneously by the interviewee. However, by asking 'what was the *big* thing for them' was I silencing other priorities and agendas? Important in other ways but perhaps not 'big' enough to mention. Was I inviting them to respond with a 'heroic' narrative? A tough manager tacking a 'big' thing. There were other aspects of my performance that would also have shaped the talk that was produced. The implication from this insight, that my performance, as well as that of the interviewees, produced a particular version of events, was that I should make these features of the context of the interaction 'central in the *analysis* and the *presentation* of the data' (Rapley 2001, p317). This was something I hadn't done. At least not explicitly or uniformly. I read Rapley's paper while I was writing up, close to the end. It was now many years after the interviews had been undertaken. And at this point the empirical chapters had already been written, and time was running out. I did not have time to return to my data set and interrogate it with this insight in mind. I did return to the empirical chapters, considering the context in which my data extracts had been produced and reworking accordingly, as time allowed. However, it remains primarily an insight for future work.

In addition to formal interviews, I attended the Board meetings of local NHS organisations. Observing Board meetings produced a different type of data to interviews - local NHS managers *doing* hospital planning rather than *talking about* hospital planning. In contrast to the 'back stage' character of some of the interviews whereby actors would refer to the political dimensions of their work, board meetings provided an opportunity to observe 'front-stage' accounts. Board meetings, which are held in public, offered an opportunity to witness how the plans to close hospital services were articulated in an effort to reaffirm the goals of the organisation, present a coherent rationale for change, and persuade other stakeholders of the appropriateness and legitimacy of the course of action. The local plans to reconfigure hospitals dominated the managerial agendas at this time and were invariably an item on the agenda of Board meetings, providing regular opportunities to be exposed to this type of talk about hospital planning. This talk was particularly valuable in terms of understanding how plans were communicated to other stakeholders. In other words, it provided an opportunity to reconstruct rhetorical strategies of legitimacy (Suddaby and Greenwood 2005) one of the key concepts

adopted in my study. The meetings also offered an opportunity to observe the interaction of different actors, namely managers, clinical staff and members of the public. In total I attended 13 such meetings. At the national level I attended conferences and seminars where the issue of 'reconfiguration' was debated by academic researchers, staff from think tanks, staff from the Department of Health and ministers.

I also collected documents, including minutes and meeting papers of NHS hospital trusts, PCTs, strategic health authorities and local government overview and scrutiny committees; annual reports; consultation documents and other information provided by organisations on plans for hospital services; documents published on organisations' websites and newspaper articles. National-level documents included policy documents, speeches and other publications from the government and other policy actors, such as think tanks, academics and the medical Royal Colleges. These documents again provided an opportunity to see how a policy of centralisation of hospital services was communicated, specifically, to see combinations of rationales and prescriptions for actions, in other words to see how the policy was 'framed' (Rein and Schön 1993) by different local and national actors. As mentioned above, a feature of an ethnographic approach is that any artefact or encounter may be used to reflect on the phenomena of interest. Thus over the last six years I have often been inspired by newspaper articles, radio interviews, overheard snatches of conversations, discussions with friends and family members and the like.

I digitally recorded interviews which lasted about an hour. I recorded observations, informal conversations and analytical memos in notebooks that I carried with me at all times. Contemporaneous notes were taken on observations made at meetings, conferences and seminars and shortly after informal conversations. I had formal interviews transcribed by a commercial transcriber who specialised in academic research, and in line with conventions designed to ensure confidentiality for research participants I stored these transcripts on the university network under a numerical identifier. A separate table contained the details of the organisation, role and date of interview against each number.

In an ethnographic approach the data collection and analysis are concurrent, rather than separate stages of the research process. As ideas began to emerge I tested these against the data and refined them in a in a process Agar (1999) describes as 'tacking back and forth' between data collection and analysis. Given the relatively large number of interview transcripts (45) I chose to

import these into a computer software programme (NVIVO) to facilitate coding and retrieving segments of text linked to particular codes. By 'coding' I mean marking incidents of data I thought might be relevant to my emerging interpretative categories (Becker and Greer 1960). The process of analysis involved reading, re-reading and thinking on texts and I did this using hard copies of texts and pencil and paper. I read each interview transcript, document and my field notes several times, compared texts and returned to the literature, noting down emerging ideas that I later elaborated to form my thesis.

As the focus of my study more clear, I thought that some sort of discourse analysis may be fruitful. I had never done an analysis that was concerned with the concept of discourse before and so began reading textbooks on the subject. My field techniques remained the same (observation, generating talk through interaction) but my analysis became attuned to text and talk as social practices and the resources (interpretive repertoires, identities and category systems) drawn on by actors in those practices (Potter 1997). As established in the previous chapter, my analytical stance entertains the possibility of both the strategic deployment of cultural resources and the unconscious entering into existing discursive practices. Potter (1997) notes that it is hard to describe how, exactly, discourse analysis is done. He describes it as a craft skill that is more akin to riding a bike than 'following a recipe for a mild chicken rogan josh' (Potter 1997, p147). Broadly, I examined the data (transcripts from interviews, field notes from observations, and the text of planning documents) for regularities in the form of assumptions, categories, logics, and claims (Miller 1997).

Although my analysis was informed by Foucault's theory of discourse, I chose not to use formal Foucauldian discourse analysis (Kendell and Wickham 1999). This decision was consistent with the emergent nature of my ethnographic approach and a resistance to imposing an analytical framework apriori. I chose instead an analytical strategy that sought to balance deductive inference (testing the 'fit' of Foucauldian theory) with inductive and abductive forms of inference. The value of this strategy is in the way it allows for the development of new theoretical insights, as Kelle describes:

> With qualitative induction a specific empirical phenomenon is described (or explained) by
> subsuming it under an already existing category or rule; whereas abductive inference helps
> to find hitherto unknown concepts or rules on the basis of surprising and anomalous

events. Abductive inference combines in a creative way new and interesting empirical facts with previous theoretical knowledge. Thereby, it often requires the revision of pre-conceptions and theoretical prejudices - assumptions and beliefs have to be abandoned or at least modified (Kelle 1997, p12).

Rigour

There are three strategies that I have used to build a credible argument, all are types of comparison. The first form of comparison is within the data set. That is I compared what was said by one individual to what is said by another, or what is written in a document or observed in the field. This enabled me not only to find patterns in the data, but also contradictions. One particular form of contradiction is the 'deviant case' which is a way of referring to an incident of talk or an event that runs counter to an emerging proposition, and that can be used to refine emerging theory. Identifying and interrogating the deviant case enables the researcher to trace the contours of the phenomena of interest, in other words, to understand more precisely 'who, where and when'.

The second form of comparison that I employed was with the theoretical literature. This was part of ongoing process of reflecting both on the data and on theory (Bulmer 1984). It is this process of comparison with the broader literature that enables what Mills (1959) called the 'sociological imagination'. That is, the ability to make links, sometimes quite wide-ranging and between sources not immediately obviously connected.

The third form of comparison is with other similar empirical studies. As established at the outset of this section, ethnographic research aims to find the general in the particular, that is, to move beyond a description of particular events to develop concepts that may be applicable in other situations. Comparing the findings of one study with those of other similar studies can help to establish the 'conceptual generalizability' of the findings.

The excerpts of data that I have presented in this thesis are illustrative of an interpretive account developed from a long interactive experience made up of the many encounters, memories, notes,

reports, and conversations that make up fieldwork (Mosse 2006). But it remains an interpretive account that cannot be proven with reference to evidence. The aim, as Hastrup describes it, is 'a kind of explanation beyond the truth of the events themselves' it is 'not simply knowledge about particular events, practices and ideas, but about the processes by which these come to appear meaningful, perhaps inevitable or mandatory, possibly contestable or even mad (Hastrup 2004, p468).

Rigour requires that analysis of data is systematic and comprehensive, I therefore transcribed all formal interviews and coded all transcripts. Nonetheless early drafts of my findings were overly descriptive and failed to comprehensively explore each data segment. These weaknesses were pointed out to me when I shared early drafts with colleagues, and subsequent drafts gradually became more analytical and more comprehensive in exploring the phenomena of interest. My analysis also benefited from sharing my work at conferences.

The emic and the etic

A key element of ethnographic inquiry is the tension between the researcher's status as an 'outsider' and their status as an 'insider', traditionally referred to as the 'etic' and 'emic' perspective. When I began my fieldwork I was employed as a researcher on the primary study. Unlike the principal investigator and the other researcher who were both from a university management department, my training was in cultural anthropology. Although I had a long-standing interest in the NHS, and had previously interviewed early career doctors about their work, I was unfamiliar with the theory and practice of management. My unfamiliarity with the subject area secured my 'outsider' perspective. I sometimes commented to colleagues, only half-jokingly, that I did not understand what the study was about. During one early interview with a local MP I struggled to explain the aims of the primary study and resorted to reading the blurb provided on the participant information sheet. The MP commented that 'you people really do speak another language'. I was inclined to agree.

Nonetheless many of the people I interviewed were managers of local health service organizations and it was evident from their openness, the language they used, and the access they offered to private meetings and documents, that they assumed that I was 'one of them'. By the

end of the fieldwork I had developed an understanding and a sympathy for the objectives of health service managers. I was certainly more 'fluent' in the language and I thought I understood what the decentralisation study was about. Indeed the difficulty at this point came from the extent to which I lost the 'outsider' perspective which stymied for a time progression with analysis for my PhD. The requirements of producing a report for the funder of the primary study (the Department of Health) meant that I had become immersed in the technical-instrumental paradigm of research for policy. This is a particularly dominant in management research. Hill (1993), for example, has described research for policy in this context as a type of 'management science' where the objectives of management are at the forefront.

There was a benefit in that doing research for policy in the NHS itself constituted a form of 'participant observation'. At this time researchers were a ubiquitous feature of NHS organisations reflecting, in part, funding streams from the Department of Health for policy evaluation. It meant that I was immersed in the social processes that I was most interested in, i.e. the construction of knowledge by social groups with specific interests, beliefs and ideas. My understanding of the practices of policy and research is thus linked to *participation,* not just *observation*, such that I was able to 'feel their nature and directive force' (Hastrup 2004, p 464). The downside was that it took some time before I could achieve the critical distance necessary to continue with the analysis for my PhD. Mosse (2006) describes how for anthropologists undertaking 'insider' organizational ethnography 'at home' the difficulty is no longer 'entering' a different world so as to be able to imagine or infer the taken-for-granted (and thus hidden) links between individual action and discourse but in 'exiting' a known world for the same purpose. For me this process of 'exit' was facilitated by two periods of maternity leave, conversations with academic colleagues and immersion in the anthropological and sociological literature.

Ethics

The particular ethical implications of ethnographic research on policy have been illuminated by Mosse (2006). Mosse recounts his own experience of undertaking policy ethnography, in his case in the field of international development. He describes how, following the publication of his ethnographic account, objections were made by co-workers and informants to his publisher, the university ethics committee, the Dean of the university, and to his professional association (the

Association of Social Anthropologists) on the grounds that his account was 'unfair, biased, contained statements that were defamatory and would seriously damage the professional reputations of individuals and institutions and would harm the work among poor tribals in India' (Mosse 2006, p935). Mosse attributes these objections to the closeness between 'desk' and 'field' of 'insider ethnography' of organisations and public policy such that:

> Those interlocutors – neighbours, friends, colleagues, or co-professionals – who directly experience ethnographic objectification, now surround the anthropologist at his or her desk; they raise objections, make new demands to negotiate public and published interpretations. (Mosse 2006, p937)

The objections raised by Mosse's informants to his ethnographic account highlight significant epistemologic differences between policy and programme evaluation on the one hand and ethnographic research on the other. Although Mosse did not intend his ethnographic account to be an evaluation of the programme, it was read this way by his informants. Their objections to the account stemmed in large part from this reading. For example, the objections that were raised revealed an assumption (among programme staff) that programme evaluation involves a negotiation between the evaluators and the project actors over *who* is qualified to construct knowledge about a project, *how* it is to be done (methodology) and *what* is to be said. According to Mosse, there is expectation that all good evaluations produce 'an acceptable story that mediates interpretative differences in order to sustain relationships and the flow of resources' (Mosse 2006, p 942). Seemingly more important to programme staff than the 'verifiability' of an account is the 'fairness', where a 'fair' account is one that minimizes the risk of damage to reputation and embarrassment to institutions. The objections raised by Mosses's informants also revealed a belief among programme staff that it is wrong to appear to criticize those who work selflessly. These fundamental epistemological differences between social scientists and programme staff have far reaching implications for social scientists employing ethnographic approaches in programme evaluation (especially the nascent 'researcher in residence' initiative that is also characterized by a 'closeness' between 'field' and 'desk') and in health services research more generally, a point I return to in my conclusion.

It has been suggested that issues of contested representation in anthropological research can be addressed by greater collaboration is the production of ethnographic accounts (Lassiter 2005,

Marcus 1998). One of the benefits attributed to collaborative accounts are their ability to redress inequalities between the interpreter and the interpreted. However, others have argued that such inequalities cannot simply be 'written out' and that efforts to do so come at an analytical cost (Spencer 1989). Mosse (2006) also argues that such solutions are unhelpful for anthropologists of public policy whose informants are policy elites with a 'strong organizational need to produce and protect authorized views' (Mosse 2006, p938).

Reflecting on my own study, the people who generously gave of their time, on the understanding that their views and experiences would inform policy, became objects of study. This objectification is an inescapable fact of ethnographic research as the relationships established during fieldwork transform into knowledge apart from these relations (Hastrop 2004). Creating an ethnographic account involves making interpretations which subjects are unlikely to share, which their own schemes of understanding would not generate, which are not captured in emic categories (Hastrup 2004). Indeed in my study it is the very schemes of understanding that I have sought to question and unsettle.

My study is critical in the sense of being attuned to the operation of power through policy. It is not intended to be critical of any particular individual or group. I am interested in what individuals do and say only so far as this constitutes text and practices which can be analysed so as to contribute to an understanding of the discursive origins and properties of policy. Nonetheless, as Mosse (2006) shows, an orientation to studying the general (in this case a theory of policy) through the particular does not, in itself, guarantee that an ethnographic account will not be perceived by an informant as a source of personal offence.

In considering the potential for my ethnographic account to be perceived by informants as causing harm I can observe some key differences between my study and that of Mosse. My insider position was as a researcher undertaking research for policy, part of an independent academic team commissioned by the Department of Health. Unlike Mosse, I was never a colleague or a trusted friend. Thus the inevitable shift from 'friend' to 'stranger' that characterizes the period of writing up was absent. Informants were unlikely to feel 'the loss of trust, of being hurt by a valued friend and respected colleague of long association' that Mosse recounts (2006, p946). In line with standard research practice, I gave assurances to research participants that what was said during interviews would be kept in confidence and I use

pseudonyms throughput this thesis, for individuals, organisations and the locality. And unlike the 'closeness' described by Mosse, my study was characterized by a distance between research participants and the ethnographic account that I produced. This distance resulted from the length of time that elapsed between when data was collected and when I completed writing up. By the time I completed writing up some of the organisations no longer existed (PCTs and SHAs were dismantled in 2013) and most of the individuals had moved on to positions in different organisations, often in different parts of the country (according to research by the Kings Fund (2014) the average period of time an NHS CEO is in post is 2.5 years). And in contrast to Mosse, my experience of sharing my ethnographic account with management colleagues was entirely positive in that it appeared to pique their own interest in research, to resonate with their own experiences, and to articulate something about their social world that they had not previously been able to put into words.

4. REFRAMING IN NATIONAL POLICY

My thesis starts from the assumption that the policy domain of hospital planning is politically contested, an example of what Schön and Rein (1994) call an 'enduring policy controversy'. Different actors, such as managers, the medical profession and community groups, hold, and mobilise, different 'frames' that assign meaning to the issue. For health service managers and the medical profession hospitals are primarily the location of hospital services and the overriding concern is with the efficiency and operational effectiveness of those services. In contrast, for community groups hospitals are places of significant social and emotional attachments. The focus of my thesis is on how, in this political contest, policy 'works' as an instrument of governance.

In this chapter I use Schön and Rein's notion of 'framing' to explore the way that a policy to centralise hospital services was presented in national policy texts during the period of the study (2007-2009). This analysis attends to the way that a policy to centralise hospital services was established as appropriate and legitimate, how this particular course of action was made to appear inevitable whilst alternative courses of action were marginalised, and how certain voices prevailed whilst others were subjugated. The primary source of data I use in his chapter are policy documents published by the Department of Health, namely:

- the White Paper *Our Health Our Care Our Say* (Secretary of State 2006);
- national service models published for the different hospital specialties;
- *A Framework for Action* (Darzi 2007b);
- *Our NHS, Our Future. NHS Next Stage Review Interim Report* (Darzi 2007c); and
- *High Quality Care for All. The Next Stage Review* (Darzi 2008).

Together these documents constitute the key national policy documents pertaining to hospital services at the time this study was undertaken (2007-2009). I also draw on other sources of data including a report on a public consultation commissioned by the Department of Health as part of the development of the 2006 White Paper *Our Health, Our Care, Our Say,* guidance published by the Department of Health for Strategic Health Authorities, and field notes.

I present my findings under three headings. Under 'From 'care closer to home' to 'the clinical case for change'' I illustrate an increasing emphasis in policy documents on the clinical necessity of centralising hospital services. I give an account of national policy during this time (2007-2009) as framing hospital planning as a clinical issue and decisions to close hospital services as based on the evidence and necessary to ensure safety. I argue that this framing can be understood as a rhetorical strategy designed to persuade other stakeholder of the need for change. Beyond the power of persuasion, the framing 'works' in the way it channels thinking in a particular direction and makes a particular course of action appear inevitable. It also works by defining the issue as 'technical' and thus not subject to public deliberation, and by constituting subjectivities (the medical expert and the laity, now excluded from the technical realm). Then, under 'The co-optation of the medical profession' I illustrate how this framing was reinforced by the enrolment of doctors in policy processes, first as authors of national policy documents, and then as a health minister. Finally, under 'The coupling of clinical and patient involvement narratives' I show how the framing of clinical necessity sat alongside a narrative of public involvement, producing a 'two-pronged' rhetorical strategy drawing on both medical knowledge and democratic engagement as sources of legitimacy.

Then, to further illuminate these discursive features of national policy, I compare the way hospital planning is depicted in national policy with a real-life case study of efforts to close hospital departments. I show how the depiction of hospital planning in national policy as a technical and comprehensively rational process contrasts with the reports of real-life planning practices that reveal an inherently political process involving multiple perspectives on the issue. I conclude this chapter by reiterating my argument that there was a strategic reframing of centralisation in national policy, and that this can be read as a rhetorical strategy employed to counter public resistance to changes that would result in closing local hospitals or hospital departments. I consider, and reject, an alternative reading of the data, that it reflects a resurgence in medical influence on national policy. I find further support for my argument in guidance issued by the Department of Health to regional offices, recommending the enrolment of doctors in the process of local implementation so as to persuade the public of the need for change, a practice I explore further in the next chapter which presents findings from my ethnographic study in a local health economy.

From 'care closer to home' to 'the clinical case for change'

When I started fieldwork, in March 2007, national policy on how and where hospital services should be delivered was contained in the White Paper *Our Health, Our Care, Our Say* (Secretary of State for Health 2006*)*. This document set out as a key objective the relocation of services from hospital to non-hospital settings. Couched in the language of rational analysis characteristic of policy texts (Shore and Wright 1997) *Our Health, Our Care, Our Say* presents national policy on hospital services as a rational response to features of the social context, including the development of technological developments that enable health care to be delivered in more local settings; an increase in long-term conditions; and patient expectations for convenient health care. In this social context, the 'reconfiguration' of services is presented, primarily, as a means of improving patient access and responsiveness. It is also presented as a means of improving efficiency, for example, at one point it says that 'a strategy centred on high-cost hospitals will be inefficient and unaffordable compared to one focused on prevention and supporting individual well-being' (Secretary of State for Health 2006, p 129). This representation of national policy as a rational response to social developments constructs change as necessary through the rhetoric of logic. It also contains a moral imperative. This imperative is derived from the inherent morality of rational action and the assumed beneficence of technology in enabling progress. Note how in the following excerpt attachment to 'tradition' is not simply irrational, but wrong:

> It is important that the organisation of health carefully reflects the speed of technological change. Procedures that could once only take place in hospital can now take place in the community. Assistive technology raises more possibilities and more people can be supported safely in their homes. Scientific advance will continue to challenge the way in which we organise our services. It would be wrong to allow a traditional method of delivery to hold back progress. (Secretary of State for Health 2006, p 6)

The notion of traditional practices might be seen as residing in the domain of the 'lifeword' (Habermas 1987) in contrast to the system imperative of progress. However, whilst traditional practices are disparaged, what might be considered another lifeworld value, that of 'community' is valorised. Indeed, like the 2003 White Paper *Keeping the NHS Local*, *Our Care, Our Health, Our Say* can be seen as characterised by a community rhetoric that employs

numerous spatialised terms. For example, the policy was called 'care closer to home' and throughout the document reference is made to providing care 'closer to home', 'in the community' and 'in more local settings':

> In future, far more care will be provided in more local settings. People want this, and changes in technology and clinical practice are making it safer, and more feasible. (Secretary of State for Health 2006, p129)

The emphasis of *Our Care, Our Health Our Say* is on providing hospital services 'in more local settings'. Significantly less attention is given to the corollary, closing hospitals or hospital departments. In fact in the entire document it is mentioned only once, in an annex that summarises the findings from a public consultation:

> Participants in the 'Your Health, Your Care, Your Say' consultation said they wanted more care provided in community settings. The majority favoured increased investment in the latter, *even if this meant changing the type and scale of services provided by their local hospital*. (Secretary of State for Health 2006, p140, emphasis added).

Thus mention of closing hospitals is almost hidden, tucked away in an annex. It is also nestled in the context of public consultation, emanating from, and legitimated by, public consultation. Public consultation and involvement was a key theme of *Our Health, Our Care, Our Say.* For example, the development of *Our Health, Our Care, Our Say* is described as involving 'major consultation exercises designed to give people a genuine chance to influence national policy' (Secretary of State for Health 2006, p14). And the policies contained within *Our Health, Our Care, Our Say* are said to 'stem directly from what people have told us they want from health and social care in the future' (Secretary of State for Health 2006, p14). These references to public involvement suggest that it was both a policy objective, that needed to be attended to in official statements, and a source of legitimacy for policy proposals. The construction of 'the public' in *Our Health, Our Care, Our Say* is as citizens and the stated aim of consultation was to involve citizens in policy making:

> We set out to ensure that our proposals truly reflected the views of fellow citizens. Putting people more in control means first and foremost listening to them – putting them more in

control of the policy setting process itself at national and then local level. (The Secretary of State for Health 2006, p14)

The 'major consultation exercises' referred to in *Our Health, Our Care, Our Say* were conducted by a research organisation commissioned by the Department of Health and involved questionnaires and 'face-to-face debate' by people who had been randomly selected from the electoral register. The consultation was described as 'one of the largest ever listening exercises to ever take place in England' (Opinion Leader Research 2006, p8). In total it involved 42,866 people, including:

- 29,808 people who completed a questionnaire, either on-line or paper-based made available via a selection of commercial magazines.
- 8,460 people who took part in local listening exercises
- 254 people randomly selected from a number of electoral registers in the region who took part in deliberative regional events (89 in Gateshead, 60 in Leicester, 51 in London, 54 in Plymouth)
- 986 who took part in a 'National Citizens' Summit' in Birmingham on 29 October 2005

The same questionnaire was used throughout and participants in deliberative events were given a 'citizen's guide' before-hand 'to introduce the issues in an informative and open manner' (Secretary of State for Health 2006, p14). A report from the consultation (Opinion Leader Research 2006) was published at the same time as *Our Health, Our Care, Our Say* and the findings were summarised in an Annex. Although the consultation covered a range of issues to do with health and social care, the question most pertinent to hospital planning was one posed to participants at the Citizens' Summit and which asked them 'to discuss whether they would like to see more services provided locally if this meant that some local hospitals would close and others would merge to become specialist centres'. According to the consultation report 'participants debated the issue (using a handout with information and evidence on the topic) and then voted on it.' (Opinion Leader Research 2006, p14). The report states that 'participants think that moving some services into the community would deliver a wide range of practical advantages' (such as quicker treatment and better customer

service) but noted that 'a substantial proportion opposed the suggestion' adding that 'they think the government is proposing to close hospitals via the back door'. Other concerns included concerns over quality, travel for patients and relatives and friends and a belief that 'governments in the past had been too quick to close local and community hospitals, which had been a mistake' and that 'there is likely to be more need for hospital services in the future not less, because the population is ageing and more people are living with long term conditions' (Opinion Leader Research 2006, p 116). The results of the vote are shown in the table below:

Table 2. Your Health, Your Care, Your Say consultation. Citizens' summit polling question

Source: Opinion Leader Research (2006)

To what extent do you support or oppose providing more services closer to home including community hospitals if this means some larger hospitals concentrate on specialist services and some smaller hospitals merge or close? Base: All respondents (n=986)	%
Strongly support	15
Support to some extent	39
Neither/nor	8
Oppose to some extent	17
Strongly oppose	12

In *Our Health, Our Care, Our Say*, the government uses the results of the consultation exercise as evidence of public support for the policy proposals, even though the report from the consultation recorded only a slim majority in support of the statement that was provided (54%) and suggested an enduring resistance to closing hospitals. The report from the consultation, in finding that some participants 'think the government is proposing to close hospitals via the back door', suggests that the use of the community narrative *as rhetoric*, concealing other motivations, was recognised by at least some members of the public.

Thus *Our Health, Our Care, Our Say* presented national policy on hospital services as a rational response to changes in technology, disease patterns and public expectations. The prescription,

moving health care out of hospital settings, was presented primarily as a means of improving access and responsiveness. In subsequent policy texts, however, the emphasis shifted to the clinical necessity of centralising some acute care. Using Rein and Schön's (1993) concept, a new 'framing' of the issue emerged which stressed the 'clinical case for change'. The 'clinical case for change' contained three suppositions (i) that hospital planning is a clinical issue; (ii) that centralisation is based on the evidence; and (iii) that centralisation is necessary to ensure safety. These three features of the framing are considered in turn below.

Supposition I. Hospital planning is a clinical issue
Framing socially constructs the problem and suggests what courses of action are appropriate. In constructing the problem a frame implies not just what is to be done but who should do it. Whilst the overriding emphasis in *Our Health, Our Care, Our Say* was on providing services 'closer to home', at one point it signalled an intention to consult the medical profession on how hospital services should be provided:

> To ensure a stronger evidence base; and a real clinical engagement, the Department of Health is working with the specialty associations and the Royal Colleges to define clinically safe pathways that provide the right care in the right setting, with the right equipment, performed by the appropriate skilled persons. (Secretary of State for Health 2006, p132)

In the above excerpt medical experts are identified as the appropriate people to be defining how and where hospital services are provided. This is in contrast to earlier policy on hospital planning, as set out in the 2003 White Paper *Keeping the NHS Local*, which was based on the principle of joint planning. Compare the following extract from *Keeping the NHS Local:*

> The aim here is to have an open and transparent process, taking everyone's views into account, and not just those who know their way around the system. If a comprehensive picture of the community's views can be developed alongside those of the local NHS organisations, there will be a firm basis for building a consensus around the best fit option, backed up by clear reasoning. This is sometimes known as 'socially sustainable decision making'. (Department of Health 2003, p37)

The aim of consulting the Royal Colleges was to 'define appropriate models of care that can be used nationwide' (Secretary of State 2006, p132). This stated intention to identify universal models of care can also be contrasted with previous policy, set out in the 2003 White Paper, *Keeping the NHS local,* which encouraged local innovation in the way working practices were organised and emphasised tailoring the organisation of services to local priorities. The apparent deference to the profession on the issue of hospital planning also contrasts with the stance taken in earlier policy, which is openly critical of the professions' working practices, suggesting that it is the way doctors work, rather than the organisation of health care, which needs to change and that 'the trend for all hospital doctors to become more and more specialised has begun to be questioned' (Department of Health 2003, p27).

The Department of Health followed the publication of the *Our Health, Our Care, Our Say* with a series of policy papers written by the national clinical directors. The national clinical directors were doctors who were appointed by the Department of Health to develop models for how services should be delivered for each hospital specialty. Thus a paper authored by a doctor and outlining the 'clinical case for change' was published for heart disease and stroke (Boyle, 2006), emergency care (Alberti, 2007), mental health (Appleby, 2007), primary care (Colin-Thome, 2007), surgery (Darzi, 2007a), geriatrics (Philp, 2007), cancer (Richards, 2007), diabetes (Roberts, 2007), maternity (Schribman 2007a) and paediatrics (Shribman 2007b). The recurring theme of these documents is that while some services can be provided locally, other care needs to be centralised to ensure the best health outcomes.

One way of understanding these new appeals to 'the clinical case for change' in national policy documents is as a rhetorical strategy deployed to persuade other stakeholders for the need for change. Rhetorical strategies use language to connect to broader social values. To appeal to a 'clinical' rationale for change is to present the plans as technical and thus politically neutral. It also gives a sense of importance, urgency and necessity. More fundamentally, this appeal draws on the cultural authority of the medical profession and its association with 'truth' (Zola, 1999).

The documents written by the national clinical directors, all with the subtitle 'The clinical case for change', often explicitly acknowledged the context of public opposition to closing local hospitals or hospital departments. The challenge, for clinicians, as presented in these

documents, was to convince patients why services needed to change. For example, in *Making it better for mother and baby. The clinical case for change for maternity services* (Shribman, 2007a) the author describes the public opposition to plans to close the consultant-led maternity service at Huddersfield Royal Infirmary:

> Campaigners were initially utterly convinced something good and beneficial was being taken away and that the changes were politically and financially motivated. Amidst the din of protest there were accusations questioning the motivation and judgement of the Trusts that had proposed the change. Some protestors said a patient-led NHS was a joke because they weren't listening to women. There were claims the extra travelling time would put the lives of mothers and babies at risk and others said reducing services was mad because demand was likely to grow. (Shribman, 2007a, p1)

Note the infantilising use of the word 'din' which undermines the legitimacy of these concerns. There is an allusion that these concerns are overstated, or that the campaigners might be mistaken. Campaigners were being led by emotion, leading to 'accusations'. Convincing them of the need for change will be a challenge (like calming unruly children) but one that can be met with scientific reason.

In June 2007 a new health minister was appointed. Lord Ara Darzi, a consultant surgeon, was previously a national clinical director and author of *Saws and Scalpels to Lasers and Robots - Advances in Surgery. Clinical Case for Change* (Darzi 2007a), the policy document that set out service model for surgical services. The government asked Darzi to review the delivery of health care in London. In the first policy document published by Darzi as a health minister he once again argued that the delivery of health care should be based on the principle of 'localise where possible, centralise where necessary' (Darzi, 2007b). Darzi followed the review for London with a review for the rest of England. In an interim report Darzi explicitly positions himself as 'a doctor not a politician' (Darzi 2007c) despite the fact that the report has the status of policy and is published by the Department of Health. In the final report the preface by the Prime Minister, and the Foreword by the Secretary of State for Health, are accompanied by 'business-style' portraits of the office holder wearing a suit. In contrast, the portrait accompanying Darzi's opening letter is of him dressed in his surgeon's gown and

mask and in the process of operating, even though the review was undertaken in his role as minister.

In an opening letter that prefaced his final report, Darzi establishes his clinical credentials and indicates that it is his clinical experience that is the basis of the report's recommendations:

> I have continued my clinical practice while leading the Review nationally. I have seen and treated patients every week. Maintaining that personal connection with patients has helped me understand the improvements we still need to make. (Darzi 2008, p8)

Darzi also draws on his clinical experience to make an assessment of policies relating to how services are provided:

> I used to be the only colo-rectal surgeon in my hospital; today I am a member of a team of four surgeons, working in a network that reaches out into primary care. (Darzi 2008, p7)

In the next paragraph he extends his jurisdiction, from the clinical team to national policy. In this way controversial government policies, such as the introduction of market-based policies, are brought into a technical realm subject to medical expertise:

> I have seen for myself the NHS getting better, and I have heard similar stories from other clinical teams throughout the country over the course of this Review. These achievements were enabled by the investment of extra resources, by giving freedom to the frontline through NHS Foundation Trusts, and by ensuring more funding followed patient choices. (Darzi 2008, p 7)

To summarise, a feature of the rhetoric of policy documents that followed the 2006 White Paper *Our Health, Our Care, Our Say* was the definition of hospital planning as a clinical issue, subject to medical expertise. This framing worked both rhetorically, seeking to persuade other stakeholders that the course of action was legitimate, based as it was on medical expertise, but also discursively, by defining the issue of hospital planning as 'clinical' and thus technical, and by creating subjectivities, namely the medical expert with jurisdiction over hospital planning and the laity now excluded from the technical realm.

During fieldwork I was invited to a breakfast meeting hosted by a policy think tank at which a minister was speaking. I mention this meeting here to further illustrate the way the issue of hospital planning was defined as technical in national policy discourse, and how this enabled the issue to be removed from the agenda for public deliberation. In addition to the minister, there were also staff from the think tank and a dozen or so other staff from the Department of Health. At one point the participants were discussing direct election to local Boards as a means of strengthening democratic participation in the local planning of health services. The minister said 'I am not convinced about the capacity and willingness of locally elected representatives to take the hard decisions, such as closing the local hospital' and pointed to the 'unwillingness of MPs to support the difficult decisions that are clinically led' (Field notes 20 February 2008). Thus by defining some decisions as 'clinically led' the minister is able to categorize these as inappropriate for public deliberation.

Another attendee, a GP working in the Department of Health, justified the exclusion of the public from hospital planning by making the analogy with individual treatment decisions: 'When you speak to them as a GP they want us to take the hard decisions'. This analogy with patients in the clinical encounter does not itself exclude the public from decision making, an inclusive model of patient involvement in treatment decisions is widespread, at least rhetorically. What it does do is suggest that, as with individual treatment decisions, there are certain situations where the public want doctors to make the decision. My argument is that the involvement of doctors in policy making is not a neutral act, it symbolically extends the jurisdiction of doctors to the issue of hospital planning, bringing with it an analogous role for the public. In this way the involvement of doctors in the development of health policy can be seen as not just reinforcing rhetoric aimed at convincing other stakeholders of the need for change, but as constituting subjectivities. Rather than seeing members of the public as service users, or citizens who, under democratic tenets, should be involved in decisions that concern them, the public here are constituted as passive patients who want doctors to take the hard decisions for them.

Supposition II. Centralisation is based on the evidence
The second supposition that can be found in the framing of centralisation as a clinical necessity is that centralisation is 'based on the evidence'. In the policy documents published

between 2007 and 2009, a single, universal model of acute services is promulgated as essential and supported by the certitude of scientific knowledge. For example, the proposals in *A Framework for Action* were described as 'rooted in the evidence' and 'from reviews of the literature and data' (Darzi, 2007b, p.4):

> This report makes recommendations for change. It is based on a thorough, practitioner-led process, and rooted in evidence – gathered from a wide range of people and organisations from the world of health care and from the NHS's partners in local government and beyond, from thorough reviews of the literature and data, and from the use of a range of analytical modelling techniques. It also reflects a major exercise to hear what Londoners say they want from their health care system. (Darzi 2007b, p4)

> A wide range of approaches has been employed to ensure that the best available evidence has been brought to bear to inform the report's conclusions. We have drawn on evidence from literature searches and that highlighted by clinical experts. We believe this report is evidenced-based and have made every effort to use references where appropriate. (Darzi 2007b, p15)

These excerpts can be seen as seeking legitimacy by appeals to scientific methods (analytical modelling techniques and reviews of the literature) and knowledge (clinical experts). References to 'data', and 'evidence' suggest the process of decision making is normatively correct and the chosen course of action is unquestionable. In the first excerpt appeals to the evidence are combined with an appeal to public involvement. Proposals were said to be based on 'reviews of the literature and data' and to reflect 'a major exercise to hear what Londoners say they want from their health care system' although it is not clear which would take precedence in situations where there are conflicting findings.

The way centralisation is framed in the policy documents between 2007 and 2009 can again be contrasted with earlier policy. The 2003 White Paper *Keeping the NHS local,* for example, adopted a critical stance to scientific knowledge. It also rejected the primacy of research findings in policy processes, instead placing them alongside other considerations, namely the views of communities and the objective of maintaining access to hospitals for staff, patients and relatives. *Keeping the NHS local* also suggested a wide range of alternatives to centralisation,

such as changes to working practices, and emphasised local innovation and the value of tailoring solutions to local priorities. The following extract from *Keeping the NHS local* illustrates the way this earlier document sought to generate a wide range of potential strategies:

> The centralising pressures experienced in smaller hospitals are felt most acutely within their medical workforce. The NHS is currently developing a range of innovative strategies to address these pressures through
> • New and extended roles for doctors, nurses, and other clinical staff
> • Shifting from traditional medical firm based to team based working
> • Exploring new ways of managing the hospital at night
> • Achieving the right balance of care from generalist and specialist (Department of Health 2003, p25)

Despite describing policy proposals as 'based on the evidence' national policy documents contained few references to research-based evidence of improved outcomes associated with the proposed model of providing health care. In some cases there were references to a small number of studies of the relationship between hospital volume and outcomes, primarily in the area of care for people who have had a stroke. There were no references to research findings on the disadvantages of centralising care. Thus on the few occasions where empirical research was included this was highly selective. In most cases references were to standards published by the Royal Colleges. As described in the previous chapter, Royal College standards specify, for a particular service area, the required minimum size of the catchment population, staffing patterns, workload, and inter-professional linkages. When these standards were retrieved as part of analysis they were found to be predominantly based on expert opinion. In some instances the basis of recommendations were surprisingly arbitrary. This is illustrated in the following recommendation from the first Darzi report:

> Obstetric units should have a consultant presence for at least 98 hours a week.[10] This will require fewer obstetric units than now in order to ensure there is an adequate workforce, that staff gain sufficient experience and that the units are affordable.(Darzi, 2007b, p.46)

The superscript notation is in the original document. It is standard scientific notation to indicate a citation. Given the 'scientific' evocation of the language I assumed that the citation would be to research-based evidence in support of this recommendation. Instead I found a footnote that read as follows:

> The Royal College of Obstetricians and Gynaecologists have suggested that units should be moving towards having consultant presence 24/7. We are not convinced that this is essential for a high quality service, so we have set a more conservative requirement of a consultant presence of 98 hours a week, which would be a significant increase in some units. (Darzi, 2007b, p.83)

Appealing to the 'the evidence' assumes an unproblematic progression from research findings to decisions about a course of action. However, research findings are contested and decisions about 'what should be done' are complicated by the need to balance competing objectives, such as effectiveness and access. In policy texts the evidence for clinical effectiveness is emphasised to the exclusion of other considerations. This, together with the sometimes tenuous links to empirical research, suggests that these appeals were primarily rhetorical, the use of scientific vocabulary serving to establish that the plans for changing how services are provided are based on objective knowledge and independent of political interests.

Thus the policy documents published during the time of my study are characterised by a selective use of the evidence and a tone of certitude. This can again be contrasted with the stance adopted in earlier policy, contained in the 2003 White Paper *Keeping the NHS local*. The body of scientific knowledge on the relationship between volume and outcome did not change between 2003 and 2007, but the 2003 White Paper can be seen as taking a much more comprehensive, measured and critical stance in relation to this body of knowledge. It also took a wider lens that considered alternatives to centralisation as a means to the stated ends of clinical effectiveness. This can be seen in the following extracts:

> Many of the most problematic reconfigurations of recent years have related to the closure or loss of core services from smaller general hospitals. These have felt the effects of competing pressures acutely, as centralising and localising pressures have pulled in opposite directions. And these hospitals are particularly hard hit by practical constraints on

providing services. Faced with these pressures, merging the services of two smaller hospitals into one larger one has been the common response. But there is evidence that centralising services into larger hospitals does not necessarily deliver the expected benefits. The link between volume and outcome for surgical procedures is often overestimated; the financial benefits often expected from such mergers do not always materialise; and access to service may be reduced, particularly for older people. (Department of Health 2003, p29)

The evidence emerging from clinical governance reviews is suggesting that the critical factor in high quality clinical practice is a culture of learning and evaluation, with a proactive approach and implementation of organisation-wide policies and strategies on clinical governance. The size of the clinical team, often suggested as the main factor in high quality clinical practice, does not appear among the most common barriers to effective clinical governance. (Department of Health 2003, p17)

What these two excerpts from *Keeping the NHS Local* illustrate is that the particular framing of policy as based on the evidence is not inevitable. What I have sought to show is that it can be seen to differ considerably from that found in earlier policy documents. Earlier policy documents are equivocal about the evidence base linking volume and quality of care, and indeed openly question the extent to which expected outcomes arise from centralisation. In contrast the later policy framing positioned the evidence not only as reaching a different conclusion, but, more importantly, as uncontestable.

Supposition III. Centralisation as necessary to ensure safety
The other recurring motif in policy rhetoric during the time of this study was an appeal to 'safety'. This can be seen in the following excerpts from *A Framework for Action* (Darzi 2007b):

Although many of our district general hospitals try to provide a wide range of specialist care, there are simply not the volumes of patients with complex needs to make this either viable or as safe as possible for patients. (Darzi 2007b, p10)

For the most complex treatment, the safest care is centralised care. That is the primary reason why specialist planned care should be provided at centres of excellence. Secondary factors behind centralisation are changes to working practices including the European

Working Time Directive (EWTD) and the increase of sub-specialisation among clinicians. (Darzi 2007b, p70)

At the breakfast meeting described above, the minister acknowledged the rhetorical effects of an appeal to 'safety':

In Manchester they were facing resistance to changes to maternity services, but once we could make the argument that the way we are doing things is killing you and killing your babies it was easier to make these decisions. (Field notes, January 2008)

An appeal to 'safety' is among the most powerful rhetorical motifs because it is seemingly unanswerable - who would argue against safety? An appeal to the safety of babies is the 'trump card' (Green, 2000). Appealing to safety makes a particular course of action (in this case centralisation) appear necessary. Thus attention is focused on one course of action, which is made to appear inevitable, whilst possible alternative courses of action are marginalised. This rhetoric can again be illuminated by comparison with the 2003 White Paper, *Keeping the NHS local* which sought to generate a wide range of possible courses of action from which localities could choose according to their own needs.

The co-optation of the medical profession

The construction of hospital planning as a clinical issue was reinforced by the practice of involving doctors in policy development. For example, the Department of Health appointed doctors to publish universal service models for each of the hospital specialties. The doctors who were appointed were medico-politicians or in senior roles in the Department of Health, what Waring (2014) has referred to as political elites. For example, Professor Sir George Alberti, the national clinical director for emergency care, was previously the President of the Royal College of Physicians, whilst Professor David Colin-Thomé, the national clinical director for primary care, was previously Director of Public Health for the London Strategic Health Authority, a regional office of the Department of Health. One of these, Sir Ara Darzi, the author of the service model for surgery, was then appointed a health minister. It is notable that Darzi was a consultant surgeon. The medical profession has enduring forms of hierarchy

with consultant surgeons at the apex. Consultant surgeons have accumulated a considerable amount of cultural capital (Bourdieu 1986) suggestive of both scientific knowledge and technical expertise.

In addition to enrolling high-profile 'political elites' to publish national policy, national policy documents also depict policy as emanating from the views of 'front-line clinicians'. For example, in *A Framework for Action* (Darzi 2007b) the policy was presented as 'supported' by clinicians, 'tested' with clinicians and, at least in part, produced by clinicians:

> The whole approach of this review has been to develop clinical support for our proposals. I have led this process as a doctor myself. The focus has been on improving quality, access and safety – the things that matter to clinicians as professionals – through evidence-based improvements. Through the clinical working groups, clinical experts and innovators have helped in the formulation of the recommendations. The proposals have also been tested with clinical leaders across London. (Darzi 2007b, p118)

Similarly, although *High Quality Care for All. The Next Stage Review* is authored by Darzi, he writes that the review was 'led by 2000 frontline clinicians' and that the changes recommended in the report are 'the changes that frontline staff want to make' (Darzi 2008, p8). This feature of the national policy discourse at this time has also been observed by Martin and Learmonth (2012). Drawing on Foucault, they suggest that the representation of front-line clinical staff as the authors of policy can be understood as a form of co-optation in the interests of policy makers:

> We highlight how health-service staff are increasingly represented not just as the *objects* of policy interventions, but as *subjects* implicated in policy design. We suggest that claims made by health policy about the engagement of professionals as leaders in the design and delivery of reform are best understood as efforts to reconstitute these actors' subjectivities: a co-optive means of 'governing at a distance' that complements more coercive modes of rule such as performance management and associated surveillance regimes. (Martin and Learmonth 2012, p282)

The coupling of clinical and patient involvement narratives

Whilst policy documents published after the 2006 White Paper *Our Health, Our Care, Our Say* increasingly emphasised the clinical necessity of centralisation, they retained a narrative of public involvement. Thus a rhetoric of medical knowledge sat alongside, rather than replaced, the rhetoric of democratic engagement. For example, in *High Quality Care for All* (Darzi 2008) the policy proposals are described as 'the product of the work of more than 2000 clinicians' (Darzi 2008, p.17) *and* 'developed in discussion with patients, carers and members of the public' (Darzi 2008, p.8). In this way government policy is depicted as reflecting a consensus between national policy makers and local actors on one hand, and between clinical staff and the public on the other. As will be shown in the next chapter, this picture is contradicted by my account from ethnographic fieldwork in which local plans for hospital services were highly contested.

Just as the clinical narrative was reinforced by the practices of enrolling professional elites into policy development, the public involvement narrative was reinforced by the practices of public consultation. These practices were characterised by the use of framing devices that served to channel thinking in a particular direction and toward pre-decided solutions. For example, participants in the consultation that was undertaken prior to the publication of the 2006 White Paper *Our Health, Our Care, Our Say*, were supplied with 'information and evidence' and were asked to respond to a particular question. The use and effects of framing devices in public consultation will be considered further in the next chapter.

In both the clinical and public involvement narratives the intention is rhetorical, aimed at persuading other stakeholders of the legitimacy of the decision making process. In a broader sense it is also discursive, as Martin and Learmonth (2012) argue, in the way it constitutes subjectivities, as both front-line clinicians, and the public, are constituted as authors of national policy.

Comparing the depiction of hospital planning in national policy with empirical case studies of local planning

The characteristics of national policy discourse that I have delineated in this chapter are brought into relief when the discourse of national policy documents are compared with empirical case studies of real-life efforts to reconfigure services. One such case study was published by the Kings Fund, a policy think tank, and reported efforts by local managers to reconfigure services in South East London (Palmer 2011). This report was written from a managerial perspective and reveals managerial imperatives in relation to hospital planning, specifically, the 'intense financial pressures' faced by the organisations in South East London and the need to realize large reductions in average costs (Palmer 2011, p 5).

In contrast to the technical and comprehensively rational picture of hospital planning depicted in national policy documents, the Kings Fund report depicts an inherently political process. For example, in South East London the process was partial and selective involving only some of the acute hospitals in the area. Hospitals that were excluded from the plans were those financed by the private finance initiative. Ironically it was these hospitals that had the largest deficits and poorer quality when compared with other hospitals in the area. The author also explains that A&E and Obstetrics and Gynaecology are the departments most frequently chosen for centralisation because they have minimum staffing requirements. From a managerial perspective minimum staffing requirements are a 'fixed cost' which prevent managers from reducing staffing levels as a means of reducing costs. In national policy documents closing an A&E or Obstetrics and Gynaecology department is said to be necessary on the seemingly uncontestable grounds of 'safety'. However what the Kings Fund report reveals is that minimum staffing levels are only 'a problem' if there is a perceived need to reduce costs, otherwise the levels would simply be maintained. Local managers may argue that there are external pressures to reduce costs, but this is related to political decisions regarding the overall level of funding, and requirements to demonstrate improvements in efficiency at a particular level (at this time set nationally at 4%). These political dimensions are obscured by the depiction, in national policy, of hospital planning as a technical process.

Significantly, in the Kings Fund report the views of community groups are depicted not as the source of policy, or as the basis of decision making, as is the case in national policy texts, but

as a barrier to implementation. For example, the report states that 'vocal opposition to change resulted in significant delay to implementation' (Palmer 2011, p2). In contrast to the importance that is placed on public involvement in decision making in national policy rhetoric, the Kings Fund report categorizes the views of community groups as 'localism', an entity the author identifies as diametrically opposed to the policy objectives of 'maximizing quality and financial benefits across the NHS as a whole':

> Localism refers to the coalition of local interests – from clinicians and trust boards to public interest groups, local government and local politicians – that seeks to oppose reconfiguration whenever the result would be downgrading or closure of a local service, regardless of the clinical benefits and wider financial savings. The nature of the consultation and approval processes is such that vocal local opposition, even if a minority view, can prevent service reconfigurations even where evidence suggests the planned changes would bring important benefits for patients. In South East London, localism influenced the reconfiguration debate in a negative way; reconfiguration options involving the foundation trusts, which could have generated important additional benefits for patients, were taken 'off the table' because of local opposition. (Palmer p2011, p21)

This is a very different conception of the views of local staff and community groups than that presented in national policy documents. In national policy documents the views of patients and clinicians are presented as coinciding with 'the evidence' and, together with the evidence, forming the basis of policy, and wholly aligned with its objectives. In the above quote they are, in contrast, seen as a barrier to the smooth implementation of a technical solution to a problem as defined by the experts.

By comparing the discourse of national policy documents with the Kings Fund report on the reconfiguration of hospitals in South East London I have sought to illuminate certain features of the national policy discourse. Specifically, I have shown how national policy documents present the process of hospital planning as technical and politically neutral, as an unproblematic, and uncontested, exercise of translating the evidence into an ideal configuration of hospital services on the ground. The Kings Fund report illustrates, in contrast, that there are multiple perspectives on the issue. These include, for example, a managerial perspective concerned with reducing costs through reducing numbers of staff and

hospital capacity, a professional concern with rationalizing hospitals to concentrate medical labour, and a community perspective concerned with retaining local hospitals. In Rein and Schön's (1993) terminology, these are different 'frames' on the issue.

The 'clinical case for change' as the strategic reframing of centralisation

My argument is that the emergence of the 'clinical case for change' in national policy texts is an instance of strategic reframing. That is, it was intentional, employed by policy makers in an effort to persuade other stakeholders of the need for change. This is suggested by national guidance issued to regional offices (Strategic Health Authorities). At this time it was the role of Strategic Health Authorities to ensure that national policy was incorporated into local plans. The guidance, sent out in February 2007, consisted of recommendations for how local plans to close services should be implemented. These recommendations included 'involving clinical staff at every stage of the process, from developing proposals and the case for change to implementation' (Carruthers, 2007, p6):

> Where clinical leaders genuinely develop and support proposals, they play a vital role in building public and patient confidence. In the best examples, medical directors have written forewords to consultation documents, clinicians have supported proposals at public meetings, articles have been written by the heads of relevant clinical disciplines and letters to correct local media stories have been sent from GPs. (Carruthers 2007, p.6)

In his first report Darzi also proposed that local doctors should be used as 'champions' for national policy, specifically to convince the public of the need for change:

> Those fears need to be confronted and assuaged. To do this, as these proposals are implemented at a local level, clinical champions will need to be identified who can make the case to their peers and the public that change is necessary to improve the quality of services. (Darzi 2007, p 118)

This means that medical champions will be crucial to driving change. The case for this Framework is a clinical one, and clinicians and other medical staff will need to continue to be involved in its implementation. (Darzi 2007, p118)

The involvement of clinicians in implementation of the policy reproduces the doctor-patient relationship and imposes it on a different context, i.e. not individual treatment decisions but a policy domain. This relationship brings with it a different role for the public with regards to 'involvement' in decision making, shifting the nature of participation down the 'ladder of participation' (Arnstein 1969) to 'informing' the public of a decision that has already been taken. This distinction can be seen in the following transcript from an interview between the broadcaster John Humphrys (JH) and Darzi (LD) broadcast on the Radio 4 Today Programme on the 9th of May 2008:

JH: If somebody, if a large enough group of people, in a given town or given area, say 'we don't want our hospital to close, we don't want a polyclinic' (or whatever it happens to be), then they will not only be listened to, but their wishes will be acted upon? Is that what you are saying?

LD: Absolutely, and these are the pledges and these are the safeguards that I have published well ahead of the nine different reports which we expect to start next Monday.

JH: Well that could be done on a strictly numerical basis couldn't it? So if you were serious about this, what you have to do presumably is to send out a little polling form or something to everybody in the area, and say tick box A or tick box B? That's not what you are proposing is it?

LD: No I'm not. What I'm suggesting, any local change has to have a purpose. That purpose has to be based on outcomes – saving lives, whatever that quality happens to be. And then, that needs a consultation with the users of the service: the patients, the public. If there is a dispute, then that dispute, you could bring in an arbitrator, a clinical arbitrator, to resolve that local dispute.

JH: right, so in the end, the decision will still be taken by either the clinicians who run the hospital or the service, or by the local politicians. In other words, I am struggling a bit to discover what's changed.

LD: What's changed, we need to be, as clinicians, we need to stand up there on the platform, engage the patients, explain why changes need to occur, if it's based on quality. Maybe we haven't done it before; we need to do more of it in the future. John, I've been in clinical practice for 20 years, I have yet to meet a patient, in whom you describe what change you might be making in your practice, what you may be offering as a treatment which will compromise their care, for them to accept it. That is not the world we are living in. We are living in a world in which quality matters and healthcare quality should matter to all of us.

In the above the excerpt 'public involvement' is represented by Darzi as 'informing' the public, as he puts it, explaining 'why changes need to occur'. This particular form of public involvement can be contrasted with alternatives, indeed one alternative is suggested by the interviewer John Humphrys, when he suggests that the issue could be decided by a majority vote. This excerpt is illustrative more broadly of the framing of centralisation as a clinical necessity. This can be seen again in Darzi's reference to the role of doctors in explaining 'why changes need to occur'. Over the course of the interview Darzi mobilises the 'clinical case for change' to redefine the issue of hospital planning, from political to clinical. To begin with we see in John Humphrys's narrative an assumption that the issue is appropriate for public deliberation and collective decision making. He even suggests a way that the process of public decision making could be undertaken - people could be sent a polling form, with Box A and Box B and so forth. In this frame authority resides with the community, there is also an assumption of community ownership of hospital facilities ('if a large enough group of people, in a given town or given area, say 'we don't want our hospital to close..'). Darzi, however, introduces a different frame on the issue, where the purpose of change is 'saving lives', making change both important and necessary, and where someone with 'clinical' expertise is the appropriate arbiter. Darzi draws legitimacy from his 20 years as a practising clinician, and he again makes an analogy between decisions about hospital planning and individual treatment decisions ('what change you might be making in your practice, what you may be

offering as a treatment'), in this way he is re-assigning both authority and ownership over the domain of hospital planning, from the community to the doctor.

To summarize my argument, national policy documents initially presented policy on hospital services as a means of making health services more accessible, responsive and efficient. Over time a new framing of the policy emerged that emphasized the clinical necessity of centralizing acute care. The emphasis in policy documents on the clinical necessity for change was reinforced by the involvement of doctors in policy development, first in authoring policy documents and then as a health minister. This framing presents the decision to close hospitals or hospital departments as based on the evidence and necessary to ensure safety. I have interpreted this as an instance of strategic 'reframing' deployed in the context of community resistance to hospital closure and a concomitant policy rhetoric emphasising the importance of public and patient involvement in decisions about how health care services are delivered.

An alternative reading of the empirical data from this study is that it reflects a privileging of the voice of the medical profession in national policy. A number of analyses have concluded that the influence of the medical profession on national policy has been eroded over the last 20 years (Harrison and Ahmad 2000, Salter 2003, Klein 1990). The decline of the influence of the profession on national policy has declined at the same time as the ideas and practices of management have gained prominence. Tenbensel (2000), for example, has argued that in public policy over the past 20 years the value afforded to the 'generic expertise' of managers, accountants and health economists has increased whilst the value afforded to 'contextual expertise' of (in this case) medical specialists has declined. The relationship between the two forms of expertise is complex and symbiotic and varies between different policy contexts. In the UK one manifestation of this trend is the increasing use of management consultants in the Department of Health and in NHS organisations (Saint-Martin 1998, House of Commons Health Committee 2009).

Thus the shift in framing that I have identified may reflect a resurgence of the influence of the profession in the formation of national policy. The profession, however, was excluded from the development of other contemporaneous national policies on health care, such as the decision to (re)introduce market-based policies encouraging patient choice and competition between hospitals. And where medical experts were involved in hospital planning these were selected

from the existing pool of medico-politicians who had previously provided advice to the Department of Health or worked in management positions in the NHS, suggesting instead the co-option of medical elites to serve the interests of policy makers.

Analyses of changes in professional influence on national policy have made two observations. Firstly, that although the profession has been excluded from policy formation in favour of management expertise, at the 'macro' level the dominance of the biomedical model remains largely intact, and there is little evidence that the overall social or intellectual place of medicine has been eroded (Harrison and Ahmed 2000). Harrison and Ahmed argue that this serves managerial interests as much as the profession. Second, while management ideas and practices dominate policy *formation*, managerial power is limited when it comes to *implementing* policy. As Salter observes 'managers lack political and media credibility' (2000, p932). The State still needs doctors to implement its policies. My argument is that at the national level 'political elites' (Waring 2014) are co-opted in the interests of policy makers. In the next chapter I consider how similar techniques operate at the local level, specifically how local 'managerial elites' are co-opted in the process of policy implementation.

In this chapter I explored national policy discourse in the field of hospital planning between 2007 and 2009 and argued that during this time there was a reframing of the policy of centralizing hospital services. Initially national policy documents presented policy on hospital services as a means of making health services more accessible, responsive and efficient. Over time there emerged a new framing of the policy that emphasized the clinical necessity of centralizing acute care. The emphasis in policy documents on the clinical necessity for change was reinforced by the involvement of doctors in policy development, first in authoring policy documents and then as a health minister. This framing presents the decision to close hospitals or hospital departments as based on the evidence and necessary to ensure safety. I have interpreted this shift in framing as a rhetorical strategy deployed in the context of community resistance to hospital closure and a concomitant policy rhetoric emphasising the importance of public and patient involvement in decisions about how health care services are delivered. In the next section I show how this framing can also be seen to be deployed in the local context. I use ethnographically collected data from one locality in England to show how local managers mobilize the 'clinical case for change' to implement changes in hospital services in the face of community resistance.

5. REFRAMING IN LOCAL PLANNING

The previous chapter identified a shift in the framing of a policy to centralise hospital services in national policy documents. In the next section I consider how the framing of clinical necessity travelled from the national level of government policy to the level of practice. Hughes (1996) has described local health service managers as essentially 'rhetoricians'. He argues that local managers must act in a political context of competing interest groups and that this process can be understood as an interplay of rhetorics, rather than the more familiar conception of negotiation and bargaining. The tendency since the 1980s to devolve responsibility for hard decisions downwards has made it necessary for local managers to explain and to justify. They must persuade other players that one course of action is better than others. This is not to say that the use of rhetoric is necessarily about manipulation or deception, it may be a way by which local actors make sense of changes in policy over which they have no control. In the context of my study, I consider how local managers introduced changes to hospital services. I look at how managers sought to persuade other stakeholders of the nature of the problem and enrol them in the process of implementation.

Using ethnographic fieldwork conducted in one locality in England between 2007 and 2009, I show how local actors deployed the same framing as that identified in the previous chapter from national policy documents, as a rhetorical strategy for implementing plans to change hospital services. I conclude that while the framing was unsuccessful in terms of persuading other stakeholders of the need for change, it was more successful in terms of its ability to control the agenda, specifically, by defining the issue as 'clinical' and therefore not suitable for public debate.

The Shire

The Shire is an English county. It has a mainly rural population to the south and an urban population in the north. Although much of the population is wealthy there are pockets of deprivation. The Shire has a large elderly population but is also experiencing a substantial amount of new residential building which can be expected to attract first home buyers with young families. It has five acute care providers. Two of these (Forest hospital and Shire General

hospital) consist of a single hospital. The remaining three (South Shire, Wildbridge and Smithton, and Warton and Judford) have services across multiple sites, a legacy of earlier mergers between organisations. Information on the NHS organisations in the Shire is given in Appendix 1.

In the Shire, as in other areas of England at the time, local health care organisations had plans to close either hospitals or hospital departments. These plans had a long and complicated history. The details of the plans, the organisations involved and the rationale had all changed over time (and continued to change whilst I was in the field). When I began fieldwork, in the Spring of 2007, both the local commissioner (The PCT) and one of the acute care providers (an NHS Trust) had plans to close hospitals or hospital departments. The following history of these plans, or 'programmes of service change' in NHS management terminology, has been constructed from documents and newspaper reports.

The programme of service change being implemented by the PCT was called 'Fit for the future'. 'Fit for the future' had been instigated by the regional office of the NHS (the Strategic Health Authority) in response to the findings from a financial audit which had been undertaken by a private firm of management consultants. The firm of management consultants had made a number of recommendations for how to respond to a financial deficit in the region, one of which was 'service reconfiguration'. The analysis that was provided by the firm of management consultants was consistent with that described by Kitchener (2002) in that it was characterized by the omission of the relative merits of centralising hospital services against other options, findings from evaluations of previous reconfigurations, implications other than for cost and operational effectiveness and possible barriers to implementation.

Rhodes (2013) has observed that one artifact of managerialism is the 'slide pack' as the dominant form of communicating analysis. In my study one report from the management consultants to the Strategic Health Authority took the form of a slide pack containing 311 power point slides. Many of these depicted the ideal configuration of health services in the Shire as a flow chart. The analysis took a 'top down' approach, arranging the various component services (accident and emergency, surgery etc) into the 'ideal' health care system. Some of these slides have been reproduced below.
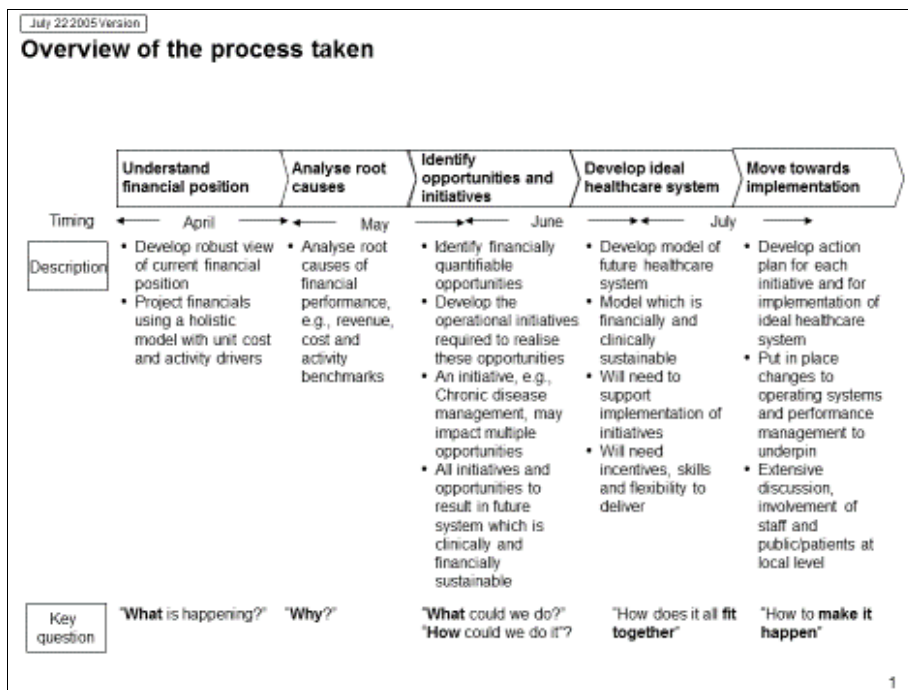
The first slide gives an overview of the process. It depicts a linear, rational process, where the objective to 'develop ideal healthcare system' is clearly identified and depicted as a response to the financial position. Note the location of the task of 'involvement of staff and public/patients at local level' under 'implementation'. In other words, the process as depicted proposes to involve staff at the time of implementation, not before, or during, decision making. Indeed the decision was taken by the SHA on the advice of a private firm of management consultants. The absence of public involvement, and involvement of local clinical staff, was a point of criticism in my first interview in the Shire (with a manager from one of the hospitals in the Shire). She told me that the management consultants were 'locked away with the SHA, without adequate buy in'.

Slide number 157 illustrates the way analysis is confined to the objectives of efficiency and service effectiveness. The slide presents the ideal number of departments in the region for each specialty. It gives two numbers, the ideal number 'economically' (E) and 'clinically' (C). The latter is derived from the recommendations of Royal Colleges on the size of catchment population for each specialty. So, for example, the recommended number of departments for Obsterics, in both cases is '6'. Slide 158 then goes on to show that the regional centralisation of services would produce cost saving of £300m.
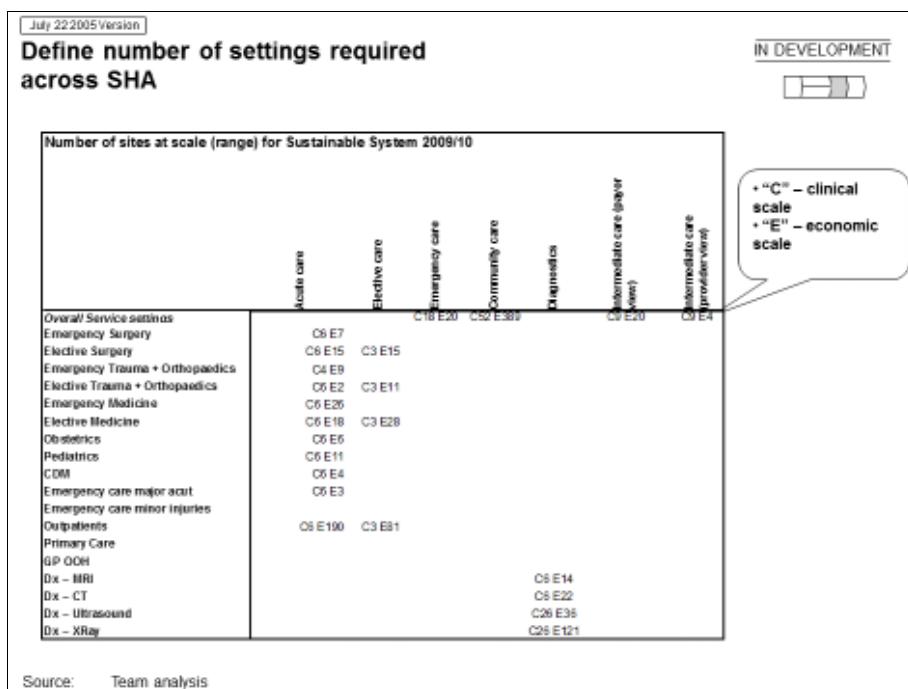
What is notable about the analysis provided by the management consultants is the way hospital services are abstracted from their social and cultural context. In slide 178 the boundaries of organisations have, literally, been redrawn. These flow charts might be seen as an inscription practice that transforms social reality, making it amenable to action (Miller and Rose 1992). The simplification involved in this process removes hospital services from their organizational and ideational settings.

Figure 2. Management consultancy analysis for the Strategic Health Authority.

Slide 1.

Slide 157

Slide 158

Slide 178

The financial audit had projected a deficit for the Shire of £119M. A subsequent analysis undertaken by the PCT had concluded that closing one of the hospitals in the county would deliver the required savings (PCT internal document, August 2006). The following is taken from the PCT analysis:

> A £69m deficit is projected for Shire acutes in 2008/09 if no reconfiguration takes place. An East Shire closure has the least impact, reducing the deficit to £34m. Closing Forest Hospital results in a deficit of £26m. Closing Judford releases £0-7m surplus (depending on level of activity retained at Smithton) and closing Shire General creates £1-9m surplus…

The PCT analysis gave the preferred option as 'major site closure' stating that 'the rationale for change needs to be based on financial necessity, not clinical quality/service improvement.' At this point in time the plans to close a hospital in the Shire were leaked to the local press. This resulted in organised protests from patient and community groups. One of my first interviews was with a manager from the PCT. During this interview, which was conducted in the Spring of 2007, she explained that the plan was no longer to close one of the hospitals but to replace three District General Hospitals (Forest Hospital, Shire General and Warton) with two 'hot' sites (with major A&E departments) and one 'cold site' (with an urgent care centre).

On the other side of the Shire, Wildbridge and Smithton, an acute provider comprising two hospitals on different sites, had been attempting to rationalise the services provided across the two sites for nearly a decade, since the Trust was created from a merger of two NHS trusts in the 1990s. In an interview with the Director of Strategy she recounted that many of the problems faced by the Trust stemmed from this merger. In her view there was no immediate reason why the two hospitals should have merged, except that merger was the 'fashion' and Wildbridge and Smithton didn't seem to have anyone else to merge with. Whilst Wildbridge is located in the Shire, Smithton hospital is in a neighbouring locality and the two hospitals serve very different populations. Wildbridge is located in a rural and affluent area while Smithton serves a largely deprived population on the edge of a metropolitan conurbation. The director of Strategy said the merger had been 'an unhappy marriage' from the start.

Plans for acute services at Wildbridge and Smithton had changed many times over the intervening years. At one point there had been a proposal, led by the commissioner of the neighbouring locality, to replace the existing configuration of hospitals in the area with a very large, newly-built critical care hospital (a 'super hospital') which would be supported by several smaller hospitals. After a long period in development and consultation these plans were abandoned following an independent review that concluded that the proposal was unaffordable and no longer consistent with national policy (Programme review final report, February 2007). When I started fieldwork the Trust's plans were to close the maternity unit in Wildbridge hospital as part of what was described on its web site as 'an internal safety and sustainability review'.

The sense that plans to change hospital services were constantly changing, is given in the following excerpt from an interview with the medical director from Warton and Judford. This interview was undertaken in 2008, after I had been in the field for about 18 months:

> when I think back to 1997 when I started, we'd been going through some major potential change, merger with Judford, reorganisation with Judford twice, *Fit for the Future* that didn't happen, merger with Shire General just briefly thought about, merger with Forest – there's something going on, something really big almost all the time, I mean, I'm sure that's obvious to you but it didn't really dawn on me until I sort of clocked up how many major things we'd approached but didn't all come to fruition –

Sometimes plans had appeared to shift in line with shifts in national policy, as when the plans for a 'super hospital' were abandoned following a change in national policy. In the following quote a manager from the Strategic Health Authority is expressing his expectation that local plans for hospital services will national policy:

> Ara Darzi did a London review, he's now being asked to do a National review and Stage One of that has already been reported – it's on the Department website if you haven't already got it. Stage two will be coming out next Spring, it won't be in the detail that he did the London review, but the expectation is that all other parts of the country will need to ensure their own service reviews and reconfigurations are consistent with the principles coming out of Ara Darzi's review.

The following excerpt is taken from an interview undertaken in October 2007. At this point in time the commissioner's plans had shifted from closing an A&E department to centralising a range of other hospital specialties. When asked, the interviewee responds that one factor was the desire on the part of the commissioner to avoid a confrontation with the public:

Me- and do you have a sense of how it happened and there was a time in fact that we were already doing field work that there was all this issue around A&E closure –

- yes –

- and then we have understood that's not an issue any more. Do you have a sense of how that evolved and why it evolved in this- in this direction, why it seemed to be a big thing and suddenly it was not anymore?

I think it's change of emphasis from the new PCT is probably the simple answer, you know, I think they, as a new PCT decided 'this isn't the direction we want to go' you know, 'we don't want a big bust-up over- with the public over trying to shut A&Es so they changed the focus of the Fit for the Future work to be commissioning intentions and improving quality of services and they shied away from that really. (Manager, Forest)

In some interview accounts organisations were depicted as seeking to avoid public consultation. The following excerpt is from an interview undertaken in December 2008. The commissioner's plans had again shifted and were, at this point in time, for a merger between Forest Hospital and Warton and Judford. Note how the interviewee is suggesting that the task of avoiding public consultation is accomplished through 'language play' (Degeling 1996):

there's a really slightly cynical reason for that which is any significant service change has to be publicly consulted upon, it's massively unpopular with the public particularly when it's all about closing A&E departments …what you do is you say 'We perhaps ought to have one Trust for the West of the Shire but let's be really clear that it's not about re-aligning services because if it was about re-aligning services of course, that would have to go to public consultation so we're not saying that' (CEO, Warton and Judford)

The local political contest over hospital closures

On my first day in the field it was immediately apparent that the plans to close hospitals or hospital departments were facing community resistance. At the entrance of Shire General Hospital, for example, hung a large banner which read 'Save our Shire General'. The 'Save the Shire Campaign' involved local politicians from all parties, the local newspaper, local charities, hospital staff and members of the public. A national leader of a political party also lent public support to the campaign. The campaign had arranged a petition against the closure of the hospital and organised a number of public meetings and rallies. Like the campaign against closing the hospital at Kidderminster described by Oborn (2008), it had used creative forms of rhetoric, such as a candle-lit vigil at Westminster.

Plans for hospitals in the Shire were contested not just by public and community groups but also by local hospitals. In my first interview, with the Director of Human Resources and Organisational Development from one of the acute trusts, she told me that Trusts felt 'under threat' by *Fit for the future*. She said that the concern was that if they set up a joint service they may lose income. She attributed this fear to the current payment system ('payment by results' - an activity based payment system for providers) that produced an incentive for Trusts to maximise income.

In the following quote the medical director of Forest hospital is making reference to Foundation Trusts which at this time were paid according to the activity they were able to attract:

> The problem is that if you are a Trust you do not want to give up anything, if you are a Foundation Trust or a potential Foundation Trust, then you start fighting turf warfare.

In contrast to the analysis provided by the firm of management consultants, which assumed that the component services of a health system could be moved around to produce the ideal configuration, the excerpt below illustrates how in reality hospital services are embedded in social relationships. Moving services is not simply a technical exercise but a process that provokes high emotions and sours relationships:

Unpleasant, it was a difficult process, people saw their hospitals and their departments being threatened and therefore got very heated and aggressive in their defence of those departments and 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 Judford as opposed to- some might say the more logical thing is for us to join with Shire General first and then go East towards Judford, is that the relationships between us and Shire General have been soured by, I think, by the whole process, so it wasn't a particularly constructive or useful thing to go through. (Hospital consultant, Forest)

Organisations were often referred to as 'fighting' over which hospital should provide the service and manoeuvring to defend their interests. In the quote below a manager from one of the hospitals is describing how they sought to exploit the fact that they also received patients from a neighbouring locality. Not the use of terms such as 'angle' and 'play into' which are suggestive of strategic behaviour and political manoeuvring:

When this reorganisation thing was first mooted, there was a potential idea that one A&E might close for example and so at that time we spoke to [commissioner of neighbouring locality] and said, 'do you want our A&E to close?' – 'well no' you know, because most patients we treat are actually [neighbouring locality] patients and so we did have that extra angle to be able to then play into the Shire thing and say 'well [neighbouring locality] want us to stay open so ..'(Manager, Forest)

It was suggested that Forest hospital, as a first wave foundation trust (and the only foundation trust in the Shire at this time) would be exempt from the planning process. This was said to be because the government wanted its then new policy of creating foundation trusts to appear successful. As the one of local MPs opined 'The government won't let Forest go'. (Field notes July 2008)

The quote below illustrates that while the national policy documents presented a picture of local clinicians from different organisations producing a rational, 'clinical' model for services, the reality of local planning for hospital services is a more political process of 'horse trading' between mutually dependent organisations.

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I know urologists and everybody in urology wants to deliver the same sort of care to the patients so having joint pathways, joint on-call rotas and stuff like that, that all makes sense, it only doesn't make sense when you go to the level above that and then you start challenging bricks and mortar saying 'well why should I move this patient to that hospital so they get the income from it?' so 'well we think it's the right thing to do because that patient's getting better- better care there' – 'OK that's fine but we'll go bankrupt so what's that hospital going to give me back?' and you just- you just get nowhere; that's when it breaks down, it's not the doctor to doctor relationship, it's above that. (Medical manager, Forest)

In the above excerpt the interviewee is suggesting that resistance is not from front-line clinicians, but is 'above' that, from the organisation. Other interviews with clinicians suggested that some clinicians were supportive of some form of change in certain specialties (the most frequent examples given during interviews were stroke services, vascular surgery and cardiology). However this was not a consistent finding across all the organisations in the Shire.

Proposals to change accident and emergency and obstetrics were the most highly contested. Closing an A&E department was widely seen as threatening the viability of the entire hospital because of interspecialty linkages. Indeed plans to close an A&E department were interpreted by other actors as an attempt on the part of the commissioner to close a hospital:

'Fit for the Future' is the thing that probably keeps most people awake at night, because if you take away someone's A&E you take away everything- it's the beginning of the end at the hospital and everybody realises that and knows that. As an example ….at Roehampton- used to be a hospital there that lost its A&E and really and truly it doesn't exist anymore. That was always the plan, you could see, but you know, anybody who says 'oh it's alright, we'll just make it an urgent care centre, blah, blah, blah' everybody just doesn't believe that for one moment. (Manager, Shire General)

The above quote also illustrates the way that the plans provoked anxiety and suspicion among members of staff. Plans to close an A&E department, in particular, were viewed as having an 'ulterior motive' of closing or significantly downgrading a hospital. The rationale for change presented in national policy documents was one of 'clinical necessity'. Fieldwork suggested

that what might be considered beneficial from a 'clinical' perspective could be defined in different ways. For example, a policy of centralisation reduces the total number of departments in a region which could mean that some high performing departments close (Harrison 2012). For local clinicians this 'didn't make sense', as one consultant observed during an interview:

> We had our A&E under major threat and I suppose it is still under threat although I think it has receded somewhat because actually our A&E is one of the best-performing in the country – it always makes people wonder quite why it's our A&E under threat.

Nonetheless, doctors at times indicated a willingness to collaborate with doctors from other organisations to provide a service. Rather than all the hospitals providing the same service, the doctors would work together to provide the medical staff for a single service for the locality, as a manager from the PCT explains:

> you contribute your clinicians to the rota so each hospital doesn't have to build-in the overheads to do a whole service themselves, that makes absolute sense if you need 12 cardiologists to run a rota and you've got 4 Trusts with 3 each or 3 with 4 each, then for them to agree that they work together for Shire patients and set-up something in the Shire is very much more sensible and it helps with that repatriation bit which helps their sustainability going forward, everyone wins.

As the above quote suggests, this type of collaborative working between trusts was seen as a way of making the best use of the scarce resource of medical staff. It also meant that patients in the Shire could receive treatment in the Shire rather than going to London (in management terms the patients are 'repatriated' from London). This type of change was at times supported by clinicians, although in contrast to the rational process of design depicted in national policy documents, and in the analysis provided by the management consultants to the Strategic Health Authority, in practice how these plans were negotiated was a political process characterised by conflict and shaped by existing relationships between individuals and organisations. As one respondent noted 'it's not always about best practice- sometimes it's just about power'.

we have been reviewed by an external body and the external body has said that the Shire General is the place where you should centralised small volume big cancer work in one centre and we've been identified as that centre but Forest are fighting it even though our outcomes are better than theirs. It'll come eventually but they're just- it's their consultant that doesn't want to come over here and operate – he would come over here and operate – we wouldn't take it from him, but he doesn't want to come over here so it's a personality issue actually rather than a strategy one I think. (Manager, Shire General)

The reluctance of clinicians to move was also referred to by the Director of Strategy at Wildbridge and Smithton. As described above, the two hospitals serve very different population, Smithton serves a very deprived population while Wildbridge was located in a more affluent area and, unlike the consultants at Smithton, the consultants at Wildbridge also had private practice. According to the Director of Strategy 'over their dead bodies are they going to move'.

In another interview account change was said to have been stymied by the refusal of a single consultant to change the way he worked. The interview was with a colleague of the consultant in question, also a hospital consultant, who attributed this to the fact that change could be threatening to individuals:

I suppose if you put yourself in their shoes, they think 'well I'm doing a good job, I don't like any suggestion that what I'm doing is not the best medicine' because we're all very proud, you know, and they don't like to think that actually it could be done better…

According to my informant, in the end the consultant in question retired which enabled the proposed changes to be introduced:

Some people can be very powerful if they, you know, stamp their feet hard enough and can make life very difficult for people and that particular individual retired which effectively paved the way for somewhat easier progress and I think, you know, now we don't have that problem on the clinicians' side now. In fact we all work together very well. (Hospital consultant, Shire General)

The following quote illustrates that even where clinicians may be supportive of the principle of change, and willing to work with clinicians from another organisation, they may disagree about how a service should be provided:

> the big things that might have been achievable were still really stuck on different personalities. So, I'm a neonatal paediatrician clinically, and we could have created quite a good children's service across both sites but I had a model and they had a model and the two weren't compatible and they had some practices, clinical practices that I couldn't countenance as being acceptable in 2008, and they weren't really ready to move away from them, just in terms of organisations of rotas and stuff like that, so nothing hands-on dangerous, so I'm not sure how we're ever going to get over that –(Medical Director, Smithton and Wildbridge)

What is notable about this quote is the suggestion that staffing rotas, which are presented in national policy documents as fixed, and one of the reasons why change is presented as a 'clinical necessity', are in fact flexible and that a range of possibilities might exist. One respondent suggested, joking, that clinicians were influenced by the implications a change had for their private practice. More often references were made to 'personalities'. It seems that clinicians, like other workers (such as academics) want to work with people they know and like. It was also suggested that long-standing relationships between clinicians in the Shire were an important albeit informal source of information on the calibre of medical staff. This is related in the following conversation with a manager from Shire General:

> Manager: …there's lots of personalities involved as well, like the orthopods here don't really get on with the orthopods at Wildbridge but get on very well with the orthopods at Forest –

> **Me: Any particular reason or is that just the way it-?**

> Manager: It's all to do with how good they think they are and how effective they are, their clinical quality and things….consultants by nature are very competitive people, that's why they've worked hard and get where they are, they're not- different groups of them are very collaborative and then other groups just want to work on their own so they're individuals

like the rest of us, they can't really be generalised but personalities definitely- they all know each other because they've all worked, you know, registrars and things together and so some of it's about who got on with whom.

In other instances local clinicians suggested during interviews that they did not support the commissioner's plans, nor did they, in contrast to the discourse of national policy documents, necessarily support the principle of centralising services. In the following quote a clinician is reacting to what he sees as the imposition of a universal model of care, regardless of local circumstances:

> if you look at London, there is more of an argument for centralising services because I think for example, St Heliers is virtually walking distance from St George's and actually there are advantages in centralising for a small number of patients …the disadvantage for the vast majority of patients coming into A&E is the journey time, so for the Shire taking A&E departments, yes you would gain a small amount by centralising, you'd lose a whole lot more because people would then spend 20 or 30 minutes longer on the road. London's a different story and already there's a degree of centralisation, you can have a heart attack in Bromley then drive past Bromley Hospital and go straight to St Thomas' for your primary angioplasty, so our take on 'Creating an NHS Fit for the Future' was actually the current service was doing a pretty good job. Now everyone keeps saying 'everybody's in agreement that we need to redesign the NHS'. I'm not sure that that's really true. By and large the current position, it's evolved fairly sensibly and you know, a district general hospital is a pretty good model for the vast majority of patients. (Hospital consultant, Shire General)

This quote illustrates that not only are alternative courses of action preferred by different individuals and groups, 'no change' might also be preferred. Thus the situation in the Shire was very different to the picture of consensus presented in national policy. While interviews revealed that some local clinicians supported some form of change in some service areas, there was considerable disagreement over who should provide what, where and how.

Getting beyond bricks and mortar

In the Shire the political struggle over the issue of closing hospitals reflected broader differences in social meaning attached to health services by different social groups. For local health service managers, hospitals were seen as barriers to the economic, efficient and effective delivery of health care. This was highlighted during interviews by the frequent references to the need 'to get beyond bricks and mortar' when planning the delivery of health care:

> ...it's very easy to revert to bricks and mortar and say, 'oh no it can't be at my hospital' so I think they are better than they were before the process, the minds are broader, but I think there is this big danger that you revert to 'it all must be at this site and not at this site' or whatever but I don't believe that's right for patients, I think what is right for patients will be playing to individuals' and departments' clinical strengths to deliver quality care rather than saying 'you must go to that set of bricks that's called itself something'. (Medical Director, Forest)

> I think by focussing on that clinical evidence, what we've seen has been the commissioning start to focus on services and how they meet those quality standards in a very different way and inevitably they have to think outside the traditional bricks and mortar into 'how can we provide better services in these specialty areas for the population?' (Chief Executive, PCT)

> The only way we can do this is by thinking about how we work collaboratively and all the stuff that's been knocking around for years about, you know, hospitals, this is about providing services, it's not about supporting bricks and mortar. (Manager, PCT)

My study did not capture the views of members of the public, although other actors often made reference to the attachment of the community to the local hospital and the sense of ownership the local community feels in regard to 'their' hospital. The following quote is from a hospital consultant speaking at an NHS trust Board meeting:

What patients want is a good service locally. They want to go to a local hospital that they want to support. They don't want to know about the one 10 miles down the road. (Field notes July 2008)

The anthropological and cultural geography literature suggests the nature of the attachment of a local community to a hospital extends beyond a simple notion of 'access' to services, it involves more complex emotional, social and symbolic attachments (Long et al 2008, Brown 2003, Kearns and Joseph 1997, Kearns 1998). This literature shows how certain buildings are imbued with such attachments and are important to people's 'sense of place' (Eyles 1985). As Brown describes it:

'Commonplace' elements within the built environment, such as hospitals and schools, are seen to hold important symbolic properties. Moreover the symbolic value attached to such buildings is seen to impact upon the sense of belonging and well-being that individuals feel. (Brown 2003, p496)

In an interview with one of the local MPs, she touched upon some of the more complex meanings health services had for a community:

People need access to emergency services close to where they live. People get reassurance from visiting an A&E department…Medicine is an art not a science. People want something rather complicated from A&E. People are happy to wait five or six hours, they understand people with more urgent conditions need to be seen. Patients want TLC. (Field notes July 2007)

The politics of hospital planning is often presented as a conflict between community groups with an interest in maintaining access to local services and planners and the medical profession concerned with improving outcomes of a service. While in one sense the MP is referring to the patient's interest in access to services, the reference to wanting 'something rather complicated from A&E' and to the 'reassurance' that A&E provides, suggests a deeper attachment than simply an interest in convenience.

The attachment of communities to local hospitals was sometimes acknowledged by local managers:

> People get very emotional about bricks and mortar and you know, 'that hospital down the road has saved my life, if it were to close you know, I'd be dead in similar circumstances' it all gets quite difficult. (CEO, Forest hospital)

> because 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. (Senior manager, Shire General)

In the above quote the hospital manager locates himself as part of the local community. In contrast, when I spoke to one of the local MPs, she suggested that local NHS managers were not always part of the community. Referring to the high turnover of NHS managers, and noting that the average length in post of CEOs was 2 years, she posed the rhetorical question 'how many will have to live with the decision?'.

The admonishment 'to get beyond bricks and mortar' constructs hospitals as material, but without meaning and value, 'spaces' rather than 'places'. In England the attachment to local hospitals has been an enduring feature of public consciousness. Haycock et al (1999) observed that at public meetings on hospital closures the public 'articulated a strong sense of symbolic importance of hospitals to a town and the more practical consideration that hospitals are large employers' (Haycock 1999, p1262). A hospital is culturally embedded in that it is more than just a physical structure, it is simultaneously a system of social organisation and a set of beliefs and ideas. However these other dimensions are excluded in the presentation of hospitals as just 'bricks and mortar'. The appeal to move beyond bricks and mortar seeks to replace this culturally embedded local hospital with the abstract schematisation of free floating health services, like that depicted in the flow charts of the slide packs produced by management consultants.

The mobilisation of the 'clinical case for change'

As public bodies an important part of the NHS organisations' processes of accountability are meetings held in public. Thus meetings are often occasions when policies are made known to the public. Observing meetings therefore offered an opportunity to see the way that decisions were publicised, justified and legitimated. Over the period of fieldwork in the Shire I observed a 'reframing' of the issue of hospital closure, consistent with the reframing that had occurred in national policy documents. The emergence of this framing, its features and impact will be illustrated with observations taken from a range of meetings that I attended during the course of fieldwork.

The Trust Board meeting

The following is an account of a Board meeting of Wildbridge and Smithton NHS Trust. It illustrates the mobilisation of the clinical framing to 'sell' plans to close the maternity unit at Wildbridge hospital to the public and resistance to that framing. The meeting was held in the Spring of 2007. The Trust had brought its plans to the Board in order to secure agreement from the Board prior to commencing public consultation. The meeting was held at Wildbridge hospital, in the Shire, where the maternity unit was to be closed. Unusually, for a Trust Board meeting, it was attended by what I estimated to be about 200 members of the public, many mothers with babies in pushchairs. The meeting was delayed as an adjoining wall was opened so as make more room by including the adjacent cafeteria. Even with the additional space the room was still filled to capacity and any additional arrivals were turned away. The members of the public who attended the meeting opposed the plans to close the maternity unit. There was a buzz of anticipation as we waited for the meeting to start.

Next to me sat a representative from a trade union who was clearly enjoying himself. He shifted excitedly in his seat, looked up expectant to the 'stage' to see if anything had started to happen and whispered to man sitting beside him. He introduced himself and asked me where I was from and I wrote down the name of his organisation. Immediately on being seated the Board was approached by a man who was disabled. The man argued that if the maternity ward was closed then more babies would be born like him. This was the only occasion when an emotional argument was used. The remainder of the meeting took the form of rational argument.

The local MP, a confident and charismatic man, spoke from the front of the room with a standing microphone. He contested the 'clinical case for change' put forward by the hospital. He argued that Wildbridge hospital met the Royal College clinical standards, it was Smithton hospital (where the maternity unit would be located) that failed to meet the standard, and even so, the standard only applied to high risk populations, while Wildbridge had a low risk population.

The plans for closing the maternity unit were set out in a meeting paper, again with the title 'The clinical case for change'. A verbal presentation was given by the clinical lead (a medical manager). Although she was speaking in her capacity as a manager, she began her presentation by listing her clinical credentials ('a consultant paediatrician, an elected member of the Royal College of Paediatrics'). Echoing the rhetoric of national policy documents, she began her presentation by stating that the plans were based on the 'recommendations of national medical experts'. The reason for closing the maternity ward she said was 'clinical viability'. This was based on Royal College standards for consultant staffing, as well as the European Working Time Directive (legislation that limits doctors' working hours).

During the meeting vocal opposition to the plans came from the local MP, medical staff, a trade union leader and members of the public. A hospital consultant also contested the Trusts' claims that the changes were necessary to improve safety. The consultant presented mortality statistics to show that the outcomes for Wildbridge hospital were better than for Smithton, and lower than the national average. Submissions from members of the public drew on personal experience and an assessment of local needs (such as no other hospital in reasonable distance and a growing population of families who will require maternity services) to argue that the plans reduced local access to services.

The Board then voted with the majority of the Board voting in favour (two non-executive directors voted against) so that the plans to close maternity services at the hospital were agreed. It was clear that the members of the public who attended the meeting were dissatisfied, especially with what they saw to be the weakness of the rationale and the fact that a decision had been made prior to public consultation. At this point the chair concluded this section of the meeting (seemingly unaware of the implications of his words) by saying 'it's a done deal'.

The next time I visited the hospital I was chatting informally with the Chair in the hall. I told him I had been at the meeting. He confided that he was taken aback by what had happened. He said he was used to working in the private sector where he was required only to give quarterly reports on profits. His admission reminded me of a comment Parker (2004) makes about managers who had been brought in to the NHS from the private sector and how these 'outsiders' were 'baffled by the political complexity of the NHS' and the requirement to simultaneously deal with the autonomy of consultants, the demands of trade unions whilst meeting the increasing welter of performance indicators from the centre (Parker 2004, p175). To Parker's list I could add the concerns of local residents and the intervention of the local MP.

Policy elites have argued that, among the public, there is a lack of understanding of the 'technical patient safety arguments' for closing hospitals (Farrington-Douglas and Brooks 2007). However it is apparent from this board meeting that it was not that the public did not *understand* the technical arguments, it was that they did not *accept* them. Similar findings have been reported elsewhere (Haycock et al, 1999). Stakeholders were confident in arguing against the plans, both 'on their own terms' with regard to the weakness of the evidence for improvements in safety, and in drawing attention to other considerations, such as access. They also mobilised alternative measures of 'safety'. In this case a particular and concrete understanding of safety was set against the universal and abstract.

The commissioner Board meeting

By the summer of 2007 I had detected a shift in the rationale for the commissioner's plans for the hospitals in the Shire, from a financial to a clinical rationale. The following is an account of a PCT Board meeting held in June 2007. It is described here because for me it was a key point in this shift. The meeting was held in local conference facilities. PCT Board meetings were held in public, although on this occasion there were only half a dozen people present. In addition to myself and the two other researchers from the primary study, there was a journalist from the local paper, a couple of members of the patient association and a couple of other people associated with the various agenda items. One of the agenda items was a presentation on 'Fit for the Future'. The presentation was to be a joint presentation by the Director of Public Health and the Director of Finance.

The title of the section to be presented by the Director of Public Health was *'The evidence-base supporting Fit for the Future'*. Again echoing the rhetoric of national policy documents, the Director of Public Health explained how the commissioner's plans for the hospitals in the Shire were based on 'national clinical evidence' and on 'expert opinion from medical royal colleges on the population base to support specific services'. The PCT was 'working closely with clinical colleagues and with the evidence base that they use'. So, for example, in relation to Maternity services she said that:

> Units delivering more than 4000 births per year should have 60 hours a week consultant presence by 2008. The reason for this is safety.

The Director of Public Health explained how the PCT would be applying a universal model to how services were provided. This was referred to as 'the hub and spoke model that is promulgated worldwide'.

The second part of the presentation was by the Director of Finance. The title of this section was 'The changing financial scene'. The Director of Finance explained that a series of incorrect assumptions meant that the commissioner no longer faced a projected deficit of £119M but a likely surplus of £20M. Thus while the original rationale for the plans to centralise services had dissipated, the programme was, nonetheless, to continue.

Thus what I saw in this presentation was the public decoupling of the commissioner's plans from financial pressures, and the recasting of the same plans as the desire to provide services that are based on the 'clinical evidence'. The new rationale for centralising services in the Shire mirrored that identified in the previous chapter from national policy documents. As in the national policy documents, the Director of Public Health makes appeals to 'the evidence' and to 'safety'. And again 'the evidence' are the standards published by the Royal Colleges for different services, which as noted in the previous chapter, are largely based on expert opinion on the size of catchment populations or staffing ratios.

Following the presentation, the Chair of the Board responded by adding that 'this is what the doctors have told us we have to do'. As a rhetorical device this statement by the Chair again

emphasises the 'clinical' and thus politically neutral nature of the plans. It also gives a sense of imperative and excludes the possibility of debate.

The internal hospital executive meeting

That the commissioner was using medical expertise strategically, to realise service change, is suggested by the 'back stage' talk of other policy actors. Whilst planning talk on the front stage can be expected to display deference to values such as rationality, objectivity, and public involvement, talk on the backstage gives more recognition to the political dimensions of planning (Degeling 1996). Examples of 'front stage talk' can be found in national policy documents, consultation documents and public presentations on the plans for hospital services. 'Back stage talk' can be found in informal conversations, some of the formal research interviews and internal planning meetings.

The presentation by the Director of Public Health on *Fit for the future* at the PCT Board meeting, described above, is an example of 'front stage talk'. In this presentation, which was given at a Board meeting held in public, the Director of Public Health presented a clinical rationale for the proposed changes to hospital services based on the need to meet Royal College Standards for staffing and catchment populations for services. An example of 'back stage' talk occurred at an internal meeting at one of the hospitals. At this time the commissioner's plans had once again shifted, now the plan was for two of the District General Hospitals in the locality to merge.

The meeting was an internal meeting of the hospital executive, held in one of the meeting rooms at the hospital. I attended the meeting with another researcher from the larger study. Although initially circumspect, the attendees soon seemed to forget out presence and to speak more frankly. The CEO of the hospital came across as confident and friendly and could be described as a 'straight talker'. He voiced an opinion at the meeting that the PCT was using the Royal College standards strategically, to force a merger between the two District General Hospitals as a precursor to closing one of them. Indeed mobilising the clinical standard for Accident and Emergency services, which set a required catchment population of 500,000, was seen as the only way this could be done.

> The PCT will want to hunker down behind college standards. That's the only lever. That's why the 500,000 was so important to Greg [PCT CEO]. (Field notes May 2008)

The strategic nature of the use of medical expertise is indicated by the reference to the Royal College standards as a 'lever' to effect change. More telling still is the military metaphor of 'hunkering down'. This not a plan that will be secured through reasoned discussion, or even negotiation, it is a battle to be won through force.

'Clinical leadership'

Echoing the enrolment of political elites in the formulation of national policy, the commissioner had contracted a firm of management consultants to run a two-day 'clinical workshop' with local doctors. That this workshop constituted the strategic use of medical expertise to secure legitimacy for the commissioner's plans again becomes apparent when 'front stage' talk is compared to 'back stage' talk. An example of 'front stage talk' can be found in the report that was published from the clinical workshop which described the process as follows:

> [The workshop] enabled clinical leaders from across the three Trusts and from primary care to come together and use their experience and judgement to help guide the future investment and disinvestment decisions being faced by [the Shire] health economy. The clinical leaders worked in three groups – one for each clinical area. They were asked to use their expert opinion and judgement to develop sustainable service models that showed the levels of care and appropriate settings for them. They then considered these clinical models and discussed them with regard to options for service reconfiguration.

In contrast, in an interview with a PCT manager she spoke about the value of the clinical workshop in terms of the importance of having all parties 'signed up' prior to public consultation: 'We can't have clinicians from the two trusts in the middle of this fighting it out in public.' (Field notes, April 2007). The manager described this as a long and difficult process due largely to the fact that the doctors involved found it difficult to get beyond institutional loyalties. Eventually, however, all three hospitals 'signed off' a proposal that had been drafted by the management consultants who had facilitated the workshop.

In subsequent interviews with a range of local actors, the purpose of the workshop was referred to in terms of 'presentation' and 'marketing' of the commissioner's plans. Local doctors who had

participated in the workshop expressed resentment at what they saw to be the superficial and strategic nature of their involvement:

it was led by [management consultants] and they tried to lead us down a particular discussion line which we successfully ignored the first day, but they then presented a set of conclusions the following day which were completely unrepresentative of what we'd talked about on the first day, I mean I commented I might as well not have been there and finally they produced some sort of last-minute data which we hadn't seen before the meeting and this sort of thing, it was all rather unpleasant and then we went away a bit disappointed in the process and we saw the sort of draft, sort of minutes if you like, of the meeting was a travesty, it bore no resemblance to the discussion we'd had and we were put under enormous amount of pressure as a Trust to just sign up and say 'yes that's what we discussed' and there were several consultants here who'd been involved, were very unhappy about that, we felt we'd been misquoted and we weren't happy with the draft but the pressure on us to sort of accept it was quite large. (Hospital consultant 1, Shire General)

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 first session was supposedly fairly broad discussion without any specifics and then the next was more 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 of things and almost none of it were 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 2, Shire General)

Closing a hospital in this kind of area is not going to be easy, that's why they tried to sort of shift it towards us clinicians having all these meetings, so we would show that we could do it without affecting clinical services so trying to make it look like the clinicians were suggesting it which was quite a crafty move and caused a lot of resentment among- 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, Forest)

The clinical workshop was one of a number of ways the commissioner had sought to involve doctors in the process of implementing the plans for hospital services. It had also enrolled doctors to defend the plans at public meetings which were held to present and explain the plans to the members of the local community. In an interview a PCT manager suggested that enrolling clinicians to defend the plans in this way supplied the plans with credibility, claiming that 'people want to hear from the clinicians' (Field notes April 2007). As she explained in a subsequent interview:

> I think in terms of the medical directors who are the key ones and especially (the medical director) at Forest who was very helpful and because he can stand up and – and that's what [the public] want – they don't want to hear people like me or even our Chief Executive, what they want to see is an actual consultant saying 'this only makes sense – why wouldn't we want to do it?' and so that's why it was always essential that we had their engagement …(Manager, PCT).

Here the manager is saying that the use of a doctor as the 'frontman' at public meetings was intentional. Her belief was that a doctor would have greater legitimacy with the public than would a manager and would be more likely to persuade the public of the need for change. This text also points to the effect of the framing of the issue as 'clinical' in terms of taking the issue beyond debate (this only makes sense – why wouldn't we want to do it?).

Thus, at the local level, it is evident from the back-stage talk of a range of actors that the primary value of 'medical expertise' in local planning was strategic – it was viewed as enabling the implementation of organisational change that would secure the managerial objective of greater system efficiency. That is not to say that the interests of the profession and of managers don't dovetail on the issue of hospital planning, but the interpretation offered here is of the co-optation of the medical profession to serve a managerial agenda of service rationalisation.

The following is a transcript of the opening sequence of a DVD explaining the plans for hospital services in the Shire. The DVD was part of the commissioner's 'public engagement' strategy. Other components of the strategy included a leaflet providing information on the plans that went out in newspapers as well as public meetings and 'co-design' events where members of the

public were invited to comment on the plans. The public engagement strategy also included a bus that travelled to different locations, such as shopping districts, with PCT staff who then sought to engage passers-by with information and discussion about the plans. According to a PCT manager the aim of the strategy was 'just to try and keep people informed of what was happening really'.

The intended audience of the DVD therefore are members of the public. As with public meetings, the commissioner's plans were presented by doctors:

GP (filmed in his consulting room): The world is changing rapidly and we need to change too if we are able to continue to offer patients best care.

Patient (filmed in a hospital waiting area): If I have an emergency I want to know that I am going to be taken to the best place straight away.

Hospital consultant (filmed in a hospitals wearing surgical 'scrubs'): Well these proposals will allow us to give better care to our patients more quickly and therefore enable better and more full recovery.

Narrator: Why do we need to change and will this really mean better health care?

GP: There are a couple of big changes happening at the moment. The first is that patients are having a far greater say in the running of the NHS and secondly clinicians, doctors, nurses, physiotherapists, all kinds of therapists, are now having an input at grass roots level.

For the remainder of the DVD doctors in the different specialties explain why services need to change. This section of the DVD is concluded by the GP:

GP: I think for me the excitement lies in the fact that for the first time ever we are looking at what has been clinically proven to be best for patients.

In the DVD a clinical rationale is coupled with a patient involvement narrative. So, for example, between the explanation for change given by the GP and the hospital consultant is a patient expressing their view of how they want services to be delivered. This coupling is seen again where the GP states that the two significant changes in the NHS are that patients are having 'a far greater say in the NHS' and that 'grass roots clinicians are having an input'. Thus national policy is represented as produced locally, by clinicians and patients.

The DVD is a way of communicating the commissioner's plans to the public but the status of the DVD is ambiguous. It is not clear where on the 'ladder of participation' (Arnstein 1969) it is located. It provides information on the plans (the lowest form of 'participation') but the voice over at the end suggests that it is more than this, perhaps constituting 'consultation':

Narrator: We are already putting some of these plans into practice but we really want to know what you think.

Contact details for the PCT are provided. The public are invited to tell the commissioner 'what they think' but there is no further indication of what will be done with these views. Indeed the statement that 'we are already putting some of these plans into practice' suggests that the views of the public will not affect the plans in any way. There were other instances where the national policy objective of 'involving' the public in decision making was interpreted by actors as 'informing' the public about decisions that had already been taken. For example, in presenting the plans to the Overview and Scrutiny committee, a doctor who was speaking on behalf of the PCT said 'I suppose this is about educating people' (Fieldnotes October 2008). One interpretation is that the appeals to public involvement are primarily rhetorical, designed to establish legitimacy, rather than a genuine attempt to involve the public in planning service delivery.

The use of the clinicians in the DVD was strategic, as indicated by the PCT CEO in the following excerpt from an interview:

And if you haven't seen the DVD it's the clinicians saying 'this is the right thing to do' so I don't appear on it! Which is a very powerful message for people and certainly gives me a high degree of assurance that it's going to happen.

The intention is to present the plans as emanating from local clinical leaders. This strategy is illustrated in the following excerpt which is taken from a letter posted on the commissioner's website in September 2007. By this time the plans to close one of the accident and emergency departments in the Shire had been abandoned due to public opposition and the commissioner's plans had changed to a proposal to centralise services in other areas. The letter was authored by the PCT, although this is not immediately apparent as the author of the text is posing as a member of the public:

> So now that the perceived holy grail of A&E has been saved, it is going to be fascinating to see how much interest [the PCT] will receive for its proposed improvements in seven areas including stroke, cardiology, maternity and vascular services. All of which anyone of us, are so much more likely to ever call upon than A&E. It would be my strong recommendation that maybe just for this once, we should adhere to the old adage that maybe just maybe 'doctor knows best' and listen to [the PCT] as it tries to create a modern, first class health care service beyond the four walls of the A&E department.

What can be seen in this example is again an appeal to medical authority, similar to the statement by the Chair of the PCT Board that 'this is what the doctors have told us to do'. It couldn't be any clearer that when it comes to planning health services 'doctor knows best'. There is a suggestion of exasperation with the irrational attachment of community groups to A&E, which they may never use. This rational view of services in terms of their utility contrasts with the suggestion from the MP that A&E might offer a community something more. Not a service but a relationship, what Mol (2006) refers to as 'caregiving' (Tender Loving Care, as the MP refered to it), and a sense of 'reassurance' that is valued regardless of an individual's own use of the service.

What is also interesting about this example is that while drawing on the authority of the medical profession, it simultaneously seeks legitimacy by drawing on a public involvement discourse. It does this by assuming the subject position of a member of the public. Whoever wrote this text is pretending to be a member of the public expressing their opinion on how services should be provided. This coupling of the clinical framing with a framing of public involvement was also identified at the national level, for example, in the Darzi report which depicted national policy as produced by both local clinicians and members of the public. Indeed by referring to the

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commissioner's efforts to 'create a modern, first class health care service' this text melds professional, managerial and public discourses.

In the examples given above, the commissioner can be seen to be following the guidance issued by the Department of Health on how local plans for centralising hospital services should be implemented. Thus local managers were not just implementing national policy on how hospital services should be provided but adopting the recommended strategy to 'sell' the plans to the public. Local doctors enrolled to 'sell' the plans to the public were without exception doctors working in management roles (so called 'medical managers' as opposed to clinicians). This distinction was referred to during an interview with a local MP. She said of the Director of Public Health: 'She's PCT, she's not a clinician. She's not working in a hospital seeing patients'. The findings of my study accord with similar studies that have interpreted these practices as the co-optation of local managerial elites to effect service change in 'hard to reach' areas (Waring 2014, Martin and Learmonth 2012, Coburn et al 1997).

'Co-design'

Another component of the commissioner's patient engagement strategy were 'co-design' events. These were a public version of the co-design workshops held with local clinicians. These were described by one PCT staff member as follows:

> events which have actually put all of the options on the table to the public and have asked for their views, is this the right direction to travel? Do you understand why we might be doing this or do we tweak that?

A limitation of my fieldwork was that I did not attend one of these events although I was provided with the slide pack that was used. These are reproduced in Appendix 3. They are unedited except to remove the branding of the commissioner so as to preserve anonymity. The presentation is the same as that given by the Director of Public Health at the PCT Board meeting described above. The rationale for the plans for hospital services again mirrors that contained within national policy documents at this time. Like the framing present in national policy documents, the decision to centralise hospital services is presented as 'based on the

clinical evidence'. In slide 6 the evidence for the commissioner's proposals is said to be contained within the 'clinical case for change' written by the national clinical 'Tsars', although, as noted earlier, these documents do not contain any empirical research. On some slides the bibliographic details of academic papers are listed, for example, on slide 17 where there a reference to McDonnel et al, however, in most cases the citations that are provided are the standards published by the Royal Colleges, which propose minimum volumes of throughput or catchment populations derived from committee consensus.

As with national policy documents, the presentation does not give an indication that the methods or interpretation of the findings might be contested, that there might be alternative policy responses, or that clinical outcomes may be only one consideration in planning hospital services. And as has been found in other studies of the use of information in decision making in organisations (Kitchener 2002), the analysis omits discussion of the relative merits of alternatives, of costs, or potential barriers to implementation.

On slide 26 the public are invited to present their views (this slide is reproduced below). After inviting participants to ask questions for clarity, the question that is posed is 'the evidence – have we got it right?'. The way that the public are invited to participate in the process of decision making assumes that they have the resources, including knowledge, skills and confidence to evaluate the single table that is provided, or sufficient familiarity with the content of the academic papers that are cited, to judge their quality and relevance. Attendees might have taken the opportunity to bring to the commissioner's attention other considerations, such as patient experience, access, or implications for the local economy, but the question does not invite them to do this. The question, 'have we got the evidence right?', posed to members of the local community, is also likely to be somewhat confusing. It upsets the 'logic of appropriateness' of this situation (March and Olsen 1989). In this presentation the medical profession are constructed as the experts. Slide 16, for example, refers to 'Expert opinion from medical Royal Colleges on population base to support specific services'. This in turn leaves the role of non-experts to the public. Thus the question 'have we got the evidence right?' would seem to fall within the jurisdiction of the former, rather than the latter. The logic of appropriateness of the institutional context would suggest that the non-expert must answer in the affirmative.

There is also something jarring about the final question: 'What next steps would you like us to take?'. The title of the presentation, 'co-design' sets up an expectation that the public will be involved in creating or producing the plans. However the language of 'next steps' is the language of implementation of a decision already taken, suggesting both a fait accompli and again, discordance with the institutional roles of participants. Implementation is the responsibility of an operational manager, an impression reinforced by the industry jargon of 'next steps'. The public is likely to be taken aback and left wondering 'why are you asking me?'. Asking, 'have we got the evidence right?' followed by 'what next steps would you like us to take?' sidesteps the intermediate question of 'what should we do?' Taken together, the use of particular questions that are at the same time confusing has the effect of both directing and stifling public participation in decision making.

Figure 3. Slide 26 from the Co-design event 'slide pack'.

Slide 26

Commissioning intentions – over to you

- The evidence: questions for clarity?
- The evidence: have we got it right?
- What next steps would you like us to take?

Thus although this is ostensibly a deliberative forum with the stated intention of involving the public in decision making, the exercise of power can be seen to invade in a number of ways. In the process of providing 'technical information' to participants the commissioners are able to 'frame' the debate, constructing and defining the problem in a particular way and channelling thinking in a particular direction. The use of particular questions controls the way the public are able to contribute. The presentation gives the impression of inclusion whilst simultaneously excluding the public from decision making. The name of these events, 'co-design' suggests that members of the public would be involved in in some way in decision making. However, the decision had been made ahead of time, by local managers on advice from private sector management consultants. This suggests that deliberative events such as this one were used as a

'gloss' or 'façade' of legitimacy for a decision that had already been taken and as a means of co-opting members of the public who might otherwise oppose the decision.

The effects of the 'clinical case for change'

As a rhetorical strategy, the clinical rationale was not successful in that other stakeholders were unconvinced of the need for change. Public opposition to the plans to close the maternity unit at Wildbridge hospital, including organised rallies and demonstrations, continued throughout the summer of 2008. Toward the end of fieldwork, in September 2008, the commissioner decided to continue to commission maternity services from Wildbridge hospital. Beyond the Shire there were a number of other high profile cases of plans to close services being abandoned in response to public opposition or rejected by the Independent Reconfiguration Panel (Torjesen, 2008; Moore, 2008). For example, in rejecting the plans of one NHS trust to close a maternity department, the panel questioned the safety of long transfer times, emphasised the importance of accessibility and choice and said that alternative models of staffing could provide better consultant cover (Moore, 2008). As one national policy maker said during an informal conversation, 'the public aren't buying it' (Fieldnotes, March 2008).

The discursive power of policy, however, goes beyond rhetorical force. It takes the form of the power to define the nature of a problem and the solution. The clinical discourse defines the nature of the problem as 'clinical' and thus the proper business of the medical profession. One of the more tangible consequences of this framing in the Shire was that it enabled NHS organisations to avoid public consultation. In the following excerpt I am talking to a PCT manager. It is December 2007, I am in her office and she is updating me on *Fit for the Future:*

> So we went through a whole load of loops really, to get to where we are which is basically that there are that there are a number of Royal College clinical best practice requirements have gone out as commissioning intentions to the providers and they've come back with proposals, some of which are about greater networking, or indeed moving services to one hospital site, rather than having them spread across all three and it was agreed by the [health overview and scrutiny committee] that we could effectively go out...through engagement rather than formal consultation. So we were all set to do formal consultation

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and then at the end it looked like we could say effectively well this is just about good

practice and why would anyone disagree with us following Royal College guidance?

In this excerpt the assumption is that planning health services is a technical exercise, a rational process of applying scientific evidence. However, as Lasswell (1936) observed, questions of who gets what, where and how are political. In Foucauldian terms, what I have shown in this chapter is the way that policy works as a political technology, taking what is essentially a political problem and recasting it in the neutral language of science (Dreyfus and Rabinow, 1982, p.196).

The recasting of political decisions as clinical decisions has significant implications for the national policy objective of involving the public in decisions about health care delivery. The government had introduced a number of mechanisms aimed at strengthening public and patient participation in decisions about how health services are provided. The power of the clinical discourse is that it does not matter how effective the democratic mechanisms are if the definition of hospital planning a clinical decision means that it is kept off the agenda.

This chapter described the emergence of a clinical framing of a policy issue. This framing presented decisions as based on the evidence and necessary to ensure safety. I have interpreted this framing as a rhetorical strategy employed to effect change in the face of community opposition to the service closure and a concurrent emphasis in health care policy on public and patient involvement in the planning of health services. I have also described how other stakeholders were unconvinced by the clinical arguments for change. The framing nonetheless produced material effects through the way it defined the issue as clinical, rather than political. In the locality this meant that plans to change how services were provided were kept off the agenda for public deliberation. At the national level it also enabled the incoming coalition government to promise to end hospital closures while simultaneously continuing with the policy. In May 2010 the newly elected government announced an end to 'top-down forced closures' except where there was 'clear clinical evidence to justify the change' (Cabinet Office 2010).

Summary

This chapter presented the findings from my study. Using ethnographic data I argue that over the course of the study (2007-2009) there was a shift in the framing of the issue of hospital planning, from a policy argument that presented changes to hospital services as a means of making services more responsive to patients, by moving them out of hospitals so that they are closer to where patients live, to one emphasising the clinical necessity of centralising acute care. In the new framing plans to close services were presented as a 'clinical' decision, based on the evidence and necessary to ensure safety. I interpreted this framing as a rhetorical strategy, deployed at both national and local levels, with the aim of realising change in the face of community resistance to closing local hospitals and hospital departments and a concomitant policy rhetoric emphasising the need to involve the public in decisions about how services are provided.

Other stakeholders, such as hospital staff and community groups, were unconvinced by the new framing. However, a more insidious operation of power was identified in the way that the framing defined the issue as 'clinical' and therefore not subject to public deliberation. In the next chapter I discuss further the operation of power in policy texts and the implications for undertaking health services research.

6. DISCUSSION

In this study I have explored how a policy to centralise hospital services was presented in national policy documents and implemented in one locality in England. In both national and local domains I found a shift in the framing of the policy, from one that presented the policy as a means of improving access and making services more responsive to patients, to one of clinical necessity. In the new framing plans to close hospital departments, or entire hospitals, were presented as clinical decisions that were based on the evidence and necessary to ensure safety. I have interpreted this framing as a rhetorical strategy, deployed at both national and local levels, with the aim of realising change in the face of community resistance to closing local hospital services, and a concomitant policy rhetoric emphasising the need to involve the public in decisions about how services are provided.

At the time this study was undertaken responsibility for planning hospital services resided with local commissioners and providers, although there was an expectation that these organisations would incorporate national policy into plans, a situation that reflects a long-standing tension between national direction and local discretion in the NHS. This study found that local plans were aligned with national policy, but more than that, local planning documents, speeches, pamphlets and other materials intended to convince staff and the public of the need for change, adopted the same framing as that found in the national policy documents. Thus localities were not just ensuring that their plans incorporated national policy but were following guidance issued from the centre on how changes should be 'sold' to the public.

Health care politics as conflicts in frameworks of meaning

In the Shire, organisations' plans for hospital services had a long and complicated history. The details of the plans, the constituent organisations, and the rationale for change had all shifted over time, and continued to change while I was in the field. For example, the local commissioners' plans had at different times involved closing a hospital; closing an A&E department; the regional centralisation of a range of acute services; and a merger of two or more NHS trusts. This conforms to Fulop et al's description of reconfiguration as 'an evolutionary process with ambiguous boundaries' (Fulop et al 2005, p129) and to March and Olsen's wider

observation that 'it is difficult to describe a decision, problem solution or innovation with precision, to say when it was adopted and to treat the process as having an ending' (March and Olsen 1989, p63).

What remained constant was a policy of centralisation, although the preferred model, and the rationales for change, shifted over time. For example, the initial rationale for change, given by the commissioner, was to address a financial deficit. When this deficit ceased to exist the plans to centralise services continued but with a new rationale of providing services that were based on 'clinical evidence'. In this way the plans seemed to take on 'a life of their own'. Harrison and Ahmad describe centralisation as 'orthodoxy' in the NHS, despite being 'based on challengeable assumptions about both economies of scale and outcome improvements resulting from concentrating of particular kinds of clinical case' (Harrison and Ahmad 2000, p134). Fulop et al (2005) also observe a preference for centralisation, despite this being only one strategy available to decision makers. The reliance on centralisation as a solution, in preference to alternatives, suggests that it is considered an ideal state of affairs, or as Cohen et al (1972) put it, 'a solution looking for a problem'. The policy to centralise hospital services can therefore be understood not just as a statement of intent but as a reinforcement of ideology (Edelman 1971). It is ideological in the sense that it is a product of deeply held beliefs about the way the world is and the way the world should be. In this case it is a reinforcement of a managerialist ideology that holds that health services should be organised so as to be standardised, uniform and efficient.

Key features of this ideology, as manifested in health care policy, are an overriding concern for efficiency, economy and operational effectiveness. This is illustrated in the following excerpt from a health policy text book published by the Kings Fund, an influential UK health policy think tank:

> The key requirement of a health care delivery system is that services are delivered efficiently and effectively and that the total cost of doing so is kept under control. While easy access may be a goal for the individual, for the system as a whole control of access is necessary for cost containment. It follows that, though health care is or should be focused on the individual seeking care, the design of the service must be carried out with an eye to other considerations (Harrison 2001, p1).

In this excerpt the primacy of efficiency, effectiveness and cost control are explicit. The notion of health care delivery as a 'system' assumes that component elements can and should be modified to realise optimal functioning. For example, the author of this text book suggests that 'existing elements are not necessarily the right ones' and asks 'If we were to design a care delivery system from scratch, how would we go about it?' (Harrison 2001, p1). This paradigm holds that key components of the system, in this case hospital services, can be reconfigured to realise improvements in effectiveness and efficiency. Parallels can be seen with the mode of analysis adopted by Alford's 'corporate rationalisers':

> Note the assumption that there is a 'best' solution, that an organizational solution is the appropriate one, and that the necessary 'elements' can be combined in some way. This is typical of a technocratic, administrative or bureaucratic mode of analysis. (Alford 1979, p205)

In my study this managerial ideology was evident in the analysis provided by the firm of management consultants where the ideal configuration of services was depicted in flow charts. These analyses abstract hospitals from their social settings. They assume that hospital planning is a technical exercise where health services have only an instrumental value and can be rearranged in an unproblematic way. Similar findings have been reported by Fraser et al (in prep) in their study of the London stroke service reconfiguration.

On the subject of hospital planning, managerial and professional interests dovetail as national professional bodies have also advocated a policy of hospital centralisation to facilitate training and staffing (although this policy of national professional associations is often contested by local clinicians). This alliance between the medical profession and managers on hospital planning reflects a deeper alignment in that, like management, medicine instantiates a narrow form of instrumental rationality. Good (1994), for example, shows how this is accomplished through the force of everyday practices, such as writing in charts, that constitute the objects of medicine. Instrumental rationality is also instantiated through the institutionalisation of norms governing what is talked about among doctors, for example, norms that limit speaking practices during ward rounds to issues of diagnosis and technical interventions, and through a clinical gaze that excludes many aspects of the lifeworld, such as the importance to patients of achieving a good death, from the domain of clinical practice (Good 1994, p180).

Proponents of centralisation on rational planning grounds often express frustration at what they see to be irrationalities, such as the persistence of local hospitals and the resistance of the public to hospital closure. For example, in one government policy document, the national clinical director for maternity services expresses frustration at the community protest over the closure of the maternity ward at Huddersfield Hospital. She quotes the clinical director of maternity services at the trust as saying:

> How do you convince people it is better to travel 20 minutes to a unit where you know a consultant will provide the best possible care if you need it, than to travel five minutes to a unit where the necessary expertise may not be immediately available? It is impossible if local people continue under the impression their local hospital is always the best option. (Schribman 2007a, p3).

Brown (2003) has argued that proponents of hospital closures on rational planning grounds 'neglect to locate the hospital, and in particular the district general hospital, within its broader context'. He draws on the work of Kearns who has shown how health services are important to people's ideas about local identity and 'sense of place'. Here 'sense of place' refers to the consciousness of a locality from the 'insider perspective' (Kearns and Joseph, 1993). It is based on the understanding that a place is more than the sum of its material characteristics; it is the centre of meanings, values, significance and emotional attachment (Pred 1983).

In the UK, hospitals also play an important symbolic role. As Glasby et al (2006) observe 'hospitals are much more than just buildings where health care is delivered, but the physical incarnation of the NHS and its values within a particular locality'. The NHS was founded as part of the post -war welfare state and is symbolic of the associated values of fairness and communality. Indeed, the original rationale for the introduction of the District General Hospital was political, reflecting an ideological commitment to the provision of a comprehensive national health service (Mohan 2002). Hospitals are also a focus of local philanthropy. In the ten years between 1990 and 2000 Kidderminster received more than £2 million in charitable donations which were used to purchase medical equipment, including a C.T. scanner and a cancer resource centre (Brown, 2003). Such philanthropy creates a sense of shared ownership and the hospital assumes symbolic importance as an expression of shared values. Hospitals are also a significant source of local employment. In Kidderminster, for instance, the hospital was the major employer

in the area, employing approximately 1,600 people. Again this is not just of instrumental significance as place of work are important locations for socializing and identity construction (Hughes 1958).

Hospitals are the settings of significant rites of passage and of both physical and existential suffering. At the same time, for parents, carers, older people and those with disabilities and long term illness, hospitals can, for a time at least, be a part of everyday life, either for themselves or for friends and relatives. Health care has a value and meaning to people that is fundamentally different to other publicly provided services. It is relational and intimate and often accessed at times of fear and anxiety. And whether by individual experience, or collective imagination, hospitals exist at the juncture of life and death and are thus intricately bound up with our notions of 'ontological security'(Giddens 1991). This refers to the confidence that humans have in the continuity of their self-identity and the constancy of everyday life. Giddens argues that much human activity involves maintaining this sense of ontological security and keeping existential anxiety at bay. Existential anxiety stems, in part, from our realisation of finitude. Thus the presence of a local hospital, with its association with life-saving technology, may offer a community a deep sense of reassurance.

The politics of hospital planning can therefore be understood as involving a conflict between two different frameworks of meaning, one shared by policy-makers, managers, the medical profession, and health service researchers, who espouse a rational approach to the planning of health services, and one shared by community groups for whom health services are more than just health services but are replete with symbolic and emotional attachments. The controversy over hospital closures can also be seen through the lens of the concerns of Weber and Habermas with rationalisation, and with the colonisation of the life-world with system imperatives. Hospitals are places of life, death, suffering, salvation, hopes, fears, anxieties, emotions, relationships, roles, beliefs, values and so forth. The narrow instrumental rationality that underlies hospital policy can be seen as deeply irrational as it 'denies the basic humanity, the human reason, of the people who work within or are served by them.' (Ritzer 1993, p154).

This is not to say that change cannot or should not be sought. But reflecting on the multiple meanings of hospitals affords greater understanding of the difficulties managers face in convincing patients, staff and the local community of the need for change. Looking back at local

protests at the Hospital Plan, it is notable that the District General Hospital, now fiercely defended by community groups when earmarked for closure, was initially seen as remote and impersonal (Mohan 2002). What this suggests is that it is not the form that a hospital takes but the role it plays in the activity of our lives that is the source of meaning.

Nor is it to suggest that a concern with efficiency is somehow unimportant or morally suspect. The problem arises when this particular concern is assumed to be a general concern, and when it comes to dominate research agendas. What an understanding of the political nature of health care offers is insight into the wide range of issues faced by local health care managers. This complexity is not well served by abstract models of service 'reconfiguration' that decontextualise hospitals and in so doing render them meaningless. Plans for service change based on such 'thin simplifications' (Scott 1998) of complex social systems are likely to 'erupt into disaster or end in failure' (Dixon-Woods 2014). Stakeholder responses to change are not just driven by rational considerations and calculations of self-interest but also by meaning and emotion. An understanding of the different ways people perceive the issue of hospital can help to inspire a creative, and ultimately acceptable, response to local circumstances.

How does policy 'work' as an instrument of governance?

Having established that the politics of hospital planning can be understood as involving a conflict between social groups with different frameworks of meaning, the following section draws on the discourse theory set out in chapter 1 to consider how, in this context, policy 'works' as an instrument of governance. In doing this I explore the operation of discursive power through multiple practices across national and local domains. This is a complicated undertaking. For one, frames are both *held* and *mobilised*. This is illustrated by the example of a claim that a decision is 'evidence based'. You might make this claim because you value rational decision making, or because of its rhetorical force, or both. Regardless of the intentions of actors a framing 'works' the same way - through establishing legitimacy, channelling thinking in a particular direction, making a certain course of action appear inevitable whilst marginalising alternatives, and recasting a political issue as technical. Moreover attending to the mechanisms of discursive power says nothing about how actors respond to a framing, and what the effects are in the material world. Nonetheless the task I have set myself with my empirical case study was to

explore these different facets, and the relationships between them. As I said, it's complicated. With this in mind I begin this discussion by considering the framing of centralisation as a clinical necessity as a rhetorical strategy, and one that was reinforced by the co-optation of the medical profession. Having found that other stakeholders were unconvinced by this framing, I then consider the way the framing continued to work, in ways that were often difficult to see.

The use of framing

In policy texts the centralisation of hospital services is presented as the epitome of rational planning. As Fulop et al observe, even the name, 'reconfiguration', 'suggests a problem to be solved by calculations of optimal design' (2012, p129). This discursive representation of the policy carries its own rhetorical force. Such is the pervasiveness of instrumental rationality in society that is has become 'naturalised' as common sense, it has become 'incontestable, inviolable, beyond political debate' (Shore and Wright 1994, p24). The policy draws additional rhetorical force from the rationale of clinical imperative. This rationale draws on the cultural authority of the medical profession and its association with truth (Zola 1999). The clinical rationale also presents the plans as politically neutral and gives a sense of importance, urgency and necessity.

The strategic use of medical knowledge and expertise by managers as part of the micropolitics of local planning is nothing new. Milewa et al (1999), for example, describe how local managers 'invoked the mantra of clinical effectiveness' when introducing changes to services. In my study policy makers and managers made similar appeals to 'the clinical evidence', with the addition of the rhetorically more muscular appeal to 'safety' (who can argue against safety?). Nor was the framing of clinical necessity the only framing in play. The framing of clinical necessity was often coupled with a narrative of public involvement, producing a 'two-pronged' rhetorical strategy drawing on both medical knowledge and democratic engagement as sources of legitimacy.

Learmonth and Harding (2006) argue that claims by managers that their practice is evidence-based serves elite interests. However, they suggest that:

> Given the taken-for-grantedness of dominant beliefs about evidence in health services,
> most managers no doubt understand the incorporation of evidence into their practices as a

politically innocent way to deal with effectiveness problems. (Learmonth and Harding 2006, p. 254)

In contrast, I have interpreted the clinical framing of centralisation as a rhetorical strategy. In other words, I see it as the deliberate use of persuasive language to initiate and sustain change. At the national level this was apparent in the guidance that was sent to regional offices advising managers to enrol clinical staff to persuade other stakeholders of the need for change. At the local level managers indicated during interviews that their actions were strategic, oriented to the political as opposed to the instrumental dimension of their work. This was particularly the case in relation to the enrolment of local clinicians to 'sell' the plans to the public.

The findings from my ethnographic study are similar to those recently reported by Fraser et al (in prep) in their study of the London stroke service reconfiguration. They also interpret the use of an evidence based rhetoric by NHS managers as a rhetorical strategy for implementing service change. They conclude that the proposed model for stroke services, although heavily reliant on a rhetoric of clinical effectiveness for implementation, was based not on clinical outcomes but on a managerial concern with 'efficiency', 'standardisations', 'predictability' and 'control'.

In my study there was, however, never an admission that the framing was *only* rhetoric, although this would not be expected, even in 'backstage' accounts, since to do so would potentially pose a moral threat to their identity (although see Fraser et al where such admissions are evident in retrospective accounts of NHS managers and management consultants). The individual managers in my study may have accepted the professional narrative contained within national policy whilst at the same time recognising its strategic value, or may have seen it primarily as a convenient alignment with managerial prerogatives and have been largely unconcerned with its veracity, or, as Jones (1999) has suggested, there may even have been an element of self-deception. What was clear from the findings from my ethnographic fieldwork was that *other* stakeholders, such as local doctors and hospital managers, viewed the framing as primarily rhetorical, designed to convince other stakeholders of the need for change. More than this, the use of rhetoric was viewed by other actors as in some way deceptive or manipulative. The closure of A&E and maternity departments, in

particular, were seen as an attempt to close or substantially downgrade a hospital. In this case the rationale of 'clinical evidence' or 'safety' was seen to be a deliberate attempt to conceal an 'ulterior motive'. Local doctors also expressed resentment at the superficial and strategic way they had been enrolled in the process of implementing changes.

The co-optation of professional elites

I have interpreted this framing of hospital centralisation as a clinical necessity as a rhetorical strategy for implementing changes to services in the face of community resistance. A key dimension of this strategy was the co-optation of political and managerial elites from within the medical profession. At the national level this involved employing doctors as civil servants (and in the case of Lord Darzi, as a minister) to produce Department of Health policy documents. These individuals were selected from the existing pool of high-profile doctors who had previously been involved in national policy development. At the local level medical managers were enrolled by commissioners and providers to present plans to the public so as to supply those plans with greater legitimacy.

Waring (2014) builds on Freidson's restratification thesis to describe various types of 'elites' within the medical profession (as distinct from the 'rank and file' members). Of most significance to this analysis are what he terms 'political' and 'managerial' elites. 'Political elites' hold leadership or representation positions within professional associations and are involved in various forms of policy-making:

> They are typically highly experienced, well regarded and often appointed by election by their profession. In terms of their relational intersections and activities, political elites are significant because they operate the interaction of the profession and the state, through representing the interests of their profession within political processes, policy making and public or media debate. They are often invited, for example, to lead public consultations, act as scientific advisors or hold public offices, such as the chief medical officer. (Waring 2014, p12)

Waring sees 'managerial' elites as an evolution of Freidson's 'administrative elites'. These medical-manager 'hybrids', as they are sometimes known, are located within operational organisations (unlike political elites who tend to sit outside the day-to-day work environment).

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The findings from my study support Waring's argument that managerial elites have been co-opted into management practices to support organisational change, especially in 'hard to reach' areas. Waring does not consider co-optation in relation to political elites but in my study it was not just managerial elites, but also political elites who were co-opted in the interests of policy makers.

Whilst centralising hospital services is in the interest of national professional bodies because, for example, it is seen to facilitate medical training, I argue that this represents a convenient alignment of interests rather than a resurgence in professional influence in national policy. In the field of hospital planning the role of political elites in policy making is primarily to provide legitimacy for government policy. It is telling that it is the leaders from the Royal Colleges rather than the BMA, who are invited to be involved in policy making. Up until the 1980s the BMA was routinely consulted on developments in national policy (Klein 2001). However, following the emergence of managerialism in the 1980s, the BMA was excluded from policy decisions, most notably the decision to introduce an 'internal market'. Whilst the Royal Colleges present themselves as primarily a 'scientific' body, the BMA, as a trade union, is a 'political' organisation. The status of the Royal Colleges as scientific bodies lends legitimacy to national policy and serves to make the policy appear to be objective and politically neutral. Co-optation is also suggested by the fact that while political elites were invited to participate in the seeming intractable issue of hospital planning, the profession continued to be excluded from decisions in other areas of health policy, such as when the New Labour government introduced a raft of policies designed to increase choice and competition in the NHS.

A similar assessment has been made by Coburn et al (1997) in the case of state-profession relations in Ontario. As with Waring (2014), Coburn et al identify medical elites as various organisations representing medical interests (such as the Ontario Medical Association), self-regulatory institutions (such as the College of Physicians and Surgeons of Ontario) and representatives on various medical or medical-state committees or commissions. Coburn et al argue that medicine is declining in power and that this is partially accomplished through the State co-option of medical elites and organisations. In other words, the State controls medicine *through* restratification. Whilst state-profession relations have increasingly taken a corporatist form with power being delegated to the Ontario Medical Association, this has been directed at increasing

the Association's responsibility to control its members. Thus the corporatism is 'bounded, constrained and defined by the state priorities and cost cutting' (Coburn et al 1997, p11).

In the NHS in England Klein (2001) has suggested that the co-optation of policy makers has been a long-standing strategy of policy makers. Klein uses the example of the rationing of renal dialysis in the 1960s to illustrate what he calls 'the strategic conversion of political problems into clinical problems'. When the technology for renal dialysis was developed it was apparent that it was a technology that would both extend lives and cost money, thus putting pressure on resources. According to Klein, elites within the Department of Health engineered a professional consensus to centralise and thus ration this technology. This was accomplished through a series of professional conferences chaired by the president of the Royal College of Physicians:

> In the outcome, medical agreement was obtained for what was all but name a strategy of rationing scarce resources: a policy of concentrating renal dialysis facilities in a limited number of centres – a policy justified, however, not by resource constraints but by medical considerations about the desirability of concentrating expertise. (Klein 2001, p85)

To say that political elites are co-opted in the interest of policy makers is not to say that these individuals are passive, or that the relationship is somehow one way. Such positions may appeal to some individuals, offering high profile, well remunerated and seemingly influential roles. As a stratum, political elites are integral to professionalism, securing and maintaining jurisdiction over a social problem (Abbot 1988), in this case hospital planning. It also furthers the interests of the profession as a whole by securing a degree of control over the context of care (Coburn et al 1997) and maintaining control over post graduate medical training and the overall size of the medical workforce (and hence remuneration). Yet the extent to which these roles represent and further the interests of the profession as a whole is uncertain and debated. In the last twenty years the medical profession has become more heterogeneous, in terms of gender, class and ethnicity. At the same time the national professional bodies have fragmented due to subspecialisation (Greener and Powell 2008). Therefore this stratum is increasingly unrepresentative of the rank and file. And while this stratum may play a role in furthering the interests of the profession in some respects, it may also serve to articulate central government objectives downwards within the profession (Waring 2014, Johnson 1995).

One question is to what extent these processes are new. Political elites, as Waring (2014) describes them, have always existed, as members of national-level professional associations, or in public office, such as the chief medical officer. However, the appointment of 'tsars' to advise on policy proliferated under New Labour and might represent a break or new expression of the political elite. There were 130 tsars appointed between 1997 and 2010 (85% of whom were male) across a range of policy areas. The appointment of 'tsars' continued under the coalition government who appointed another 93 between 2010 and 2012 (Levitt and Solesbury 2012). One reading of the appearance of tsars is as exemplary of attempts to 'depoliticise' policy issues, which came to prominence under New Labour (Burnham 2001) and have since become embedded as a feature of contemporary governance (Flinders and Wood 2014). There also appears to be some key differences between the contemporary cohort and their predecessors. Historically political elites have been located within the medical profession. For example, holding office in the British Medical Association from where they negotiated on pay and sought to represent the profession in national policy debate. And prior to 1980 there was a distinctly *medical* hierarchy that ran parallel to the organisational hierarchy of the NHS (Klein 2006). In contrast, contemporary political elites are incorporated as hybrids into external bodies, such as central government departments, arms length bodies, and the NHS hierarchy. Crucially, whereas historically political elites were appointed from within the profession, where they were elected by their peers, many current political elites are appointed directly by the government, suggesting their perceived benefit is more in relation to the formulation of government policy than in representing the interests of the profession.

There is little existing research in this area. Future research could fruitfully ask who are these individuals? What is their background and career path? How are they selected? What do they do? What characteristics do they have (some important characteristics appear to be clinical credibility, personal charisma and political 'savvy')? How are they perceived by the public and how are they perceived by the clinical rank and file? To what extent are they seen as part of the profession and to what extent are they seen as acting in the interests of the state? To what extent are they co-opted in the interest of policy makers and to what extent do they represent and further the interests of the profession?

The recognition of rhetorical strategies and the erosion of trust

What is notable about the approach taken by local NHS managers in my study to implementing a policy to centralise hospital services was that it was *entirely* rhetorical. There was, for example, no evidence of the negotiation and bargaining that might be expected to occur when collective decision making is undertaken in the context of plural interests and values. However, as a rhetorical strategy, the framing of clinical necessity was not successful in that other stakeholders were unconvinced of the need for change. This finding suggests that in an era of more critical trust in expertise the 'politics of expertise' (Fischer 1990) is insufficient to contain social protest. But it is not simply that the rhetoric is unconvincing, the tactics themselves engender distrust. Baumberg (2008) argues that the discourse of 'evidence based policy' is characterised by the absence or manipulation of research, leaving 'a rhetoric of using evidence but with no substance' (2008, p1). The result is a 'hyperreality' in that the words are detached from everyday understandings of reality. Fischer (2003) argues that when the public recognise these manipulations it has the effect of turning them off politics generally:

> A phenomenon of considerable concern to serious observers of the political scene, its manifestations are decreasing levels of citizen participation, dwindling levels of voter turn-out, indifference to important issues, poor understanding of the issues, and low levels of civic involvement, among other things. (Fischer 2003, p 59)

Such tactics are also likely to produce the opposite of what is intended, for as Hajer (1995) has shown in relation to environmental policy, it is trust, rather than simply empirical evidence, that is key to the acceptance of change in intractable controversies. In so far as the public recognise communication as strategic this will result in an erosion of trust. This has implications beyond the 'acceptability' of a controversial policy, it has implications for public trust in both the NHS and in individual clinicians.

According to Luhmann (1988) trust is required in situations where there is an awareness of risk. Trust deals with the essential unknowableness of the future by assuming away aspects of uncertainty (Brown and Calnan 2009). As risk and uncertainty are at the core of medical practice, trust is an inherent aspect of health care systems. Trust can relate to public trust in institutions and to patient trust in individual doctors. Among policy makers there is widespread concern about declining public trust in welfare state institutions (OECD 2001, Cabinet Office Strategy

Unit 2002, Department of Health 1997). Scholars have argued that the public is less likely to take on trust the virtue of government policies and the claims made by authorities (Taylor-Gooby 2006, Bauman 2000, Lupton 1999). Taylor-Gooby (2006) argues that this can best be understood as a shift to 'critical trust' rather than a decline in trust per se, such that 'citizens challenge, test and assess for themselves the validity of pronouncements and the quality of institutional provision' (Taylor-Gooby 2006, p7).

Furedi (1997) highlights a broader cynicism towards expertise, particularly scientific expertise. Looking specifically at the medical profession, Scambler and Britten (2001) suggest a number of factors that have influenced declining levels of trust, including economic rationalism, consumerism, a more general lack of certainty in the post-modern era and the questioning and deprivileging of medical knowledge. Aleszeweski and Brown (2007) argue that a combination of an increased sensitivity to risk combined with a heightened awareness of the limitations of medical knowledge means that trust is both more crucial, and harder to win. Nonetheless, survey research suggests that trust in doctors has remained high, at least compared to other professionals, and especially when compared to health service managers (Rowe 2004, Ipsis Mori 2006). However, like Taylor-Gooby, Brown (2008) argues that in the context of the deprivileging of medical knowledge, and a heightened awareness of risks and of the limitations of medical expertise, there has been a shift to a more sceptical trust. In this context trust is earned rather than assumed (Brown and Calnan 2009). In this age 'trust has to be won, and the means of doing this is demonstrable warmth and openness' (Giddens 1990, p 121). Empirical research confirms that trust is associated with the experience of patient-focused care (Calnan and Sanford 2004). Brown (2008) has argued that whereas before the competence of the doctor would have been taken for granted, the paternal model of patient interaction is insufficient to develop trust. He draws on Habermas to suggest that:

  …the professional's standing as caring and competent is now likely to depend to a greater degree on involving the patient, where some approximation of an ideal speech situation of equitable, frank discussion is necessary for legitimating authority and thus earning trust (Brown 2008, p357).

Giddens (1990) emphasises that the trust at the micro and macro levels are interconnected. The trust that is built through interpersonal interactions is critical to sustaining trust in the broader

system. Individual professionals (e.g. GPs, hospital consultants) act as the 'access points' of expert systems, representing and reaffirming the system's trustworthiness. Therefore positive interactions with individual professionals reinforce trust in the expert system of medical knowledge.

The literature on trust highlights its mulitdimensional nature. For example, trust is said to involve assessments of both 'competence' and 'care' (Hovland et al, 1953). 'Care' corresponds to a belief that the trustee and trustor share values, and that the trustee has the trustor's best interests at heart. Whilst an assessment of competence can be arrived at through deliberation of evidence, an assessment of 'track record' and other information, an assessment of 'care' can only be arrived at through familiarity and experience of interaction. Thus trust has a dual basis (Taylor-Gooby 2006) grounded on both cognitive and affective factors. The cognitive dimension is grounded on rational judgments whilst the affective dimension is grounded on relationships and emotional bonds generated through empathy and identification with others (Calnan and Rowe 2005). What this means is that if the public believe that local doctors are not acting with their best interests at heart, if they see local doctors seeking to 'sell' planning decisions to the public, and perceive this to be done in a way that is deceptive or manipulative, then this will erode trust. And it is conceivable that this will occur not just in relation to the NHS but in relation to the individual clinician also.

The effects of framing

Beyond the recognisable use of rhetoric, the clinical framing 'worked' in other, less visible ways. Frames present an interpretation of the way things are, of what should be done and who should do it. Through the discursive act of framing, policy texts channel thinking in a particular direction and make a particular course of action appear self-evident. In this case centralising hospital services is presented as a clinical necessity. However, if the objective is improving health outcomes, there are alternative courses of action. To take the example of maternity care, outcomes might be improved by action to reduce obesity and diabetes in the population, improving uptake of antenatal care, improving identification of 'at risk' women in the third trimester and so forth. Even taking a more narrow concern with medical staffing and training, for any given objective, such as training doctors, maintaining practitioner skills or ensuring sufficient input from a senior doctor to patient care, there are alternative courses of action. These might include, for example, employing additional staff, improving teamwork, using clinical

networks or exploiting burgeoning innovations in telehealth. The aim here is not to suggest how best to organise hospital services but to argue that the framing of one course of action as a clinical necessity restricts the extent to which alternative responses can be considered.

The way an issue is framed can also make some elements appear fixed and proper while others are open to change (Fischer 2003). The clinical framing holds that hospital services need to be organised so as to meet Royal College standards for medical training. But why are Royal College standards for training doctors assumed to be fixed and not open to debate? Given the limited evidence regarding the effectiveness of particular training patterns, it could be argued that medical training should fit around the needs of hospitals to meet other objectives, such as providing a humane and responsive service to patients. Lewis (2007) has emphasised the need for creativity in finding solutions to difficult health care issues. The planning of health services is just such an issue, involving a complex interrelation of service, staffing and training. Health services are also not just health services but play important instrumental and symbolic roles in communities. Framing the problem as an issue of 'clinical viability' elides this complexity and hinders the development of effective policy.

Framing constitutes the objects and subjects of policy. In my study this was achieved by defining hospital planning as a 'clinical' issue. By defining the issue as 'clinical' the rationale defines the issue as 'technical' rather than 'political'. It also identifies the medical profession as the appropriate group to be making decisions and excludes other voices. While the clinical framing had limited success in terms of convincing other stakeholder of the need for change, it had more success in the way it removed the issue of hospital planning from the agenda for public deliberation by defining it as a clinical and thus a technical issue. Following the framing to the level of managerial practice, it had a concrete effect in the way the PCT was not required to consult with the public over planned changes to hospital planning, even though the involvement of the public in decision making was a key plank of national policy.

The process and practices of what has variously been referred to as the 'scientisation' (Habermas 1971), 'technicalisation' (Rose and Miller 1992) and 'depoliticisation' (Burnham 2001) of politics are nothing new. Indeed it has been described as 'the oldest task in politics' (Rancière, 1995, p16). Edelman (1975) identifies it as a key political technique for immobilizing opposition:

Whenever a political issue produces conflict, an impasse or a result unacceptable to elites, some will define and perceive the issue in question as inappropriate for politics, as professional or technical in character, calling for specialised expertise, rather than political negotiation and compromise. (Edelman 1975, p137)

What is historically novel is the way that technicalisation has been institutionalised and ideationally embedded in managerialism (Hay 2014). It is this that has led to the pervasiveness of technicalisation that allows Flinders and Wood (2014) to describe it as the 'dominant model of statecraft' of the 21st century. Technicalisation is embedded in managerialism in the form of privatisation and the devolution of decisions to local-level administrators. My study looked primarily at a third form of technicalisation, the delegation of an issue to experts, in this case the medical profession. In all three forms (privatisation, devolution to managers, and delegation to experts) there is a discursive denial of the inherent contestability of the provision of collective goods (Hay 2014). From a Foucauldian perspective, the effect is not less politics but less visible politics. Political control is enhanced because decision making occurs behind closed doors.

In the literature the process of technicalisation has been approached from diverse theoretical stances and scholars have focused variously on 'why', 'how', and 'with what effect' the process occurs. Burnham (2001), who saw depoliticisation as a distinctive feature of the New Labour government, views the process as a strategy of politicians seeking to insulate themselves from criticism. This stance assumes that politicians are motivated by self-interest, an assumption that has been questioned by Hay (2014) who suggests that 'political elites engage in depoliticisation not because they think it is in their own self-interest so to do, but because they have been convinced (and have convinced themselves) that it is in our interests for them to do so' (Hay 2014, p 301).

Fournier and Grey (2003), on the other hand, attribute the process to a belief or perception that political issues are amenable to 'technical' solution through expert management. In their analysis of the policies of New Labour, for example, they say that the government 'tends to see' political issues as such. Thus in contrast to Burnham, it is not that individual politicians are acting strategically, but rather the actions of politicians reflect a particular view of the world. Edelman (1975) suggests that the motivations of individuals as often multiple and confused. For Edelman

depoliticisation is the *consequence*, although not necessarily the *intention* of authorities who label issues in this way.

Technicalisation is inherent to governmentality. Miller and Rose (1992), for example, describe depoliticisation as occurring in two ways, either by re-locating issues as 'private' matters to be resolved by individual market transactions, or by transforming them into technical, professional or administrative matters to be resolved by the application of rational knowledge and professional expertise. In contrast to Burnham, their focus is on 'how' this process occurs, rather than on the intentions of individuals. For example, they highlight the way the incorporation of expertise into welfare systems 'facilitates the creation of domains in which political decisions are dominated by technical calculations' (1992, p196).

My thesis is that the framing of hospital planning as a 'clinical' issue is a rhetorical strategy intended to convince other stakeholders of the need for change. This is not to say that it is only rhetoric. As Rein and Schön note, sometimes the rhetorical frame is the same as the action frame. In a similar vein Flyvbjerg (1998, p228) argues:

> A rationalized front does not necessarily imply dishonesty. It is not unusual to find individuals, organizations, and whole societies actually believing their own rationalizations. Nietzsche, in fact, claims this self-delusion to be part of the will to power. For Nietzsche, rationalization is necessary for survival.

It is likely that the representatives of the medical profession do believe that centralisation of hospital services is a clinical imperative, reflecting the instrumental rationality at medicine's intellectual core. Individual managers may also be convinced of the clinical rationale. The literature on hospital planning indicates that the framing is also 'sponsored' or otherwise accepted uncritically by many academics.

For the purposes of analytical clarity I have distinguished between the often obvious use of rhetoric and the less visible effects of discourse. In reality these processes occur simultaneously. Whilst I have inferred strategic behaviour on the part of policy actors in mobilising the frame of 'the clinical case for change', the data does not indicate to what extent actors were aware of, or intended, all the various mechanisms and effects of the framing. Nor have I sought to infer the

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full range of motivations of policy actors. What is important about my study is that I showed that the mobilisation of the framing was strategic and that it was seen to be strategic by other actors. It was the perception of local doctors and hospitals managers that the commissioner was using the framing to convince the public and hospital staff of the need for change. In addition to this readily recognisable strategy, I also showed how the operation of power *exceeded* the intentions of individuals (Shapiro 1992) and how it operated in less visible ways, channelling thinking in a particular direction, marginalising alternatives, and removing the issue from the agenda for public deliberation.

In my research I have found Rein and Schön's (1993) concepts of 'frames' and 'framing' fruitful in gaining analytical purchase on my empirical data. Specifically, they allowed me to explore links between the discursive origins and properties of policies, the intentions in policies, and the responses to and effects of policy in the material world. This is a novel approach to exploring the operation of forms of discursive power in policy processes. Whilst other scholars have come to understand the operation of power as assemblages of knowledges, practices, rationalities and morality, they have not explicated how these elements are brought together. I argue that they are brought into alignment through the agential act of framing. The act of framing works beyond the intentions of individuals, constituting the objects and subjects of policy and thereby assigning authority and status and shaping thinking and acting. Whether we hold or mobilise a frame, or both, it brings a whole world with it. I explore the implications of this further in the next chapter when I consider the implications of my findings for health services research.

The potential for more deliberative policy processes

The recasting of political decisions as clinical decisions has significant implications for the national policy objective of involving the public in decisions about health care delivery. The government has introduced a number of mechanisms aimed at strengthening public and patient participation in decisions about how health services are provided. The power of the clinical rationale is that it does not matter how effective the democratic mechanisms are if the definition of hospital planning as a clinical decision means that it is kept off the agenda.

The operation of power through framing has a significant bearing on current debates regarding the potential for more democratic policy processes. In this study I have employed discourse theory based on the insights of Foucault regarding the operation of modern power and the way in which language shapes and constrains thinking and action. Other scholars have, in contrast, drawn on the work of Habermas (1987) and focused instead on the potential of language to facilitate consensus. Habermas focused not on the subject but on the interaction between subjects. According to Habermas, an inherent feature of inter-subjective interaction is the desire for understanding. The drive for understanding is inherent in human communication because it is necessary for social coordination. Habermas refers to this as 'communicative rationality'. Communicative rationality is achieved when there is no coercion present, other than 'the force of the better argument' (Habermas 1996, p306). Communicative rationality is present in the 'ideal speech situation' which is rendered through the application of the following principles:

    i.   No party affected by what is discussed is excluded

    ii. All participants have equal possibility to be present and to criticise validity claims in
         the discourse

    iii. Participants are willing and able to empathize with each other's validity claims

    iv.   Existing power differences between participants have no effect on the outcome of
         debate

    v.   Participants openly explain their goals and intentions and desist from strategic action.

Some scholars have used these 'discourse ethics' as a model for identifying the strategic use of power in texts. In other words, discourse ethics are used as an analytical tool, akin to Weber's notion of an 'ideal type'. Other scholars have seen in the work of Habermas the philosophical basis for more democratic policy processes (Torgerson 2003, Fischer 1990, Dryzek 2000, 1990, 1987a). These scholars argue that discourse ethics can be used to inform the development of procedures for involving citizens in decision making and as design principles for forums or spaces for public deliberation of policy issues.

One criticism of Habermas' work, in the context of the present discussion, is that it assumes a degree of shared socialization. However, many policy issues are controversial precisely because they involve groups of people with very different views of the world and these are not something that can easily be put aside. People's ideas about themselves and others are not abstract

statements which can be accepted or rejected on the basis of rational argumentation but are deeply ingrained in their way of life (Fay 1975). These ideas are guides for action. They provide support for roles and serve to validate a particular way of life in which people are engaged in living. As Fay argues:

> A person learns who and what he is through his early education as he acquires a language, internalises norms, beliefs and values, and attitudes, as he becomes a member of a specific social group, and this means that his very identity as a person is tied up with the particular world-view of this group and the particular beliefs which are rooted in this world-view. The emotional power which ideas have stems from the fact that such ideas go to the core of what it means to be a person, and it is thus no accident that such ideas are avidly held on to, and that competing interpretations of what one is doing are seen as personally threatening or ridiculous.(Fay 1975, p89).

The underlying assumption about the desirability of consensus has also been challenged. Flyvbjerg (2001) for example, notes that recognition of the rights of women and people from ethnic minorities has been achieved through political activism, not 'the force of the better argument'. Others have shown how forums for shared decision making have, in practice, been used as devices for co-optation that have reinforced the powers that dominate in policy processes (Amy 1987). As Hajer observes, 'concessions might be made, but the dam/road/airport gets built' (Hajer 2003, p 99).

The proposition that it is possible to design forums that enable more democratic collective decision making is countered by the Foucauldian view that communication is *always* permeated by power. This position holds that there is always the presence of discourses constraining not just what can be said (and thought) but constructing the very identities of participants. To use an example from health care policy, some writers advocate that the principles and procedures of communicative rationality be used to involve the public in collective decisions about health care delivery (e.g. Doyal 1992, 1995). In practice this would involve supplying all participants with technical knowledge to address the problem at hand. However, technical knowledge cannot exist outside of discourse. That is, technical knowledge is itself a controlling mechanism that 'frames' the debate (Jones 2001).

Flyvbjerg (2001) argues that the question of whether communication offers the potential for emancipation or whether it is always constraining and controlling must remain open and calls for empirical examination of concrete situations:

> The researcher must ask how communication takes place, how power operates. Is communication characterized by consensus seeking and absence of power? Or is communication the exercise of power and rhetoric? How do consensus seeking and rhetoric, freedom from domination, and the exercise of power, eventually come together in individual acts of communication? (Flyvbjerg 2001, p94).

Similarly Torgerson (2003) proposes that:

> ....there is a need for research into actual experiences with discursive designs in the policy process, neither to praise them as open communicative forums nor denounce them as inevitable tools of co-option, but to examine the ambivalent potential they exhibit as they interact with contexts of power. (Torgerson 2003, p128)

In this study I showed how, in policy texts and in the practices of policy implementation, power operated in ways that were often difficult to see. Discursive power worked *before* and *within* deliberative forums, such as public consultations and 'co-design' workshops, shaping thinking and creating objects and subjectivities. *Before* deliberative forums framing was able to make a political issue appear as if it was not in fact political at all, but technical and therefore not subject to public deliberation in the first place, for example, when the Local Authority Overview and Scrutiny Committee decided that plans for service changes would not need to be subject to consultation.

Within deliberative forums, framing had the effect of channelling thinking in a particular direction and making a particular course of action appear inevitable whilst marginalising alternatives. For example, the commissioner held 'co-design' workshops with members of the public. As the name suggests the implication was that these were fora in which the public could be involved in decision making. Yet by providing participants with seemingly 'technical' information about the issue to be discussed, the commissioner was able to set the terms of the debate and control how the problem was understood and what courses of action were available.

Moreover, in this study I found that the forums themselves were co-opted in the interests of managers and policy makers. For example, the commissioner also ran 'co-design' workshops with local clinical staff. Again the implication was that the plans for service change would reflect a consensus arrived at through discussion with other stakeholders. In this instance it was clear that these workshops were co-optive devices, rather than efforts at more participatory policy processes. Participants recognised the strategic nature of the workshops, observing that the intention was to present the commissioner's plans as if they had originated from local doctors. Participants also reported how the final proposal bore little resemblance to the discussion as if 'whoever wrote it had decided it all beforehand'.

My findings accord with those of Fraser et al (in prep) from their study of the 2008-2011 London stroke service reconfiguration. They found that in stakeholder workshops managers were able to control how problems were conceived and how solutions were constructed. This is illustrated by the following excerpt from their study. The excerpt is from an interview with a management consultant involved in running the stakeholder workshops. In this account the strategic use of these workshops is explicit:

> We had our first pan London conference and that was attended by representatives across London…and we mixed everyone up and we eventually workshopped ideas…but we kind of had the answers in our back pocket…And we were able to guide that conference to an answer that we had already, I suppose, decided on…

Similar workshops were held at the national level as part of the development of the Darzi report. The resultant report then presented the national policy as produced by front-line staff and members of the public. Observing these practices, Martin and Learmonth (2012) have highlighted how both front-line staff and the public are increasingly represented not just as the *objects* of policy interventions, but as *subjects* implicated in policy design. They argue that this can best be understood as an effort to reconstitute these actors' subjectivities as a means of 'governing at a distance'.

One of the limitations of my study was the extent to which my empirical focus enabled me to analyse the response of individuals and groups to policy framings. For professional groups it was clear that other stakeholders, such as local clinicians, rejected the framing of clinical necessity,

viewing it as a political ploy. In my observation of a planning meeting members of the public also rejected the framing, offering alternative constructions of the issue. Thus although I demonstrate that the framing had significant discursive effects, including material effects, it was insufficient to contain debate. Where and how this debate continued was not the focus of this study. That these debates are ongoing is evident from newspaper reports, such as those that followed the recent controversial decision to close services at Lewisham Hospital. In this instance community groups not only rejected the framing of the decision as one of clinical necessity, they self-organised to bring a judicial review (Cooper 2013).

I have found Foucault's theory of discourse and governmentality to be a potent theoretical resource in understanding contemporary governing practices. However, in so far as this study has shown that a discursive strategy that drew on medical authority and expertise was insufficient to contain the politics of hospital planning, it mounts an important critique of Foucauldian scholarship, suggesting a greater role for agency than has previously been allowed. Whilst Foucault's work highlights the potential for subjectivities to be resisted and re-constituted through human agency (Heller 1996) the work of scholars such as Miller and Rose (1993) have tended to emphasise the structural influence of discourse in constituting and governing subjectivities. These scholars suggest that discursive rationalities and truths, as articulated through policy, constitute the fields and subjects of policy within regimes of government. The findings from my study suggest actors utilise their agency to invoke alternative truths (subjugated discourses) and challenge policy. In this way my study exposes the limits of governmentality.

A more recent study of centralisation of hospital services also found that the discourse of evidenced-based decision-making was mobilised strategically by managers to realise change (Fraser et al in prep). However, only where there was top-down coercion exerted through the NHS hierarchy, was radical change actually realised (Turner et al 2016). This demonstrates the combination of governmentality and sovereign power in healthcare settings (Martin et al 2013) and suggests that more visible forms of power are required to compensate for the failure of governmentality.

Fieldwork for my study was undertaken between 2006 and 2009. My intention was to use hospital planning during this period as a case study to explore the use and effects of framing in policy and practice. My study therefore makes a more general contribution to the understanding of the role of policy in political contests. Moreover, in the current economic climate the issue of hospital planning has become more acute as local managers are facing pressure to reduce costs. Hence, the findings remain relevant to the present day.

Since this study was undertaken policy framings have continued to shift and in recent years there has been more emphasis in policy texts on the need to close facilities in the face of austerity and to move spending from acute to community services. Scholars have argued that the rationale of 'austerity' can also be seen as having discursive effects in the way it makes decisions appear to be necessary due to non-negotiable external constraints (Hay 2014). There has also been an increasing emphasis on 'co-producing' plans for service change with the public, suggesting a continuing reliance on a form of governmentality as described by Martin and Learmonth (2012).

Nonetheless, the framing that I have explicated remains in play (Academy of Medical Royal Colleges, National Voices and NHS Confederation 2013; NHS Northwest London 2012). For example, in justifying his decision to downgrade the Accident and Emergency department at Lewisham Hospital (a decision taken in response to the financial failure of a neighbouring provider) the Secretary of State for Health claimed during a public meeting that the decision 'would save 100 lives a year', to which a member of the public immediately responded with 'bollocks' (The Times, 31 January 2013).

Since fieldwork was completed the co-optation of medical elites to facilitate service change can be seen to have continued and extended in continued growth of hybrid clinical-managers and models of distributed leadership in organisational change. For example, PCTs, staffed largely by managers, have been replaced by 'clinical commissioning groups', staffed by clinicians. According to central guidance distributed to these organisations, the value of having clinicians as commissioners includes:

> Better involvement and engagement of local people to adopt improved services and move from familiar but out-dated services based on the focus on quality and outcomes and the trusted positions held in communities. (NHS Commissioning Board 2012, p8)

As Perkins et al (2014) observe, this suggests that the rationale for establishing clinical commissioning groups was in part the ability of General Practitioners to persuade local community groups to accept proposals to close hospital services.

In the next section I draw out some implications from my study for health services research. I consider the way that researchers are involved in framing in policy processes and implicated in the technicalisation of politics. I consider how academics can do research in such a way as to contribute to, rather than undermine, public deliberation. I conclude by offering 'scholarship' as an alternative to 'science' in health services research.

7. IMPLICATIONS FOR HEALTH SERVICES RESEARCH

In this section I consider the implications of my research for health services research. I consider the way health services research is implicated in the framing of policy issues and in the technicalisation of politics. My argument is that the implicit orientation of health services research to the needs of policy makers and health care managers, and the adoption of the scientific paradigm, has consequences in terms of the kind of values that are included in our research and for the public deliberation of policy issues. I conclude with a call for a reorientation of health services research from 'science' to 'scholarship'.

Health services research adopts the scientific method and seeks generalizable knowledge. It is a field of study, rather than a scientific discipline, that draws from the social sciences, such as sociology and anthropology, as well as from natural sciences, such as biology, and clinical areas, such as medicine and nursing. Nonetheless a scientific paradigm predominates. So, for example, according Black (1997) the aim of Health Services Research is to 'provide unbiased, scientific evidence to influence health service policy at all levels so as to improve the health of the public'.

Drawing from Socrates, Descartes and Kant, Flyvbjerg (2001) sets out the scientific ideal as holding that explanation of phenomena must be:

  i.   Explicit. It must not stand not stand or fall on interpretation or intuition.
  ii.   Universal. It must apply in all places at all times.
  iii. Abstract. It must not require reference to concrete examples.
  iv.   Discrete. It must be formulated only with the aid of context-independent elements, which do not refer to human interests, traditions, institutions etc
  v.   Systematic. It must constitute a whole, in which context-independent elements are related to each other by rules or laws.
  vi.   Predictive. The way a theory accounts for its domain must specify the effects of its elements. This allows precise predictions.

There is a long-standing debate as to whether the natural science model is an appropriate ideal for the study of human activity. One argument is that the natural science ideal cannot even be found in the natural sciences. That what constitutes 'science' must be determined and this

implies interpretation. Scientific practices represent a concrete practical rationality and are therefore just as lacking in objectivity as the social sciences. Although, as Flyvbjerg (2001) notes, the natural sciences might be considered relatively predictive whilst the social sciences cannot.

Another argument holds that science is an inappropriate model for the study of human activity because of the nature of the object of investigation. Natural sciences study physical objects while social sciences study sense-making humans and must therefore take into account the interpretations of the objects of study. In other words, in social science 'the object is a subject' (Flyvbjerg 2001, p 32). Social science involves what Giddens (1982) calls a 'double hermeneutic'. The people who are the object of study make interpretations, which must be understood in order to understand why people act the way they do. But the researcher also makes interpretations. Social science is thus the 'interpretation of interpretations'. Furthermore, these interpretations are not stable but subject to change.

A further, related, argument for why the ideal of scientific endeavour is inappropriate for the study of human activity relates to the importance of context. The scientific method requires the abstraction of phenomena from context. Context, however, is essential for understanding human social life. Any attempt to predict human action by reference to abstract laws will fail to accord for what action actually occurs in a particular context. As Flyvbjerg (2001) observes, even identifying the more enduring 'rules of the game', such as rituals or traditions, will not predict what happens in a particular context because, just as the rules of chess are not the same as a game of chess, and grammar is not the same as language, traditions are not the same as actual social behaviour. In human activity the rules are not the game. This has practical significance in that the focus on abstraction in our analytical methodology can result in impractical decisions. For policy to be effective what decision-makers require is information about what actually happens in real-world situations.

The adoption of the scientific paradigm, combined with our orientation to the needs of policy makers and managers, also has implications for how we, as researchers, understand health care, and the values that are included in analysis. In health services research the ideal is of an objective, instrumental analysis. One assumption of this mode of analysis is that the methods themselves are neutral, that is they can be applied to any ends. However any language, including scientific language, structures out knowledge of the world (Tribe 1972). Foucault (1970) illustrated this

with his reference to Borges' description of a Chinese encyclopaedia which divided animals into: (a) belonging to the Emperor, (b) embalmed, (c) tame, (d) sucking pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification, (i) frenzied, (j) innumerable, (k) drawn with a very fine camelhair brush, (l) et cetera, (m) having just broken the water pitcher, (n) that from a long way off look like flies. Foucault observes that what we apprehend from this taxonomy, more than 'the exotic charm of another system of thought', is 'the limitation of our own, the stark impossibility of thinking *that*' (Foucault 1970, pxv). In the same way the classifications and categories of our analytic methodologies make certain possibilities and perspectives unthinkable.

Accepting the frame of reference provided by prevailing policy or the agenda of health service managers presupposes certain values, which in the case of the clinical or managerial paradigm, may involve a narrow concern with the objectives of 'clinical effectiveness' or 'efficiency'. This combined with the scientific focus on what is measurable excludes many dimensions of 'quality' that are more intangible but nonetheless important to patients, such as the quality of interaction between staff and patients, time spent at the bedside, emotional support and so forth (Brown 2008). Moreover there is a tendency in the analytical methodologies adopted in health services research to focus exclusively on the end result of health care processes in order to assess their value. As Tribe (1972) observed, 'such 'end-result' theories have great appeal, for the notion of maximizing some desired end may seem the very essence of rationality'. However, in many cases, such as when patients have a long-term condition, it is the process of care, rather than an end-result, that matters most to patients (Mol 2008).

It is not just that these values are excluded from out analyses but that our analyses construct a particular version of health care. The objective, instrumental ideal brings a whole world with it. The discursive effects of our analyses have implications in the material world in the way that they influence policy, managerial practice and, in turn, the behaviour of health care staff. Indeed our relentless concern for 'getting evidence into practice' means that health services research explicitly seeks to change the practice of health care staff. However, the focus of our analytical methodologies on outcome measures (for example) has the effect of influencing the behaviour of health care staff in such a way that attention is diverted from other activities which patients may in some situations highly value.

To illustrate, time spent in hospital can be a time of anxiety and distress. As Brown (2008) argues, 'it is the attentive and caring nature of professionals that helps to bring some degree of familiarity and thus to foster an environment where trust can alleviate anxiety'. It is the time that health care professionals spend with patients which provides the familiarity 'amidst what would otherwise be chaos' (Brown 2008, p358). The focus on outcome measures in our analytical methodologies, which are actively proffered by researchers for use in performance and risk management regimes, have the effect of constructing the individual not as a suffering individual in need of care, but 'as a body to be administered to; a potential liability' (Brown 2008, p358). Where the activities of overstretched staff are closely monitored (in line with our analytical methodologies) unmonitored aspects of care, such as time spent with patients and bedside manner, are neglected. Moreover the time available for staff to spend sitting down with patients, as a result of performance and risk management regimes, is dramatically reduced.

These effects are not restricted to the behaviour of health care staff in hospitals, as Harrison and Dowswell's (2002) findings from primary care illustrate. As one GP in their study explains:

> You will not be dealing with them as an individual, you'll be doing some things with them because you've been told that you must, not because of some carefully reasoned thought process of your own. It's all so time consuming. All these things they want you to do are just paper exercises. It's going to reduce time that you could be spending on patient care. (Harrison and Dowswell 2002, p214)

Health services research supplies the knowledge and methodologies for performance and risk management regimes, and service and policy evaluations, that abstract the patient and distance the professional (Castel 1991). To the extent that the actions of health care staff must conform to performance and risk management regimes, and are influenced by policies informed by research and evaluation, our analytical methodologies constitute an indirect control technology, shaping the subjectivities, meanings and practices of both health care staff and patients.

Our implicit or explicit orientation to a policy agenda reinforces the pathologies of political discourse, for example, the way that policy discourse segments the social world into discrete issues that are highly interrelated (Edelman 1975). The result is research that neglects the logical and empirical ties between what are viewed as distinct issues, and thus to ineffective policy. Tribe

(1971) called for researchers to be less passive in their acceptance of the decision-makers' formulation of what they want to accomplish and more attentive to the questions being asked, to yielding alternatives not yet considered by the decision-maker and more willing to challenge the underlying values of policy. In other words, rather than saying to policy makers 'we can answer that question' researchers should, more often, be saying 'you are not asking the right question'.

Within sociology similar calls have come from Scambler (1996) and from the field of Critical Management Studies (Fournier and Grey 2000, Learmonth 2003). Learmonth (2003), observes that research is often orientated to solving problems as if this was unproblematic goal. By positioning these endeavours within the paradigm of science they are presented as neutral and value free. However, 'the best way of doing things' is from the perspective of 'the people in charge', greater efficiency or more management control for example. The 'problem' to be solved is that of managers or policy makers. It is not that addressing these questions is somehow immoral or unethical, the problem is when they are presented as universal concerns. Whilst health services research presents itself as disinterested, the formulation of the research is through managers' own language (using terms such as 'strategy' and 'reform' for example). Learmonth argues that this 'taken-for-grantedness' has become part of the way that managerial power is reinforced: 'Indeed, academics' complicity with such managerial notions, as if they were neutral, merely compounds its hegemony' (Learmonth 2003, p103). For Learmonth a more critical approach to research would refuse to grant managers the privilege most orthodox research grants them, 'to define what is important' (Learmonth 2003, p110).

Drawing from Fournier and Grey (2000), Learmonth (2003) advocates an approach to health services research that is anti-performative, denaturalising and reflexive. By 'anti-performative' he means a stance that 'challenges management theorising that simply aims towards finding better ways of getting things done'. This focus on performance, he argues, excludes consideration of other substantive issue for organisations, such as exploitation and manipulation. 'De-naturalisation' relates to efforts to uncover and unsettle assumptions and orthodoxies so as to explore them critically. Finally, reflexive research is that which is committed to reflecting on itself and the way that what counts as 'problems' and 'solution' are shaped by the predilections of the researcher. Reflexivity 'challenges the idea that management research-evidence can give us neat answers.'

Critical Management Studies has been criticised with being overly intellectual, concerning itself with esoteric issues of little interest outside academia, and as an elitist undertaking that alienates practitioners who are unfamiliar with the jargon of academia. It has also been suggested that, given that it takes up public resources, 'one might wonder whether there are more important things to do in the health sector than indulge in critical management theory' (Holland 2004, p93). The criticism of Critical Management Studies, in this regard, has been summarised by Holland (2004):

> Critical management theorists are said to be positively unconcerned with the practicalities of managing, or organising anything, content with sniping from the sidelines: and, consequently, [Critical Management Studies] is a project that makes no difference in the world 'out there'. (Holland 2004, p93)

Similar concerns might be expressed in relation to my critique of health services research. I would contend that managers and policy-makers are not well-served by instrumental research where this abstracts policy issues from their relational settings, a point I return to. Furthermore, I am explicitly concerned that my approach has practical benefits. I see these as arising from my orientation to how things are, rather than how things should be, and a methodology well suited to the complexity of issues facing local managers. These benefits are that, firstly, studying policy processes in their broader social and cultural context illuminates why policies may not have their intended effect and identifies unintended consequences. Secondly, attending to the frames in policies, and the effects of these frames in the material world, can create space for alternative ways of seeing the issue and alternative courses of action. Thus, ultimately, understanding the multiple perspectives on policy issues can lead to more acceptable and effective policies.

Health services research and the 'technicalisation' of politics

My concern is not just that the scientific model is inappropriate for the study of human activity, and that it excludes certain values from analysis, but that it contributes to the technicalisation of politics. My attention to the implications of my research for health services research began during fieldwork when I attended a health services research conference. At this time there had

been a recent announcement that the Secretary of State had decided against local managers' plans to close services at Horton Hospital in Oxfordshire. This decision had followed recommendations from the Independent Reconfiguration Panel (a body set up to provide recommendations in cases of contested hospital closures) that services should remain open at this hospital. The panel had decided that closing the hospital would reduce access to services for the local community and that other courses of action were available to achieve the commissioner's objectives of ensuring safe and sustainable services (Independent Reconfiguration Panel 2008). One of the academics speaking at the conference expressed frustration at the decision by the Secretary of State for Health, commenting that 'I don't know why we bother doing this research if the government keeps siding with the public'.

This statement caught my attention and I made a note of it. It later occurred to me that this statement by the academic illustrates the tendency in health services research to conflate the separate questions of 'what do we know' and 'what should be done'. Russell et al (2008) describe this tendency as stemming from the 'naïve rationalism' of much health services research. As they describe it:

> The naive rationalist approach to evidence-based policy often implies (and occasionally states overtly) that 'what to do' will be self-evident once enough high quality research evidence of 'what works' has accrued. (Russell et al 2008, p41)

Naïve rationalism is evident in the predominant concern within the field with 'evidence-based policy'. In this paradigm research findings in relation to a single objective ('effectiveness' say) are assumed to be directly transferable to policy. This view neglects the fact that public organisations have multiple and often competing objectives. It also neglects the way that under democratic principles the question of 'what should be done?' would be subject to public deliberation, not to technical expertise. In our orientation to the problems of policy makers and service managers, and in our adoption of the scientific paradigm, health service researchers are implicated in the technicalisation of politics. The question I turn to now is, therefore, 'how can we do research that supports, rather than undermines, public deliberation in collective decision making?' I consider possible strategies below.

Don't make recommendations

One option for researchers is to describe their findings but to not make recommendations for policy. This avoids the conflation of the separate questions of 'what do we know?' and 'what should we do?'. It restricts the researcher to the former, leaving the latter as a matter for public deliberation. However, policy makers and funders of research usually say that they want research to contain practical recommendations. Similarly editors of journals where research is published ask, if not for recommendations, then for the implications for policy to be drawn out. Thus such a course of action may not always be feasible, even if it is desirable.

Value-sensitive recommendations

Given the requirement, from funders and publishers, for researchers to make recommendations for policy and practice, one way forward is for researchers to frame recommendations in such a way as to make values explicit. In other words, they could draw out the implications of their research for different value positions. Baumberg (2008) illustrates how this approach might work in the contested field of alcohol policy:

> A study showing that alcohol taxation reduces alcohol-related mortality more than previously thought could say that policy makers:
>
> ….whose sole value is health should raise taxes;
>
> ….whose sole value is liberty/economics/democracy should not raise taxes;
>
> …with multiple values, including health, should give more consideration to alcohol taxes than previously, but should continue to weigh this up against other facts (liberty/economics/democracy).

While this approach allows for the possibility of multiple, possibly conflicting objectives, it does not in itself address the way power operates in the framing of policy problems. The researcher in this case will be accepting the frame of reference implicit in the topic or research question.

Advocacy

Another approach rejects entirely the assumption that researchers occupy a 'neutral' or 'objective' position and instead calls for researchers to 'throw their hat in the ring' with whichever group they feel most kinship. This would have the effect of making the implicit frame explicit. So, for example, a researcher concerned primarily with the interests of citizens or users

would do research either funded by these groups or otherwise conduct research from the explicit perspective of these groups. This is not to imply that to do research in the interests of elite groups, such as policy makers or managers is morally dubious. As Scambler (1996) has argued, research driven by the imperatives of economy and state is not intrinsically undesirable. The problem is the extent the imperatives of the economy and state come to dominate research agendas and when these imperatives are assumed to be shared concerns.

Opening up rather than closing down alternatives

Researchers often undertaken evaluations of particular models of delivering care, such as centralising hospital services, or else seek to answer questions that frame issues as technical, for example, 'how best to deliver care?' As already established, such topics and questions are political in the sense that they relate to distribution. One way that health service researchers can better support public deliberation of political questions is to be clear about the *mechanisms* by which a particular model of health care delivery has produced outcomes. This is because focusing on the mechanisms provides alternatives and thus greater flexibility for planners to agree a way forward with other parties. This approach allows the researcher to 'open up' rather than close down policy alternatives. Rather than searching for the 'one best solution' this approach explicates a range of possible courses of action.

A recent illustration of this approach is provided by Harrison (2012). Harrison systematically considers the options available to managers concerned with improving quality in hospitals. He argues that the apparent advantages of larger units may not be intrinsic but can be matched in other circumstances. For example, skilled clinical staff, knowledge transfer and well-defined care processes can all be made available in hospitals with lower levels of activity. By carefully explicating the mechanisms involved in quality improvement Harrison generates a range of alternatives to centralisation, including moving the individual clinician to the patient, using telemedicine to allow local clinicians to seek advice from specialised units on the basis of electronic transfer of imaging; or linking the smaller units into networks with agreed referral to ensure that the most difficult cases are transferred to better equipped units and the rest treated in smaller more accessible facilities (Harrison 2012, p4). Not only does this approach support public deliberation of policy issues, it provides for a flexible and creative response to local circumstances.

Illuminating frames

In this study I have drawn on the work of Schön and Rein (1993, 1994) on frames and framing. In the context of the present discussion, one way in which researchers can contribute to public deliberation of policy issues is through illuminating frames. Drawing on Habermas, Schön and Rein suggest that they see illuminating frames as enabling critical self-reflection that can, in turn, lead to political consensus. They are optimistic in their belief that illuminating frames will allow for a process of frame reflection that could potentially lead to the resolution of intractable policy controversies. This occurs through the greater understanding that comes from seeing the opposing party's point of view, as well as understanding one's own, and by opening the way for parties to find a new, mutually acceptable, frame for the policy issue.

Whilst illuminating policy frames may contribute to public deliberation by facilitating understanding, there remains the possibility that once a frame is illuminated, elites will simply pay lip service to the frame, or co-opt it, rather than have any sort of genuine engagement with opposing parties. Indeed Schön and Rein acknowledge this possibility, using Henry Kissinger as an example of the strategic use of frame reflection. Kissinger, they argue, sought to discover the meanings an opponent attached to actions, so as to manipulate them more effectively (Schön and Rein 1994, p 39).

Fay (1975) has argued that a social science oriented only to illuminating what people think and why they think it has the potential to be deeply conservative. This is because it suggests that conflict is generated by mistaken ideas about social reality, rather than inherent tensions and incompatibilities in society. The risk is that it leads to reconciling people to the social order by seeking to demonstrate that it is their beliefs that has led to a breakdown in communication, rather than seeing the breakdown in communication as resulting from irreconcilable interests and beliefs of the conflicting parties:

> In a time of upheaval the interpretive model would lead people to seek to change the way they think about what they or others are doing, rather than provide them with a theory by means of which they could change what they or others are doing, and in this way it supports the status quo. (Fay 1975, p90)

A social science that contributes to public deliberation needs to be not just interpretive but theoretical and critical. I suggest that this can be achieved by the rejection of 'science' as a paradigm for inquiry to be replaced by 'scholarship'.

Replacing 'science' with 'scholarship'

My aim is to find a paradigm for research that is not only more appropriate to the nature of the phenomena under investigation but one that supports public deliberation. I propose that for the researcher concerned with supporting public deliberation the paradigm of 'scholarship' is more conducive than that of 'science'. This argument draws from Grace's (1995) critique of 'policy science'. 'Policy Science' is a mode of analysis that extracts a social phenomenon from its relational context. It follows the model of natural science and is uninterested in the history or cultural antecedents of the phenomenon under investigation. The concern of policy science is to understand a current policy issue in order to formulate a rational and scientific prescription for action and future policy. According to Grace, policy science is attractive to governments because is promises to 'deliver the goods' in a technical and usable form. The work of management consultants, think tanks and much health services research in academic departments can be seen as informed by a policy science approach. It attempts to deliver a 'solution', such as a model of care that can be universally applied.

What is excluded in the policy science approach is consideration of the issue in relation to the deep structure of history, culture, politics, ideology and values. This exclusion is significant because many policy issues are manifestations of these deeper contradictions and, as Grace argues 'there can be no fundamental appreciation of these problems and no effective policy resolution of them, unless they are properly contextualised by detailed scholarship' (Grace 1995, p12). Policy scholarship, on the other hand, does not attempt to abstract problems from their relational settings, rather policy scholarship insists that a problem can only be understood in the complexity of those relations. Policy scholarship seeks to show how issues are constituted and shaped by their cultural settings. Thus the notion of 'scholarship' that is employed here relates to an attempt to locate the matter under investigation in its historical, theoretical, cultural and socio-political setting and integrate these relational features with contemporary fieldwork data. The aim is for a 'wider and deeper understanding' (Grace 1995, p12).

This agenda coincides with the aims of the 'anthropology of policy'. Anthropology has always rejected the ideal of the natural sciences as a model of investigation, instead seeking to understand a phenomena in its social and cultural context. This approach is of practical benefit to service managers and policy makers. For service managers it recognises that some aspects of quality improvement are more like an art than a science, requiring creativity and flexibility in adapting to aspects of the local context, rather than standardised solutions (Dixon-Woods 2014). By providing insight into the multiple perspectives on policy issues it can also help local managers make more creative and ultimately more acceptable, plans. By focusing on what actually happens in real-world contexts this approach is also of practical benefit to policy makers in helping make more realistic, and hence more effective, policies and in avoiding serious policy mistakes. Finally, it can support public deliberation by unsettling orthodoxies, certainties and the 'taken-for-grantedness' of the present and in so doing make room for alternatives.

CONCLUSION

In this thesis I have extended Foucault's theory of discourse to develop a theory of policy as discursive practice. My thesis is that policy is a cultural practice that combines knowledge and power so that truth itself becomes central to the operation of power. I argue that knowledge, expertise, rationality, and versions of truth are cultural resources that are mobilised in policy. Thus policy is not so much rational decision making as the *mobilisation* of rational decision making, as a cultural resource. Rational decision making is both the prevailing lens to view the world and a 'sacred value' in society, to such an extent that it has become naturalised as 'common sense'. It is this very 'taken-for-grantedness' that gives it potency when mobilised, through policy, in political contests. The way it works is rhetorical, in that it is impossible to argue against the proper order of things. But it is also, in a broader sense, discursive, in that it constitutes the subjectivities of policy actors, and constructs a world that privileges certain values as it excludes others.

Whilst other scholars have understood the operation of power as assemblages of knowledges, practices, rationalities and morality, they have not explicated how these elements are brought together. I argue that they are brought into alignment through the agential act of framing. The effects of framing, however, exceed the intentions of individuals, constituting the objects and subjects of policy, assigning authority and status, and shaping thinking and acting. This is a novel approach that links agency, rhetoric and discourse.

My approach challenges existing Foucauldian inspired approaches to the study of policy that emphasise the structuring and disciplining role of discourse without attending to the role of agency in the making and framing of policy. It does this, firstly, by showing the importance of agency in the operation of governmentality, and, secondly, by bringing to light the limits of governmentality. In particular I show how subjects contest and resist the frames of policy by mobilising alternative truths and local meanings, suggesting, in turn, the need for more sovereign regimes of power to compensate for the failure of governmentality.

I developed this thesis from ethnographic fieldwork undertaken in the NHS in England between 2007 and 2009. My approach was of 'studying through', that is, following a policy through time and space, exploring both how it was espoused in national policy documents and how it was

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enacted in practice. This approach enabled me to link the discursive origins and properties of policy to the intentions in, responses to and effects of policies. This link between policy and practice is a key feature of my theoretical contribution. Whilst other studies have explored the discursive origins of policies, empirical research has often been restricted to a focus on policy as presented in national policy documents or in the interview accounts of policy elites. Power, however, does not operate in policy apart from the effects on practice and what my study contributes is a focus on this link to the material effects of policies. My study therefore also highlights the benefits of an ethnographic approach to the study of policy.

The topic of my study emerged during fieldwork. I was struck by the way local managers would refer to the 'clinical case for change' when introducing plans to close hospital services. I noticed this because it was something I heard repeatedly and because it contradicted earlier planning documents where the financial rationale for given for the same plans. I was also struck by the rhetorical force of this rationale which appeared to me to have the effect of shutting down debate. This seemed significant in the policy context of increasing public involvement.

Hospital planning exemplifies what Schön and Rein (1994) call an 'enduring policy controversy'. Such controversies cannot be resolved by appeals to 'the evidence' because they are inherently political, involving not just a conflict in interests but in meanings. In the case of hospital planning it involves a fundamental conflict over what a hospital means. For health service managers and the medical profession hospitals are primarily the location of hospital services and the overriding concern is with the efficiency and operational effectiveness of those services. In contrast, for community groups hospitals are places of significant social and emotional attachments. My concern was not with how hospital services should be provided but with how, in this political contest, policies 'work' as instruments of governance.

The existing literature has failed to adequately capture the political nature of hospital planning. For the most part research in this area has treated the issue as technical and has been orientated to the question of how best to organise hospital services so as to improve efficiency and operational effectiveness. It is also largely normative in that is assumes the need for change and is focused on evaluating the 'success' of efforts to introduce such changes. Where the issue has been acknowledged to be political this has been presented as a simple trade-off between 'effectiveness' and 'access'. Alternative values have been either excluded from analysis entirely,

or classified as a 'barrier to change' and treated as an implementation issue. This technocratic approach to hospital planning is ill-suited to the needs of policy makers and local managers who must act in a social context where policies are no longer the outcome of politics but a source of politics, where the act of making policies public encourages people to reflect on their values and on who they are.

I found Rein and Schön's (1993) concepts of 'frames' and 'framing' to be a valuable resource for studying policy as they enable prevailing definitions of policy problems, and their implied solutions, to be located in their historical and social context. I used these concepts to show how there was a shift in the 'framing' of the policy to centralise hospital services, from a framing of centralisation as a means of making services more responsive to patients, to a framing of clinical necessity. In this new framing decisions to close hospital services were presented as based on the evidence and necessary to ensure safety. I interpreted this reframing as a rhetorical strategy adopted in response to community resistance to hospital closures and in the context of simultaneous policy rhetoric emphasising the importance of involving the public in decisions about the delivery of health services.

The terminology of 'reconfiguration' presents the policy of centralisation as the epitome of rational decision making. This in itself has rhetorical force in so far as rational decision making has become 'naturalised' as common sense. Added to this is the framing of clinical necessity which draws on the cultural authority of the medical profession and its association with truth. The framing of clinical necessity also gives the appearance of political neutrality, importance and urgency. A key component of this strategy was the co-optation of doctors. These doctors occupied hybrid roles as either medico-politicians (at the national level) or medical-managers (at the local level), what Waring (2014) refers to as political and managerial elites.

As a rhetorical strategy the framing was not successful in that other stakeholders were unconvinced of the need for change, indeed local doctors both recognised and resented their co-optation. Nonetheless, beyond rhetoric, power continued to operate in ways that were often difficult to see. Central to these processes were medical knowledge and expertise which served to frame the debate and undermine public involvement in decision making. Using data from fieldwork I showed how framing channels thinking in a particular direction and restricts the extent to which alternative courses of action can be considered. The classification of hospital

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planning as a 'clinical' and thus technical issue also defines the issue as the proper business of the medical profession and removes it from the agenda for public deliberation. I argue that health service researchers are implicated in these processes by sponsoring or otherwise accepting dominant policy frames and by supplying the knowledge and expertise through which these forms of power operate.

While my first theoretical contribution is the development of a theory of policy as discursive practice, my second theoretical contribution is the extension of governmentality theory to health services research. This builds on previous literature which has considered the role of professionals in governing social life and applied governmentality theory to health care settings (Johnson 1993, Rose and Miller 1992, Waring 2007, Ferlie et al 2012, Martin et al 2013). My argument is that our knowledge and analytical methodologies are not neutral but 'do things', 'in reality, with reality' (Royle 2000). Our knowledge and analytical methodologies embody both disciplinary and governmental forms of power, categorising and classifying the social world, assigning authority, and constructing subjectivities and versions of healthcare.

I concluded this thesis by proposing a reorientation from 'science' to 'scholarship'. Whilst science abstracts problems from their relational settings, scholarship seeks to show how issues are constituted and shaped by their social and cultural context. Scholarship supports public deliberation of policy issues and is of practical benefit to decision makings, opening up policy options and illuminating the different perspectives on policy issues thereby contributing to more creative, more acceptable, and more effective policies.

My research has implications for policy and practice, suggesting that efforts to 'co-produce' decision making, a central tenet of current policy, can be, in practice, co-optive devices. I showed how power operates before and during 'co-design' forums, shaping how the problem is understood, which solutions are considered (and which were not) and who is included in decision making. Public recognition of these strategies is likely to further undermine trust in the NHS.

My research also has implications for current developments in health services research, particularly the nascent fields of implementation and improvement science which seek an explicitly 'closer' relationship between researcher and health service managers. In England these

developments include the funding of Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) and the 'researcher in residence' model, which has as its explicit remit bringing 'the producers of evidence' closer to the 'users of evidence' (Rowley et al 2012, Marshall et al 2014). My research suggests that the connotations of objectivity and neutrality implied in this discourse are highly problematic and that there is a risk that these practices constitute a co-optation of the knowledge and analytical methodologies of health services research. It is here, at the nexus of research and practice, where I set out my agenda for future research.

My theoretical proposition is that policy evaluation, programme evaluation, implementation science, improvement science, and related developments form an assemblage of procedures of documentation, calculative technologies, rationalities and forms of thought that combine both disciplinary and governmental forms of power to embody and give effect to governmental ambitions. My proposed agenda for research asks 'what is being accomplished in these practices?', 'how does the knowledge and analytical methodologies of health services research shape the understandings and the actions of clinical staff and of patients?', 'how, in effect, does health services research 'work' as an instrument of governance?'. As my study has shown, this research would benefit from involving ethnographic observation of the practices of researchers, managers, clinicians and patients. The risk is that this agenda would be a critique of these developments without offering a potential alternative. This is not the intention. The intention is critique as a first step to a consideration of what academic independence may mean in this context and of what is the uniquely *academic* contribution to be made to policy and practice in health care.

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APPENDIX 1. NHS organisations in the Shire

Strategic Health Authority	Created in July 2006 from the merger of two Strategic Health Authorities.
The Shire PCT	Created in October 2006 following the reorganisation of English PCTs which reduced their number in England from 303 to 152. The Shire PCT was created from the merger of five PCTs. Budget £1.2 billon Catchment population 1.2 million
Forest	A Foundation Trust since 1st of April 2005. Catchment population 365,000 700 beds 2500 staff
Warton and Judford	Catchment population 450,000 Warton Hospital 250 beds Judford Hospital 400 beds
Shire General	570 beds 2300 staff
South Shire	Created in 1998 following the merger of three NHS trusts 500 beds 2500 staff
Smithton and Wildbridge	Established in 1999 from merger of two District General Hospitals Catchment population 420, 000 Wildbridge Hospital (Smithton Hospital located across the border in the neighbouring locality)

APPENDIX 2. 'Co-design' event slide pack

Slide 1

Welcome

Co-design 12 June 2007

Slide 2

What have you asked us to do

- Tell you what our policy is
- Tell you why we want to change it
- Tell you the changes we are planning and how they will improve things
- Ask you what you think of the proposals and whether you have any of your own
- What is the final policy and how was it influenced

Slide 3

What are we here to do tonight

- Understand the money
- Consider the clinical evidence in our commissioning intentions
  - Questions for clarity
  - Have we got the evidence right?
  - What are the next steps you want from us?
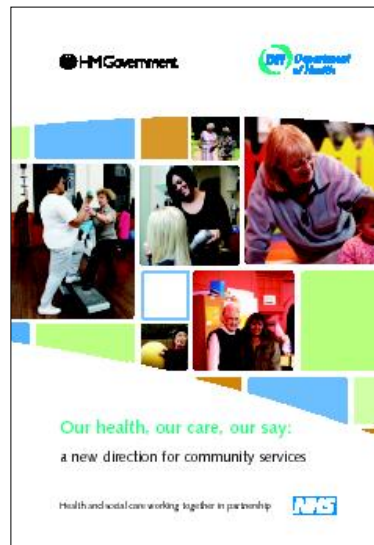

Slide 4

Commissioning Intentions
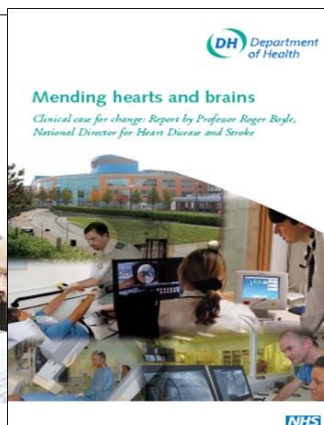
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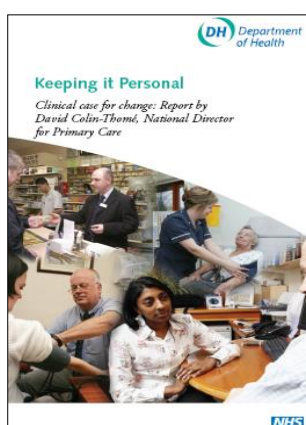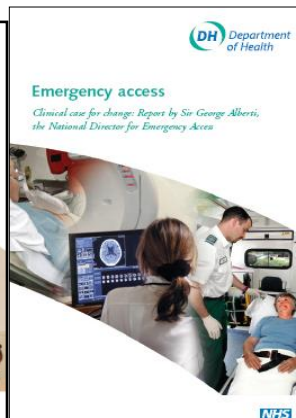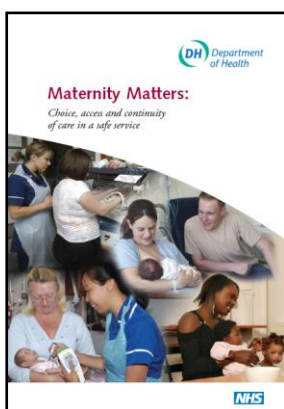
Co-Design 12 June 2007

Slide 5

National Drivers for Change

- The NHS Plan (2000) and the NHS

- Improvement Plan (2004)

- Our Health, Our Care, Our Say:

- A New Direction For Community Services

- Choosing Health: Making Healthier

- Choices Easier

- European Working Time Directive and specialisation

Slides 6 Fit for the future – based on national clinical evidence

Slide 7

Local Drivers for change

- **Population Growth:** In 2005, The Shire estimated to have a population of 1,075,500. Projections are that there will be 1,104,200 million people in the Shire by 2011 – growth of 2.35% on the 2006 population estimate

- **Ageing population:** those aged 65 and over is projected to increase in both England and the Shire. Albeit from 2010 at a slower rate in the Shire

- **Average life expectancy:** is significantly better than England average but there is a 5.4 year gap between those living in the fifth of wards with the highest life expectancy and those living in the fifth with the lowest levels.

Slide 8

Disease Prevalence 1

- **Fertility:** In 2005 there were 12, 303 registered live births in the Shire however, the Shire 'imports' births delivering up to 18, 000 babies per year

- **Coronary Heart Disease:** Rates for the Shire are lower than rates for England

- **Left Ventricular Dysfunction:** Rates are lower for the Shire than for England

- **Stroke and Transient Ischemic Attack:** Rates are lower for the Shire as a whole

- **Hyper-tension:** Rates for the Shire are lower than rates for England. However there is variation is some areas

- **Diabetes:** Rates for the Shire are lower than rates for England but prevalence is increasing – between 1993 and 2004 increased by two-thirds for men and doubled for women

Slide 9

Disease Prevalence 2

Chronic Obstructive Pulmonary Disease: Rates in the Shire are lower than in England

Epilepsy: Higher rates of epilepsy are observed in east Shire comparable to the national rate

Hypo-thyroidism: Higher rates of hypo-thyroidism are observed across the Shire except xx and xx and xx and xx

Cancer: Rates of cancer are slightly lower in the Shire than in England as a whole

Mental Health: Rates are lower than England

Asthma: Rates are lower than England

Slide 10

Disease Prevalence 3

Dementia: Upwards of one in 20 of the population aged 65 and over in England and Wales suffers from a significant degree of dementia

Alcohol-related hospital admissions are increasing and there are higher drink related deaths in deprived areas

Death rates due to road traffic injuries, smoking, heart disease and cancer in Surrey are all significantly lower than the national average, although 1, 550 people still die each year from the effects of smoking

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Slide 11

Commissioning for improvement 1

- The Shire PCT has reviewed services delivered to our population against the clinical evidence base and professional guidance and standards produced by the Royal Colleges
- The PCT intends to commission high quality health care against the evidence base and appropriate professional standards to optimise health care outcomes for our population

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Slide 12

Commissioning for improvement 2

- Units (or staff) treating more patients achieve better outcomes – volume effect
- Trend toward specialisation and sub-specialisation with growing evidence of better outcomes for certain diagnoses treated in specialised units or by specialised teams – resource centralisation effect

Effective Health Care December 1996

Soljak M; BMJ 2002; 325:787-8

Improving Outcomes Guidance, NICE November 2004

Intercollegiate Working Party for Stroke, National Clinical Guidelines for Stroke, Royal College of Physicians 2004

Slide 13

Commissioning for improvement 3

Specialization can have a great impact on quality

Treatment	Mortality reduction Percent	Comments
Pancreatectomy	63%	• Difference between hospital volume =1 and >10 per year
Abdominal aortic aneurysm	58	• Difference between few (<6) and many procedures in hospital per year
Colorectal resection	42	• Difference between surgeon volume <5 and >10
Breast cancer	37	• Difference between yearly hospital volume <10 and >150
Intestinal operations	29	• Difference between hospitals performing more and less the 40 operations a year
Acute myocardial infarction	17	• 30 day mortality difference between 1st and 4th quartile

Source: NHS: Effective Health Care December 1996; Journal of clinical oncology

Slide 14

Commissioning for improvement 4

- Advances in technology may favour centralisation – angioplasty as treatment for acute heart attacks

American College of Cardiology/American Heart Association Clinical Competence Statement June 2000

- In the future primary angioplasty may become the first treatment for AMI – this is a specialised technique that will be undertaken in specialist centres

Boyle R. Mending hearts and brains – Clinical case for change; London: Department of Health,

Advances in technology may also favour moving care into community (including home) settings

- Near patient testing
- Telehealth and telecare systems

Slide 15

Commissioning for improvement 5

- Centralisation and decentralisation are not mutually exclusive
- Centralisation is vital for some services where there is evidence of a positive relationship between large volumes of activity and clinical outcome

Delivering high quality surgical services for the future. Royal College of Surgeons of England, 2006

- Decentralisation may be appropriate where advances in technology or changes in staff skill use allow services previously delivered in hospitals to be delivered in other settings closer to the patients home

Our health, our care, our say. Department of Health, 2006

Slide 16

Commissioning for improvement 6

- Expert opinion from medical Royal Colleges on population base to support specific services
- Major trauma 3 million
- Emergency surgery 450,000 – 1 million (depending on surgical specialty)
- Level 3 neonatal care 1 million

Better care for the severely injured. Royal College of Surgeons and British Orthopaedic Association, 2000; Delivering high quality surgical services for the future. Royal College of Surgeons of England, 2006; The provision of vascular services. The Vascular Society of Great Britain and Ireland, 2004; Report of the Neonatal Intensive Care Services Review Group. Department of Health, 2003.

Slide 17

Commissioning for improvement 7

- **Travel times:** much of the evidence on the relationship between travel time, treatment and clinical outcome is focused on trauma - this frequently refers to the "golden hour"

- The "golden hour" is founded on the idea that trauma patients have better clinical outcomes if they receive definitive care within 60 minutes of the occurrence of their injuries

- There are no sufficiently large, well-controlled studies in civilian populations to support or refute the concept of the "golden hour"

  Lerner EB, Moscati RM, Acad Emerg Med 2001; 8(7): 758-60

- However, evidence does show that head-injured patients have a 10% lower risk of mortality if taken to a specialist trauma centres than to lower level facilities

McConnell et al. Mortality benefit of transfer to level I versus level II trauma centers for head-injured patients. Health Serv Res. 2005 Apr;40(2):435-57

Slide 18

Commissioning Intentions – vascular

- The evidence: vascular services require a minimum population of one million to provide a robust service

Emergency work forms a substantial proportion of the workload including leaking abdominal aortic aneurysms where evidence also shows mortality rates of up to 95% under the care of a non-vascular surgeon compared to as low as 35% if transferred to a vascular centre

The provision of vascular services. The Vascular Society of Great Britain and Ireland, 2004

- What this could look like?

A hub and spoke comprehensive vascular service for the population of the Shire provided within the Shire

Slide 19

Commissioning Intentions – cardiology

- The evidence: the most common cause of death. Evidence supports ready access to angioplasty and thrombolysis. Most Shire patients travel to London for emergency angioplasties but the service is delivered by Shire-based consultants

- "The evidence for pre-hospital intervention is strongest for arterial reperfusion after acute myocardial infarction (AMI), that is, thrombolysis after heart attack"

Boyle R. Mending hearts and brains – Clinical case for change; London: Department of Health, 2006

- What this could look like?

- Shire delivered cardiology services to include all urgent angioplasties with a view to extending to emergency services in due course

Slide 20

Commissioning Intentions – stroke

- The evidence: admission to a specialist unit and then specialist stroke rehabilitation saves lives and reduces disability

- What this could look like?

    o Stroke services that enable patients rapid admission to and early CT/MRI scanning at dedicated stroke units with rapid treatment as appropriate and further access to specialist stroke rehabilitation

    o The acute trusts could develop their stroke services to meet this model which could be aligned with cardiac services

Slide 21

Commissioning Intentions – renal

- The evidence: the Renal National Service Framework sets out the evidence based care expected but does not set a recommended population base however, the Shire is the only major county without an acute renal centre
- Specialist renal services are currently provided by London
- Estimated that between 60 – 80 new Shire patients will need renal support each year
- What this could look like?
    - The Shire PCT commissions a specialist inpatient renal centre (not transplantation) so Shire patients can be treated in Shire and not travel unnecessarily

Slide 22

Commissioning intentions – maternity

- The evidence:
- Units delivering more than 4000 births per year should have 60 hours a week consultant cover by 2008
- With a move to 168 hours by 2010 with a midwife to woman in labour ratio of 1.2 to 1.4 to 1
- Smaller units should have minimum of 40 hours per week
- Obstetric units also require dedicated obstetric anaesthetic services

The future role of the consultant. Royal College of Obstetricians and Gynaecologists, 2005

Towards safer childbirth: minimum standards for the organisation of labour wards.

Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, 1999.

CNST Maternity Clinical Risk Standards. NHS Litigation Authority, 2006

Slide 23

Commissioning intentions – maternity

- What this could look like?
    - Maternity services at Warton and Judford, Forest, Shire General and South Shire all deliver over 4000 births per year and will have 60 hours of obstetric presence by 2008 and 98 hours a week by 2009
    - Judford provides a level 3 neonatal intensive care unit that meets required standards for medical staffing and population to remain clinically safe. Between 125 – 175 Shire babies a year require intensive care

Report of the Neonatal Intensive Care Services Review Group. Department of Health, 2003.

Slide 24

Commissioning intentions – maternity

- What this could look like?
- However, the number of births at Wildbridge hospital under 2000 with consultant cover available for 24 hours a week
- Smithton delivers just under 3000 births per year with 28 hours of consultant obstetric cover
- Wildbridge and Smithton has proposed to co-locate maternity and paediatric services at Smithton with an option to deliver home births at Wildbridge.

Slide 25

Commissioning intentions – emergency surgery

- The evidence: required to meet explicit clinical standards for example, dedicated emergency teams and theatres who don't do planned surgery
- Preferred population base is 450,000 – 500,000
- Delivery of highly specialised emergency care in specialist centres without initial care at local hospitals but, the evidence also supports local, nurse practitioner delivered minor care injury care

Delivering high quality surgical services for the future. Royal College of Surgeons of England, 2006

- What this could look like?

Discussions due to take place in the last week of June with the acute trust working group but trusts could deliver this through a networked model of emergency surgery

Slide 26

Commissioning intentions – over to you

- The evidence: questions for clarity?

- The evidence: have we got it right?

- What next steps would you like us to take?

APPENDIX 3. Primary study interview topic guide

1. <u>**Context – personal and organizational**</u>
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 you position within the Trust?
d. How long have you been working in the LHE (considering previous jobs) and where were you before?

2. <u>**Strategic change (influences on decision making and organizational development)**</u>
a. What are the current issues in (name of the organization) with respect to organisational change?
b. <u>Probe</u>
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. <u>Probe</u>
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. <u>**LHE**</u>
a. What are the current issues with respect to LHE-wide change?
b. <u>Probe</u>
      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. <u>Probe</u>
      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. <u>Probe</u>
      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. <u>Probe</u>
    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. <u>Probe</u>
    a. How does the Trust initiate collaboration?
    b. What are the drivers to collaboration?
n. What are the main factors influencing collaboration?
o. <u>Probe</u>
    a. What are the main barriers/success factors in collaboration?

4. **<u>System reforms (inspired by central government)</u>**
a. How are (national) system reforms (e.g. PbR, patient choice, reconfiguration, Foundation Trusts, PbC) impacting on existing relationships in the LHE?
b. <u>Probe</u>
    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. **<u>Performance</u>**
a. In what areas is the Trust performing well and in what areas is performing less well?
b. <u>Probe</u>
    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 4. Ethics 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:

Document	Version	Date
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	Please quote this number on all correspondence

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 Gover Street

London

London - Surrey Borders Research Ethics Committee

Attendance at Committee meeting on 12 July 2006

Committee Members:

Name	Profession	Present?	Notes
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:

Name	Position (or reason for attending)
Ms Amanda Jackson	REC Assistant
Mrs Sheree Manson	Committee Co-ordinator