

**The politics of innovation: a critical analysis of the conditions in
which innovations in health care may flourish.**

Ann Louise McMahon

**Submitted in accordance with the requirements for the degree of
Doctor of Philosophy**

**The University of Salford
Institute of Health and Social Care Research
Salford Centre for Nursing, Midwifery and Collaborative Research**

April, 2008

CONTENTS

Acknowledgements	v
Abstract	vi
LIST OF FIGURES	vii
LIST OF TABLES	viii
PART I INTRODUCTION & METHOD	1
Chapter 1 Introduction	2
Chapter 2 Method	11
2.1 Introduction	11
2.2 Epistemological Standpoint	13
2.2.1 The problem with the orthodoxy	13
2.2.2 Critical management studies (CMS)	15
2.3 Case Study Methodology	19
2.3.1 Case selection, access negotiation and data collection.....	20
Case study 1	20
Case Study 2.....	23
2.3.2 Data sources.....	25
Case study 1	28
Case study 2	31
2.3.3 Data analysis	33
2.4 The Healthcare Policy Context	37
2.5 Ethical Considerations	46
2.6 Summary	48
PART II THE POLICY CONTEXT	49
Chapter 3 A view from the world of policy	50
3.1 Introduction	50
3.2 Thematic Framework	51
3.3 Innovation	55
3.2.1 The meaning of innovation	56
3.3.2 Legitimacy of innovation	62
3.3.3 Drivers of innovation.....	70
3.3.3.1 Innovation as a political imperative.....	70
3.3.3.2 Innovation as a consequence of increasing demand for healthcare	72
3.3.3.3 Innovation as a result of factors which impact on the supply of health services.....	75
3.3.3.4 The slow uptake of innovations as a driver of innovation.....	77
3.3.4 The policy response.....	78
3.3.4.1 Pay modernisation.....	79
3.3.4.2 Structural developments.....	80
3.3.4.3 National targets and standards	82

3.4	Stakeholders.....	85
3.4.1	The public as stakeholders.....	85
3.4.2	The media as stakeholders.....	88
3.4.3	The UK Governments and politicians as stakeholders.....	88
3.4.4	Managers as stakeholders.....	91
3.4.5	NHS staff as stakeholders.....	93
3.5	Summary.....	96
Chapter 4 Discussion of Policymakers' Perspectives.....		97
4.1	Introduction.....	97
4.2	A Short History of the NHS Policy Context (1948-1997).....	99
4.3	The Blair Years (1997 – 2007).....	108
4.4	Innovation: the Policy Context.....	113
4.4.1	The meaning of innovation.....	113
4.4.2	The innovation imperative.....	114
4.4.3	The problem with orthodox managerialism.....	116
4.4.4	The rhetoric of partnership.....	119
4.4.4.1	Medical science and innovation.....	120
4.4.4.2	Support for innovation.....	121
4.4.4.3	The efficacy of the commodification strategy.....	124
4.5	Summary.....	128
PART III THE CASE STUDIES.....		129
Chapter 5 Case Study 1 - The Farmers' Health Project.....		130
5.1	Introduction.....	130
5.2	Stakeholder Analysis.....	134
5.2.1	Farmers as the focus?.....	135
5.2.2	Nurse practitioners as the focus?.....	141
5.3	The Nature of the Project.....	152
5.3.1	Cultural sensitivity.....	155
5.3.2	Foot and mouth.....	160
5.4	Sustainability.....	164
5.5	Summary.....	169
Chapter 6 Case Study 2 – “The Corner”.....		175
6.1	Introduction.....	175
6.2	Stakeholder Analysis.....	183
6.2.1	The media, the controversy and the Roman Catholic church.....	185
6.3	The Nature of The Corner Project.....	189
6.3.1	Appointment of the project coordinator.....	189
6.3.2	Appointment of the project team.....	192
6.3.3	The Corner culture.....	194
6.3.4	The management group.....	200
6.3.5	The acquisition of culturally acceptable premises.....	203
6.3.6	Team building and policy development.....	206

6.4	Macro-, Meso- and Micro-Politics	208
6.4.1	Macro-level politics	208
6.4.2	Meso- & micro-level politics.....	210
6.5	Summary	223
<i>PART IV DISCUSSION, CONCLUSIONS & RECOMMENDATIONS.....</i>		227
<i>Chapter 7 Power, Politics and Innovation.....</i>		228
7.1	Introduction	228
7.2	Power.....	229
7.2.1	Lukes on power	230
7.3	Power and Innovation	239
7.3.1	Partnership.....	241
7.3.2	Purpose	262
7.3.3	Politics	265
<i>Chapter 8 Conclusions.....</i>		270
8.1	Introduction	270
8.2	Were the aims achieved?	271
8.3	Contribution to knowledge	271
8.4	Limitations of the study.....	271
8.5	In conclusion.....	272
<i>References.....</i>		278

Acknowledgements

Without the support and encouragement of my friends, colleagues and family I would not have started or completed this thesis. I am indebted to so many, including: Professor Julia Davies, for creating the MPhil programme in critical management at Lancaster University, which challenged and inspired me beyond measure; Dr Charles Hendry, for persuading me to go the extra mile, and aim beyond an MPhil degree; Jenifer Caveney and Dave O'Carroll for their endless encouragement and for 'holding the fort' at work, when I had my head down, and Dave, Beth and Johnny Clifford for their infinite love and tolerance.

The relationship between a doctoral candidate and her supervisors can make or break the process. When I arrived at Salford, my doctoral journey was close to breaking point. The quality of supervision from Professor Martin Johnson and Dr Carol Haigh has been first class. Without it, I would not have reached completion.

This study offers an interpretation of the conditions in which innovations in health services may flourish. I am indebted to the many individuals who freely gave of their time and shared their thoughts and experiences of innovation with me.

Abstract

Innovation and research have been key features throughout the sixty years the UK has publicly funded a National Health Service. Over the last thirty years, in planning health service reforms, successive Governments have drawn on the values of the private sector, where innovation is considered an imperative if firms are to survive in the global market place. Consequently, the innovation imperative is now at the heart of UK health policy.

Traditionally innovation is regarded as a technical rational endeavour resulting from research and development activity. In order to examine the assumptions underpinning this orthodox view, this study takes a critical perspective. A view from the world of policy, captured through the analysis of semi-structured interviews with a cohort of eleven policymakers using the *Framework* method is complemented with an inductive examination of two innovations in health care, using case study methodology in which twenty-six participants were interviewed in some depth. Analysis of interviews with policymakers highlighted the contested nature of the concept of innovation, the range of, sometimes competing, stakeholder perspectives regarding the legitimacy of an innovation and the tensions and paradoxes in the system. Both cases examined sought to identify and address the health care needs of groups of people who do not routinely access mainstream health services. They were compared and contrasted by drawing on Lukes' conceptual analysis of the concept of power, and served to illustrate the complexity of the innovation process, the multiplicity of stakeholders involved and the potential of competing agendas to stifle innovation.

This study demonstrates how political processes at an individual, organisational and national level have the capacity to impact on the potential of innovations in health care to flourish. It offers a range of factors that policymakers and practitioners may wish to consider when seeking to foster innovation in health care.

LIST OF FIGURES

Figure 3.1: Respondents' views of innovation.....	55
Figure 3.2: The 5 P's of innovation	56
Figure 3.3: The legitimacy of an innovation:a typology of perspectives.	62
Figure 3.4: Groups of stakeholders in innovation	85
Figure 3.5: NHS staff approaches to innovation	93
Figure 5.1: Farmers' Health Project stakeholder analysis.....	135
Figure 5.2: The Interconnected Themes within the Farmers' Health Project.....	170
Figure 6.1: Range of issues raised by The Corner Young People.....	184
Figure 6.2: The Corner stakeholder analysis	185
Figure 7.1: The relationships between the critical incidents and the themes	240
Figure 7.2: The relationships between the themes.....	266

LIST OF TABLES

Table 2.1: Data Collection Timelines	12
Table 2.2: Epistemological routes of scientific knowledge in nursing (and health) (adapted from Thompson (2000)).....	13
Table 2.3: Underpinning Principles of Critical Management Studies (after Reynolds 1999).....	17
Table 2.4: Limitations of data sources (adapted from Yin (2003b page 86)).....	27
Table 2.5: Case Study 1 Data Sources.....	29
Table 2.6: Semi-structured interview schedule used in case studies.....	31
Table 2.7: Case Study 2: data sources.....	33
Table 2.8: Probing questions used to analyse critical incidents (adapted from Angelides (2001)).....	34
Table 2.9: Policymakers interviewed.....	39
Table 2.10: Semi-structured interview schedule used with policymakers	40
Table 2.11: The Key features of Framework (Ritchie & Spencer 1994 p 176).....	41
Table 2.12: The five key stages in Framework.....	41
Table 2.13: Index of Concepts.....	44
Table 2.14: Thematic Framework.....	45
Table 3.1: Section of chart illustrating examples of policy-related innovations.....	54
Table 4.1: Models of healthcare in the UK post devolution (after Greer 2004).....	112
Table 4.2: Types of Innovations (Buchanan 2003).....	113
Table 4.3: NICE guidance and recommendations.....	125
Table 6.1: Remit of Senior Health Promotion Officer (Redman 1992)	177
Table 6.2: The Joint YMCA Community Education service proposal (Easton1997).....	178
Table 6.3: Aims of the Young Person's Health Project Consultation Exercise (Redman1992).....	179

Table 6.4: Recommendations of the Young Person's Health Project Consultation Exercise (Redman1992).....	180
Table 6.5: Key issues raised by Redman (1992) Report (Easton 1997)..	181
Table 6.6: Project Specification	182
Table 6.7: Project Premises Specification.....	182
Table 6.8: Quote on wall of original project coordinator's office	196
Table 6.9: Young people's views of what drop-in facility should provide (Easton1997).....	205
Table 6.10: Refurbishment specification (Easton1997).....	205
Table 6.11: Nursing and Midwifery Council Code of Professional Conduct.....	213
Table 6.12: Nursing & Midwifery Council Guidelines on records and record keeping.....	218
Table 6.13: The Corner Critical Incidents.....	224
Table 7.1: Illustration of the One-Dimensional View of Power.....	232
Table 7.2: Typology of power after Bachrach and Baratz (1970).....	234
Table 7.3: Illustration of the Two-Dimensional view of Power.....	234
Table 7.4: Illustration of the Three-Dimensional view of Power.....	237
Table 7.5: Hierarchy of Evidence.....	242

PART I
INTRODUCTION & METHOD

Chapter 1 Introduction

The aim of this study is to contribute new insight into the conditions in which innovations in healthcare that seek to identify and address the healthcare needs of groups of people who not routinely access mainstream services, may flourish. The clarity and focus of this aim developed over time. As a student, on a taught MPhil programme in critical management studies (CMS) between 1997 and 2001, I was encouraged to think critically about a wide range of issues. Through the teaching and the debate with my fellow cohort members, both within and beyond the classroom, I was challenged to articulate and confront the fundamental assumptions that underpinned my life and my work. It was a destabilising process, at times painful, at other times exhilarating. There were occasions when I felt bereft, as if I did not know what I thought about or believed in anymore. Reynolds (1999) notes that critical reflection can prove to be mentally or emotionally unsettling and lead to disruption in home and, or, work life. This destabilising effect is not uncommon within CMS and Reynolds suggests that it is 'the dark side'. Whilst Reynolds problematises this effect, other CMS scholars, such as Knights (2005), argue that disruption is a legitimate and necessary part of the learning process. From my own position, I side with Knights and place significant value on the personal learning that resulted from this process.

From a professional point of view for instance, CMS led me to surface and question some of my deeply rooted assumptions. For example, in my role as Research and Development Adviser at the Royal College of Nursing, I had previously published an article in a professional journal suggesting that recently announced funding arrangements for healthcare research within the UK Government health departments created opportunities for nurses and nursing (McMahon 1997). Later, upon critical reflection, I concluded that my analysis had been too superficial. When I looked more deeply into the context in which healthcare research funding was distributed (McMahon 1999), I suggested that it was extremely unlikely that there were any real opportunities for nurses and nursing, in this particular case (McMahon 2002). The

healthcare research agenda was effectively colonised at the inception of the NHS in 1948 by the medical profession, who as part of their professionalising strategy sought to underpin their practice with a solid, scientific foundation (Klein 2001). Any endeavour to destabilise that power base would inevitably meet with formidable opposition.

Perhaps more fundamentally, I began to re-examine why I was focussing my energies on research in nursing. When I left school, I went to university to study for a degree in Biochemistry. Mixing with more senior students at university, who were exploring their career options post graduation, I rapidly reached the conclusion that I did not want a desk based job in, for example, the civil service, nor did I want to pursue a career centred on laboratory work. I knew that I wanted to work with people and I was attracted to the caring professions. After a summer job working as a nursing auxiliary in an inpatient facility for young, chronically sick people, I was clear that I wanted to be a nurse. I moved to a higher education institution where I could study for a degree in nursing. Inspired by the quality of teaching I felt privileged to receive from a mental health nurse academic, I registered as both a general and mental health nurse. Post-registration, I became increasingly interested in the mental health of people with physical illnesses and elected to specialise in cancer nursing. Working in a tertiary specialist centre, I was in a strong research environment. As a clinical nurse specialist I was recognised as a pivotal member of the multidisciplinary research team and often invited by principal investigators to contribute to the development and delivery of research protocols. These included, for example, surgeons trialling implantable drug delivery systems (Lambert et al. 1988) and medical oncologists trialling new combinations of cytotoxic drug regimes (Anderson et al. 1987). Whether the aim was to find a cure, halt or slow down the progression of disease or improve patients' experiences, research was a central component of the work of the centre and an integral part of my daily routine. It was 'a given' that research was the right thing to do and that we were doing the right research.

One nursing colleague, whom I met during a clinical placement on the ward where I was working whilst she was undertaking a Masters degree in nursing, particularly inspired me. She went on to complete her doctorate and specialise in teaching communication skills to nurses and doctors. By participating in her doctoral research, I not only improved my communication skills but reached the conclusion that I too should undertake postgraduate studies and develop my own research skills. I went on to complete a Masters degree and investigated the potential of cognitive behavioural interventions to reduce the severity of anticipatory nausea and vomiting, a particularly unpleasant side effect experienced by some patients receiving cytotoxic chemotherapy (McMahon 1989a; McMahon 1989b).

After completing my Masters degree and returning to the clinical environment, I had the distinct and uncomfortable sense that some of my senior nursing colleagues perceived my higher degree as a threat. In addition, the small team of clinical nurse specialists, of which I was a part, felt that we fared particularly badly in the newly implemented 'clinical grading' review. This particular job evaluation scheme was supposed to reward clinical expertise. In theory, it should have worked in the favour of clinical nurse specialists. In practice, in the hospital I was working in it was implemented by managers who, to all intents and purposes, appeared to reward managerial skills above all else. My peers and I undertook a national survey of similar posts and this confirmed our assessment. One colleague, the most experienced member of our team, moved north and was graded two grades higher for undertaking a comparable role. After a great deal of soul searching, I reached the conclusion that the only way I could survive the system was by getting myself into a more senior position from where, I believed, I could endeavour to change it. I, therefore, applied for, and took up, a senior post in a district general hospital, where I would lead a small team responsible for research and development across the organisation. Here I was able to apply and develop my research skills and bring about changes in practice. For example, the implementation of our research recommendations led to the development of more patient- and carer-centred respite service (Darby, Lam, & McMahon 1991) and, through the development of audit systems, we introduced a clinical risk management

programme to, for example, reduce the incidence and improve the management of pressure sores (Jackson, McMahon, & Cage 1993). I believed passionately that applied research led to better patient experiences and better patient outcomes (McMahon 1998). This was, for me, an unquestionable given.

Translating national policy into local developments was a significant part of my role and so, for example, I worked closely with social service colleagues when the NHS and Community Care Act (Department of Health 1990) threatened to impact negatively on hospital discharge and patient throughput, in order to ensure the best outcomes for our patients. As a consequence of our close working relationship, I was able to persuade senior social service managers to commission a nurse-led research team to evaluate the impact of the systems we had put in place on patients and their families.

My mantra in this post was that we should uphold patient dignity and treat all of our patients with respect. To expect our staff to do this, they too should expect the same treatment from their peers, managers and patients. In my sixth year in post, due to fiscal pressures on the NHS, a new deputy director of nursing was appointed specifically to review the nursing workforce and cut costs. Adopting a 'macho' management style, she made swingeing cuts in the nursing workforce and downgraded as many staff as she could. I had never seen morale so low and I felt deeply compromised and completely powerless. Once again, I reached the conclusion that I should move into a position where I might have more influence. I started actively applying for Nurse Director positions in the NHS when, as I saw it, a 'once in a life time' opportunity was advertised. The Royal College of Nursing (RCN) was seeking to appoint a "Research Officer" as a professional adviser. At the time, I was a member of a group within the RCN, drawn together by the then Director of Nursing Policy and Practice, to examine the future of nursing leadership. As a result of this experience, I felt that working for the RCN would sit more comfortably with my own professional values and that I could play a role in actively promoting and supporting research in nursing, which, as stated above, I fundamentally believed was good for patient care and public health.

CMS led me to question my assumptions, my reasons for getting up in the morning. I was working with the nursing research community to promote and develop research within nursing. I was driven, upon reflection, on autopilot, by my unwavering belief that research made a difference. My time as a CMS postgraduate student stopped me in my tracks and led me to question the legitimacy of my assumptions. Was research the right thing for nurses (and other members of the healthcare team) to do and were nurses (and other members of the healthcare team) doing the right research? Did research and development actually lead to improvements in health and healthcare?

I was not the first to ask these questions and I will not be the last. The National Health Service Act (Great Britain Parliament 1946) formally gave the Minister of Health powers to “conduct research or assist by grant, research into matters relating to the causation, prevention, diagnosis of illness or mental defectiveness” throughout the NHS. In the early 1970’s, Government investment in NHS research was formally examined by Lord Rothschild (1971), who recommended that a customer / provider relationship would enable a more effective alignment between the respective agendas of policymakers and researchers. Research conducted within the NHS was examined once again within a House of Lords Select Committee in 1988. This committee concluded that the impact of research activity within the NHS was severely hampered by the absence of a coherent strategy for the articulation of research needs and a lack of attention to the implementation of research findings (House of Lords Select Committee on Science and Technology 1988). As noted above, the NHS research agenda had been colonised by the medical profession and the prevailing view at this time was that NHS research was investigator-led and did not address the needs of the NHS. This was considered problematic because it allowed powerful professionals to pursue their own research interests in order to further their careers and their academic standing, at the expense of the NHS. Nevertheless, the Government of the day rejected the politically challenging recommendation that an independent body should be established to identify research priorities within the NHS and instead appointed a medical academic, Professor Michael

Peckham (later, Sir), as the first NHS Director of Research and Development (R&D), to develop a strategy for R&D within the NHS. Perhaps the thinking was that only a medical academic could harness the expertise of the medical establishment and at the same time challenge vested interests. The argument for shifting the balance of power was to ensure value for money (VFM) through a measurable return on the investment of public funds in health research. The first NHS R&D Strategy "Research for Health" was published by the Department of Health (1991a). It had three broad aims, to provide the NHS with the capacity to identify problems appropriate for research, to make NHS decision making research-based and to improve the relationship of the NHS with the science base as a whole, rather than solely with medical research (Smith 1991).

R&D Strategies were subsequently developed in all four countries of the UK. Their purpose was common:

"to ensure that the content and delivery of care in the NHS is based on high quality research relevant to improving the health of the nation....."
(Department of Health 1993)

To this end, there has been considerable investment in the synthesis of research evidence in order to increase certainty and thus provide more definitive, research-based guidance to planners, policymakers, practitioners and managers. The implicit assumption within the R&D strategies was that there is a cause and effect relationship between R&D and improvements in health and this is predicated as a linear relationship from research through to development through to innovation. Clearly this assumption sat very comfortably with my, arguably naïve, belief that applied research, almost inevitably, offered the potential of better patient experiences and better patient outcomes. By taking a more critical view, I began to question whether my belief could, or should, be taken for granted. I began to consider the possibilities and the consequences of vested interests. I concluded that I should shift my gaze from research as the presumed means to an end, that is better patient experiences and health outcomes through 'innovation', and

focus on these ends, and cast aside any preconceptions about how these ends might be achieved.

There is a body of knowledge, that challenges the conventional wisdom, that science follows a logical rational linear pathway through to innovation and discovery. This includes, for example, the works of Peter Medawar and Thomas Kuhn. Medawar (1969) challenged the belief that medical scientific advance was achieved through laborious, detached observation, and argued instead that true discovery was in fact a far more creative process. Based on his observation that scientists organise themselves into groups who operate within “paradigms”, or conceptual boxes, Kuhn’s (1996) thesis was that it takes nothing short of a crisis within a paradigm to bring about an innovation. Any attempt to innovate within a paradigm would at best be resisted and at worst vilified as it would sit outside the “common sense” dominant view. For example, today we take it as a given that the earth travels around the sun. At the time Polish astronomer Copernicus (1473 – 1543) muted this proposition, it was considered blasphemous to suggest that the earth was not at the centre of the universe. Galileo (1564-1642), an Italian mathematician, was later tried in a court of law for supporting Copernicus’ position, where it was argued that to assert that the earth revolves around the sun was as erroneous as to claim that Jesus was not born of a virgin (Miller 1996).

In more recent times, Le Fanu (1999) charted the rapid rise in medical knowledge through developments in clinical science, technology and pharmaceutical innovation over the last sixty years. He observed that most of the major breakthroughs, such as the discovery of penicillin, were serendipitous and an indirect or unanticipated consequence of scientific programmes. Examining the serendipitous discovery of penicillin as a case study, D'Andrade (1999) concluded that the development and application of new drugs were not dependent on scientific understanding of the underlying cause of a given disease. Penicillin was observed to kill bacteria long before the mechanisms by which this happened were understood. However, in order to turn a discovery such as the properties of penicillin into a marketable drug, the resources of industry were required.

More recently, Greenhalgh and colleagues published a systematic review of the evidence regarding the diffusion of innovation in healthcare organisations. In their conclusions they identified areas for further research. These included:

“The main gap in the literature on complex service innovations in healthcare organizations is an understanding of how they arise, especially since the process is largely decentralised, informal and hidden from official scrutiny.” (Greenhalgh et al. 2005 p 17)

and:

“The empirical literature in the implementation of service innovations in healthcare is currently extremely sparse. We recommend.....a wide range of in-depth qualitative or mixed methodology studies into the process of implementation in organizations should be commissioned, perhaps ideally as responsive funding to capture innovative ideas as they emerge and spread.” (Greenhalgh et al. 2005 p 18)

In this study, I have, therefore, taken an inductive approach and tried to put to one side any of my previously held assumptions about research and innovation, in order to examine from a critical perspective the conditions in which innovations in healthcare are developed and sustained. There are four parts to the study. In part one, a chapter outlining my epistemological standpoint and the methods employed, complements this introductory chapter. From a critical perspective, I have applied case study methodology (Stake 1995; Yin 2003b) to examine two cases of innovation in healthcare inductively. Both cases are of innovations that sought to identify and address the healthcare needs of people who do not, as a routine, access mainstream health services. As top-down policy innovations appeared to impact on both cases, these data were complemented with a view from the world of policy. In section two, I present my analysis of semi-structured interviews with a cohort of eleven policymakers based in Scotland and England, using ‘*Framework*’ (Ritchie & Spencer 1994), a method of choice within the policy analysis field, as my method of analysis. A discussion of this policy context, drawing on the political history of the National Health Service, completes the second section. In two chapters in part three, I present my analysis of the two case studies of innovation. By drawing on current debates within the literature, I discuss my

analysis of these cases in part four. This section incorporates a final chapter that draws together conclusions, examines the limitations of the study and offers recommendations for policy, practice, education and future research.

Chapter 2 Method

2.1 Introduction

The initial aim in this study was to examine the conditions in which innovations in the provision of health services can flourish, from a critical and arguably innovative perspective. Taking an inductive approach, the research focus became sharper during the course of the research process. This chapter describes that process, providing a rationale for the epistemological standpoint and methodological choices made. I discuss the ethical implications of the study in the penultimate section of the chapter.

Utilising an exploratory case study methodology (Yin 2003a), I examined two cases of innovations in health service provision. The first sought to address the healthcare needs of farmers in the north west of England. The second endeavoured to identify and address the health needs of young people who did not as a rule access mainstream services, in a city on the east coast of Scotland. In both of these cases, it became apparent that current NHS policy had a significant impact on their development and sustainability. I, therefore, elected to incorporate a healthcare policy perspective into my research design and so identified and interviewed a sample of healthcare policy makers. Punctuated by poor health, data collection occurred over a protracted period from September 2000 through to April 2002. Table 2.1, for example, illustrates the timescales over which interview data were collected.

This chapter begins with a rationale for the critical epistemological standpoint taken in this study. In the following section, the case study methodology used to examine these innovations in practice is presented and discussed. The concluding section details the methods used to incorporate a policy perspective into the research design.

Table 2.1: Data Collection Timelines

DATE	Interview Data Collection FHP	Conversion MPhil to PhD	Interview Data Collection <i>The Corner</i>	Interview Data Collection Policymakers
Sep-00				
Oct-00				
Nov-00				
Dec-00				
Jan-01				
Feb-01				
Mar-01				
Apr-01				
May-01				
Jun-01				
Jul-01				
Aug-01				
Sep-01				
Oct-01				
Nov-01				
Dec-01				
Jan-02				
Feb-02				
Mar-02				
Apr-02				
May-02				
Jun-02				
Jul-02				
Aug-02				
Sep-02				
Oct-02				
Nov-02				
Dec-02				
Jan-03				
Feb-03				
Mar-03				
Apr-03				
May-03				
Jun-03				
Jul-03				
Aug-03				
Sep-03				
Oct-03				
Nov-03				
Dec-03				
Jan-04				
Feb-04				
Mar-04				
Apr-04				

2.2 Epistemological Standpoint

2.2.1 The problem with the orthodoxy

When Thompson (2000) examined the development of empirical and scientific knowledge in nursing he delineated three epistemological positions (table 2.2):

Table 2.2: Epistemological routes of scientific knowledge in nursing (and health) (adapted from Thompson (2000))

Post-positivist (arising out of logical positivism): characterised by efforts to identify patterns and regularities to describe, explain and predict phenomena, and encompassing the use of diverse types of data and methods to develop, test and revise or replace theories

Interpretative / humanistic or naturalist: concerned with understanding the meaning of experience.

Critical or emancipatory: combines elements of the other two to address how socio-political and cultural factors influence experiences. This approach encompasses critical theory and action research

In chapter 1, I suggested that the orthodox view reflected within the context of UK health policies would appear to interpret innovation as the product of R&D which follows a rational linear process. Arguably, this interpretation draws on the post-positivist tradition, where it is assumed that innovation is a technical-rational endeavour that can be managed and therefore controlled to 'deliver' a planned and predictable outcome.

Whilst the attraction of this interpretation is clear – a technical-rational epistemology appears to reduce ambiguity and perpetuates a sense of control – it is not without its limitations and difficulties. In a world of chaos and uncertainty, anything that appears to reduce ambiguity is seductive. However, a technical-rational epistemology assumes that through the development of scientific knowledge it is possible to establish an absolute, value-free truth. This assumption is contested on the grounds that knowledge is neither universally authoritative nor value-free (Willmott 2003).

The interpretation of innovation as a technical-rational endeavour is, in part, based on a traditional view of management as a science. Taylor (1911), one of the founding fathers of management theory, defined the manager as a scientist whose role was to calculate and define the best method for undertaking any routinised task in a production process. Taylor assumed the legitimacy of the privileging of the manager over the worker on the grounds that the worker, through lack of education or mental capacity, was incapable of understanding 'his' scientific approach.

Critics argue that the traditional view of management as a science ignores the socio-political aspects of organisational life or assumes that they can be resolved through technical-rational interventions. The "moral-practical" is subordinated to the "technical-instrumental" (Alvesson & Willmott 1996). A technical-rational view of innovation is based on the assumption that it is possible and desirable for managers to 'manage (and therefore control) innovation' and legitimate that they should endeavour to control the behaviour of subordinate workers to achieve political ends (in this case, speed up the process of modernisation of the NHS). Management is, therefore, not a politically neutral process (Alvesson & Willmott 1996).

In chapter 1, I suggested that a technical-rational epistemology has significant currency within the NHS, and, within this context, innovation is conceptualized as a rational, predictable and controllable endeavour. My own experience of working in the NHS, echoed elsewhere (Buchanan & Badham 1999; Klein 2001), is that it is a politically-charged, socially-complex enterprise. Consequently, I have purposefully employed an alternative approach to the traditional, authoritative and value-free scientific approach in this study. In order to give due regard to the socio-political complexity of the context, and offer an alternative, and arguably innovative, analysis to that provided through a technical-rational lens, the conditions in which innovation can flourish are examined from a critical management standpoint.

2.2.2 Critical management studies (CMS)

Critical management theorists have asserted that traditional 'scientific' epistemologies remain dominant within health service management theory and management practices within the NHS, despite a plethora of alternative discourses within the literature (Learmonth 2001; Learmonth & Harding 2004). Alternatives, whose contribution has been considered within the context of health services management, include, for example, chaos and complexity theories (Plsek & Greenhalgh 2001; Plsek & Wilson 2001; Stacey 1992; Stacey 1996).

Critical Management calls for no less than a paradigm shift in management thinking. According to Kuhn, scientists (in this case, those who study management, and the management of healthcare in particular, from a quasi-scientific perspective) organise themselves into groups who operate within "paradigms", or conceptual boxes. He states:

"Men whose research is based on shared paradigms are committed to the same rules and standards for scientific practice [*which Kuhn argues is essential*] ... for the genesis and continuation of a particular tradition." (Kuhn 1996 p 11)

Taking the analogy of a jigsaw puzzle, Kuhn argues that those working within the same paradigm share the same picture of what they are seeking to achieve. There is then a sense of cohesion amongst those working within the field. Scientists collectively seek understanding of how the bits of the jigsaw fit together. A crisis arrives, however, when the paradigm is challenged, when there is sufficient evidence to question the picture the jigsaw is believed to represent. Kuhn calls this a 'scientific revolution' because it brings into question all the work undertaken within the original paradigm and can lead to the emergence of a new paradigm. An examination of innovation in the provision of health services from a CMS perspective therefore aims to examine the limitations of the orthodox view of innovation and offer alternative insights.

CMS developed in the main as a sub-discipline within UK and European Management Schools (Fournier & Grey 2000), bringing together a range of sometimes contradictory critical perspectives which challenge the dominance of the orthodox, technical-rational paradigm. Empirical evidence suggests that a single perspective is incapable of providing all of the solutions to the shortcomings of management practices. Arguably, it would be treacherous for CMS to replace one sort of absolutism with another hence CMS embraces a plurality of theoretical perspectives. These include feminism, neo-Marxist theories, post-structuralism and post-modernism. Fournier and Grey (2000) argue that the unifying features of CMS which distinguish it from mainstream management theory are threefold:

- a) an anti-performance stance,
- b) a commitment to de-naturalization
- c) reflexivity.

Non-critical management studies take the pursuit of efficiency as a given. Efficiency, effectiveness and profitability, the key concepts within orthodox management studies, contrast with the concepts of power, control and inequality which feature within CMS discourse. Where the "reality" of organisational life is promulgated as "natural" or unavoidable within orthodox management studies, CMS seeks to expose alternatives. CMS is a dynamic process of perpetual critique of the orthodox which strives to be philosophically and methodologically self-critical through reflexivity. The technical-rational 'solutions' proposed by modern management gurus such as, for example, Peters and Waterman (2004) are problematised because, it is argued, that the imposition of an organisational 'monoculture' is potentially totalitarian (Barley 1992; Willmott 1993) precisely because it attempts to stifle debate about alternatives (Parker 2004). The technical-rational, problem-solving approaches advocated within orthodox management theories effectively mask political agendas and perpetuate the status quo. Alvesson and Willmott (1996) have proposed that the concerns of CMS include:

1. the “pathological consequences of ‘progress’”, namely the exploitation of natural resources, inequalities of wealth and opportunity and institutional discrimination
2. the privileging of a scientific ethos over common sense reasoning and the resultant exclusion of particular voices
3. the view that science is always akin to progress
4. the capitalist exploitation of labour
5. the negative impact of consumerism and commercialization
6. the assumption that the promulgation of capitalism will result in a world that is more civilised, caring and just.

From a review of the literature, Reynolds (1999) isolated four principles which appear to underpin CMS (table 2.3).

Table 2.3: Underpinning Principles of Critical Management Studies (after Reynolds 1999)

To question the assumptions and taken for granted embodied in both theory and professional practice

To foreground the processes of power and ideology subsumed within the social fabric of institutional structures, procedures and practices

To confront spurious claims of rationality and objectivity and reveal the sectional interest which can be concealed by them

To work towards an emancipatory ideal – the realization of a more just society based on fairness and democracy

CMS is not an end in itself. A key principle is to work towards the realization of a more just society based on fairness and democracy. Through the questioning of assumptions and the foregrounding of power and ideology, a CMS perspective offers the potential for the development of alternative and creative courses of action. Alvesson and Deetz (2000) argue that a CMS perspective should both challenge current hegemonies and, at the same time, propose alternative interpretations. Like nursing, management is an applied discipline and proposals for action are an important element of CMS:

“... critical management....research should...have things to say to actors – managers and (other) employees – that is of relevance for their situation.” (Alvesson & Deetz 2000 p 208)

The application of CMS approaches within the context of health and healthcare is relatively new in the UK. Learmonth and Harding (2004) were the first to publish an edited compendium of research which offered a critical analysis of health service management. Their motivation was their lack of faith in the prevailing discourse that “all the NHS really needed was better management”. According to Learmonth (2001), contributions to CMS have demonstrated the capacity to provide a coherent challenge to the orthodoxy within the context of UK healthcare.

Learmonth and Harding (2004) included in their compendium one contribution from nursing. Michael Traynor “unmasked” the uncritical adoption of managerialism and evidence-based practice (EBP) within nursing. Traynor problematised the assumption that through managerialism and EBP nurses and nursing could achieve greater influence. Nursing might achieve greater influence Traynor argued, through building an intellectual identity closer to the routes of nursing theory and nursing practice, based on feminism (Traynor 1999).

In order to offer a critical insight into the conditions in which innovations in the provision of services flourish, this study offers a contribution from a CMS perspective. It is, to the best of my knowledge, the first study to examine innovations in healthcare service delivery from this epistemological standpoint.

2.3 Case Study Methodology

Case study is a strategy used in professional practice and education as well as in research. In the practice of, for example, the law, the testing of a particular case is used as a mechanism through which precedents are set and new laws or “case laws” are defined. In the clinical disciplines including medicine and nursing, case study is used for educational purposes. Here, the management of a patient or “a case” is examined so that lessons may be learned to inform future practice. This may involve the retrospective examination of an individual or cohort of patients presenting with similar symptoms with a discussion of interventions and outcomes achieved. In professional practice and education, the examination of the case is used as a means of taking a comprehensive look at the particular to inform future action, either through the setting of precedent or by learning through reflection about what did, and did not, work, with the opportunity to theorise as to why this was so.

Case study is also recognised as a comprehensive research strategy (Jones & Lyons 2004; Yin 2003a). The two most frequently cited authorities on case study as a research methodology are Stake (1995; 1998) and Yin (2003a; 2003b). According to Stake (1995), case study methodology as a research strategy is the study of the particularity and the complexity of a single case within its specific context. For Yin (2003b) it is an all-encompassing research method which allows complex phenomena to be examined in their natural setting, thus enabling the researcher to examine contextual conditions when they are considered to be pertinent to the phenomena under investigation. Examination of the context in which a case is situated is, therefore, fundamental to case study research. Yin (2003b) states that case study methodology has been used for exploratory, descriptive or explanatory purposes and, therefore, can be applied within a positivist, interpretivist or critical paradigm. For example, Yin argues that Graham Allison's (Allison & Zelikow 1999) examination of the Cuban missile crisis as a single case

“forcefully demonstrates how a single case study can be the basis for significant explanations and generalizations” (Yin 2003b p 4).

This study is conducted within a critical paradigm. A case study research strategy has been applied to gain insight into the underlying socio-political processes and the conditions in which innovations in the provision of health services can flourish.

A co-operative enquiry research methodology (Reason 1988; Reason & Rowan 1981) was considered as an alternative critical research strategy within this study. Had I employed this strategy, I would have explored opportunities to engage as a co-researcher with individuals participating in the development and implementation of an innovation in practice and learned experientially from our shared experiences. As co-researchers, we would have employed a range of methods as required to inform a cyclical process of data collection and analysis, change, reflection and theory development (Lewin 2000; Meyer & Batehup 1997; Titchen 1994; Webb 1989). I selected the case study methodology in preference to an action research strategy because, through an inductive, reflexive process of data collection and thematic analysis, the case study methodology allowed for the identification and examination of two discrete innovations in practice which could be compared and contrasted. The similarities and differences between the cases thus serve to illuminate the conditions in which these innovations have flourished and when they have failed. The next section discusses the research methods employed.

2.3.1 Case selection, access negotiation and data collection

This section describes how the cases were identified and how access was negotiated.

Case study 1

The first case study was selected for professional, philosophical and pragmatic reasons. *The Farmers' Health project* (FHP), an action research project, aimed to assess and improve the health of farming communities in

North Lancashire and South Cumbria. An outreach service provided by nurse practitioners was launched in July 1999.

The project was brought to my attention when it was reported at professional conferences and in the professional nursing press (Walsh 2000a; Walsh 2000b) as a nurse practitioner-led outreach service supported by nurse researchers. In addition, it was presented as an exemplar of an action research project on the MPhil in critical management programme I was undertaking within the Management School at Lancaster University. Researchers advised that the project arose from a shared concern about farmers' health amongst stakeholders coupled with compelling research evidence of high levels of accidents and general morbidity (Burnett et al. 1998; Gerrard 1998).

Within the context of her doctoral dissertation, Cath Gerrard, a nurse and farmer, had posed the question "*Are farmers' health and safety needs being met?*" (Gerrard 1998). Her personal experience suggested that they were not. She demonstrated how statistics showed that farmers were a high risk group with high morbidity rates related to accidents and chronic illnesses including cardiovascular disease. There were also higher than average suicide rates within farming communities. Gerrard (1998) reported that farmers were isolated and were known for their reticence, stoicism and self-reliance. These traits, coupled with reported deficits in the knowledge and expertise of health professionals with regard to farmers' health issues, were thought to contribute to the under-utilisation of mainstream health services by farming communities.

To answer her research question Gerrard conducted a telephone survey with a sample of 150 farmers drawn from three English counties. She concluded that the health and safety needs of farmers were not being met and recommended that alternative models of occupational health provision should be piloted and evaluated within the farming sector. She added that an action research approach would seem to be an appropriate way forward (Gerrard 1998). The Farmers' Health action research project was funded through the NHS North West Regional R&D capacity and capability building programme.

Philosophically and professionally I considered this to be an interesting project. Firstly, it was presented as an innovative service development which appeared to have been brought about as the result of research findings and thus was consistent with the rational policy rhetoric that there is a logical linear order where research progresses through to development and on to innovation in practice. In addition, it was an action research project, where action research is recognised as a methodology which operates within a critical, emancipatory paradigm (see table 2.2).

Secondly, the project was of interest to me in my professional role as the RCN's R&D adviser. It was reported as a nurse-led initiative (Walsh 2000a; Walsh 2000b), based on nurse-led research (Gerrard 1998), and it was contributing to a primary nursing R&D policy concern, namely the development of R&D capacity and capability within the nursing profession (Rafferty, Newell, & Traynor 2002).

On a pragmatic level, as a result of my professional and academic association with the researchers involved in the FHP, negotiating access proved to be a relatively straightforward process. At that time, I was registered on the MPhil programme and had not converted to PhD studies. The Director of the programme was my initial research supervisor and was a member of the FHP steering group. Following preliminary discussion with my supervisor, I approached the principal investigator on the FHP based within the Lancaster University Institute for Health Research. She advised that access may be negotiated by liaising with the general practitioner (GP) who chaired the project steering committee. The GP proved to be very supportive and invited me to attend the next steering committee meeting (19/7/2000) to outline the aims of my research and answer any questions or respond to any concerns raised by committee members. This proved to be a straightforward process and steering committee members were wholly supportive of my intentions. The ethical considerations here are discussed within the context of the ethical considerations across the entire study in section 2.5 below.

In order to contrast and compare the themes emerging from the FHP case study, I had considered criteria for the identification of a second case. Farmers are classified by health professionals as 'hard to reach' – they do not routinely access mainstream services. It became clear in the FHP that one of the reasons for this is that mainstream health services do not fit in with the demands of farming life. I, therefore, sought to identify a second case of an innovation seeking to address the healthcare needs of individuals who were considered "hard to reach" by professionals or who, as individuals themselves, felt that they had been let down by mainstream health services. Secondly, the multiple-agency input into the FHP added to its complexity. My second criterion, therefore, was that the innovation should be a complex multi-agency initiative.

Through talking to colleagues in my professional and academic networks I scanned the horizon for a suitable match. A professional colleague was associated with the first "Healthy Living Centre" at Bromley by Bow in London. She advised me that this was an innovation which has been driven from outside the system. Community dissatisfaction with the quality of palliative care for a young woman in this socially deprived area of London was reported as the initial impetus for the innovation. The champion of the innovation, a local vicar, was reported to have "the ear" of the Prime Minister and, as a result, the innovation had a very high profile and had essentially achieved 'celebrity status'. Consequently, access was very tightly controlled and I was advised that research access would be very difficult to negotiate. My colleague recommended strongly that I consider alternative cases. I felt that on ethical grounds this was the right thing to do. As Williamson (2007) points out, individuals have the right not to be over-researched. I, therefore, took my colleague's advice and started to look elsewhere.

Case Study 2

I became aware of *The Corner young people's advice and information service* when I was preparing for the RCN annual international nursing research

conference in 2001. In my role as RCN Research and Development Adviser, one of my responsibilities is to facilitate the scientific process of abstract review for inclusion in the conference programme. At this time, I was seeking to identify a second case when "*Health outreach for socially excluded young people*" (Elliott 2001) caught my attention. *The Corner* had commissioned the research that was to be presented at the conference

The Corner is an information and advice centre for young people, situated in the centre of the city of Dundee on the east coast of Scotland. Morbidity amongst young people often goes unreported as they do not, as a rule, access mainstream NHS services. The birth rate, however, is recorded with a relatively high degree of accuracy. Dundee is reported to have the highest teenage pregnancy rate in Scotland and one of the highest rates in Europe. A local authority-led multi-agency initiative, *The Corner*, operated on a drop-in basis, where no appointment is required. Trained staff and volunteer young people offered an informal, free and totally confidential service in areas of concern to their clients. These included a wide range of health matters as well as pregnancy testing and contraception. *The Corner* sought to respond to the actual problems and issues experienced by its clients, in order to ensure that it remained responsive to the real needs and concerns of young people in the city of Dundee. A complex project, involving multiple stakeholders, *The Corner* matched my inclusion criteria.

I arranged to meet the author of the conference abstract to discuss his research, *The Corner* Project, and how I might negotiate access. From his perspective, he felt that access could be difficult to negotiate because, in his view the project team guarded against external scrutiny. I was given an e-mail contact address for the project coordinator and wished well in my endeavour. I constructed an email letter of introduction requesting a meeting to explore the potential of access to the project. However, my e-mail bounced back so I tracked down a telephone number for *The Corner* on the Internet. I rang up to speak to the project coordinator and explained to the woman who answered the phone why I was ringing. She asked me who I was and, when I explained, she said "I thought it was you!" It turned out to be one of my cousins who,

unbeknown to me, had recently taken up a clerical post on the project. I acknowledge here that having someone “on the inside” may have facilitated my request for access to the project. The project coordinator agreed to meet me the following week to discuss my proposal. Following our meeting he agreed to recommend to his senior manager, who had been the original project coordinator, and colleagues within the project, that they support my request. Access was agreed. The ethical considerations here are discussed within the context of the ethical considerations across the entire study in section 2.5.

2.3.2 Data sources

Methods of data collection and analysis are explained and critiqued in this section. Multiple sources of evidence were accessed in order to examine the cases: interviews, documents, participant and non-participant observation. The rationale for using multiple data sources in case study research is to facilitate data triangulation (Patton 1990), that is the corroboration or augmentation of one source of data with another.

More specifically data collection included:

1. *semi-structured interviews* with key stakeholders and informants
2. *grey and published documentation* including
 - administrative documents - project proposals and progress reports
 - formal evaluations of the cases
 - agendas, announcements and minutes of meetings and conference reports
 - communiqués including letters and e-mails
 - published policy
 - peer-reviewed publications
 - media reports in the form of newspaper clippings
3. *observation* of practice through shadowing, attendance at relevant meetings, conferences and workshops associated with the case studies

Yin (2003b) argues that the interview is one of the most important sources of case study information. Here, the interview is a fluid process which, whilst

pursuing a consistent line of enquiry, appears more like a guided conversation. The strengths and weaknesses of interview data in case study research are presented in table 2.4. I was aware that my personal positional power as a professional adviser within the Royal College of Nursing, had the capacity to not only influence potential informants' willingness to speak to me but also to influence informants' responses to my questions. As Yin (2003b) points out, this is a potential weakness of the interview method (table 2.4). To minimise this potential and increase the quality of research interviews researchers must be self-aware at all times. According to Oakley (1981) the goal of interviewing is best achieved when the relationship between the interviewer and interviewee is non-hierarchical and when the interviewer is willing to invest something of their personal identity into the process. I endeavoured to achieve the former through reflexivity and sought continually to be self-aware throughout this study. With regard to the latter if I was ever in a position to offer any professional support to any of the people I interviewed I carefully followed this up. For example, I supported a nurse in the *The Corner* in her preparation of a paper for presentation at a professional conference several months after I had interviewed her.

Over the two cases, 26 people were interviewed. All interviews were conducted face to face and an open-ended, semi-structured interview schedule was used to facilitate the process. With the verbal consent of informants, all but one of the interviews were tape-recorded. In the one case where consent for the use of a tape-recorder was withheld, consent was given for notes to be taken by me during the interview. A touch typist transcribed recorded data before I listened to each tape, at least twice, and edited the transcripts.

Reviews of grey and published documentation and a limited degree of participant and non-participant observation facilitated methodological triangulation within each case. The strengths and weaknesses of documentary evidence and observation in case study research are listed in table 2.4. Warning of the limitations of documentary evidence, Yin recommends:

“For case studies, the most important use of documents is to corroborate and augment evidence from other sources.” (Yin 2003b p 87)

Table 2.4: Limitations of data sources (adapted from Yin (2003b page 86))		
Source of evidence	Strengths	Weaknesses
Documentation	<p>stable – can be retrieved repeatedly</p> <p>unobtrusive – not created as a result of the case study</p> <p>exact – contains exact names , references and details of an event</p> <p>broad coverage – long span of time , many events and many settings</p>	<p>retrievability – can be low</p> <p>biased selectivity. If collection is incomplete</p> <p>reporting bias – reflects (unknown bias of author)</p> <p>access – may be deliberately blocked</p>
Interviews	<p>targeted – focuses directly on case study topic</p> <p>insightful – provides perceived causal inferences</p>	<p>bias due to poorly constructed question</p> <p>response bias</p> <p>Inaccuracies due to poor recall</p> <p>reflexivity – interviewee gives what interviewer wants to hear</p>
Direct observation	<p>Reality – covers events in real time</p> <p>Contextual –covers context of event</p>	<p>time consuming</p> <p>selectivity – unless broad coverage</p> <p>reflexivity – event may proceed differently because it is being observed</p> <p>cost – hours needed by human observers</p>
Participant observation	<p><i>(same as above for direct observation)</i></p> <p>insightful into interpersonal behaviour and motives</p>	<p><i>(same as above for direct observation)</i></p> <p>bias due to investigator’s manipulation of events</p>

Case study 1

The first step in examining the FHP was the identification of stakeholders in the project who could be informants. A preliminary map of stakeholders was identified with the support of my initial primary supervisor at Lancaster University (R1) and the principal investigator for the project (R2), who was also located within the University. As I met with and interviewed those on my initial list of stakeholders, many of these informants would ask, "*Have you spoken to (so and so) yet?....I really think you should speak to 'x' ..or.. 'y' will give you a very different perspective,*" and thus the list of key informants was developed through this snowballing (Patton 1990) or network mapping (Procter & Allan 2006) mechanism.

Whilst the snowballing technique can introduce bias in research that is seeking to ascertain statistical significance (Faugier & Sargeant 1997), when used in the context of a case study design, the mapping of networks can add to the richness of the data. I noted that informants were particularly keen that I spoke to others who may hold a perspective different to their own and so, arguably, informants themselves were seeking to illuminate their own personal bias within my data. Table 2.5 lists all the data sources which informed case study 1 including the stakeholders interviewed. R1 and R2 were interviewed in the first instance and, thereafter, I telephoned other stakeholders to ask them if they would be willing to be interviewed by me. I approached in total 18 potential informants who all agreed in principle to be interviewed. With fifteen of these potential informants I was able to establish a mutually convenient date and venue to meet with them to conduct an interview. For three potential informants the identification of a mutually convenient date and time proved too challenging, so wherever possible, I ensured that I spoke to someone who could offer a similar perspective. For example, the first community psychiatric nurse (CPN) I approached was one of the three potential informants that I was unable to arrange to meet. I was, however, able to fix up a meeting with the other CPN involved in the project.

Table 2.5: Case Study 1 Data Sources
(Rural) Mental Health Issues for Primary Care Working Group
Minutes
Letters / progress reports
Improving access to healthcare for farming communities - Research Bid
Farmers' Health Project
Management Group Minutes
Steering Group Minutes
Project reports
The Grange Team
The Carnforth Team
Telephone evaluation of the Farmers' Health Project
Dissemination Developments
Advertisement for Countryside Agency funded Research Assistant
Video: Taking Action in Rural Health: the case of farmers
Information pack
Seminars and Conferences
Mental Health Issues for Rural Practices - Programme and Notes
Rural Health Study Days
Institute of Rural Health, 'Joined Up Countryside' Conference, Gregynog, Wales
Research Reports
The organisation of primary care for mental health services in East. Lancashire. & Morecambe Bay
"The Farmers' Health project"
Informants
Academics
Researcher (R1 - Professor in Management) \$
Researcher (R2 - Senior Lecturer / Sociologist) \$ *
Researcher (R3- Reader in Nursing) \$ *
Researcher (R4 - Research Assistant - employed to work on the project) \$ *
Service Providers
Community Psychiatric Nurse (CPN) \$ *
Farmers' Nurse (FN employed to work on the project) \$ *
General Practitioner (GP1) \$ *
General Practitioner (GP2) \$
Healthcare Support Worker (HCSW employed to work on the project) \$ *
Health Visitor (HV) \$ *
Manager (Mental Health Services) (M1) \$ *
Manager (Nursing) (M2) \$ *
Nurse Practitioner (NP1 employed to work on the project) \$ *
Nurse Practitioner (NP2 a local service provider) \$ *
Service Users
Farmers (F1 & F2) \$
Key to level of involvement in the FHP
\$ = member of project steering group (quarterly meetings)
* = member of project management group (monthly meetings)

I interviewed two farmers together. They were married to each other and both members of the multi-agency steering committee. Together they provided the consumer's voice on the committee. The husband had lost his arm through a farm accident and his wife was now the primary farmer within the 'team'. There is always a danger when interviewing two or more people at the same time that a member or members of the group can dominate the proceedings effectively silencing other interviewees and thus masking any political agendas. As foregrounding the power dynamics within the innovation was part of my purpose, interviewing two or more people at the same time could have been problematic, however, I had no sense of that happening in this case. The two informants had clearly discussed, at length, their thoughts on the project and they 'bounced' their contributions off one another, effectively checking out their interpretations, thus adding depth to their collective contribution, throughout the interview.

I interviewed all other informants on their own. Following an initial telephone call with an informant I sent a standard letter confirming the arrangements we had agreed and outlining six questions that would form the basis of a semi-structured interview schedule (see table 2.6). My purpose in providing my semi-structured interview schedule in advance of my interviews was twofold. Firstly, by making explicit the nature and purpose of my interview I hoped to allay any anxieties informants might have. Secondly, informants could reflect on my questions in advance of our meeting should they wish to do so. My letter also incorporated a formal request to tape-record our interview. Before beginning an interview, I verbally reiterated the purposes of my study and requested permission to record the interview. Informants were free to give their verbal consent or deny my request.

As concerns of the sustainability of the FHP emerged, I interviewed three informants for a second time, in order to, further explore this issue.

Table 2.6: Semi-structured interview schedule used in case studies

Your understanding of the genesis of the initiative, where it is now and how it got to this point

How you got involved and why

Your perceptions of the barriers that have hindered the initiative and factors that have enabled it to happen

Any thoughts you might have on the process and the evaluation of the project

Your thoughts on the future of the project, its dissemination and possible replication elsewhere

Any other pertinent issues

Case study 2

Whilst negotiating access to *The Corner* with the project coordinator, potential informants were discussed. The project coordinator (PC2) made very useful recommendations about whom I might meet and interview. He even proposed to co-facilitate a focus group with some of the young people who accessed the service.

As it turned out, PC2 was unable to set up a focus group interview with young people on the dates I gave him when I was available to come to the project. He did, however, arrange for me to meet with and talk to two of the young people who accessed the project on a one-to-one basis. In fact, PC2 offered to arrange all of my interviews for me. This support was greatly appreciated, as PC2 essentially acted as my advocate with the range of stakeholders that we identified I should interview. The concern I had with this approach, however, was that members of the project team, further down the managerial hierarchy, who were approached on my behalf by their line manager, may have felt coerced into participating in my study. This created an ethical concern which was validated when the first project worker I met with to interview, who was relatively new to the project, expressed some anxiety about what I might do with my data. Whilst she consented to talk to me about

the project, she declined my request for the interview to be recorded. I reassured her that only myself and my supervisors would have access to my raw data and that I would handle these data sensitively. I assured her of confidentiality and anonymity in any publications that may emerge from my research. In the light of this, she consented to continue with the interview, but not for it to be recorded. In addition, whilst it felt like the project coordinator was extremely facilitative, an alternative view could have been that he acted as a gatekeeper controlling the degree of access I was given to the project and thus introducing bias into my sample of informants . However, during the course of the analysis of the interview data collected, it became apparent within the emergent theoretical themes, that senior management support for the project had been instrumental in its success. In order to explore this further with senior managers associated with the project I had to negotiate access to them. Once again, the project co-ordinator was equally facilitative. He did offer to join me when I went to meet with one member of the management group, but did not seem in any way concerned when I declined the invitation. Indeed, at no time was I denied access to anyone or any of the resources within the project. Therefore, as in the FHP case study, a snowballing sampling technique was applied in this case. Table 2.7 lists the data sources which informed my analysis of case study 2 including the stakeholders interviewed. The letter sent to stakeholders confirming details of the interview incorporated details of the semi-structured interview schedule listed above in table 2.6.

Table 2.7: Case Study 2: data sources
Project Reports
Young Persons' Health Project
Evaluation of The Corner Young People's Health and Information Project 1 April 1995 - March 1997
Challenging Myths, Working with Realities: Principles and Policies
Food for Thought
Lochee Primary School and "The Corner": Facing the facts of life
Guidelines for care and protection of children and young people
Eye Opener: Annual Report 2000 - 2001
The Traveller's Guide to Working with Vulnerable Young Men
Trends, Myths, Realities, Eye Openers: The Corner Young People's Health and Information Project, Dundee 1996-2002
Interviews
Project Co-ordinator 1 (PC1 appointed when PC2 promoted)
Project Co-ordinator 2 (PC2 original project co-ordinator)
Project Worker - Nurse 1 (PW1)
Project Worker - Nurse 2 (PW2)
Young Person 1 (YP1)
Young Person 2 (YP2)
Researcher (R1 Commissioned to undertake a specific, discrete piece of research)
Researcher (R2 Employed as the project evaluator)
Local Authority Sponsor (LA)
NHS Sponsor (NHS)
Additional Information
The Corner Press clippings. March 1996 - January 2003
The Shore Update September 2002
Have Your Say: patient focus, public involvement, public partnership. NHS Tayside

2.3.3 Data analysis

Whilst there are clear and accepted conventions for the analysis of quantitative data, there is no parallel convention when it comes to the analysis of qualitative data (Robson 1993). Neither should there be, according to Webb (1989), who argued that qualitative data analysis should not be treated as a reductionist, mechanistic process but as a creative endeavour.

Qualitative interview data collected in these cases were all transcribed verbatim. Through listening and re-listening to the tapes, I immersed myself in the data and annotated the transcriptions. I analysed these data using intuition and empathy by entering into the spirit of what Christine Webb has coined her “osmosis method”:

“I have found the intimacy gained by this process gives such a close ‘feeling’ for and familiarity with what participants have said that it leads to a process of analysis that could appear almost to be automatic and even to have physical elements. It is as if the ideas almost literally flow up one’s arm as one annotates transcripts and makes notes, enter one’s brain, and flow back to the paper on which the analysis is written. I have coined the term Webb’s osmosis method for this process of intuition...” (Webb 1989 p 329).

Using different coloured pens, I highlighted within my data decisions and actions taken which I identified as “critical incidents”. From the different perspectives of the stakeholders interviewed, these incidents appeared to shape the course of the innovation, whether through ongoing development or to the point of its demise. The critical incidents, therefore, served to illuminate the conditions in which the innovations flourished and the conditions in which they failed. In line with the principles of CMS (table 2.3), I examined these critical incidents through consideration of the questions I adapted from Angelides (2001) (table 2.8), in order to identify the underlying socio-political factors which militated for and against the development and sustainability of these innovations.

Table 2.8: Probing questions used to analyse critical incidents (adapted from Angelides (2001))

Whose interests are served or denied by the actions of these critical incidents?

What conditions sustain or preserve these incidents?

What power relationships are expressed in them?

What structural, organisational and cultural factors are likely to prevent actors from engaging in alternative ways?

The critical methodological question is, 'can my interpretation be trusted?' Assessing the quality or trustworthiness of qualitative research is recognised as problematic, and Cutcliffe and McKenna (1999) have argued that criteria such as "valid" and "reliable" have been inappropriately imported or translated into assessments of the trustworthiness of qualitative research when researchers have endeavoured to assure readers and examiners of the quality of their work. According to Sandelowski (1993 p 8):

"...we can preserve or kill the spirit of qualitative work; we can soften our notions of rigor to include the playfulness, soulfulness, imagination and technique we associate with more artistic endeavours, or we can further harden it by the uncritical application of rules. The choice is ours, rigor or rigor mortis."

Arguably, these are the potential pitfalls of the uncritical application of more formal, arguably technical-rational methods of qualitative data analysis offered by, for example, Miles and Huberman (1984). It seemed to me to be both illogical and counterintuitive to problematise the potential limitations of a technical-rational view of innovation and then to analyse case studies of innovation through the application of technical-rational methods. I decided, therefore, that in this context Webb's intuitive osmosis method was not only intuitively the right approach to take but also coherent with my epistemological standpoint.

Drawing on Benner's theories of expert nursing practice (Benner 2001), Cutcliffe and McKenna (2004) juxtaposed the proposal that qualitative researchers should keep a rigorous audit trail of each step of their data analysis to ensure the trustworthiness of their conclusions with their notion of an expert qualitative researcher. They concluded that exaggerating the case for method did not necessarily establish the credibility of research findings. Instead, they argued from a pragmatic standpoint:

**“If the theory explains, predicts and solves problems for the group for which it was produced, then it may be of less importance that it has little credibility vis a vis recognisable methodological patterns.”
(Cutcliffe & McKenna 2004 p 132)**

The aim of this study is to increase understanding of the conditions in which innovations flourish. It seeks to inform healthcare policy and practice. To that end, I have avoided potentially reductionist, mechanistic methods of data analysis and have sought to demonstrate creativity and rigour through the internal / intrinsic logic and trustworthiness of my argument. My aim has been to provide a reflexive, creative, critical account with respect to the four principles Yin (2003b) states are required to assure a high quality of case study analysis :

- 1. all the evidence should be attended to**
- 2. all rival interpretations should be considered**
- 3. the most significant aspect of the case study should be addressed**
- 4. the researcher should use their own prior expert knowledge**

Following initial analysis of these cases and the apparent significance that the policy context may have on an innovation's potential to flourish, I elected to incorporate a policy perspective into my study design. The data collected during the third phase of data collection (see table 2.1) served to augment what Yin describes as my 'prior expert knowledge' of innovation (discussed in chapter 1) and the context in which these innovations were taking place. The next section examines the methods applied to incorporate a policy perspective into the study design.

2.4 The Healthcare Policy Context

Initial analysis of these two cases of innovation (which are presented in turn in chapters 5 and 6) indicated that the policy context had a significant bearing on the potential of these innovations to flourish. Healthcare policy clearly set out the UK Governments' intentions to support and enable an innovative culture in the NHS. However, evidence from the two cases examined suggested that, paradoxically, NHS policy had the capacity to stifle innovation "in the field". I, therefore, decided to incorporate a view from the world of policy into my study design in order to gain a greater insight into the complexity of the policy context in which these innovations were taking place.

When considering potential sources of data, I acknowledged that I had ready access to published government policy. My cases, however, suggested that policy and policymakers may have a significant impact on whether an innovation can flourish or not. This suggested that policymakers themselves potentially played a part in the success or demise of an innovation. For the purposes of this study, I, therefore, sought to establish the perceptions and interpretations of innovation held by policy makers and decided to negotiate access to, and interview a sample of, policy makers, using a semi-structured interview schedule, to increase my insight and understanding of the context in which my case studies of innovation were taking place and what bearing that might have on their capacity to flourish.

Reflecting on the focus of the research, the themes emerging from the cases, and through discussions with senior policymakers within my own profession, I was enabled to identify a preliminary sample of policymakers. This sample was considered representative of the range of professional and managerial backgrounds of healthcare policy makers. As my first case study of an innovation was located in England and the second in Scotland, coupled with the acknowledged impact of political devolution on the NHS policy (Greer 2004), policymakers in both Scotland and England were included in this initial sample.

I contacted potential informants identified within the initial sample by telephone in the first instance. I introduced myself in my professional and researcher capacities, advised that I was making contact on the recommendation of my professional colleagues (where appropriate) and asked if they would be willing to be interviewed. Everyone contacted agreed and a follow-up letter was sent confirming the date, time and venue for the interview. The proposed interview outline was also detailed in the letter and informants were advised that responses would not be attributable and treated as confidential. I cannot measure the impact of my professional role and networks and the bearing this may have had on my ability to access policymakers so freely, but I acknowledge that it may have been significant. Knowing someone 'on the inside' appeared to make a difference when it came to negotiating access in Case Study 2 and it may have in this instance as well.

At interview, some policy makers in the initial sample recommended additional policymakers from whom they felt I should get a view. Once again, as in the cases described above, this led to the incorporation of a snowballing sampling technique, where a preliminary sample is further developed on the recommendation of respondents (Patton 1990). Access was, therefore, negotiated on the grounds of peer referral.

All eleven policymakers interviewed had either a national responsibility for the development and/or implementation of policy or in offering a critique on policy developments. Five men and six women were interviewed. They came from a range of professional backgrounds including nursing (4), management and accountancy (3), medicine (2) science and social science. They all held senior positions within their respective organisations as illustrated in table 2.9. Five had a policy focus within the NHS in England, which is under the political jurisdiction of the United Kingdom (UK) Government, and six had a policy focus within Scotland, where 'health' is devolved to the Scottish Parliament.

Table 2.9: Policymakers Interviewed
Employing organisations
Scotland
NHS Scotland Quality Improvement Scotland (QIS) Centre for Change and Innovation (CCI)
England
Department of Health Health Development Agency (HDA) NHS Modernisation Agency (MA) The Commission for Patient and Public Involvement in Health (PPI) NHS Confederation (NHSC)
Range of Job Titles
Chief <ul style="list-style-type: none"> • Executive (CEO) • Nursing Officer (CNO) • Medical Officer (CMO) Director <ul style="list-style-type: none"> • Executive • National Clinical (DPC) Head Policy Manager

As with the interviews in the cases studied, these interviews were guided by the use of a semi-structured interview schedule (table 2.10).

Table 2.10: Semi-structured interview schedule used with policymakers

What does innovation in the provision of health services mean to you?
What are your perceptions of the barriers to innovations in health service provision and the enabling factors?
What is your view of the relationship between policy and innovations in health service provision?
Are there any other issues you think are pertinent?

Whenever it was logistically possible, interviews were held face to face because face to face interviews are believed to increase the potential of achieving a rapport with respondents when compared to telephone interviews (Robson 1993). Seven interviews were conducted face to face and three over the telephone. I had previously met face to face with two of these three respondents. The telephone interview with the third respondent, whom I had not met before, was conducted on a Sunday morning in order to fit in with his busy schedule.

All interviews were recorded with the verbal permission of respondents and these data were also transcribed. In this case however, because I was engaging policymakers in discussion specifically to illuminate the policy context in which innovations were taking place, and the potential impact of policy on their trajectory, I elected to employ a more structured method of analysis commonly used within the field of policy analysis. *Framework*, a matrix-based method for ordering and synthesising qualitative data (Ritchie, Spencer, & O'Connor 2003), was applied specifically because of the congruence between these data and the context in which the method was developed and is applied. *Framework* was developed in an independent social research unit, Social and Community Planning Research (SCPR), where applied policy research was carried out (Ritchie & Spencer 1994). The key features of *Framework* are listed in table 2.11.

Table 2.11: The Key features of *Framework* (Ritchie & Spencer 1994 p 176)

Grounded or generative: it is heavily based on, and driven by, the original accounts and observations of the people it is about.
Dynamic: it is open to change, addition and amendment throughout the analytic process
Systematic: it allows methodical treatment of all similar units of analysis
Comprehensive: it allows a full, and non partial or selective, review of the material collected
Enables easy retrieval: it allows access to, and retrieval of, the original textual material
Allows between- and within- case analysis: it enables comparisons between, and associations within, cases to be made.
Accessible to others: the analytic process, and the interpretations derived from it, can be viewed and judged by people other than the primary analyst.

The developers argue that *Framework* offers the qualitative researcher a means of making analytical tools accessible by providing an explicit audit trail from data collection through to research findings. *Framework* is, therefore, seen to increase the credibility of qualitative data analysis in the policy field where, traditionally, quantitative data analysis was the methodology of choice because of the apparent factual certainty it offered (Ritchie & Spencer 1994). With *Framework* the 'answers' to policy questions policy commissioners seek to address can be readily traced back to raw research data. *Framework* also makes it possible for teams of researchers to collaborate and provide a rapid response to policy questions. It involves a systematic process of sifting, charting and sorting data according to key issues and themes and incorporates five key stages illustrated in table 2.12.

Table 2.12: The five key stages In *Framework*

1. Familiarisation
2. Identifying a thematic framework
3. Indexing
4. Charting
5. Mapping and interpretation

The first phase, familiarisation, involves the researcher immersing herself in the data – listening to tapes, reading transcripts and reading observational notes – and listing key ideas and recurrent themes. From these observations, an initial index or thematic framework can be developed within which the data can be sifted and sorted. Ritchie and Spencer (1994) suggest that when developing a thematic framework the researcher draws on *a priori* and emergent issues and analytical themes:

- *a priori issues*: those informed by the original research aims and introduced into the interviews via the topic guide
- *emergent issues*: raised by the respondents themselves
- *analytical themes*: arising from the recurrence, patterning of particular views and experiences.

They suggest that the first version of a thematic framework or index incorporates, in the main, *a priori* issues and, through both logical and intuitive thinking, a thematic framework is refined and developed.

Following familiarisation with the interview data collected in this part of this study, I developed an initial index of concepts. I then systematically re-read and mapped or 'indexed' all of the transcribed interview data against this initial index. During this process I continued to refine and develop the index. The final index is listed in table 2.13. During the next phase, 'charting', I used Excel spreadsheets, copied data from their original transcripts and charted these according to the appropriate index. I carried out this analysis thematically and examined each theme across all respondents.

Ritchie and Spencer (1994) recommend that charting involves abstraction and synthesis of the original data. Whilst charting in this manner would clearly be particularly useful with a very large data-set, data in this part of this study were limited to the transcripts of eleven interviews. As a result, in the main, I copied and pasted verbatim data chunks from the interview transcripts onto

the charts. Where I abstracted responses, I recorded them in blue italics on the charts.

Analysis was a dynamic process of refinement. I highlighted data in the charts in turquoise, to signify where data were either imported from, or exported to, other themes during the process of refinement. Data, which offered insights such as linkages with other themes, I highlighted in yellow and I used red font to highlight specific points. I recorded my interpretations in a comments column at the end of each row. Table 3.1 provides an illustration of a section of a chart developed.

During the process of charting, the framework continued to be refined and further developed. Table 2.14 illustrates the thematic framework ultimately developed through this process which is discussed in detail in chapter 6. It illustrates four overarching or 'meta-themes' namely innovation, stakeholders, power and control and paradoxes and tensions. Once this framework was realised, and all of the charts were examined collectively, mapping between themes and across respondents was possible. The charts were all re-read and, using pencil and paper, the linkages between the themes were, literally, mapped-out.

The 'key objectives and features of qualitative research' described by Ritchie and Spencer (1994) were realised, namely:

- defining concepts
- mapping range and nature of phenomena
- creating typologies
- finding associations
- providing explanations
- developing strategies, etc

This mapping process provided the outline for chapter 3 where the analysis and interpretation of these data are presented.

Table 2.13: Index of Concepts
Control / power
Tensions
Vested interests
Boundaries
Culture
Definition / meaning of innovation
Innovation problematised
Drivers of innovation
Legislation as a driver
Policy as a driver (and an inhibitor)
Examples of innovation - policy-related
Examples of innovation - role development
Examples of innovation - service redesign
Examples of innovation - new technology
Dissemination
Uptake
Government / Politicians
Management
The Staff
Professionals
Medicine
Nursing
Professional Associations / Trade Unions
Professional Regulatory Bodies
The Public
Media
Boundaries
Size of the NHS
Devolution (political and managerial)
Evidence
Standards and Regulation
Risk
Management Support
Management Technologies tools and Techniques
Targets & Performance Management
Resources structural
Resources financial
Resources human

Table 2.14: Thematic Framework

INNOVATION	STAKEHOLDERS	POWER & CONTROL	PARADOXES & TENSIONS
Meaning Innovation problematised	Govt. Politicians & Policymakers Management	Boundaries Size of the NHS Devolution (political and managerial)	Paradoxes Tensions Vested Interests
Drivers Legislation Policy	"The Staff" Professionals Medicine Nursing Professional Associations / Trade unions Professional Regulatory Bodies	Evidence Standards & Regulation Risk	
Examples Policy-related Examples Role Development Examples Service Redesign Examples New Technologies	The Public The Media	Management Support Management Technologies - tools and techniques Targets & Performance Management	
Dissemination Uptake		Resources Financial Resources Human Resources Structural	

2.5 Ethical Considerations

As a researcher, I have a duty of care to safeguard the dignity, rights and well-being of any informants. With regard to the data collection phase, in Case Study 1 and Policymakers I personally initiated a verbal invitation to potential informants to contribute to my research. I introduced myself in my professional capacity and as a postgraduate, at that time, at Lancaster University.

If they agreed (consented) to contribute, I sent a letter:

- a) detailing the aims of my study
- b) outlining my proposed semi-structured interview schedule
- c) confirming the agreed date, time and venue for the interview
- d) requesting their permission to tape-record the interview.

Before the interview formally commenced, I reiterated the aims of my research and I requested permission to tape-record the interview. None of my Case Study 1 or Policymaker informants expressed any concerns with regard to being interviewed by me or with the interview being tape-recorded. On one occasion, a policymaker requested that the tape recorder be turned off at the end of the interview. She continued to offer a contribution "off the record" and additional information was recorded in field notes but not used in the analysis.

In Case Study 2 this procedure was not followed and this raised ethical concerns. The project co-ordinator acted as a facilitator, negotiating access to potential informants on my behalf. As he was in a position of authority, I had to be extra vigilant, to ensure that potential informants did not feel coerced or obliged to talk to me, and that they were at ease with our terms of engagement. Because the project co-ordinator facilitated my access, I did not have the initial telephone introduction with these informants. Their first point of contact was through a (non-personalised) photocopy of my standard letter of introduction passed on to them by their line manager. I, therefore, took particular care, when I first met these potential informants, to try to ascertain whether they were participating of their

own volition or because their line manager had asked them to, as this could affect their responses. If they thought that I was acting on behalf of, or colluding with their line managers, they may be less likely to disclose their views if they felt critical of their management. As discussed above, in one instance, a relatively newly appointed member of staff was suspicious of my purpose, expressed concern about what I might do with the data and denied my request to record our interview. She did, however, agree to talk to me and I recorded aspects of our discussion, with her permission, as field notes. When it became apparent to me that I needed to talk to senior managers, I was able to negotiate that I would write to them personally prior to our meeting.

The NHS research governance framework, which was first published in 2001, stipulates:

“All research involving patients, service users, carers or care professionals and other staff, or their organs, tissue or data, is referred for independent ethical review to safeguard their dignity, rights, safety and well-being.”
(Department of Health 2006)

This study was not referred for independent ethical review for three reasons. Firstly, data collection began in 2000, prior to the introduction of the Research Governance Framework. Nevertheless, at this time, ethical approval from a Local Research Ethics Committee for studies conducted within the NHS was a requirement. However, the focus of local research ethics committees was, in the main, on research involving patients and service users directly and they did not routinely concern themselves with research that focused on healthcare professionals and other staff.

Secondly, the case studies, whilst they involved some personnel whose contracts were held by the NHS, were multi-agency innovations which sat very much on the margins of the healthcare systems (rather like the client groups whose health needs they were seeking to address). Case study 1 was a university-led initiative and case study 2 was, in the end, led by personnel whose contracts were held by

their local authority. In response to the atrocities of Nazi Germany (Schmidt 2007), the regulation of medical research and the governance of research ethics, in particular, have been a strong feature of research involving medical interventions since the Second World War. It is only within recent years that similar attention has been given to the ethics of social research (ESRC 2005).

Thirdly, whilst many universities have their own internal research ethics committees, Lancaster does not (or at least did not at the time) and presumably holds research supervisors accountable for the ethical conduct of research carried out under the auspices of the university. Upon transfer to the University of Salford, all data collection had been completed thus negating a requirement to seek ethical approval to complete this study.

2.6 Summary

In this chapter I have presented a rationale for the critical management epistemological standpoint underpinning this study. Following consideration of alternative critical methodologies a rationale was put forward for the selection of a case study approach. Two cases have been described and case selection and within-case sampling strategies presented. A rationale for augmenting these data with an inductive view from the world of policy-making has been offered with a justification for the sample selected and the methods used to collect and analyse these data. Ethical considerations have been discussed.

PART II
THE POLICY CONTEXT

Chapter 3 A view from the world of policy

3.1 Introduction

In order to explore the policy context in which the cases of innovations examined in Part III were developed, I elected to incorporate a view from the world of policy into my study design. The methods are detailed in chapter 2. In summary, eleven individuals in policy-related roles (referred to from here on as 'respondents') were interviewed. The organisations represented, the professional backgrounds, the gender and the job titles of respondents are listed in table 2.9. Interviews were carried out using a semi-structured interview schedule as a guide (table 2.10). All interviews were transcribed and analysed through the application of Ritchie and Spencer's (2003) *Framework* method for analysing qualitative data.

Following the systematic process of sifting, charting and sorting data according to key issues and themes, a thematic framework was created (illustrated in table 2.14). The synthesis and interpretation of these data through the mapping of the linkages between concepts and across the themes is presented in this chapter. The chapter is presented in three sections. The first describes the thematic framework and how data were synthesised and interpreted. The second section examines respondents' understanding of the drivers of innovation within the NHS and the policy response to those drivers. Respondents' interpretations of the meaning of innovation appeared to be confused and, it is suggested, somewhat ubiquitous. Perhaps, as a consequence, there was a range of views of what could legitimately be regarded as an innovation. From my analysis of these data, I develop and discuss a typology. In the third section of this chapter respondents' views of the stakeholders in health service innovation are explored. As well as the public, the actual and potential users of health services and those who provide the said services, the professionals, other staff, managers, Government and politicians and the media were identified as key stakeholders. Respondents' views on the relationships between stakeholders and their impact on innovation

are examined and discussed. Throughout the analysis, issues of power and control were constant themes and tensions and paradoxes emerged. These concepts are raised and discussed throughout the chapter.

3.2 Thematic Framework

I asked respondents *“What does innovation in the provision of health services mean to you?”* (see table 2.10) and whilst they described what innovation meant to them, I asked for examples to illustrate the points they were making. From the examples offered, I identified four categories of innovations, namely ‘role development’, ‘service redesign’, ‘new technologies’ and ‘policy-related’. Examples of role development innovations included the introduction of nurse endoscopists, the development of community nurses as public health nurses and the piloting of the World Health Organisation’s ‘family health nurse’ in Scotland (WHO 2007). Examples of service redesign offered by respondents ranged from primary to secondary care and from planned through to acute care services. They included the introduction of nurse-led dermatology outpatient services, the redesign of maternity services in response to a falling birth rate and a shortage of professionals, empowering optometrists to refer directly to ophthalmologists thus bypassing the general practitioner, the traditional gatekeeper of access to secondary services and the introduction of triage in Accident and Emergency departments.

Whilst the identification of categories helped to make sense of these data, it is important to note that the emergent categories were not mutually exclusive. Some of the innovations described did not fit discretely into any one category, but mapped across a number of categories. For example, the Centre for Change and Innovation in Scotland was charged with reducing waiting times – a policy imperative. The Centre for Change and Innovation applied queuing science and established a call centre where they created a new role for ‘schedulers’ or booking clerks to manage waiting lists from a patient-centred perspective:

“The way people currently get an appointment is you go to your GP, they decide that you need an appointment, they send a letter to the hospital, the hospital eventually finds your letter at the top of the list, they write and tell you when you have to come and that is how it currently works. The net effect of that is that one in seven people don’t come, a considerable number of the people who do come have actually had their problem disappear or get worse and be treated in the meantime and the way in which people are selected to come to a particular clinic is often done on the whim of a consultant. I will see this one, I’ll not see that one, this is urgent, this is not urgent. The science shows that if you wanted to, the science of queuing shows that if you want to see people and keep queues shorter, which should see people in date order of referral, apart from absolute emergencies which shouldn’t be referred to an outpatient clinic anyway, that people should be seen in date order of referral. The other thing is that if people are allowed to negotiate the time they are much less likely to fail to attend. So you take away from doctors the right to pick and choose their holidays at the last minute, you take away from doctors the right to select who is coming to the clinic at whatever time. You put all that in a telephone centre where schedulers will actually negotiate with patients and say you know you can have an appointment in the next month is there a time you can and can’t do and you then deliver to the patient choice; respect - you are not just told when to come, your life is respected; comfort – you are actually in the safety of your own home, you can ring that clinic and you can say I would rather not come on this particular day or if I am going to come on that day you are going to have to provide me with an ambulance because my son’s in America. You are providing some of those aspects of a different way of looking after people which you don’t if you just leave people in silence and ignorance for a long period of time and then summon them at a time not of their choosing to a clinic which may be cancelled at the last minute because of the whim of the person leading the clinic, who decides just not to turn up that week.” (CCI)

This innovation was, therefore, policy-related because it was developed in response to a policy imperative. It involved a redesign of the means of accessing secondary healthcare services and it incorporated the development of a new role.

Table 3.1 illustrates a section of the chart developed for the responses that I indexed as ‘policy-related innovations’. Where responses were abstracted and I recorded these in blue italics. The CMO respondent, for example, offered a detailed account of how public expectation has a significant impact on policy-related innovations. A 9% incidence of hospital-acquired infections is

unacceptable to the general public. Consequently, public expectation drives innovations in this area:

“Around about 9% of all patients coming into contact with NHS leave it as a result of that contact with an infection acquired during that contact. That is a figure which is actually not dramatically out of line with other healthcare systems around the world, but nonetheless it’s a figure which most people find astonishing. You couldn’t run an airline that way. The public expect us to take steps to manage that 9 down to as low a figure as we can possibly can get it.” (CMO)

During the process of refinement, data were either imported from or exported to other concepts or themes and cross-linkages were identified. These data I highlighted in turquoise and yellow in the charts. For example, the CEO’s account of how policy was developed with stakeholders was seen to be linked to the stakeholder theme and ‘public’ and ‘staff’ in particular. I purposely did not *cut* and then paste these issues as the process of highlighting *copied* and pasted sections helped to illustrate linkages across the charts between concepts and themes. I used the right hand comments section to record the rationale for insights such as linkages with other themes. Red font was used to highlight specific points of interest, so, for example, I noted respondent CCI’s emphasis on the focus of the Centre for Change and Innovation on practice and I linked this to her previous comments about the reform agenda as the purpose of the Centre for Change and Innovation.

KEY to table 3.1
Yellow highlight = where data offered insights such as linkages with other themes
Red italics = to highlight specific points
Turquoise highlight = where data were either imported from or exported to other themes during the process of refinement
Blue italics = abstraction and synthesis of original data as recommended by Ritchie and Spencer (i.e. refer to transcript for detail)

Table 3.1: Section of chart illustrating examples of policy-related innovations

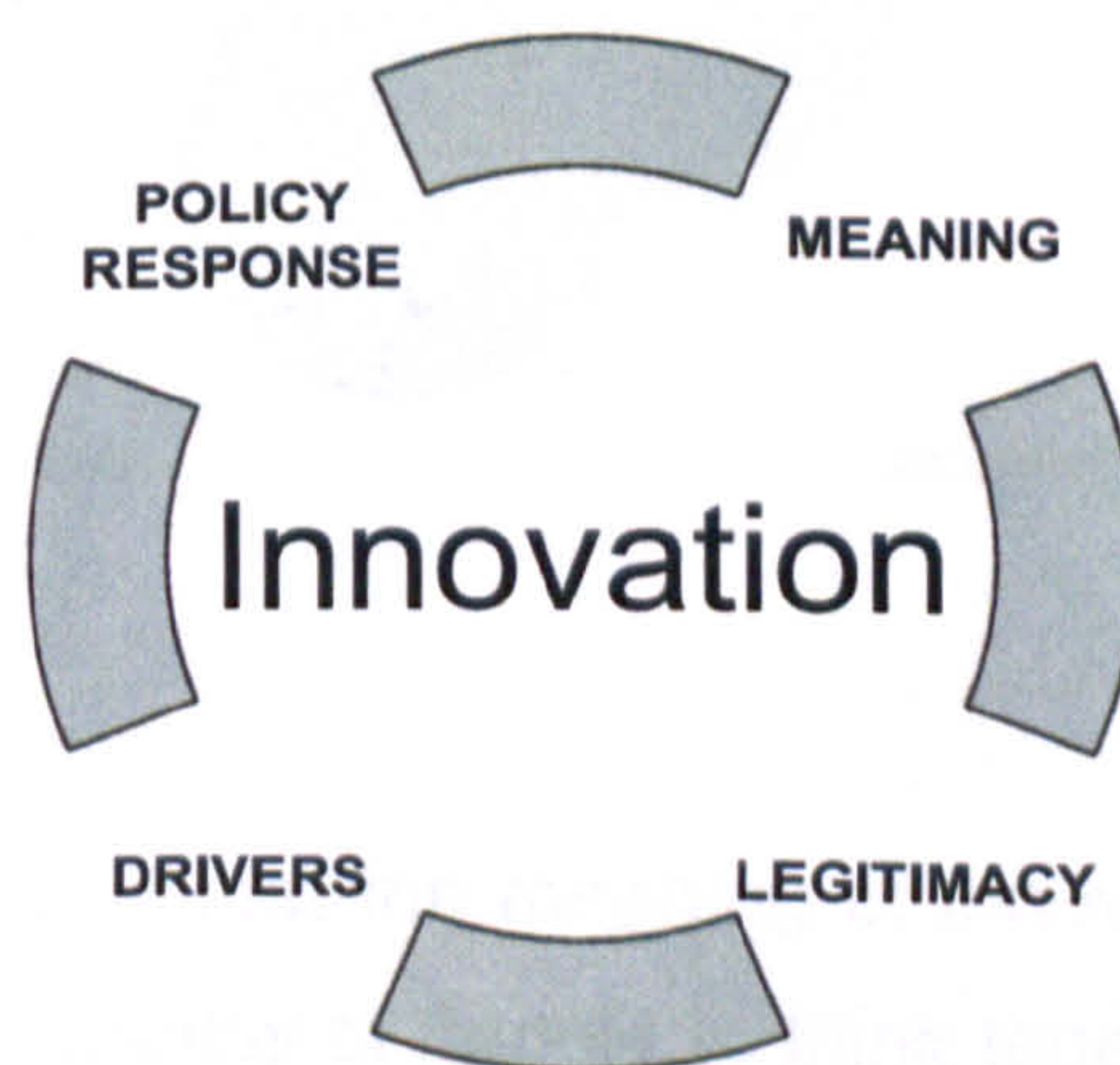
RESPONDENT	POLICY-RELATED	COMMENT
CCI	It is a good question for me because I run something called the Centre for Change and Innovation and I think the title is going to have to change because we have innovated nothing. All we have done is change and implementation because nothing that we are doing is something that people didn't know about or isn't based on research or hasn't been tried before. If there is any kind of innovation in it it's the fact that for once people are utterly focused on the implementation. There are masses of guidelines there are masses of good practice there is masses of people inventing stuff but the real thing that never happens is it never gets put into practice, so we are utterly focused on putting things into practice, and if that in itself is innovative to have a practice focused organisation then that's the innovation part of it.	CCI established to drive forward reform agenda so we are utterly focused on putting things into practice, and if that in itself is innovative to have a practice focused organisation then that's the innovation part of it.
CCI	Yes, the Civil Service is changing hugely and the Civil Service is, the change is typified by a number of principles; talk don't write; take risks, don't be secretive; focus on results rather than process. Now for the Civil Service that is just massive...It's a spirit of modernisation through public services that is nationwide...You know when I come in and do mad things now they think I am a moderniser whereas if I had gone in and done mad things 10 years ago they would have thought here is a person who hadn't quite been socialised into the system properly	Modernisation of the Civil Service
CEO	We actually have a different method of establishing policy , of developing policy, and we do that with our stakeholders in the Service rather than do it to, you know the traditional Civil Service model is that Civil Servants will write policy get it signed off by ministers then it is for the delivery agents to implement. We actually are developing policy with the stakeholders so when we developed Partnership for Care or our National Health in 2000 we started with a blank sheet of paper, we had discussions with stakeholders about what the issues were and about what the future might look like and policy emerged from those discussions, so that policy development process is much more inclusive and allows people to come up with the bright ideas and they can be built into policy...	Policy development processes per se are innovative. Policy developed in partnership with stakeholders link to public and staff
CMO	<i>Reduction in Hospital Acquired Infections</i>	
CMO	One of the things that we always worry about is the gap between evidence and practice. There is a constant, even where innovations are policy based, I mean you could go to immunisation policy for example, you could look at the immunisation policy around Hepatitis B, it has been in existence I think since about 1997 or 1998, it says that all pregnant women should be offered the Hepatitis B test, that Hepatitis B should be offered to all intravenous drug users and their associates, that it should be offered in care homes, that it should be offered to the parents of adopting children, that it should be offered in all custodial situations, is it? Nobody knows. What I do know is that (a) I know that nobody knows and I know that what we do know is very patchy application in all of those situations and yet there is innovation which is evidence-based, policy backed, and which has just never actually been put through into practice.	move to policy as a driver

A separate chart was prepared for each of the concepts within the thematic framework (Chapter 2, table 2.14). The charts provided a means of organising the interview data. They facilitated the process of synthesis and interpretation and the mapping of the linkages between concepts and across the themes. The charts also enabled the retrieval of the raw data within the presentation of my analysis.

3.3 Innovation

Innovation was predictably a key theme within my thematic framework. Synthesis and interpretation of respondents' views on innovation and cross-referencing with other concepts and themes in the framework led to the development of four key themes in relation to innovation, namely, the meaning of innovation, the legitimacy of an innovation, the drivers of innovation and the policy response to innovation. These themes are illustrated in figure 3.1 and each is discussed in turn.

Figure 3.1: Respondents' views of innovation



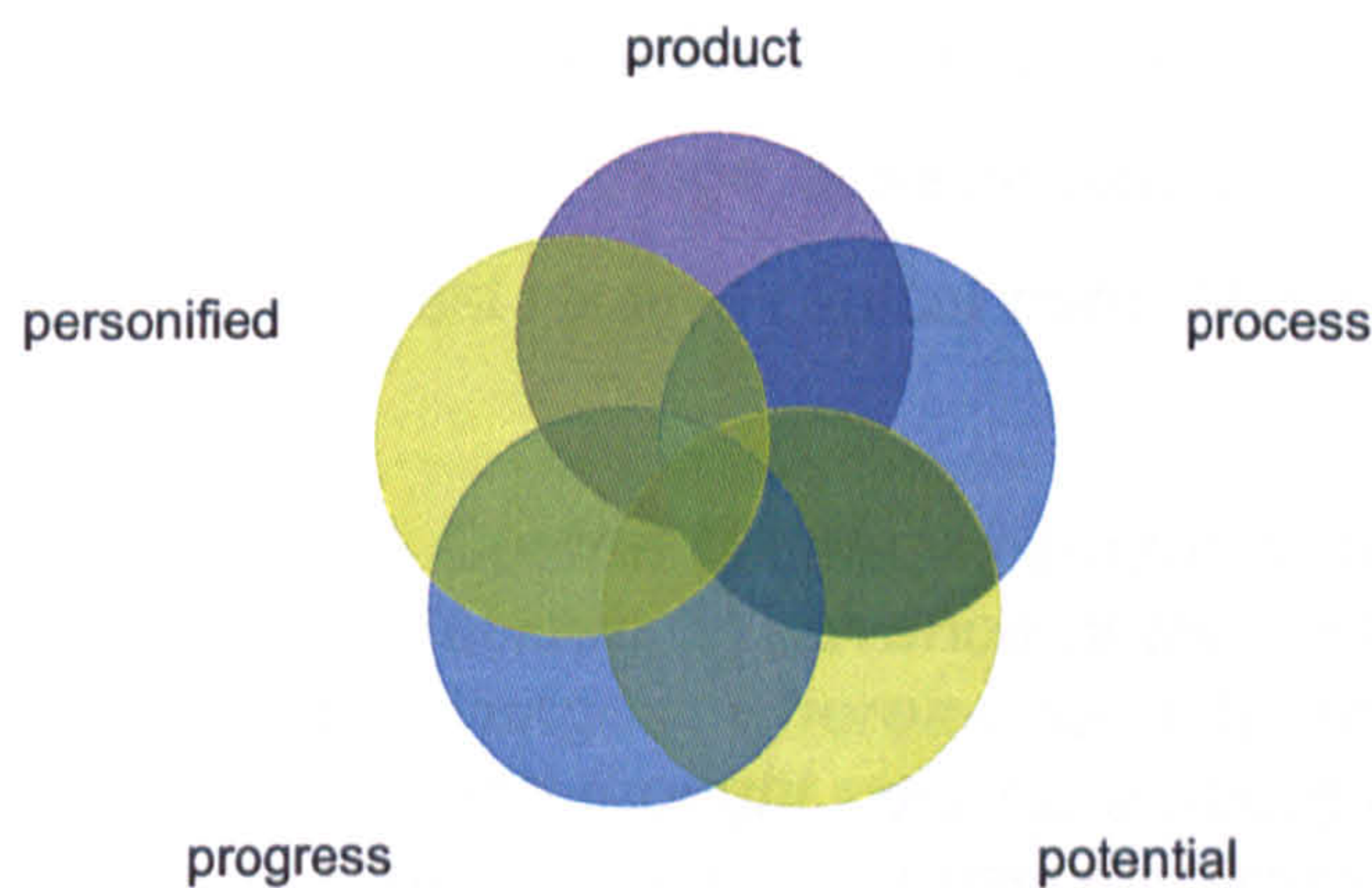
3.2.1 The meaning of innovation

When asked what 'innovation' means to them, respondents offered a wide range of responses. The concepts of "reform", "modernisation", "change", "improvement" and "innovation" appeared to be used interchangeably by respondents. This suggested that, in practice, the meaning of innovation is confused and highly subjective. It was acknowledged that innovation:

"islots of different things (PPI) and "..... can mean lots of different things" (CCI).

Through the interpretation and synthesis, I isolated five categories of responses which I have called the five "P's" of innovation in healthcare. These are illustrated in figure 3.2.

Figure 3.2: The 5 P's of innovation



Respondents suggested that the meaning of innovation was about human capacity, about the *potential* of people to think together and problem solve, to take risks, make mistakes and learn from them, for example:

"...bringing people together so they can start to problem solve and come up with creative solutions across service boundaries" (HDA).

It was proposed that innovation creates a culture which breeds further innovation, a culture where that potential is realised. The human genome project was cited as a *potential* source of innovation with the *potential* capacity to transform healthcare:

"It is the science, that all the genome research and all this sort of thing is just transforming what potential, what in twenty years' time we may be able to do, we may be able to treat cancer and it will no longer be the killer that it currently is, many of these things are possible" (QIS).

As a *process*, innovation was described as meaning the introduction of something new, of trying new things out, reflecting and being more imaginative. *Process* innovations included the reorganisation of services which respondents described as "*service-redesign*", "*streamlining*" or "*re-engineering*". A 'classic' example of service redesign cited was the fast tracking of certain patients in Accident and Emergency departments through the application of, for example, "triage" where patients are rapidly assessed upon arrival and allocated into one of three groups according to their clinical need. Their allocation then impacts on where they are further assessed and treated and by whom. Their triage assessment also implies the degree of urgency in which they must receive clinical care (Mackway-Jones 2006):

"I think it was the Central Middlesex Hospital, where within their A&E department they decided, in advance of the stuff that was coming out nationally about changes, whereas as a team within the A&E they actually sat down and thought very hard about the ways that patients were seen and treated, and as a result of some quite small changes they actually made quite a big difference to things like waiting times. They were some of the early implementers around things like triage and so on" (NHSC).

Nurse-led clinics were also cited as examples of *process* innovations. Here, nurses were providing assessment and intervention in outpatient clinics, such as rheumatology, which had previously been the sole domain of the medical profession. Enabling optometrists to refer patients directly to hospital-based ophthalmology services was cited as an innovation which streamlined healthcare processes:

“So previously the optometrist said to you, ‘I think you have got a cataract or said I know you have got a cataract, but you are to go to the GP’ who says ‘oh yes, I think that is probably right I will send to you to the consultant’ who then confirmed you had a cataract, and what needed to be done. So they cut out some of these processes” (CNO).

By missing out the general practitioner, who traditionally acted as the gatekeeper to services located in that which is known as ‘secondary care’, patients were offered speedier access to specialist care. Maternity services were another area cited where services were ‘redesigned’. In this context, service-redesign appeared to be a euphemism for the rationalisation of maternity services. The rationale offered was a fall in the birth rate and a shortage of healthcare professionals trained in obstetrics and midwifery care.

Innovation was seen as a *process* not just in areas of service provision but also within the policy arena itself. In Scotland, the policy development *process* had been redesigned to accommodate a philosophy of ‘partnership working’. Traditionally, those who developed healthcare policy were somewhat removed from those responsible for implementing it. It was argued that an innovative approach to policy-making had been adopted in Scotland, where those who would ultimately be responsible for implementing Government policy were engaged in the *process* of its development (see table 3.1, yellow highlighted section). Such innovations were seen to go beyond policy-making in healthcare as the whole of the Civil Service was said to be being “modernised”.

Innovation as a *product* included reference to new technologies that it was argued had the capacity to fundamentally change the way healthcare was provided. The introduction of a new *product*, disposable syringes, was offered as an example from the past, that transformed healthcare practices by negating the hitherto requirement to sterilize all such equipment locally prior to its use. An example from medical / pharmaceutical research offered was a pharmaceutical discovery that negated a hitherto requirement for surgical intervention. Histamine 2 (or H₂) antagonists control the production

of stomach acid and prevent acid build up which can lead to the development of stomach and duodenal ulcers. Prior to the introduction of H₂ antagonists, patients who developed ulcers required invasive surgical intervention. Here, pharmaceutical *product* innovation transformed healthcare practices.

More recent, new technologies were cited as currently transforming the way healthcare is provided, such as telemedicine:

“...bring in new technology and allowing us to do things very differently; supporting rural communities; the concept of not always having to have someone with a white coat sitting next to the patient; actually getting treatment provided in very different ways...”(CEO).

In the context of clinical care, the aim of telemedicine is to provide patients living in rural areas, and the health professional caring for them, with access to specialist practitioners, through the application of information and communication technologies, negating the need to travel long distances to access expert assessment and care (Wooton 2006).

Policy-led structural innovations were also cited and categorized as *products*. In Scotland, the Centre for Change and Innovation was a policy-led initiative established to drive forward innovation and change. In England an organisation set up with a similar remit was the Modernisation Agency. Other policy-led structural innovations cited included: call centres for managing elective hospital appointment processes; Health Action Zones to facilitate community-focused health improvement; Primary Care Trusts to enable commissioning of holistic healthcare provision, based on assessment of local need, through meaningful engagement with local communities and health service providers; the devolution of central power to Foundation Hospital Trusts with local management autonomy to manage their resources creatively and provide services based on a combination of professional expertise and assessment of need and clinical networks to encourage the promulgation of “best practice”. This ‘shopping list’ of structural innovations cited by respondents serves to highlight the relentless stream of policy initiatives that have impacted on the NHS in recent years. Whilst

respondents were able to offer them as policy innovations and articulate their potential, there was a degree of cynicism as to whether the people involved have in the past, and would in the future, be 'allowed' to carry out the functions these new structures were set up to do. The interference of Government, as a major stakeholder in healthcare, was considered likely and problematical in the light of the highly politicised nature of the healthcare agenda:

"...there will be shift over time, in theory at least towards the Primary Care Trusts with a more local community focus that they are being encouraged to look at much more holistic approaches, the health, looking at things like social inclusion and the generation and engaging with more creative partnerships and looking at how they deliver things differently and so on and becoming much more of a kind of health umbrella, a local political sort of organisation than they have been traditionally. And that also offers lots of opportunities for local people and primary care practitioners to feed through the system, to create innovation or to demand innovation from other providers, and again that has lots of opportunities. The issue is the extent to which they will be allowed to do it, because if people like Rosie Winterton [Government Minister], who I see on a semi regular basis, very eloquent about these things, and I think probably believes in them, but the problem is whether, in the next 18 months, the most important thing that is happening about the Health Service is the General Election will take place because the consequences are for change are that we will, there will be no encouragement for any risk-taking at all over the next 18 months that can't be presented as an unremittingly positive thing that makes people want to vote for the government. So that is always the dilemma between the kind of need to unfetter people, let them be creative, let them work at local solutions with local people, which there is a lot of good will to do, particularly in primary care, and this underlying concern of the government that the Health Service is just too important to be left to the people to run it". (PPI)

The meaning of innovation was *personified* through the introduction of new roles such as "Modern Matrons". Created in England to "improve the patient experience", modern matrons were believed to have the power to redesign care and services by putting patients at the centre (NHS 2003). In Scotland, access to services was seen to be hindered by archaic practices in the management of waiting lists for secondary care, which had hitherto been controlled by individual clinicians, some of whose practices were regarded by one respondent as rather idiosyncratic. As discussed above, a new call centre with dedicated booking clerks was established in order to involve

patients in the process of arranging hospital appointments. It was argued that from the patients' perspective this humanised the process and put them in the driving seat, which in turn improved attendance and productivity.

Whilst there may be merits in making health services more accessible for patients, the consequence of increasing productivity and the concomitant work intensification may paradoxically reduce the innovative capacity of an organisation. Respondents suggested that the ability and the time to think differently were requirements for developing innovative capacity. Work intensification arguably further eroded individuals' capacity to stand back from what they are doing and think differently about it.

The fifth "P" suggests that innovation is synonymous with *progress* and that progress is both essential and desirable – an economic imperative. The assumption that "innovation is (inevitably) a good thing" was, however, recognised as problematic by one respondent who argued that any innovation should be assessed on its own merits:

".... People, especially at Government and political level, certainly they know that it is a good thing, I mean innovation does carry with it the idea that this is a good thing, I think it is patently not..... It is a change, it is something new but I would always judge it on its merits rather than just accept because it is new, it has to be good" (Q1S2)

This assertion is itself problematic when another respondent argued that what may be perceived as innovative to one may be assessed as quite ordinary by another.

"I suppose if there were ten of us in a room, we would probably all think different things were innovative, and we might discount something because it seems pretty ordinary to us but actually it was pretty innovative" (CNO).

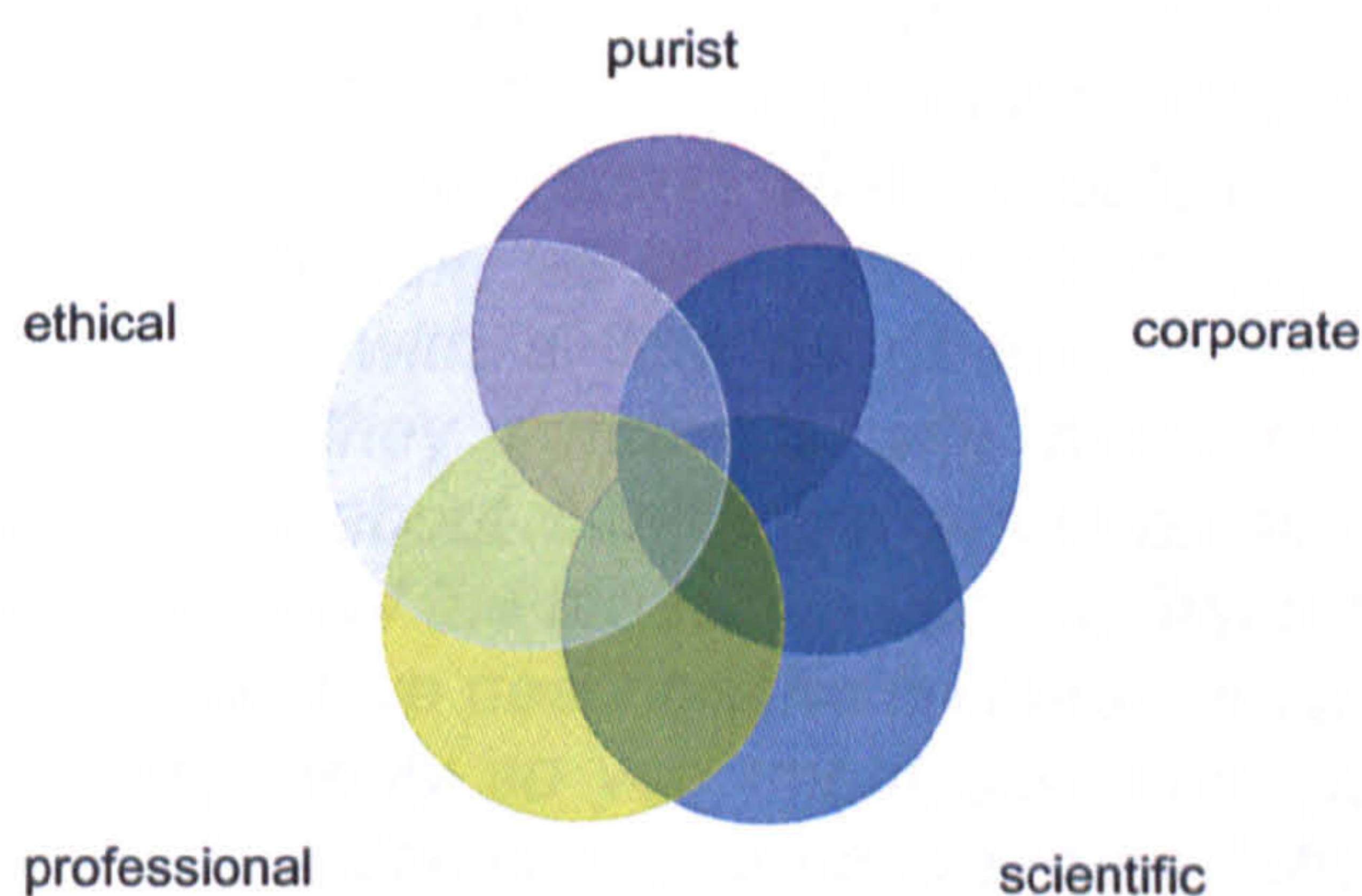
This conundrum illustrates the connections between an innovation and its stakeholders and sets the scene for the following discussion on policymakers' perspectives on what constitutes the legitimacy of an innovation.

3.3.2 Legitimacy of innovation

The use of the language of 'reform', 'change', 'modernisation', 'improvement' and 'innovation' interchangeably by respondents gave the impression that innovation was 'nowhere, and everywhere'. In practical terms, this meant that the legitimacy of any given innovation was not without controversy. The value of an innovation appeared to be a subjective assessment and innovation a relative concept. For some, the sustainability of an innovation was considered particularly important. It was argued that an innovation that was small and sustainable was more valuable than one that was high profile and yet unsustainable. The size of an innovation did not seem to matter because a very tiny change could have a profound impact.

Through interpretation and synthesis of the opinions expressed by respondents, I isolated five categories of perspective from which the legitimacy of an innovation may be assessed. These are represented as a typology in figure 3.3:

Figure 3.3: The legitimacy of an innovation: a typology of perspectives



No one individual offered a unilateral perspective, but each perhaps had one or more leaning(s) in a particular direction. For example, I labelled some responses from CCI and MA as predominately '*purist*' as they drew a clear

distinction between what they regarded as 'innovation' and that which they considered to be 'traditional improvement', where the latter was deemed to be of a lesser order than the former. The promulgation of what was considered "good practice", that is practice "already known about" whether "based on research and development" or "tried and tested elsewhere" was considered to be 'just' improvement. Innovation was regarded as "brand new", as something considerably more radical than traditional improvement:

"It is a good question for me because I run something called the Centre for Change and Innovation and I think the title is going to have to change because we have innovated nothing. All we have done is change and implementation because nothing that we are doing is something that people didn't know about or isn't based on research or hasn't been tried before..... "What is innovation? I get asked a lot what it is that we are doing that's new and we could provide a list of the things that we are doing and everything that we list people say "well that's not new, that's not new, we have been doing that in the Western Isles for years, been doing that in Glasgow, we have always done that before, that's what we used to do", so very little of what we say, there is very little that is brand new" (CCI).

and

"I think my thinking has changed since I started this work and I know more about innovation and the potential of innovation because when I first started I thought it would have potential in really moving things further perhaps than improvement traditional, what we now call traditional improvement had, but the more I understand about it and the more I understand about what other people are doing with innovation the more I understand what the potential is and the more I understand is that actually we have got a lot of people out there in the Health Service who with a little bit of help could really think very differently so that they come up with more innovative em, not solutions but ideas about healthcare provision and I think....., you know where in terms of the model we use the first order second order change model where we describe the first order changes more or less of the same thing really so you might see more patients in an Out Patients Department because you have reduced the DNAs¹ and that will bring the waiting time down and that's fantastic and that is really really good improvement but second order changes really thinking very differently, standing back and re-framing the picture and saying well why do we need Out Patients at all and do we need Out Patients? All the patients who are currently going there and are there other ways that we could communicate with these patients like

¹ When a patient does not turn up at the time when they have been offered a scheduled hospital appointment, the appointment is recorded in their file and in hospital statistics as a 'DNA' because they 'Did Not Attend'.

telephone conferencing and things or email consultations or just give patients good information and let them self-manage to a degree. So I think the potential is much greater than I originally thought it would be and I think it is down to really, it does have the potential to fundamentally change the way health services are delivered in comparison with the last 50 years really” (MA).

This ‘purist’ leaning was apparent in respondents who could be regarded as “innovation professionals” and whose primary focus was on innovation within the NHS. These respondents held key roles within the NHS and carried a responsibility for speeding up the reform process and developing an innovative culture. They appeared to be familiar with the literature in the field.

I considered some responses from QIS1 and CMO, for example, to be leaning towards a ‘scientific’ perspective. CMO defined innovation through a series of scientific and technological developments including plastic syringes, H2 antagonists and laparoscopic surgery:

“Who does vagotomy and pyloroplasty anymore? You know at one time in my life I was a part-time anaesthetist at the West Highland Hospital up in Oban and there would be a vagotomy and pyloplasty on every list. Did we have some sort of policy document about new gastroenterology? Of course we didn’t, we just, suddenly we had H2 antagonists and suddenly there wasn’t any vagotomy and pyloroplasty going on, you know” (CMO).

Similarly, QIS1 insisted that all innovations should have improved patient outcomes as their ultimate objective. His focus was on the core business of the organisation he leads which is to move towards a health service based on the best available evidence. Achieving a standards-based service was recognised as a challenging task:

“I think what we have all learned through bitter experience, although staff in the NHS are very committed to their work, they are human beings, under very considerable pressure and therefore innovation just doesn’t happen, and particularly those of us, most of the things that my organisation produces are guidelines, reports of various kinds, standards and this sort of thing, just the production of um.. a set of standards, a document whether it is on paper or whether it is electronic doesn’t produce the change in behaviour, it doesn’t

produce the innovation that one is looking for. One has got to think about how one follows that up. It can be through education and training. It can be through other support mechanisms...." (QIS1).

These respondents indicated that it was highly desirable for an innovation to be based on sound scientific evidence. However, it was recognised that this was not always the case, especially with regard to policy innovations and when experimentation, in a relatively controlled environment, was considered to be a pre-requisite to the development of this evidence. The CMO, a policymaker and a professional lead within the field of medicine argued:

"I think there is a spectrum of, need for, you have to make a choice between the balance between waiting for evidence which is so good and so overwhelming that it brooks no argument and the time which would be required to get that evidence. The simple fact is that the world isn't made to wait forever for things and so there is a spectrum of innovations which are, as I have said take the innovation around out of hours, that is an innovation which is going to be new and exciting and different but not evidence-based we just have to recognise that. Doesn't meant to say we shouldn't evaluate the process, evaluate it post hoc, study its effects, but it will not be an evaluation of evidence-based innovation and that's just the way it is" (CMO).

Additionally, QIS1, Director of QIS with a scientific background, advised:

"..today ... we are announcing ...something called 'The Intervention of Procedures Programme' which used to be called 'SERVIT' that was run by the colleges and is now run by NICE. NICE took it over but it has only been in England and Wales but it is now coming to Scotland and this is recognising that in..mainly in surgery, but surgeons will be introducing new and relatively untested procedures. This is all about advancement of science, you can't wait until you have got all the evidence, you do need to experiment, but there needs to be safeguards in terms of ..to make sure that the person who is introducing the new technique has had appropriate training in it and he or she is not just doing it at their own will but they have got clearance from, in this case, their clinical governance committee which is what we are proposing and they are telling patients what they are doing in the same, the same as clinical trials generally. But one has to accept first of all there are risks in all healthcare procedures and if we are going to push forward the frontiers then we have got to have trials and that means that one is doing things and involving

patients in treatments when we don't know what the outcome is going to be" (QIS1).

Those with a leaning towards a scientific perspective of innovation, where innovation is at best based on scientific evidence, would appear to hold a view in opposition to those who argued that 'true' innovation involved trying out brand new and radical ways of doing things.

Within this typology, a '*professional*' perspective of what constituted a legitimate innovation suggested that the pursuit of innovation can be for professional (and personal) ends, such as recognition and career progression. One respondent suggested that engaging in innovation provided a discipline the opportunity to professionalize their field:

"If we want to convince Chief Execs. etc. that these are effective, efficient, cost effective ways to be deploying their staff in the culture we have today you need to have the evidence that they work, so you have the hard evidence that they work. So, it's professionalising the field, you know, its just not anybody out there you know doing whatever they think is appropriate, and so it is about being able to tell quite clearly that we do know that these things work because we have got a research base for it, but also we know how to put them into practice and we know how to help your staff locally make those changes happen and we know how to help you make your organisation perform better" (HDA).

Another respondent suggested that a professional perspective could be construed as self-serving, if it was not clear how it contributed to health service policy priorities and patient benefit. In this case it was argued an innovation would be self-indulgent and, therefore, not a legitimate pursuit:

"Right, well innovation for its own sake em is welcome because we want people to try things out, but I think what you need to have is not innovation for its own sake solely you want some purposes to how it can be measured against what you want the health service to do in improvement. So a lot of people do all sorts of fancy things, brought in by clinical research and any models of working, but they are not always very cost effective or necessarily make that much difference to the betterment of our patients. So I think the first task is you have to have some template what ever you call it, against which you want to measure yourself, and I think the one thing the health service has been keen to push in the last few years is how does this make a

difference to patients, and we have measurements like access because patients rate that highly. So, if you're looking at where innovation should be going it should be measured against how does this measure against what patients want from the service and value from the service, and I think otherwise it's a little bit self indulgent" (DPC).

Those with a 'professional' perspective may, in the eyes of those with a 'scientific' perspective, put patients at risk if they were pursuing an innovation that was not underpinned by a strong, scientific evidence base. One respondent argued that patients could also be put at risk if an innovation was promulgated through professional networks without due regard to the requisite education and training. Laparoscopic surgery was offered as an example. Also known as 'key-hole' or minimally invasive surgery the application of this technology effectively required surgeons to be retrained in novel surgical techniques. However, the application of this innovation spread in advance of the necessary training which led to unforeseen, detrimental effects on patients:

"Great idea, but something which had a rocky start because individual surgeons, and in fact, people who weren't surgeons sometimes, quickly, almost too quickly, grasped the idea that this was the shape of the future and they could do this just like any other single operator innovation that they have previously done. Get one, or watch one, or see one do one, teach one, that is what we used to say, that is the way innovations were brought in, see one, do one, teach one and I think not unnaturally thought oh we will just do it like this with laparoscopy and of course it turned out to be a bit difficult because laparoscopy as a technique is something which requires actually much more careful training, much more careful preparation, a different set of skills from those required for open surgery, and there have been some worries about laparoscopic surgery, its speed of spread, its safety, its efficacy and so on, and there have been, you know we have had to sort of go back to the start in some respects and now codify entry to laparoscopic surgery in a way that we didn't in the past" (CMO).

This example highlights a potential dichotomy between the desires to speed up the diffusion of innovations and, at the same time, control the process.

Those with a 'corporate' perspective appeared to be the biggest critics of those perceived to be pursuing a professional / personal agenda. From a

'corporate' perspective, an innovation had to clearly "be measured against what you want the health service to do in improvement" (DPC) which I interpret to mean, to "deliver" on Government policy, as articulated by this respondent:

"The purpose of the Centre for Change and Innovation is to drive change in key areas within the NHS in Scotland. Those key areas are to arise from government policy, and those key areas within the wide spectrum of government policy to be selected because they are particularly problematic" (CCI).

In addition, from a corporate perspective there would be an expectation that an innovation would be proven to be cost effective and improve patient care before it could be considered legitimate.

The legitimacy of an innovation might also be contested on ethical grounds. For example, ethical concerns were raised when an innovation was seen to reduce mortality, but in turn, have a detrimental effect on morbidity. Here, the provision of neonatal care for younger and younger babies was cited as an example of innovation raising an ethical dilemma:

"...let me give you one example that immediately pops into my mind there and that is the benefit and dis-benefit associated with the innovations which have let us deal effectively with smaller and smaller babies to the extent that we are now dealing successfully with babies which are very tiny indeed below 1 kg. I am not an expert on this I wouldn't be surprised if it was significantly lower than 1 kg., but the point is that although you can achieve success at that end at that small baby end, the risk of less than 100% success goes up, so yes you do achieve some benefit and you do manage to get some children who are extremely small at birth who make it through to a normal happy chance of a fulfilling life, but you have a higher proportion at that innovative end of practice of babies who do not..... I think the question is, the issue that there is a relative definition of success. If success is a live baby as opposed to a dead baby then yes it is success, but success is defined as an entire whole and fully functioning human being then it's not success because we have created more live babies but we have more children who have more disabilities because these very very tiny babies sadly with the state of technology, innovative though it is, there is a price to be paid in that we know that although they are alive more of them will have disabilities and will require more support, that price is accepted by society as a reasonable cost in fact, in the face of the fact that you

don't know until you try which one is going to make it through. And I guess, we are all aware of the very difficult ethical choices that have to be made here and the way that we have increasingly had to regulate practice in this respect" (CMO).

The dilemma here appears to arise when innovations are applied uncritically, or the context in which they are applied may not be reviewed on a case-by-case basis, or periodically on a societal basis.

These different and sometimes competing perspectives of what might be regarded as a legitimate innovation clearly have the capacity to create considerable tension within the system. New Labour's policies became known as "The Third Way" (Finlayson 1999). Grounded in pragmatism, the slogan of "The Third Way" politics soon became "What counts is what works". The ethical dilemma cited above serves to illustrate the glibness of this sound bite and the reality of the complexity of assessing 'what works' in a clinical context. The political ideology of old Labour was replaced by the ideology of managerialism, based on the premise that the ends justify the means (Klein & Rafferty 1999). This, perhaps, offers an explanation as to why the Government appears to have invested considerably in what are potentially competing agendas. For example, substantial resources were invested in the Modernisation Agency (£230 million was cited by policymakers) where, in part, a 'purist' innovation agenda was being developed. Equally, considerable sums were, and continue to be, invested in the generation of national standards and guidelines - the 'corporate' agenda based on the type of evidence valued from a scientific perspective, that is:

"clinically relevant research, often from the basic sciences of medicine, but especially from patient centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy of the safety of therapeutic, rehabilitative, and preventative regimes...(it) both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer" (Sackett et al. 1996).

Evidence which may, paradoxically, have been initially generated, not as a consequence of a rationale scientific endeavour as R&D is constructed in

NHS R&D policy, but through the creative instinct of a serendipitous professional (Le Fanu 1999).

Some respondents offered contributions embracing multiple perspectives. The elements of my typology (figure 3.3) are, therefore, not mutually exclusive. It simply serves as a heuristic device to interpret the complexity of the context in which healthcare innovations are driven and developed.

3.3.3 Drivers of innovation

Through analysis of interview data, I identified four key drivers of innovation. One respondent cited Government policy and expressed the view that innovation was a *political imperative*. Other drivers cited by respondents included the ever increasing *demand for health services*, external factors which impact on the *supply of health services* and the *slow uptake of innovations* which have proven health and / or fiscal benefits. The latter, which may at first appear somewhat paradoxical, was recognised as a driver of process innovations, so that the gains of the innovations with proven health and / or fiscal benefits could be realised. Each of these is now examined in turn.

3.3.3.1 Innovation as a political Imperative

The UK Governments were cited as major drivers of health service innovations. One respondent, personally responsible for innovation and improvement within the NHS in Scotland, cited the:

“.....things that are keeping the minister awake at night” (CCI)

as a driver of innovation. According to another respondent, with similar responsibilities in England, a central driver for innovation within Government appears to rest within the Cabinet Office and the Department of Trade and Industry (DTI):

“..... there has been a quite interesting Cabinet Office report into innovation in the public sector which came out in the summer as a discussion document really, and you know, and also there has been a report from Department of Trade & Industry that came out just before Christmas. what they are saying in there is actually there is a lot of innovation going in the public sector, it's mainly, particularly Health Service, but it is mainly around devices like widgets on scalpels or pharmaceuticals or areas like that and increasingly it is about technology. Where all the reports, when they talking about health, but also some of the public sector industries, where they say we have a lack of creativity and innovation is in processes” (MA).

Innovation would therefore appear to be driven from within the heart of Government and regarded as an economic imperative. Guinet and Pilat (1999) have described innovation as the heartbeat of global market economies. They describe innovation as imperative for the development of new products, services and processes, which in turn are essential to increase market share, reduce costs and increase profits. They dramatically argue that if the pulse of innovation is missing within a company, it will die. 'Innovate or die' is the mantra within capitalist market economies such as the UK. The DTI describes innovation as:

“the motor of the modern economy turning ideas and knowledge into products and services” (DTI 2000 p 3).

Innovation is seen as a means of increasing productivity in order to realize the Government's central economic objective, which is to achieve high and sustainable levels of growth and employment through

- the exploitation of new science and technology (or research and development)
- changes in skills or business processes
- the exploitation of new markets (DTI 2002).

Respondent MA cited the appointment of a Minister for Innovation as a measure of the level of importance the Government places on innovation:

“There is a lot of interest in innovation at the moment, and it is sort of climbing up the ladder of importance and you know we even have Lord Warnock who is the Minister, we have a Minister for innovation, that means it must be important” (MA).

The UK Governments have publicly committed themselves to reform of the public services (discussed in chapter 4). As they see it, they too must 'innovate or die'.

3.3.3.2 Innovation as a consequence of increasing demand for healthcare

Demand for healthcare provision 'free at the point of delivery' has continued to outstrip the resources available since the inception of the NHS in 1946. Financed through a compulsory national insurance scheme, the aim of the NHS was to provide a comprehensive range of health services to all in need. One of the assumptions underpinning the establishment of the NHS was that supply would quickly outstrip demand as the health of the nation dramatically improved. This soon proved erroneous. The fact that a health service was available and 'free at the point of delivery' actually increased demand, as those who had hitherto been unable to afford healthcare made good use of the service (Klein 2001).

Respondents suggested that current demand pressures are a result of previous underinvestment in the NHS which is further exacerbated by four key drivers, namely demographic changes, scientific developments, globalisation and public expectations. A Chief Executive view was that:

"The status quo isn't an option. We have an ageing population, we have the ability to treat more and more new conditions; we are driving standards up through Quality Improvement Scotland, all of that puts extra demand on the Service so what we need to do is to provide the Service differently..." (CEO).

Demographic changes, and the ageing population, in particular, were seen to place increasing demands on the UK's health services. Scientific developments, with the potential to treat more and more conditions, also increase demand. A Director, with a science training stated:

"It is the science, that all the genome research and all this sort of thing is just transforming what potential, what thinking what again in twenty years' time we may be able to do, we may be able to treat cancer and it will no longer be the killer that it currently is, many of these things are possible" (QIS).

One respondent argued that scientific developments which appeared 'left field' were potentially problematic as they made it difficult for policy makers to plan for their consequences. A policymaker from the medical profession offered a hypothetical scenario:

"Think of the possibility, for example, of treating osteoarthritis which is really a disease of cartilage. How do we treat this disease of cartilage weight bearing circumstances largely? What we do is we whack out the entire load bearing circus on both sides of the joint and we replace them with some kind of steel prosthesis. Think of the possibility of doing it a different way. It is the cartilage which is diseased and degenerating, why don't they just replace the cartilage? So instead we inject into the joint some kind of genetically engineered new cartilage solution containing new bright viable cartilage cells which latch onto the damaged surface and recoat it. Now are we planning for large scale redundancies in theatre staff? No of course we are not because that kind of technology is there to do I think..... Yes, sometimes, there is technology which comes from left field." (CMO).

Within a global market economy, such scientific innovation is seen as an economic imperative. However, it also increases demand for health services that in turn acts as a driver for service innovation. There is a potential for an innovation to be seen here as part of the solution from a scientific perspective, and at the same time, potentially part of the problem, from a corporate, fiscal, perspective if a new technology does not 'fit in' with current Government policy priorities. This tension links to the discussion above as to whether an innovation is considered legitimate or not, and by whom.

The globalisation of healthcare knowledge and information through the media, and the internet in particular, has enabled some sections of the public to benchmark health service provision internationally. This in turn has increased demand for health services:

"...patient expectation is a big driver as well. It is not unusual for people wandering into GP surgeries now with the internet diagnosis, so people have a big expectation of what the service can do quite quickly." (CEO).

Benchmarking is a tool used to drive up standards *within* the NHS. For example, the Department of Health Essence of Care initiative:

“..helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice.” (Department of Health 2007c)

External benchmarking by members of the public, who can access the global market through the internet, arguably has the capacity to place the publicly-funded NHS at the mercy of the healthcare market. Respondents argued that access to the internet and higher levels of general education have led to a much more discerning *public*, who no longer look up to highly educated health professionals whom they consider best placed to make autonomous decisions about their healthcare requirements. An expert in public and patient involvement argued:

“Unquestionably there are also lots of people now who see the doctor much more as an equal, much more inclined to ask questions and their expectations of how they will respond to them....” (PPI).

Increasingly *“lots of people”* regard health professionals as their equals and partners in their healthcare. Arguably these are, in the main, knowledgeable, articulate, users of health services. They are likely to be people who vote and people the Governments have to listen to and respond to if they want to remain in office.

Respondents argued that, as a result of the Government's public commitment to reform of the health services, 'public' concerns regarding their health services rapidly become political concerns. For example:

“My observation is that ministers are most driven to introduce, admittedly arbitrary targets, in situations where there isn't any evidence, where all they have got is a weight of public opinion, where the only evidence is the evidence shows that the public wants it this way...” (CMO).

and political concerns, in turn, rapidly become managerial imperatives:

“Tony Blair is not going to win the next election is he if he doesn’t reach the targets so there is a lot of political pressure and the Government has invested a lot of money. They really have more than any other Government that I know since I have been in nursing which is since 1977. And so the Government have stuck their neck out and Tony Blair says if the NHS doesn’t improve by the time of the election ‘I will stand down’. So obviously he is putting, you know there is pressure coming down the line on that” (MA)

and

“That culture is now there in the Health Service isn’t it so sometimes what happens is that Chief Execs and Boards focus on the things that have to be changed because they have got a target that they have to make and some other things that perhaps would be as well to be changed they don’t quite get round to those because they are not the imperatives, they are not the “must do’s” the things that they absolutely have to do” (NHSC).

These quotes suggest that the legitimacy of politically-driven ‘innovations’ are contested. Thus, from the perspectives of the respondents in this study, demographic changes, scientific developments, globalisation and public expectations, all have the potential to become political priorities, and have the capacity to increase demand for healthcare, which in turn has the capacity to drive forward innovation.

3.3.3.3 Innovation as a result of factors which impact on the supply of health services

Respondents cited European Union (EU) legislation as an external driver for innovation. The 1993 EU Working Time Directive (Department of Health 2007a) which limits the number of hours any individual can legitimately be expected to work in a given week to a maximum of 48, was cited as a major force for innovation and change in the health service. For example:

“At the Royal College of Nursing I campaigned for ages to have nurse-led things. My reason quite often was both the interests of patients and also the social and economic well-being of nurses, more jobs, better jobs for nurses, and I beat at the doors of the dermatologists and they all said 'no no no no', if your girls wanted to be doctors they should have gone to university for 7 years. In reality now they are queuing at my door saying can we have a nurse working in our clinic, can we have a nurse-led clinic, and the reason why they want to do that is much more to do with the European working time directive and the fact that those consultants can't get a junior. It's to do with the consultant contract and the fact that they can't do all their work now without a junior in ten sessions a week and they are not going to get paid for more than ten sessions a week, and so now they are looking round at other possibilities and they are seeing that you might get a nurse to be able to do it” (CCI).

Introduced for health and safety reasons, the legislation, somewhat ironically, originally exempted doctors in training. However, they, and other exempted workers, were brought into line in 2000. EU member states were required to ensure that no doctor in training worked more than 48 hours a week from 1st August 2004. Hitherto, doctors in training were known to work 80 hours or more per week as a result of the on-call cover they were required to provide. Patients who are ill in hospital have no regard for the time of day and being on-call often meant actively working for most of the night and throughout the following day. Training in this way arguably exposed junior doctors to a wide range of clinical conditions and symptoms and this rationale for long working hours was strongly embedded within the tradition of medical training. The capacity of junior doctors to function effectively in such conditions was not challenged from within the medical establishment but imposed by EU legislation. Respondents cited the EU directive as a driver for innovation, particularly with respect to new nursing roles, which often provided services in areas which hitherto had been the protected domain of medicine. Nurse-led clinics and new roles for nurses such as nurse endoscopists were offered as examples.

Professional evidence was also cited as a factor with the capacity to impact on the supply side of health services and serve as a driver for innovation. A number of respondents cited the redesign of maternity services as an example:

“.....all of the evidence, all of the professional evidence suggests that we need to change dramatically how maternity services are delivered; falling birth rate, shortage of professional staff. So we need to do it differently; need to get value for money” (CEO).

However, professional evidence, as evidenced in this example, can sit in opposition to public opinion. This is discussed further in section 3.4.1.

3.3.3.4 The slow uptake of innovations as a driver of innovation

As discussed above, this category appears to be self-contradictory. However, respondents cited the slow uptake of innovations as a driver of innovation when these innovations were known to have proven health and / or fiscal benefits. Indeed, the rationale for establishing the Centre for Change and Innovation in Scotland and the Modernisation Agency in England, which themselves were arguably policy innovations, were to speed up the reform processes and the uptake of innovations and improvements across the NHS.

There appeared to be a general recognition by respondents that systematic approaches to the promulgation of innovations were lacking. For example:

“when you think about putting money in place around an innovation strand you need to think very hard about how you will then ensure that learning is taken up more systematically and I think that is one of the weaknesses of the way we fund innovation or seek to stimulate innovation more formally in the NHS” (PPI).

The spread of innovations was considered to be too slow and as a result resources were potentially wasted and patient care potentially compromised. This situation was regarded as a threat to the efficiency and / or effectiveness of the health service and hence a driver for process innovations.

3.3.4 The policy response

Healthcare policy in both England and Scotland stresses the importance of innovation (discussed in Chapter 4). Government Adviser, former NatWest Group chief executive and current non-Executive Director of the Northern Rock Bank, Sir Derek Wanless was cited by respondents as a man who had had a significant impact on the direction of travel within the NHS. For example, in terms of investment in information management and technology:

“Derek Wanless, when he reviewed the UK health services, estimated that we under-invest by a factor of 10 in IM&T based on his experience in the finance sector, so we have a big agenda to catch up and take hold” (CEO)

and in terms of public health:

“Obviously clear government drive on getting the problems in the Health Service sorted out. Public Health an add-on, add-on to the NHS Plan then a bit in Shifting the Balance of Power it became more central to that policy. But in the process of the funding going into the modernising the NHS, the structure of DH continued to parallel, you know, public health group and the rest sort of thing, that's sort of how it feels anyway, and the lack of integration across, Now what we are seeing, now is the rest, if you like, of the NHS, waking up through the Wanless reports, to the need to actually address prevention across the whole, not as an add-on or just a.... yeh...” (HDA).

It would appear that the impact of Wanless was not to be underestimated.

Within this wider policy context, three specific areas were identified as a policy response to the reform agenda. These included pay modernisation, structural developments and the setting and monitoring of national targets and standards.

3.3.4.1 Pay modernisation

Pay Modernisation was cited by respondents as a policy development which created a vehicle for increasing flexibility within the workforce (containing cost) and driving forward innovation and improvement.

According to the Department of Health, the Agenda for Change policy has led to the biggest overhaul of NHS-wide pay, terms and conditions in over 50 years (Department of Health 2004a). It has involved all NHS staff, with the exception of medical staff, who negotiated separate, and, arguably, much better pay, terms and conditions packages for consultants, junior doctors and GP's. Agenda for Change was implemented in the NHS, across the UK, on 1 December 2004. It involves a complex process of job evaluation carried out in partnerships between NHS Managers and Trade Union representatives. Job evaluation is coupled with a compulsory annual appraisal system where 'performance' is linked to annual increments in pay (Department of Health 2004b). The stated purpose is to ensure that the NHS workforce has the knowledge and skill to achieve the aims of the NHS. Consultant contracts aim to increase hospital consultants' commitment to the NHS through locally negotiated annual job plans developed within the context of nationally agreed criteria. New contracts for junior doctors embraced the European Union legislation (discussed above) and reduced the number of hours worked by hospital doctors, thus creating the opportunity for role substitution. The new General Medical Services (GMS) Contract has not only provided general practitioners with the option of opting out of on-call work, it has also linked their income to the achievement of performance targets aimed at improving productivity and the quality of services provided.

With reference to the GMS contract, respondents argued:

"We are about to introduce a new General Medical Services Contract. It is going to fundamentally change access to care by GP's out of hours. It will be extremely innovative and some very innovative thinking is going into how you maintain a primary care service 24 hours a day" (CMO)

“...the new GMS contract is the largest quality based contract attempted with professionals anywhere in the world, because a third of the money of GP practices will come from achieving quality targets, and the quality targets were developed by professionals mainly doctors because it was a GP contract initially...” (DPC).

3.3.4.2 Structural developments

NHS policy in both Scotland and England announced innovative structural developments to speed up the processes of reform, innovation and improvement. Respondents cited the Modernisation Agency (MA) in England:

“But also energetic change agents of that nature, the innovators, aren't naturally good teachers and spreaders, it's often a different skill. And the MA recognize that and say 'we will pick up the good ideas and we'll help spread it'. Now I've no idea whether it's going to be that successful, but since it's our best shot that we have ever tried because no one has ever tried that developmental approach systematically in the past in the health service.” (DPC).

“... I have been very interested to see the sorts of techniques and ways in which the Modernisation Agency has been attempting to harness innovation but often in very clear ways. You know we would have a very clear goal to reduce waiting times or you know increase access, whatever the particular targets are, how innovatively can we approach that? And they have used all sorts of really interesting techniques. I mean I think that you know a legacy, whatever happens to the Modernisation Agency, a legacy would be probably be the skilled people they have got round the country now who are much more familiar with improvement techniques and how you can innovate in a systematic and controlled sort of way which again is almost like a paradox” (HDA).

The Centre for Change and Innovation in Scotland (CCI) was also cited by respondents:

"I guess the other thing, talking of innovation, we have created 'The Centre for Change and Innovation' as the central resource that the Service can use to help that, to help the change happen." (CEO)

"There are masses of guidelines there are masses of good practice there is masses of people inventing stuff but the real thing that never happens is it never gets put into practice, so we (CCI) are utterly focused on putting things into practice, and if that in itself is innovative to have a practice focused organisation then that's the innovation part of it" (CCI).

As indicated in these responses, the Modernisation Agency and the Centre for Change and Innovation were policy responses to a political imperative. Subsequently, the Modernisation Agency has itself been 'modernised' suggesting that it did not prove to be as (cost) effective as originally anticipated. It has been considerably downsized and the NHS Institute for Innovation and Improvement is now located within the University of Warwick. The challenges of evaluating the impact of such a structural developments did not go unnoticed:

"One of the questions I was frequently asked is how I would evaluate the effectiveness of the Centre for Change and Innovation and that's an embarrassing question for me because I think it is very very difficult to evaluate it and I think the problem is complexity because the situation we are working in is so complex when you are deciding how to evaluate it what you are actually doing is simplifying, you are simplifying, you are saying of the possible reasons why this change might have taken place we are going to focus on one or two of the ones that actually relate to our interaction in this incredibly complex system. So what you do is you make a simplistic analysis of what it was that happened, you try and attribute some of the change to the intervention that you are particularly interested in you add a dose of 20/20 hindsight and see that this was or was not a successful change. In fact the success or the lack of success of any of the changes that we try to implement are quite often dependent on things that are completely outside of our control because you can't control a system" (CCI).

These developments highlight a dissonance between the rhetoric of Government policy and the reality of Government policy-making. It is clearly considered legitimate for the Government to invest considerable sums of tax payers' monies into structural developments like the Modernisation Agency and the Centre for Change and Innovation. However, this is done in the

absence of either an evidence base to justify the investment or an evaluation strategy to demonstrate accountability for a return on that investment, irrespective of how difficult this might prove to be in practice. It would be difficult to imagine anyone receiving Government monies to invest in innovating and improving patient care under these terms.

Other structural developments cited by policymakers included the National Institute for Clinical Excellence (NICE) in England:

“Well I always, because I am boring, I always like when I give presentations to flag up the Prime Minister’s four principles about public service reform. And what he has enunciated, and I think it is a good framework, is 1) that in any national organisation we need to have national standards, that’s how we got national service framework that’s how we got NICE.....” (DPC)

and Quality Improvement Scotland (QIS):

“.....we are driving standards up through Quality Improvement Scotland” (CEO).

In England and Wales, the Government established the Healthcare Commission (HC) (Healthcare Commission 2005) to assesses local compliance with national guidance. In Scotland, the two functions of producing national guidance and monitoring compliance are incorporated into one national organisation – Quality Improvement Scotland (QIS).

3.3.4.3 National targets and standards

With NICE and QIS established to develop national clinical standards and guidance, and QIS and the HC monitoring compliance, other developments were cited by respondents as additional policy initiated innovations to drive forward innovation in service provision. These included the setting of *national targets* and the development of *National Service Frameworks (NSFs)*.

Respondents acknowledged the legitimacy and the significant contribution of national standards:

“evidence about evidence should come centre, I don’t think people should have to go about rooting that out on their own and that can be the lever for change that is exerted from the top” (QIS2)

“... I think that in many ways a lot of the changes in the Health Service would not have happened without there being the national standard that then people were required to implement” (NHSC)

and the inherent challenges were acknowledged:

“We are able to populate frameworks and targets with evidence-based targets and part of the move over the last five years to a standards driven health service is a very bold one, and it is a very testing one, not least because actually the evidence is a bit thin in places” (CMO).

However, the centralisation of standard setting and the subsequent monitoring of these standards through national ‘performance management’ systems were regarded as problematic, when the methods were too prescriptive and did not allow for local freedom to address local priorities or determine the means of implementation:

“I think what the target culture does is set, it sets an atmosphere in an environment that perhaps says that one bit of innovation is more important than another from a Government perspective or a national perspective but that might not actually be the local perspective, so it distorts what is seen as local priorities and perhaps local innovations that could happen because you have got to do a certain thing because there is a national target for it..... you might get a bit of policy that is perceived to be the thing to implement on a national basis and it doesn’t fit the local circumstances and that therefore stops what might be a jolly good way that people were actually developing something or doing something different because they are told they can’t do that because they have got to do it a certain way. Now I think a really good example of that is the mental health NSF. Whereas some of the things in that were quite appropriate for some areas but they didn’t quite fit others, yet everybody had to have a crisis resolution team, they had to have an assertive outreach team because that is what the NSF said and that’s the policy that was going to be implemented on a national basis. Whereas what they

were doing locally was perfectly appropriate and was meeting the need and was dealing with the thing that the piece of policy wanted to, was set in place to deal with. Yet they had to change it all because the policy said no you have got to do it this way. So I think that's sort of balance between policy being developed in a way that reflects innovation but doesn't then impose, it's back to the targets thing, it doesn't say that everybody has got to do it exactly the same way..." (NHSC).

There was a sense that 'one solution does not fit all' and that, whilst there was recognition of the value of setting standards nationally, there was a view that the means of implementation should be determined locally. As one respondent put it:

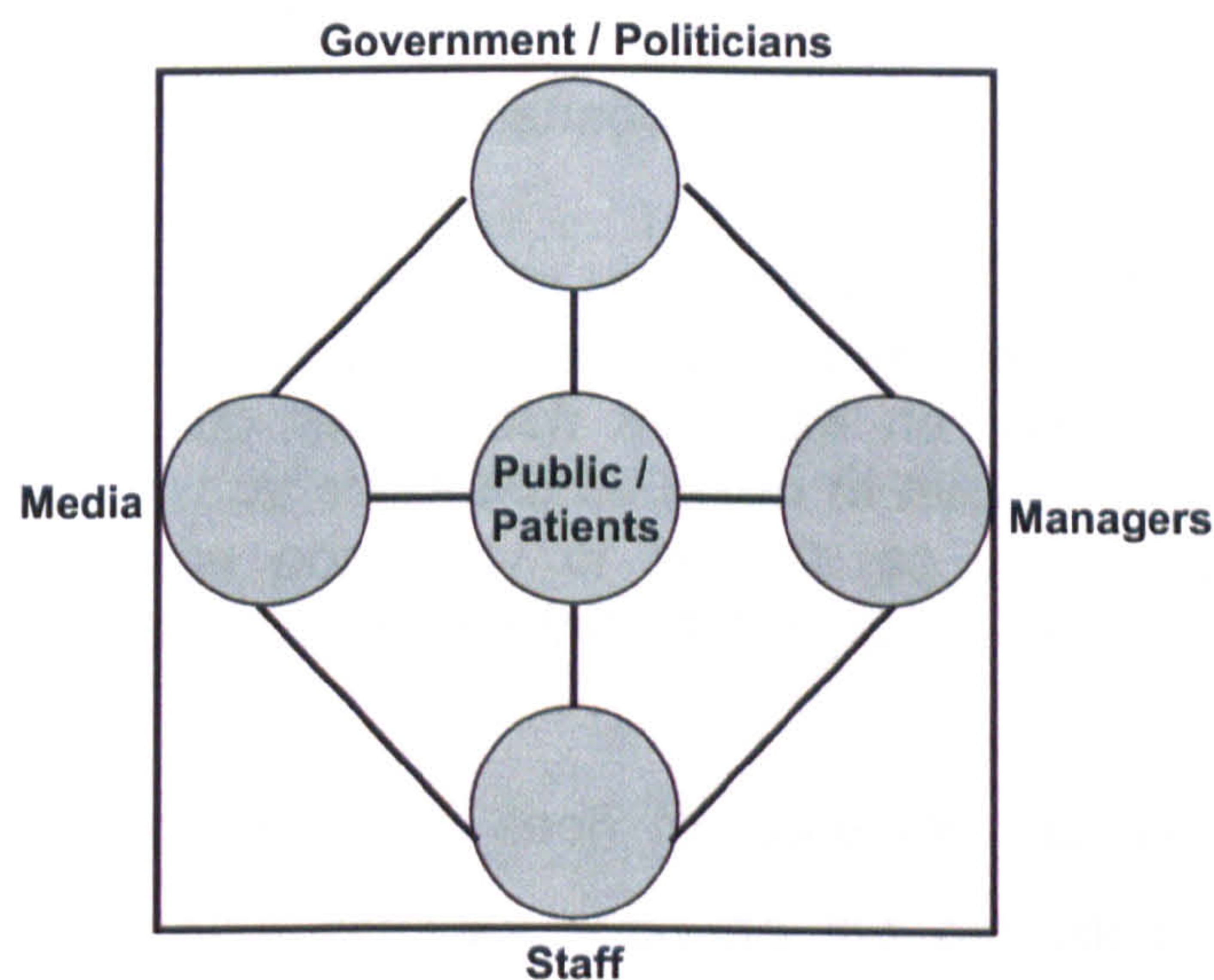
"The assumption inherent within the evidence-based standards agenda is that healthcare is controlled and predictable – it is in practice much more chaotic" (HDA).

However, the setting and monitoring of standards nationally creates a paradox within an NHS that is required to be innovative, if it is to survive. The monitoring of national standards appears to require centralised 'command and control' methods of performance management. These were the very managerial methods that New Labour berated the previous Conservative Government for adopting and stifling innovation as a consequence (see chapter 4). On the one hand, the Government were calling for innovation within the health service and on the other they were commanding and controlling a standardised service from the centre with the latter, respondents argued, having the capacity to stifle innovation.

3.4 Stakeholders

Analysis of interviews suggests that there is a wide range of people who may be considered stakeholders in innovation within the NHS. Synthesis of these data led me to cluster those who were reported to have a stake in NHS innovations into five overarching groups of stakeholders. These are illustrated in figure 3.4 and are each discussed in the following sections.

Figure 3.4: Groups of stakeholders in innovation



3.4.1 The public as stakeholders

Respondents argued that society as a whole was more litigious and this was a factor of the development of a widespread questioning culture. Within this context, (sections of) the public were far more informed about health matters than they had been in the past and, as Wanless (2000) had urged, sections of the public were considered to be “fully engaged” in their personal health agenda. The increasingly articulate public were more vocal about the direction of *their* health services. It was stated that public opinion influenced political targets. For example, as a result of analysis of complaints about the health service, it was argued that access to healthcare (or waiting times) was *the* key concern raised by the public. There did not appear to be any

deeper analysis as to whether 'complainers' were representative of the population, but they were clearly vocal, and in this instance demonstrating a greater capacity to influence political agendas than their silent neighbours, whether they be content, inarticulate or disaffected or any combination of these possibilities.

In this instance, the public are seen by respondents as enablers of change and innovation. The establishment of call centres in Scotland to manage waiting lists and reduce waiting times, was arguably a direct response to public opinion. It was suggested that public opinion was a driver for healthcare reform and the setting of standards. For instance, the public were described as increasingly risk averse and were seen to have low levels of tolerance when it came to patient safety issues such as hospital acquired infection. As a consequence, management of risk was considered a priority:

"Openness, accountability, transparency, reveals to the public that there is a level of dis-benefit or harm associated with a certain procedure, up with which they will no longer put. There is an expectation that steps will be taken to minimise the risk of harm and maximise the possibility of benefit, so you have to put in place procedures to make sure that that happens" (CMO).

In addition, the public were seen to have the capacity to influence the establishment of new services such as the provision of complementary therapies by the NHS (QIS).

The public were also seen as resisters to change and innovation. The public voice arguing to 'save our local hospital' was cited as a resistance to change, even in the face of 'evidence' of 'better patient outcomes' if services were centralised:

"People love the institutions they are used to around the NHS, a much loved hospital .. even though it maybe out of date, not fit for purpose any more, but try closing one!" (CEO)

and

"So quite often and in ways that we don't predict the public are resistant to change and obviously particularly when that change

involves removal of services from localities, like through investment we are able to provide what is a clinically more effective service from a smaller number of locations. This is something that, as you will know in Glasgow at the moment these issues are very controversial indeed” (QIS).

The dichotomy of patients calling for national standards based on scientific evidence, to end the so called postcode lottery, on the one hand, and then arguing against the recommendations of NICE on the other hand, was cited as a barrier to innovation and improvement and as an example of the impact of public opinion. Patients expecting to see a doctor, and not a nurse, was also cited as a resistor to role substitution:

“... there are many cases where the public can actually be an inhibiting factor in this..... and I think there is evidence both ways, but the public expect to see a doctor rather than a nurse, and if they don't see a doctor, some people feel they have been short changed” (QIS).

and patients' resistance to the use of information technology (IT) during healthcare consultations because IT was seen to dehumanise healthcare:

“I was reading something relatively recently in a different context about all sorts of electronic prompts that are now available to GPs, but I gather this has a mixed reaction from members of the public, partly because people feel that for the doctor to have his attention divided between them and the computer screen is not good; but also they felt well the doctor ought to know all these things, he shouldn't need to have the assistance of the computer to enable him to do it” (QIS).

Whilst Wanless (2000) argued that public engagement in healthcare was of fundamental importance to both the nation's health and the longer term affordability of the NHS, respondents in this study acknowledged that recognition of the public as stakeholders created considerable tension within the healthcare system. On the one hand, patient expectation was cited as a key driver for healthcare reform and, on the other, it was argued that the public generally do not like, and will resist, change. The relocation and centralisation of Glasgow maternity services was cited as a *public relations*

disaster (QIS2) and policymakers argued that public and patient involvement in healthcare had to be '*managed better*' (CEO).

3.4.2 The media as stakeholders

The media were seen to be instrumental in keeping 'health' high on the public and, therefore, the political agenda. They were seen to be *driven by anecdote* (PPI) and portray a very negative perspective, which it was suggested, did not reflect the experience of the majority:

"I was recently looking at these surveys that show that people's personal view of the Health Service is 60-65% but their perception of the national situation of the Health Service is 50% sort of thing. You think, how does that work? And it is because, you know, everybody seems to be having a reasonably good time with the Health Service as individuals when we have conversations, when we read stuff in the media the news isn't good, we think oh I must be wrong then, I must have been lucky" (PPI).

3.4.3 The UK Governments and politicians as stakeholders

Not only because of concerns that demand continues to outstrip supply, but also because the public are active stakeholders in health, the government and politicians in general are recognised as stakeholders themselves. Indeed, one respondent proposed that *"the Government will stand or fall by what happens within the health service"* (CEO). Because of the public interest in health, it was recognised as a key election issue. Respondents in Scotland argued that the political interest in health had intensified as a consequence of political devolution.

New Labour claimed they would end the command and control, top-down management of the NHS which they argued had been the hallmark of the previous Conservative administration. Perhaps because political careers were at stake, New Labour's rhetoric did not appear to be borne out in practice. It was suggested that an underlying concern within Government was that *"the NHS was too important to be left to those who deliver services to run them"* (PPI) The UK and the devolved Governments have committed themselves to improving the health of the nation and the NHS in particular. They have to demonstrate improvement and, in order to do that, have set a

series of political targets including, for example, improved access to healthcare and reduced waiting times.

Respondents offered that the UK Government and politicians were influenced by their political advisors, who, it was suggested, were the architects of some of the most radical proposals:

“some of the more radical ideas come from political leadership and political advisors but sometimes I think as it transmits itself through the health service, it gets bureaucratised out of existence and therefore the original idea lessens its usefulness” (DPC).

The Prime Minister’s staff located within the ‘No.10 Delivery Unit’, was also cited as key people policymakers sought to influence, because they in turn could influence Government thinking and Government policy:

“Yes, well what our role is, is to act if you like as spokespeople for people within healthcare organisations.....we are going to try and raise the issue, well we are not going to try, we are going to raise the issue with policy makers and also with the No. 10 Delivery Unit” (MA).

The fact that the Prime Minister (PM) himself has a framework for improving the NHS illustrates the size of the stake the Government has in the future of the NHS. The PM’s Framework was cited by one respondent (DPC) as a blueprint for achieving the NHS reforms and for fostering innovation. There are four elements to the PM’s framework namely, *national standards, devolution, flexible contracts and choice and contestability*. Presenting these concepts as a framework implies a sense of internal cohesion. However, the tensions raised within this chapter are embedded within this “framework”. The setting and monitoring of national targets and standards appear to re-enforce command and control centralisation making the rhetoric of devolution in England a distant reality in spite of the development of new NHS structures such as Foundation Hospitals. In addition, flexible contracts might be seen as a means of controlling the workforce to achieve national targets and standards, but they are also seen to increase work intensity and limit innovative capacity and patient choice. The assumption is that

contestability (or benchmarking for competition) has the capacity to both raise standards *and* reduce costs and, therefore, increase efficiency. One respondent (NHSC) argued that being recognised as having a good star rating (the mechanism used to performance manage and benchmark the NHS in England) should encourage innovation, but thought that, paradoxically, it may stifle it because innovation was a risky business and nobody wanted to risk losing a high rating. An organisation with a low star rating may think they have nothing to lose and, therefore, be willing to take risks. However, when careers are at stake, innovation and risk-taking may be very low on the agenda.

One respondent (CEO) also advised that politicians were sometimes inappropriately influenced by what they saw working in other countries, which they had an annoying tendency of imposing within the UK, out of context. In Scotland, where political devolution is a reality, health is a devolved responsibility. In a relatively new parliament, it was suggested that ministers were influenced mostly by their Civil Servants.

The PM's framework, coupled with the fact that one respondent indicated that they have to influence the PM's staff to bring about a change in healthcare policy, appears to imply that the Government, and the PM in particular, is personally attempting to command and control the NHS. Paradoxically, on New Labour's own admission, command and control limits the capacity to innovate. Perversely, the Government's 'hands on approach' to the management of the NHS is seen to act as a barrier to achieving the innovation they are advocating in their policies. In addition, it was noted that political sensitivity gave rise to an aversion to risk-taking, "*especially within sight of a General Election*" (PPI). Innovations which break the mould were considered risky. An aversion to risk-taking was cited as a barrier to innovation. Conversely, Ministerial endorsement of an innovation in Scotland was alluded to as an enabler of an initiative that was recognised as professionally sensitive.

3.4.4 Managers as stakeholders

Respondents argued that public and political interest in the NHS made managing the NHS particularly challenging. NHS management was described as a balancing act. Managers had to balance the sometimes competing agendas of public opinion, political imperatives and scientific evidence. Managers were responsible for supporting reform of the NHS and bringing innovation into the NHS. They were required to meet targets and modernise the service whilst under the gaze of the media, the public and their political masters.

Targets were thought of as a *'quick fix'* (QIS) , a *'sound bite'* for politicians who wanted to be seen to be improving the health service. Respondents considered some political targets as problematic because of their reductionist nature. Managers were forced to focus on specific issues at the expense of others. It was suggested that managers were not given permission (NHSC) to think about or respond to local need. The burgeoning number of political targets, referred to as *'targetitis'* (QIS), was seen as more of a problem than a solution, stifling the potential for any meaningful innovation. Managers know that they are "performance managed" and if targets are not seen to be met they are 'named and shamed' through the Star Rating of NHS Providers and they are likely to lose their job:

"We have seen it time and time again, if they don't meet their targets they get the sack" (NHSC).

These practices make managers risk averse. *"You cannot afford to get it wrong"* (CEO). Consequently, managers who supported innovation were recognized as exceptional and willing to take a personal risk.

One informant described the gulf between the Government rhetoric and the behaviour of ministers in their dealings with NHS managers as a fundamental barrier to managers' capacity to support innovation. He reported hearing a Government Minister extol the virtues of localism and how this thinking had underpinned the development of policy around creating Foundation Hospital Trusts. However, the same minister was known

to personally telephone NHS Chief Executives to berate them if they did not meet all of the national targets:

“Alan Milburn talks eloquently about localism and mutuality and the need to engage the public and finding more and more effective ways to do that, but this same Alan Milburn, when he was Secretary of State for Health, used to ‘phone up friends of mine who are Chief Executives of Trusts or Health Authorities as they were then, and when didn’t have good news and would harangue them personally over the ‘phone, ask “What the fuck they were doing” that kind of thing. It is quite difficult to see how you could, have the fairly fragile social entrepreneurial approach working really well for the Health Service if there is still this stonking great command and control voice at the end of the ‘phone demanding to know what the hell you are up to. That squashes innovation, innovation is of course about the capacity to make mistakes and learn as well as to be very successful and get lots of you know plaudits for so being. So there is a difficulty, but because of the high level of public and political scrutiny of the Health Service and the kind of fear that governments will stand or fall by what happens inside the Health Service that they won’t relinquish the command and control grip and therefore they won’t get their innovation because innovation is far too risky.” (PPI)

This illustrated a perceived dissonance between the rhetoric of Government philosophy and the daily reality of those managing the NHS. The rhetoric of innovation was, in reality, counterintuitive in a culture which focused on national standards and politically-driven targets, which respondents reported were sometimes at odds with clinical priorities and if not met, led to managers losing their jobs. One respondent, however, (DPC) argued that managers who were not able to manage national targets *and* support local innovation were simply lazy and lacked the capacity to conflate agendas. This particular policymaker had a medical background and I interpreted his responses to indicate a strong ‘corporate’ perspective on innovation (figure 3.3). He was very critical of middle managers for upholding a bureaucratic culture within the NHS and for being risk averse. He accused them of being silo thinkers, lacking in imagination, unable to conflate targets and in need of leadership development!

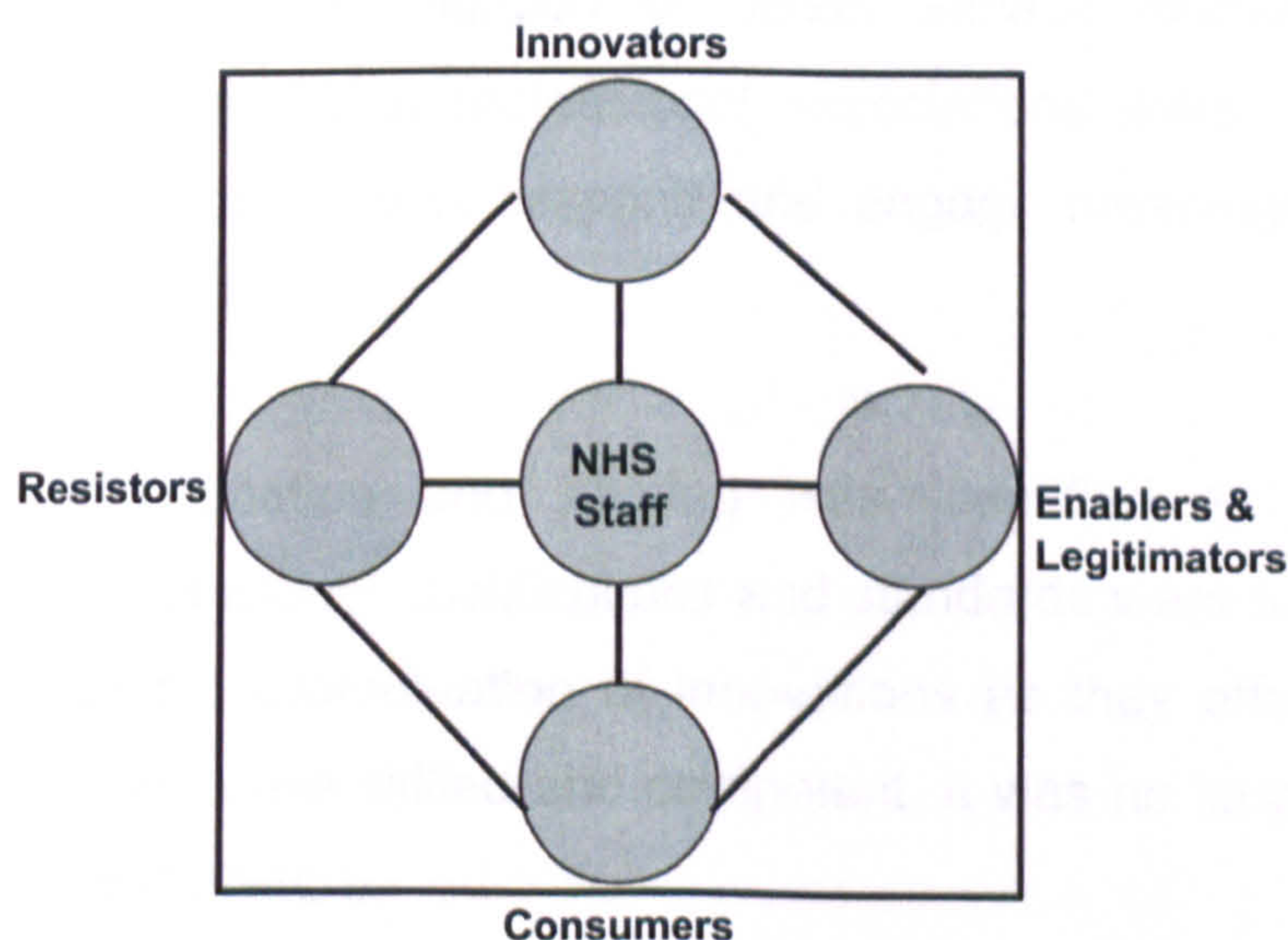
Whilst managers themselves were regarded as stakeholders in innovation, management support was recognized as a key factor if the potential of an innovation was to be realized. Managers were seen to be capable of making

or breaking an innovation proposed by any one other than the most tenacious innovator. It was suggested that the support of management for anything that was not seen to be a managerial imperative was virtually negligible. The rhetoric of devolution within the PM's framework for reform of the NHS was reported to be the experience of those working in the NHS in England. Where political power had been devolved in Scotland, the rhetoric of empowerment and partnership working was perhaps more of a reality.

3.4.5 NHS staff as stakeholders

NHS staff were also seen to have a stake in innovation which they might approach from a number of perspectives depending on the context in which they found themselves (see figure 3.5). By creating this typology my intention is not to imply that stakeholders held unitary interests. I acknowledge that all actors have multiple interests which can be conflicting. My intention here is simply to offer this typology as a device for making sense of these data.

Figure 3.5: NHS staff approaches to innovation



One respondent acknowledged that NHS staff could themselves be consumers of healthcare. They were, therefore, arguably able to offer a perspective on innovation from this standpoint albeit one that was influenced

by their NHS role. NHS staff was also recognized as having the potential to innovate, to be social entrepreneurs and the architects of local innovation. The capacity of NHS staff to innovate was thought to be enabled when they were given the requisite *“space and time to see the bigger picture”* (HDA) and this potential was enhanced when these opportunities were afforded to teams. It was suggested that engaging in innovations can be professionally beneficial as it helps to *“professionalize a field”* (HDA).

Innovation potential was thought to be dependent upon organisational culture and management support, and inhibited by national targets. One respondent suggested, however, that the approach of local innovators *“would probably not be very scientific”* (QIS). This particular respondent had a scientific background who I considered to have a strong leaning towards a ‘scientific’ perspective of innovation (figure 3.3). Staff representative bodies were identified as partners in policy-led innovations such as pay and career modernisation and NHS staff were seen to have a stake in the legitimisation of innovations. One person's assessment of a positive innovation may be perceived by another as catastrophic if, for example, they lose their job as a consequence. In this regard, one respondent (PPI) highlighted the role of professional associations such as the Royal College of Nursing in the legitimisation and promulgation of health service innovations. Another, however, suggested that professional associations were too bureaucratic and, therefore, too slow to respond and engage meaningfully in times of rapid change (CCI).

Professional education and training was identified as an enabler of innovation. Professional qualifications and standards were seen to provide a safety net for the promulgation of innovations as they offered assurances that practitioners were skilled and competent. It was no longer *“see one, do one, teach one”* (CMO).

Policymakers noted that within some professional groups any innovation which fell short of their ‘Gold Standard’ of evidence of effectiveness was dismissed as irrelevant. It was also noted that an innovation is more likely to

be promulgated within a professional group if it recognized as "*invented by one of their own*" (CMO). "*Professional buy-in*" (CMO) to an innovation was considered an important enabling factor – especially when all concerned felt that they had a part to play in the success of an innovation. Other enabling factors cited were external factors beyond the immediate control of professional groups, such as EU legislation and the '*incentivising*' (DPC, CMO) of professional groups through, for example, the GMS contract. Health professionals were seen, in the main, to be conservative, sceptical and resistant to change. Any innovation, which threatens professional autonomy or status, erodes a power base, puts jobs in jeopardy or impacts significantly on productivity, will inevitably meet some resistance from staff and their representative bodies. Tribal loyalties were seen to come into play if a professional group felt threatened by an innovation. Examples offered here included medical resistance to innovations, which they may have regarded as an erosion of their professional autonomy, such as nurse-prescribing and midwifery-led care.

From this analysis of stakeholders, it would seem that there is considerable vested interest in the NHS. There would appear to be strong evidence of central command and control through national targets and it has been suggested that the Prime Minister himself was trying to 'manage' the NHS. Sensemaking of these data is complex because of the inherent contradictions and paradoxes. The Government itself seems at best confused and at worst duplicitous in both its words and its deeds with reports of a government minister berating Chief Executives for not meeting national targets and, at the same time, extolling the virtues of localism. There is a policy push for greater flexibility within the system, which should allow for and enable innovation, through the modernisation of pay and terms and conditions of employment. At the same time, endeavours to increase efficiency lead to work intensification which, arguably, squeezes out the space and the capacity to think and do things differently. Perhaps, ironically, "targetitis" has intensified the work of NHS managers to the point where it has squeezed out management's capacity to offer much needed support to enable local innovation to address local need.

3.5 Summary

In this chapter, a thematic framework constructed from analysis of interviews with policymakers has offered insight into the wide range of policymakers' interpretations of the concept of innovation in healthcare. Through analysis of their responses, I have developed and discussed a typology of innovations. I have also categorised policymakers' interpretations of the conditions in which they consider innovation to be a legitimate pursuit and highlighted the tensions inherent within these, sometimes, competing perspectives. Four key drivers of innovation in healthcare are identified and the policy response to these drivers, namely pay modernisation, structural developments and the setting and monitoring of national targets and standards, discussed. In addition, five groupings of stakeholders in healthcare innovations have been identified, namely the public, the media, the UK governments, healthcare managers and NHS staff. Through analysis of policymakers' views of the impact these stakeholder groupings have on innovation, the dynamic between this complex array of stakeholders has further illuminated the tensions and paradoxes surrounding innovations in healthcare.

In chapter four I discuss this analysis by examining the political and historical context in which these interviews with policymakers took place. This in turn sets the scene for the examination of the cases of innovations in healthcare in part three.

Chapter 4 Discussion of Policymakers' Perspectives

4.1 Introduction

The concept of innovation appeared with the mainstream of NHS policy when New Labour came into power in 1997. The interviews with policy makers in this study were conducted close to the end of Tony Blair's New Labour Government's second term of office (see table 2.1). Prior to New Labour's reforms, innovation had only featured within the context of R&D health policy, where, as stated in chapter 1, from a technical, rational perspective, R&D was regarded to be the natural precursor to innovation.

New Labour came into power with a landslide majority following three consecutive terms of Conservative (Tory) administration. The Tories had been led by the UK's first female Prime Minister Margaret Thatcher from 1979 through to 1990 and then by John Major from 1990 through to 1997. Prior to securing election victory, the elite within the Labour party had argued that the world had changed dramatically during 18 years of Conservative rule. They argued that these changes included the globalisation of markets and culture, the decline of traditional British industries and Trades Union membership, the emergence of new technology, service and information based industries, the transformation of the role of women, the rise of consumerism and disaffection with distant political institutions (Finlayson 1999; Klein 2001). Not only had the world changed, but so too had the electorate. Class-based politics was to be confined to the history books. Labour, according to the elite, had to acknowledge these 'social facts' and 'modernise'. If Labour was to get elected, they argued, Labour had to be pragmatic. It had to abandon the values which reflected the past, which essentially made Labour unelectable:

"...Blair's New Labour rhetoric requires that an ideological wedge is driven between the past and the future. Distance between "old" and "new" is achieved by denigrating the past and praising the present..."
(Klein & Rafferty 1999)

The Labour modernisers argued that the only way that a Labour Government could ever come to power would be if Labour changed too. “New” Labour, therefore, emerged as distinctly different from “Old” Labour. Most importantly, Clause 4 of the Labour constitution was revoked and Labour’s traditional commitment to public ownership of the means of production abandoned. New Labour sought to resolve the conflicts inherent in “the old” political ideologies of the left and the right by working in partnership with key stakeholders.

New Labour’s policies, based on sociological analysis (Giddens 1998) rather than political philosophy, became known as “The Third Way” after Giddens. Third Way policies, like those of the previous Conservative administration, promoted individual responsibility (Leadbeater 1988) and they embraced the market, not on ideological grounds but as a tool to achieve the fixed values and goals of New Labour. Grounded in pragmatism, the slogan of The Third Way soon became ‘What counts is what works’. The aim was to achieve social justice within the context of a dynamic market economy (Klein 2001), by whatever methods were available, based on the assumption that the ends justify the means. Klein (2001) argued that the key word was ‘new’ and a twin of new is ‘modernisation’ or ‘permanent revisionism’.

Part of New Labour’s election manifesto stated: “We want to save and modernise the NHS” (Labour Party 1997). This was particularly poignant in the light of the fact that New Labour were to inherit an NHS which, under the Conservative regime, had undergone some of the most far-reaching reforms since its inception (Klein 2001). A short account of the NHS New Labour inherited is necessary to explain the context of the New Labour reforms which, in turn, explain the context in which the policymakers interviewed, responded to the questions I posed. The discussion of the policymakers’ perspectives serve to illuminate the policy context in which the case studies of innovation examined in this study took place and further illuminate the conditions in which innovations both flourish and perish.

4.2 A Short History of the NHS Policy Context (1948-1997)

The UK's National Health Service (NHS) was a post war policy innovation financed through a compulsory National Insurance Scheme. The aim of the NHS was to provide a comprehensive range of health services to all in need. Introduced on 5th July 1948, the NHS was, for more than 20 years, the only comprehensive nationalised health service in the Western world. It was built on political compromise and fraught with controversy from inception, with "conflict within consensus" a common theme running throughout its political history (Klein 2001).

Despite political differences at the outset, there was a collective faith in the past achievements and the future potential of medical science to triumph over disease and illness (Klein 2001). Thus, medicine, and medical "scientific knowledge" in particular, was reified. This put the medical profession in a very strong negotiating position when the NHS was in the process of being established. Consequently, a number of concessions were achieved:

- GPs retained their independent contractor status
- hospital consultants retained the option of engaging in private practice and they were afforded access to 'pay beds' in NHS hospitals
- a system of 'distinction awards' was introduced for consultants to be awarded on a peer review basis which enabled those in receipt of an award to gain a significant increase in their salary
- doctors secured a major role for themselves in the administration of the new Health Service at all levels
- proposals to put the control of local health services into the hands of local Government was successfully resisted (Ham 1999)

The then Minister of Health, Aneurin Bevan, was reported to have said that he stuffed the mouths of hospital consultants with gold (Abel-Smith 1964)! Not only did hospital consultants secure financial privilege, but all doctors

maintained professional autonomy and the medical profession was assured substantial power and influence in the future running of the service.

The assumption that medical science would triumph over disease was coupled with the assumption that a comprehensive health service, free at the point of delivery, would over time become less of a burden on the public purse as the health of the nation systematically improved (Klein 2001). Despite the regular injection of resources into the NHS, demand has continuously outstripped supply. Advances in medical science and technology have made new, hitherto unthinkable, interventions possible. New interventions have the capacity to create new demand and reduce morbidity (a stated goal of the NHS). People, in turn, live longer and place more and often complex (and, therefore, expensive) demands on the health services as they grow older. Nature has at times responded or adapted to new interventions in unanticipated ways. New morbidities, some, arguably iatrogenic, have appeared or mutated in response to the use (or abuse) of medico-scientific technological interventions (a point I elaborate upon in Chapter 7). Thus, history has shown that the assumption that a National Health Service, free at the point of delivery, could effectively socially engineer improvements in the health and economic productivity of the nation and, as a consequence, gradually become less of a burden on the public purse, was fundamentally flawed.

The NHS has, therefore, been high on the political agenda throughout its history (Greer 2004). Klein (2001) has proposed three main reasons for this. Firstly, there is a general consensus amongst the population that "free" medical care for the entire population is a good thing. In that sense, the NHS has become an important British institution and, thus, a central political issue for those in power and those aspiring to positions of power within the UK polity. Secondly "free" medical care is in truth a myth. It has to be paid for somehow and any state-owned institution with a track record where demand outstrips supply, that is dependent upon the Treasury purse, is inevitably high on the political agenda. Thirdly, the diversity of the NHS workforce, with multiple professional, semi-professional and ancillary groups and sub-

groups, each with their own interests and representative organisations, adds significantly to the complexity and the politics of the NHS. Consequently, the NHS has undergone serial reforms since its inception.

Throughout the first thirty years of the NHS, the authority of the medical establishment, based on the normative privileging of medical scientific knowledge, remained effectively unchallenged. For this reason, Klein (2001) refers to the reforms which began under Margaret Thatcher's Conservative administration as the 'big bang' reforms. These reforms (Secretaries of State for Health 1989a; Secretaries of State for Health 1989b) both in content and through their mode of conception, fundamentally challenged the hitherto normative assumption that the medical establishment should, based on the primacy of their professional knowledge, dominate NHS decision-making.

Fuelled by the oil crisis of the mid-1970's, many Conservatives were reported to have regarded the NHS as a manifestation of a "post war malaise". The NHS was considered to be over-bureaucratized, dominated by powerful professions, lacking in both consumer choice and incentives for innovation and efficiency and hugely demanding on the public purse (Butler 1992). Margaret Thatcher turned to the profit-orientated private sector to provide the solution to the ills of the NHS. Based on the assumption that the cure for all the countries ills, including the perceived problems within the National Health Service (NHS), lay within 'better management', this ideology, known as 'managerialism', was initially expressed unequivocally in 1980 by Michael Heseltine when he was Secretary of State for the Environment:

"Efficient management is the key to (national) revival...And the management ethos must run right through our national life – private and public companies, civil service, nationalised industries, local government, the National Health Service." (Michael Heseltine, British Secretary of State for the Environment 1980, cited by Pollitt (1993))

Many of the publicly-funded utilities which were viewed in the same light were sold off to the private sector during the 1970's. The privatization of the NHS, viewed by the public as a national institution, was considered politically a step too far. A middle ground approach was adopted where private sector

values were introduced into the NHS. This, it was argued, would increase efficiency and make the NHS more "consumer orientated". The key to achieving efficiency within the NHS was to import private sector management methods (and personnel) into the public sector (Griffiths 1983).

Sir Roy Griffiths, the then Deputy Chairman and Chief Executive of the food retailer Sainsbury's, and his team were invited by the Secretary of State to assess the quality of management within the NHS. In their report, they were critical of the NHS's lack of ability to provide a service which focused on the needs of its users. To make the NHS more efficient and more responsive to service users the government's private sector advisers prescribed an injection of managerialism. Professional managers should be introduced into the NHS and made accountable for reducing costs and increasing efficiency. The majority of Griffiths' recommendations were accepted and 'General Management' was introduced in the NHS in 1983, thus creating a whole new health service occupation and hierarchy (Kirkpatrick, Ackroyd S, & Walker 2005). This was to become known as "The New Public Sector Management" (NPM) (Clarke & Newman 1997). The managerialist goal of the New Public Sector Management (NPM) Managers initially manifest through a series of initiatives which were arguably 'soft targets', inasmuch as they focused on areas where managers' authority to make decisions, was relatively easy to exercise. Under the guidance of Marks and Spencer chief Sir Derek Raynor, NHS managers were charged with scrutinising areas for potential savings, such as transport services, recruitment advertising and residential accommodation for NHS staff. Through the application of management techniques, it was controversially estimated that the NHS could save a potential £750M from the sale of NHS staff residential accommodation (Ham 1999), with little or no regard for staff who 'lived in'. In 1983 NHS managers were also charged with the commercial tendering of their laundry, catering and domestic services in order to "purchase" the most cost effective service and test the cost effectiveness of the current NHS provision within the marketplace. Whilst the majority of contracts were awarded to NHS providers, costs were pared down significantly, which yielded an estimated saving of £110M in the first round of contracting (Ham 1999). These

initiatives were closely followed in 1984 by efficiency drives known as “cost improvement programmes”, which were to release cash for service developments through greater efficiency. It is reported that these initiatives yielded approx £1B per annum in the first ten years of implementation (Ham 1999). The “income generation initiative” was launched in 1988 and an estimated £10M was generated through the introduction of car park charging, the leasing of retail premises and the provision of services for private patients. Thus, the new breed of NPM managers were able to introduce some cost savings by addressing issues that were relatively peripheral to the concerns of the powerful medical establishment, but quite fundamental to those lower in the organisational pecking order.

Once fiscal efficiency was increased in the areas where the NHS already had bureaucratic control before the introduction of General Management, the Conservative Government aimed to tackle the powerful professions who effectively had an unfettered reign over NHS expenditure. In 1987, the Government introduced the first of a series of reforms of the NHS which focused on primary care provision (Secretaries of State for Social Services and others 1987). The policy aims were to raise standards of health and healthcare, increase the emphasis on health promotion and health education activities and offer wider choice and information to patients. More importantly, it heralded the introduction of a new contract for GPs and dentists, which essentially incentivised conformity to Government policy with additional payments when centrally-defined targets were met. More mouths were being stuffed with more gold, but this time it was GPs and dentists and this time there was a catch.

The introduction of private sector ‘General Management’ into the NHS was just one aspect of the wholesale import of ‘managerialism’ into the UK public sector. Coupled with internal efficiency drives within the NHS, the Government also encouraged the development of private provision and insurance schemes and there was a notable increase in their take up as a consequence. By 1989, it was estimated that approximately 15% of all UK

hospital-based treatment and care was provided by private and voluntary hospitals and nursing homes (Laing 1990).

In the late 1980's, those at the sharp end endeavouring to deliver healthcare claimed that the service was in a state of crisis. In an unprecedented move, the Presidents of the Medical Royal Colleges sent a joint letter to the Prime Minister outlining their concerns (Ham 1999). These powerful professional voices of dissent had the potential to embarrass the Government considerably so the Prime Minister, Margaret Thatcher, herself intervened. Determined not to be undermined by the professions, in January 1988 the Prime Minister made a public announcement on the BBC Television programme Panorama that there would be an immediate injection of £101M into the NHS and that she would personally oversee a review of the service (Ham 1999). This Ministerial review was like none previous. In this case, the professions, who had hitherto been central to the decision-making processes, were kept at arm's length. Thatcher marginalised the powerful dissenting voices and then oversaw the development of far-reaching policy changes, which endeavoured to force the hand of the dissenters by transforming them into business men and women within the context of an internal market. Here, where classical authoritarian hierarchical management was unlikely to work, policies aimed to colonise the professions with the managerial ethos, in order to contain the spiralling costs of the NHS, brought about in part by the unfettered demands of doctors making decisions based on their clinical expertise, which had been hitherto unchallenged because of their protected clinical autonomy (Harrison 1999). An internal market was to create a sense of competition between health service providers in order to increase their efficiency, to increase professional involvement in the management of the NHS (i.e. in difficult decisions regarding the allocation of finite resources) and to increase the public responsiveness of the service.

The reforms also challenged the professional autonomy of medicine and sought to increase medical practitioners' accountability for their performance and activities through systems of medical audit. At this stage, however,

these initiatives focused on increasing the accountability of professionals to one another. Systems of confidential peer review were introduced for 'educational purposes' as an optional activity with a resource incentive to participate (Harding & Learmonth 2000).

In practical terms, the internal market led to the separation of the management of the provision of health services from a newly-created responsibility of purchasing or commissioning healthcare under contractual arrangements. The theory was that hospitals and other service providers would be commissioned by District Health Authorities (DHAs) to provide services based on local need. The White Paper also signalled the introduction of NHS self-governing trusts and GP fund holding schemes. Both initiatives aimed to increase the financial autonomy of the respective organisations. However, in the first instance, Trust or Fund holding status was only awarded to organisations that met certain criteria and could demonstrate competence in the management of their finances. NHS Trust status was to allow organisations to look at more creative forms of income generation that had not hitherto been deemed acceptable. GP fund holders enjoyed devolved budgets which enabled them, alongside their local DHA, to commission inpatient services for their own patients through contracts that they negotiated with other service providers. Contracts between commissioners and providers detailed the cost, quality and quantity of care that was to be purchased. Over time, as policy was made on the hoof, the criteria for Trust and Fund holder status was softened (Ham 1997).

The implementation of these NHS reforms was facilitated through post-bureaucratic modes of managerialism (Ferlie et al. 1996). 'Changing the organisational culture' was seen as the key to addressing the perceived problems of the NHS (Parker & Dent 1996). NPM practitioners applied the tools of their trade, Total Quality Management became everybody's business and organisational mission statements appeared in hospital foyers. In order to prevent the internal market from creating a level of disruption that could have been politically embarrassing to the government, *planning* sat alongside *competition* and the internal market became a managed market.

This tendency for political intervention, which led to management from the centre, was completely at odds with the Griffiths recommendation that responsibility should be discharged to the Units (Griffiths 1983) and clearly impacted on the direction of the NHS (Ham 1999).

Following the reviews of primary (Secretaries of State for Social Services and others 1987) and acute care provision (Secretaries of State for Health 1989b), attention focused on community care. Once again, the Government called upon the expertise of Sir Roy Griffiths for advice and once again his recommendations (Griffiths 1988) were accepted and translated into legislation (Secretaries of State for Health 1989a). This put local authorities in the driving seat for planning, co-ordinating and purchasing community care. The aim was not only to manage resources more effectively, but also to increase patient choice and provide means tested, tailored packages of care in people's own homes as an alternative to residential care, if desired. The implementation of the *Community Care Act* was, however, delayed until 1993 due to concerns over the implications of the replacement of domestic rates with the community charge and the unknown effect this might have on local government finances (Ham 1999).

In 1990, John Major replaced Margaret Thatcher as the leader of the Conservative Party and Prime Minister, and the focus on making the NHS more accountable to patients and tax payers grew sharper. According to the ideology of the market "the consumer is king", therefore consumerism, which Kelleher et al (1994) have argued is a de-professionalizing strategy, was considered *the* means of increasing efficiency by the Major Government (Bolton 2004). Against a background of individualism, coupled with declining public trust and antagonism towards the professions and the state, the consumer discourse was mobilised in an effort to reshape medicine and bureaucracies (Henderson & Peterson 2002). The following year saw the publication of *The Patient's Charter* (Department of Health 1991b) which set out a series of rights and standards for patients. *The Patient's Charter* also provided the foundations for the development of performance league tables which would, it was argued, enable the public to see how NHS Trusts

compared with each other, in relation to crude measures of hospital waiting times and numbers of cancelled operations, thus creating a mechanism through which the managerialist discourse could penetrate the authority of the professions (Henderson & Peterson 2002).

Hoggett (1996) argued that the Conservative Government's endeavours to take control of the NHS did not lead to the replacement of a bureaucratic hierarchy with markets but to a "plural mode of governance". The policy and strategy function was centralized and the delivery function decentralized through operational units where business was conducted through competition, contracts and markets. To ensure that the Government's ends were achieved, decentralized units were increasingly monitored and their performance managed as normative managerial control strategies, such as "shared values", proved ineffective when perceived as empty rhetoric in the face of labour process intensification and staff shortages:

"...for many staff, the talk of a shared organisational mission, commitment to quality and customer responsiveness flies in the face of their experience of...inadequate nursing cover." (Hoggett 1996)

In summary, the Conservative reforms of what was hitherto characterised as an overly bureaucratic, inefficient, unresponsive NHS, were driven by a capitalist, neo-liberal ideology. Because outright privatisation of the NHS was considered politically too risky, the Conservative administration compromised. The values and practices of the free market were introduced into the NHS in the belief that they would increase efficiency (and thus reduce costs) and make the NHS more responsive to its users. Thus, a traditionally bureaucratic, professionally dominated organisation was to be transformed through the introduction of General Management and competition and market mechanisms. However, counter to the ideology of the free market, new modes of central control entered the public sector as a consequence of the reforms. In 1996, Hoggett articulated the views of many working in the public sector when he contemplated whether a change of Government, with a different ideological perspective, would address these mounting concerns:

“Would a Blair led government arrive with a mandate to restore commitment and reduce the exploitation of the public sector workforce and dismantle the massive centralization of state power which has accumulated in the last decade and a half?” (Hoggett 1996)

4.3 The Blair Years (1997 – 2007)

When New Labour came to power in 1997 they proposed a ‘far reaching reform programme for the NHS’. Just as they were modernising the Labour Party, they sought to ‘modernize’ or transform the NHS, from a traditional, historically evolved institution, into an organisation that was deemed fit for purpose within the context of a modern global economy. In line with Third Way principles, they developed their first wave of reforms within a spirit of reconciliation (Delamothe 1995), in partnership with the professions, who in turn, fully endorsed the reforms (Department of Health 1997). A part of New Labour’s reform agenda was to dismantle the Thatcher policy innovation, the internal market. It is arguable as to whether this intent was more about political gesturing than a substantial shift in policy. Apart from this one, arguably symbolic act, to distance New Labour’s health policies from those of the previous administration, there was little to distinguish between them. The policies of both administrations appeared to follow similar trajectories and there is evidence that command and control managerialism intensified in the NHS under the New Labour regime in their endeavours to realise their high profile modernization agenda (Klein & Rafferty 1999). For example, there was a marked increase in the numbers of centrally defined performance targets and structures were put in place to performance manage the organisations responsible for delivering them. Performance league tables were published and ratings for individual consultants and NHS organisations were developed. A national initiative, developed in partnership with complicit Trade Unions, has standardized non-medical job roles and put systems in place to monitor individual performance. The Agenda for Change policy (Department of Health 2004a) has led to the biggest overhaul of NHS-wide pay, terms and conditions since the NHS was established. It involved a complex process of job evaluation carried out in partnerships between NHS Managers and Trade Union representatives. Job evaluation was coupled

with a compulsory annual appraisal system where performance was linked to annual increments in pay (Department of Health 2004b). The stated aim was to ensure that the NHS workforce had the knowledge and skills to achieve the aims of the NHS. This policy innovation appeared to bring Trade Unions and Professional Bodies into partnership with the Government, thus ensuring normative control, and securing the ongoing performative control of the NHS workforce through a compulsory annual appraisal process.

Arguably the most fundamental change under New Labour, was the introduction of managerialism at the very heart of professional practice. Where under the Conservative administration, NHS Trusts were given corporate fiscal responsibility, under New Labour they were also given corporate clinical responsibility with the new 'Clinical Governance' arrangements (NHS Executive 1999; Secretaries of State for Health 1989b). Under the Conservative administration, medical audit was conducted as a system of confidential peer review, whereas under New Labour, participation in national speciality-based audit programmes became a requirement for hospital doctors. The hitherto 'black box' of medical practice was opened to public scrutiny.

The National Institute for Clinical Excellence (NICE) was established to provide authoritative guidance to the Health Service on the clinical and cost effectiveness of both new and existing technologies, including pharmaceuticals, diagnostic tests, surgical procedures and other treatments. Initially, NICE was established to cover both physical and mental illness. In 2004, NICE merged with another body, the Health Development Agency, which previously held the remit for developing evidence to inform public health practice. This new alliance formed the National Institute for Health and Clinical Effectiveness and the original acronym, NICE, was retained.

New Labour's political rationale for establishing NICE was to rid the NHS of the so called "postcode lottery" which, they argued, had resulted from the introduction of an internal market into the NHS by the previous Conservative administration. The internal market led to local commissioning. Local

commissioning meant that decisions about how the NHS budgets should be spent were taken locally. Local decision-making meant that one commissioning authority might fund, for example, in-vitro fertilization (IVF) whilst a neighboring authority might not. Access to IVF was thus seen to depend on an individual's postcode rather than on clinical need. New Labour's response to this was to centralize the production of national guidance on where the NHS should and should not spend its finite resources. NICE guidance would be developed in partnership with the professional elite and ensure value for money in NHS decision-making through the provision of high-quality research evidence from an objective source. The argument was that a truly national health service should offer a universal service, based on national, universal standards, founded on a sound evidence base. The NHS should be "modern and dependable" (Department of Health 1997).

In addition to NICE and the clinical guidelines they produce, other Government initiatives to universalise or standardise clinical care included the development and publication of National Service Frameworks (NSFs). NSFs were to set national standards and identify key interventions for a defined service or care group, put in place strategies to support implementation and establish ways to ensure progress within an agreed time scale. NSFs were developed in areas of high diagnostic morbidity and mortality such as Cancer, Mental Health, Diabetes, Renal Disease and Coronary Heart Disease, in areas of public concern, for example paediatric intensive care, and in other specialties including Older People, Children and Long-term care conditions. Healthcare providers were "performance managed" centrally by the Healthcare Commission (HC) in England and Wales, to assess local compliance with national targets and standards. In Scotland, the functions of producing national guidance and monitoring compliance were undertaken by one organisation – Quality Improvement Scotland (QIS).

In order to intensify the processes of Modernisation, the Modernisation Agency (MA) was established in England and the Centre for Change and

Innovation (CCI) in Scotland. The MA website stated that innovation was a strategic imperative for the NHS and the CCI website claimed that change and innovation had become normalised within the healthcare system.

The stated purpose of the CCI was to:

“... provide practical support and innovative expertise to help local NHS systems deliver on national priorities. It will build the capacity to achieve transformational change to help NHS Scotland close the gap between policy and delivery” (Centre for Change and Innovation 2002).

and the MA website stated:

“Developing a climate of innovation in healthcare has become a strategic imperative for the acceleration of modernisation enabling organisations to move beyond ‘improvement’ to ‘innovation’”(Knowledge and Innovation Group 2004).

A sub-Group within the MA, the Innovation and Knowledge Group, was set up to support local NHS organisations and modernisation programmes across the Agency to explore and develop tools and techniques and innovative approaches to change. Even the Modernisation Agency itself was subsequently ‘modernised’. A considerably downsized MA was established as the NHS Institute for Innovation and Improvement at the University of Warwick.

The Conservatives adopted a consumerist project in order to raise public awareness of their rights as a means of improving the performance and the public accountability of NHS professionals. New Labour furthered the consumerist project whilst embracing the notion that rights are accompanied by responsibilities. Consumers of healthcare were encouraged to consider their personal responsibilities for their own health. The ideal, rational, mythical consumer of healthcare was portrayed as an individual who exhibited appropriate information-seeking behaviour, consulted relevant expertise, took the right medicine and engaged in personal risk management (Henderson & Peterson 2002).

To add to this complexity, in 1997 New Labour began a process of political devolution. The 'paradox of devolution' was that, whilst Scotland, Wales and Northern Ireland were, to varying degrees, afforded devolved powers to manage their own health services, there was increasing centralization of power in England (Klein & Rafferty 1999). Greer (2004) has argued that the extent of policy divergence was greater as a result of political devolution than initially anticipated and suggested that four distinct models emerged. Market managerialism was seen to have had the greatest impact in England whilst in Scotland, for example, the professions appeared to have retained a much stronger voice in decision-making (table 4.1)

Table 4.1: Models of healthcare in the UK post devolution (after Greer 2004)

Country	Focus of Governance	Implications
Scotland	Professionalism	A reduction in management layers and development of clinical networks. Increased role of professionals in rationing and resource allocation
England	Markets	Independent trusts, similar to private firms, contracting with each other for care. Approx. 30 regulatory organisations ensuring quality. Competition, management and regulation seen as key to assuring value from health spending and distancing the Minister from front line services
Wales	Localism	Integrated health and local government in order to coordinate care and focus on underlying health determinants rather than treating the sick.
Northern Ireland	Permissive managerialism	Focused on keeping services going in tough conditions. Produces little overall policy and enforces less. Benefits can be local experimentation and variation

4.4 Innovation: the Policy Context

4.4.1 The meaning of innovation

The interpretation of the meaning of innovation by respondents in this study appeared to be both confused and highly subjective. This would appear to be the norm. For example, after undertaking a systematic review of the literature on the diffusion of innovations, Greenhalgh et al (2005) noted there was not, nor would there ever be, a consensus on terminology as people are influenced by different professional, disciplinary and sociocultural traditions. Where there appeared to be greater clarity from respondents, a very deliberate distinction was drawn between “traditional improvement” and “innovation”. Within the management literature, Christensen et al (2000), for example, label the former incremental or sustaining change and the latter disruptive change. Arguing that these two types of innovation should be viewed as ends of a continuum, commissioned by the Knowledge and Innovation group within the MA, Buchanan (2003) developed table 4.2 to illustrate their most common features:

<i>Adaptations: type 1 innovation</i> Sustaining innovations Improving the familiar Lower risk of failure More readily acceptable to others Potentially modest benefits	<i>Breakthroughs: type 2 innovation</i> Disruptive innovations Inventing the new Higher risk of failure Harder to attract supporters Potentially strategic benefits
---	---

Established as a New Labour policy innovation, The Knowledge and Innovation Group within the Modernisation Agency sought to influence the conditions in which type 2 innovations could flourish in the NHS, initially by working with a small number of self-selecting organisations and ultimately through the production of a toolkit for widespread use (Plesk et al. 2003). The MA itself, however, had a primary focus facilitating the spread of type 1 innovations across the NHS in England.

4.4.2 The innovation imperative

The 'innovation imperative' would appear to be driven by the ideology of the market, where innovation is considered imperative for survival:

"Innovation is the heartbeat of OECD economies. Without it firms cannot introduce new products, services and processes. They find it hard, if not impossible, to gain market share, reduce costs or increase profits. In effect, if the pulse of innovation is missing, firms quite simply die." (Guinet & Pilat 1999).

Based on Darwin's theory that only the strongest within a species survives (Darwin 1872) the argument here is that within a global market, only the strongest, that is those most effective at introducing new products, services and processes, survive. This ideology underpins the rationale for regarding modernisation as an imperative. If New Labour did not modernise it would remain unelectable. If the NHS is not modernised it will perish along with those whose political careers rest on 'delivering' a modernised service. According to Klein and Rafferty (1999), New Labour's modernisation programme led to the abandonment of political ideology which left a vacuum which was effectively filled by the ideology of managerialism, based on the premise that the ends justify the means. They also suggest that, however politically expedient "Third Way" interventions may appear to be, they may lack any inherent intellectual or moral justification, as means do not always result in the ends intended.

The innovation imperative within the ideology of the market is located at the very heart of Government, where the central economic objective is to achieve high and sustainable levels of economic growth and employment throughout the UK. Innovation is seen to include the exploitation of new science and technology, changes in skills or business processes and the exploitation of new markets (DTI 2002) and is identified as an essential mechanism for realising the Government's economic objectives. To this end, the Government has put policies in place to support innovation, including, for example, tax credits for firms investing in R&D (HM Treasury, Department of Trade and Industry, & HM Customs 2005).

Whilst innovation has for a considerable time been regarded as an imperative within the private sector its prominence within public sector policy is, as stated earlier, a relatively new phenomenon. Within the context of the New Labour modernisation project, innovation would appear to be regarded as a vehicle for speeding up the processes of reform of the NHS. New Labour policy innovations, from the monitoring of performance targets and the publication of league tables through to the creation of Foundation Trusts and the contracting out of NHS provision to the private sector in England, seek to increase the level of competition within the NHS. Within this context, Government advisers have advocated that innovation is an imperative within the public sector. They argue:

“In the past many successful innovations have been generated internally, and, as a rule, those organisations and sectors that fail to generate new possibilities will be vulnerable to stagnation” (Mulgan & Albury D 2003 p 13).

In essence, the New Labour modernisation project will fail if the NHS lacks the capacity to be innovative. It is incumbent upon the NPM managers, introduced by the Thatcher Government and retained by New Labour to reform the NHS, to ensure that the NHS has the capacity to innovate.

With perhaps the exception of the 'product' innovations, which I discuss later in this chapter, the innovations cited by respondents in this study appear to support this interpretation. For example, role substitution reduces costs and redesign or re-engineering of services aim to increase throughput. These innovations are managerial initiatives which draw on orthodox management theories to increase efficiency and, at the same time, improve patients' experiences of the NHS and contribute towards better health outcomes. When the latter are achieved, and innovations are portrayed with a positive spin, it can be difficult to question their merit, even when there is strong evidence of work intensification. However, this creates a paradox in a system that openly claims a desire to foster innovation. Respondents cited 'time to reflect' as an enabler of innovation and this is echoed within the literature (Ekvall 1996). When work is intensified in order to increase efficiency, 'idea time' may be squeezed out of the system. Focussing on and

rewarding the NHS through, for example, star ratings, or indeed, failing to punish Chief Executives, by allowing them to keep their jobs if they achieve single issues such as efficiency savings or waiting time targets, has the capacity to lead to a reductionist mindset and behaviour which creates an imbalance in the system. There have been reports of fiddles and the orchestration of results through the deployment of additional staff whilst the monitoring of targets was in progress, because, as respondents stated, failing to meet them was known to be at best career limiting and at worst, a sackable offence (Gulland 2003). In addition, critics have claimed that politically-driven, centrally-defined, performance targets have the capacity to undermine clinical priorities (Young & Heymann 2003). The assumption that a narrow rational managerial indicator like 'waiting time' can be unproblematically privileged and measured within an organisation as complex as the NHS, without creating unintended consequences, would appear to be fundamentally flawed.

4.4.3 The problem with orthodox managerialism

Thus NPM and its use of orthodox, reductionist managerial methods is not without their critics. The history of managerialism can be traced back to the beginning of the 19th Century and the work of Frederick W. Taylor (1911). Taylor was the author of 'scientific management'. His aim was to transform the act of management into a scientific process and he is particularly well-known as the founder of the 'time and motion' study. Here, work activity was broken down into segments and the time taken to undertake each segment of work recorded. Taylor also introduced a reward system to control the consciousness and thus increase the performance of workers (Kanigel 1997). Armed with this knowledge, it was argued, the manager could ensure that the workforce was as efficient and as productive as possible by managing and controlling the performance of each and every worker. Bolton (2004) has suggested that such performative control mechanisms within the NHS are "reinvigorated Taylorism" Performative control mechanisms cited by respondents included the monitoring of centrally defined targets. Reflecting on organisational behaviour during a week in March 2004 when

trolley waits in A&E at the Leeds Teaching Hospital were audited Lynch concluded:

“The trust achieved the target holy grail, but did so by employing a tayloristic scientific style of management. There was little dialogue or discussion. Decisions were cascaded in a top-down manner. I for one felt as if I was working in a factory.” (Lynch 2004 p 130)

The 'No.10 Delivery Unit', established at the start of Blair's second term of office, was a direct response to concerns at the centre that reform of the public services was not happening quickly enough across the board. Having convinced Blair of the potential of targets to improve literacy and numeracy in schools, whilst working under David Blunkett during New Labour's first term, Michael Barber, a man passionate about equality of opportunity, was appointed as the units Director. In a candid account of Government during this period, Barber demonstrated how the Delivery Unit embraced and developed its own brand of managerialism which was labelled 'deliverology' (Barber 2007). Delivering reform of the public services was seen to be so important that failure to meet targets put the Government into crisis mode. For example, failure to demonstrate a reduction in street crime was classified as a national crisis and a civil contingencies committee, or 'COBRA', meeting was convened. Chaired by the Prime Minister himself, all key Government stakeholders met in the Cabinet Office Briefing Room in the bowels of Downing Street. Previously COBRA meetings had been convened for the 7th July London bombings, the fuel protests and 11th September attack on the twin towers in New York, thus illustrating the importance the Government placed on the achievement of centrally set targets for the improvement of the public services.

Respondents suggested that some of the targets set nationally were politically motivated measures of performance rather than clinically relevant assessments of patients' experiences and their health outcomes. This rationalist discourse, arguably, had the capacity to be an ideological oxymoron within the NHS, which is recognised as a politically-charged, socially-complex enterprise (Buchanan & Badham 1999; Klein 2001), in a

complex, constantly changing society, outside of the control of the NPM managers. Despite the development of alternative discourses within management which I discuss in chapter 7, these data would indicate that the orthodox remains dominant within management practices within the United Kingdom's (UK) National Health Service (NHS). Learmonth (2001) has argued that they also dominate health services' management literature. From this perspective, it would appear that there is a dissonance between the desire of Governments to modernise the UK Health Service and their use of traditional command and control management methods, from the very centre of Government, to achieve this end.

For nearly three decades, successive Governments have relentlessly pursued the ethos that the key to containing the costs of the NHS was to be found through better management. Doctors, who had hitherto been at liberty to commit resources based on their relatively autonomous estimation of clinical need, are now required to account for their demands to NHS managers. From the standpoint of a healthcare professional employed within the NHS prior to the introduction of NPM, it is understandable why Pollitt (1993) argued that the imposition of uncritical private sector managerialism was akin to injecting an 'ideological foreign body' into the public sector.

Taylor's principles may well have increased the productivity of uneducated manual workers within a manufacturing context:

"the science which underlies each workman's act is so great and amounts to so much that the workman who is best suited actually to do the work is incapable (either through lack of education or through insufficient mental capacity) to understand the science." (Taylor 1911)

The suggestion that the educated professions within the NHS should be managed in such a manner unsurprisingly met with a great deal of resistance (Kirkpatrick, Ackroyd S, & Walker 2005).

To drive forward the efficiency agenda and overcome the dissonance between professional and managerial discourses concerted efforts have

been made to colonise professional practice with the ideology of market managerialism. Doctors and nurses are amongst the healthcare professionals who were actively encouraged to embrace managerialism, with the rationalist argument that professional engagement in management is a mechanism for professional empowerment. A mainstream analysis of these measures is that they were introduced to contain the spiralling costs of the NHS, brought about, in part, by the unfettered demands of doctors, making decisions based on their clinical expertise which had been hitherto unchallenged because of their protected clinical autonomy (Harrison 1999). An alternative interpretation is that professional engagement in these management processes is a means of achieving normative control (Traynor 1999).

4.4.4 The rhetoric of partnership

Partnership was identified by respondents as an enabler of innovation and, as discussed above, was integral to the Third Way methodology for achieving New Labour's modernisation agenda. However, as one respondent pointed out, innovation can give rise to losers as well as winners. If a nurse is substituted for a doctor, for example, the service may be seen to be more efficient as it will cost less. From a managerial perspective this is a positive outcome. The nursing profession may readily embrace such an innovation if it is seen to contribute to a professionalizing strategy. However, it may be perceived as an exploitation of labour if the nurse is paid less for doing essentially the same as the doctor. The modernisation of careers within the Health Service may have addressed this inequity if the medical profession had been included in the process, but they were not. Once again they negotiated separate, far more lucrative, deals. Professional resistance to undertake new roles on the grounds of inequity or indeed on the grounds that it may result in an erosion of expertise within medicine, for example, may lead to the punitive marginalisation of the professional group that does not 'dance to the tune' of the economic imperative. Nevertheless, as Hull and Kaghan (2000) acknowledge, all people involved in innovation processes have some ability and power to act to change, or to resist change, in their circumstances.

Despite the rhetoric of innovation and the appearance of investment in innovation through the establishment of the MA and the CCI, evidence from the respondents interviewed within this study would indicate that unless an innovation clearly contributes to the achievement of centrally defined Government targets, it is unlikely to be considered a legitimate pursuit. It is equally unlikely that managers, focused on meeting Government targets because their job depends on delivery, will risk diverting time and effort to support a locally grown innovation, developed to support a locally identified need.

The Agenda for Change (Department of Health 2004a) careers modernisation programme, developed in partnership with the Trades Union, incorporates a compulsory annual appraisal system and performance is linked to annual increments in pay. Whilst the stated aim of this initiative is to foster self-motivation and autonomy amongst the workforce, Traynor (1999) has argued:

"The managerial talk of self-motivation, autonomy, excellence and closeness to the customer can be understood as a rhetorical mask for ...deep and penetrating control of the workforce by management (and ultimately by government)." (Traynor 1999)

4.4.4.1 Medical science and Innovation

Some stakeholders in healthcare would argue that the NHS has embraced innovation since its inception. Health professionals and medicine, in particular, grounded their professional standing on the basis of medical science and innovation. The rather tired examples of product innovations offered by the CMO interviewed serve to illustrate this point. The fact that innovations in medical science can lead to improvements in health and, at the same time, have a significant cost implication illustrates the tension that has existed between stakeholders since the inception of the NHS.

Currently, the professional agenda to ensure that medical practice is, wherever possible, underpinned by the best available scientific research evidence, is progressed under the label of evidence-based medicine (EBM).

New Labour's commitment to partnership working has brought the Government and the proponents of the EBM into close alliance through the work of NICE. Sheldon and colleagues (2004) have described NICE as the policy embodiment of EBM.

NICE, the Healthcare Commission and QIS were policy innovations designed to work collaboratively to eradicate the politically maligned postcode lottery of health service provision. Kirkpatrick et al (2005) argue that NICE and the Health Commission are amongst a series of quangos and agencies established to support management in achieving the Government's aims of 'modernising' the Health Service. Their work, and the other manifestations of the New Labour's efforts to standardise the NHS in partnership with the professional elite, is based on the assumption that it is both possible, and desirable, to centrally standardize, or commodify, healthcare and monitor local compliance with its delivery.

4.4.4.2 Support for Innovation

The local implementation of a national standard would, according to table 4.2, be classified as a type 1 innovation. It is possible that the conditions in which a type 1 innovation might thrive may be very different to the conditions in which a type two innovation can flourish. For example, one respondent suggested that, from a policy perspective, type 2 innovations could be problematic if they appeared 'left field'. This point was raised, not in relation to the legitimacy of an innovation, but with regard to the need to prepare the system, if an innovation had associated staff training needs and required resources for implementation. Another respondent, however, quite explicitly suggested that innovations were only legitimate if they clearly served the interests of policy. Whilst criteria to identify which innovations would be supported by an organisation with finite resources, may be inevitable, the commercial sector has already recognised that the application of such criteria can be problematic. Xerox, for example, recognised that many good ideas, whose potential was not initially seen by their Board, ended up as serious money-making ventures - for their competitors. In order to address this they established a technology ventures business unit which essentially

supplied in-house venture capital for 'good ideas'. Their initiative proved so successful that other companies have since followed their lead (Vallery 1999).

Whilst there is a strong rhetoric for supporting innovation within Government health policy, it would appear that the very methods employed to modernise the NHS perversely stifle the NHS's innovative capacity. Their very own methods appear to create what Kanter (1992) describes as a segmentalist organisation where innovation is stifled.

Kanter has contrasted *segmentalist* with *integrative* organisational structures and cultures and suggests that the former are innovation smothering and the latter stimulate innovation. She suggested that the characteristics of *segmentalist* structures where innovation is smothered include:

- Compartmentalised problem solving
- Over-occupation with hierarchy
- Efficiency-orientation
- Rules orientation

The Government's focus on specific targets would appear to have led to compartmentalised problem solving. The rules of the game were very clear - targets had to be met, at all costs. One respondent suggested, disparagingly, that the problem was that NHS managers lacked the capability to conflate targets or engage with the Government to identify more appropriate targets. The centralised monitoring of targets appears to strengthen an over-occupation with hierarchy and the primary purpose of NPM is to focus on efficiency. From a managerial perspective, NPM should have a greater capacity to facilitate innovation than the previous, much maligned, bureaucratic, NHS administration and NPM should have a greater capacity to effectively (and, of course, efficiently) implement new policy and legislation. However, where there are competing demands and competing discourses, NPM appears to struggle with the complexity. Carter (2000), for example, found policy innovation on equal opportunities gave rise to tension between competing discourses, namely NHS Equal Opportunities and NPM.

Carters' research illustrated how managerialism served to reinforce rather than diminish ethnic inequality within the health service.

The characteristics of *integrative* structures where type 2 innovation is stimulated include:

- Team orientation
- Co-operative environment
- Mechanisms for ideas generation and exchange
- Holistic problem solving
- Sense of purpose and direction
- Ability to overthrow history and precedent
- Use of internal and external networks
- Person and creation centred
- Results orientated

Ironically, there appeared to be a strong rhetoric from the Government that they wanted to create an integrative culture within the NHS. Respondents spoke of ministers espousing the values of localism and cited policy innovations with that very intent. Policy commentators Klein and Maynard (1998) argued that one of the purposes of creating an internal market in the NHS was to facilitate the diffusion of blame for the ills of the NHS away from central Government to the decentralized operational units, where general managers, doctors and nurses were formally responsible and accountable for the operational management of the service. Because of the centralising tendencies of the Conservative regime, this was only achieved to a limited degree. Dismantling the internal market, however, brought the spotlight firmly back to the centre as the New Labour Government played a more visibly active role in the NHS:

"Command and control concentrate blame and conflict, which is why the white paper may lead ministers to a political Calvary" (Klein & Maynard 1998).

The establishment of Foundation Trusts in England in 2004 (Department of Health 2003) may have been a strategy the New Labour Government

employed to politically distance themselves from the service. The stated purpose of establishing Foundation Trusts was to decentralise and democratise the NHS (Klein 2004). The attainment of these ambitions would be dependent upon the degree of autonomy that the Trusts actually realised, coupled with the volition and capability of local communities to assume the new social ownership of their NHS. Hoque et al (2004) argued that the success of Foundation Trusts would not only be dependent upon Trust Managers perceiving greater autonomy as realistic, but also upon them considering it desirable. If the Government's top-down targets are the only means NPM managers have of influencing entrenched professional interest, they would not necessarily be motivated to earn greater autonomy. The desire of the government to shift responsibility for the NHS away from central Government in the run-up to a General Election could be interpreted as more about politics than policy. However, there was an overwhelming sense of cynicism that, particularly at a time so close to a General Election, the NHS was too politically sensitive and the Government were too risk averse to follow through.

4.4.4.3 The efficacy of the commodification strategy

If type 2 innovations were ideal in theory but too risky in reality, then it is important, perhaps, to consider the efficacy of the Government's endeavours to modernise the NHS through the introduction of type 1 innovations. Some five years since the launch of NICE, a national evaluation of the extent to which national guidance had been implemented in the NHS was commissioned. Sheldon et al (2004) assessed twelve pieces of tracer NICE guidance. In table 4.3, I categorised these as surgical, prosthetics and pharmaceutical interventions. My traffic light colour coding indicates where NICE guidance broadly speaking recommended:

1. interventions should be stopped (red)
2. interventions should be administered under specific conditions (orange)
3. interventions should be fully implemented (green).

Using time series analysis, audit of patient records, survey and interviews, the researchers found that the implementation of NICE guidance varied by

NHS Trust and by topic. Of the three surgical interventions, the only change observed was in the extraction of wisdom teeth. However, it was noted that there had already been a downward trend in the numbers of extractions and so it was impossible to conclude whether the NICE guidance had in fact any significant impact

Table 4.3: NICE guidance and recommendations		
<i>Surgical interventions</i>	<i>Prosthetics</i>	<i>Pharmaceutical</i>
Removal of wisdom teeth	Prosthesis for hip replacement	Taxanes for treatment of breast cancer
Laparoscopic surgery for the treatment of colorectal cancer	Hearing aids	Taxanes for ovarian cancer
Laparoscopic surgery for the treatment of inguinal hernia	Implantable cardioverter defibrillators for arrhythmias	Zanamivir for influenza
		Donepezil, rivastigmine, and galantamine for Alzheimer's disease
		Orlistat for obesity
		Chemotherapy for non-small lung cancer

There had been no change in laparoscopic surgery, despite NICE recommendations that it should, in the main, be stopped in these instances. It was acknowledged that most laparoscopic surgery was concentrated in a few Trusts. The rationale for these practices was that:

“some local expert surgeons had the support of managers and commissioners to continue the use of laparoscopic surgery for primary repair. It was also claimed that some patients often requested laparoscopic procedures..” (Sheldon et al. 2004 p 1005).

This rationale arguably serves to illustrate the prevailing decision-making power of surgeons at a local level.

There was no change recorded in the use of any of the prosthetics since the NICE guidance was produced. The rationale provided for the lack of implementation of NICE guidance on analogue hearing aids was that technological innovation, that is, digital hearing aids, had superseded the guidance. In the case of implantable cardioverter defibrillators, cost and skills were considered to be limiting factors and, in terms of the recommendations for hip prosthesis, orthopaedic surgeons essentially did not agree with the recommendations arguing that that they did not acknowledge the complexity of hip surgery.

Where NICE guidance did appear to impact was with regard to pharmaceuticals. There was a high level of compliance in the appropriate use of Taxanes for breast cancer. One argument put forward to explain this compliance was that NICE guidance had made funding easier to obtain. In this instance, therefore, the guidance appeared to reduce the incidence of postcode prescribing. The level of compliance with regard to ovarian cancer was less impressive, however, and it was reported that oncologists felt that the NICE guidance had overstated the effectiveness of these drugs in this instance. The guidance was subsequently amended by NICE as a result. Whilst crude statistics showed an increase in the use of Orlistat for obesity which seemed to concur with NICE guidance, closer inspection of case notes revealed (where data was available) that a rise in the prescribing of the drug did not necessarily mean that the drug was being prescribed appropriately.

The audit for Zanamivir in influenza indicated little inappropriate prescribing. However, the growth in the prescription of drugs for Alzheimer's disease was noted to be similar to the case of wisdom teeth extraction, inasmuch as the trend had started prior to the guidance being formally issued.

From analysis of their interview data, they identify five factors which appeared to impact on compliance with NICE guidance. These are Trust culture; locality decisions; systems for managing guidance; funding and consultant buy-in. The researchers concluded that, whilst the establishment of NICE was a unique initiative, it alone is not sufficient to secure “the rapid and universal implementation” of evidence-based healthcare. This would suggest that the achievement of type 1 innovations may also be relatively limited. Ironically, in a system so evidently focused on efficiency, the cost effectiveness of guideline development is unknown due to insufficient evidence to assess the financial costs:

“owing to the poor quality of reporting of the economic evaluation, data on resource use and costs of guideline development, dissemination and implementation, were not available for most of the studies...” (Grimshaw et al. 2004).

4.5 Summary

At face value, from a policy perspective, as successive Governments have imposed private sector values and management practices upon the NHS, innovation in healthcare would appear to be a Government priority. Indeed, the Governments in both Scotland and England invested in infrastructures to support innovation in healthcare. One might therefore assume that innovations would flourish within the context of UK health services.

Upon closer inspection, however, through analysis of interviews with policymakers and discussion of these findings within the context of UK Government policy, there would appear to be considerable tensions within the system, which may militate against endeavours to innovate. There were multiple interpretations of the meaning of innovation and a diversity of opinion over what constituted a legitimate innovation. The wide range of stakeholders in healthcare harbouring these multiple perspectives appeared to add to this complexity. For instance, Governments' attempts to control powerful professionals by empowering and marshalling public opinion was seen to have the capacity to backfire, when the public did not agree with policymakers endeavours' to, for example, centralise health services.

Policymakers recognised the healthcare context as a highly politicised environment where there was a strong rhetoric of innovation. However, paradoxically, this rhetoric was coupled with centralised command and control managerialism, totally focused on 'delivering' reform of the public services and standardising healthcare provision, in the name of equality. The strength of these centralising tendencies may make local endeavours to develop innovative health services a considerable challenge. I examined two cases of innovation in health within this context and these are reported in the next section of this thesis.

PART III
THE CASE STUDIES

Chapter 5 Case Study 1 - The Farmers' Health Project

5.1 Introduction

This chapter reports on the analysis of Case study 1: The Farmers' Health Project (FHP). The case was introduced in chapter 2 where the methods deployed to investigate the case were set out. Types and sources of evidence examined were listed in table 2.5 and the semi-structured interview schedule used was presented in table 2.6. In analysing and interpreting these data, I identified fifteen critical decisions or incidents which appeared to me to have had a significant impact on the trajectory of this particular case. Critical analysis of these incidents, through the consideration of the probing questions set out in table 2.8, offers insight into the conditions where innovations, which endeavour to enable access to a group of people who do not routinely access mainstream health services, can flourish.

In 1999, the FHP, a research project employing an action research methodology, was launched. The Project aimed to improve the health of farmers in North Lancashire and South Cumbria through the introduction of an innovative nurse practitioner (NP)-led outreach service.

Action research is a research strategy located within the critical paradigm. The dual aims of action research are to change practice and develop theory. Action research is most often undertaken as a co-operative enquiry in a social setting, where actors collaborate as co-researchers in a project where together they gather, analyse and reflect on research evidence to inform and evaluate their change processes (Lewin 2000).

A NP is a registered nurse who has undertaken post-registration, graduate-level training with mentorship and supervision to prepare her to operate independently at an advanced level of practice. The definition of a NP endorsed by the Royal College of Nursing is in table 5.1. The duration of a NP course, on a part-time basis, is usually between 2 and 6 years and leads to an Honours or a Masters degree. In the UK, the NP qualification is not

currently a recordable qualification. Consequently, there is no national register of qualified NPs in the UK. Maclaine (2007) advises that the NP movement began in the USA and developments in the UK began in the early 1990's. From then, through to 2002, there was a slow but steady growth in the numbers of NPs. Since 2002, there has been a rapid increase in the numbers. There are currently thought to be approximately 4000 qualified NPs in the UK.

Table 5.1: Definition of a Nurse Practitioner (Royal College of Nursing 2002)

A Nurse Practitioner is a registered nurse who has undertaken a specific course of study of at least first degree (Honours) level and who:

1. makes professionally autonomous decisions, for which he or she is accountable
2. receives patients with undifferentiated and undiagnosed problems and makes an assessment of their healthcare needs, based on highly developed nursing knowledge and skills, including skills not exercised by nurses such as physical examination
3. screens patients for disease risk factors and early signs of illness
4. makes differential diagnosis using decision-making and problem-solving skills
5. develops with the patient an ongoing nursing care plan for health, with an emphasis on preventative measures
6. orders necessary investigations, and provides treatment and care both individually, as part of a team, and through referral to other agencies
7. has a supportive role in helping people to manage and live with illness
8. provides counselling and health education
9. has the authority to admit or discharge patients from their caseload, and refer patients to other healthcare providers as appropriate
10. works collaboratively with other healthcare professionals
11. provides a leadership and consultancy function as required

The seven stated aims of the FHP are set out in table 5.2.

Table 5.2: Aims of the Farmers' Health Project:

1. to gain understanding of the particular health needs of the farming community of the MBHA (Morecambe Bay Health Authority) area.
2. to address the problem of the exclusion of many farmers from the main stream healthcare.
3. to examine whether creating new pathways for healthcare can address rural health inequalities
4. to explore the interface of primary and secondary care in rural settings
5. to explore opportunities for joint working/collaboration between physical and mental health services and between health/social/welfare agencies in rural areas.
6. to evaluate any emerging differences in practice between two different rural locations
7. to evaluate the development of the Nurse Practitioner role in rural settings

The FHP was financed through a mixed portfolio of funding, which included the Rural Development Commission (RDC), the Ministry of Agriculture and Fisheries (MAAF), the Foundation of Nursing Studies (FONS) and the North West Regional NHS Executive R&D Directorate (Burnett, Mort, Walsh, & Easterlow 1998). The latter was sourced from a regional NHS Research & Development capacity-building, funding stream and provided the largest single funding source (65%). The project was located within a large geographical area, which was divided in two by local authority boundaries, namely South Cumbria and North Lancashire. The named principal investigator of the project was a local general practitioner based in a semi-rural practice. He worked closely with a full-time academic. The academic was a medical sociologist, with a background in Journalism, whose previous experience may have helped significantly in the marketing of the initiative. A press conference was called when the project was launched and press releases were issued. Two farms, one in each of the project areas, participated in the launch. The team was briefed that there were three key messages to convey. The project was about mental health, farm accidents

and chronic health problems (Management Group Meeting Minutes 21 July 1999).

The media launch and subsequent profile of the project led to considerable demand for information about the initiative:

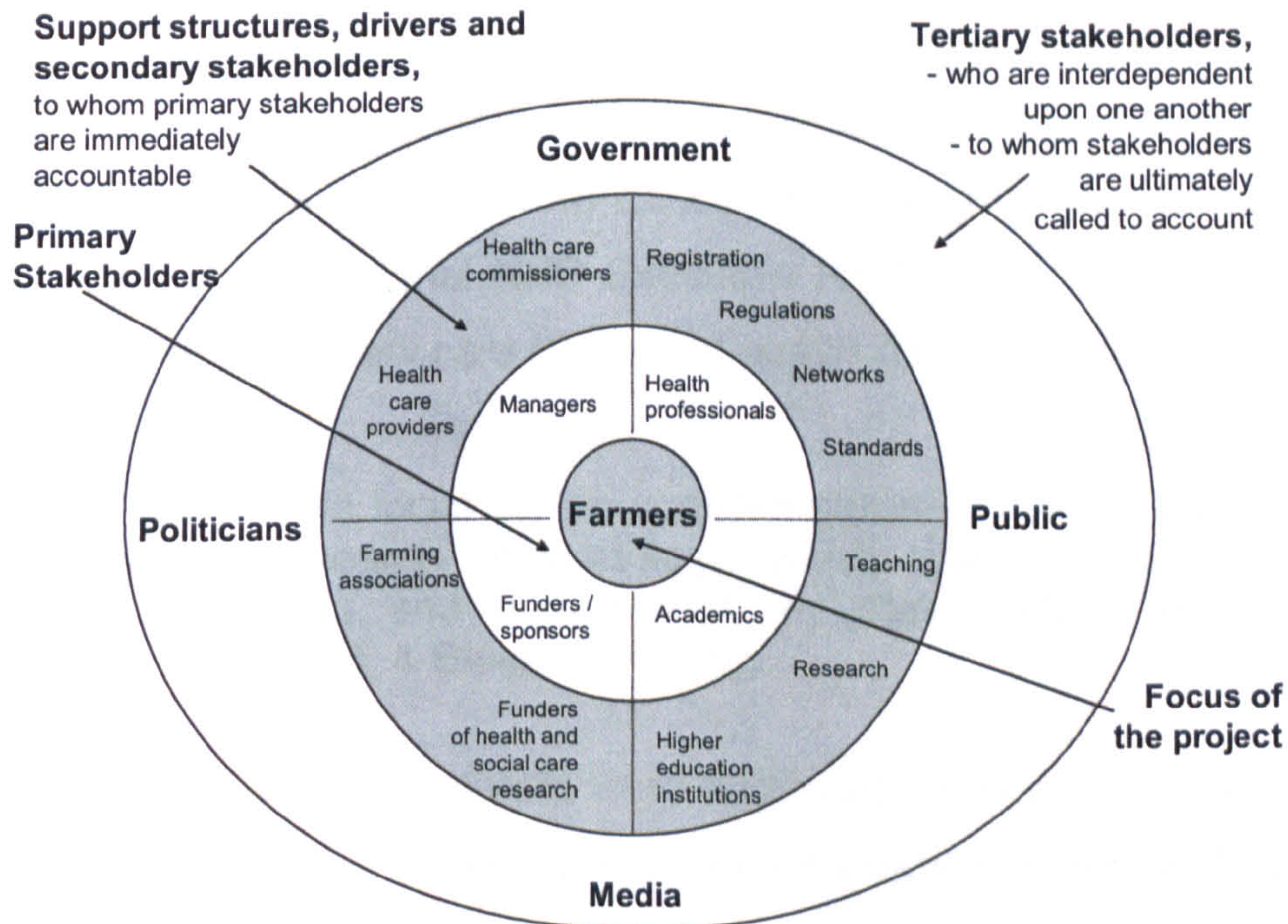
“We have had enormous interest in this project because it is the only one of its kind, with all the issue around agriculture even before foot and mouth we have been in almost every version of the media you can imagine including Radio 4, the national Guardian, BBC. ..., we have been inundated with media requests. Also requests from other people who wanted to set up something similar” (Manager 2)

The initial pro-active approach to marketing and dissemination turned into a reactive one as the team became inundated with enquiries. Indeed, the professional and media interest in the initiative became so onerous that the project team began to be concerned that the time spent on dissemination activity was taking them away from developing the core aims of the project. However, as a result of the high profile achieved, the Countryside Agency (CA) invested in the project in order to support further dissemination so that lessons learned from the initiative could be promulgated across the country. CA funding was a critical incident in the project, which enabled the project team to appoint a research assistant to co-ordinate dissemination activities. Her work included the development and dissemination of an information pack and the co-ordination of the development and dissemination of a video about the project, which was also funded by the CA. In addition, members of the project team published articles in their professional press to raise awareness of the project and disseminate some of the findings, including for example Burnett (2000) and Walsh (1997; 2000a; 2000a; 2000c; 2000b). The experiences here would indicate that there is a delicate balance to be found between the time and energy invested in the marketing and dissemination of an innovation in service delivery with the imperatives of implementing and evaluating the innovation itself.

5.2 Stakeholder Analysis

Through the process of analysing these data, the complexity of the relationships between the multiple actors and agencies involved in this project became apparent. Figure 5.1 provides an overview of the range of stakeholders I identified within the FHP. It implies that farmers themselves are the focal point, at the centre of the project. The project was steered by a wide range of stakeholders, which included farmers, a range of healthcare professionals, healthcare managers, academics and representatives from the project funding bodies. Each of these stakeholders reported to, and was accountable to, a wider constituency, so, for example, through their professional regulatory frameworks, healthcare professionals are ultimately accountable to the public. Academics, on the other hand, are accountable to those who fund their activities. Traditionally, academic activity has, in the main, been funded through the public purse. However, this pattern is changing as other investors, including the commercial sector, seek to work in partnership with the academic community, to their mutual advantage. The portfolio of funding underpinning the FHP serves to illustrate this trend. Irrespective of the source of academic funding, academic performance, and research activity in particular, is currently assessed according to research outputs, the majority of which appear within peer-reviewed academic journals. Managers within a national publicly funded health service are ultimately accountable to the Government of the day. Any institution such as the NHS, which has the public interest at its core, and is dependent upon the public purse, is constantly under the scrutiny of the media. As discussed above, this project purposefully engaged the media as a marketing strategy.

Figure 5.1: Farmers' Health Project stakeholder analysis



5.2.1 Farmers as the focus?

As outlined in table 5.2, one aim of this project was to identify the health needs of farmers and address their exclusion from mainstream service provision. It has been argued that farmers' exclusion from mainstream services is in-keeping with their culture. According to Gerrard (1998), farmers are known for their reticence, stoicism, self-reliance and isolation and, therefore, unlikely to seek external assistance on any issue, let alone health matters. One informant, herself a healthcare professional from a farming background, described the farming culture and suggested that it was under considerable strain. She argued farmers are:

"...a breed of their own, it's a culture, it's like the Incas, it's nothing to do with being British or Australian or anything, it's a breed of us, we are self sufficient really. But in the political-social climate that self-sufficiency is being eroded ..., the community is eroding, the families are eroding, and so is the whole culture, our culture, my culture is altering..".(Nurse Practitioner 2)

The decision to make farmers a focus of this project is, in itself, interesting because, however compelling the evidence that farmers have unmet health

needs (Gerrard 1998), this concern was not the issue that initially drew people together. The original driver appeared to be a shared concern about mental health within rural communities and the urban focus within local research into mental health services.

In 1996, a research team from Lancaster University secured funding from the North West Regional NHS Executive R&D Directorate to research the organisation of primary care for mental health. This research was:

“designed to focus on the complex nature of service provision and to use a research methodology which would allow a degree of collaboration and involvement, by stakeholders in the system” (Davies, Mort, & Stead 2000 p 5).

Collaboration and involvement were facilitated through the establishment of a research steering committee made up of local stakeholders. This research consisted of five discreet projects. One steering committee member, a local general practitioner from a rural practice, noted that the first two projects had a predominantly urban focus. She shared her experiences as a rural GP and cited clinical case studies to illustrate the difficulties in supporting people with mental health problems in rural communities. *“...getting access early on”* was highlighted as particularly problematic.

This GPs “story” was heard and recounted by other informants. For example:

“she told us of anecdotal evidence of (well it is not anecdotal in the sense that it wasn't true) but it was a sort of personal case-study ... of a young maneventually the police got involved because he took a gun to himself in ...in a multi-storey car park and she traced it back..., if in a sense he was so isolated from the health service and a lot of the rural problems came up. Well we said well yes this seems to be quite a considerable problem but what we will do is we will... look and see whether we could gather a rural advisory group” (Researcher 1)

Thus, the sharing of a “real” life and death case study, coupled with this GP's account of her personal frustration with the challenges of supporting people with mental health problems in rural communities, shaped the focus of the

third project funded by the North West Regional NHS Executive R&D Directorate, to research the organisation of primary care for mental health (Davies, Mort, & Stead 2000).

With collaboration and involvement a key aim, the research team organised an awareness-raising conference. ***“Mental Health Issues for Rural Practices”*** was held on 26th February 1998 at Westmoreland General Hospital in Cumbria. Designed primarily for local GPs the event was promoted widely in order to try to attract lay, voluntary and professional organisations and individuals interested in rural health issues and mental health in particular. Organisations approached included Rural MIND and the Citizens' Advice Bureau.

To facilitate discussion, conference delegates were offered three anonymised case studies, about a mechanic, a farmer and a teacher, to explore the problems experienced by rural practices when caring for patients with mental health needs. Although the researchers knew that the primary focus was on the mental health of the individuals within the case studies, they advised me that they had anticipated the discussion would raise infrastructure issues associated with isolation such as transportation. However, such issues were not identified as concerns by the conference participants.

All of the issues raised were captured on flip-charts and conference participants were invited to join a Rural Mental Health Working Group to explore solutions to the problems raised at the conference. Attendance at the awareness-raising conference and the establishment of the Rural Health Working Group appeared to suggest that there was a critical mass of people with a shared concern about the mental health of rural communities.

The critical question is how, and perhaps more insightfully why, did a collective desire to improve the mental health of rural communities result in a NP-led farmers' health outreach project?

The Rural Mental Health Working Group met on a number of occasions to discuss the issues raised at the conference. One informant advised that, over time, some of the self-selected members of the working group “fell away” (R1). It was suggested that that some ‘voices’ were more dominant than others at these meetings.

“..the people who were not in professional roles dropped out very quickly including ..um..people from MIND who we had invited sometimes extra-specially who would say something and then the professionals would continue to talk and ignore them” (Researcher 1)

Therefore, despite the intention of giving lay participants, members of these rural communities and their representatives, a voice, according to this informant, the professional members of the groups dominated the proceedings and marginalised the lay participants.

This informant suggested that two camps emerged within the working group. The first camp was comfortable and relaxed at having a wide-ranging and inclusive exploration of the issues. They knew that, in the end, they would do ‘something’. The second camp appeared to be uncomfortable with this approach. They appeared to be more anxious to get on and ‘do something’. Were members of this second group eager that ‘something’, or ‘anything’ should be done because of a sense of urgency about the issue? Did they have a particular solution in mind that they were anxious to realise, and if so, what was the solution and why were they so keen to make it a reality?

Three months after the initial conference, the rural mental health working group had identified three possible “rural research initiatives”. These are presented in table 5.3.

Table 5.3: Possible Rural Research Initiatives (18.05.98)

1. Bid for £50,000 over 3 years to NHS region for a Nurse Practitioner to work peripatetically across a number of practices i.e. Kirkby Lonsdale, Sedbergh, Ambleside, Kirkby in Furness, addressing farmers' and their families' health.
2. A rural 'expert' i.e. National Farmer's Union (NFU) (or other) representative to set up a regular (e.g. monthly?) session in the general practice, which GPs can make use of to refer patients for advice on farming and related issues.
3. A primary care support worker for rural health via Morecambe Bay Health Authority (MBHA) – this role to be defined after further discussion with MBHA

Davies, Mort and Stead (2000) reported that it was decided very early on to focus on the physical *and* mental health needs of farmers and their families. It appears that the general practitioners (G.Ps) in the group had significant influence:

"..there were a couple of GPs there who said very urgently we have this population which we think are highly at risk and their industry is in crisis and we know that..... they called it a "storm warning", we have had a "storm warning" about these people and we actually have a responsibility to do something about it" (Researcher 2).

One GP informant suggested that the decision to focus on the healthcare needs of farmers was politically expedient as a result of the high public and media profile of the issues of concern within rural communities championed by lobby groups such as the Countryside Alliance:

"...it has been a political "hot potato" ... rural issues... Countryside Alliance and all the protests about one problem after another hitting the farmers from milk, BSE, sheep you name it, as well as the agricultural policy and drop in farming incomes all this has hit farmers really hard ...It is a national priority, it is highly politicised now which it wouldn't have been five years' ago, and it is sort of, there is like a groundswell, there is a like a whole movement about rural issues " (General Practitioner 2).

The concerns expressed by the G.Ps. when coupled with academic research was described as compelling evidence:

“... as soon as I read this piece by Gerrard I realised that those two things came together and that what you have got is a group identifying need and saying that action has to be taken and you have got academic research evidence and when you put the two together it is so compelling that I could just see immediately that we would get some money.” (Researcher 2)

The decision to focus on the physical *and* mental health of farmers shifted the scope of the project from the mental health of rural communities. There appeared to be at least five factors which steered the group towards their decision to focus on farmers' health. These were:

1. the currency of what was described as “compelling” evidence where academic research identified a hidden morbidity amongst the farming community which could be addressed through a targeted occupational health service (Gerrard 1998)
2. the contribution of powerful professional people, where they draw on their tacit and experiential knowledge and they use emotive language and talk of a “storm warning” within the farming community. This was a concern which they argued they have a professional responsibility to do something about.
3. the perception that some of the professionals dominated the debate, professionals who may indeed have been harbouring personal ambitions to steer the development of the initiative in a way that would help them achieve their personal and professional goals.
4. the perception that those who dominated the debate effectively silenced alternative and lay voices by not listening to their contributions and continuing to talk over them. Consequently, it was reported that those who were not from professional groups dropped out very quickly thus closing down opportunities to discuss alternative options.
5. an awareness of the political landscape with the plight of farmers described as a political hot potato and a sense that consequently the time was right to endeavour to address farmers' health needs.

The decision to focus on farmers' health, however, only explains the first two of the seven aims of the project outlined in table 5.2. It was not clear if all seven aims were of equal importance. Consequently, it was not clear what would happen if one aim militated against another.

5.2.2 Nurse practitioners as the focus?

The decision to focus on farmers' health was interestingly coupled with two other major decisions. The rural mental health working group elected to pursue an aspect of the first option (table 5.3) and address farmers' health needs through a NP-led service. The rationale put forward for an NP-led service was, that based on the relatively stoical nature of farming communities, a comprehensive health service, which did not focus exclusively on mental health issues, would be more acceptable and less threatening. NPs, with their advanced level of practice, could provide a "one-stop-shop" to identify and address the majority of farmers' healthcare needs. The second key decision taken was that the NPs should provide an outreach service. It was argued that an outreach service offered the most culturally sensitive approach, meeting farmers on their own terms and on their own territory. In this section I examine the decision to provide a NP-led service. In the next section I critically examine the actions taken to provide an outreach service.

The decision to provide an NP-led outreach service proved to be less than straightforward. For example, one respondent suggested:

"... this project started off as two completely separate projects, there was a project going on at Lancaster University with Rural Minds interested in rural mental health issues and at the same time at St. Martins, that given the track record of nurse practitioners as being very good at filling in niches in the whole provision market..... (and) realising that there was major problems in farming, I sort of put two and two together and said could nurse practitioners provide a service for farmers in Cumbria? ... and really the genesis of the project, I guess, was when those two came together" (Researcher 3).

This informant was a nurse academic involved in the provision of educational programmes for the development of NPs and a member of the

rural mental health group. When I interviewed him I detected a sense of passion in his voice about the NP role, which I raised with him. He replied:

"It's passion because to me it's actually letting nurses do what they should be doing. For so long I think nurses have been held back by constraints, by bureaucracy, by the traditions the way the health service has always run, by traditional medical dominance, it has always held nurses back and to me this whole nurse practitioner concept is empowering nurses to fulfil their potential in a true way" (Researcher 3).

Another informant, herself a farmer and a qualified NP who worked alongside the GP who became the principal investigator for the project, indicated that a NP outreach service for farmers was originally her idea. She had undertaken the NP degree course at St. Martin's some five years previously and in part fulfilment of her degree had proposed piloting a NP service for farmers at auction marts, the place where she knew farmers congregated. To her frustration, her proposal had been rejected because of its complexity. However, she felt passionately that this would be a means of identifying and addressing the health needs of farmers and she had had many conversations with her GP colleague both about her concern for farmers' health and her vision of how their needs could be met. This GP became the Principal Investigator for the Farmers' Health research project.

The academic who ran the NP educational programme argued that the coupling of a NP-led service with a focus on farmers' health was a win-win solution. It both had the potential to meet farmers' needs and at the same time was a strategy to take nursing, and NPs in particular, forward.

The decision to establish a novel NP-led outreach service was clearly significant. Some informants however, felt that the decision was neither one that was reached by consensus nor was it one that they felt particularly comfortable with:

"I just think, I feel that the role of nurse practitioner isn't the right one for what we had envisaged or some people had envisaged the project to be about and so that's now, sort of, is the lead part of the project isn't it? the emphasis suddenly turned to having a nurse practitioner because that was also looked upon as being innovative and I think that if it had been left with CPN's and community nurses, I think we would have addressed farmer's health needs in a much wider way, I think it has become very specialised and very particular now, which wasn't, I think, what we set out to do.... I think it was because the nurse academic is, you know, quite a dynamic person, quite determined and he was training nurse practitioners and I think he just felt that they were the only people who could do the work as he envisaged it, which was very clinical and diagnostic and those sort of things whereas in my view the origins of it was to extend the role of community nursing to give a better service to farmers." (Health Visitor).

The introduction of a novel NP-led outreach service was seen as particularly galling by those staff who were already endeavouring to address the needs of the farming communities they served by working in partnership with them. For example, one respondent reported that "*farmers' wives*" worked with community health workers and it was proposed that to "*get at the men folk*" the workers should set up a stall at the Auction Marts. With a focus on lifestyles, these members of staff had attended Auction Marts on three occasions before their intervention "*was all put on hold because this other thing was really getting closer then to happening*" (Health Visitor). This account would suggest that, in this case, the dominant voices within the project not only had the capacity to steer the innovation in a particular direction, they also, through the project, had the capacity to stifle local endeavours to develop services in partnership with local communities.

A community psychiatric nurse (CPN) was noted to have expressed concern at the beginning of the project about "the balance within the nurse practitioner role between mental health and general skills" (Management Group minutes 21/6/99). It would appear that her concerns were not addressed as she reiterated them in her interview with me some months later. She stated that she:

"...was concerned that the mental health aspect has not been thoroughly addressed" (Community Psychiatric Nurse).

Perhaps somewhat ironically, a recommendation within the final report of the project appeared to echo the very concerns about the mental health of rural communities that were raised at the outset:

“Mental health problems/needs in the farming community need addressing in ways which are more culturally acceptable. Often, especially in isolated, rural areas, problems are not identified until too late, or until the symptoms are severe enough for the Mental Health Act to be invoked. Such situations, with all their destructive potential, can be prevented by providing easier access to mental health workers who are familiar with the culture and problems of such communities.”
(Burnett & Mort 2001)

The ultimate criticism of the development of a NP-led service was perhaps that offered by the NP appointed to the project, who, once established in the role, questioned the necessity of NP qualifications to identify and address the health care needs of farmers. She said:

“I honestly think that a good district nurse or occupational health nurse or even to some degree a community psychiatric nurse could have done this job as long as they advertised what they were offering”
(NP1)

and, had she been in a position to start again would have handled the project differently. She suggested:

“they might have had a focus group of farmers to say this is what we have found, what do you feel about this, if you were wanting to have a health service how would you like it done?” (NP 1)

Did the decision to introduce a novel NP-led outreach service, to focus on identifying and addressing the physical and mental health needs of farmers, lead to a win-win situation as suggested? From my analysis, it would appear that this decision fragmented rather than cemented the critical mass of people who came together with a common agenda to address the mental health needs of rural communities. There was more of a fission (splitting) than a fusion (blending together into one, coalition, union) of the members of the rural mental health working group.

According to one respondent, at the point where these decisions were made, the rural mental health working group membership “*diminished dramatically*” (Researcher 1) and for some, there was a great sense of disappointment felt at that stage. Was this because people might actually have to do something or that names might actually be in the frame? One informant suggested that this was a behavioural pattern that she had witnessed before within the health service. Her interpretation of this behaviour was that people complained when decisions were not made quickly but as soon as a decision was made and action was to be taken, “*they melted like the snow*” (Researcher 1). However, another interpretation might be that the focus was becoming too narrow or too far removed from the original mental health agenda for some group members. They may have lost interest because they felt that the dominant voices in the group were taking control or even hijacking the agenda.

From a critical perspective, it is helpful to examine the events as both fusion and fission. Through the fusion lens we witness the emergence of a critical mass with a focus on the health needs of farmers. Within this group there was also a small but powerful coalition of professionals who argued passionately that a NP-led service was the most appropriate means of addressing farmers' health needs. Indeed, at least one member of the group clearly had a vested interest in making this a reality. Through the fission lens we see the marginalisation of the “hidden voices” within the community. These were perhaps the people drawn to the initiative because of its original aim to focus on and address mental health issues within rural communities. A critical question is whether the potential to address mental health needs in innovative ways was thwarted as a consequence of the decision to focus on farmers' health and the coupling of that focus with a NP-led service as the solution. My analysis would suggest that during the course of this project it sometimes became unclear if, as illustrated in figure 5.1, farmers were indeed at the centre of the project, or whether the agenda to further the role and contribution of the NP took centre stage. I concluded that the presence of multiple aims within this project led to a lack of clarity over the primary purpose of the initiative. In the following paragraphs, I will illustrate how the

pursuit of the aim to evaluate the impact of NPs in a rural setting had the capacity to place the NP role centre stage, at the expense of the farmers. As a consequence, identifying and addressing the healthcare needs of farmers became a means to an end rather than the primary aim of the project.

Funding for the project was eventually secured in March 1999. The Rural Mental Health Working Group, along with representatives from the organisations who funded the project and co-options from the farming community, established a project steering committee. Charged with the responsibility of taking a strategic view, this committee met every three months throughout the duration of the project. A smaller management group was formed to oversee the project which met monthly. Minutes of both the steering committee and the management group were disseminated to relevant parties as a means of keeping key stakeholders abreast of developments.

With the funding in place, two NP posts were advertised initially. The plan was for each NP to appoint a Support Worker to their team. The steering group not only sought to appoint nurses with a NP qualification but four individuals with rural backgrounds and / or experience of working within rural / farming communities.

Over 60 enquiries were fielded and 30 applications were received for the NP positions. The size of the response surprised many members of the management group because this was a research project offering a two year fixed-term contract. Despite the encouraging numbers of nurses who responded to the advert, only one qualified NP applied for a position. The interview panel appointed the qualified NP and decided to also appoint an experienced nurse with the right background, who agreed to undertake NP training "on the job". This was a critical incident in the project and the decision appeared to be based on the assumption that one individual could simultaneously:

1. undertake a demanding, clinically focused, skills-based academic course with an extensive requirement for clinically based supervision and assessment,
2. manage and support the development of a support worker
3. establish an outreach service and work autonomously at an advanced level.

There was a view, however, that the majority of the steering group members did not appreciate the remit of the NP role and as a result were unaware of the implications of this decision.

The qualified NP appointed to the project advised me that she felt that the members of the project steering committee, with the exception of the academic who ran the NP course, were unaware of the scope of the NP role and, consequently, did not understand the rationale for, and implications of, developing a NP-led outreach service. Early on in the project she expressed concern about the difficulty of meeting expectations in terms of in-service training and clinical supervision (Management Group minutes 15/09/99). She also expressed concern that she felt that she was losing her clinical competency due to the lack of “hands-on” nursing in the early days of the project.

“... the first six or seven months were really quite frustrating. I was worried about losing my skills because I had been seeing between 40 and 60 patients a day, to seeing 1 or 2 a week, and I was concerned that it wasn't going to get off the ground” (NP 1).

These issues were compounded for the other nurse appointed to the project who was endeavouring simultaneously to train and qualify as a NP.

"I think the problem in south Lakes ... was very difficult, you know, up there for the nurse, because she tried to do the nurse practitioner course at the same time which is a huge amount of work and perhaps wasn't able to give the same amount of time initially to be going out and if you like marketing and promoting this, so I don't think there is the same response in South Lakes as there has been in North Lancashire which is worrying in terms of South Lakes sort of seeming to view it as a valuable service because you know I live in Cumbria and farmers in Cumbria have very similar problems to farmers in North Lancashire they are no different, but I felt that South Cumbria were going to miss out on a possible potential service because you know the nurse up there was trying to do too many things all at once really.....I look at it in terms of trying to go out there and promote the Farmers' Health project, trying to do all the networking that needed to be done initially, trying to gain people's confidence whilst trying to meet all the demands that a nurse practitioner course makes on you, I think it must be very difficult thing to try to achieve" (Community Psychiatric Nurse).

There was a sense here that the appointment panel "made do" and I was left with the impression that the nurse who was not qualified as a NP was perceived by some as "second best".

"Well, one of the nurses wasn't a nurse practitioner and so we decided to take a risk and appoint that person and then look to train that person as a nurse practitioner.... and that was because of the pressure of getting the project up and running. In hindsight I am not sure that was the right decision really, we might have been better re-advertising or looking at having a different staff structure to the project" (Manager 2).

On paper, the impression is given is that the differences between the two nurses were acknowledged more positively than they appeared to be in reality. The methodological approach taken in this project, action research, allows for reflection, flexibility and change throughout the course of a project. The centrality of the NP role to this project appeared to make reflection and change a significant challenge.

The nurse who was not qualified as a NP stated that she began to realise that she was not doing the project justice and was concerned that she was working unsupervised and beyond the scope of her professional practice. She felt that she was not being fair to the farmers, the project, her support worker or herself. As a consequence, she began to question whether a NP

outreach service was the only means of addressing the health needs of the farming community. She began to ask whether an additional service should be established when an alternative and potentially more sustainable approach would be to work with farming communities to help farmers help themselves and work with the healthcare professionals “in situ” to raise their awareness of the needs of the farming community and how to support them most effectively. Consequently, she proposed a different way of working. Her challenge led to one informant advising that the two nurses appointed “*had a different emphasis on the work they wanted to do, which has caused quite a bit of tension*” (Manager 2). This tension was widely reported by informants as leading to poor communication and strained working relationships.

Some, perhaps committed to a NP-led outreach service, viewed the nurse electing to operate in a different way as a failure. Others, frustrated by the strong focus on evaluating NP interventions and “numbers of farmers, clinically assessed by a NP”, perhaps at the expense of exploring other ways of identifying and addressing the healthcare needs of farmers, believed that focussing on this single measure was “missing the point”. It wasn't until the catastrophe of Foot and Mouth (discussed below) stymied the NP outreach service that alternative approaches were accepted as legitimate.

In an interim report, it was recorded that “*Much time and effort was spent on (nurse prescribing) in the early months of the project*” (Davies, Mort, & Stead 2000). It was not clear, however, why this was the case. There did not appear to be any data collected or presented indicating why this was believed to be an issue that warranted attention, let alone “much time and effort”, within this particular context. For example, how many times would the NP have prescribed had she had the authority to do so? What percentage of the farmers seen required a prescription? How many times did the NP have to make a referral to a patient's GP for medication? Whilst some data were collected by the project team (see table 5.4), these specific questions did not appear to be asked or answered and, had they been, arguably the time and effort expended by project members on this issue may have been justified.

The legislative framework at the time allowed NPs limited prescribing rights within agreed protocols within a General Practice. The legislative framework was evidently a source of frustration for NPs who were educationally prepared to prescribe beyond the bounds of current legislation. Reflecting on her experience in general practice, the NP advised:

“..... I’ll see patients and they say, ‘oh do you always have to wait for a prescription?’ and I say ‘yes I do’, I say ‘nurse practitioners can do this and they can do that but the prescribing laws in this country cannot allow them to prescribe some of the drugs which they know help” (NP 1).

Table 5.4: Data collected by the Farmers’ Health Project Team (adapted from the final report (Burnett & Mort 2001))

Data collected	Number(s)
Farmers registered (including the rate and source of referral, age, gender, location / postcode and initial reason for consultation)	277*
Consultations held	500*
“Health promotion” contacts direct	approx 1400*
“Health promotion” contacts indirect	approx 5500*
Telephone evaluation of clients seen by a NP	98
Number of farms visited	not published
Number of auction marts attended	not published
Number of agricultural shows attended	not published
Dissemination activities such as presentations given	not published
Reflective diaries	not published
In addition, two parallel studies were undertaken.	
a) one member of the project team instigated a review of farm accidents within the project area from 1999 to 2000. Data were collected from an Accident and Emergency department out with the study area and across five General Practices within the vicinity.	
b) an audit of Coroners inquest records was also conducted to endeavour to establish the rate and causes of farm related deaths within the project area.	
* Data were collected and analysed over the twelve month period once the project van was fully operational and prior to the onset of Foot and Mouth	

Presumably, those within the project team who influenced the decision to develop a NP-led service were aware of the legislation and could have anticipated that NPs working autonomously and providing an outreach

service, which crossed primary care and health authority boundaries, would not have had the legal right to prescribe. They should also have known that setting up prescribing protocols across multiple General Practices would be immensely problematic. Nevertheless, "much time and effort" was spent trying to find ways around this situation.

The debate here is not whether N.P's should, or should not, have extensive prescribing rights or whether legislation should be changed to accommodate extensive nurse prescribing. The focus of this debate is whether a professionalising agenda has the capacity to hijack an innovation which purports to have clients with healthcare needs at its centre. Without evidence to substantiate the impact of the absence of NPs actual or potential prescribing rights in this context, it is difficult to ascertain whose interests were being served. The evidence to support the argument that this was indeed in the interest of the Farmers appeared to be lacking. Nevertheless, one of the five final recommendations from the project was based on this assumption:

"Nurse prescribing is integral to an outreach health service for a marginalised community. Urgent attention should be given to the legal framework currently inhibiting practice and undermining the effectiveness of initiatives that seek to redress inequalities in health service provision." (Burnett & Mort 2001)

The project, therefore, clearly served as a vehicle to promulgate the desires of those within the NP movement to extend prescribing rights and "*empower nurses to fulfil their potential*".

The project had multiple aims (table 5.2). Whilst, on the face of it, the health of farmers seemed to be the explicit primary aim, the desire to promulgate the NP role appeared to have the capacity to dominate the agenda. Indeed, these two aims serve to illustrate how multiple aims can militate against one another when the explicit primary aim is moved stage left to allow another of the project's aims to take centre stage.

I conclude that this project tried to meet too many agendas, which had the capacity to compete with one another for time and resources. The supremacy of the NP role as an aim of key stakeholders stifled debate about alternative ways of identifying and addressing the health needs of farmers. The nurse appointed to the project, who did not hold an NP qualification, was seen as second best and her ways of working, whilst tolerated, did not receive the same degree of status, support and evaluation as the contributions made by the qualified NP. In addition, “much time and effort” was spent on the issue of nurse prescribing, an issue central to the concerns of the NP movement. Yet this appeared to be done without any concrete evidence about the impact nurse prescribing might actually have on farmers' health. I would also suggest that this lack of clarity, and the resulting competition for time and resources, may have impacted negatively on the sustainability of the initiative.

5.3 The Nature of the Project

Another tension within this project arose through different stakeholder perspectives regarding the nature of the project. For example, an academic argued that the project was primarily a research project:

:

“...I mean it's not about service development, it is not about service provision, it is about research” (Researcher 2).

A major funder of the project was the NHS Regional R&D Directorate and a primary and explicit expectation was that this action research project would develop research capability within the NHS. The practitioners were, therefore, employed as co-researchers. However, the NP recruited by the research team as a co-researcher to provide the intervention in this study appeared to struggle with this position:

“...it was one of the arguments we had. ‘We are not offering a service we are a research project.’ I am a service worker I am a service person I offer a nurse practitioner service, that's what I do” (NP1).

These tensions arose, in part, through the coming together of stakeholders from two different cultures and perspectives. Academics are largely based

within the Higher Education Sector and healthcare practitioners are, in the main, based with the service sector. Traditionally, academics aim to question and challenge assumptions. Practitioners on the other hand are expected to operate within tightly controlled standards and regulatory frameworks. Collaborative working can create opportunities for learning but this requires mutual understanding and respect. However in this project, practitioners did not always view criticism as constructive:

“The other thing as well that I found was that sometimes some of the academic staff seemed very critical of the existing service staff. You know the staff that had actually been out there before the farmers' health project came along trying to do and trying to give and trying to reach and trying to work with these people with very limited resources, and sometimes I think they were perhaps being a little bit critical in the way that they have said things” (Community Psychiatric Nurse).

There was a perception that academics were unsympathetic to the context and the power of the professionals they were working with:

“... policies, protocols, confidentiality all of those kind of things that we are constricted by that maybe academic staff aren't in the same way” (Community Psychiatric Nurse).

Critically examining the research context is an integral part of the research process. However, when the NP presented the research at the end of the project, she did not welcome criticism:

“it was bizarre in a way that every single time when you would stand up to present your findings you would have somebody in the audience who would say, yes but nurse practitioners don't have a recognisable qualification do they? And it was always a practice nurse..... I just said obviously you are doing a really good job and we are not saying that we are doing it perfectly, this is a research project and we are just presenting the findings. I felt like saying, if you didn't want to know about it what are you doing here. Why just come to argue?” (NP1)

In addition, despite the project being disseminated widely, the practitioners, support workers and farmers appeared to be *written about*. There was relatively little evidence of the development of the writing for publication skills

of other members of the management or steering groups, even in the outputs which targeted specific audiences. As one practitioner noted:

"I mean, to be honest, I felt it was quite difficult to get your name on stuff... I felt very bad in some respects because the support worker didn't get her name on anything and her input was phenomenal and there were often times I felt that we had all pinched the words out of her mouth somewhere along the line" (NP1).

Therefore, there appeared tension arising from a lack of clarity or shared understanding about the nature of the project. Equally, whilst there were tangible inputs into the development of the research capability of the clinical staff in the form of study days for example, there appeared to be a lack of negotiation and agreement about what outputs they might produce to illustrate the impact of this investment.

This lack of clarity or shared understanding about the nature of the project also became apparent when I examined what was regarded as relevant in terms of the ethics of the project. As the study was to involve potential patients as participants, the research proposal was subject to NHS ethical review before proceeding. The issue of informed consent was of particular interest within the context of the debate as to whether the project was a service innovation or a research project. Normally, it is the intervention within a research project, that is the focus of informed consent procedures. However, in the FHP this was not the case. My assumption would be that a farmer's willingness to be examined by a NP was taken as a form of implied consent for a clinical assessment but there was no evidence that the issue of informed consent to participate in an action research project was ever raised within this context. Formal, informed consent processes were implemented, however, when these Farmers were invited to participate in a telephone evaluation of the service at a later date. I believe this point serves to illustrate the lack of clarity over the nature of the project. More fundamentally, the issues I considered real ethical dilemmas never appeared to be raised. These included:

1. the potential risk to the lone clinician-researchers appointed to access a potentially vulnerable client group in remote locations

2. the potential of raising expectations within a community, for whose mental health, health professionals had expressed concern, with a new, tailored health service, provided within the context of a research project with fixed term funding without any commitment to sustain the service should it prove to be "successful".

This point will be discussed further in chapter 7.

5.3.1 Cultural sensitivity

The FHP was set up as an outreach service because farmers did not access primary care services as a matter of course (Gerrard 1998). This was seen, in part, as a cultural issue, in that farmers are noted for their stoicism. However, the introduction of technology and the subsequent reduction in the workforce on many farms was seen to have exacerbated the situation. Many farmers were now working in isolation and unless they had a problem that they themselves perceived to be of an acute or urgent nature, they simply could not afford to leave livestock unattended and get washed and dressed and leave their farm to attend a doctor's surgery at a pre determined time. Consequently, it is believed that mental illness is often undetected.

Nationally, there is a higher than average incidence of reported suicide amongst the farming community (Booth, Briscoe, & Powell 2000). The NHS Mental Health National Service Framework states:

"Evidence indicates that access to firearms or poison increases the risk that a person may use them to commit suicide. Although in absolute terms the number of deaths is small, the excess risk for certain groups is significant. Farmers and vets have the highest proportional mortality ratio." (Department of Health 1999)

According to the mental health charity MIND, the actual suicide rate is likely to be substantially higher than those reported as suicides. This, they argue, is because the percentage of 'open' or 'undetermined' deaths for farmers is very high, and there is substantial evidence that the majority of these are

suicides. In addition, women married to farmers have a suicide rate more than 20 per cent higher than the average (Kelly 1995; Price & Evans 2005).

At certain times of year, the pace is relentless and when people are tired and under stress, they make mistakes. In the context of farming, mistakes can result in serious or even fatal injury. One local GP systematically recorded the farm accidents which presented within his practice and, accounting for gross under-reporting, concluded that the incidence was approximately two to three times that of the average industrial worker and probably around 500 per 100,000 workers (Burnett 2001).

Endeavours to ensure that the FHP was sensitive to farming cultures "...presented a challenge for professional and geographical boundaries." (Management Group minutes 17.11.99). This discussion above, regarding the development of protocols to enable nurse prescribing, serves to illustrate this point. The acknowledgement that farmers' networks and the geography of those networks are very different to the artificial boundaries of the health service was a critical incident in this project:

"Farmers go to the auction marts because of whether they can get a good price, who they want to meet there.....which is totally different to the health or local authority boundaries which don't always bear much resemblance to geography" (Manager 2).

An analogy was drawn with the prison population:

"I mean, another issue, where we have quite a lot of discussion about how you get across boundaries is the prison population. Totally different, but prisoners often are not in areas that are their own. We have got a young offender's institute here, and a lot of the young men there are from Manchester and Liverpool. So how do you link back to their local area? We haven't really got that one sorted yet but that is the sort of challenge that working with other people's networks causes" (Manager 2).

Boundaries were identified as an issue with regards to accessing farmers and how the nurses providing the service networked, communicated and practised. With the benefit of hindsight, the NP stated:

“If I had been setting up the project I would have started small and then see how it grew, rather than put somebody in where they are crossing five boundaries” (NP 1).

Ironically, this proposal appears to reflect the initiative cited above, where the health visitor and her team were working with their local farming community, before they were stopped in their tracks. This would suggest that there should be a comprehensive assessment and evaluation of current service provision before a new initiative is implemented.

The arguments for ensuring the service was culturally sensitive were compelling and it was agreed that the FHP should be set up as an outreach service. As stated above, the research proposal was subject to ethical review before proceeding. Management group's minutes reported that “research ethics made cold calling impossible” (Management Group Meeting Minutes 20th June 2001). One of the lead applicants reported that the local NHS research ethics committee chair had informed her there should be no “cold calling” of farmers, that is no visiting of farms without an expressed invitation. It is unclear why this was raised as an ethical issue as it was not an explicit intention within the research proposal. However, within an action research methodology, the course of events unfolds and, therefore, cannot be predicted from the outset. “Cold calling”, therefore, could have come up at a later stage in the process. More importantly, why cold calling might be of concern on ethical grounds is unclear. Nevertheless, the subject was raised on a number of occasions by members of the project team and most importantly by farmers themselves:

“One of the things that I suggested early on when they were looking at different ways of getting to this group of people, cold calling to me was OK, you just drive up the drive and say hello here I am which is what a rep would do who was selling you veterinary products or whatever he was selling just turns up. That is what farmers are used to. They are used to people driving up the drive and say spending twenty minutes talking about the price of sheep or wool or the weather and then oh and by the way” (Farmer 1).

This would appear to suggest that cold calling would have been culturally acceptable within the farming community but the local research ethics

committee chair ruled cold calling out as an option for the project and the project team did not appear to contest this position.

It was decided that the outreach service would be provided by NPs in a converted van which would serve as a mobile clinic. The van would be taken to the places where farmers congregate such as the auction markets, and from there it could be taken to farmers' own homes, by invitation only. This decision required the procurement of a van with the relevant kit to enable the NPs to assess and treat, or refer, farmers. This decision was based on the assumption that this modus operandi would be acceptable to the farmers. The project put this assumption to the test.

There was a five month delay between the appointment of the nurses and the arrival of the van. The nurses suggested that the delay in getting the van gave them space and time to network extensively with organisations nurses would not routinely connect with. These included the Citizen's Advice Bureau, the Agricultural Institution, the National Farmers' Union, Business Link and the Fire Service. This time and opportunity they regarded as extremely productive. The NP stated:

"....that networking has been one of the innovations of this job I think"
(NP 1).

The time the nurses spent prior to the arrival of the van "getting connected" was invaluable. It meant that they had a specialised knowledge of the context in which they were to be operating. They could examine farmers' health within a wider socio-economic context.

"If we had had the van initially we might have seen more clients, but it was felt we would then be networking to find solutions to problems, whereas now that networks are becoming established the NPs are more likely to respond appropriately to problems." (Management Group Minutes 15/09/99)

When the van did eventually arrive, its use varied from area to area.

“The van is always reasonably busy at Lancaster. At Sedbergh, the farmers prefer to see me in the auction. They give the van a wide berth but will chat about the state of farming and then about health issues as they arise.” (Nurse Practitioner and Support Workers Report 13/07/00)

The van, quite literally, was the vehicle through which private clinical consultations could be carried out. It was reported that some farmers were put off by the highly conspicuous act of actually getting into the van at the auction marts. Others were happy for the NP to visit their farm to see them there but did not appreciate the van coming up their drive. In both cases, farmers were put off because they did not want it to be known by their friends, colleagues and neighbours that they were getting their health checked out as others may conclude that they had a problem which might impact on their business. Thus the location of the van in the auction marts required careful consideration. In addition, the signage on the van proved to be significant and had to be changed. Initially, there was no reference to the NHS and consequently many farmers assumed that the service was a private enterprise and that they would have to pay.

The nurse who was not a qualified NP often challenged the utility of the van and, much later on in the project, even the NP herself admitted:

“it was just as helpful walking around, than it was having the van there, because nearly everybody wanted us to go to their home” (NP 1).

There was no specific analysis of hard data to support this comment but, as the NP was ultimately the only project team member who undertook clinical consultations with clients, her impressions would indicate that in the final analysis, the capacity of the van to serve as a mobile clinic was relatively limited.

It was acknowledged that the farmers who attended the auction marts and accessed the service in this way represented only a proportion of the farming community. Arguably, those who were socially networked in this way were perhaps less likely to have mental health problems.

“We know we are not reaching everybody and it concerns us that those most in need of help are least likely to spend time at the auctions because of pressures of work and second jobs” (Nurse Practitioner and Support Worker report 13.07.00).

“The thing ...we have said is that if somebody is so severely depressed then they are likely not to go to the mart, they are likely not to come off the farm, so we are still missing them in that sense” (Community Psychiatric Nurse).

Some farmers, particularly the younger ones, were inclined to drop their stock off at the markets and leave. Others used mechanisms which prevented them from personally attending the marts. For example, some farmers utilised facilities which provided:

“... lorry collections to their farms that were then taking the animals to central distribution or abattoirs and so the need for some of those farmers to go to the auction marts is disappearing” (Manager 2).

There appeared to be mounting evidence to suggest that, whilst a mobile clinic and attendance at auction marts provided a means of accessing a section of the farming community, it was by no means the total solution. Nevertheless, it seemed to take an unforeseen catastrophe before alternative ways of working were accepted as legitimate by the whole of the project team.

5.3.2 Foot and mouth

Attendance at auctions marts was totally eradicated during the 2001 Foot and Mouth crisis, which was officially identified in the UK on Monday 19th February (The Anderson Inquiry 2002).

Foot and Mouth Disease (FMD) is a highly contagious and economically devastating disease of cattle and swine. It also affects sheep, goats, deer, and other cloven-hooved ruminants. Many affected animals recover but the disease leaves them debilitated. FMD causes severe losses in the production of meat and milk, has grave economic as well as physical consequences and is considered to be one of the animal diseases that

livestock owners dread most. FMD spreads widely and rapidly. It is highly contagious with nearly 100 percent of exposed animals becoming infected. Transmission is understood to be through a range of media:-

- Direct or indirect contact (droplets)
- Animate vectors (humans, etc.)
- Inanimate vectors (vehicles, implements)
- Airborne, especially temperate zones (up to 60 km overland and 300 km by sea)

The UK Government elected to contain the epidemic (and thus prevent FMD from becoming endemic within the UK) through a massive cull of both infected and potentially infected animals, prevention of the movement of all livestock and severe curtailment of traffic to and from farms across the UK. The impact of this FMD epidemic in the UK was catastrophic for rural communities:

“By the end of September over 2000 premises had been declared infected, millions of animals destroyed and many rural lives affected in a manner unknown for a generation” (The Anderson Inquiry 2002 p 20).

FMD forced the stakeholders in the FHP to have a rethink. It was clearly a critical incident in the development of the initiative:

“I mean who would have thought a few months ago that there would be no auction marts and those sorts of things? So you have got to keep thinking about how you are accessing if you are taking a service to people rather than them coming to you, you have got to think about how you do that and keep evaluating it and keep modifying until it is not working” (Manager 2).

Outreach via auction marts was now impossible:

“Unfortunately our strengths as a mobile outreach service are not effective in present circumstances” (Management Group Minutes 21st March 2001).

The team had to identify new ways of reaching people and so they took the van to supermarket car parks and forest clearings as alternative venues.

They also provided a telephone advice service throughout the catastrophe. Much of this type of work was regarded as more of a social type of support and clearly had a huge impact on the number of farmers physically seen by the NP. This was highly significant when 'number of farmers seen' was identified as a key measure of success (see table 5.4.). The impact of the telephone advice service was, however, far-reaching. The NP reported fielding calls from:

"...literally all over England I would say there were people ringing up because they had seen the number in the press, the farming press and read about it, so we gave out a lot of advice" (NP 1).

It was reported in the management group minutes that much of the advice that was being given included "dealing with the stress caused by bureaucratic muddle and delay and changes necessitated by regulations" (Management Group Meeting Minutes 20th June 2001).

The project nurses and support workers were appointed because of their backgrounds. As they were supporting farmers through the crisis, they were themselves living in the midst of it all. They had first-hand experience. One of the support workers lost all of her livestock. They knew intimately how it felt to lose everything. They also knew how it felt to see their friends and neighbours experience similar losses or face economic paralysis as a result of the crisis, with no prospect of compensation because their animals had survived the cull.

The critical incident here was the learning that occurred. The service was initially established as an outreach service and the focal point for the activity was the auction mart. The team began to appreciate that the farmers who were accessing the service represented only one section of the farming community and there was still considerable unmet need. When access via auction marts was cut off as a result of Foot and Mouth, they were forced to reconsider their modus operandi:

"The way we designed the project to access farmers was being challenged and we were having to think of new ways to access them when they were going to stay on their farms and not come off to the auction mart. So the challenge is to constantly look at how you are designing access to services and if that access changes to look at ways of keeping on top of that" (Manager 2).

Nationally, part of the process of managing the outbreak was to try and identify the source of FMD. The supplier of the sows to the abattoir in Essex where FMD was first officially identified was a Northumberland pig farmer, Bobby Waugh. In May 2002, Waugh was found guilty of cruelty to animals and of concealing the outbreak of FMD, a notifiable disease, amongst his livestock. He was, however, never formally accused of starting the outbreak. Waugh maintains that he was made a scapegoat. In *The Guardian*, Fran Abrahms reported:

"He still maintains that if he hadn't taken pigs to Cheale Meats that week in February 2001, the foot and mouth epidemic would still have happened but someone else would have been blamed. He was just in the wrong place at the wrong time, he says." (Abrahms 2002)

Perhaps he was in the wrong place at the wrong time. Perhaps his predicament was another of the collection of incidents that led to the GPs talk of a "storm warning", some twelve months before the outbreak. Had the Government both the volition and the capacity to take heed of these local voices, the epidemic might have been handled very differently. One of the reported lessons to be learned in the Anderson Inquiry was to "respect local knowledge" (The Anderson Inquiry 2002).

5.4 Sustainability

Three years after it was established, the Farmers' Health initiative was disbanded. My analysis of these data would indicate that securing the sustainability of the Farmers' Health Initiative was dependent upon the coming together of three essential ingredients:

- a) integration with mainstream service provision
- b) secured funding
- c) a champion within the system

The FHP began as a two year action research project with a mixed portfolio of funding. A successful R&D bid to the NHS North West Region provided the majority (65%) of the funding and this was augmented by contributions from a variety of other sources, including the Regional Development Agency. Therefore, with respect to mainstream health service provision, the project was effectively externally funded. The project was also additional to, and was seen to operate out with, mainstream health service provision:

"... being a stand-alone project we never really fully integrated what was happening with General Practice and primary care so it was seen as a secondary service (probably not the right word) but it was not seen as part of mainstream primary care....."

....When we have been to the primary care groups to talk about ongoing funding, there has been a mixture of responses from some who have seen the benefits from the project and who are very keen, to others who have not been as actively involved and not certain about the value of the project" (Manager 2).

The lack of integration of the initiative into mainstream service provision appeared to cause budget holders to question the value of the service and thus impact negatively on the sustainability of the project.

The lack of strategic integration was probably compounded by the fact that NHS primary care provision was in the midst of organisational restructuring. Primary Care Groups (PCGs) were being disbanded and Primary Care Trusts (PCTs) were in the process of being set up. An NHS manager advised that during these changes the team "should keep the initiative in the eye of the trust" (Management Group Minutes 20th September 2000).

In their efforts to secure the future of the project, the project team also engaged in political lobbying. A local Member of Parliament, who was also a Government Health Minister, was shown around the project van by the project team and was reported in the management group minutes to have stated that “one-stop shops” in primary care should be the way forward and should be funded (Management Group Minutes 18th April 2001). This rhetoric was echoed within the rural white paper which promised £100m towards one-stop healthcare centres in 100 communities (Department for Environment Food and Rural Affairs 2000). Great effort was put into trying to track down this funding, but, despite lobbying the Minister for Rural Affairs, a member of the project team reported:

“..we never got any confirmation that there was any new money attached to the promises of funding” (Manager 2).

Thus, engagement in national politics, in this instance, proved to be a red herring.

The two year action research project came to an end in the midst of the foot and mouth crisis. “Exit funding” for one more year was made available from both the Lancashire and the Cumbria Regional Development Agencies. Additional funding was provided by the Wyre Primary Care Group (PCG). This resource supported one full-time and one part-time NP and a part-time healthcare support worker. It also secured the maintenance of the van. The initiative was now no longer an action research project but was essentially an NHS service, wholly managed under the auspices of the Morecambe Bay NHS Trust. Academic colleagues, therefore, were no longer directly involved in the management of the project. However, some of the academics did continue to provide advice and support, keep a watching brief and attend some of the meetings. A smaller management group was established which met monthly throughout the 3rd year of the initiative and a smaller steering group met on a quarterly basis. There were no published reports of any data collected during this period. The group was still chaired by the GP who was the principal investigator in the action research study and was now retired from General Practice. Other members included two NHS managers from

the PCT who had been involved in the initial study and the staff who were still providing the service. The research assistant funded by the Countryside Alliance to disseminate the action research project kept in close contact with the initiative until she resigned near to the time that the funding for her post ran out.

As a result of the reduction in the number of personnel involved in delivering the service, a decision was taken to reduce the size of the geographical area covered, although it was still operating within two distinct areas. At the same time, a decision was taken to broaden the focus beyond farmers and the service was re-badged as a rural health service.

Now that the initiative was no longer a research project, it was no longer subject to the limitations imposed by the local research ethics committee. This meant that cold calling, the method of engagement proposed by the farmers themselves, was now a possibility. When the foot and mouth crisis came to an unexpectedly abrupt end, every farmer in the locality was contacted by letter and advised that a NP would visit them on their farm at a designated time unless they contacted the service to decline the visit.

According to the NP, cold calling proved to be very successful:

".. we thought, why didn't we do this right from the beginning? It was amazing. we picked up all kinds of things..... I did see quite a lot of people who I have never seen at markets but they had heard of us as well, so that was something.....I think we saw something like half again as many patients between the January and February and the end of the project than we had in the whole of the previous 18 months which was amazing really". (NP 1).

Encouraged by these successes, but with only twelve months' funding secured, the sustainability of the project was the primary concern throughout this third year when the initiative was no longer a research project. The lack of integration of the service within mainstream provision was recognised as a key issue and identified as a factor which led to the demise of the project.

“the danger of a sort of “stand alone” project is ‘how do you integrate that with other services?’ Whilst we place the staff within community clinics and they are working with other staff within those clinics. In a rural project how do you engage with all the other rural staff, GPs in other practices, district nurses in other practices? (Manager 2)

Of the 277 farmers registered with the service during the period that data were formally collected and analysed by the project team (see table 5.4), 89% referred themselves. The NFU made 4% of the referrals and the support workers 1%. Only 6% (n=17) of farmers were referred by health professionals from within the system.

The Research Assistant employed through the Countryside Agency investment in the initiative spent the last few months of her contract endeavouring to secure rescue packages for the service within the two areas in which the project was operating. The PCT was so large it was subdivided into three local health groups which covered defined geographical areas. The local health groups had the autonomy to make decisions about service provision within their locality. The service was being provided within two of these areas.

In one area (the most rural) the Research Assistant was able to secure funding but, unfortunately, there was no will from the local health group to integrate the service into their portfolio of service provision. In the other area, funding was promised and the local health group wanted to provide the service, but there did not appear to be anyone within the system with the capacity to champion the initiative. One of the NHS managers I interviewed suggested that it was not seen as a priority. She did not suggest that the initiative was not a priority on the grounds of the quality of the evidence presented (see Burnett and Mort (2001)) when pitted against competing demands, but because it did not have a political champion within the system:

“well I guess it is when money is tight and services have to be cut, you ask the people closest to you and when people are worried about their jobs and their future they lobby for the services they are responsible for, so if you are talking about something that is seen as the icing on the cake which the Farmer’s Health Project and the health visitor service to the homeless in Morecambe was seen as, then they are the ones that get cut”.(Manager 1).

When discussing the lack of capacity in the service to champion local innovations such as the Farmers’ Health Service and a Health Visitor service for homeless people in Morecambe, I was advised that this was largely down to the burden of managing the implementation of national initiatives such as National Service Frameworks (NSFs).

“ If you listen to what a lot of the managers, or co-ordinators or team leaders are having to do with this modernising of older people’s services (they are bringing NSF after NSF and there is a huge amount of work in each NSF and mental health has theirs, NSF for older people and things like that) and unfortunately we have not got enough people to pull people in to sort of work short term on specific things, they have got their day job still to do” (Manager 1).

The FHP appeared to stifle the local initiative cited above, where a health visitor and her team were working with farmers’ wives to improve the health of farming communities. In addition, national initiatives such as NSFs appeared to have the capacity to stifle local innovations which aimed to address the health needs of communities who appeared to be marginalised from mainstream health services.

When it seemed unlikely that the initiative would be sustained beyond year three, the staff that were providing the service, were served their notice and forced to seek alternative employment. It was felt that the termination of the service represented a considerable loss of knowledge to both the local and the national health economy:

“That was the saddest thing for me, in a way, that we had gathered all this expertise about organophosphates and .. farm situations and everything else and we packed that all up into boxes. Will it ever see the light of day again? I just thought what a waste!” (NP 1).

5.5 Summary

As stated in the introduction to this chapter, during the course of my analysis of this case I identified fifteen 'critical incidents' which I believe shaped the trajectory of the FHP. These are listed in table 5.5.

Table 5.5: Farmers' Health Project: Critical Incidents (CI)

CI 1. The marginalisation of the initial contribution and the voices of lay participants and groups members "melting like snow" when major decisions were taken

CI 2. The decision to shift the focus from the mental health of rural communities and focus specifically on the general health of farmers

CI 3. The decision to endeavour to address the health needs of farmers through the establishment of a nurse practitioner-led outreach service

CI 4. The decision to locate the project over a large geographical area incorporating two local authority boundaries

CI 5. Securing a mixed portfolio of funding

CI 6. The decision to appoint a nurse without an NP qualification with the expectation that she would simultaneously:

- undertake academic training and supervised clinical practice to function as an NP
- manage a support work
- establish a novel outreach service

CI 7. The decision to establish an outreach service from a mobile clinic

CI 8. The lead in time which allowed the project team members to network extensively (facilitated by the delay in getting the van)

CI 9. The stifling of a local innovation to work collaboratively with farmers' wives to address farmers' health issues in order to make way for this initiative

CI 10 Funding for a RA to co-ordinate dissemination activities as a consequence of the initial media profile of the initiative and concern that dissemination activities were taking the project team away from the development of the project itself

CI 11. The focus on nurse prescribing without an evidence base to justify the time and effort vis-à-vis its potential impact on the farming community. Professionalising agenda hijacking an initiative to improve the health of a marginalised community?

CI 12. A service innovation or a research project? A clash of cultures?

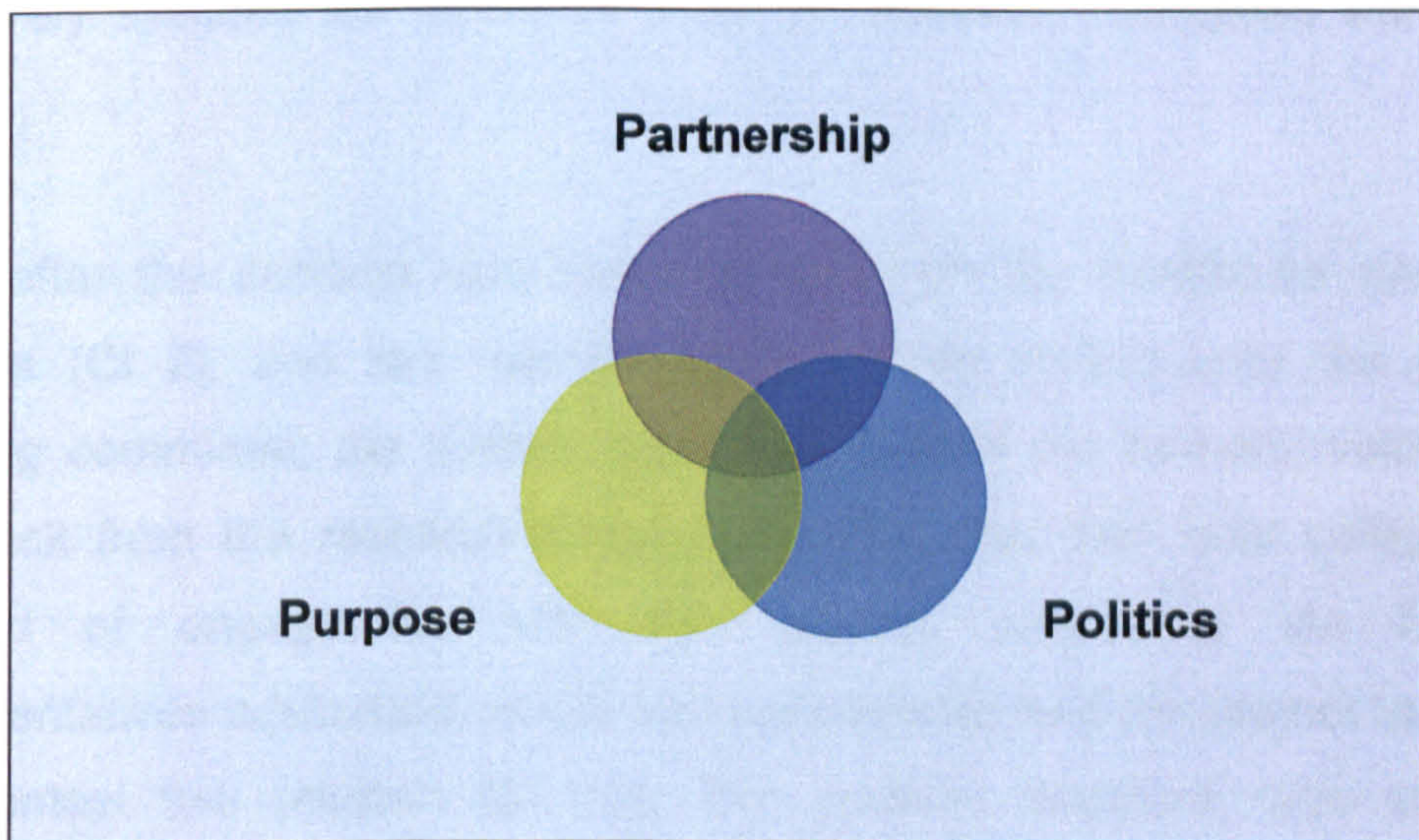
CI 13. No to cold calling: the silencing of the farmers' voice

CI 14. Foot and Mouth: the catastrophe that legitimated alternative ways of identifying and addressing farmers' health needs

CI 15 The demise of the project through lack of funding, lack of integration with mainstream service and the absence of a champion within a system in a constant state of flux

I suggest that the implications of these critical incidents may be synthesised into three interconnected themes (figure 5.2).

Figure 5.2: The Interconnected Themes within the Farmers' Health Project



Firstly, authentic engagement of the key stakeholders in an innovation in healthcare provision would appear to be fundamentally important. This theme I have labelled 'partnership'. Secondly, clarity, or agreement amongst stakeholders about the primary focus of a project, would appear to be equally important. This second theme I have labelled 'purpose'. Thirdly, political engagement may be necessary to develop and sustain an innovation in healthcare provision. This third theme I have labelled 'politics'. In this chapter I have presented the empirical evidence and the argument to justify these three themes. In this concluding section I draw together the threads of these debates.

Authentic engagement of stakeholders looked as if it was fundamentally important in this case, in three key areas. Firstly, despite what appeared to be genuine endeavours to engage people, with a concern about mental health within rural communities, at the outset of this initiative, I was informed that professionals effectively silenced the voices of lay members of the

group (CI 1). The sense of urgency – a storm warning – expressed by the GPs and the passion of the nurse academic to allow nurses to realise their potential, fuelled their collective professional power and their capacity to dominate the debate, control the agenda and deny lay participants the opportunity to offer alternative perspectives. Indeed, it appeared that these particular professionals were considerably more influential than others and effectively silenced the voices of other professional colleagues within the team.

Even after the decision was taken to focus on the healthcare needs of farmers (CI 2), and two married farmers were invited onto the project steering committee, the system conspired against the farmers' voice. The feedback from the research ethics committee was that 'cold calling', the method of engagement with the farming community the farming representatives advocated, would be unacceptable and the project team did not contest this position (CI 13). The system, therefore, was seen to conspire against authentic engagement with the community whose healthcare needs the project sought to address in a culturally sensitive way. With the benefit of hindsight, the NP suggested that if she were starting all over again, she would invite farmers to join a focus group to ascertain what sort of a health service they would like, which arguably would have been more in keeping with the spirit of action research, engaging the farming community as co-researchers in the process. Instead, the project team engaged in providing a service designed by professionals, for professionals. For example, the decision to establish a mobile outreach service (CI 7), because such a service would be an appropriate and sensitive foil to the stoical reticence of the farming community to access health services, proved erroneous. It is possible that this expenditure could have been avoided if more lay farmers had been authentically involved in the project as co-researchers, from the outset.

Secondly, tensions arose in this case between the clinical and academic members of the project team (CI 12). There appeared to be a lack of clarity about the roles and contributions of each member of the project team and

consequently criticisms were not always recognised as constructive. Consequently, there were perceptions that vested interests were being served and the potential to build research capability was not fully realised. For example, there was relatively scant evidence of the project team engaging in writing for publication, despite a plethora of outputs.

Thirdly, despite the time the project workers invested in networking at the outset of the initiative (CI 8) and the additional funding secured to support dissemination (CI 10), the initiative was not fully integrated with mainstream service provision and this appeared to be a factor which led to its demise (CI 15). This may have been exacerbated by the decision to provide a mobile outreach service (CI 7) over a vast geographical area (CI 4) thus adding considerably to the complexity of the project and the numbers of potential stakeholders. Certainly, within the most rural community served, local service providers were not sufficiently engaged with the initiative to incorporate it into their portfolio of service provision.

Some of the tensions which surfaced in this case were a result of, and exacerbated by, the multiple aims of the initiative. At face value, the FHP was an action research project seeking to identify and address the health needs of farmers (CI 2). Upon closer inspection however there was an explicit agenda to further the role of NPs (CI 3). Whilst one of the advocates of a NP-led intervention saw this as a win-win situation, I have argued here that this professionalizing agenda demonstrated a capacity to distract attention and resources away from the farmers or service users. In this case, for example, considerable time and effort was expended in trying to address the national legal framework for nurse prescribing (CI 11). This appeared to be without evidence of the tangible difference nurse prescribing would have made to the farmers accessing the project. In addition, a nurse, who was not qualified as an NP or experienced in the role, was recruited to fulfil the role of an NP in the project. The expectation was that she could develop and autonomously deliver the outreach service and at the same time attain the skills required to provide the service (CI 6). This emerged to be unrealistic and so she proposed alternative means of identifying and addressing farmers' health needs. However, her proposals did not appear to be fully

legitimised until Foot and Mouth conspired against what appeared to be considered the 'Gold Standard' NP outreach service (CI 14).

With a portfolio of funding (CI 5), with the lion's share from an NHS R&D capacity building budget, there was a lack of clarity and hence agreement amongst stakeholders as to whether this initiative, as an action research project, was primarily a research project, or primarily an innovation in service provision (CI 12). This lack of clarity manifested most vividly through the aspects of the initiative deemed to require formal informed consent.

In this case, macro-, meso- and micro-politics appear to impact on innovation. By macro-politics I mean politics at a national level, by meso-politics I refer to politics at an organisational level and interpersonal politics I refer to as micro-level politics.

Analysis of the decisions made and the surfacing of hidden tensions in this case study illustrate that there was a significant amount of interpersonal politics in this case. The stakeholder analysis, discussed in section 5.2 above, illustrates some of the structural, organisational and cultural differences which fuelled these micro-politics. The political capital achieved from the project by the academic committed to championing the role of NPs appeared to be significant. Arguably, his ability to negotiate the development of a NP-led outreach service (CI 3) illustrates a degree of personal political acumen. The degree of media coverage the project enjoyed clearly put NPs under the spotlight. Equally, the amount of time and effort the project team spent on nurse prescribing (CI 11), a policy concern central to the NP movement, without any clear evidence of the impact the right to prescribe could have had in this particular case, illustrates the depth of this influence on the project as a whole. Set against this argument, the authentic engagement of stakeholders can be constructed as a political issue.

The identification of the necessity for an innovation champion at a senior level within an organisation to sustain an innovation in service provision illustrates the importance of engagement in meso-level politics (CI 15).

Equally, there is the apparent necessity for the integration of an innovative service into mainstream service provision and the capacity of a local health group to curb that potential. The constant re-configuration of health services, in this case from PCGs to PCTs, with the inevitable impact this has on the personnel involved, makes it particularly difficult to identify and sustain an innovation champion.

Equally, the capacity of the research ethics committee to thwart the very intervention farmers themselves advocated serves as an example of the capacity of systems to stifle innovation (CI13). Indeed, this was further illustrated by the power of this innovation to thwart the local endeavours of a health visitor and her team working innovatively with her local farming community (CI 9).

National political issues also appeared to have a significant bearing on this innovation. Rural issues were recognised as “*a political hot-potato*” and this was seen to provide political capital and, perhaps, help to secure funding for the project (CI 5, CI 10). In addition, the politically-driven requirement to implement numerous NSFs was proposed as a rationale for the absence of any capacity to champion this service within the local health economy (CI 15). Here again, a top-down policy driven innovation is seen to stifle a locally grown one. The NP movement was an innovation seen to be limited by the national legislation on nurse prescribing. Even when this local innovation appeared to explicitly match nationally policy, with the explicit implication that there were resources to support the policy, there was, in fact, no new ring-fenced resources. This innovation was, therefore, totally dependent upon meso- and micro-political processes for its sustainability.

The next chapter presents the second case study of innovation examined in this study and in chapter 7, the cases are compared and contrasted.

Chapter 6 Case Study 2 – “The Corner”

6.1 Introduction

This chapter reports on the analysis of Case study 2: *The Corner*: health and information services for young people. Introduced in chapter 2, where the methods deployed to investigate this case are set out. Types and sources of evidence examined are listed in table 2.7 and the semi-structured interview schedule which was used is presented in table 2.6. In analysing and interpreting these data, I identified fifteen critical decisions or incidents which appeared to me, to have had a significant impact on this particular case. Critical analysis of these incidents, through the consideration of the probing questions listed in table 2.8, offers insight into the conditions in which initiatives that endeavour to innovatively facilitate access to healthcare, to groups of people who do not routinely access mainstream services, can flourish.

The Corner drop-in centre opened its door to the public in March 1996. Based in the city of Dundee, in Scotland, *The Corner* provided a wide range of confidential health and information services to young people aged between 11 and 25 years. *The Corner* had a long gestation period which spanned over ten years. This appears to be significant as it may offer a rationale for the clarity of thinking that emerged around the purpose and the modus operandi of *The Corner*.

Throughout the 1980's, the authorities in Dundee were concerned about social and housing issues along with the high incidence of drug, alcohol and solvent misuse amongst the young people in the city. Consequently, the Regional Council Community Education Service sought to gain the support of other stakeholders to establish a city centre facility for young people. Despite receiving support in principle from a number of agencies, reservations from others meant that early proposals never came to fruition (Easton 1997). Between 1981 and 1991 the local health board and the local

authority independently undertook a range of consultative initiatives with young people in the city. For example:

“... we held a thing called ‘The Dundee City Youth Forum’ and we had a lot of young people came, probably as many as 1500 young people came to the event in the Caird Hall, an all day event with bands and all that sort of stuff, and one of the things that came through that event was the need for a city centre facility, and the other thing that came through that event was the need to respond to the whole issue of sexual health, by independent confidential advice for young people” (Local Authority Senior Manager).

There was a groundswell of evidence emerging in both the local authority and the health service that young people needed a confidential health and information service, developed with, and specifically for, the young people of Dundee, within a city centre location. This evidence included the views of the young people consulted coupled with the concerns cited above, the relatively low uptake of family planning services and a need for effective HIV/AIDS health promotion activities. In 1990, the health board's Chief Area Medical Officer (CAMO) annual report stated:

“Innovative ways of working with young people need to be initiated and a Project Team should be established to speed up the development of appropriate health and education prevention services.” (Chief Area Medical Officer 1990)

It was increasingly clear that the health needs of the local young people were not being addressed and young people were not accessing traditional health services. Consequently, in 1991, the Public Health Medicine Department proposed that a joint health board / local council project team should be set up to develop health promotion initiatives related to the sexual health of the young people of Dundee. A senior health promotion officer was appointed for three years by the health board to progress the consultation work with young people. A local authority community education professional was seconded to work with her for a period. The senior health promotion officer's brief was defined within the CAMO's report. She was to find innovative ways of working with young people to develop appropriate health and education prevention services. Her remit is detailed in table 6.1.

Table 6.1: Remit of Senior Health Promotion Officer (Redman 1992)

- To study similar initiatives in other parts of the UK
- To define and appraise the options for service developments
- To identify and recommend projects which should be developed by the health board
- To pilot these projects
- To co-ordinate the long term establishment of the projects

The CAMO's recommendation of a project team emerged as a steering group with representation from the health board, the community education service, health education, the family planning service and the voluntary sector (Easton 1997). In 1992, a joint bid from the YMCA and the community education service was made to the health board to support a collaborative venture to provide a range of services from the YMCA premises (see table 6.2). For reasons which were not documented, the CAMO did not support this bid and these plans were not progressed.

The Senior Health Promotion Officer visited several youth projects across the UK and recommended that any local developments should have a positive image with young people and should be run by young people. She also recommended that any sort of healthcare provision should not adopt a traditional medical model of care (Easton 1997). To progress her agenda, the senior health promotion officer ran an extensive consultation exercise with young people throughout the summer of 1992.

Table 6.2: The Joint YMCA Community Education service proposal (Easton 1997)

- a youth information counselling service
- a supportive environment
- a base in support of street work
- promotion of health education
- safer sex advice / contraception clinic
- peer education
- engaging young people in challenging opportunities
- promotion of personal / social development
- drugs primary prevention
- cultural / European opportunities
- promotion of workshops

Her aim was to:

- Begin a dialogue with young people about their health needs
- Make contact with young people who might want to become involved in setting up a health project
- Inform the health promotion officer- young persons' project
- Ensure the recommendations for project development best meet young people's needs (Redman 1992)

The specific aims of the consultation are detailed in table 6.3.

Table 6.3: Aims of the Young Person's Health Project Consultation Exercise (Redman 1992)

To find out young people's views on different aspects of a young person's health project

What should be offered? – i.e. what health services, information or support do young people need?

How can services be made accessible? - i.e easy to get to and open at the right time

How can services be made acceptable? – i.e. welcoming and OK to go in, provided in the way young people want them

253 young people took part in the consultation in 35 focus groups. The average group size was 7 (range 2-17). The average age was 15 (range 11 – 20) (Redman 1992). The consultation raised many issues and the report offered 11 recommendations (see table 6.4).

In a review of this report, the level of consultation was challenged, and it was argued that certain key decisions had been made prior to consulting with the young people:

“it was clear from the methodology of the consultation that it had already been decided that a young people's health and information project should be created and that the consultation was to establish what young people would expect from such an initiative.” (Easton 1997)

Some of the report's recommendations were also challenged. For example, a number of the issues raised were not important to young people, but had a more professional focus, such as the legality of services to the under 16's and the benefit of outreach workers.

Table 6.4: Recommendations of the Young Person's Health Project Consultation Exercise (Redman 1992)

1. Single door access to a variety of services because:
 - a. issues are often linked
 - b. the service which is most often needed i.e. condoms, contraceptives, pregnancy test is least acceptable if provided on its own.
2. A range of services are required including:
 - a. information and support on health issues, benefits, legal and housing issues
 - b. short-term and long-term counselling for a variety of problems including family problems, pregnancy, physical or sexual abuse, bullying, homelessness
 - c. a doctor who is separate from the family doctor
 - d. healthy things to do (e.g. exercise, meeting with others).
3. There is a need for services in different locations, i.e. both in the schemes and in the city centre. Accessibility, safety and discretion all need to be considered.
4. A health project needs a positive image, i.e. it needs to look attractive, have a positive name, be a drop-in, have a crèche. It needs to avoid a clinical or official atmosphere and health education posters.
5. Confidentiality must be guaranteed. This will be a major if not the major factor in young people being able to use a service.
6. Outreach workers would need to be an ongoing aspect of any health project.
7. Support groups should be encouraged.
8. Under 16's need to be explicitly welcomed. Education is needed for young people and adults about the legality of providing services to under 16's.
9. Those with special needs must be considered so they have access and feel safe.
10. Staff are needed, who listen, understand, don't treat young people like kids, are street wise, can be trusted, have been through it themselves. For many this means that staff have to be young. Young women in particular need to be assured that they can see a woman. Training will be needed whether they are professional or lay people.
11. Young people involved. Young people want and should be involved in decision making and involvement in other ways should be explored. This is important to ensure that the services are what they want and are what they would use.

Easton (1997) identified four key issues from this report (see table 6.5).

Table 6.5: Key issues raised by Redman (1992) Report. (Easton 1997)

1. There was an unmet need for contraception including the use and the negotiation of use of condoms, emergency contraception and pregnancy testing
2. The under 16's perceived that they were excluded from current service provision
3. Young people felt that there was a need for a range of services to be provided all under one roof
4. The ability to guarantee confidentiality was of paramount importance to the young people consulted

Ninety-six of the young people who participated in the consultation exercise expressed an interest in getting involved in the establishment of a health project. Twenty-one turned up to the first meeting of what became "The Bodymatters Youth Group". Approximately twelve young people met on a regular basis to progress this agenda through a variety of media. They also developed their own magazine "Bodytalk". Supported by health promotion and community education staff, they became active in promoting the need for a city centre facility (Easton 1997).

A working group was also set up where representatives from Public Health Medicine, the Community Education Service and Health Promotion joined the two workers who had already been assigned to the project. Other professionals had an input into this group depending on the issues they were discussing. Momentum was clearly building up and a number of proposals and bids for development were put together by the various stakeholders. There was unanimous agreement that a city centre young people's health and information service with multi-agency input was the way forward and a project specification was agreed (table 6.6).

Table 6.6: Project Specification

1. To be developed with the active involvement of young people
2. To combine the provision of youth information with targeted health information, health education and a confidential counselling service
3. The youth information was to mirror national developments in youth information services
4. To deliver contraception and other health services

Start-up funding would be made available from multiple sources including the health board, the local council and the YMCA. The longer term view was that the project would become a charitable trust. Concern arose that this momentum could be lost, however, as the complexities of sorting out the funding arrangements became apparent and finding suitable city premises that met with the project premises' specification (see table 6.7) was proving problematic (Easton 1997).

Table 6.7: Project Premises Specification

- A. Premises that would accommodate:
1. A Youth Enquiry Service to provide information on a variety of issues e.g. housing, welfare rights
 2. Access to information and advice on health issues
 3. Contraception and pregnancy tests, including a twice weekly session by a family planning doctor
 4. A counselling service for young people on issues relevant to them e.g. family problems, pregnancy, homelessness
 5. Groups activities to address social and educational need
 6. Support / self help groups in conjunction with appropriate specialist agencies.
- B. Premises should be:
1. in the city centre
 2. away from the main shopping streets
 3. in an area which young people considered to be safe and neutral
- with a shop front with rooms and meeting areas

These bureaucratic complexities delayed the development of the project for several months and this had a negative impact on the morale of the Bodymatters Youth Group. They complained that they felt as if they were now taking a back seat in the project's development. In April 1994, the health board assured its share of the funding and the Health Education Board for Scotland (HEBS) committed to provide £20,000 per year for three years to evaluate the project. Following complex negotiations, a joint NHS / local authority management model was finally agreed. Health board and local authority funding was complemented by a Scottish Executive urban aid grant for outreach work (Easton 1997).

Proposals to establish a city centre health and information service for the young people of Dundee had been banded about for nearly fifteen years. The appointment of the project coordinator, in October, 1994 was clearly a watershed:

“It is arguable whether the appointment of the Project Coordinator hailed the birth of the Young People's Project but it would seem to be a suitable description because the next stage of the Project has been reached and the lengthy gestation period is over.” (Easton 1997)

6.2 Stakeholder Analysis

From my account of the genesis of this initiative, it would appear that there were multiple stakeholders in *The Corner* and that young people were firmly at the centre. To facilitate an analysis of stakeholders I have mapped the range of issues highlighted by informants as the types of concerns raised by the young people who used *The Corner*. These are illustrated in figure 6.1. Figure 6.1 not only serves to illustrate the range and complexity of the health and social concerns of the young people who attended *The Corner*, it also serves to indicate the potential range of agencies that may have a stake in *The Corner*. Whilst the concerns of the authorities may have driven the development of the *The Corner*, a holistic approach to the issues of concern to young people led to the engagement of a wide range of stakeholders.

Figure 6.1: Range of issues raised by The Corner Young People

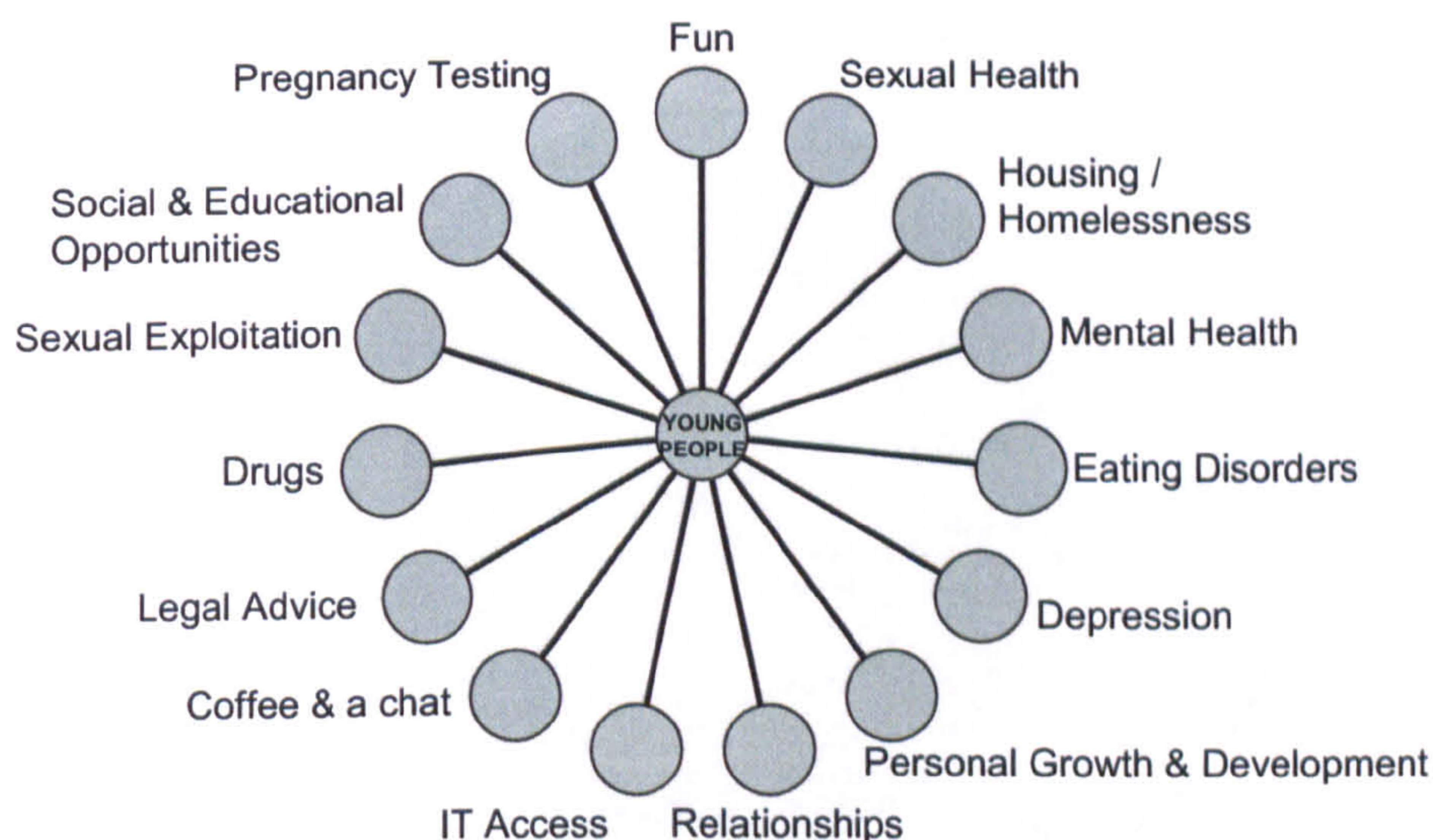
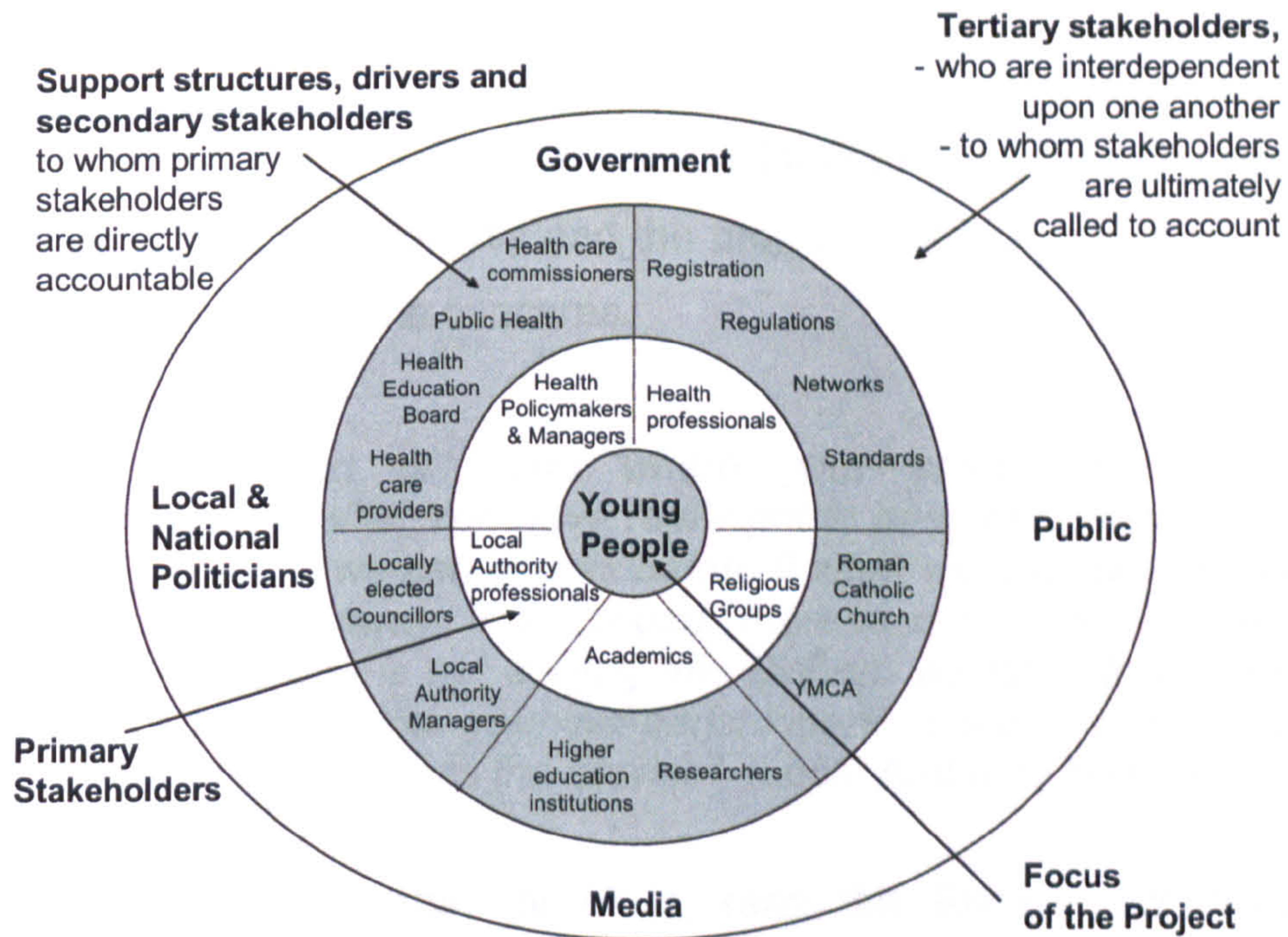


Figure 6.2 provides an overview of the range of stakeholders I identified. Here young people are seen to be firmly at the centre. The other primary stakeholders are identified in the second circle. The third circle includes the organisations and entities which support and drive the agendas of the primary stakeholders. It also identifies the agencies that the primary stakeholders are accountable to. Tertiary stakeholders are identified in the outer circle. These are recognised as interdependent upon one another and the entities to which both primary and secondary stakeholders are ultimately accountable.

... a range of publicity with the Roman Catholic Church, ... 'scumbag' ... (Project Coordinator 1).

... was contacted by the press two weeks before the ... that the Roman Catholic Bishop was ... for his comments. Because of his lack of ... with the media, he declined to comment. The result ... it made front page news and it didn't stop ... The Scottish tabloids and eventually the broadsheets ... followed up on the story.

Figure 6.2: The Corner stakeholder analysis



6.2.1 The media, the controversy and the Roman Catholic church

An endeavour to work with young people and address sexual health issues, with a brief to deliver contraception (table 6.6), was not without its opponents and the local press seized the opportunity to sensationalise the opening of *The Corner* and create as much controversy as possible:

"...we opened in a blaze of publicity with the Roman Catholic Church giving us "den of iniquity", "scurrilous", em "ill thought out venture" and all that sort of stuff" (Project Coordinator 1).

The project coordinator was contacted by the press two weeks before the centre opened, advised that the Roman Catholic Bishop was *"up in arms"* about the centre and asked for his comments. Because of his lack of experience in dealing with the media, he declined to comment. The result was that, when the centre opened, it made front page news and it didn't stop with the local press. The Scottish tabloids and eventually the broadsheets and Scottish Television followed up on the story.

"...it led to myself and young people being on television and interviewed ... So the press stuff was a huge learning curve for me because I had never dealt with the press in that way before" (Project Coordinator 1).

Support from the management group facilitated a pro-active approach to dealing with the controversy and the project coordinator was encouraged to tackle the source of the concerns.

"...that sort of stand where your enemy is. I believe that fundamentally. You have really got to hear what they are saying and say, well if we can do this better, if what we are doing is not needed, we will go away. It is needed, there is a big social need out there, prayer alone is not solving this Bishop, we have to be here and we are here for your younger parishioners as well as for those who are atheist who access the service" (Local Authority Manager)

The project coordinator, therefore, rang the Bishop and asked for an appointment. The Bishop agreed to meet with him and their meeting appeared to diffuse the controversy. The project coordinator believed that he had been able to persuade the Bishop that they had shared concerns – the health of young people, whether that is spiritual, mental, physical or social. He also persuaded him that *The Corner* project was not ill thought-out, was not being run by "a bunch of amateurs" and was not "chucking condoms at young people" but "engaging in challenging discussions".

The media frenzy was a steep learning curve for the Coordinator:

"...what it confirmed was just how you can be stitched up in the press and what is reported in the media doesn't reflect always what the general public feel..". (Project Coordinator 1).

This controversy fizzled out but the upshot was that *The Corner* has enjoyed a huge amount of media interest since the day it opened. I was afforded access to four lever arch files in the offices which were full of press cuttings about the project and associated issues. The project coordinator and his team have learned how to work with the media interest in their work to the advantage of the project and the young people in the city. The consequence of this is that whenever any issue such as local teenage conception rates

(which are reported to be the highest in Western Europe) get back on the agenda, *The Corner* is always one of the first places the press go to for a comment. They do not give an instant response but ask for details of the questions to be addressed with a promise that that they will get back in time for their deadline, once they have garnered the appropriate evidence to back up their claims. They have also become proactive in their dealings with the media, feeding them positive news stories at every available opportunity in order to put young people and the project in a positive light with both the media and the public.

“There has been an openness there. Early on they got some good stories and they got some good coverage and they were brought in to what the ideas were and I think [journalist] in particular in the local press developed quite strong personal relationship with PC1 in terms of his willingness to share with her, she could phone up and say what do you think about this, and that has helped, enormously” (Local Authority Manager).

By the very nature of the project, it inevitably courts controversy and other incidents have arisen as a matter of course. Two years after the drop-in opened, a parent who had found an appointment card for *The Corner* in her daughter’s bedroom, complained to her local councillor and the media because her daughter had been given an appointment with a doctor and a prescription for contraception, without her consent.

“...there was front news headline from a parent who had ‘phoned the local paper and was incensed that her 13 year old could access an injectable contraceptive at the drop-in” (Project Coordinator 2).

Partnership working actually helped to diffuse some of the controversy. When the project was initially set up, no one was quite sure whom to point a finger at. There seemed to be an assumption that, because the project was so different to mainstream services, it was actually run by a voluntary organisation with financial input from both the local authority and the health board. The management team could see that this was working to their advantage because:

“..it had that image, the press were more benign to it. It had that kind of arms length feel so people, if they wanted to attack it, couldn't attack Dundee City Council, they had to attack this thing which was working for the benefit of young people in difficulty, in a fair and reasonable way of involving them, quite hard to attack” (Local Authority).

Because a significant chunk of the project's funding was provided by the local authority, keeping elected members of the Council on-board was seen as important.

“...the powers that be always want it to be portrayed in a positive light which we do as well” (Project Coordinator 1).

One way of doing this was to link the city, Dundee, to the major reports which resulted from *The Corner's* work. *“Made in Dundee”* for example is often stamped on reports to celebrate the work that is being achieved within the city. Another way was to have an open-door policy for local councillors so they could see the work of the project in action. Building alliances was seen crucial to the future of the project.

“in the early days, it was like a lot of leg-work just establishing relationships” (Project Coordinator 1).

The project coordinator told an anecdote about how he was feeling at the end of the week before the drop-in opened. He was exhausted with dealing with the media and all the controversy over what the project was about. He was standing in the drop-in with his colleagues just commenting on what a week it had been and how ready he was for the weekend when a middle-aged woman put her head round the door and asked *“Is this The Corner?”* Fearful of what was coming next, he admitted that it was. To his delight she said...

“Well, I tell you what, I've been reading about you in the newspapers and listening to you on the telly and I think this place is great. My daughter took part in one of your workshops up in Kirkton neighbourhood centre and I think you are doing a good job” (Project Coordinator 1).

The project was clearly controversial. In order to help young people reduce their own personal risk-taking behaviour, the project team were actively encouraged to employ innovative methods which could themselves have been considered risk-taking. For example, young people from *The Corner* were reported to have used drama in the Council Chambers in order to communicate their message to local Councillors and secure ongoing support to address the concerns of young people within the City.

6.3 The Nature of The Corner Project

Young people were firmly at the centre of this initiative. The appointment of a project coordinator, with a strong value base, by a panel of key stakeholders, was regarded as a key factor in the success of *The Corner*. The project coordinator, in turn, appointed like-minded individuals to the project team which led to the development of a strong '*Corner* culture'. The support of a senior, cohesive and committed inter-agency management group was cited by the project coordinator as a significant factor in the success of the initiative. The acquisition of culturally acceptable premises to operate from, were also considered to be a major milestone in the development and success of the project.

6.3.1 Appointment of the project coordinator

It was agreed that the project coordinator's post would be jointly funded by the two lead funding agencies, the health board and the local authority. There was apparently a good history of joint health board / local authority working in the city but what was unique about this project was the decision from the outset to jointly fund and jointly recruit into the Project Coordinator role. The appointment panel, therefore, included representation from the NHS and the local authority. There were also four young people from the Bodymatters group on the panel. National representation was provided by the person responsible for establishing the "Young Scot"² initiative. This

² Young Scot is a national initiative (www.youngscot.org) with a philosophy to support young people to take advantage of as many opportunities as possible. It offers incentives, information and opportunities to young people aged 12 to 26 and aims to help them make informed choices, play a part in community life and make the most of their leisure and learning.

appointment process was a critical incident in the development of *The Corner*.

The man appointed to the post³ had a professional background in community education and had supported the young people that he was working with at the time to participate in the consultation exercises with the young people in the city in the early nineties. He was not from Dundee but had had considerable experience of working with young people in the city and in other cities in Scotland. He had worked in a variety of settings including street work, school work, children's hearing work and residential care.

"You name it, it was right across the spectrum" (Project Coordinator 1).

He advised me that he had made very considered career choices:

"I had trained in community education. I had done four year's work in a residential social work setting with young people before that, and I saw at first hand what happens when you have got young people and children in places they don't want to be. They might have to be for their own safety or for what other reason but the bottom line is most of them didn't want to be there, and I thought long and hard about which route I went down in terms of professional qualification and ultimately saw community education as the one as having most scope in that it was all about voluntary engagement and people, you know, were in contact because they wanted to be, for whatever purpose" (Project Coordinator 1).

Through drawing on this experience, he was acutely aware how difficult it was, at times, for young people to access the services they needed. This was either because the services just didn't exist or because young people didn't know about them. The fact that services were rarely young people friendly coupled with the artificial boundaries between services, added to his frustration.

³ NB During the period of time I collected data for this case, the original Project Coordinator had been promoted and was working on the development of a sister initiative. He was line managing the person who was acting up as his replacement. After a period of time this acting post was made substantive.

"You know, a service for this, a service for that, a service for something else. And not necessarily geared towards young people" (Project Coordinator 1).

He applied for the job because he saw it as a means to filling in some of the gaps in current service provision.

"I thought, ah, this is the opportunity to join up some of the gaps that I've seen in relation to mental health, sexual health em and broader health issues. This is a chance to pull it together, and I went, ah, that's for me" (Project Coordinator 1).

He believed that he was offered the job because he was able to demonstrate that he wasn't particularly tied in to his own discipline:

"And I don't know, I think probably without trying to boost myself too much they sawthey being the management groupthat I didn't have the preciousness of the local authority although my background was working with young people in a pretty focused way, that was about, this is about everybody wins, it is not about trying to push a particular agenda other than get it right for young folk..." (Project Coordinator 1).

The two members of the management group interviewed, from the Health Service and from the local authority, identified the appointment of this man as one of the key factors that they believed to be critical to the success of the project:

"I think the appointment of [PC1] as the project manager originally was really important as he had certain thoughts, ideas, principles around what he wanted to do and even things like the artwork they used was very innovative the way they engaged with young people..... I was constantly amazed at the ideas they came up with that were fresh and different to what we had experienced before..using young people's imaginations." (NHS Chief Executive)

"We needed someone who could both manage and develop a project, manage and develop work with young people, manage and develop partnership work on an inter-agency basis and have a competence to manage and cope with information retrieval, presentation and it was very hard to find that in any one person.....I think the project leader was the person that made it work and if it hadn't have been [PC1] it might not have been as successful, so he had made a huge personal contribution and he has carried that through". (Local Authority Senior Manager).

Once appointed, the project coordinator had three major tasks. They were to find suitable premises, to appoint staff to the project and to develop a framework under which they would operate.

6.3.2 Appointment of the project team

It was agreed that all other approved posts would be held within the establishment of the lead agency depending upon the role specification. Appointment panels would involve young people and representation from both the health board and the local authority (Easton 1997):

"young people have been involved in probably 80% of all staff interviews and a whole range of other things " (Project Coordinator 1).

Whilst recognising the range of skills the project would require, the Coordinator was clear that he was not interested in appointing anyone who was in any way precious about their professional discipline:

“staff who have come to the projectit is not the about their qualifications it is about their experience, their attitude and at times that doesn't have to be a lot of experience. I would rather have somebody employed who had a really healthy attitude, a lot of energy, was open to development, that maybe had not had lots of experience than someone who has been around for ten years bitten and chewed all the strategies, all the lack of resources, caught in professional identify” (Project Coordinator 1).

A willingness to learn and an ability to engage with young people as equals and on their terms were seen as the key attributes:

“two of the most necessary things are being open to learning and the other one is having a strong sense of seeing young people, being able to see young people as people they can learn from as opposed to just preach to or teach or educate” (Project Coordinator 1).

At the time of the opening of the drop-in the project team was seven strong. The project coordinator in collaboration with the Bodymatters Youth Group and the management group had appointed five professional staff from a range of health and social care backgrounds. A senior clerical officer was appointed to provide administrative support to the project. Staff appointed included nurses (with specialist qualifications in family planning), health promotion specialists and community education specialists. By virtue of their professional backgrounds, they had had experience of either working for the NHS or for the local authority.

Despite professional backgrounds and despite the fact they might have been appointed for the different skill set and experience they brought to the project, the project coordinator advised that all professional staff should carry the title “project worker”. The rationale for this is to help breakdown any potential professional barriers between the staff themselves and between the staff and the young people within the project. The project coordinator was very clear in his own mind about this issue:

“when I qualified it wasn't about the discipline and I am still not precious about that, and one of the first things I did when I came in post was change all the job titlesbut I had to consult with the staff” (Project Co-ordinator 1).

The exception to the rule was the doctor who was contracted to work on a six hours per week sessional basis in the drop-in. This person was referred to as the Project Doctor.

6.3.3 The Corner culture

There was a sense that the *The Corner* had a very explicit culture. I asked what this was:

“...it is about respecting people, it is about going at their own pace, it is about making things fun, it is about getting rid of status which prevents people from being approachable and it is ... about accountability I suppose, making information, making staff, making the agencies responsive to the rapidly changing needs of young people from all the different places that they come from. (Project Coordinator 2).

The culture was one where it was acceptable to take risks. Staff at *The Corner* claimed that they were able to tackle difficult issues that no one else felt they could address. For example, sexual exploitation:

“Ace magazine, sexual exploitation, young people involved in prostitution, for the want of a better word....wanting to raise awareness of it and everybody going uhhh! don't want to touch it because Dundee will get slammed as being the child prostitution centre and we don't want that. And we worked, how long did it take to get that out? six months? Consultation with the Chief Constable, this was heavy stuff by the way, not even what is in the magazine which is quite challenging but the bigger picture around paedophile rings, drug dealers, big networks, internet all .. stuff like that. People know it goes on but to actually raise awareness of it, and this, by the way, was at the highest level, it was all elected members...administration, Chief Constable, Director of Social Education, NRD [Neighbourhood Resources Department], and that magazine would not have been produced if it had not been for us, The Corner, because we agreed to say we will do it and, what was it like?Discomforts to small a word for it. Fear of, again. labels being attached ... and young people being more exploited” (Project Coordinator 1).

It was suggested that *The Corner* culture was in fact a counter-culture:

“if you are going to innovate you have got to take some risks and some stuff will bomb, that is being in the risk game, if you weren't in that it wouldn't be what it is, so the endorsement to do that, the right to fail, the right to fail in a project without you failing as a member of staff because you are associated with the project is critically important and again that is a kind of counter-culture thing isn't it, it is not the dominant culture in the public sector. We couldn't have done that as easily if we had not had the support of a senior member of staff in the local authority and the health authority. If people feel they are punished or under the cosh or they take a risk and it bombs and they put quite a lot of money behind something and it isn't used they way people think it will be then that makes them more cautious, and the one thing that project cannot afford to be is conservative with a small c, it has to always be given the kind of support to challenge conventional approaches” (Local Authority Manager).

The Corner culture actively encouraged risk-taking within the project team in order to find innovative ways to help young people reduce their risk-taking behaviour:

“But like the stories around the 13 year getting contraception and the Bishop going mad because condoms were going to be given out, I think they are all part of the process and we have had to take risks to be able to prevent risks” (Project Coordinator 1).

There was also a culture where problems should be tackled head on, which began as described above, when PC1 met with the Bishop to identify their common ground and respect for their differences. When a new nightclub opened in the city, it produced a four-page glossy brochure which clearly had the potential to undermine the advances *The Corner* had made in addressing sexual health issues:

“,,,we were very angry about the new stripper's nightclub in Dundee, it was promoting “shag tag” all that jazz, it was awful awful stuff. They produced a colour 4 page brochure and were giving it out to young people” (Local Authority Manager).

The Corner team took direct action against the proprietors, and, when they became fearful that they might lose their licence, they invited the project coordinator to meet with their staff. The club had the capacity to cater for 2000 young people each night and PC1 was afforded the opportunity to meet with and train the bouncers and the bar staff.

It was suggested that *The Corner* culture was in fact a counter culture, which challenged the status quo. On the wall of the office of the project coordinator was a quotation from the inside cover of *The Dance of Change* by Peter Senge (1999). See table 6.8:

Table 6.8: Quote on wall of original project coordinator's office

“Organisations that establish change initiatives discover after initial success that even the most promising efforts to transform or re-vitalise organisations - despite interest, resources and compelling business results, can fail to sustain themselves...because organisations have complex well built immune systems aimed at preserving the status quo”

There was a sense that those who were working to champion the voices of the young people within the city were never going to be complacent. There was awareness, within *The Corner*, that their purpose and the methods they use presented a constant challenge to the status quo. Consequently there was a view that external commentators, including researchers like myself, were viewed with suspicion, and that *The Corner* lacked the ability to examine itself critically. The researcher I liaised with before I approached *The Corner* articulated this view:

*"I don't know whether you have felt this when you were going in and asking questions but I think sometimes external researchers come under some kind of suspicion and that what they are doing is sort of not quite right, or, you know, I definitely got that feeling when I went along there, I was allowed in to do this piece of work but there was a lot of, sort of, put it this way, in terms of the report of the findings I felt there was quite a lot of constraint on what you could and couldn't say at times, and that came to kind of like focus when we released the press release for *The Corner*, it was just before the conference started we released this press release and I had to go back to *The Corner* and say well look what do you think of the wording of this and all the rest of it, and they weren't happy about anything you know, and eventually we found a form of words that was acceptable to both sides, but it was probably one of the most difficult press releases I have ever written and I have written a few you know in relation to some of the work I have done. It was highly sensitive, you knew at the time that what you were saying was highly sensitive and that you had to tone it down a bit or whatever on their side or adjust the meaning of some of the sentences. So it kind of reinforces itself after a while and I think these researchers who are external I don't think are terribly welcome after a while."* (Researcher 1)

My own experience was one in which the project coordinator was extremely facilitative in enabling my access to the project. In the light of the concerns expressed above, the question must be asked as to whether this was genuine facilitation, or in reality, about control. R1 had found his dealings with the project problematic in as much he felt that he was constrained in what he could and could not say about his research.

At no time, has any effort been made to either have sight of or censor my work. The key difference between R1's research and mine was that his was funded by *The Corner* and mine clearly was not. It is not uncommon for an organisation, like the Department of Health, for example, to withhold the right to publish research they have funded until they have approved the wording of the report and any associated press releases.

My sense is that *The Corner* team have a strong philosophy which puts young people at the centre. Because this philosophy challenges the prevailing orthodoxy, they are seen to be protective of the culture they have created. From my own experience, *The Corner* was open to uncensored scrutiny. They are totally focused on young people and are extremely

protective of the trust and respect that they as a team have been able to build up with the young people who access their services.

How was *The Corner* culture sustained and how did they prevent it from becoming corrupted? There appeared to be two key, interdependent elements to the strategies adopted to sustain *The Corner* culture, namely, consultation and evaluation. *The Corner* staff developed and utilised dynamic, innovative, consultation processes with young people:

“we have got a consultation framework which highlights the process that is involved in consulting young people and the choices that need to be within that because some people you know, hate the idea of questionnaires, or hate the idea of speaking into tapes, so it is using video, it is using feedback boards, graffiti you name it, I think it has just been creative a lot of the time” (Project Coordinator 2).

“..we never developed a model which was, that’s the one group of young people which would advise on everything. We avoided that like the plague” (Project Coordinator 1).

To ensure the active involvement of young people from the outset, a project advisory group was established with representation from the Bodymatters Youth Group, project staff and other agencies committed to supporting the project (Easton 1997). Keeping focused on young people was a key strategy and an integral aspect of *The Corner* culture:

“The main way that we have done that is going back to young people time and time again and confirming or reaffirming that what they are looking for is what we are giving them and again that can sound cheesy and people can say well you know but we have always said that young people are at the core of everything we are involved in so although they never wanted to be in amongst suits and ties or necessarily certainly making up strategies with me or drawn up great big strategic plans they do have a lot of energy, ideas and honesty and I think whether it is painting the kitchen or making a new leaflet or pulling together an annual report, there is a responsibility for everybody working here to check that we are still on track and we are still on the lines and a lot of that comes through from evaluation and feedback” (Project Coordinator 2).

The appointment of a half-time project evaluator at the outset was a critical incident in this project and was described as a key enabling factor. The post

was funded by the Health Education Board for Scotland (HEBS) and the post holder was located within the department of Public Health Medicine. The purpose of the role was to focus on the processes of multi-agency working with young people who were considered to be both a 'hard to reach' and vulnerable group of people.

An evaluation group was set up to support the appointment of the evaluator and to consider evaluation reports and make recommendations for policy and practice (Easton 1997):

".. in terms of developing our practice, one of the other key strengths was that because of the interest in this model HEBS [Health Education Board for Scotland] wanted to fund an evaluation of the implementation, not the impact, of just how you bring together this kind of service" (Project Coordinator 1).

This led to the development of an evaluative culture within the project and amongst the members of the project staff team.

"The team that were there in the beginning very quickly realised the value of it..... and then it just became part of the culture so that as the team expanded, evaluation was just something that they did, and I think that the team sold it to new people" (Researcher 2)

"And now what you have is staff who see evaluation as very important and they build it in to different areas of their practice and at times staff have worked with young people ... there is an example of young people being trained by the research officer and then the staff to conduct a needs assessment in one area and that was a really good bit of work" (Project Coordinator 1)

"(R2) instigated a lot of the evaluation systems including the enquiry sheet, some of the interview focus groups and everything like that and the reality is that most of the staff here now are quite confident and able to do that themselves" (Project Coordinator 2).

The benefits realised from this degree of evaluation have included providing the evidence for additional funding, team development and the direction the project has taken. Perhaps most importantly, through the inclusion of consultation work and needs assessment, evaluation has provided the

evidence to keep the project focused on its purpose, its primary client group, young people.

Therefore evaluation and feedback was embedded into the fabric of the ways of working within *The Corner* and this was coupled with a strong value base:

“That is a simple answer to a big question in terms of how do we prevent things from heading down other people’s agenda I suppose. There is a strong conviction within the project” (Project Coordinator 2).

Even on an individual level there was a culture amongst the staff of openly challenging one another, which one informant advised was “done very nicely” (Project Worker 1). The project team held weekly team meetings which addressed support and development (SAD) issues, described as “almost like supervision” (Project Worker 1).

Another key factor which helped sustain *The Corner* culture was the support of the project management group.

6.3.4 The management group

The original project coordinator identified the project’s management group as one of the enabling factors in this innovation. Words he used to describe it were “*joint*”, in that it was multi-agency and “*tight*” because it had been in existence for six years, with three out of the four members having been there since the start and therefore offering consistency, “*strategic*” and “*extremely supportive - from a distance*”. The management group appeared to have confidence in the project coordinator and gave him autonomy to run the project as he saw fit. Nevertheless, they were there to provide advice and support as and when required. It was also suggested that the management group had seen the initiative come to fruition and had fun in the process:

"The management group have, I think, enjoyed their experience and this has been enjoyable, this is your ideal, it has been created, it wasn't always that way.....this one has been good fun, pretty hard going, and pretty scary at times, but good fun" (Project Coordinator 1).

Membership of the group included senior staff from both the NHS and the local authority with a wide range of expertise and networks. The project coordinator said that the management group had developed strong professional relationships with one another and had a shared understanding of what they were jointly endeavouring to achieve. The group advised on policy matters, strategic development, funding routes and connections. It met formally every six weeks but the project coordinator knew that each member of the group was only a phone call away. He described a sense of trust. The management group had got to know the staff and the young volunteers on the project and the project coordinator felt that they had faith in their ability to deliver. Continuity within the management group was considered to be a key factor in the success of the project. The group members remained committed to the initiative even when their roles changed over time:

"We have been complemented in the health side by the Director of Finance for the NHS Healthcare Trust who became the acting Chief Executive when [NHS] got promoted, so not only did we have the Chief Executive we had the Director of Finance, these are senior people who, if they are committed to something, they can make it happen and I guess the interesting thing is, why do people get as passionately interested and committed to a project? And they wouldn't have stuck with this project as long, they would have left it behind when they had career moves themselves if they weren't getting something back out of this" (Local Authority Manager).

Senior managers stated they could see the strategic advantages of working collaboratively. They were able to achieve objectives they would not have been able to achieve without the support and input of the other agencies and they were able to secure funding from their own organisations on the basis that it was matched by their partner organisations.

Established on a project basis, sustainability was always dependent upon funding streams and the management team were focused from the outset on mainstreaming the project to secure its funding base:

“The funding strategy, as you know, has been to take project funding and to gradually mainstream it, working all the time to mainstream the core. So now we have got to a point where within the local authority budget and within the health board budget, if all the project funding stopped, the core would still be secure, it would be a vastly slimmed down core, but there would be a core of service which is now mainstream and opposed to entirely dependent on short term external funding, and that’s not universally the case with short-term funded projects. A lot of them get to the end of their short-term funding and close and that won’t happen with The Corner” (Local Authority Manager).

Management group members used evidence of successful multi-agency working as a negotiating tool, to secure “matched funding”:

“I have had the ability to say in local government this is matched funding. If you don’t match it, not only do we lose our share, but we lose the health board’s share and I know that has been played the other way round.in the case of local government it is a hard slog getting money for innovation and for development and it has been in Dundee in particular with the budget position. So to mainstream something which was urban programme or SIP⁴ funded or innovation funded through the health board executive, to get the funding for the core budget for that is really difficult and we would never have managed it unless we could have used the lever, this is a match funding the health board is putting more money in and we are just keeping balance here and if you don’t do it then it won’t be a partnership project, so it has been tremendously helpful. That partnership, I wouldn’t want to undersell in any way the importance of the partnership because it has allowed the local authority to do things that it couldn’t do on its own for a whole variety of reasons, the funding reason I have referred to, the policy reasons, we couldn’t have provided the direct access to sexual health services without having a GP a family planning accredited GP” (Local Authority Manager).

⁴ SIP – Social Inclusion Partnership funding was introduced by the New Labour Government in 1999 for disadvantaged communities in Scotland. Whilst badged as a *new* approach there was no new or additional money made available to address poverty and social exclusion in Scotland. The ‘new’ approach placed more emphasis on prevention rather than cure and a key element of SIP funding applications was that they had employed a multi-agency approach with communities actively involved at the heart of the process (Johnstone & McWilliams 2005).

The decision that the health board and local authority should collaborate to address their shared concerns regarding the health and well-being of the young people within the city, also appeared to impact more widely. For example, I was advised that evaluation had since become standard practice within the Health Service and all new service developments had inbuilt evaluation strategies. In addition, the lessons learned from *The Corner* regarding public involvement had informed the development and implementation of the local health board's Patient and Public Involvement strategy:

“if you can do it with young people you can do it with anyone, so I think we have learnt from that if you are serious about taking this patient involvement thing forward then there are principles that we have learned from this that we can use.....we talk within the health service about engaging people and listening to people but we don't take it to the sort of extremes that The Corner took it to. Extremes is the wrong word, it's about putting your money where your mouth is really and saying if you are serious about this thing you have to put this in place....” (Chief Executive NHS).

It was acknowledged that public and patient involvement “at this sort of extreme” requires a significant cultural change which does not happen overnight. It was suggested that there was still a great deal of defensiveness within the establishment, and so, for example, there were considerable anxieties about the potential of a patient sitting on an appointment panel for a hospital consultant.

6.3.5 The acquisition of culturally acceptable premises

As an interim measure, the project coordinator and the team he appointed were initially based on the outskirts of Dundee in a psychiatric hospital. This was considered to be less than ideal. They were relocated to temporary city centre premises as soon as was feasible but had to wait a considerable length of time before they were to move into the premises that would be known as “*The Corner*”. Their temporary premises at first seemed so much better than their initial location. However, their office was open-plan and, therefore, offered no privacy. As the team grew, these premises soon became very cramped and increasingly unsatisfactory.

Finding suitable premises was a major hurdle and was seen as essential as young people were clearly not using health facilities that they perceived to be designed by adults, for adults (Easton 1997; Redman 1992). A city centre drop-in facility was seen as central to delivering the project's aims:

"The acquisition of premises to be used as a drop-in centre for young people had always been central to the whole concept of having a health and information project. Without a central point the Project could only be delivered in a fragmented, selective way." (Easton 1997)

Box 5.7 details the specification for suitable premises. The location was considered of primary importance so that no young person in Dundee felt excluded because of the territorial issues that were associated with neighbourhood gangs. Only certain parts of the city centre were considered to be safe and neutral. The difficulty of finding suitable premises was compounded by the fact that young people had been explicit in that they did not want the premises to be in or near a shopping centre where they could be seen entering and leaving. They detailed their specification:

"It could only be in five streets. all on the South side of the High Street.....and we want a café, we want services integrated and we want a staff base all in a one-er⁵" (Project Coordinator 1).

They also detailed what they felt should be provided within a drop-in facility (table 6.9):

Finding suitable premises was a major challenge for the project coordinator, taking him into hitherto unknown territory:

"I mean to be quite honest at that time I felt like a property agent, I spent so much time... I was based in Liff Hospital⁶ and I was by the Chapel praying for premises to turn up" (Project Coordinator 1).

⁵ "All in a one-er" is Dundonian colloquialism meaning "all together"

⁶ The local mental health facility

Table 6.9: Young people's views of what drop-in facility should provide (Easton 1997)

1. Place specifically for young people
2. Somewhere safe and welcoming
3. Someone of the same age to talk to
4. Confidential Services
5. Family Planning Services specifically for young people
6. Information to make choices

In March 1995, five months after the co-coordinator was appointed, he found premises that matched most of the criteria identified. It was a listed building, on three floors and on a corner. One entrance led to a facility that staff would use on the second floor. Around the corner from there, on a corner, there was a shop front entrance to the facility that would be refurbished for use as the drop-in. Refurbishment plans were drawn up by the Project management group in partnership with the Bodymatters Youth Group. Table 6.10 lists the refurbishment specification agreed.

Table 6.10: Refurbishment specification (Easton 1997)

- a front reception area
- a computer corner
- racks for leaflets
- large windows suitable for displays
- café area and drinks machine
- two one-to-one rooms
- toilets with provision for disabled young people
- a kitchen area
- a meeting room
- a doctor's room with waiting area

With refurbishment complete and all but a café area in situ, the drop-in opened on 11th March 1996.

When approaching *“The Corner”* premises you are immediately struck by the window displays. They are bright, eye catching and creative and carry key messages. All the displays are developed with young people in the drop-in. At the time of my site visit, in one window there was information about when young people can access legal advice in the drop-in. In another there is a large poster which at first glance looks like the map of the River Thames shown during the credits for the television soap, *“Eastenders”*. On closer inspection you see that it is in fact a map of the River Tay, the river on which Dundee sits. The caption is not *“Eastenders”*, but *“STI-Enders”*. It asks, *“Are you talking about it? If you are going TAY (local dialect for “to”) have sex – protect your self from unplanned pregnancy and Sexually Transmitted Infections (STI’s), use a condom.”* The poster and the message were developed with and by young people. It draws on popular culture, plays on the local vernacular and conveys an important health message about safe sex.

6.3.6 Team building and policy development

Although there was considerable frustration in the time it took to find and refurbish the city centre premises for the project, this time was productively used in team building and developing a framework under which the team would operate and endeavour to ensure a consistency in approach. This was believed to be extremely important considering the wide range of skills and experiences the team offered and the different organisational cultures they had previously experienced:

“..... when we brought the initial staff team together it was like, psychiatric nurse, 2 nurses, one that worked in a hospital, one that worked in a psychiatric background, a health promotion worker that worked in a drugs project and a youth worker that had done street work and everything, and a family planning doctor that worked in a very clinical setting within a medical framework and the challenge for me was ... to merge medical and social models of health and

help people to see that their role was really important but that there is more than one way here, and that took time” (Project Coordinator 1).

During their protracted induction period the team were afforded the opportunity to undertake two residential team building sessions. Affording local authority staff the space to do so this was considered very high risk and extremely innovative:

The risks involved in saying yes to that were being pilloried in the press, costs that would be exposed, it was just against culture it would be seen as a precedent to the other staff who would love to do that but don't get a chance in their working lives, how can we justify for one lot and not the others...” (Local Authority Manager).

There was no doubt amongst informants that these team-building initiatives were a legitimate investment, as they not only enabled team building but allowed the project coordinator and his team to begin the process of developing the policies and procedures under which *The Corner* team would operate. On one of their residential team-building sessions the team worked together to agree a common policy with regard to child protection. In order to ascertain their differing approaches, all members of the team were given the same scenario. The five different disciplines that were represented offered five different views about how to respond to the situation. Consequently, *The Corner* staff had to develop their own policy for managing child protection issues (*The Corner Young People's Health and Information Service 2001*) which would allow them to integrate their multiple perspectives with their collective focus on the young people they were working with. This was a major challenge because of the complexity and legality of the issues. There were pressures from many directions. The local authority for example wanted *The Corner* to adopt their policies. The guidelines that were eventually produced, the Co-ordinator believed allowed *The Corner* staff team to move at the pace of the young people they were working with and take them with them, rather than “chuck them into the system”. He clearly was seeking to preserve the confidentiality of the young people, a key concern young people themselves raised of primary importance to them (see table 6.5). He was of the firm belief that both he and his team were happy with the set of child protection guidelines that they

had developed even though he acknowledged that he had been accused of being naïve.

The policy was cited by a member of the management group as an example of innovation which demonstrated that *The Corner* was not afraid to take risks and challenge the status quo:

“One of the major risks they took was to stand at some distance from the local authority’s child protection policy and to offer a much higher guarantee of confidentiality than social workers, youth workers, community education workers and teachers could offer” (Local Authority).

6.4 Macro-, Meso- and Micro-Politics

The Corner project appeared to have clarity of focus, a cohesive and committed management team, strong value driven leadership and a dedicated project team. Young people appeared to be firmly at the centre of the project and fully engaged with the development and the delivery of the service. However, no project operates within a political vacuum. Political controversy was evident at a national (macro) level, an organisational (meso) level and at an interpersonal (micro) level.

6.4.1 Macro-level politics

Top-down policy initiatives appeared to have the potential to undermine *The Corner*. National level concern over the incidence of teenage pregnancy in Scotland led to the development and implementation of national policy aimed to address this concern. The solution selected by the Scottish Executive was to establish a new, nationwide service to provide the young people of Scotland with confidential advice, information and support on any aspect of sex, contraception and relationships. In developing and implementing their plans, the Scottish Executive did not appear to take account of any provision that was already in place in different parts of the country. The provision, or rather the imposition, of a “Caledonia Youth” service within Dundee was not recognised as a useful contribution by those

involved in *The Corner* management group. It was seen as a State-driven intervention, which cut right across the philosophy of *The Corner*.

"I think it is an outrageous waste of money. I think they could have added value, they could have stabilised us and I believe it is purely as a result of a Scottish Executive top-down decision. It had no bearing on a local analysis of what was needed. Once the decision was taken to create Caledonia Youth and franchise it down to local level I further believe that they should have actually targeted identified needs that The Corner couldn't meet, and that would have been primarily around looked after young people..... The young people who were either in care or foster care where there are many of the sexual health issues, many of those who go in for terminations and serial terminations, many of those who are involved as young people in prostitution in Dundee come from that cohort, and there are lots of reasons for that, it is not to blame the care environment it is the function of how chaotic their lives have been before they came into care, and they are the ones at The Corner because it doesn't have dedicated outreach capacity, it is a centre, cannot work on a one-to-one basis or a group work basis or in a home setting with that group of extremely vulnerable young people and we lobbied that Caledonia Youth should take on board that challenge in Dundee and we would work with them as a clear partner. But they wanted to open a centre with open times which overlap with The Corner do a service which is the same as The Corner, I don't think it does anything different but offer alternative.... the crazy thing was that it wasn't done in a way that was reflected by the local evidence of need in the sense that it didn't plug gaps" (Local Authority Senior Manager)

"I think more recently the introduction of Caledonia Youth, Brook Advisory as it was, for me is unnecessary, I think we have got a good service through The Corner and this was a ministerial initiative which I thought the money could have been better used with The Corner with an established service but we were told it was happening and it has happened" (Chief Executive NHS).

As discussed in 6.3.3 above, an evaluative culture was recognised as a key element which served to sustain *The Corner* culture and the centrality of the young people within the project. However, there was a national view that the level of evaluation embedded within *The Corner* was unsustainable, a position which a member of the management group described as *"absolutely staggering"*:

“...The Chief HMI [Her Majesty's Inspectorate] for Scotland came visiting and he was very very impressed and as he came away he said that is a completely unsustainable level of investment in monitoring evaluation ‘ don't know how you can justify that’.....he had made it on the basis that we couldn't justify that everywhere therefore how could you justify it anywhere and we were just gob smacked because we had actually egged it and said look how much we have put into this, we have argued for this, the health board invested in it, look at the return. It's really action research where we are continuously shaping policy in the light of evidenceBecause the evidence we have got is that it changed practice, it changed culture, it improved targeting, it provided the management information necessary to make the case for future funding, all of those things, it provided the frightening information about what was still going on, it provided the kind of qualitative assessment of how difficult this was going to be to actually tackle the problems” (Local Authority Senior Manager).

This position does appear somewhat ironic when it is pitched against a National decision to invest in a service without any assessment of local provision. Whilst evaluation might appear expensive, there is a strong argument in this case, that an overall analysis of costs and benefits could justify the outlay. By building evaluation into the fabric of this innovation, it remained focused and the skills to evaluate the services were passed onto the project workers themselves in order to sustain a level of evaluation beyond the life of the initial investment from HEBS. For example, one project worker, armed with the statistical facts, articulated the need for the project to continue:

“..... young people using the service speaks for itself and getting it across, not having to justify, but just putting across the very fact that young people are coming again and again, 12,000 young people a year use that drop-in for a variety of different reasons. It confirms that their lifestyle more than ever requires the kind of support services that we offer” (Project Worker 2).

6.4.2 Meso- & micro-level politics

Within *The Corner*, it was suggested that organisational politics may have been exacerbated by a project's funding arrangements. For example, one respondent argued that in an environment where innovation is encouraged and risks are taken, some projects will inevitably fail. Some of the failures

within *The Corner* were identified as developments driven by the availability of funding rather than based on an assessment of the needs of the Young People. Funding-led projects were reactive, not always as carefully thought through as other proactive initiatives and often carried within less than optimum timescales. This in turn, meant that issues such as recruitment were rushed and the project workers appointed were not necessarily the most competent to undertake the role required. All of these factors were seen to militate against the success of an initiative.

Whilst the project enjoyed continuity in the membership of its management group, it did not, to the same degree, amongst its staff, and this was regarded as problematic:

“...funding arrangements that depend on how high issues are on the government’s or the health boards or the council’s list of targets that tends to affect how much funding we get and for how long.....It is a major frustration to work with young people whose problems are long term and whose lifestyles are long term and have to do it on a short term fragmented basis when staff, who maybe high quality, but they move on because their contracts are never extended” (Project Coordinator 2).

It was suggested that this situation may also have impacted on a gender bias amongst the staff:

“we have lost some male staff through funding problems, and through the feedback young people are saying yes we love the service but where are the male staff, there is a lack of male staff” (Project Coordinator 2).

Interestingly, there was a counter-gender bias in the management team, the majority of who were male and appeared to enjoy a relative degree of job security. The health board and local authority leads were both male as was the initial project coordinator and the acting project coordinator.

At the time when data was collected for this case study, the project employed 14 full-time staff and had managed to secure three quarters of its funding on a long-term basis. However, the majority of these staff was not around when the project was initially set up. They had not, therefore, been

afforded the time-out opportunities that their predecessors had enjoyed and when they joined the team they were expected to “hit the ground running”. The consequence of this was that at times they appeared to have difficulty taking ownership of some of the philosophies, policies and procedures that were developed in the early days of the project.

For example, I uncovered that some newer members of the staff team, who were not party to those earlier discussions, did not share the same degree of confidence in *The Corner's* Child Protection Policy. They felt strongly that it needed updating. For example, whilst the nurses currently working on the project recognised that their professional peers had been represented at the time the policies were developed, they argued that the service they are offering had further developed since then, and, as a consequence, the policies needed to be updated to reflect these developments:

“I believe that policies should be reviewed every year once they are established” (Project Worker 2).

When *The Corner* first opened, the nurses were offering pregnancy testing services. Now, due to the advent of new legislation on nurse prescribing, they were also able to offer the morning-after pill and repeat prescriptions for oral and depot contraceptives [PW1].

With regard to the Child Protection Policy, the original project coordinator was identified within the policy as the named Child Protection Officer for the project. According to the policy, it was with him that the buck would stop. The nurses I interviewed, who were not amongst the initial staff cohort, were concerned that this policy was no longer workable as the original project coordinator had been promoted and in his new role was no longer as accessible as he had been. In addition, the nurses were concerned about their own professional accountability:

“..... if you are a child protection nurse you would deal with it because you are accountable for itAt The Corner, we use a different process, and that can take longer time and it doesn't always sit comfortably” (Project Worker 1).

However, they found this difficult to convey “without sounding obstructive” (Project Worker 1).

The purpose of the Nursing and Midwifery Council (NMC) is to protect the public. It is a body which essentially gives nurses and midwives their licence to practise. Nurses registered by the NMC must abide by a code of professional practice (Nursing and Midwifery Council 2002a). The Code of Conduct clearly states that nurses are personally accountable for their professional practice (see table 6.11).

Table 6.11: Nursing and Midwifery Council Code of Professional Conduct

As a registered nurse, midwife or health visitor, you are personally accountable for your practice. In caring for patients and clients you must:

respect the patient or client as an individual

obtain consent before you give any treatment or care

protect confidential information

co-operate with others in the team

maintain your professional knowledge and competence

be trustworthy

act to identify and minimise risk to patients and clients.

These are the shared values of all the United Kingdom healthcare regulatory bodies.

These nurses were struggling with their personal professional accountability to act to identify and minimise risk to patients and clients when it came to child protection issues.

The Corner policy clearly states that it has been developed for the use of the multidisciplinary staff team, sessional workers and volunteers. It states:

"The project is committed to working in collaboration with other agencies and its strength of response is in moving at each young person's pace and involving them in each stage of a process of communication with third parties.....

Should any service user(s) disclose they are abusing a child or young person, the information must immediately be passed to the Project Leader.....

In the case of a young person disclosing abuse the young person must be advised of what may/will happen next and the Assistant Project Leader and/or Project Leader must be informed as soon as possible....

If neither are available staff should contact (the child protection unit) directly." (The Corner Young People's Health and Information Service 2001)

The nurses I interviewed argued that the requirement within *The Corner* to pass a problem up a hierarchical chain of command had the potential to delay due processes and this was problematic for them, as they believed that they were both trained and professionally accountable for taking direct action. On the other hand, it could be argued that *The Corner* policy embraced other elements of the code as guiding principles, namely, respect the patient or client as an individual, obtain consent before you give any treatment or care, protect confidential information and co-operate with others in the team.

The nursing staff stated they were committed to the philosophy of *The Corner*, "The Corner culture". They joined the project staff team because that valued the centrality of the young people to the project. They appeared to really appreciate the culture. However, despite being employed on the basis of their professional knowledge and skills, they struggled with the expectation that they should leave their professional identity (but not their skills) at the door when they came into the project:

"I don't think I would feel devalued if I wasn't told that you can't do this and you shouldn't do this and you shouldn't call yourself nurses, to me that is unnecessary, I don't think anything as such needs to change, I just think we need more recognition from people on high" (Project Worker 2).

They were committed in principle to the philosophy that young people should always be at the centre but they struggled with the methods employed to achieve this - methods which the project coordinators were clearly committed to:

*"A lot of our job has been opening boxes and trying to get people to see out with the box. It has been a ... theme that has been continuing and having a project which from the word go in 1995 embraced multi-disciplinary working with all its ups and downs there has been nursing staff, youth work staff, health promotion staff, social work staff and a whole mix of disciplines which have offered that kind of richness of services and it has grown to the point now where we have people who have done like therapy courses, taken placements within the project and people who have good health and welfare qualifications to do healthy eating projects within *The Corner* so the whole idea of boxes and people being stuck in them or trying to put other people in them has been a major pattern of frustration and challenge but it has also been positive in the sense that as the team has grown and we have seen things, I suppose cross-fertilising and changing, there is a great buzz from that, sharing skills and sharing learning and training"* (Project Coordinator 2).

The nurses' struggle manifested when they were faced with scenarios which they believed had the potential to compromise their professional accountability. It also manifested when they felt marginalised from service development discussions which they believed they could have expedited, for the benefit of the young people they were working with, had they been included.

Consultation with young people identified concern over sexually transmitted infections (STI's). Only a small number of the young people referred to the one genitourinary medicine (GUM) clinic within the major teaching hospital at the west end of the city by the *The Corner*, actually attended the clinic. This led to discussions around how services might be developed to incorporate an STI clinic within *The Corner*. It was proposed that an experimental clinic

should be introduced and evaluated. Getting GUM partners to agree to participate in an experiment and provide clinical services within the Drop-in was cited as an achievement in itself.

Within this experiment, the cultural differences between medical and social models of care gave rise to tensions which remained unresolved at the end of the experiment. The expectation from the GUM clinical partners was that the experiment would essentially run like a GUM clinic but within a city centre venue so there would be an appointment system and “patients” would be processed through the system. They would first be seen by a nurse appointed by *The Corner* to run the clinic who was expected to pass “the patient” on to the (one and only, male) GUM consultant within the city, who would make a unilateral decision about the level of screening required. “The patient” was then passed on to another nurse known as a “Health Adviser”. This nurse was a part of the hospital-based GUM clinic team and would be responsible for the provision of advice and information, contact tracing and “counselling”. This task-orientated approach to care was completely at odds with the holistic model that *The Corner* staff and young people valued, and more importantly, would access. Delivering STI services according to the GUM model was dependent on a chain of people. It frequently ground to a complete halt because one link in the chain was missing. For example, if either the consultant or the Health Adviser were on holiday, sick or absent for any other reason, the service was not provided. The GUM consultant would not support the nurses employed by *The Corner* to do any screening or prescribe any treatment.

This situation was particularly frustrating for the nurse I spoke to who had been employed by *The Corner* to run the clinic. Prior to coming to the UK, she had autonomously run “suitcase clinics” where, single-handed, she provided a ‘one-stop shop’ sexual health screening service for young people in schools and other community settings. She joined *The Corner* team because she believed in the consultation process and felt deeply privileged to be working with young people. The frustration expressed by this nurse and her professional colleague was exacerbated by the fact they had been

excluded from the GUM project management meetings. The project coordinator represented *The Corner* at these meetings and fed back the outcomes to the nurses in the project. The nurses felt strongly that his professional background and lack of clinical knowledge slowed up negotiations and served to further undermine their professional contribution to the project.

The Corner culture aimed to ensure that professional agendas did not supersede the agendas of the young people for whom the service was set up to serve. Management endeavours to ensure this was the case, however, had the capacity to leave the professionals within the project, committed to the project ethos, feeling personally and professionally undervalued, underutilised and oppressed:

“that is another thing, we have come across a wee bit of a challenge against linking into networks that are specifically nurse networks, we are discouraged from that, because it seemed to reinforce our role as nurses, and we are project workers” (Project Worker 2).

This scenario illustrates a relationship between organisational and interpersonal, or meso- and micro-politics. The methods used to liberate the voice of one suppressed group, in this instance young people, appeared to lead to the suppression of another, namely the nurses employed in *The Corner* as Project Workers because of their professional skills.

A third area of concern for the nurses employed at *The Corner* was in relation to record keeping. Although they kept records of those who accessed their clinical services they had difficulty with the fact that in the name of confidentiality, no individual records were kept of each encounter within the drop-in. At the end of each drop-in session, the team held a debriefing. Brief notes were made about any individuals that caused specific concern.

The nurses felt that, if they were dealing with young people who, for example, came in to talk about a drug or relationship issue or bereavement, the lack of record keeping presented a threat to the continuity of care the young person received. This also concerned the nurses in terms of their professional accountability. The NMC provides guidelines on records and record keeping for registered nurses which includes the following statements:

“Good record keeping is a mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individual’s practice.....

Good record keeping is, therefore, both the product of good team work and an important tool in promoting high quality healthcare.”
(Nursing and Midwifery Council 2002b)

The guidelines go on to state that registered nurses have both a professional and a legal duty of care and provides details of what a nursing record of care should contain (table 6.12).

Table 6.12: Nursing & Midwifery Council Guidelines on records and record keeping

As a registered nurse or midwife, you have both a professional and a legal duty of care. Your record keeping should therefore be able to demonstrate:

- a full account of your assessment and the care you have planned and provided
- relevant information about the condition of the patient or client at any given time and the measures you have taken to respond to their needs
- evidence that you have understood and honoured your duty of care, that you have taken all reasonable steps to care for the patient or client and that any actions or omissions on your part have not compromised their safety in any way
- a record of any arrangements you have made for the continuing care of a patient or client.

The NMC is currently one of nine health professional regulatory bodies tasked with protecting the public from unsafe or poor quality practice:

The system of professional regulation in the United Kingdom is designed to ensure that if a patient is seen by a healthcare professional, such as a doctor or a midwife, the patient can trust that the care they receive will meet certain minimum standards of safety and quality. (Maybin 2007).

Evidence indicated that young people do not access mainstream services principally because they fear a lack of confidentiality. This created a dilemma for professionally regulated practitioners who ultimately had to make a judgment that they feel able to defend. The question is whether:

a) the public interest is served better when young people access services and receive the support they require and confidentiality is assured,

or

b) when records are maintained by professional staff, in the belief that such records can facilitate the continuity of care that a patient receives, and offer a degree of professional accountability for the actions taken by the professional concerned.

Young people accessing services are a precondition for professionals to provide continuity of care. Professional contact with vulnerable young people is so fragile and appears to be so dependent upon their trust in the system that their concerns over confidentiality should arguably supersede all other concerns. However, operating in this non-conventional manner clearly did make professional nursing staff feel as if they are operating beyond the scope of their professional code of conduct and they feel the need for professional support and permission to take these risks, in the interests of the young people for whom they are providing a service. They reported that within *The Corner* they were actively discouraged from engaging in professional networking activities. Despite claims that team meetings were “almost like supervision” and offered a supportive and challenging environment, it was clear that the nurses I interviewed were struggling to reconcile the tension created by the pull of young people’s insistence upon confidentiality and the professional push for documented evidence of ‘public safety’ and ‘professional accountability’. Analysis of this case illustrates the capacity of innovation to create professional dilemmas for individuals, i.e.

'micro-level politics'. This would suggest that systems should be put in place to support individuals who are willing to take what might effectively be described from a professional perspective as personal risks in order to innovate in the provision of health services.

Identity politics not only affected individual staff members; it was also an issue for *The Corner* itself. The team aimed to deliver their project specification (table 6.6) by working with young people and taking holistic approaches to addressing their needs. Whilst delivering contraceptive services was within their brief, *The Corner* was not just a sexual health service. Figure 6.1 offers a flavour of the range of issues raised by young people who attended *The Corner*. *The Corner* team consistently sought to change the impression that their sole purpose was to provide sexual health services because they knew this could act as a deterrent to some young people:

"we have struggled at times because of the early press interest to get rid of the sexual health tag, and done loads of work around housing, homelessness, drugs, mental health, relationships everything to get away from that sexual health tag but still unfortunately at times we are seen as a place that, you know, open for sexual health services and that is within professional circles as well, not just with young people" (Project Coordinator 1).

The project coordinator was keen to tell me how the initiative had had far-reaching effects on the lives of some of the young people who participated in activities within *The Corner*.

I am just thrilled to bits what it has represented for people who use it, as a stepping stone in their careers, young people who have come through it, I have met quite a number of young people who have personally gained not just "the service" they have gained a huge amount of pleasure and esteem from being associated with doing things there and the feedback from that has been tremendous and it has gone on innovating so it is quite a different project in some senses from the one that was talked about ten years ago (Project Coordinator 1).

It was argued that the success of *The Corner* was evidenced by the numbers of young people accessing the service and the requests for outreach work:

"I think the project's success is down to the fact that we do consult with young folk and that is reflected in the numbers that we see coming through our door and you know I suppose we have proven ourselves in lots of ways to other agencies, to schools, to community groups because we are getting more requests to do outreach work, we are really busy..." (Project Worker 2).

This was coupled with a high media and political profile and national recognition:

"We have hundreds of visitors from all over the country and I know that people have gone away and been influenced by it. Not necessarily set up the same thing but they have done what has been relevant to them and their resources and capacity" (Project Coordinator 1).

However, the success of *The Corner* and sustained support from senior managers within both the local authority and the health board led to a degree of local resentment:

*"...none of the others in my experience have pulled off quite the dynamic *The Corner* has, and that works both for it and sometimes against it. I think you need to be up front about that. There is either a professional envy issue or there is a resentment of the profile, or there is a resentment of the seniority of the support that is available for that project that sometimes comes through in my contact with others. I think it just comes with the territory and you have just got to kind of like live there and then dismiss it because if you let that become something that gets to you it will eat at you so if you keep a focus on the young people and keep a focus on what the project is there to do and keep listening to the critics as opposed to reacting to the critics it will keep alive"* (Local Authority Senior Manager).

The Corner culture, maintaining a strong focus on young people, appeared to be the strategy adopted to deal with the local resentment from other service providers who were also endeavouring to provide services to young people.

Indeed, even within *The Corner*, the potential for resentment was recognised. The original project coordinator was in the throes of developing a complementary, innovative initiative to provide a social meeting place and

educational opportunities for young people right next door to *The Corner*, called *The Shore*:

“The Shore’s... I don’t know if you have been through to it, it is worth a look .. because The Corner is a key partner in its development because we didn’t have space to do what we wanted to do, because we were hiring other venues, because we saw the need for social and educational opportunities as well as access to focused services, and young people saying all the time, ‘we want to have fun, not to be seen as problems, we might have lots of problems, but we want to have fun, and sometimes, by the way, adults, you give us loads of mixed messages’. So that led along with a number of other agencies to the creation of The Shore (Project Coordinator 1).

There was a very real potential to create tension through shifting attention away from *The Corner* and onto *The Shore*:

“the link with The Shore, this kind of tension that is a wee bit around just now, but I think is completely resolvable, that The Corner doesn’t feel that it is being left behind by The Shore development, that is the kind of tension that has to be carefully managed (Local Authority Senior Manager).

This was a political tension that was recognised and that would be carefully and proactively managed.

6.5 Summary

As stated in the introduction to this chapter, during the course of my analysis of this case I have identified fifteen 'critical incidents' which I believe shaped the trajectory of *The Corner*. These are summarised in table 6.13. As with the first case, I suggest that the implications of these critical incidents may also be synthesised into the three interconnected themes illustrated in chapter 5 (figure 5.2), namely partnership, purpose and politics.

The Corner initiative had a long and protracted gestation period (CI 1) and clearly acknowledged the wide range of stakeholders with a concern for the health and social well being of the young people within the city. This shared concern did not, however, lead to universal support for *The Corner* team's methods. The criticism expressed by the local Bishop, fuelled by the local media, served to illustrate this point and highlighted the capacity of the media to heighten the differences between stakeholders and influence public perception (CI 10).

The ability of the project coordinator to address these concerns proactively, by identifying the common ground between the two stakeholders, illustrates the political acumen of the project team and their advisers (CI 5, CI 11). Equally, their capacity to turn the media spotlight on the initiative to their advantage, by working in partnership with the media, showed a considerable degree of insight into the potential of the media to influence public opinion and the views of local politicians. In addition, working in this way illustrated a willingness to take risks, a trait which appears to be a feature of *The Corner* culture (CI 12).

Established as a joint venture between the local authority and the NHS (CI 2), this partnership enabled members of the management group to negotiate for additional resources for the project from their respective organisations on the basis that their input was matched by their partner (CI 3). In addition, the learning gained from this partnership working had wider ramifications. The level of engagement of the young people in the project in particular informed

the development and implementation of the health board's Public and Patient Involvement Strategy (CI 4).

Table 6.13: The Corner Critical Incidents

CI 1. A gestation period of over 10 years

CI 2. The decision that the local authority and the health board should address their concerns for young people together

CI 3. Securing a portfolio funding package thus binding the stakeholders together with a common goal and providing a mechanism for defusing some of the controversy

CI 4. The authentic engagement of young people in the planning and delivery of the service and the development of an innovative consultation framework

CI 5. The appointment of project coordinator with a clear vision, appropriate experience, strong leadership skills and quick to learn new skills

CI 6. The appointment of a project team of staff with appropriate experience and attitude

CI 7. Time to build the multi-professional multi-agency team and develop and agree policies (and the lack of engagement of new staff in policy development / policy revision processes)

CI 8. A de-professionalizing agenda to ensure that young people remain centre stage (leading to the exclusion of professional staff from meetings about the development of services they were appointed to provide)

CI 9. The acquisition of premises that met with the criteria drawn up by the young people

CI 10. Identity management which began with the proactive management of the media fuelled reaction of the Catholic church to the opening of The Corner and led to a strong relationship with local media

CI 11. The existence of a strong cohesive committed and stable multi-agency senior management group

CI 12. The development of a distinctive *Corner* culture to ensure that young people remain centre stage and staff are enabled to take risks to achieve that end

CI 13. Evaluation informed development embedded into the culture of the enterprise (in the face of a National perception that this level of evaluation was unsustainable)

CI 14. The primacy of the importance of confidentiality (because of its significance to young people and the challenge this posed to health professionals and their sense of professional accountability)

CI 15. National policy development and blanket implementation without due regard to local initiatives

This project was firmly focused on working with young people to identify and address their needs, on their terms (CI 4). There was a strong philosophy within the project to maintain and protect this focus both internally and externally. Authentic engagement with young people in all of *The Corner's* activities and a commitment to evaluation (CI 13) were key elements of *The Corner* culture (CI 12) and led to the acquisition of *The Corner* property in a strategically important location within the City centre (CI 9). Factors which were thought to have aided the development and sustained the culture included the personal attributes and commitment of the original Project Coordinator (CI 5) and a strongly supportive management team (CI 11). Internally, the management style adopted to maintain this culture was reported to cause some staff, who had not been members of the original staff team that drew up the operational policies and agreed the ways of working, to feel marginalised, underutilised and oppressed (CI 7, CI 8). It also led to an external perception that *The Corner* was not open to external scrutiny and was self-fulfilling (CI 10).

There was evidence of political controversy and tension within *The Corner* at macro-, meso- and micro-levels. Top-down Scottish Executive policy initiatives which did not take account of local innovations were thought to be unnecessary and unwelcome (CI 15). They were seen as a duplication of efforts and a waste of resources. There was also top-down criticism of the level of externally funded evaluation associated with the project, which it was argued was unsustainable (CI 13). The view from *The Corner* was that evaluation had become embedded within the culture of the project which enabled it to effectively function as an action research project. Internal evaluation, as stated above, left the project open to external criticism that it was self fulfilling.

The Corner enjoyed a high profile and a significant degree of high-level managerial support (CI 11). This caused some local tension, particularly from those who were also working with young people but without the same high level of support.

Short-term funding arrangements created pressures and exacerbated organisational politics. It was also suggested that it did not always lead to the best appointments and meant that short-term projects were not always thought through adequately (CI 6). A gender bias within the hierarchy was evident and, as stated above, the management style adopted to suppress any professional tribalism left some staff feeling underutilised and undervalued (CI 8). In addition, endeavours to secure confidentiality, left these staff feeling concerned that their record keeping practices were inadequate, and a threat to their ability to professionally account for their practice (CI 14).

PART IV
DISCUSSION, CONCLUSIONS & RECOMMENDATIONS

Chapter 7 Power, Politics and Innovation

7.1 Introduction

The initial aim of this study was to examine the conditions in which innovations in the provision of healthcare services may or indeed, may not, flourish. The first case examined was the development of a NP-led outreach service to farming communities in the North West of England. By facilitating access to health services for a group of people who did not routinely access mainstream health services, the project innovatively sought to identify and address their healthcare needs.

Based on the premise that access to healthcare is a key concern of the public, successive UK Governments have made 'access' a key health policy priority. Through the identification of a second case, which also endeavoured to facilitate access to healthcare for a group of people who did not routinely use mainstream health services, comparisons can be drawn to build up a picture of the conditions in which such innovations do and do not prosper.

Within each case, I identified fifteen 'critical incidents' which I have argued shaped the trajectory of the innovations and which offer insight into the conditions which have enabled or militated against their capacity to flourish. Examination and comparison of these two cases have enabled a narrowing and focussing of the original research question. Thus, this study specifically aims to provide insight into the conditions in which innovations, which seek to identify and address the healthcare needs of groups of people who not routinely access mainstream services, do and do not develop and thrive.

From within each case, three interconnected overarching themes were identified and these are illustrated in Chapter 5, figure 5.2. Firstly, authentic engagement of key stakeholders in an innovation in healthcare provision appeared to be important. Specifically, the authentic engagement of the group of people whose health needs the innovation seeks to identify and address would appear to be of fundamental importance. Whilst at face value

this might seem to be rather obvious, in practice this can prove to be a considerable challenge. In this chapter I will compare and contrast the cases examined and consider the conditions in which potential service users may be fully engaged in an innovation aimed at facilitating their access to health services. Secondly, clarity and agreement amongst stakeholders about the primary focus of an innovation appeared to be equally important. Again, when written about, out of context, in a seemingly objective way, this also seems to be rather obvious. Why then does it emerge as a key issue? I will compare and contrast the cases and consider the conditions in which clarity and agreement about the primary focus on an innovation can be identified and sustained.

In chapter 2 I suggested that much of the writing on the management of innovation is presented in a sanitised form and, consequently, is rather unhelpful. I suggest here, that through the close examination of the third theme, 'politics', and the impact politics has on 'partnership' and 'purpose', I will offer insight into the conditions in which such innovations might flourish.

7.2 Power

In identifying the critical incidents which shaped the development of the cases examined, in each case I uncovered tensions between the various stakeholders. The concept of power is, therefore, central to this discussion. Power is recognised as a complex concept and it has been analysed from a number of theoretical perspectives. Consequently, there are multiple interpretations of the meaning of power and methods by which it has been researched and understood. Lukes (2005) and others have suggested that power is a concept that is 'essentially contested', for example:

"The study of power has meant a behavioural focus for some researchers, and attitudinal or hegemonic factors for others. Power has been berated as being repressive and lauded for being productive. Small wonder then that there is little agreement!" (Hardy & Clegg 1996 p 636)

Spinoza (1958) helpfully distinguished between '*potentia*' and '*potestas*' where the former signifies the power of things in nature to exist and act and the latter refers more specifically to being in the power of another. '*Potestas*' is where an agent has the capacity to have power over an other or others, constrain their choices and secure their compliance. Whether this is positive (beneficence) or negative (domination) will depend upon both context and perspective. Recent legislation throughout the UK, for example, has banned smoking in confined public places. I personally think that on public health grounds this was appropriate state intervention, the right thing to do. I would argue that this was justified paternalism for the common good. Smokers on the other hand, may see it as the intervention of a nanny state infringing upon their civil liberties. Lukes defines *potestas* or power as domination as:

“...the ability to constrain the choices of others, coercing them or securing their compliance, by impeding them from living as their own nature and judgement dictate.” (Lukes 2005 p 85)

Morriss argues that we need to know our own power and the powers of others so that we know how to get others to do things and how to avoid unwanted things being done by them, to us. Our own power depends upon our abilities to harness or diminish the powers of others. In these terms, an understanding of the concept of power would appear to have both practical importance and moral significance (Morriss 2002).

Power is thought to be of moral importance because with power comes responsibility. The argument here is that powerful members of society have a moral responsibility and should be called to account to improve the conditions of the less powerful. Thus, Lukes (2005) argues that the question of responsibility is not only a moral issue but also a political one.

7.2.1 Lukes on power

Over thirty years ago Steven Lukes published an analysis of the concept of power which is now recognised as a seminal text. Currently Professor of Sociology at New York University, Lukes is a Fellow of the British Academy. As a graduate, fellow and former tutor in politics at Balliol College Oxford,

Lukes has also held positions at The European University Institute in Florence, the University of Siena and the London School of Economics.

In his original analysis Lukes proposed that theorists had hitherto analysed power from two different standpoints. Power, therefore, was seen to have two faces or 'dimensions'. Lukes offered a radically new 'third dimension'. The original text has recently been re-published and Lukes has defended and augmented his original position in two new chapters (Lukes 2005).

The one-dimensional view of power takes a behavioural perspective, which Clegg (1989) argues is founded on Hobbes' mechanistic world view and is essentially positivist. It is based on the assumption that power lies solely within the process of decision-making and that decision-making is either an elite (sovereign) or a pluralist (democratic) activity. Where decision-making is considered to be democratic it is assumed that all stakeholders have equal access to decision-making processes and that non participation in decision-making is an indication of agreement. Here, it is argued that, without overt evidence of conflict, there is no observable evidence of power and the conclusion drawn from the one-dimensional view is that where there is no conflict power does not exist.

In his analysis, Lukes assessed the contribution of American political theorists who studied political decision-making processes from this behavioural perspective. These included, for example, Dahl (1957; 1961), who sought to apply scientific principles, in order to introduce methodological rigour and observe and measure power being exercised through the analysis of cases of political decision-making. By virtue of their technical expertise, political scientists such as Dahl could, with empirical evidence, challenge the hitherto ideological based theories of sovereign power, held by, so called, elite model theorists which included, for example, Marx (1995). Lukes argued that Dahl's empirical examination of local politics in New Haven, Connecticut, USA in the late 1950's concluded that the decision-making process involved a variety of interest groups, all attempting to influence political decision-making. Some groups were dominant over some issues,

whilst others were dominant over other issues. Thus, Dahl explicitly rejected the Marxist ruling class theory which argued that power is fundamentally lodged with the owners and controllers of economic production (the bourgeoisie) and so these economically dominant groups or classes dominate political decision-making process. Dahl concluded that decision-making in American politics was a democratic, pluralist activity rather than an elite or sovereign activity. Recent accounts of US national politics might serve to challenge the assumption that Dahl's assessment of New Haven politics was generalisable and is still relevant. For example, the Bush family's dynastical hold over national Republican politics and the emerging Clinton hold over Democratic politics would appear to reflect a country governed from sovereign power bases.

In table 7.1 I offer illustrations of elite and pluralist one-dimensional views of power within a healthcare context.

Table 7.1: Illustration of the One-Dimensional View of Power
<p>Consider a hospital ward round. If a hospital consultant instructs ward staff to discharge a patient in spite of protests from an Occupational Therapist (OT) who argued that the patient was not yet able to function independently, a one-dimensional view of power might conclude that this one instance signified both conflict and sovereign power. If this pattern was seen to repeat itself, then this analysis may appear to be conclusive. If, however, the OT simply acquiesced because she knew from past experience that the consultant would overrule her, there would be no observable conflict and the one-dimensional view would assume that power does not exist. Where a multidisciplinary clinical team operated under a consensus model, and would only discharge a patient when all members of the team were in agreement, this could be considered to illustrate a one-dimensional, pluralist view of power, as conflict would be observable, but any member of the team to express concern could be the final decision maker as to when a patient was ready to be discharged.</p>

The two-dimensional view of power offers a qualified critique of the one-dimensional view by suggesting that, because it is based on the premise that power only exists where it is visibly exercised within decision-making

processes in order to resolve conflict, it is limited. The two-dimensional view sought to address this perceived limitation by acknowledging "non-decision-making power". This dimension still maintained that conflict was necessary for power to manifest but suggested that, to avoid public displays of conflict, agendas were controlled, formal decision-making processes were confined to 'safe' questions and difficult issues were dealt with behind closed doors through, for example, the co-option of potential adversaries. The main proponents of this second face of power were Bachrach and Baratz (1962; 1963) who maintained that the pluralist analysis only illuminated the public face of power. They saw failure to acknowledge the second, private face of power as a methodological weakness and argued that the covert exclusion of the interests of particular individuals or groups was the result of the 'mobilization of bias', that is:

"A set of predominant values, beliefs, rituals, and institutional procedures ('rules of the game') that operate systematically and consistently to the benefit of certain persons to defend and promote their vested interests. More often than not, the 'status quo defender' are a minority or elite group within the population in question. Elitism is neither foreordained nor omnipresent: as opponents of the war in Viet Nam can readily attest, the mobilization of bias can and frequently does benefit a clear majority." (Bachrach & Baratz 1970 p 7)

Bachrach and Baratz, therefore, redefined the boundaries of the political system examined and sought to include control of the political agenda within their analysis. Consequently, they developed a typology of power which embraces coercion, influence, authority, force and manipulation, which the defenders of the status quo may apply covertly when required (table 7.2).

Table 7.2: Typology of power after Bachrach and Baratz (1970)

Coercion	Where there is a conflict over values or course of action, A secures B's compliance by the threat of deprivation
Influence	Without resorting to either tacit or overt threat of severe deprivation, A causes B to change his or her (sic) course of action
Authority	B recognises that A's command is reasonable in terms of his or her own values and therefore complies
Force	A strips B of the opportunity for non-compliance
Manipulation	A subset of force where B complies without knowledge of who A is or the demand placed upon him or her

Despite highlighting the methodological weaknesses within the pluralists' behavioural analysis, they concluded that conflict, either overt or covert, was a precondition within both faces of power. Some commentators have suggested that Bachrach and Baratz themselves acquiesced in response to the pluralists' challenge and, by agreeing that observable conflict was a prerequisite, effectively weakened their argument (Clegg 1989; Lukes 2005). In table 7.3 I offer an illustration of a two-dimensional view of power within a healthcare context.

Table 7.3: Illustration of the Two-Dimensional view of Power

The Occupational Therapist (OT) cited in table 7.1 may have elected not to question or challenge the hospital consultant's decision to discharge a patient on the ward round and, to all intensive purposes, may have appeared to have acquiesced. In reality, however, the OT may have challenged the consultant privately and, if unhappy with the outcome of the challenge, may have documented these concerns in writing. A behavioural methodological analysis of clinical decision-making could have missed these activities and reached the erroneous conclusion that power was absent. A two-dimensional view would acknowledge that the absence of observable power from the ward round would not necessarily equate to the absence of power per se. It would have acknowledged the conflict that existed between the consultant and the OT and perhaps concluded that the OT was according to Bachrach and Baratz's typology, forced to comply, as the consultant retained the ultimate power to make the decision to discharge the patient.

In response, Lukes observed political quiescence and argued that power was not confined to observable conflict, the outcome of conscious decisions or even suppressed issues. Lukes looked beyond the behavioural limitation of one and two-dimensional power and suggested that defenders of the status quo may be unaware of their actions. There was, he argued, a third and perhaps greater, non-behavioural dimension where the Gramscian conceptualisation of *hegemony* is recognised.

Gramsci was an Italian writer, politician and political theorist. A Marxist and a founding member and onetime leader of the Communist Party in Italy, he was imprisoned by Mussolini's Fascist regime. From the confines of his prison cell he reflected on the question which troubled him most: *How is consent to capitalist exploitation secured under contemporary conditions, in particular democratic ones?* Gramsci documented his thinking in notebooks which were later published (Gramsci 1971). He concluded that an anti-capitalist revolution had not occurred in Italy because the perspective of the ruling class had been absorbed by the masses of workers. The workers' ideology, their self-understanding, had been effectively captured by the hegemonic (ruling) capitalist culture. Gramsci proposed that workers had been indoctrinated with a *false consciousness*. Instead of working towards a revolution that would truly serve their collective needs, workers in "advanced" societies were listening to the rhetoric of nationalist leaders, seeking consumer opportunities and middle class status, embracing an individualistic ethos of success through competition and accepting the guidance of bourgeois religious leaders. Gramsci argued that prevailing cultural norms should not be viewed as "natural" or "inevitable". Rather, cultural norms - including institutions, practices and beliefs - should be investigated for their roots in domination and their implications for liberation.

Therefore, theories of hegemony attempt to explain how dominant groups or individuals can maintain their power and explain the capacity of dominant groups such as classes to persuade subordinate ones to accept, adopt and internalize their values and norms. Lukes concludes that the supreme and most insidious exercise of power is where cultural and normative assumptions dominate:

“Is it not the supreme and most insidious exercise of power to prevent people, to whatever degree, to have grievances by shaping their perceptions, cognitions and preferences in such way that they accept their role in the existing order of things, either because they can see or imagine no alternative to it or because they see it as natural or unchangeable, or because they value it as divinely ordained and beneficial?” (Lukes2005 page 28)

Unlike the first two dimensions, Lukes' third-dimension does not require evidence of actual conflict to conclude that power exists. It does, however, acknowledge that when there is a contradiction between the interests of those exercising power and the real interests of those they exclude, *potential* or *latent* conflict may exist, may never actually be expressed and may even be subconscious.

Lukes' third-dimension, where the powerful prevent people from having grievances by shaping their perceptions, thoughts and preferences in such a way that they accept their role in the existing order of things, was radical, because its interpretation requires a shift away from the traditional positivist epistemology. By proposing a theory that power is most effective when it is least observable and, therefore, could not be empirically demonstrated by the scientific method, it could be argued that Lukes' contribution to the discourse on power was nothing short of a Kuhnian scientific revolution within the field. Lukes' third dimension arguably widened the debate beyond a traditional positivist epistemology and moved towards a critical paradigm (see Chapter 2 table 2.2) (Hindess 1996). Alternatively, it could be argued that Lukes' third dimension closed the loop and facilitated acceptance of the contribution of the Marxists' notion of ideology, which the positivist sought to refute, thus, creating a paradox for the empirically-minded researcher - a paradox which can be explored through seeking out observable examples of the third-dimension, by finding means of falsifying it or by examining contexts which the first and second dimensions cannot explain.

Lukes suggests that the wider the scope of one's conceptual framework of power, the more power in the world one can see. Set against the three

dimensions, by failing to acknowledge the existence of power that is unobservable and by offering empirical evidence of situations where dissatisfied groups have successfully penetrated the system, the one-dimensional view and, albeit to a lesser degree, the two-dimensional view of power serves to preserve the status quo and perpetuate the biases that lie within the system.

In table 7.4, I provide an illustration of the three-dimensional view of power within a healthcare context.

Table 7.4: Illustration of the Three-Dimensional view of Power

In a democratic society, we might expect that any member of the public, or professionally regulated healthcare professional, would have the power and autonomy to challenge any clinical or managerial action or decision that, in their opinion, put a patient at risk. We would also hope and expect that the concerns raised by any such 'whistleblowers' would be dealt with, with the utmost respect and expediency. Evidence, including recent public scandals and their subsequent enquiries, would suggest that in reality, this is unfortunately not always the case. For example, the public inquiry into mortality rate within children's heart surgery at the Bristol Royal Infirmary 1984 -1995, which were above the national average, highlighted the potentially devastating consequences of unchecked medical hegemony, coupled with system failure (The Bristol Royal Infirmary Inquiry 2001). This is an example of three-dimensional power, when such hegemony is taken as normative and remains unchecked.

Having reflected on his earlier contribution, Lukes acknowledges its limitations. Its focus was on the securing of compliance to domination through the exercise of power, within the context of binary relations between actors who are assumed to have only unitary interests. Lukes concludes that power is a capacity and not merely the exercise of that capacity. Equally, holding the resources of power such as wealth, status, military forces or weapons, does not necessarily make you powerful. This assumption Lukes describes as the 'vehicle fallacy' and cites the USA position with regard to Vietnam and postwar Iraq as evidence. He delineates four aspects of power, namely 'issue scope', 'contextual range' 'intentionality' and 'activity'. *Issue scope* considers whether an agent has power over a single issue or if they

have power to prevail over several different issues. In most cases, an agent able to prevail over several issues would be considered more powerful than one championing a single issue, but the nature of a single issue can have a significant impact here. *Contextual range* considers whether an agent's power is 'context bound', that is, only effective within tightly defined conditions, or if they have power to prevail over a range of contexts. Once again, the former would, in most cases, be less powerful than the latter, although Lukes notes that an agent whose power is context bound is likely to meet less resistance than one whose power is context transcending. *Intentionality* acknowledges that power is manifest where an agent is able to realize what he or she wants or intends. However, unintended consequences can also be a manifestation of power which can be highly significant. Finally, *activity* acknowledges that a decision not to act can also be a form of power and action can also be a form of weakness. Proposing power differentials implies that one is more able to bring about a significant change than another when 'significant' may be judged by the impact it may have on the 'interests' of the agents involved:

"If I can affect your central or basic interest, my power (in relation to you) is greater than someone who affects you only superficially."
(Lukes 2005 p 80)

What constitutes an agent's 'interests' is, however, recognised as equally contestable. Based essentially on value judgements, a degree of objectivity may be introduced if interests are assessed with regard to an agent's preferences, whether these be overt or covert, notions of their welfare or their well-being. In summary:

"The power of the powerful is to be viewed as ranging across issues and contexts, as extending to some unintended consequences and as capable of being effective even without active intervention... and power as domination will present wherever it furthers the interests of the powerful and bears negatively upon those subject to it..." (Lukes 2005 p 86)

In order to provide insight into the conditions in which initiatives, which innovatively seek to facilitate access for groups of people who do not

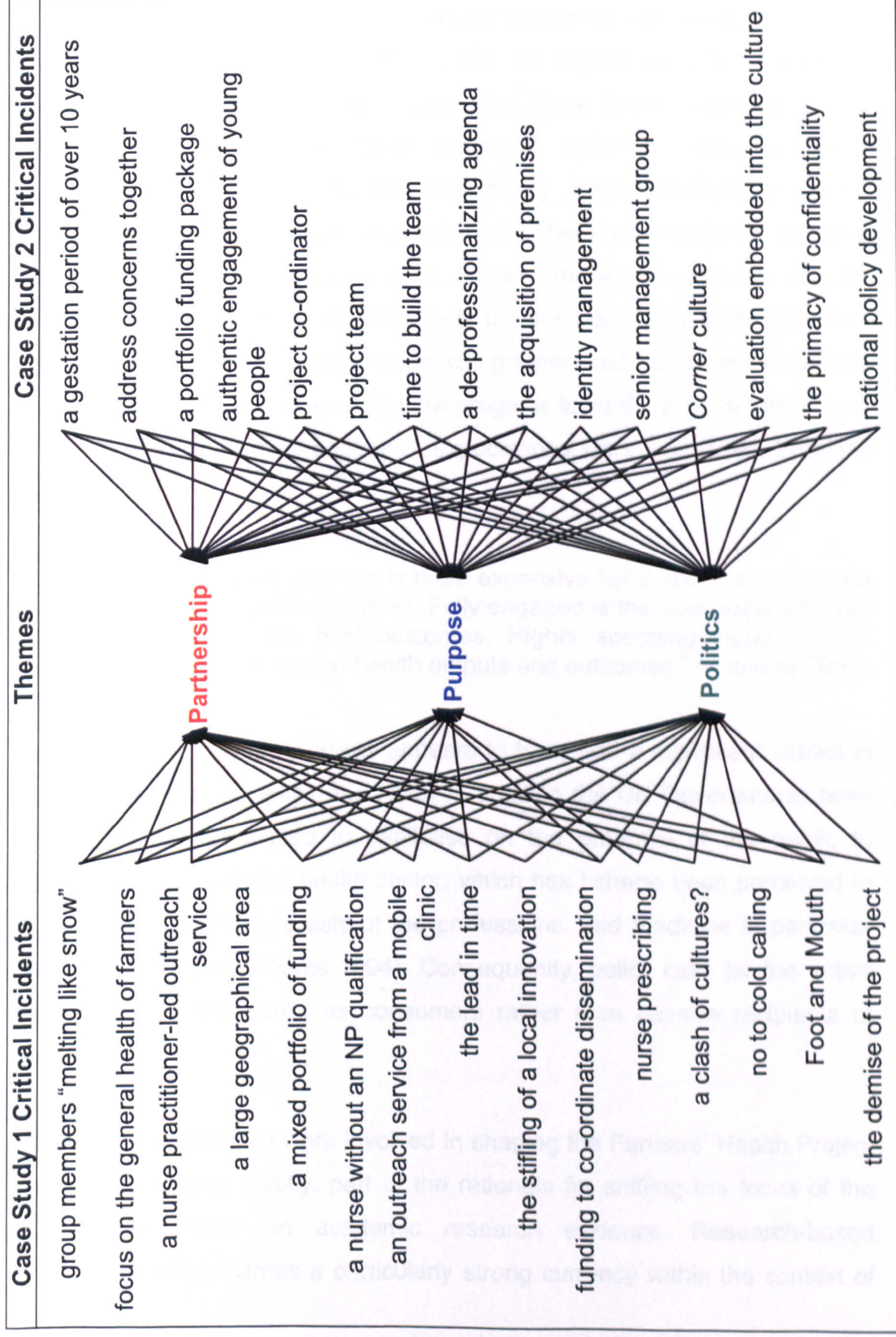
routinely use mainstream health services, might flourish, Lukes' analysis of power serves as a heuristic device to facilitate a comparative analysis of the cases of innovation examined in this study.

7.3 Power and Innovation

The cases of innovation examined in this study both aimed to facilitate access to healthcare for people who were known to have physical and mental health problems. They were groups whose healthcare needs either remained unchecked, were addressed outside of the formalised healthcare system, or were addressed within the system at a relatively advanced stage. They did not routinely access mainstream health services. Consequently, the extent of the healthcare needs of these populations was not known.

Through critical analysis of these cases, I identified within each, fifteen incidents (chapter 5 table 5.6 and chapter 6 table 6.13) which I have argued had a critical impact on their trajectory. I will now consider these critical incidents within the context of the three overarching themes presented in chapter five, figure 5.2, namely partnership, purpose and politics, using Lukes' analysis of power as my conceptual framework. Figure 7.1 illustrates the complexity of the relationships between the critical incidents and the themes identified.

Figure 7.1: The relationships between the critical incidents and the themes



7.3.1 Partnership

In March 2001, the then Chancellor of the Exchequer commissioned Derek Wanless to undertake a review of the long-term trends affecting the health service in the UK and attempt to quantify the resources that would be required to provide a publicly-funded NHS in 2022. To predict the 2022 healthcare resource requirements, Wanless constructed three future scenarios. In the first scenario, there was “*solid progress*” towards increased public engagement in their health, life expectancy rose considerably, public confidence in health services increased and there was evidence of more effective use of primary care facilities. Equally, there was evidence that the service was more responsive; there was greater take-up of technology and more efficient use of resources; there was greater productivity. In the second scenario, “*slow uptake*”, there was slow progress towards all of the above and in the third scenario “*fully engaged*”, expectations were surpassed. Wanless concluded:

“The slow uptake scenario is more expensive but it also the one based on the worst health outcomes. Fully engaged is the least expensive but based around the best outcomes. Higher spending inputs do not necessarily imply better health outputs and outcomes.” (Wanless 2000)

As discussed in Part II, Wanless appears to have had a significant impact in the direction of travel within the NHS. In addition the UK Governments have recognised and attempted to capitalise on the potential of the public to mobilise change with the health sector, which has hitherto been perceived to be dominated by the interests of the professions, and medicine in particular (Gabe, Kelleher, & Williams 1994). Consequently, policy calls for the active engagement of the public as consumers rather than passive recipients of healthcare.

The farming community were involved in shaping the Farmers' Health Project (FHP) in four ways. Firstly, part of the rationale for shifting the focus of the project was based on academic research evidence. Research-based evidence currently carries a particularly strong currency within the context of

UK healthcare. For example current professional discourses indicate that medicine, nursing and, indeed, all of healthcare policy and practice should be based on, or informed by, the best available research evidence. Aside from whether they adopt a uni- or multi-disciplinary focus, healthcare professionals all appear to subscribe to the following definition of what it means to practise from an evidence base:

“the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson 1996).

This evidence-based practice (EBP) movement is based on the premise that appropriately designed objective research studies have the capacity to reduce uncertainty about whether a clinical intervention will work or not. Thus, the more research evidence can be seen to reduce uncertainty, the stronger it is regarded. Consequently, proponents of EBP subscribe to frameworks where they privilege certain types of research evidence over others. In such a “hierarchy of evidence” (Sackett 1986) the more research evidence is considered to offer certainty, the greater it is privileged over other forms of evidence (see, for example, table 7.5).

Table 7.5: Hierarchy of Evidence

1. Systematic reviews and meta-analyses
2. Well-designed randomised trials
3. Well-designed trials without randomization (e.g. single group pre-post, cohort, time series or matched case controlled studies)
4. Well- designed non experimental studies from more than one centre
5. Opinions of respected authorities based on clinical evidence, descriptive studies or reports of expert committees.

Rated at number one, the systematic review and meta-analysis are considered the 'gold standard' form of evidence. Systematic review is the review of a body of data that uses explicit methods to locate primary studies and explicit criteria to assess their quality. Meta-analysis (also known as pooling and quantitative synthesis) is a statistical analysis that combines or integrates the results of several independent clinical trials considered by the analyst to be "combinable", usually to the level of re-analysing the original data. Booth (2006) suggests that the hierarchical approach can be problematic if it leads decision-makers to uncritically privilege a poor randomised control study over a good observational study. It is also limited in cases where evidence at the same level within the hierarchy is conflicting or where a body of evidence at a lower level, conflicts with, for example, a single study located with a higher position in the hierarchy.

Whilst in Sacket's definition of EBP, practice refers explicitly to clinical decisions made in relation to individual patients, it has been argued that the same principles should be applied in, for example, management decision-making (Hewison 1999) and policy development (Gray 2001). Paton (1999), however, has argued that, whilst technical-rational knowledge may have a useful place in assessing the efficacy of clinical interventions, its contribution to the complex worlds of management and policy-making may be limited. Nevertheless, the currency of research-based knowledge and the impact of hierarchies of knowledge such as the one, illustrated in table 7.5, cannot be underestimated.

Gerrard (1995) conducted a telephone survey of 150 farmers across three English counties and concluded that farmers believed that the health and safety risks in farming were increasing; that current statutory means of informing them of health and safety risks in the form of written communications from the Health and Safety Executive (HSE) were ineffective; that farmers had more trust in their vet than their GP; and that farmers would be more inclined to listen to a health and safety professional with a farming background than to an 'outsider', especially an outsider employed by the HSE 'inspectorate'. Within the context of the hierarchy of evidence in table 7.5,

Gerrard's research might be considered relatively weak research evidence. Nevertheless, it was emotively described as *compelling* and part of the justification for developing a farmers' health outreach service. Gerrard proposed that her findings lent themselves to further research. She recommended action research to investigate the benefits of an occupational health service tailored to the needs of the farming community.

Secondly, two farmers were actively involved in the project steering committee. They advised that they had advocated at the outset of the project that cold calling, that is, visiting farms unannounced, would be a culturally acceptable modus operandi within the farming community. However, it was reported that, as this initiative was being progressed within the context of a research project, ethical approval was contingent upon there being no cold calling. One reason for this may have been that cold calling was considered to be a coercive means of recruiting research subjects. If this was the thinking behind the ruling, arguably it was both culturally insensitive and methodologically problematic. Blanket rulings about what is, and what is not, acceptable practice in the recruitment of research subjects have the capacity to exclude certain groups from research processes (Johnson 2007). By rejecting the recommendations of the farmers on the steering committee and by not appearing to challenge the chair of the research ethics committee on these grounds, the hardest-to-reach farmers, those who did not come off their farms to access the auction marts, arguably those who were most at risk and in greatest need of support, were excluded from the research process. In the third year of the initiative, when it was no longer a research project and the Foot and Mouth exclusion zones had been lifted, cold calling was introduced and reported to be very successful.

Thirdly, the project team brought back feedback from the farmers they encountered when in 'the research field' and this, for example, led to a change in the signage on the mobile clinic. Fourthly, telephone interviews were held with farmers who accessed the NP-led service to ascertain their levels of satisfaction with the service.

A one-dimensional view of power might conclude that farmers were fully engaged and central within the FHP. They informed both its development and evaluation and, where there had been observable conflict on the point of cold calling, the farmers on the steering committee appeared to acquiesce. A two-dimensional view might argue that cold calling as a potential *modus operandi* never actually made it on to the agenda. The reported telephone call between the chair of the research ethics committee and the project researcher left no audit trail that cold calling was formally rejected by the research ethics committee. A third-dimensional view might look more critically at the role of an ethics committee and conclude that, through exercising his positional power, the chair of the research ethics committee, albeit, perhaps, unwittingly, effectively silenced the voice of the farmers and stifled the potential of this particular innovation to flourish.

The issue of cold calling was the only area of conflict between the farmers on the steering committee and the project team that I uncovered. This might have been the only area of contention, but it might not. I suggest that, whilst there were two farmers on the steering committee which met quarterly, there were no farmers (who were not themselves also members of the healthcare team) on the management group, which met monthly, to make key operational decisions. Thus, I conclude that the FHP was fundamentally professionally-led. Indeed, it was marketed as a NP-led service.

Whilst I criticise the FHP for not fully engaging farmers as co-researchers in their action research project, I recognise that failure to fully engage farmers in my own study is a key weakness in my analysis. Nevertheless, I am able to highlight the marked comparison between the FHP and *The Corner* in this regard. The centrality of the young people within *The Corner* and their engagement in it was explicit. This was not a service developed *for* people who do not routinely access mainstream services but a service developed *with* them. *The Corner* developed and used creative means of engaging and empowering young people, which were shown to not only have a powerful impact on the young people themselves, but also on local politicians, the media and the wider community. Here, young people were not just actively

involved in decision-making processes, they also worked alongside the staff and together they shaped the agenda. The culture within *The Corner*, which placed young people firmly at the centre of the project, was facilitated, in part, by a strong culture of evaluation and feedback incorporating an innovative consultation framework. The centrality of the young people was evidenced by, for example, the trouble that was taken to acquire premises within the City, that met with the stringent criteria developed by the young people and the controversial impact on some of the more recently appointed staff of ensuring that the preservation of the confidentiality of the young people who accessed the service was maintained.

In the example of the *The Corner*, this level of 'consumerism' is seen to provide disadvantaged young people with a voice, or what Henderson and Peterson (2002) describe as an 'identity label', and the language to reclaim their rights. In contrast, within the FHP it may have been assumed that because a plurality of stakeholders appeared to be involved in decision-making processes, they all had equal capacity to influence the agendas and the outcomes. For example, by taking an inclusive approach, the project team may have operated under the assumption that all participants in the rural health steering group were afforded the opportunity to influence the decision to focus on the health of farmers. However, it is possible that, due to the effective silencing of certain, less traditionally powerful voices, alternative proposals did not even reach the agenda.

Professionals may be under the illusion that working in 'partnership' with lay participants means that consultation will lead to a convergence of lay and professional views, but this is not necessarily the case (Anderson, Shepherd, & Salisbury 2006). Authentic engagement with the public will require professionals and others to ensure that everyone has a voice, and is listened to, and that those in traditionally powerful positions are open to challenge, and accept the fact that they must face the potential of relinquishing their power. One informant suggested that the lay members of the rural health steering group, who may have been participating in a voluntary capacity because of a real concern about the mental health of rural communities, were not given a

voice, and they left the group. If they did not feel anyone was listening, they were faced with three choices. They could 'voice' their protest, they could leave or 'exit' the group or they could acquiesce through a sense of 'loyalty', perhaps, in the hope that someone else, whom they perceived to be more powerful than themselves, might share their reservations and voice their concerns:

"It is true that in the face of discontent with the way things are going in an organisation, an individual member can remain loyal without being influential himself, but hardly without the expectation that *someone* will act or *something* will happen to improve matters." (Hirschman 1970 page 78)

Economist Albert Hirschman (1970) first recognised these three concepts as a means of understanding consumer practices and concluded that they reflect behavioural choices within a wide range of contexts where individuals are dissatisfied. The problem that arises when dissenting voices exit, as some members of the rural health steering group chose to, is that the status quo prevails and the traditionally powerful groups continue to dominate the agenda with their position even further entrenched by the perception that it has been endorsed by the local community.

In order to ensure that the concerns of young people were not overshadowed by professional agendas, the strong, focused project co-ordinator within *The Corner* purposefully adopted a de-professionalising strategy. As this strategy showed no observable signs of conflict, a three-dimensional interpretation is required to assess what, if any, power might have been exercised in this regard. As a result of surfacing the sense of exclusion felt by the nurses I interviewed, I conclude that this strategy effectively replaced one type of hegemony with another. The potential of professionals appointed as project workers to dominate agendas was managed out of this particular system and these professional voices were effectively silenced by a managerial hegemony.

The imposition of managerialism into the UK public sector and the health sector in particular, was introduced in chapter 4. It is fair to say that the legitimacy of the authority of the 'manager' has been normalised within Western Society and the genesis of thinking about management can be traced back to the turn of the 20th Century. The Industrial Revolution heralded the development of large-scale industrial and organisational units. Frederick Winslow Taylor (1911) in the USA (discussed, in brief, in chapter 4) and Henri Fayol (1949) in Europe were two of the most notable "classical" management theorists. They were both engineers and their thinking was underpinned by a rational, bureaucratic, scientific view of the world. They believed that organisations could, and indeed should, be run as efficiently as machines and the role of the 'manager' was to ensure these ends. Whilst Taylor focused on work organisation and efficiency, Fayol's interests lay in the implementation of authority.

Taylor was greatly influenced by what he perceived to be the increasing capacity throughout the nineteenth century of science, and physics in particular, to explain and problem-solve fundamental questions about the physical world. If the laws of motion could be identified through scientific processes, so too, thought Taylor, could the laws of maximum efficiency. Taylor was greatly perturbed by what he saw as overwhelming inefficiency throughout the USA. He believed that the answer lay within systematic, scientific management that could be learned and applied within any context. By applying scientific principles to analyse the processes of production, Taylor became the founding father of the principles of 'scientific management' and the 'time and motion study' (Taylor 1911). Scientific management privileged science over experience and claimed to replace the subjective judgement of the workman with an objective, scientifically controlled measurement of each routinised task within the production process. Through the application of scientific principles, Taylor argued, a manager could calculate and define the 'best method' of production. Taylor's scientific management not only privileged science over experience, it also privileged the scientific manager over the worker claiming that the worker, through lack of education or mental capacity, was incapable of understanding the science of management. Once

the scientific standard or quota for a particular task was known, Taylor believed that, through the application of scientific principles, management could ensure the optimum performance of the workforce through motivational training and financial reward. Taylor advocated that any financial gains accrued through increased scientific productivity should be shared with the workforce. By objectifying both the worker and work processes, Taylor held a reductionist, objective view of human beings. He viewed them as the 'basic raw material' that scientific managers could, through the application of scientific principles, transform into efficient, well-ordered and productive members of a clearly ordered workforce.

Henri Fayol was considered the first management theorist in Europe to produce a theoretical analysis of what administration (or management) was and, more importantly, what administrators had to do in order to manage properly and effectively. Fayol published his '*General and Industrial Management*' in France in 1916. It was translated into English in 1949 (Fayol 1949). Fayol's theories were developed through the application of "Social Darwinism". Charles Darwin was a British Naturalist who became famous for his theories of evolution and natural selection (Darwin 1872). In particular, Darwin observed that species adapted to changing environments, and those species best able to adapt or evolve over time, were the most likely to survive. According to Fayol, organisations able to adapt to changing environments were most likely to survive and the means to survival was through rational management, based on principles, laws and rules (Fayol 1949). Fayol identified and codified fourteen generalisable, unifying principles of management. Within the ninth, Fayol recommended the 'scalar chain' or line of authority, from the top executive to the shop floor operative, should be 'sensible, clear and understood'. The legitimacy of the ultimate authority of the top executive was taken as a given, as part of the natural order. This 'natural order of things' was picked up in the tenth principle, order, where, in good management practice, there is 'A place for everything and everything in its place' as well as 'A place for everyone and everyone in his place'. Where there is order, management exercises seamless and invisible power and control over both the material of the business and the people within it. Fayol's

principles were not intended to be rigid, but with the right adaptation, could be used in any management situation to improve efficiency and productivity, and thus the chances of survival, through harnessing co-ordination and control of activities.

The Human Relations management theorists, which included, for example, Mayo (1945) and Maslow (1970) were critical of the classical management theorists for their focus on the task, at, what they saw as, the expense of the human being performing the task. Scientific research conducted at the Western Electric Hawthorne Plant between 1924 and 1932 became widely known as the "Hawthorne Experiments" (Roethlisberger 1939). The first studies sought to identify if worker fatigue, which had an affect on their productivity, was affected by the quality of the lighting in the plant. The "Illumination studies" were abandoned because they "didn't work". No matter how the researchers manipulated the lighting environment, productivity was increased. It was later concluded that the increased productivity resulted from the researchers showing an interest in the female workforce who in turn tried to please them, irrespective of how the variable (the lighting) the researchers were measuring was manipulated⁷. Further experiments manipulating multiple variables also proved equally inconclusive. However, it was noted that productivity was affected by non-pay considerations and the researchers began to develop the theory that social dynamics influenced worker performance, a variable which Taylor and Fayol considered at best irrelevant and at worst a hindrance to the production process.

Elton Mayo was regarded as an excellent publicist of the Hawthorne studies (Rose 1975). According to Trahair (1985), Mayo did not himself initiate, direct or control the research. His contribution was that of an appreciative helper, counsellor-cum-publicist, cooperative collaborator and protective supporter. Mayo's lasting contribution was to herald the Hawthorne Experiments as a watershed, leading to a fundamental shift from scientific management which focused on the tasks of the production process, to human relations

⁷ Subsequently, this was regarded as a phenomenon where a researcher has the capacity to "corrupt" a scientific experiment and it became known as the "Hawthorne effect".

management which focused on the people involved in the process (Mayo 1945).

Whilst it is acknowledged that the new human relations management differed from classical scientific management in its focus, it has been argued that the purpose remained the same. Both schools of thought sought to increase efficiency through management control (Bolton 2005). With its focus on the social psychological element of work, the aim of the new human relations management was to identify and minimize, or eliminate, the factors which hindered performance. Equally, the privileged position of the manager was taken as a given and, if anything, was enhanced through this development as further social commentators such as Maslow (1970) and McGregor (1960) provided managers with theories and a language of management which enhanced their status (Fournier & Grey 2000a).

Maslow, for example, observed that in monkeys, some needs take precedence over others, and he transferred this learning to his assessment of the human condition. He offered an analysis of human motivation which became widely known as 'Maslow's hierarchy of needs'. Physiological needs are at the base of Maslow's hierarchy. Oxygen, water, nutrients and homeostasis are fundamental to human existence and Maslow argued that only when these needs are taken care of can the second layer of needs, safety and security, come into play. The third layer on Maslow's hierarchy was love and belonging needs and the fourth esteem needs. All of these Maslow described as 'deficit needs'. According to Maslow, people are only ever really aware of these needs when they are not being met. He also described these needs as 'instinctoid' and argued that they were genetically built into the human condition. If you have enough to eat you don't feel hungry. At the pinnacle of Maslow hierarchy is "self-actualization". This need, which was not a deficit need, was about an individual realizing their fullest potential. Maslow argued that if someone has deficit needs they cannot fully devote themselves to realizing their potential. The contribution of Maslow and other human relations commentators to the field of management studies was to provide managers with theories that could be used to assess the motivational factors

contributing to or hindering workers' performance. If so inclined, managers may elect to apply these new psychological theories to manipulate and control workers performance. Edwards (1979), for example, refers to 'welfare capitalism' where social and other benefits have been provided by employers in an attempt to control the behaviour of their staff.

Critical of both the classical and human relations management theorists for being both inward-looking and reductionist, systems management theorists argued that they offered a more holistic, outward-looking approach that facilitated innovation and the capacity for organisation change (and survival) in response to their external environment. Through mathematical modelling, the 'systems approach' to management was seen to offer greater precision and control. The systems approach was based on Ludwig von Bertalanffy's 'General Systems Theory' (Bertalanffy 1968). Bertalanffy initially developed a general theory of biology where he proposed a holistic, organismic view of nature and life. Bertalanffy proposed that organisms were open systems which developed and maintained stability or homeostasis through their engagement with their external world. Essentially, Bertalanffy argued that life happened according to its environmental circumstances. This fundamentally challenged the prevailing reductionist view in Biology where the focus of analysis was on activity at the subcellular level which disregarded the external environment. From this general theory of Biology, Bertalanffy developed a General Systems Theory (Bertalanffy 1968) which has found multiple applications including within organisation theory. Organisations are, therefore, seen as consisting of interdependent internal parts in a relationship with their external environmental circumstances. Systems thinking has had a considerable impact on the literature within the field of organisation and management (Bolton 2005) and laid the foundations for the application of complexity theory to management in general (Stacey 1996) and healthcare management in particular (Kernick 2004).

In 1961, for example, Burns and Stalker examined the capacity of electronics firms in Scotland to innovate (Burns & Stalker 1961). Through comparing the differences between 'organic' and mechanistic' organisations they argued that

'organic' organisations had a greater capacity to innovate and survive in a changing external environment, whereas a 'mechanistic' bureaucratic organisation functioned most effectively in a stable environment. The legacy of the influence of social Darwinism on Fayol's thinking can be seen clearly in this context.

Whilst the influence of the classical theorists can be related to systems thinking, the human relations influence can be clearly linked to the rise in popularity of the pursuit of 'quality' or 'excellence' and 'culture management' (Peters & Waterman 2004). In their best selling book "In search of excellence", Tom Peters and Robert Waterman offered a seductive degree of certainty. Through their analysis of what, at the time of their research, were the 10 most successful companies in the USA, they identified *the* eight themes for corporate success, namely:

1. **A bias for action, active decision-making** - 'getting on with it'.
2. **Close to the customer** - learning from the people served by the business.
3. **Autonomy and entrepreneurship** - fostering innovation and nurturing 'champions'.
4. **Productivity through people** - treating rank and file employees as a source of quality.
5. **Hands-on, value-driven** - management philosophy that guides everyday practice - management showing its commitment.
6. **Stick to the knitting** - stay with the business that you know.
7. **Simple form, lean staff** - some of the best companies have minimal HQ staff.
8. **Simultaneous loose-tight properties** - autonomy in shop-floor activities plus centralised values. (Peters & Waterman 2004)

The appeal of Peters and Waterman's work was that they appeared to offer a 'recipe for success'. They provided a sense of certainty amidst the chaos and complexity of everyday existence. They provided 'engineer' managers with a 'toolkit', which, if deployed effectively, would guarantee success. Failure to utilize the toolkit successfully, however, would put the blame firmly at the manager's door.

Managers were urged to 'manage the culture' of their organisations and the values of their employees in order to enhance employee and organisational

performance. The ultimate scenario here would be where employees imbued the organisation culture to the degree that they 'self managed', or engaged in what Freedman described as 'responsible autonomy' (Freedman 1992), which negated the need for managers to exert any overt power or influence over highly skilled or professional employees. O'Reilly and Tushman (1997), for example, advocated 'using culture for strategic advantage' and 'promoting innovation through social control'. The role of the manager as 'culture manager' is seen as legitimate and whatever means are employed to achieve these ends are deemed unproblematical. Indeed, according to the orthodoxy, theories of management from classical and human relations through to systems and culture are unproblematical means to achieving legitimate ends and the authority and status of the manager are taken as a given.

Through the lens of Lukes' analysis of power, it is clear that power is present within all of these theories. Specifically within the context of culture management, arguably the insidious nature of three-dimensional power is present, and as critical management theorists would contend, potentially considerably problematic. Fournier and Grey (2000) contest that orthodox management studies take the pursuit of efficiency as a given, that is, the production of maximum output for minimum input, by whatever means. CMS in this respect can be seen as the antithesis of the orthodoxy, the voice of 'the other', or perhaps more accurately, 'the other voices'.

From the perspective of the professional nursing staff employed within *The Corner*, their sense of oppression, which I interpreted to be as a result of a managerial hegemony, where managers attempted to manage the Culture of the enterprise, was deemed problematical. The project co-ordinators either assumed that all new members of staff bought into the philosophy of *The Corner*, or alternatively, they did not care, as long as young people remained central to the initiative, the means justified the ends. From a critical perspective, in their desire to ensure the centrality of the young people to the project, the Leaders within *The Corner* appear to have replaced one hegemony with another. I would argue that it is both possible and desirable for a plurality of perspectives to co-exist and create the tension required to

sustain a critical, questioning edge to our thinking about innovation and healthcare in general. I fail to see how engaging the nursing staff in the negotiations with the Genitourinary Medicine (GUM) consultant could have undermined the centrality of the young people within the Project and indeed, will later argue that their inclusion in the process *may* even have resulted in a better outcome for the young people.

The de-professionalizing strategy itself appeared to have its limitations. All those who contributed to the drop-in sessions within *The Corner* were known as project workers, with the notable exception of the 'Project Doctor'. The *relative* power of the nurses employed to work within *The Corner*, who were managerially accountable to the project co-ordinator, was relatively easy to suppress by authority, if not through influence. Whereas the professional power of the GP with Family Planning qualifications, contracted to work within *The Corner* on a sessional basis, was not.

The occupation of healing was not fully professionalized until the middle of the 19th Century. As stated in Chapter 4, an alignment with science was part of medicine's professionalizing strategy at this time, and the dominant discourse to this day remains one in which medicine is seen as a science (Harding & Learmonth 2000). This alignment, in part, enabled the professions which practised medicine to enjoy considerable power, authority and status (Kelleher, Gabe, & Williams 1994) and the assumption that medical science had the potential to triumph over disease and illness put the medical profession in a very strong position of influence when the NHS was established (Klein 2001). Whilst ownership and control of the means of production is recognised as a source of power and at the heart of Marxist sociology, Weber also acknowledged that knowledge of operations was a source of power (Hardy & Clegg 1996). Both of these sources of power can be attributed to the traditional dominance of the medical profession. Their hegemony extends to "ownership" of "their" patients and their allegiance to science serves to legitimise their knowledge base and their authority to dictate health service expenditure. More recently there have been political endeavours to curb the powers of the medical profession and their spending

powers in particular, through the introduction of managerialism by the Thatcher Government (1979-1990) and consumerism by the Major Government (1990 – 1997), ideologies which have been embraced by successive New Labour Governments. Better management was seen as the means of increasing financial efficiency (Kelly & Glover 1996) and of making the NHS more patient or consumer orientated (Pollitt 1991). Against a background of individualism, coupled with declining public trust and antagonism towards the professions and the state, the consumer discourse was mobilised in an effort to reshape medicine and bureaucracies (Henderson & Peterson 2002). Despite these systematic political endeavours to erode the power of medicine and challenge the fundamental assumption that “good” decision-making is based on scientific knowledge (Harrison 1998a; 1998b; 2002), medicine’s allegiance to science remains intact (Sackett, Rosenberg, Gray, Haynes, & Richardson 1996), as does its position as the most powerful professional group within UK health systems. Medicine still harbours, albeit to a lesser degree, power and status within the community and in the majority of cases is recognised as the lead member of healthcare teams. GPs are the major employers of practice nurses and nurse practitioners and, through the new NHS Primary Care management arrangements in England, the indirect employers of nurses who work in the community. It is arguably normative for GPs to lead clinical teams in primary care and for other members of the healthcare team to accept this as the given order of things. Only recently has this traditional position been challenged, under the auspices of new policy initiatives, which aim to improve access to primary care by introducing more flexibility within General Practice and for the first time allow nurses to take a lead in the provision of primary care (Chapman, Zechel, & Carter 2004).

The two GPs in the FHP rural health working party who spoke of a *storm warning* would have been perceived to carry a considerable degree of power and gravitas within the group, thus making it particularly difficult for any one to challenge them.

The relatively less powerful project co-ordinator within *The Corner*, therefore, did not have the authority or the ability to coerce, influence, force or

manipulate the Project Doctor to be stripped of her professional title. Nor was he able to persuade the GUM consultant to operate within the framework of *The Corner* culture. I suggest that had the *issue* and the *context* been given due consideration, engagement of the professional nursing staff, employed within the project with the requisite knowledge and expertise to deliver the sexual health services in these negotiations, may have met with less resistance and may have achieved a different outcome, possibly an outcome more favourable for the young people accessing the service.

The construction of the rural health working party and the presentation of their recommendations gives the impression that the decision to develop a NP-led outreach service was reached through democratic means. The concern expressed by the community mental nurses involved in the project, that NPs may not have the requisite skills to identify and manage mental health problems, provides documented evidence of conflict. Nevertheless, at face value, it appears as if a consensus was reached which from a one-dimensional view of power could be interpreted as democracy in action. The decision to attempt to identify and address the healthcare needs of farmers through a NP-led outreach service could also be interpreted as a professionalizing strategy, which served the interests of those within the nursing professions who sought to progress the role of nurses as nurse practitioners.

Whilst the dominance of some professional voices within the FHP may be attributed, in part, to medical hegemony through the influence of the GPs involved, the other key professional influencer was a nurse who was also an academic who provided a University based nurse practitioner programme within a neighbouring University.

Nursing began to embrace science and the academy considerably later than medicine. With the notable exception of Florence Nightingale (Nightingale 1859), some of the earliest documented research in nursing in the UK is less than fifty years old, for example 'The Study of Nursing Care Project' (McFarlane 1970). Those who engaged in research activity at this time were

an elite minority within nursing. It was not until the 1990's when nursing education moved out of the NHS and into the Higher Education sector, that nursing began to move comprehensively towards the professional goal of an all graduate, research-based profession. Prior to this time, only small numbers of nurses were university educated to degree level and, still to this day, the majority within England register with a diploma level qualification. Whilst the numbers of nurses with doctoral level qualifications are rising, they still represent an elite minority within the profession. Therefore, the doctorally prepared nurse academic involved in the FHP may have commanded more power, in part, as a consequence of his academic background:

“Knowledge construed as the preserve and private playground of a few has given power to those few: the power to exclude , to theorize about, and to intellectually dominate the other members of the species.” (Cole 1993 p 79)

He may also have commanded more power as a result of his gender. Feminist writers such as Carol Gilligan (1993), for example, argue that there is a cultural bias within society where the male is assumed to be the norm and, therefore, the female is perceived as 'the other'. In her analysis of psychological theory and development, Gilligan illustrates how theorists, including Freud and Piaget, project a masculine image of the ideal psyche. Feminists argue that this bias is a hegemony which is endemic within society and serves to diminish the female contribution. Consider, for example, the relative proportion of men in leadership positions within nursing (Evans 2004).

The male academic in the FHP was described by a female with a different view, as “*quite determined*”. Equally, within *The Corner* hierarchy, the nurses were female and the project co-ordinators were both male.

The dominant male professional voice argued with conviction that the coming together of two parallel agendas presented a win-win situation, addressing both the interests of farmers and the interests of those within the nurse practitioner movement. In this context, the focus on farmers may have been perceived simply as a means to securing funding to progress the nurse

practitioner agenda. This conviction was not shared by all members of the project team. Nevertheless, a nurse without NP experience or qualifications was appointed to develop an NP-led outreach service autonomously within a defined geographical area. The assumption was that this nurse could simultaneously train for a NP qualification and establish a novel nurse-led outreach service. By not completing the training and electing to work differently, this nurse was perceived as a failure by some members of the project team. This raises two key issues, which I suggest are indicative of three-dimensional power. Firstly, whilst tolerated, the role adopted by this nurse was spoken of as if it was 'the other' and, within the context of the project, the practice of the NP was referred to as the norm. As stated in Chapter 5, it was the crisis of Foot and Mouth Disease which effectively stopped the outreach service in its tracks and opened the minds of the project team to alternative possibilities. Secondly, her inability to perform as a nurse practitioner may have been an unintended consequence of the decision to appoint her, or alternatively, she may have been set up to fail and thus highlight the complexity and potential impact of the NP role.

I have argued that there was no evidence presented to justify the amount of time and effort the FHP team expended on trying to circumvent the then legislative framework for nurse prescribing. As a result, I concluded that, whilst such a focus may have served the interests of the nurse practitioner movement, I could uncover no evidence in this case, to support the final conclusion that the legislative framework for nurse prescribing was a barrier to the development of outreach services for marginalised communities. Arguably, such a conclusion not only serves the interests of the nurse practitioner movement, but it also, by default, serves to expand the reach of the pharmaceutical industry. Whilst the positive impact of pharmaceuticals on health is evident, as an industry it has been reported to have acquired the capacity, hitherto attributed to the medical profession, to shift everyday problems into the domain of professional biomedicine in order to maximise profit (Metzl 2007). In the 1970's, Historian-Philosopher Ivan Illich expressed concern that medicine had overextended its scientific and cultural authority. In so doing, it had 'medicalised' society to the point where medicine itself

actually caused harm. For example, the use (and abuse) of medico-scientific technological interventions has arguably created new, iatrogenic illnesses and risks, including, for example, auto-immune deficiency disease (AIDS) and the hospital “superbug” methicillin-resistant staphylococcus aureus (MRSA). To avoid this ‘iatrogenesis’, Illich recommended that the public become more active in the management of their own health (Illich 1995) and reduce their dependency upon the medical profession, which had overstretched the mark. Metzl (2007) has argued that within the 21st Century, the pharmaceutical industry has commandeered this agenda. For example, the Chief Executive of Glaxo-Wellcome, Robert Ingram boldly stated:

“We are on the cusp of a new paradigm....(which) can best be described as moving from treating disease to creating health.” (Ingram 1999)

There is increasing evidence of what some might describe as innovative attempts to medicalise normal life processes in order to expand pharmaceutical markets. Moynihan and colleagues have argued:

“the social construction of illness is being replaced by the corporate construction of disease.”(Moynihan, Heath, & Henry 2002)

Payer (2004) does not see these endeavours as positive innovations. He has labelled those self-interested parties, who promulgate manufactured, mythical diseases in order to profit from the sale of overpriced, oversold remedies, which in some cases have the potential to do more harm than good, as “disease mongerers”. For example, endeavours to medicalise female sexuality to create a market amongst women for the pharmaceuticals currently used in the medical management of male impotence, has been described as disease mongering (Moynihan 2003).

The paradigm shift described by Ingram (above) is driven by profit margin and not by the burden of ill health. For example, the focus of the pharmaceutical industry is seen to have a tendency to rest on the sections of society who have the capacity to pay, rather than on communities and parts of the world with the greatest need. To put this in context, globally, for example, around

40% of the population is at risk of malaria. In sub-Saharan Africa, three thousand children under five years old die of malaria every day. Pharmaceutical industry critics argue that because there are no profits to be made here, the industry would rather engage in disease mongering in the first world than address this global atrocity. Third-dimensional power appears to be present here as the pharmaceutical industry, arguably, have the capacity to act in the Third World, but choose not to. Critics argue that, by failing to act, they are culpable. Instead, they choose to act in a manner that is seen to be self-serving and potentially dangerous.

Whilst there were undoubtedly some farmers who would have benefited from pharmaceutical intervention, the pursuit of nurse prescribing in this context was problematic for two reasons. Firstly, there was no evidence base from which to justify the amount of time and effort the project team expended on this massively complex issue. Secondly, the capacity to prescribe increases the potential for the medicalisation of a community with complex health and social needs, which may benefit more from social, non-pharmaceutical interventions.

Dominant professional voices appeared to have the capacity to silence the voices of lay and other less powerful members of staff, and the FHP was steered in a particular direction. Managers colluded by stifling endeavours in their own patch to develop services for, and with, local farming communities. From a one-dimensional view of power, the FHP infrastructure appeared to offer the opportunity for democratic, pluralistic decision-making. From both a one and two-dimensional view, elite decision-making processes appeared to dominate the project and they were sustained by the uncritical acceptance of cultural norms, or three-dimensional power.

I suggest this analysis confirms Lukes' latter conclusion that examination of power is much more complicated than simply the assessment of binary relations between actors with unitary interests. In these cases we can see multiple layers of potential overt and covert biases which have the potential to

impact both positively and negatively on the capacity of an innovation to flourish.

7.3.2 Purpose

The FHP emerged from a group of people with a shared interest seeking to identify a common purpose. *The Corner*, on the other hand emerged from two major stakeholders, with a common purpose, who decided to join forces. In the former, the partnership preceded the purpose and in the latter the purpose preceded the partnership. More significantly, in the former there were multiple purposes with relatively limited room for manoeuvre and in the latter there appeared to be absolute clarity of purpose with the capacity to take risks and try out new ideas. Senge proposes that where there is a shared focus and mutual purpose:

“...people learn to nourish a sense of commitment in a group or organisation by developing shared images of the future they seek to create and the principles and guiding practices by which they hope to get there.” Senge (1999 p 32)

This appeared to be borne out in *The Corner* with the initial members of the project team, who were able to take time out together prior to the opening of the drop-in and collaboratively work on the development of policies such as *The Corner* Child Protection Policy. The experiences of those who joined the project at a later stage would suggest that projects should have inbuilt systems for reviewing their policies in the light of new developments and experiences, and new staff should be encouraged to question and challenge current practice without fearing that they may be perceived as being obstructive. Evaluation was an integral part of the ways of working within *The Corner* and its focus was entirely on young people. *The Corner* may benefit from building into their evaluation strategy a survey, perhaps on an annual basis, to assess the experiences of the staff working in the project.

The decision-making processes within the initial *Corner* project team were presented by the project co-ordinator, from his perspective, as pluralist. The

concerns raised by the nurses appointed at a later stage and their reticence to question current practices has, from a one-dimensional perspective, more of an elite view of power. Acknowledging that different members of staff had differing experiences within the same environment, in part, depending upon when they joined the project, further serves to highlight the complexity of the dynamic and the limitations of considering binary relations between actors with unitary interests in isolation.

The outreach staff on the FHP team also valued the time they were afforded to network extensively prior to the arrival of the mobile clinic from which they would deliver their service. The difference here was that these staff were telling other people about their new service and learning about the services provided by others. They were not specifically negotiating new ways of collaborative working. The FHP team were not negotiating at this stage but, with the benefit of hindsight, perhaps an assessment of the *capacity* of the various stakeholders they encountered to support, or indeed stifle the project in the long term, could have been commenced at this stage. Had this happened, negotiation to secure the sustainability of the initiative could have begun at an earlier stage, with potentially a different outcome. Part of the reason the project proved to be unsustainable was that it sat on the periphery of the system and there was no-one within the system either willing, or able, to champion it. Part of the reason for this was that the system was going through yet another reorganisation and those within the system reported that they were overwhelmed by the demands of national policy implementation and faced uncertainty over their own futures. Supporting local innovation can be challenging at the best of times. Perhaps it is next to impossible if managers feel overwhelmed by centrally-driven changes and they do not know if they will still have a job the following week.

Understanding the context in which these NHS managers were operating is necessary to appreciate why they felt unable to support an innovation developed outside of the mainstream. The empirical data of a view from the world of policy collected and analysed in this study and presented in chapter 3 and discussed in chapter 4 has served to illuminate this context.

Serial reorganisation and reform have become regular features of the NHS over the last twenty years as a result of repeated endeavours to improve the service and at the same time contain NHS costs (Klein 2001). Managerial interventions have sought to increase fiscal efficiency and top-down policy initiatives have endeavoured to increase control of professional practice in three main ways. Firstly, national standards have been developed in partnership with the professional elites. Secondly, conformity has been incentivised through new contractual arrangements and thirdly, as discussed above, consumerism in healthcare has been actively promoted. Comparison of these two case studies has illustrated some of the inherent tensions within the promotion of consumerism, especially if this is seen to pose a threat to professional power or autonomy. In addition, analysis of the sustainability of the FHP has demonstrated the tensions managers face when trying to balance the demands of central control with their capacity for local responsiveness.

In sharp contrast, *The Corner* project team were supported by a strong, cohesive, senior management team which enjoyed a considerable degree of stability. Their commitment was evidenced when members of the team who were promoted within their respective organisations continued to serve on *The Corner* management group. It was a team that was clearly politically aware at macro-, meso- and micro-levels. They actively encouraged a proactive approach to the management of political tensions. This was evidenced through, for example, the management of top-down national policy initiatives which threatened to undermine the progress *The Corner* team had achieved locally, the proactive management of the identity of the project, in part, by building a strong relationship with the local media and the awareness of the potential threat of the new initiative, *The Shore*, posed to the morale of *The Corner* team. Where the FHP was driven from outside of the system, and was never fully embraced by the system, *The Corner* was driven from within the system, but because of its project status and its multi-agency backing, it appeared to sit outside of the system and the senior management team recognised the political advantage of this position.

The gestation period of each of these initiatives may have been a factor which impacted upon the degree of clarity of purpose within each case. The gestation of the FHP was less than a tenth of the time it took to begin to address the pressing health needs of the young people within the city of Dundee through the establishment of *The Corner*. During this long and protracted period, the key stakeholders within the local authority and the health board were persuaded of the value of tackling their concerns in partnership. This, in turn, eventually led to a joint, matched funding package. Funding for the FHP, on the other hand, was secured from a range of sources outwith the local health economy. By definition, therefore, the establishment of this project, outside of the system, may have appeared to be an overt criticism of the capability of planners and healthcare providers within the local health economies to address the health needs of the farming communities they were supposed to serve. It is possible, that this legacy may have impacted negatively, when endeavours were made to mainstream the initiative, if local managers felt that those within the project were seeking to manipulate them and their decision-making.

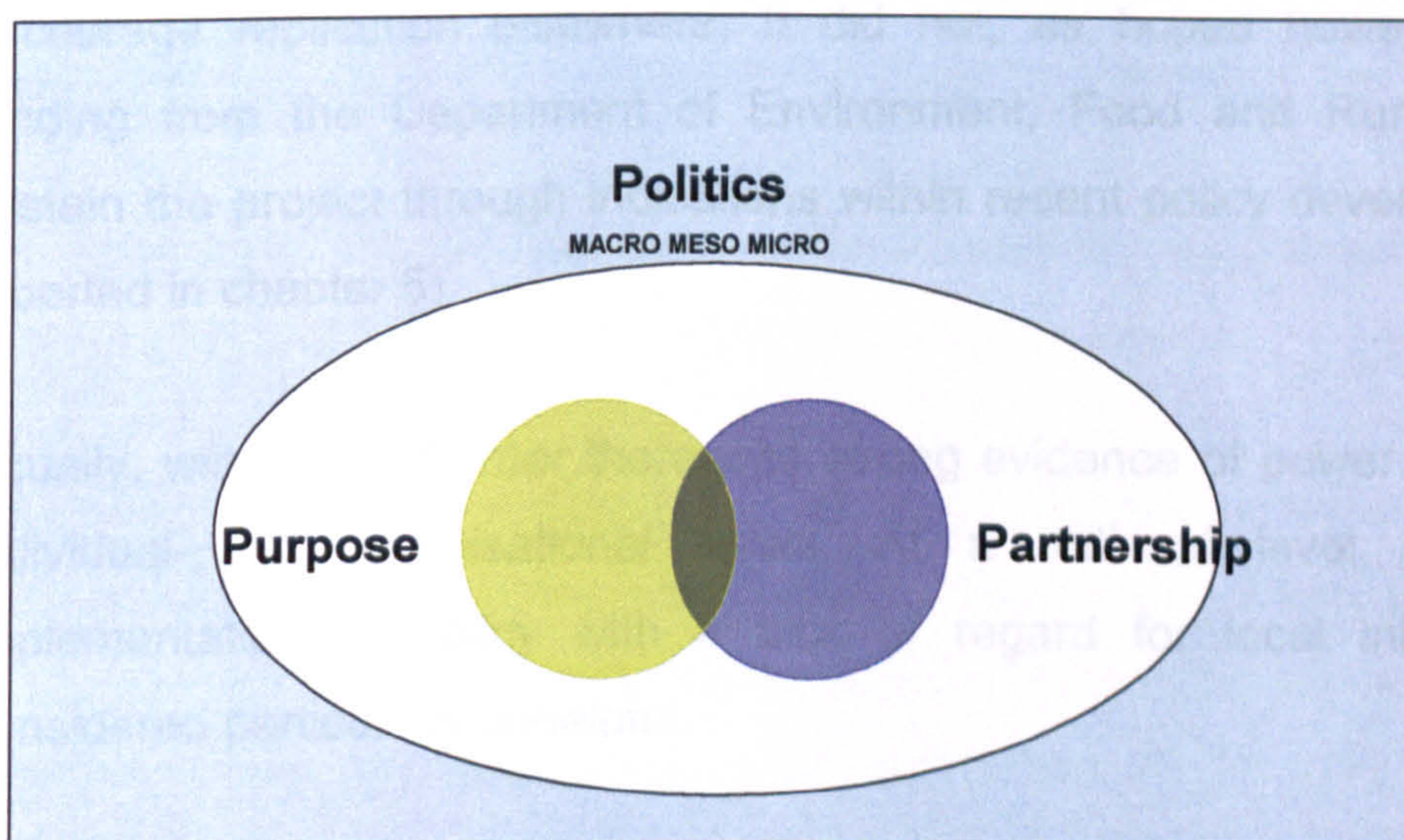
7.3.3 Politics

For the purposes of this discussion I define politics as the processes through which groups of people make decisions through the acquisition and application of power. In order to illuminate the conditions in which innovations may flourish, I have considered these political processes taking place on three levels, namely micro, meso and macro. Micro-level politics refers to interpersonal politics, meso-level politics refers to organisational politics and macro-politics refers to governmental / national politics.

The discussion above, comparing and contrasting the two cases examined and the critical incidents, which shaped their trajectories, through the conceptual framework of power constructed by Lukes, has illustrated the significant impact of micro- and meso-level politics on the capacity of an innovation to flourish. In the FHP, the interpersonal power relations between the health visitor and the academic serves as an illustration of micro-level

politics. The influence of professional power in the decision to focus on the health of farmers illustrates meso-level politics. In *The Corner* the dynamics between the nurses and the project co-ordinators highlights micro-politics and the complexity of the genesis of the project, the subsequent joint-funding and management arrangements between health and social care illustrates the significance of meso-level politics. For this reason, I have elected to redesign figure 5.2, as figure 7.2, illustrating the relationships between the interconnecting emergent themes within this study, with politics serving as the meta-theme.

Figure 7.2: The relationships between the themes



In addition to the interpersonal, intra-professional, inter-professional and inter-agency power dynamics between the various stakeholders and stakeholder groups within the FHP, and their capacity to shape the purpose and the trajectory of this innovation, politics was also evident at a macro-level. Rural issues were described by one informant as a *political hot potato*. The Countryside Alliance, a membership, subscription-funded, lobbying organisation, was established in 1997, and according to their website:

**“The Countryside Alliance works for everyone who loves the countryside and the rural way of life. Through campaigning, lobbying, publicity and education the Alliance influences legislation and public policy that impacts on the countryside, rural people and their activities.”
(The Countryside Alliance 2008)**

There was awareness within the project team that, through their lobbying activities, The Countryside Alliance had raised the political stakes with regard to the concerns of rural communities. The decision to focus the project on the health of farmers was, therefore, considered to be politically expedient. It was thought this probably gave the project a much higher national profile than it might have enjoyed and indeed it led to additional funding from the Countryside Agency specifically to support dissemination, and, potentially, encourage replication elsewhere. It did not, as hoped however, lead to funding from the Department of Environment, Food and Rural Affairs to sustain the project through indications within recent policy developments (as reported in chapter 5).

Equally, within *The Corner* there was strong evidence of power dynamics at individual and organisational levels. At a national level, the blanket implementation of policy with a lack of regard for local initiatives was considered particularly unhelpful.

Both of the cases of innovation examined in this study aimed to facilitate access to healthcare for people who were known to have physical and mental health problems. Access to healthcare was identified by policymakers as a key public concern and improving access to health services was, and still is, a public policy priority in England (Department of Health 1997; Department of Health 2007b) and in Scotland (The Scottish Office Department of Health 1997; The Scottish Office NHS Scotland 2003).

A critical examination of these policy positions suggests that there are a number of possible reasons why the government should choose to focus on access to healthcare. Firstly, by improving access, the government of the day can tangibly demonstrate its impact on health services and potentially win or

retain the support of the public. Leys (2001) has argued that, within the global economy, the political landscape is driven by the market, policy-making is sensitive to 'market sentiment' and state institutions are restructured to serve business interests, remodel internal operations along business lines and reduce Government exposure to political pressure from the electorate. Here, the economic well being of the country is the primary concern of the Government and the 'consumer is king'.

Untreated morbidity is known to have a negative impact on the economy. One of the assumptions underpinning the creation of the NHS was that by increasing access to healthcare, morbidity would be reduced (Klein 2001). The fiscal argument is that national productivity will be increased if morbidity is reduced and, as discussed above, endeavours to manage the nation's poor health serves the interests of the pharmaceutical industry. This in turn, serves the interests of the UK economy which in turn serves the interests of the Government and helps them to retain their political power.

Improving access to healthcare may, at face value, appear to be an altruistic, benign undertaking. By examining whose interests are served in specific endeavours to improve access, it may be possible to throw some light on what enables, drives and sustains such an innovation. Whilst rural issues were described as a political 'hot potato', particularly as a consequence of the activities of groups such as the Countryside Alliance, the reality is that the farming industry is an industry in decline in England and is no longer a significant contributor to the UK economy. Had the economic significance of the farming industry been greater, it is arguable that the FHP may have garnered stronger political support and its future may have been secured. *The Corner*, on the other hand, was driven from local concern within the overtly, highly politicised environment of the local authority, shared with the equally, but relatively covertly politicised health board, with the collective concern that the health and social care needs of young people were not being adequately addressed. With its long gestation period, matched funding arrangements and stable management group membership, *The Corner* enjoyed strong local

political support from the outset. It was also seeking to address a concern of national, not just local, significance.

Discussion of the similarities and differences between the two cases has illustrated a significant degree of political tension and influences at many levels. However, these tensions and influences were, in the main, hidden from the public face of these innovations. Indeed 'politics' appear to be hidden from the public face of innovations in general. Innovation in the organisation and management of health services is generally presented as a rational, ordered process. According to Buchanan and Badham:

"...political behaviour plays a more significant role in organizational life than is commonly recognised – or than is openly admitted. We...like to think of our social and organizational cultures as characterized by order, rationality and trust. The reality is different." (Buchanan & Badham 1999)

The uncovering of macro- meso- and micro-level politics in the analysis of these innovations supports this assertion. My thesis is that it is necessary to surface and acknowledge the political dimensions within innovations in order to understand the conditions in which they may flourish.

Chapter 8 Conclusions

8.1 Introduction

In this study, I have considered the conditions in which innovation in healthcare may flourish. It is the first, to my knowledge, to focus on innovation in health care from a CMS standpoint and, thus, offers an innovative contribution to the field. My starting point was a critical reflection of the assumption underpinning the orthodox scientific world-view, namely that innovation is the potential product of research and development. By taking the endpoint of this process - innovation - as the starting point for my study, I have examined two initiatives which have innovatively endeavoured to identify and address the health care needs of groups of people, who, as a routine, do not access mainstream health services. With the aim of looking beyond the traditional technical-rational perspective, I inductively applied a case study methodology in order to foreground processes of power and ideology, reveal sectional interests and question any assumptions and 'taken-for-granted' embodied therein. In order to contextualise my analysis and offer insight into the potential impact of national policy on local endeavours to develop innovative services, I coupled these data with an empirically-based assessment of the policy context. This approach served to reveal the differences between the rhetoric within Government policies and the reality of their implementation, and highlight the tensions and paradoxes therein.

From a CMS standpoint, my aim in this study is, as Reynolds (1999) states, to work towards an emancipatory ideal. Through the questioning of assumptions and the foregrounding of power and ideology, I aim to offer recommendations that can usefully inform policy makers and practitioners who innovatively seek to identify and address the health care needs of people who do not routinely access mainstream health services.

8.2 Were the aims achieved?

The orthodox, technical-rational view, where innovation is conceptualized as a rational, predictable and controllable endeavour, would appear to have a place, inasmuch as it supports the development of national standards. However, because it fails to recognise the socio-political complexity of innovation at an interpersonal, organisational and national level, I would suggest that the orthodox view is limited. Indeed, a lack of engagement with this complexity may be part of the reason that the potential of nationally defined standards to shape the provision of services locally has not been realised (Sheldon, Cullum, Dawson, Lankshear, Lawson, Watt, West, Wright, & Wright 2004).

8.3 Contribution to knowledge

In this study I have discussed the often hidden impact of micro-, meso- and macro-level politics on the potential of innovations in health care to flourish. Through analysing, comparing and contrasting two case studies of innovation, I have highlighted the role of interpersonal and organisational politics and the impact of national policy. By exploring the policy context, I have offered insights into why national policy and the methods of implementation may affect local endeavours to innovate.

8.4 Limitations of the study

Since the study was conceived, there have been significant developments in the involvement of service users in the research process, from study design through to the execution of social and health research (Williamson 2007). I see it as a limitation of this study that, as stated in chapter 7, I failed to engage people as informants who do not routinely access mainstream services other than the farmers who were actively involved in the strategic management of the FHP. I also wish I had been able to engage with some stakeholders who were accused by one informant of 'melting like the snow' when the intent to progress the FHP, for example, was formalised. A first-hand account of why these initial stakeholders distanced themselves from the

initiative would arguably have enriched my analysis. I would recommend that any future research on innovation addresses these issues.

My terms of engagement with informants in *The Corner* were negotiated differently in comparison with other case study informants and policymaker respondents in this study. This created an ethical dilemma that possibly could have been avoided had I thought through the consequences of allowing the process to proceed differently in this case. I would recommend that consistency in the process of negotiating the informed consent of potential informants is applied wherever possible.

8.5 In conclusion

The assumption that innovation, under the guise of modernisation, as a means of increasing efficiency and effectiveness, was a prerequisite to the future sustainability of the NHS (and indeed the Government) appeared to underpin Government reform. However, this push for innovation appears to be inhibited by the pull of the Governments' centralising tendencies, which, in turn, were fuelled by the highly politicised nature of the health care agenda. These included centrally, 'performance managed' demands for the implementation of nationally defined standards and evidence that national, some might argue, politically motivated, targets, were met. In addition, drives to redesign or 're-engineer' services, in order to increase efficiency and 'throughput', may cause labour process intensification that, in turn, may limit innovation capacity. In stating that the ends justified the means, the Third Way politics embraced by the UK and Scottish New Labour Governments appeared to assume a teleological ethical position. The problem with this position is that it denies the capacity of 'means' to produce unintended consequences. Policymaker respondents argued that the Governments' national targets created unintended consequences and this was confirmed in the literature.

This study would indicate that, if the National Health Service were genuinely to foster innovation, decision-making authority must be devolved so that priorities can be set and resources allocated locally. However, the political costs of the risks associated with localism may mean that Governments will continue to centralise and the innovation paradox will continue. Ultimately, it may be up to the public to decide whether they want a centrally-defined, commodified health service or a locally-defined, responsive service. However, to suggest this arguably creates a dualism. It oversimplifies the argument and leads to a false dichotomy. A compromise - a third way - may be a Health Service that adopts the best within these two positions and has balances and checks in place to prevent the domination of one (centralisation) at the expense of the other (localism). The evidence presented in this study would suggest that unchecked centralisation, particularly within the market governed NHS in England (see table 4.1), may stifle the capacity to flourish of innovations, which seek to identify and address local health need. Equally, absolute localism would inhibit the pooling of knowledge and expertise to create national standards, which in turn, may limit the capacity of a health service to commit resources locally to interventions that may be the most clinically- and cost-effective. This would suggest, that in order to foster innovation, UK Health Services need to merge the best of centralisation with the best of localism and put balances and checks in place to prevent the domination of one (centralisation) at the expense of the other (localism).

Innovation is clearly not an apolitical process and I would suggest that political engagement would appear to be a requirement for innovation to flourish. By contrasting two cases of innovation, I have illustrated the importance of achieving clarity and consensus with regard to the primary purpose of an innovation. I suggest that a lengthy 'pre-innovation' period may be necessary to ensure that all key stakeholders sign up to a shared primary purpose. Additionally, any new members of staff who join a project that is up-and-running should receive a comprehensive induction to the project.

In initiatives that seek to identify and address the health care needs of groups who do not routinely access mainstream services, it would appear imperative

that these groups of people are authentically engaged in the process from the outset. Lack of authentic engagement may otherwise lead to the development of a service based more on professional priorities than on the priorities of the community in question, as was argued in the analysis of the case of the FHP. The nurse academic on the FHP proposed that the coupling of his goal of a NP-led service with the aim of improving the health of farmers was a win-win situation. However, I have argued that the 'means', that is a NP-led service, appeared at times to be to be the primary goal, forcing the 'ends', namely the health of the farmers into second place. In contrast to the teleological ethic of the Third Way, discussed above, where the ends are considered to justify the means, in this case a deontological ethic appeared to be assumed where the means are thought to justify the ends. This interpretation offers a possible rationale for the fundamental differences between the stakeholders and a route of some of the tension within the project. It also further serves to highlight the importance of achieving clarity of purpose from the outset.

The purchase and maintenance of the van in the FHP served to illustrate the capacity that untested assumptions about what would, and would not, be culturally sensitive, can lead to expenditure that could possibly be avoided or invested elsewhere more effectively. In *The Corner*, on the other hand, young people appeared to be firmly at the centre of the project and fully engaged with the development and the delivery of the service. Without critical analysis of decision-making processes, however, systems, set up to protect the public, such as research ethics committees and professional regulatory bodies, have ironically been shown to have the capacity to conspire against authentic engagement with the community whose health care needs these innovations sought to address. In short, without the authentic engagement of these stakeholders, innovations risk their design and delivery being based on assumptions, with no means of checking them out. Further, the silencing of certain, less traditionally powerful voices risks the marginalisation of alternative proposals before they even reach the agenda.

When engaged authentically, stakeholders have a voice, which, if necessary, is heard by using unorthodox, creative means. Only then can their concerns

be recognised and treated as paramount. Indeed, the authentic engagement of all stakeholders directly affected by decision-making processes would appear to be essential, if innovations that endeavour to minimise the perceived negative impact of a traditional hegemony are to avoid replacing one type of hegemony with another, for example, replacing a professional power base with a managerial one. From my critical, emancipatory standpoint, I would argue that whenever possible they should. All staff, irrespective of their traditional status, should be afforded the opportunity to engage in the regular review of operational policies and procedures to which they are expected to adhere.

There would appear to be unequivocal evidence that innovation was a risky and unsettling business, shrouded in uncertainty. Agents who engage in innovation would seem to have to be prepared to take personal risks, be reflective and reflexive, amenable to challenge, and willing to challenge others openly. Without this human capacity and organisational culture, there may be a lack of clarity about the roles and contributions of each member of a project team. Consequently, criticisms may not always be recognised as constructive and perceptions may be harboured that vested interests are being served. Traditionally powerful people, such as professionals and managers, may find the legitimacy of their power bases questioned and their professional safety nets, or other aspects of their authority, openly challenged. Hence, innovation can be disruptive for all concerned.

It would appear useful to couple clarity of focus with a willingness to question, systematically, whose interests are served by any proposal and if those interests are 'legitimate'. In the FHP, the legitimacy of spending time and effort to progress nurse prescribing was not challenged. The legitimacy of the position of the chair of the research ethics committee on cold calling remained unchallenged. It took the crisis of Foot and Mouth before the legitimacy of the proposals offered by the project nurse who was not an NP came into focus. Here, evidence of a proposal's potential contribution to the agreed focus, the primary purpose of an innovation, could help to assess its 'legitimacy'. Arguably, this was the position held by policymakers with a leaning towards a

'corporate' assessment of the legitimacy of an innovation (figure 3.3) discussed in chapter 3, which highlights the potential of any screening process, such as the one at Xerox described in chapter 4, to stifle innovation. Thus, the potential impact of a decision taken at any stage throughout the process of an innovation should not be underestimated. Indeed, it may be a 'critical incident'. This study would suggest that there should be a considered analysis of the socio-political consequences of each potential course of action (or inaction) that has the potential to shape the trajectory of an innovation. In order to be transparent and open to scrutiny, that analysis should incorporate a stakeholder mapping, perhaps similar to those presented in figures 5.1 and 6.2, with the primary focus placed clearly and firmly at the focal point. This may serve to remind stakeholders of their collective purpose, and help to inform their decision-making. Illustrating the structural, organisational and cultural differences that have the capacity to fuel micro-politics, a stakeholder analysis can also facilitate open and frank discussion about the potential of vested interests to undermine the primary purpose of an innovation.

Arguably, this principle could apply in the case of a local innovation or a policy driven innovation. For example, a stakeholder analysis may have demonstrated that the initiative taken by the health visitor and her colleagues, cited in the FHP analysis, working in partnership with 'farmers' wives', was in the interests of the local farming community. Equally, a stakeholder analysis may have demonstrated to policymakers in Scotland, seeking to reduce the incidence of teenage pregnancies, the contribution *The Corner* was making in this area. Perhaps, then they would have been in a position to invest in *The Corner* or channel additional investment into areas of unmet need rather than potentially duplicate services.

Within *The Corner*, this clarity of focus was coupled from the outset by a cohesive and committed management team, strong, value-driven leadership and a dedicated project team. In contrast, the FHP sat on the margins of a health care system that was subject to permanent revisionism and the sequential, structural changes that ensued. This appeared to be part of the reason the FHP failed to find champions within the various systems it

impacted on and failed to achieve integration with, and be sustained by, the system. This would indicate that engagement in meso-level political processes at the outset of an innovation may be necessary to sustain it. However, this may prove close to impossible in a system that offers no continuity of personnel in key positions. The Government must recognise that permanent revisionism does not appear to create an environment where innovation can be supported and nurtured.

Innovation clearly needs investment. However, there was a tendency for innovations to be investment-led rather than needs-led. This practice serves to undermine the primary stakeholders of innovations aiming to address the health needs of people who do not routinely engage in, or have any influence over, service provision. Therefore, efforts should be made to ensure that, wherever possible, innovations are needs-led rather than funding-led.

Innovation is a dynamic process and evaluation and feedback was shown to be a useful mechanism for sustaining vibrancy within *The Corner*. Evaluation was also used successfully here as a tool to ensure that the service provided, and any new developments, were in keeping with the needs and concerns of the young people - the primary stakeholders in the initiative.

In conclusion, my thesis is that it is necessary to surface, acknowledge and engage with the political dimensions of innovations in order to understand the conditions in which they may flourish.

References

- Abrahms, F. They just wanted a scapegoat. *The Guardian* 31st May. 2002.
- Allison, G. T. & Zelikow, P. 1999, *Essence of decision: Explaining the Cuban missile crisis* Adison Wesley Longman, New York.
- Alvesson, M. & Willmott, H. 1996, *Making Sense of Management. A Critical Introduction* Sage, London.
- Alvesson, M. & Deetz, S. 2000, *Doing critical management research* Sage, London.
- Anderson, E., Shepherd, M., & Salisbury, C. 2006, "'Taking off the suit': engaging the community in primary care decision making", *Health Expectations*, vol. 9, pp. 70-80.
- Anderson, H., Scarffe, H., Lambert, M., Smith, D. B., Chann, C. C., Chadwick, G., McMahon A, Chang, J., Crowther, D., & Swindell, R. 1987, "VAD chemotherapy - toxicity and efficacy - in patients with multiple myeloma and other lymphoid malignancies", *Haematological Oncology*, vol. 5, no. 3, pp. 213-222.
- Angelides, P. 2001, "The development of an efficient technique for collecting and analyzing qualitative data: the analysis of critical incidents", *Qualitative Studies in Education*, vol. 14, no. 3, pp. 429-442.
- Bachrach, P. & Baratz, M. S. 1962, "The two faces of power", *American Political Science Review*, vol. 56, pp. 947-952.
- Bachrach, P. & Baratz, M. S. 1963, "Decisions and non-decisions: an analytical framework", *American Political Science Review*, vol. 57, pp. 641-651.
- Bachrach, P. & Baratz, M. S. 1970, *Power and poverty. Theory and practice* Oxford University Press, Oxford.
- Barber, M. 2007, *Instruction to Deliver. Tony Blair, Public Services and the Challenge of Achieving Targets* Politico's, London.
- Barley, S. R. a. K. G. 1992, "Design and Devotion: Surges or Rational and Normative Ideologies of Control in Managerial Discourse", *Administrative Science Quarterly*, vol. 37, no. 3, pp. 363-399.
- Benner, P. 2001, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* Prentice-Hall, New Jersey.

- Bolton, S. C. 2004, "A Simple Matter of Control? NHS Hospital Nurses and New Management", *Journal of Management Studies*, vol. 41, no. 2, pp. 317-333.
- Booth, A. 2006, "Critical Appraisal of the Evidence," in *The Research Process in Nursing*, K. Gerrish & A. Lacey, eds., Blackwell Publishing, Oxford, pp. 107-122.
- Booth, N., Briscoe, M., & Powell, R. 2000, "Suicide in the farming community: methods used and contact with health services", *Occupational and Environmental Medicine*, vol. 57, no. 9, pp. 642-644.
- Buchanan, D. 2003, *Why innovate?: the evidence base*, Modernisation Agency, Leicester.
- Buchanan, D. & Badham, R. 1999, *Power, Politics and Organizational Change* Sage, London.
- Burnett, T. 2000, "How we improved farmers' health", *General Practitioner* no. July 21, p. 38.
- Burnett, T. Injuries on Farms. Observations in the Lune Valley 1981-1991. 2001. Unpublished Work
- Burnett, T. & Mort, M. 2001, *Improving Access to Healthcare for Farming Communities. "The Farmers' Health Project"*, Institute for Health Research, Lancaster University, Lancaster, Report to NHS Executive (North West) of Project RDF/LSC/99/0037.
- Burnett, T., Mort, M., Walsh, M., & Easterlow, P. Improving access to health care for farming communities. 1-18. 1998. NHS Executive North West, R&D Directorate R&D Fund Full application form.
- Butler, J. 1992, *Patients, Politics and Policies: Before and after Working for Patients* Open University Press, Milton Keynes.
- Carter, J. 2000, "New public management and equal opportunities in the NHS", *Critical Social Policy*, vol. 20, no. 1, pp. 61-83.
- Centre for Change and Innovation. Centre for Change and Innovation Statement of Purpose. http://cci.scot.nhs.uk/cci/cci_sub_change_panel.jsp . 2002.
- Chapman, J., Zechel, A., & Carter, Y. 2004, "Systematic review of recent innovations in service provision to improve access to primary care", *British Journal of General Practice*, vol. 54 , no. 502, pp. 374-381.
- Chief Area Medical Officer 1990, *Public Health Matters in Tayside*, Tayside Health Board, Dundee.

- Christensen, C. M., Bohmer, R., & Kenagy, J. 2000, "Will disruptive innovations cure health care?", *Harvard Business Review*, vol. 78, no. 5, pp. 102-112.
- Clarke, J. & Newman, J. 1997, *The Managerial State* Sage, London.
- Clegg, S. R. 1989, *Frameworks of Power* Sage, London.
- Cole, E. B. 1993, *Philosophy and Feminist Criticism* Paragon House, New York.
- Cutcliffe, J. R. & McKenna, H. P. 1999, "Establishing the credibility of qualitative research findings: the plot thickens", *Journal of Advanced Nursing*, vol. 30, no. 2, pp. 374-380.
- Cutcliffe, J. R. & McKenna, H. P. 2004, "Expert qualitative researchers and the use of audit trails", *Journal of Advanced Nursing*, vol. 45, no. 2, pp. 126-133.
- D'Andrade, H. A. 1999, "The Golden Age of Medicine", *Vital Speeches of the Day*, vol. 66, no. 5, pp. 142-145.
- Dahl, R. A. 1957, "The concept of power", *Behavioral Science*, vol. 2, pp. 201-205.
- Dahl, R. A. 1961, *Who governs? Democracy and power in an American city* Yale University Press, London.
- Darby, M.-A., Lam, B., & McMahon, A. 1991 "An evaluation of the respite care services at a hospital for the elderly", Royal College of Nursing Research Advisory Group, ed., Royal College of Nursing, London.
- Darwin, C. 1872, *The origin of species by means of natural selection, or the preservation of favoured races in the struggle for life* John Murray.
- Davies, J., Mort, M., & Stead, V. 2000, *The organisation of primary care for mental health services in East Lancashire and Morecambe Bay Health Authority*, Lancaster University Management School, Lancaster, HRA 7408.
- Delamothe, T. 1995, "Margaret Beckett's third way: cooperation and partnership", *British Medical Journal*, vol. 311, pp. 13-14.
- Department for Environment Food and Rural Affairs 2000, *Our Countryside: The Future A Fair Deal for Rural England*, The Stationery Office, London.
- Department of Health 1990, *The NHS and Community Care Act*, HMSO, London.
- Department of Health 1991a, *Research for Health: A Research and Development Strategy for the NHS in England*, HMSO, London.
- Department of Health 1991b, *The Patient's Charter*, HMSO, London.

Department of Health 1993, *Report of the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting*, Department of Health, London.

Department of Health 1997, *The New NHS. Modern. Dependable*, The Stationery Office, London.

Department of Health 1999, *National service framework for mental health: modern standards and service models*, Department of Health, London, HSC 1999/223.

Department of Health 2003, *A Short Guide to NHS Foundation Trusts*, Department of Health, London.

Department of Health 2004a, *Agenda for Change: Final Agreement*, Department of Health, London.

Department of Health 2004b, *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process*, Department of Health, London.

Department of Health 2006, *Research Governance Framework for Health and Social Care*, Department of Health, London.

Department of Health. European Working Time Directive.
<http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/WorkingDifferently/EuropeanWorkingTimeDirective/fs/en> . 5-3-2007a. 5-3-2007a.

Department of Health 2007b, *Our NHS Our future: NHS next stage review - interim report*, Department of Health, London.

Department of Health. The Essence of Care: Patient-focused benchmarking for health care practitioners.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4005475&chk=A0A4iz . 4-3-2007c. Department of Health . 4-3-2007c.

DTI 2000, *Excellence and Opportunity. A Science and Innovation Policy*, DTI, London.

DTI 2002, *Investing in Innovation; A strategy for science engineering and technology*, DTI, London.

Easton, P. 1997, *Evaluation of The Corner Young People's Health and Information Service*, Tayside Public Health Medicine Services, Dundee.

Edwards, R. 1979, *Contested terrain; the transformation of the workforce in the twentieth century* Basic Books, New York.

Ekvall, G. 1996, "Organizational Climate for Creativity and Innovation", *European Journal of Work and Organizational Psychology*, vol. 5, no. 1, pp. 105-123.

- Elliott, L. 2001 "Health outreach for socially excluded young people", Royal College of Nursing, London.
- ESRC 2005, *Research Ethics Framework*, Economic and Social Research Council, Swindon.
- Evans, J. 2004, "Men nurses: a historical and feminist perspective", *Journal of Advanced Nursing*, vol. 47, no. 3, pp. 321-328.
- Faugier, J. & Sargeant, M. 1997, "Sampling hard to reach populations", *Journal of Advanced Nursing*, vol. 26, no. 4, pp. 790-797.
- Fayol, H. 1949, *General and Industrial Management* Pitman, London.
- Ferlie, E., Ashburner, L., Fitzgerald, L., & Pettigrew, A. 1996, *The new public management in action* Oxford University Press, Oxford.
- Finlayson, A. 1999, "Third Way Theory", *The Political Quarterly*, vol. 70, no. 3, pp. 271-279.
- Fournier, V. & Grey, C. 2000, "At the critical moment: Conditions and prospects for critical management studies", *Human Relations*, vol. 53, no. 1, pp. 7-32.
- Freedman, D. H. 1992, "Is management still a science?", *Harvard Business Review*, vol. November-December, p. 26.
- Gabe, J., Kelleher, D., & Williams, G. 1994, *Challenging Medicine* Routledge, London.
- Gerrard, C. 1995, *Farmers' occupational health: a case of policy set aside?*, PhD, Lancaster University.
- Gerrard, C. 1998, "Farmers' occupational health: cause for concern, cause for action.", *Journal of Advanced Nursing*, vol. 28, no. 1, pp. 155-163.
- Giddens, A. 1998, *The Third Way* Polity, Cambridge.
- Gilligan, C. 1993, *In a different voice. Psychological theory and women's development* Harvard University Press, London.
- Gramsci, A. 1971, "Selections form the Prison Notebooks of Antonio Gramsci," Q. Hoare & G. Nowell Smith, eds., Lawrence and Wishart, London.
- Gray, J. A. M. 2001, *Evidence-Based Health Care: How to Make Health Policy and Management Decisions* Churchill Livingstone, Edinburgh.
- Great Britain Parliament 1946, *The National Health Service Act*, HMSO, London.

- Greenhalgh, T., Robert, G., Bate, P., Macfarlane, F., & Kyriakidou, O. 2005, *Diffusion of Innovations in Health Service Organisations. A systematic literature review* Blackwell Publishing Ltd, Oxford.
- Greer, S. L. 2004, *Four Way Bet: How devolution has led to four different models in the NHS*, The Constitution Unit, University College London, London.
- Griffiths, R. 1983, *NHS Management Inquiry: Report to the Secretary of State for Social Services*, Department of Health and Social Security, London.
- Griffiths, R. 1988, *Community Care: Agenda for Action*, HMSO, London.
- Grimshaw, J. M., Thomas, R. E., MacLennan, G., Fraser, C., Ramsay, C. R., Vale, L., Whitty, P., Eccles, M. P., Matowe, L., Shirran, L., Wensing, M., Dijkstra, R., & Donaldson, C. Effectiveness and efficiency of guideline dissemination and implementation strategies. 8[6]. 2004. Southampton, Health Technology Assessment.
- Guinet, J. & Pilat, D. 1999, "Organisation for Economic Cooperation and Development", *The OECD Observer* no. 217/218, pp. 63-65.
- Gulland, A. 2003, "NHS staff cheat to hit government targets, MPs say", *British Medical Journal*, vol. 327, no. 7408, p. 179.
- Ham, C. 1997, *Management and Competition in the NHS* Radcliffe Medical Press, Oxford.
- Ham, C. 1999, *Health Policy in Britain*, 4th edn, Palgrave, Basingstoke.
- Harding, N. & Learmonth, M. 2000, "Thinking critically: The case for health policy research", *Technology Analysis and Strategic Management*, vol. 12, no. 3, pp. 335-341.
- Hardy, C. & Clegg, S. R. 1996, "Some Dare Call It Power," in *Handbook of Organization Studies*, S. R. Clegg, C. Hardy, & W. R. Nord, eds., Sage, London, pp. 622-640.
- Harrison, S. 1998a, "Evidence-based medicine in the National Health Service: towards the history of a policy," in *Fifty Years of the National Health Service: Continuities and Discontinuities in Health Policy*, R. Skelton & V. Williamson, eds., University of Brighton, Brighton, pp. 72-86.
- Harrison, S. 1998b, "The politics of evidence based medicine in the United Kingdom", *Policy & Politics*, vol. 26, no. 1, pp. 15-31.
- Harrison, S. 1999, "Clinical autonomy and health policy: past and futures," in *Professionals and the New Managerialism in the Public Sector*, M. Exworthy & S. Halford, eds., Open University Press, Buckingham.

Harrison, S., Moran, M., & Wood, B. 2002, "Policy emergence and policy convergence: the case of 'scientific-bureaucratic medicine' in the United States and the United Kingdom", *British Journal of Politics and International Relations*, vol. 4, no. 1, pp. 1-24.

Healthcare Commission. About the Healthcare Commission.
<http://www.healthcarecommission.org.uk/Homepage/fs/en> . 2005.
Commission for Healthcare Audit and Inspection.

Henderson, S. & Peterson, A. 2002, *Consuming Health. The commodification of health care* Routledge, London.

Hewison, A. 1999, "Evidence based medicine: what about evidence based management?", *Journal of Nursing Management*, vol. 5, no. 4, pp. 195-198.

Hindess, B. 1996, *Discourses of Power. From Hobbes to Foucault* Blackwell Publishers, Oxford.

Hirschman, A. O. 1970, *Exit, Voice and Loyalty* Harvard University Press, London.

HM Treasury, Department of Trade and Industry, & HM Customs 2005, *Supporting Growth in Innovation: Enhancing the R&D Tax Credit*, HM Treasury, London.

Hoggett, P. 1996, "New modes of control in the public service", *Public Administration*, vol. 74, no. Spring, pp. 9-32.

Hoque, K., Davis, S., & Humphreys, S. 2004, "Freedom to do what you are told: Senior Management Team Autonomy in an NHS Acute Trust", *Public Administration*, vol. 82, no. 2, pp. 355-375.

House of Lords Select Committee on Science and Technology 1988, *Priorities in Medical Research*, HMSO, London.

Hull, R. & Kaghan, W. N. 2000, "Innovation - But for Whose Benefit, For What Purpose?", *Technology Analysis and Strategic Management*, vol. 12, no. 3, pp. 317-325.

Illich, I. 1995, *Limits to Medicine: Medical Nemesis - The Expropriation of Health* Marion Boyars, London.

Ingram, R. 1999, "The Pharmaceutical industry: Creating health instead of treating disease", *Vital Speeches of the Day*, vol. 65, no. 7, pp. 213-218.

Jackson, S., McMahon, A., & Cage, R. 1993, "Prevention and Management of Pressure Sores", *British Journal of Nursing*, vol. 2, no. 13, pp. 672-677.

Johnson, M. 2007, "The theoretical and social context of research ethics," in *Research Ethics in the Real World*, T. Long & M. Johnson, eds., Churchill Livingstone Elsevier, Edinburgh, pp. 29-46.

Johnstone, C. & McWilliams, C. 2005, "Urban policy and the city in the 'new' Scotland," in *Exploring Social Policy in the 'New' Scotland*, G. Mooney & G. Scott, eds., The Policy Press, Bristol.

Jones, C. & Lyons, C. 2004, "Case Study: Design? Method? Or comprehensive strategy?", *Nurse Researcher*, vol. 11, no. 3, pp. 70-76.

Kanigel, R. 1997, *The One Best Way: Frederick Winslow Taylor and the Enigma of Efficiency* Little Brown and Company, London.

Kanter R, M. 1992, *The Change Masters: Corporate Entrepreneurs at Work* Routledge, London.

Kelleher, D., Gabe, J., & Williams, G. 1994, "Understanding medical dominance in the modern world," in *Challenging Medicine*, J. Gabe, D. Kelleher, & G. Williams, eds., Routledge, London.

Kelly, M. & Glover, I. 1996, "In search of health and efficiency: the NHS 1948-94," in *Beyond Reason? National Health Service and the Limits of Management*, J. Leopold, M. Glover, & M. Hughes, eds., Avebury, Aldershot.

Kelly, S. C. J. a. J. R. 1995, "Suicide deaths in England and Wales 1982-92: The contribution of occupation and geography.", *Population Trends*, vol. 80, pp. 16-25.

Kernick, D. 2004, *Complexity and Healthcare organization* Radcliffe Medical Press, Oxford.

Kirkpatrick, I., Ackroyd S, & Walker, R. 2005, *The New Managerialism and the Public Sector Professions* Palgrave Macmillan, Basingstoke.

Klein, R. 2001, *The new politics of the NHS*, 4th edn, Longman, Harlow.

Klein, R. & Rafferty, A. M. 1999, "Rorschach Politics. Tony Blair and the Third Way", *The American Prospect*, vol. 10, no. 45, pp. 44-50.

Klein, R. 2004, "The first wave of NHS foundation trusts", *British Medical Journal*, vol. 328, no. 7452, p. 1332.

Klein, R. & Maynard, A. 1998, "On the way to Calvary", *British Medical Journal*, vol. 317, no. 7150, p. 5.

Knights, D. 2005, "Changing Spaces: The Disruptive Impact of a New Epistemological Location for the Study of Management," in *Critical Management Studies*, C. Grey & H. Willmott, eds., Oxford University Press, Oxford, pp. 107-131.

Knowledge and Innovation Group. The Modernisation Agency.
<http://www.modern.nhs.uk> . 2004. 8-8-2006.

Kuhn, T. S. 1996, *The Structure of Scientific Revolutions*, 3rd edn, Chicago University Press, Chicago.

- Labour Party. *New Labour because Britain deserves better*. 1997. London, Labour Party.
- Laing, W. 1990, *Laing's Review of Private Health Care 1990/91*, Laing-Buisson Publications Ltd., London.
- Lambert, M., Chadwick, G., McMahon A, & Scarffe, H. 1988, "Experience with the portacath", *Haematological Oncology*, vol. 6, pp. 57-63.
- Le Fanu, J. 1999, *The Rise and Fall of Modern Medicine* Little, Brown and Company (UK), London.
- Leadbeater, C. 1988, "Power to the Person", *Marxism Today* pp. 14-19.
- Learmonth, M. 2001, "Making health services management research critical", *Sociology of health and illness*, vol. 25, no. 1, pp. 93-119.
- Learmonth, M. & Harding, N. 2004, *Unmasking Health Management* Nova Science Publishers, Inc, New York.
- Lewin, K. 2000, "Action Research and minority problems", *Journal of Social Issues*, vol. 2, pp. 34-46.
- Leys, C. 2001, *Market Driven Politics. Neoliberal Democracy and the Public Interest* Verso, London.
- Lukes, S. 2005, *Power. A radical view*, 2nd edn, Palgrave Macmillan, Basingstoke.
- Lynch, J. 2004, "Foucault on targets", *Journal of Health Organisation and Management*, vol. 18, no. 2, pp. 128-135.
- Mackway-Jones, K. 2006, *Emergency triage* Blackwells, Oxford.
- Marx, K. 1995, *Capital an abridged edition* Oxford University Press, Oxford.
- Maslow, A. 1970, *Motivation and Personality* Harper & Row, New York.
- Maybin, J. 2007, *Professional regulation*, Kings Fund, London.
- Mayo, E. 1945, *The Social Problems of an Industrial Civilisation* Ayer, New Hampshire.
- McFarlane, J. K. 1970, *The proper study of the nurse: an account of the first two years of a research project "The study of nursing care", including a study of the relevant background literature.*, Royal College of Nursing, London, Series 1 Introduction.
- McGregor, D. 1960, *The human side of enterprise* McGraw-Hill, New York.

McMahon, A. 1989a "A study of anticipatory nausea and vomiting in cancer patients receiving cytotoxic chemotherapy", 5th European Conference on Cancer Nursing, London.

McMahon, A. Cognitive therapy skills in oncology nursing. Monograph Number 2. 1989b. University of Manchester. Good Practices in Community Nursing.

Ref Type: Serial (Book, Monograph)

McMahon, A. 1997, "Implications for Nursing for the NHS R&D Funding Policy", *Nursing Standard*, vol. 28, no. 11, pp. 44-48.

McMahon, A. 2002, "Let's get critical!", *NT Research*, vol. 7, no. 5, pp. 322-323.

McMahon, A. 1998, "Developing Practice through Research," in *Research and Development in Clinical Nursing Practice*, B. Roe & C. Webb, eds., Whurr Publishers Ltd., London, pp. 219-246.

McMahon, A. A cultural analysis of the healthcare R&D business. 1999. Unpublished Work

Medawar, P. B. 1969, *The Art of the Soluble* Penguin Books, Harmondsworth.

Metzl, J. M. 2007, "Medicalisation in the 21st century: Introduction", *Lancet*, vol. 369, pp. 697-698.

Meyer, J. & Batehup, L. 1997, "Action research in health care practice: Nature, present concerns and future possibilities", *NT Research*, vol. 2, no. 3, pp. 175-184.

Miles, M. B. & Huberman, A. M. 1984, *Qualitative data analysis: A sourcebook of new methods* Sage, Newbury Park, California.

Miller, A. 1996, *Insights of Genius: Imagery and Creativity in Science and Art* Copernicus, New York.

Morriss, P. 2002, *Power. A philosophical analysis* Manchester University Press, Manchester.

Moynihan, R. 2003, "The making of a disease: female sexual dysfunction", *British Medical Journal* no. 326, pp. 45-47.

Moynihan, R., Heath, I., & Henry, D. 2002, "Selling sickness: the pharmacological industry and disease mongering", *British Medical Journal* no. 324, pp. 886-891.

Mulgan, G. & Albury D 2003, *Innovation in the Public Sector*, Cabinet Office, London, v 1.9.

NHS 2003, *Modern Matrons Improving the Patient Experience*, Department of Health, London.

- NHS Executive. Clinical Governance in the New NHS. 1999. Leeds, Health Service Circular, HSC 1999/065.
- Nightingale, F. 1859, *Notes on Nursing, what it is and what it is not*. Harrison, London.
- Nursing and Midwifery Council 2002a, *Code of Professional Conduct*, Nursing and Midwifery Council, London.
- Nursing and Midwifery Council 2002b, *Guidelines for records and record keeping*, Nursing and Midwifery Council, London.
- Oakley A (1981) "Interviewing women: a contradiction in terms" in *Doing Feminist Research*, Roberts, H, ed., Routledge, London.
- O'Reilly, C. & Tushman, M. L. 1997, "Using culture for Strategic Advantage: Promoting Innovation Through Social Control," in *Managing Strategic Innovation and Change*, M. Tushman & P. Anderson, eds., Oxford University Press, Oxford.
- Parker, M. 2004, "Structure, Culture and Anarchy: Ordering the NHS," in *Unmasking Health Management: A Critical Text*, M. Learmonth & N. Harding, eds., Nova Science Publishers, New York, pp. 171-185.
- Parker, M. & Dent, M. 1996, "Managers, Doctors and Culture", *Administration and Society*, vol. 28, no. 3, pp. 335-361.
- Paton, C. R. 1999, "Books: Evidence-Based Medicine. Evidence-Based Health Care: How to Make Health Policy and Management Decisions", *British Medical Journal*, vol. 318, no. 7177, p. 201.
- Patton, M. Q. 1990, *Qualitative evaluation and research methods* Sage, Newbury Park, California.
- Payer, L. 2004, *Disease-Mongers: How Doctors, Drug Companies, and Insurers are Making You Feel Sick* John Wiley & Sons, Indianapolis.
- Peters, T. & Waterman, R. H. 2004, *In Search of Excellence: lessons from America's best run companies* Profile, London.
- Plesk, P., Godfrey-Harris, L., Mayer, L., & Buchanan, D. 2003, *The Healthcare Innovation Toolkit. How to generate and implement creative ideas for service improvement*, NHS Modernisation Agency, Leicester.
- Plsek, P. E. & Greenhalgh, T. 2001, "Complexity science: The challenge of complexity in health care", *British Medical Journal*, vol. 323, no. 7313, pp. 625-628.
- Plsek, P. E. & Wilson, T. 2001, "Complexity science: Complexity, leadership, and management in healthcare organisations", *British Medical Journal*, vol. 323, no. 7315, pp. 746-749.

- Pollitt, C. 1991, *The politics of quality: managers, professionals and consumers in the public services* Royal Holloway and Bedford New College, Egham.
- Pollitt, C. 1993, *Managerialism and the public services* Blackwell, Oxford.
- Price, L. M. & Evans, N. J. 2005, "Work and worry: Revealing Farm Women's Way of Life ," in *Critical Studies in Rural Gender Issues (Perspectives on Rural Policy and Planning)*, J. Little & C. Morris, eds., Ashgate, Aldershot, pp. 45-59.
- Procter, S. & Allan, T. 2006, "Sampling," in *The Research Process in Nursing*, K. Gerrish & A. Lacey, eds., Blackwell Publishing, Oxford, pp. 173-191.
- Rafferty, A. M., Newell, R., & Traynor, M. 2002, "Nursing and midwifery research in England: Working towards establishing a dedicted fund", *NT Research*, vol. 7, no. 4, pp. 243-254.
- Reason, P. 1988, "Three Approaches to Participative Inquiry," in *Strategies of Qualitative Inquiry*, N. K. Denzin & Y. S. Lincoln, eds., Sage, Thousand Oaks.
- Reason, P. & Rowan, J. 1981, *Human Inquiry. A sourcebook of new paradigm research* John Wiley & Sons, Chichester.
- Redman, J. 1992, *A young person's health project. What do young people want in Dundee?*, Tayside Health Education Centre, Dundee.
- Reynolds, M. 1999, "Grasping the Nettle: Possibilities and Pitfalls of a Critical Management Pedagogy", *British Journal of Management*, vol. 9, pp. 171-184.
- Ritchie, J. & Spencer, L. 1994, "Qualitative Data Analysis for Applied Policy Research," in *Analyzing Qualitative Data*, A. Bryman & R. G. Burgess, eds., Routledge, London, pp. 173-194.
- Ritchie, J., Spencer, L., & O'Connor, W. 2003, "Carrying out Qualitative Analysis," in *Qualitative Research in Practice*, J. Ritchie & J. Lewis, eds., Sage, London, pp. 219-262.
- Robson, C. 1993, *Real World Research* Blackwell.
- Rothschild, L. 1971, *The organisation and management of government research and development*, HMSO, London , Cmnd 4814.
- Royal College of Nursing 2002, *Nurse practitioners - an RCN guide to the nurse practitioner role, competencies and programme accreditation*, Royal College of Nursing, London.
- Sackett, D. L. 1986, "Rules of evidence and clinical recommendations on the use of antithrombotic agents", *Archives of Internal Medicine*, vol. 146, pp. 464-465.

- Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. 1996, "Evidence based medicine: what it is and what it isn't", *British Medical Journal*, vol. 312, no. 7023, pp. 71-72.
- Sandelowski, M. 1993, "Rigor or rigor mortis: The problem of rigor in qualitative research revisited", *Advances in Nursing Science*, vol. 16, no. 2, pp. 1-8.
- Schmidt, U. 2007, *Karl Brandt - The Nazi Doctor: Medicine and Power in the Third Reich* Continuum, London.
- Secretaries of State for Health, W. N. I. a. S. 1989a, *Caring for people: community care in the next decade and beyond*, HMSO, London.
- Secretaries of State for Health, W. N. I. a. S. 1989b, *Working for Patients*, HMSO, London, CM 555.
- Secretaries of State for Social Services and others 1987, *Promoting better health: the Government's programme for improving primary health care*, HMSO, London.
- Senge, P. 1999, *The Dance of Change*, Nicholas Brealey Publishing Ltd, London.
- Sheldon, T. A., Cullum, N., Dawson, D., Lankshear, A., Lowson, K., Watt, I., West, P., Wright, D., & Wright, J. 2004, "What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews", *British Medical Journal*, vol. 329, no. 7473, pp. 999-1007.
- Smith, R. 1991, "Filling the lacunae between research and practice: an interview with Michael Peckham", *British Medical Journal*, vol. 307, pp. 1403-1407.
- Spinoza, B. d. 1958, "Tractatus Politicus," in *The Political Works*, Wernham A.G., ed., Clarendon Press, Oxford.
- Stacey, R. 1992, *Managing Chaos*. Kogan Page.
- Stacey, R. 1996, *Strategic Management and Organisational Dynamics* Financial Times Pitman Publishing, London.
- Stake, R. E. 1995, *The art of case study research* Sage, London.
- Stake, R. E. 1998, "Case Studies," in *Strategies of Qualitative Inquiry*, N. K. Denzin & Y. S. Lincoln, eds., Sage, London, pp. 86-109.
- Taylor, F. W. 1911, *Principles and methods of scientific management* Harper and Brothers, New York.
- The Anderson Inquiry 2002, *Foot and Mouth Disease 2001: Lessons to be Learned Inquiry*, The Stationary Office, Norwich.

The Bristol Royal Infirmary Inquiry 2001, *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995*, The Bristol Royal Infirmary Inquiry, Bristol, Command Paper: CM 5207.

The Corner Young People's Health and Information Service 2001, *Guidelines for care and protection of children and young people*, The Corner Young People's Health and Information Service, Dundee.

The Countryside Alliance. The Countryside Alliance. <http://www.countryside-alliance.org/> . 2008. 7-3-2008.

The Scottish Office Department of Health 1997, *Designed to care. Renewing the National Health Service in Scotland*, The Stationery Office, Edinburgh.

The Scottish Office NHS Scotland 2003, *Partnership for Care. Scotland's Health White Paper*, The Stationery Office, Edinburgh.

Thompson, D. R. 2000, "An exploration of knowledge development in nursing - a personal perspective", *NT Research*, vol. 5, no. 5, pp. 391-394.

Titchen, A. 1994, "Action research: a strategy for theory generation and testing", *International Journal of Nursing Studies*, vol. 31, no. 1, pp. 1-12.

Trahair, R. C. S. 1985, *The Humanist Temper: The Life and Work of Elton Mayo* Transaction Publishers.

Traynor, M. 1999, *Managerialism and Nursing. Beyond oppression and profession* Routledge, London.

Vallery, N. 1999, "Innovation in industry: Adopting orphans", *The Economist*, vol. 350, no. 8107, p. S21-S22.

Walsh, M. 1997, "How nurses perceive barriers to research implementation", *Nursing Standard*, vol. 11, no. 29, pp. 34-39.

Walsh, M. 2000a, "A Nurse Practitioner-led Farmers' Health Service: setting up and evaluating a UK project", *Australian Journal of Rural Health*, vol. 8, pp. 214-217.

Walsh, M. 2000a, "Country Life", *Nursing Standard*, vol. 14, no. 22, pp. 14-16.

Walsh, M. 2000c, "Farm Accidents", *Emergency Nurse*, vol. 8, no. 7, pp. 24-31.

Walsh, M. "Farmers' Health Project", Royal College of Nursing Annual Nursing Research Conference, London.

Wanless, D. 2000, *Securing Our Future Health: Taking a Long-Term View*, HM Treasury, London.

Webb, C. 1989, "Action Research: philosophy, methods and personal experiences", *Journal of Advanced Nursing*, vol. 14, pp. 403-410.

WHO. Family Health Nurse Multinational Study Meeting.
http://www.euro.who.int/nursingmidwifery/meetings/20060210_1 . 4-6-2007.
Europe, World Health Organization.

Williamson, T. K. 2007, "The individual in research," T. Long & M. Johnson, eds., Churchill Livingstone Elsevier, Edinburgh, pp. 9-28.

Willmott, H. 1993, "Strength is Ignorance; Slavery is Freedom; Managing Culture in Modern Organisations", *Journal of Management Studies*, vol. 30, no. 4, pp. 515-552.

Willmott, H. 2003, "Organization Theory as Critical Science? Form of Analysis and "New Organizational Forms", in *The Oxford Handbook of Organization Theory*, H. Tsoukas & Hudson C., eds., Oxford University Press, Oxford.

Wooton, R. 2006, *Introduction to telemedicine* Royal Society of Medicine, London.

Yin, R. K. 2003a, *Applications of Case Study Research*, Second edn, Sage, London.

Yin, R. K. 2003b, *Case Study Research*, Third edn, Sage, London.

Young, K. K. Y. & Heymann, T. 2003, "Target centred medicine: Targets can seriously damage your health.", *British Medical Journal*, vol. 327, no. 7416, p. 680.