# Implementation of health policy and health care reform using a case study of maternity services in England 1994 – 1997.

Final submission July 2003

In accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy by Angela Tinkler.

# Contents of the thesis — Page No.

List of Contents 2
List of Tables, Figures and Boxes 7
Preface 8

## Chapters

1. Introduction to the thesis 10
2. The purpose of the Study 15
3. Literature Review 17
Section one - Reorganisation of the NHS 1991 – 1997 17
The 1991 reform agenda 19
Priorities, guidance and functions of the New NHS 25
Management reform 31
The role of consumers 34
-The promotion of the role of consumers 35
-Patients as consumers 38
-Consumers of healthcare and their relationships with health managers and health professionals 42
-Consumerism versus self-advocacy 44

Section two Changing Childbirth - the national context 47
Introduction 47
Report of the Expert maternity group 47
Professional issues 53
-Midwives 53
-General Practitioners 55
-Obstetricians 57

Section three Changing Childbirth - the local context 58
Introduction 58
The review process 58
Local consultation with key stakeholders 1994 59
-Women's views 60
-Midwives views 62
-Obstetricians views 62
-GPs views 63
Proposals for service change 63
-The acute hospital Trust 45
-Team Midwifery 64
Potential barriers to implementing Team Midwifery 68

The Health Authority's Maternity Strategy 68
Team Midwifery : implementing organisational change 70
Evaluating organisational change 71

Section four summary and conclusions from the literature review 75

4. Methodology 80

Section one - Choice of Method 80
Qualitative versus quantitative 80
Why a case study approach using participant observation? 81
The sampling technique 82
- Research subjects 83
- Meetings and key events 84
- Documentation 84

Section two – Primary Data Collection 86
Introduction 86
Qualitative research 87
Background rationale 87
-The significance of choice of method – self study and researcher role 89
The ethnographic approach 90
-The ethnographic approach and this case study 93
- A note about tense 96
Fieldwork 96
-Fieldwork role 98
-The gendered researcher 100
Participant observation 101
-Introduction 101
-My role – a dimension of participant observation 102

Section three - How the fieldwork was conducted 107
Entering the field 107
Finding the field 108
Sources of information for field notes 109
Field notes 111
Working in the field - reformulation of hypotheses 111
Moving in and out of the field 113
Leaving the field 114
Additional relevant literature and documentation 114
Additional material 114

Section four – Some Theoretical Constructs 116
Guiding principles for a theoretical approach to understanding and analysing data and relevant literature 116

5. Analysis 119
Introduction 119
What was analysed 119
The process of analysis 121
Deviant cases 123
Some methodological implications regarding the approach I adopted 123
-Objectivity 123
-Validity 124
-Reliability 127
-Researcher role 129
-Strategies to protect against bias 130
-Establishing rigour in qualitative research 132
-Ethics 133

6. Policy analysis 136
Overview 136
Transforming the evaluation and post evaluation stage into a wider research process 138
The value of a case study approach for analysis of policy implementation 141
Policy analysis in practice – a multi-dimensional research context 144
-Introduction 144
-Levels at which policy analysis takes place – a changing agenda 144
-Theoretical concepts used to inform theoretical formulations for the thesis 146
-Power and control 148
Concluding remarks on primary data collection methods and policy analysis 154

7. The case study data: local and national findings 156
Introduction 156

Section one – summary of the local evaluation studies 157
The qualitative evaluation 157
-Summary of key findings 158
-Conclusion of qualitative evaluation 160
The quantitative evaluation 161
-Samples 161
Summary of key findings 162

Section two – a description of chronological critical incidents 164
The fieldwork period, November 1995 – March 1997 164
Development of a local maternity module 166
The 'lead professional' issue lacks clarity 169
GP seeks information from the qualitative evaluation 169
Maternity services highlighted as a prime area for GP locality growth monies 171
Midwives presentation – exploding the myth 172
Initial concerns after the midwives presentation 180
Comparisons to other pilot projects 183
GPs views on maternity care 186
Quality manager sends letter to Directorate manager of maternity unit 188
Visit to Bolton Hospital Trust Midwifery service 189
Directorate manager of maternity unit sends letter of reply to quality manager 191
Further information regarding costs of Team Midwifery models of care 193
Presentation of the qualitative evaluation to Health Authority board 195
Presentation of the qualitative and quantitative evaluation to the MSLC 199
Further information on financial issues 205
The local maternity module –some developments 207
International research on Team Midwifery published 207
The purchasing of leaflets for local women 208
Team Midwifery – internal discussions continue at the Health Authority 210
GPs continue to seek alternatives to Team Midwifery 215
The hospital Trust respond to the Health Authority 216
The Health Authority respond to the hospital Trust 219
Mixed messages 220
Local and national priorities 221
Continued written negotiations 222
Local negotiations continue into 1997 226
Understanding implications of national guidance on local contract negotiations 228
Local attempts to resolve contract negotiation, the final stages 229
Further attempts by GPs to introduce alternatives to Team Midwifery 231
Internal managers meeting at the Health Authority 231
Outcome of the end of the financial year negotiations 235
What happened to Team Midwifery 237

Section three – the context of the 1991 reforms and its impact on the local case study 239
How the 1991 reforms affected the implementation of *Changing Childbirth* 239

Policy implementation as a dialectical process 243

8. Discussion 249
Policy and change, revisiting the issues within a macro context 249
Effects of the 1991 reforms 249
The new public management, trials and tribulations 256
Policy and underlying (political) factors and influences, the rationing debate 259
The role of the consumer in the prioritisation and rationing debate 263
Patients as consumers, pure rhetoric? 267
Policy implementation and power 269
The research process, my role and methodology 273

9. Concluding observations 276
Effects of the 1991 reforms, the failure of organisational control and inadequacies of inter-professional relationships 276
Changing Childbirth 280
Managerialism 284
Implications for research and the NHS R&D programme 287
Policy implementation: local freedoms and national responsibilities 289
Implications for the future NHS Policy agenda 291

References 294
Local documentation 325
National Changing Childbirth Conferences 325

Appendices

## List of Tables

Table 1 – Preliminary research – local maternity services strategy group (p60)
Table 2 – Commonality of issues pertinent to the case study (pp78-79)
Table 3 - Levels of evaluation (p140)
Table 4 – Examples of sources of power (p148)
Table 5 – Sample details, qualitative evaluation of Team Midwifery (p157)
Table 6 – final sample used in quantitative evaluation of Team Midwifery (p161)
Table 7 – key findings from the quantitative evaluation (p162)
Table 8 – The post evaluation fieldwork period, November 1995 – March 1997 (p165)
Table 9 – Type of conflict and the policy context – a process of re-adjustment (p245)

## List of Figures

Figure 1 - The structure of the NHS before 1991 (p18)
Figure 2 – The structure of the NHS in 1991 (p20)
Figure 3 – The structure of the NHS in 1996 (p24)
Figure 4 – Changing Childbirth Ten indicators of success (p49)
Figure 5 – Five key aims of the local maternity strategy (p69)
Figure 6 - My dual fieldwork role (p104)
Figure 7 – Preliminary underlying research questions (p109)
Figure 8 – Key sources of fieldwork data (p110)
Figure 9 – Routes for analysis and testing emergent findings (p120)
Figure 10 –A matrix for public involvement in decision making (p264)

## List of Boxes

Box 1 – Defining Team Midwifery (p65)

## Acknowledgements

Keith Tinkler, for support and encouragement

# Preface

This thesis is based upon an observational case study of the implementation of *Changing Childbirth* (DoH 1993), a national NHS initiative, in a North West District Health Authority. The Health Authority under study had merged with the Family Health Services Authority in 1994, an arrangement which became legally binding in April 1996 (Health Authority Bill 1995).

During the period within which the research was undertaken I was a full time employee of the Health Authority. In September 1994 I was seconded for a period of twelve months to the University of Liverpool in order to conduct a qualitative evaluation of a Team Midwifery pilot project. The pilot project was part of the local implementation of the national policy of *Changing Childbirth.* Team Midwifery was implemented, in this particular Health Authority in 2 of 6 localities within the district Health Authority under study.

My position as an employee of the Health Authority enabled me to develop the qualitative evaluation into longitudinal research project to explore local policy implementation after the introduction of the purchaser provider split to the NHS in 1991. Thus I became involved in observing the negotiation and decision making process concerning the local implementation of a national policy. As an opportunistic participant observer I was able to gain insight into the negotiating process and to become aware of many of the tensions and much of the complexity surrounding how decisions were made and observe outcomes in relation to the local implementation of a national policy.

Data collected during this part of the research process was invaluable, providing access to information that may have been difficult for an independent academic researcher to access. Observing the day to day implementation of such reforms has proved to be a unique experience in terms of gaining an understanding about the effects of structural and operational issues on health professionals and patients.

The research made me aware that by not allowing the public to be privy to negotiations and power relations intrinsic to the NHS prevents them from acknowledging certain structural difficulties. These difficulties include managing the provision of public services in a culture of uncertainty and insecurity at a time when professional, managerial and patient roles were being redefined.

I conducted the case study whilst still an employee of the District Health Authority, therefore the case study is anonymised. Local documents are referenced as originating from a North West District Health Authority and a North West Acute Trust, the main provider of maternity care.

I believe the opportunity my role afforded me outweighs the slightly restrictive nature of anonymising local documentation.

# Chapter one Introduction to the thesis

This thesis aims to offer a more explicit understanding of and insight into the complexities of attempting to implement policy through a change in service delivery, i.e. the introduction of a pilot Team Midwifery scheme in response to national policy. The setting for the research was a North West district Health Authority where I was a full time employee in the Public Health Department. The main acute provider unit, a hospital which achieved Trust status at the beginning of the 1991 NHS reforms, piloted a Team Midwifery project. I was seconded as a researcher to an academic unit at Liverpool University to conduct a qualitative evaluation of the pilot project.

After completion of the qualitative evaluation and on my return to the Health Authority I realised that there was the potential for further research. This research would be focused on what I defined as the post evaluation period and formed the basis of a case study. The case study aimed to examine how a Health Authority attempted to implement national health policy which required changes to the organisation of maternity services and delivery of care to women.

The implementation of *Changing Childbirth* at a local level was also part of a much wider context of national NHS reforms. Therefore the *Changing Childbirth* initiative provided a focus for examining the wider 1991 conservative NHS reforms. Such an initiative was appropriate as it included the following:

(i) it could be considered as the service where the capacity for empowerment of patients (women) and the potential for redistribution of power between professionals (and women) could be facilitated by specific central policy (DoH 1993) and opportunities promoted by other policies and government documentation, (DoH 1991a, 1991b, DoH 1994a, 1994b, 1994c, NHSE 1992, NHSE 1994a, 1994b, 1994c, 1994d).

(ii) it focused on the redistribution of provision of care (DoH 1993);

(iii) *Changing Childbirth* followed a succession of major reforms and attempts had been made nationally to implement it amidst :

(a) growing dissent from many professionals, i.e. non clinical mangers (Butler et al 1996), GPs (Vaughan & Higgs 1995), Consultants (Letters, BMJ 1996; 312:1297), and nursing staff (Bradshaw 1995) and;

(b) further restructuring and rationalisation of district and regional Health Authorities and the development of a primary care led NHS.

These concurrent structural changes and persistent professional unrest continued to underlie the policy reform context and process.

In addition to the above, the case study approach adopted allowed for potential exploration of change related to those factors and processes which could either constrain or promote policy implementation at a local, meso and micro, level. Meso level being the middle policy implementation tier, a role ascribed to Health Authorities as purchasers and planners of healthcare, functioning as 'corporate rationalizers'. Whilst the micro level here refers to individual professionals implementing policy through their day to day decision making as 'operational rationalizers'

I also suggest that users of maternity services are potentially unique in their relationship with the health service in that they could be viewed as 'contested patients'. Contested in the sense that pregnancy and childbirth are a natural phenomena, not dependent on a cure or healing. As such users of maternity services are not sick or ill although some women may be treated as such, (Oakley 1993, p124), and their contact and usage of health services is transitional. Yet the creation of a national health service system has

arguably created a dependent iatrogenic relationship between professionals and pregnant women. Therefore, in this context, users of maternity services as 'patients' could be disputed. However if episodes of care are purely transitional, unless high risk, users of maternity care in the main may be potentially more 'suited' to a quasi-managed market system where choices for, and responsiveness to, 'consumers' are meant to prevail. This then seemed relevant to the study to consider if the 1991 NHS reforms accommodated what they promoted, i.e. choice and responsiveness.

Maternity care is an area of service delivery which involves all key stakeholders, i.e. professionals from the primary and secondary care interface (the providers of care), the Health Authority (purchasers of care) and patients (consumers of care). Research within a local context of the nature described in this thesis, I will suggest, facilitates the exploration of the 1991 reforms from a multi-layered perspective. This thesis therefore represents a historical picture of policy reform in the NHS.

There have been few formal studies of Health Authority purchasing and generally not much attention given to Health Authorities in respect of policy implementation (Mulligan 1997). The topic chosen, i.e. maternity care, I suggest is a useful area to use when assessing policy implementation within the wider macro reform perspective. It encompasses some of the key underlying concepts that post 1991 NHS reforms and priorities sought to address, i.e. patient focused care, enhanced information, more explicit decision making processes, increased control and choice for service users (consumers) and improved inter- professional relationships. In addition, the promotion of the role of GPs and Health Authorities as responsive purchasers of care created the climate for more explicit accountability (DoH 1994c, NHSE 1994b, NHSE 1994c, DoH 1994a,1994d, NHSE 1994c).

In view of the above the case study sought to not only provide a critical review and analysis of NHS policy documentation relevant to *Changing Childbirth* but also consider inter-organisational relationships and intra-professional and inter-professional

relationships. Therefore it seemed appropriate to provide a summary of local documentation relevant to *Changing Childbirth* and to obtain local data to help illustrate the factors and processes which influence the decision making process when implementing change in response to NHS policy.

The literature review forms a substantial part of the thesis with particular reference to the wider NHS reforms of the early 1990's. Relationships between recipients of care, providers of care and purchasers of care are explored. A detailed description of the fieldwork role, incorporating a description of qualitative research and the ethnographic approach, is presented in the methods chapter. This chapter also includes an overview of how the research was developed and considers policy analysis in relation to some relevant theoretical concepts. The empirical data and conceptual theoretical frameworks are then used to explore the negotiation for and ownership of resources between organisations and between groups of individuals.

Primary data collection for the thesis began when I resumed the role of full time employee at the Health Authority. My employee role enabled me to conduct further research but I had to complement this role with a more pro-active research approach and as such I used a form of participant observation. I labelled this role opportunistic observing participant.

Both roles, employee and researcher, involved consideration of findings from the evaluation of the pilot Team Midwifery project in relation to the processes of implementing change and decision making by senior health professionals and managers. This dual role of researcher and employee was used, in the first instance, to explore and assess how the results of the qualitative evaluation were received (via presentations to executive and non-executive directors of the Health Authority, senior members of the Trust, local GPs, midwives and the local Maternity Services Liaison Committee). Any subsequent action, negotiation and decision making with regard to local maternity care provision and service delivery was then subject to the research process. The issues

covered within the thesis are wide ranging and multi-dimensional, however locating the local case study in a broader context seeks to reveal not only the possible barriers to implementing change in service delivery but also some very complex power relations.

Much strategic activity and institutional change had been promoted by the NHS reforms of the early 1990's. This thesis attempts to offer a theoretical and practical analysis of implementation of health service policy using themes and conclusions drawn from the literature review and findings from the case study. Some of these themes and conclusions are used in the final chapter where I consider their contribution to theory and their relevance to recent NHS policy initiatives.

# Chapter two The purpose of the Study

The purpose of the study was to assess and understand how national policy is translated into action at a local level in the NHS system through the management and service delivery interface. This required analysis of the national policy context and local policy documentation. The approach to the study was multi-dimensional and sought to incorporate research into professional relationships, organisational activity and decision making processes in relation to policy implementation.

The study was primarily focused on local decision making because the 1991 NHS reforms had promoted, amongst other things, national responsibilities and local freedoms. I wanted to assess what this actually meant for professionals and managers working at a district locality level. For example I was interested to find out the extent to which local freedoms could be exercised in relation to national policy directives from central Government and in turn ascertain what other factors influenced local policy implementation. In order to do this I needed access to local documentation, contact with local professionals and managers, participation in managerial meetings, and participation in presentations and forums set up to manage, implement and monitor the particular policy chosen, i.e. *Changing Childbirth.*

*Changing Childbirth* was chosen because it represented many aspects of the 1991 reforms intentions for the NHS. This included, more choice for patients, more effective use of resources through better use of midwifery skills, a shift away from a provider driven NHS and, implicitly, challenges to historical patterns of service delivery and professional relationships. The study therefore comprised of the following key components-

>observation of organisational activity in relation to policy implementation
>observation of relationships between key stakeholders
>analysis of communications, verbal and written, between key decision makers

>analysis of national initiatives and information related to *Changing Childbirth* implementation, including attendances at national conferences
>reflection on the role of the researcher participating in activities relevant to the decision making process about changes to service delivery in response to national policy.

As the study developed observations generated further components of data collection. This included economic evaluations of other models of Team Midwifery and pilot schemes in other parts of the country. The reasons for conducting the case study were extended too. For example it became important to attempt to understand why the future of maternity services became so difficult to gain a consensus on when it was not considered a priority for senior managers in the case study. This suggested various possible explanations which could have been to do with patterns of behaviour between different professional groups. Furthermore the exercise of power between the chief executives of the purchaser and provider organizations, and the lack of priority in the local and national NHS system, did actually give some scope for local freedoms to be used. Therefore routine and systematic observations of interaction and the different methods of communication between key stakeholders and decision makers became pivotal to gauge the complex nature of management decisions.

The Conservative Government had set a significant agenda in the early 1990's for reform of the NHS. I wanted to gauge if it was possible to have a national NHS system which enabled local freedoms to exist; and if so how this would impact on policy implementation through a national framework of indicators of success.

# Chapter three Literature Review

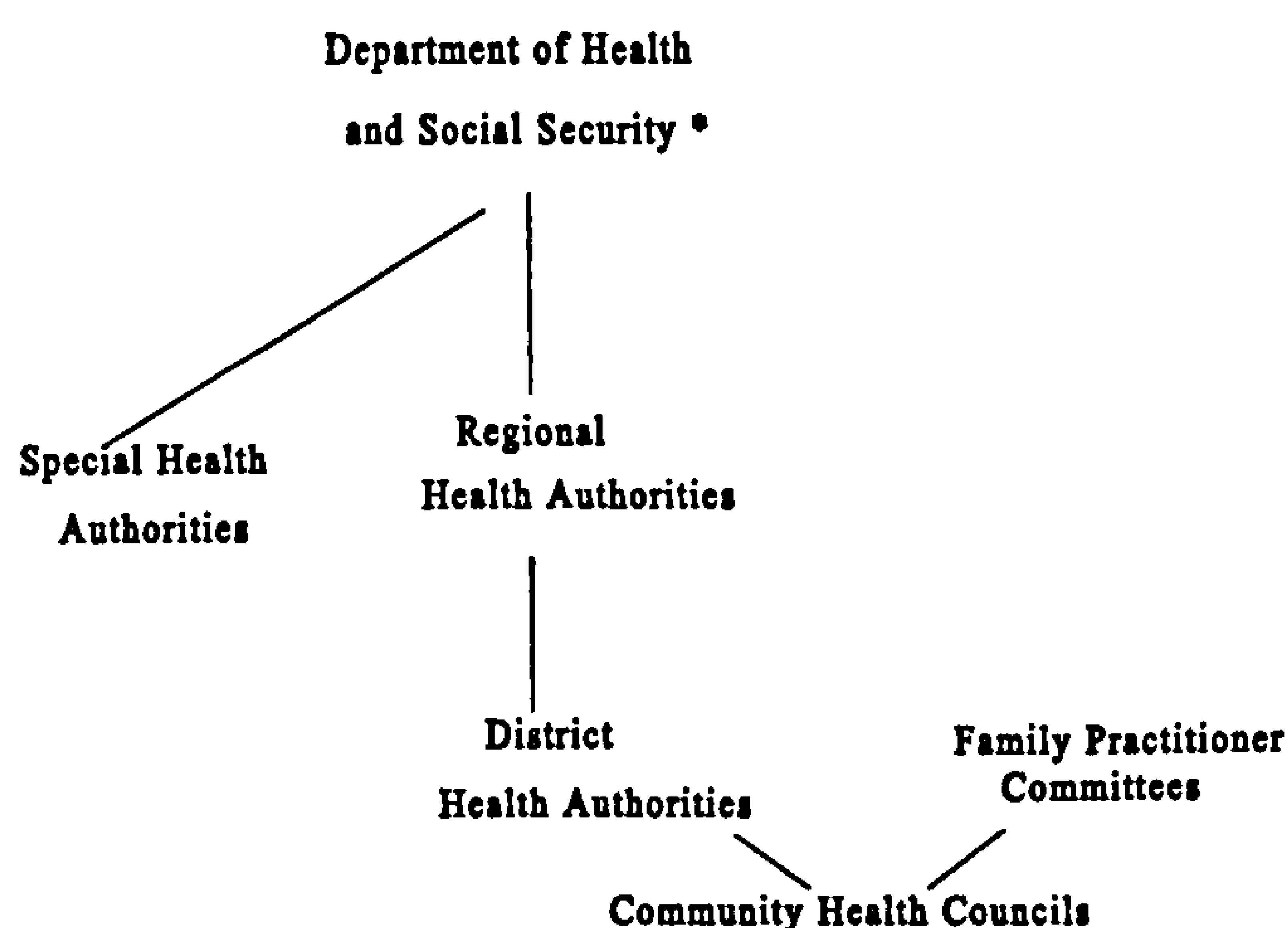
This chapter will provide a critical review of NHS policy reform between 1990 and 1998. The review will consider national policy and academic observations regarding the reforms and the wider context for analysis of local implementation of a specific government health policy, *Changing Childbirth.* Changing Childbirth will be discussed at a macro level and then consideration of it will be discussed in relation to the case study. Local documents and local service developments will also be highlighted.

## Section one NHS Policy Reform

### The reorganisation of the NHS 1991 - 1996

The British NHS system has been subject to substantial reform since the late 1980's and was the subject of academic and media review as it 'celebrated' a five year anniversary of one of the most influential periods of reform, 1991 - 1996 (Brindle 1996a, Brindle 1996b, Crial 1996, Davies 1996, Moore 1996a). The subsequent 50th birthday of the NHS (1998) resulted in further academic and media reflections and most notably a cradle to the grave review of those fifty years (Rivett 1998). The 1991 conservative reforms, made law by the NHS and Community Care Act, which introduced a 'managed market' structure to the NHS came into effect on the 1 April 1991 (DoH 1990). The 1991 Act was preceded by numerous White papers, noted below, which had already begun to change the shape of health care delivery and pave the way for further reforms and the impetus behind them, i.e. efficiency, effectiveness, accountability and the notion of consumerism. The key white papers, instigated by a ministerial review in the mid 1980's (Ham 1992, p48), initially focused on GP services and the promotion of health (Secretary of State for Social Services and others 1987), community health and social care (DoH 1989b) and culminated in the introduction of market principles to the NHS (DoH 1989a).

**Figure 1. The structure of the NHS before 1991 (England).**




* This became the Department of Health (DoH) in 1988. (Adapted from Ham 1992, p 31)

An internal market was created as the result of the reforms whereby the responsibility for purchasing, or commissioning, services was separated from the responsibility for providing them. District Health Authorities and GP Fundholders were charged with assessing need and purchasing services on behalf of their populations and NHS Trusts were the key providers of services. The internal market was pivotal to much of the changes that took place, despite the Secretary of State in office in 1991 distancing himself from the idea of *"a market in the real sense"* (Smith 1991). This was partly due to a political reluctance, even for the Conservative Government, to publicly introduce comprehensive business principles into a national public sector organisation. In addition an apparent lack of competition between providers of services, i.e. NHS Trusts, made it difficult to justify that it was a real market. So as few providers were actually external to the NHS system itself and it was imposed upon those working within it some preferred to call it a 'managed market' (Ham.1994.p.10) or a 'quasi-market' (Tilley 1993, Le Grand and Bartlett 1993, Dixon 1998). Which in effect helped reinforce its potential inability to deliver responsiveness and choice for purchasers and patients.

The desire to highlight its inadequacy as a real market through the use of terms such as 'quasi' and 'managed' was subsequently reflected in the idea of a system dependent on contestability, combining competition with planning (Ham 1996a, Ham and Shapiro

1996). Contestability was based on the premise that the *threat* of shifting contracts was enough to ensure that providers would produce a quality service within a defined budget. In contrast to this context is consideration of the increasing use and advocacy of 'consensus' techniques, i.e. the use of Search Conferences[1] (Spear and Howell 1995), in planning and decision making processes (Hand 1996, Jones and Hunter 1995, Watson 1996). This indicates a recognition that 'competition' and even contestability had created a climate that required conciliation.

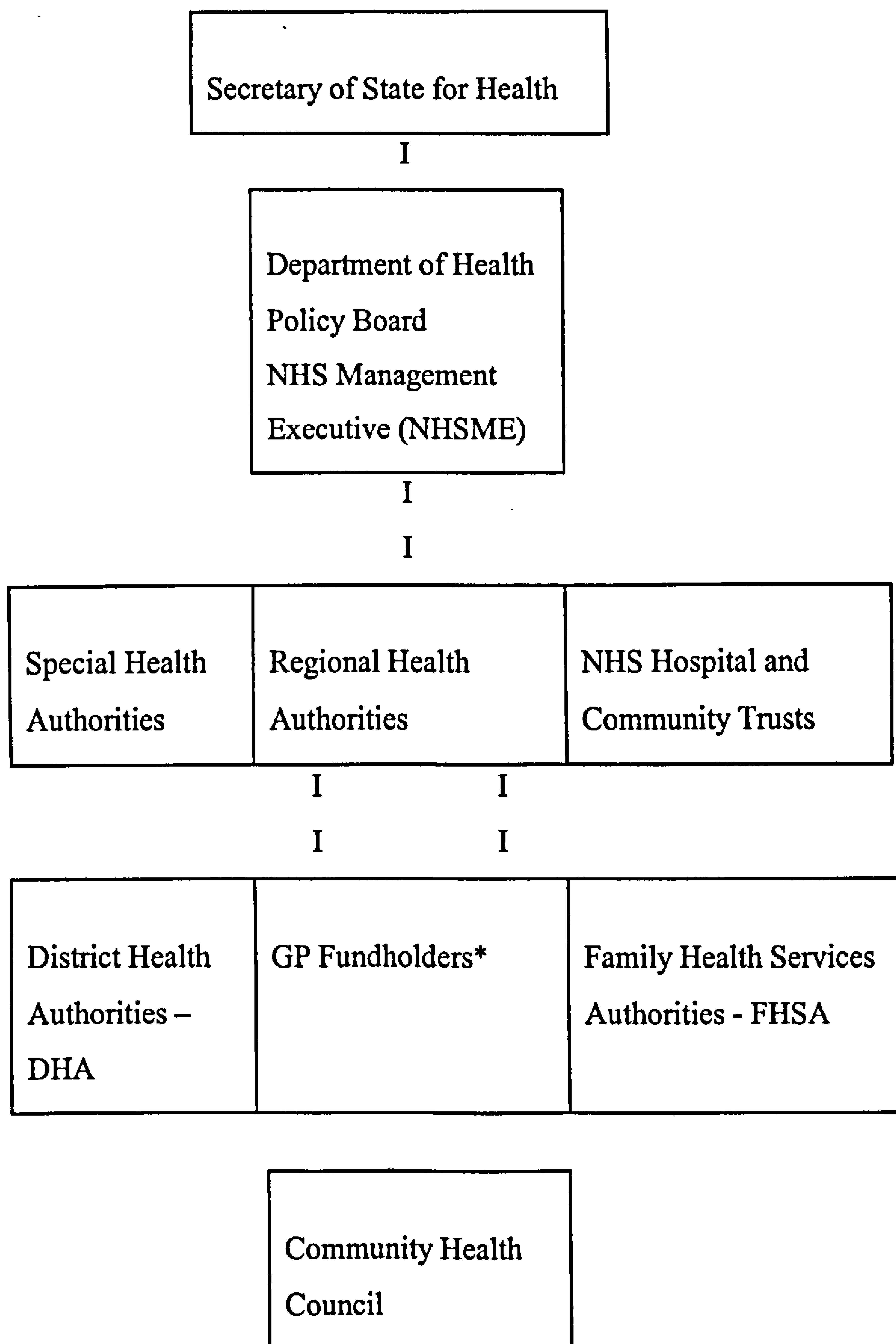
The culture of the NHS was shifting and professionals working within it, particularly those responsible for providing care, were crucial to the change process (Caines 1996). In view of this one of the important issues to explore and understand, I would suggest, is the impact of reforms at a local level in terms of relationships between professional groups managing and implementing change. The issues driving the 1991 reform agenda, and how they shaped the roles of those charged with implementing it, will be considered next.

**The 1991 reform agenda**

The management and function of the new NHS was to be grounded in, " *twin objectives of maximising the responsiveness of service to local people and achieving best value for money for patients and the public from the resources spent on the NHS*" (DoH 1994c).

[1]The Search Conference is a participative planning method that enables people to plan and agree on desirable future outcomes in relation to communities, organisations and service delivery. (Spear and Howell 1995)

**Figure 2. The structure of the NHS in 1991. (England)**




* GP Fundholders have been included in this figure to represent the new role they adopted as purchasers of (some) health care services directly on behalf of their practice population, and the formal accountability that this ensued. However they were still expected to liaise with the DHA and FHSA. Non Fundholding GPs continued to refer patients to services which were purchased by the DHA.

The underlying drive of the reforms arose from a need to break from a supposedly inefficient system dominated by, " *corporate groups concerned more with preserving their privileges than with modernising their attitudes and activities"*, (Robinson and Le Grand, 1994, p14). The vision for the NHS was embedded in an explicit shift away from a provider driven to a purchaser led system[2]. It was argued that, *"purchasers needed to move away from the old style focus on institutions and service inputs localising services on grounds of access alone without regard to other aspects of quality and money.."* (NAHAT 1993a).

There was some emphasis placed on the need to 'manage relationships' and identification of seven imperatives for effective contracting which included better working between purchasers and providers, involvement of doctors and nurses in the contracting process, robust information systems and perhaps most important, *" realism about activity and the impact of change "* (NAHAT 1993a).

At the heart of the reforms according to Butler (1994) was the split between those who purchased care and those who provided it. There were, he argues, six key 'buttresses' erected :

1. clear effective line of management command, responsive to pressures from ministers;
2. the mechanism for funding HA's would change to reflect populations rather than volume of work in local hospitals;
3. capital assets would be charged in a similar way to private capital;
4. modern information systems would drive the market;
5. medical audit would be promoted to protect patient care re : profitability;
6. the clinical freedom of the hospital consultants would be subjugated to a greater

2 In 1997 when the Labour government took office they introduced plans for dismantling the NHS 'internal market' through the abolition of GP Fundholding. The new NHS: Modern, Dependable (DoH 1997a) described these intentions and became law through the 1999 Health Act.

extent than hitherto to the business needs of the hospital, by changing their contracts in ways that would make them more accountable to local managers. (Butler 1994, p.19).

Purchasers of health care had to adopt a role which meant they contracted, commissioned and purchased services and Sheaff (1994) makes a distinction between these terms. Contracting meant specific information regarding service provision and corresponding cash allocations had to be documented in contracts and not operational and strategic plans. Commissioning was seen to be about the use of purchasing power to influence health care providers and the shape of the managed market. Purchasing meant District Health Authorities (and GP Fundholders) were to take a more active role in selecting providers to make them more accommodating to the purchasers' requirements. Although commissioning and contracting were intrinsically linked it is worth noting that the 'contract' between purchaser and provider was not a legal document and therefore not legally binding (Maynard 1993, p60, Opit 1993, p86).

Furthermore Hughes et al (1997) argued that the development of the NHS contracting policy was less about organisational adaptation than periodic administrative shifts deriving from the centre, i.e. Department of Health. So although managerialism in the NHS was designed to promote closer involvement of doctors at a local level of planning to achieve 'integration of medial decisions and political management' (Hunter 1993, p38), scepticism about this type of relationship was also evident, *" doctors are adept at finding ways around controls over their work which they believe to be unacceptable"* (Hunter 1993, p40).

This had the potential to create an environment of national agendas being subsumed by local and historical power relationships. The 1991 reforms were also grounded in a policy context which located central planning at a level removed from direct command and control in favour of local contracting and commissioning. To realise the impact of this type of arrangement various questions needed to be asked, for example, *" how will*

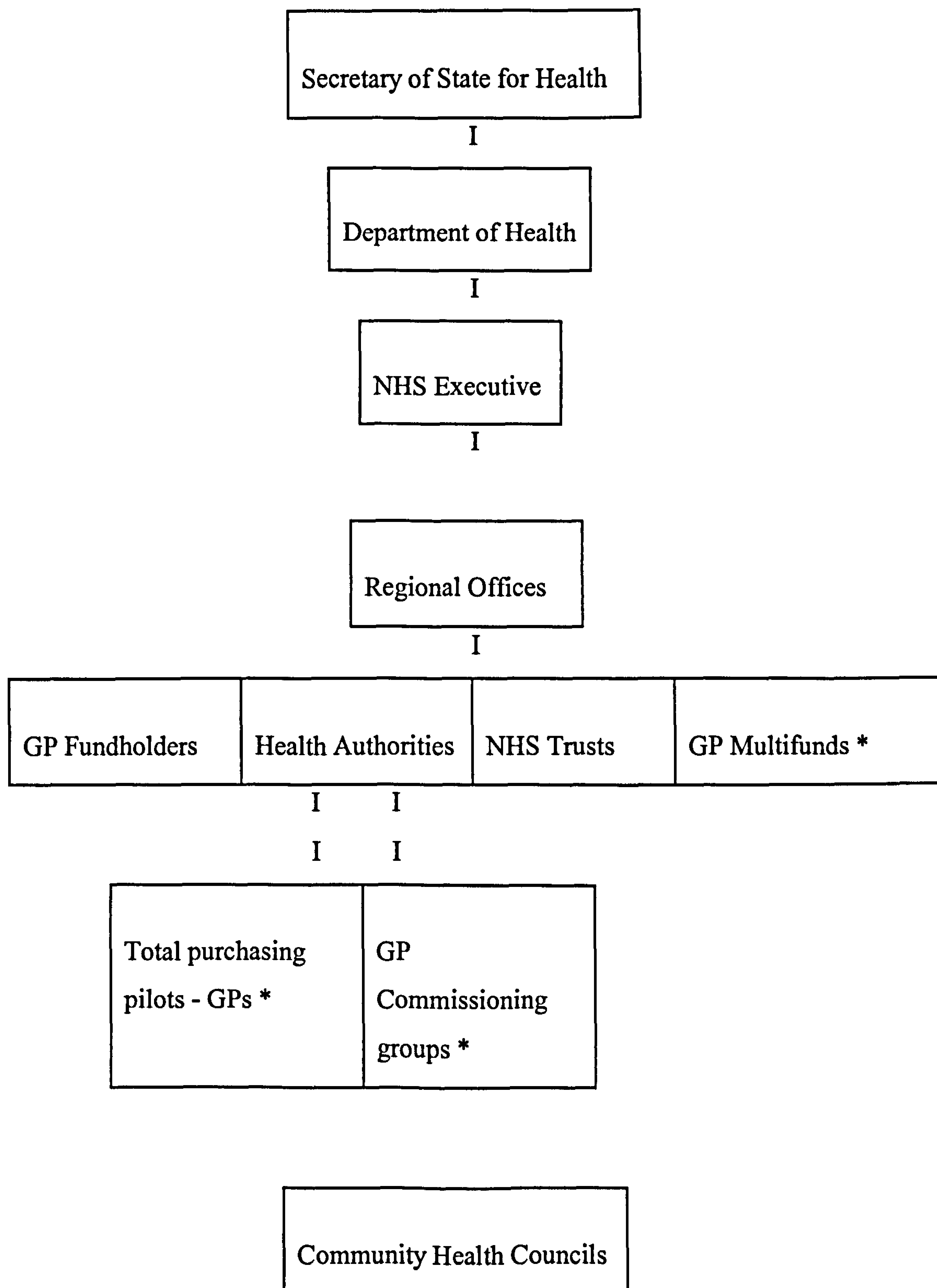
*the degrees of competition impact upon health services and how will the interface between the various components be managed ?* " (Spurgeon 1993, p55), i.e. how will competing priorities be managed at a local level.

Formal guidance on priorities and functions, (discussed in the next section), may reveal policy and strategic intentions from a national perspective but this may not be in synergy with local priorities. The reforms appeared to have been subject to a shifting and evolving agenda. For example prior to the NHS White Paper (DoH 1997a) the attention had shifted away from the idea of annual contractual arrangements towards the desire for long term arrangements (with penalty clauses) and periodic stages of contractual negotiations.

Additional structural changes also occurred after the introduction of the 1991 reforms. In 1993 proposals were introduced to abolish the fourteen existing regional Health Authorities and replace them with eight Regional Offices working under new contracts as civil servants. Joint working between District Health Authorities (DHA's) and Family Health Service Authorities (FHSA) was to be consolidated, establishing one authority at a local level with responsibility for implementing national health policy. (NAHAT 1993b).

Although the merging of DHA's and FHSA's did not become statutory until 1 April 1996, some informal mergers began to take place shortly after the Department of Health's intentions became more public. This further reform is mentioned here to highlight a major re-organisation of the structure of health services at a regional and district level. Regional offices were considered to be allies to DHA's and their transformation to civil service employees indicated an alignment with the Department of Health.

**Figure 3. The structure of the NHS in 1996. (England)**




* Various models of GP purchasing emerged after the introduction of GP Fundholding, some schemes were introduced to accommodate Practices who were not Fundholders.

One of the main implications of this structural change was related to resource allocation for DHA's, FHSA's and GP Fundholder's which would be controlled from the centre, at the Department of Health. The role of non-executives in the newly created purchasing agencies was to be enhanced and expected to increase local accountability.

Tackling institutional and professional cultural systems appeared to be at the root of these NHS reforms. At the same time there was a drive to harness the support of patients and engage them in decision making processes, (Patients Charter, DoH 1991a, DoH 1994b, DoH 1994c, NHSME 1992). The involvement of the 'public', in their new found role as consumers of health care will be explored in more detail below.

It has been suggested that counter measures to reform are intrinsic to the process, *"so as to reduce the political, professional and managerial opposition that radical systematic reforms of any kind invariably encounter, they are often accompanied by measures of various kinds whose effects obscure the consequences of the reforms themselves "*, (Robinson and Le Grand 1994, P64, Appleby et al 1994, p26).

Thus opportunities (compensation mechanisms) were made available for certain professions, i.e. Midwives (DoH,1993), General Practitioners (GP Fundholding), non-GP Fundholders (locality commissioning). However at the same time constraints and control on individual practices were introduced, i.e. Evidence Based Medicine, Clinical Effectiveness, Indicators of success. In effect these counter measures could serve to contribute to an inevitable 'dialectical process' which is necessary for the practical implementation of policy, this theme will be explored further in subsequent chapters.

**Priorities, Guidance and functions of 'The New' NHS[3] 1991 - 1997**

This section will briefly highlight and discuss the key functions of the new NHS in

---

[3]the new NHS here refers to those structural changes introduced since 1991 and their effect until 1997 and as such prior to the NHS White Paper - Modern and Dependable (DoH 1997a) and the new National Plan (DoH 2000)

relation to the role of purchasers and providers and guidance given to them from central government.

In July 1994 three significant documents emerged, one from the Department of Health, Managing the new NHS :

(i) Functions and Responsibilities of the new NHS (DoH 1994c.);

(ii) Priorities and Planning Guidance for the NHS 1995/96 (NHSE 1994b); and

(iii) The operation of the internal market: Local freedoms, national responsibilities (NHSE 1994d).

These documents defined key managerial and functional responsibilities and guidance for Health Authorities, GP's and NHS Trusts and explicitly defined short and medium term priorities for purchasers.

In the first document, 'functions and responsibilities', emphasis was placed on the role of the 'new health authorities', new being the result of the proposed mergers between existing District Health Authorities and Family Health Service Authorities. The creation of a single purchasing authority intended to provide a context for streamlining management and also encouraging integration between the primary and secondary care interface.

The new Health Authorities had a strategic responsibility for implementing national policy In addition, for them to be effective, their functions and responsibilities at a local level demanded a supportive and monitoring capability. They also had to be more accountable to their local population, *" the role of the Health Authorities as agents of the public will increase as they take on more responsibility for explaining how the NHS works and what is being purchased for local people."* (DoH 1994c. p.6 para. 3.10).

GP Fundholders were deemed to be accountable to NHS Regional offices (replaced by the National Health Service Management Executive, NHSME, Regional Offices in April 1994) but their main relationships were with the new Health Authorities, operating

within a national framework. Hospital Trusts were also accountable to the provider arm of the NHS regional tier, working actively with Health Authorities who had to, *"...ensure that contract specifications are met but will not intervene in operational matters",* (DoH 1994c, p.27, para.9.5). Therefore accountability arrangements for NHS Trusts meant that they could effectively by pass health authorities. Hospital Trusts were also encouraged to develop their responsibilities in the management of human resources which translated, in the main, as a drive towards local pay bargaining for their employees. This created a particular set of local dynamics between managers and health care professionals.

Purchasers received, for the first time, direct notification of Priorities and Planning Guidance for the NHS (NHSE 1994b) which are produced annually. The underlying theme of the document pre-empted the notion of a system which demonstrated national accountability and local responsiveness, *" ..we expect local health strategies and purchasing plans to address national priorities, they should also be supplemented by local priorities ",* (NHSE, 1994b). Objectives specified in the above document focused on quality and responsiveness of services, input by local people into key decisions and the active involvement of health professionals in the contract process who were expected to, *"feel able to own activity and quality standards"* and, *"...increase value for money",* (NHSE, 1994b). (It is worth noting here that the 1997 reforms (DoH 1997a), enacted in 1999, sought to build on the above themes). Purchasers and providers also had to adhere to principles of corporate governance based on, *" sufficient transparency about NHS activities to promote confidence between the NHS Authority or Trust and its staff, patients and the public..",* (NHSE, 1994 b).

At the end of 1994 further guidelines were introduced for purchasers and providers (NHSE, 1994d) under the banner of 'Local Freedoms, National Responsibilities". The reforms had given, *"health professionals and managers the freedom and incentives to respond to patients' needs.....Health Authorities and GP fundholders are increasingly using their purchasing power to ensure that services respond to the needs of their*

*patients"*, (NHSE,1994d). Amongst these repetitive comments by the former Chief Executive of the NHSE there appeared to be some inherent assumptions. Not only were purchasers and providers to have the type of relationship which facilitated responsiveness over and above the day to day operation of the quasi-internal market, but this context and relationship implied a significant shift in power away from the provider arm of the NHS, in particular the acute sector.

An announcement was made in October 1994 to further expand GP Fundholding and Health Authorities were given additional guidance on how to 'support, monitor and develop strategies' in collaboration with GPs, and local people. (NHSE 1994c). Phrases such as 'constructive partnerships' and the provision of support through 'advice, investment and training' (NHSE 1994a) indicated that Health Authorities would establish a comfortable, reciprocal and consensual relationship with GP fundholders. However previous and existing structures and personnel would have an influence on the type of role and the nature of these relationships the Health Authority developed in order to fulfil its 'monitoring ' function.

These issues and others related to priorities and guidance for the NHS will be revisited in chapters 7,8 and 9, particularly in light of recent NHS policy reform. Before moving on to consider management reform, the notion of 'Local Freedoms, National Responsibilities' warrants further attention. The documents which promoted this system, (DoH 1994c, NHSE, 1994d), and at the same time offered further guidance on how to achieve it by suggesting that it already existed, was confusing. For example it was argued that equity of access had been achieved through a national policy of resource allocation to Health Authorities and GP fundholders who, *" usually need a choice of providers to get the best possible service"*, but, " *......it may be more efficient to have just one provider, whose behaviour is stimulated by the knowledge that another provider could replace it "*, (NHSE, 1994d, p.3), i.e. contestability.

It appeared then still problematic to achieve equity with regard to the same quality and

standards for all in these circumstances. There certainly had to be consideration of the above in relation to power relationships and purchasers negotiating capacity to secure responsive services. Purchasers of health care, i.e. DHA's and Fundholders, were expected to assess the needs of the populations they served and in doing so reflect those needs in the choices they made regarding the provision of services. This role did warrant scrutiny because, in some districts purchasers were dependent on one main provider, usually for historical and geographical factors and this would restrict choice. Therefore assessment of how, for example, women using maternity services were given choices in this situation may reveal the strength of contestability.

Assumptions also continued to prevail with regard to the public's role in the quasi-market system whereby, *"public comparison, in the form of league tables for example, will challenge poor performing purchasers to improve "*, (NHSE, 1994 d, p.3). The 'public' challenging Health Authorities and the ease at which they may have been able to do so is difficult to envisage particularly with regard to choice and how to change providers of care if dissatisfied. These issues will be highlighted further on in the thesis in relation to the patient as consumer.

Another theme which emerged from the policy arena was clinical effectiveness and evidence based medicine. Health Authorities had been given a policy steer about ensuring services were contracted to provide maximum benefits ( NHSE, 1993). In priorities and guidance (NHSE 1994b), priority G dictated that purchasers and providers, *" invest an increasing proportion of resources in interventions which are known to be effective and where outcomes can be systematically monitored, and reduce investment in interventions shown to be less effective "*, (NHSE 1994b).

The promotion of evidence based medicine appeared to be set to become a more prominent feature of the reforms (Morrison and Smith 1994). But the above also indicated some assumptions:

(i) only those outcomes which could be systematically monitored would be considered as options for treatment and care;

(ii) there were resources available to systematically monitor the vast array of treatment and care.

This had relevance to some of the underlying themes of *Changing Childbirth* and its focus on the psycho-social aspects of maternity care and unnecessary clinical interventions. The former attracting less research (resource) attention whilst the latter although often proven was not always implemented at individual clinical level of care (Oakley 1994, p71). As clinical effectiveness and evidence based medicine moved up the policy agenda implications for clinical and organisational change increased. Clinical Standards Advisory Groups formed to make recommendations on various aspects of disease and service specific procedures including maternity care (CSAG 1995). However although Clinical Governance (DoH 1998a) has re-focused the above from a macro perspective, i.e. National Service Frameworks (NSFs) and the National Institute for Clinical Effectiveness (NICE), the interplay and tensions between national responsibilities and local freedoms, I suggest, remained a feature of the NHS during the 1990's.

The potentially counterproductive aspect of this context for maternity care, i.e. the components which are not easily quantifiable or open to the parameters of clinical effectiveness, such as choice and continuity of care and carer could result in a service that was considered 'clinically safe' with little scope for more qualitative improvements. This approach had the potential to create a system of short term clinical gain (clinical effectiveness) against longer term outcomes (psycho social outcomes for mother and baby). The drive for clinical effectiveness in a culture of Randomised Controlled Trials may then serve to sustain and even increase the power of professionals, i.e. doctors, the reforms were introduced to control and contain.

In the NHS system where resources are finite the *Changing Childbirth* agenda would be

pitched against other priority areas competing for service development and service review. The national impetus for evidence based medicine and clinical effectiveness would therefore have a bearing on what influenced planning and purchasing decisions at regional and local levels of the NHS.

**Management reform**

The introduction of general management to the NHS prompted by the Griffiths review (DHSS, 1983) can perhaps be identified as the beginning of the managerial 'revolution'. Managers were required to shift and restructure a system historically characterised by medical professional dominance, the aim was to rationalise the distribution of power and redefine labour relations. However in 1989 a study exploring general management and medical autonomy concluded, *"for many of their proponents, the Griffiths and related reforms of NHS management were expected to produce a change in culture......there is little evidence from our study to suggest that any such change has so far occurred in respect of the relationship between managers and physicians in the NHS"*, (Harrison et al 1989, p 44). Professionals from the private sector were encouraged to enter this domain and at the same time clinicians were also encouraged to take on more managerial responsibilities (Baggot 1994). One observer of the 1991 reforms, however, suggested that the NHS had adopted an outmoded management style at a time when the private sector were re-evaluating the macho management image associated with it (Tilley 1993, p294).

Although the introduction of market principles to the NHS were usually identified by policy documents emerging from the turn of the decade i.e. DoH 1989a, DoH 1989b, DoH 1990 and DoH 1991, competitive tendering had been introduced in 1983, (DHSS 1983). The key difference being that up until the publication of the white paper Working For Patients (DoH 1989a) market principles had predominantly been in the domain of non-caring services in the NHS. So although the introduction of general management had been in place since 1983 one could argue that opportunities for this

group of professionals to exercise their 'visionary management skills' was delayed for several years. In the meantime various contradictions emerged. For example fundamental business principles of cost effectiveness, efficiency and money following patients had been offset by an expensive administrative infrastructure dependent on systems of contracting, incompatible information flows and financial monitoring (Baggot 1994).

The paradox here being the rise of bureaucratic managerialism and then a subsequent drive from the centre to introduce a 'market' system supposedly less reliant on top heavy managerialism. As noted above it was in effect a 'quasi' or 'managed' market system, where consumers were not consumers at all in the real sense of exercising choice and control, i.e. Health Authorities and GP Fundholders acted as proxy consumers, and as such were constrained by central government. The effective involvement of non Health Authority professionals to influence the purchasing process was also problematic as this function would be a new aspect of their role, untried and untested (NHSE 1995a).

One of the many objectives of Working For Patients (DoH 1989a), it has been suggested, was to ensure, *" more power and responsibility would be delegated down the management chain; doctors and nurses would become intimately involved in service management; and a closer partnership would develop between the NHS and the private sector "*, (Butler 1994, p20). This was coupled with a belief that there would be minimal interference from the government (Butler, 1994 p22). However the reality was somewhat different as the DoH generated more and more documentation offering guidance and directives which culminated in the publication of 'patients not paper' (NHSE 1995b). This was the Conservative Government's own recognition that the NHS system was being overloaded with circulars and executive letters.

The reform agenda of central planning from a distance which promoted 'local freedoms' was still experiencing implementation problems. This was borne out by a continuing

necessity to clarify the 'new' arrangements. Three years into the 1991 reforms there still appeared to be a need to reiterate some of the key messages, *"patients will benefit directly from the changes as substantial savings will be released by streamlining NHS central management and channelled into patient care. They will see further advantage from efficiency savings as local management exercises new freedoms"*, (DoH 1994c, p.5 para. 3.2).

However a further 'contradiction' in the system appeared to emerge as the government attempted to control the rise of managerialism and keep to its promise regarding decisions being made closer to the patient. In 1995 there was growing concern regarding the apparent phenomenal increase in the number of health service managers, *"the cumulative increase in the number of managers suggests a staggering increase of nearly 7,700% between 1985 and 1994"*, (Appleby 1995). Although Appleby highlights the need to interpret this data cautiously, as yearly re-definition of clerical and nursing staff obscured the real picture, he still concluded that the 1991 reforms in particular had a significant impact on these figures, *" As managerial functions were devolved to trusts, the increase in the number of managers has inevitably accelerated, ....an additional 1,700 managers in three years"*, (Appleby 1995 ).

In effect it would appear that streamlining central management had resulted in transferring existing managers to different tiers and roles within the reformed NHS as opposed to reducing the actual number of managers overall. Bureaucracy seemed more endemic to the NHS. This questioned whether or not, *" Decision- making is being brought closer to the patient through the devolution of responsibility to local level in individual Trusts, GP Fundholding practices, and DHA's"*, (DoH 1994c, p.5 para. 3.3). It also highlights another issue which threatened to produce strains and contradictions, i.e. a market actually being managed. (Butler 1994, p20). For if the market was being tightly managed centrally through national policy and specific standards the capacity for local freedoms and responsiveness to local need was potentially limited.

Another very important component of the effect of the reforms and consequential relationships between Health Authorities and Trusts is analysis of local contexts and local cultures. This is not an easy component to analyse but crucial for understanding opportunities and constraints in the system and the process of implementing national policy. Thus the government had sought to deal with a simultaneous desire for central control and local autonomy, (mainly through the introduction and expansion of general management), which resulted in a dispersal of existing managers to newly defined roles and an increase in the overall numbers of professionals with management responsibilities. Potentially this would have an impact on local power structures and professional relationships. However implementation of reforms and policy at a local level are invariably dependent upon the perceptions and interpretations of management and relationships that preceded any such reforms. Primary data collection reported and discussed in subsequent chapters will seek to highlight the complexities of this and reveal the less visible barriers to change.

As the roles of managers were being re-defined as a result of the restructured NHS (1991 – 1997) the relationship between local freedoms and national responsibilities (NHSE 1994d) was becoming increasingly difficult to manage. Influencing change was therefore dependent upon achieving a balance between national and local responsibilities, local roles and relationships and prioritisation of service provision and investment (DoH 1994c, Dorrell 1996). However this would imply a direct compatibility between the two, when considering service delivery within strict budget controls a judgement needs to be made with regard to where national responsibilities end and local freedoms begin and what is the outcome of this structural context. These are issues pertinent to this thesis.

**The role of 'consumers'**

This section will consider whether or not patients are consumers and reference will also be made to the wider drive for the public to become more involved in the process of

decision making. This would include whether or not Health Authorities, and to an extent GP Fundholders, had involved them in prioritisation of service delivery. There will be a brief analysis of policies which have promoted this role and a discussion of the role of the consumer in a health service context.

*The promotion of the role of the 'consumer' in health care*

Community Health Council's, (CHC's), were created in 1974 as a result of the first major reorganisation of the NHS since its inception in 1948. Community Health Councils were established to represent public views to Health Authorities (Ham 1992, p28) and they arose amid a growing concern regarding public accountability, paternalism and a bureaucratic health service. They were also set up to represent 'the community's interests in the NHS'. However CHC's had been criticised for their lack of power and variation in effectiveness and performance (Williamson, 1992, p128). Although still regarded as the 'consumer watchdog' for health services their role became more focused on monitoring the newly created District Health Authorities (DHA's) with less emphasis on the accountability of service providers.

In effect Community Health Council's were encouraged to shift away from being the body which channelled the public's views to DHA's, their new role was to monitor the role of the DHA and its progress towards the Patients Charter (DoH 1991, revised 1993). To a lesser extent they also assessed how DHAs consulted or involved service users in the purchasing cycle (NHSME 1992). This supposed shift in their role appeared to have a relationship with the more individual 'consumerist' approach at a macro and micro level and suggests encouragement of more direct consumer input to influencing the quality of health services. The collectivist approach to consumerism seems to have been replaced or become second class citizen to the individualist consumerism of the early 1990's, partly because consumer groups are limited in their representation and partly because of the market ethos of the NHS and an increasing societal ethos of materialism.

The promotion of the role of consumer can be traced from an intention to make services more responsive to those who use them, *" throughout the 1980's the introduction of market based systems of resource allocation in a range of economic and social policy areas was seen by the government as a means of widening consumer choice and, thereby, increasing producer responsiveness to consumer preferences.."* (Robinson 1994, p7). This also generated a context where the 'consumers' role became involved in discussions regarding prioritisation of services using methodologies such as Citizen's Juries (Millar, 1996a). Lay representation on Primary Care Group boards, a structure which replaced GP Fundholding after 1997, was a move to make the above type of process more explicit.

The word 'consumer' in relation to a public service context had been used before the 1991 health service reforms, *"the interests of the consumer have to be central to every discussion taken by the authorities and its management - it's not a bolt on 'option' to be used occasionally",* (Griffiths 1988, p202 quoted in Robinson and Le Grand 1994, p110). Working For Patients aimed to give people, *"....better health care and greater choice of the services available ",* (DoH 1989a, p.3 ). However the 1991 reforms signalled a shift in the consumerism agenda because central policies and documentation from the Government appeared to legitimise and sanction the need for lay involvement in the decision making process. Thus 'consumers' receiving health care 'appeared' to have been given a far more pro-active role in their involvement in the process of care as a result of the introduction of the 'internal market'. Health Authorities were more explicitly charged with consulting their local population as demonstrated by the publication of Local Voices (NHSME 1992). This focus on a consumerist approach developed in documentation and issues of 'accountability', patient's rights and involvement in service commissioning increasingly emerged (DoH 1991, NHSME 1992, Marchment 1992, Sang 1994, Sheldon 1994, Brazil 1994, Wilson 1993).

Prior to 1991 lay/patient involvement had largely been confined to the inspection role of

the CHC or dependent on specific service/disease 'user groups' but post 1991 the emphasis had changed with more of a focus on the individual. Brian Mawhinney argued that," *Health Authorities must try to establish local legitimacy for their priorities and purchasing intentions....it is their business to improve people's knowledge about health and health services so they can exercise informed choice.*" (NHSE 1994c).

Health Authorities not only had an obligation to consult with local residents (DoH 1994a, NHSE 1994b), they had to ensure they were involved in the development of services which implied, and for some demanded, a redistribution of power (Clarke 1995, Harris 1995, Spiers 1995, Stocking 1995). So 'consumers' would be 'empowered' and services would be more responsive to their needs. However as Stacey has illustrated (1991) this approach failed to acknowledge that patients contribute to their own health status and labelling them consumers detracts from this. Stacey (1991) was highlighting an aspect of the patient's role that tends to be ignored, namely their own skills in coping with health and ill health. The use of the word consumer implies a dependency on a service/professional whereas in a health services context the relationship may often be inter-dependent, but not recognised as such.

As responsiveness to patient care and the emphasis on enhancing 'consumer' choice appeared to dominate national publications, (DoH 1994a, DoH 1996a) some statements presumed that principles were being implemented and that change was being effectively managed, " *by encouraging efficiency and by giving health professionals and managers the freedom and the incentives to respond to patients' needs, the NHS internal market has shown itself to be a powerful tool for putting patients interests first*", (Langlands, forward to NHSE 1994d). The above statement implied that the reforms and any subsequent restructuring had changed the boundaries between key stakeholders, i.e. clinicians, managers and patients, as consumers. The effects of these changes in relationships were deemed most beneficial for patients.

However the reality of the impact of the restructuring of the NHS at a local level may

be constrained and power may shift from one profession to another as opposed to a more democratic redistribution in power, i.e. the empowerment of consumers of health care. These issues will be examined again in subsequent chapters as the empirical data reveals the reality of the reforms in relation to the redistribution of power between key stakeholders. The capacity of consumers to exercise choice and influence the planning and development of services will now be considered.

**Patients as 'consumers' ?**

As noted above, government policy, such as the Health and community Care Act (DoH 1990), Local Voices (DoH 1991b, 1bNHSME 1992) and the Patients Charter (DoH 1991a), promoted the role of the consumer in healthcare and stipulated that Health Authority purchasers had to take a lead on this. What is made explicit by Lupton et al (1995) is the difference between promoting the rights of patients and on another level a more consultative customer relations approach, which the authors argue through their analysis of work by Winkler has, *"....resulted in a harmless version of consumerism which focuses on the way that services are provided rather than on wider issues concerning the planning and development of services.....this approach has delivered little in the way of real change..",* (Winkler, quoted in Lupton et al 1995).

Patients as consumers, of health care, implied a certain degree of choice for them and an ability to influence those responsible for directly purchasing health care services on their behalf. So although Local Voices (NHSME 1992) generated numerous patient satisfaction surveys, and some innovative approaches at a local level to patient involvement, many argued that the views of these 'consumers' were still marginal with regard to influencing the purchasing agenda (Pfeffer and Pollock 1993, Lupton and Taylor 1995). As the drive for accountability particularly at a DHA level persisted (Whiting 1994) new methods for 'engaging the public' were piloted and 'consumers' became 'decision makers' through their involvement in Health Panels and Citizen's Juries (Richardson and Bowie, 1995, Millar 1996a, Sims 1996). Even the 'pure' arena of

clinical effectiveness did not escape 'involving patients' (Kings Fund 1994, 1996).

Concern has been expressed with regard to the 'lay persons' ability to make informed judgements about healthcare in relation to their given role by the NHS system, *" unless the public understands the NHS – how and why decisions are made, the values and principles that inform those decisions, and gets some real say in how they are shaped in the future – demand will not shut down. You get realistic expectations from knowledge and understanding "*, (Evans 1996). Therefore a lay person has to be given the scope for this type of role based on a shift in the structure of relationships and the knowledge base that influences those relationships. As international research has demonstrated, an informed decision making role for the 'consumer' is not there to detract from the role of paid decision maker (Abelson et al 1995). Williamson (1992) makes the distinction between a 'consumer' who is a 'patient' in clinical circumstances and a user of services per se, who would have a role in a more collective context and discourse about health services. This distinction is crucial and suggests Health Authorities needed to make it explicit how they viewed their local consumers of healthcare. However users of services could, in theory and in practice, fulfil both roles but the 'patient' role indicates a more personal view. This may not be appropriate to collective representation, although 'collective views' of individual patients could be assimilated in a meaningful way.

Conversely a general lack of awareness of services available and little understanding of the 1991 reforms and re-organisation of the NHS (Neuberger 1995, Rudat 1995) amongst the general population could create additional scepticism regarding the role of 'consumerism'. Further mistrust of strategies created to inform the public of the performance of the NHS, i.e. through League Tables, is also evident (Butler et al 1994). Organisations such as the National Association of Community Health Councils and the Patients Association also saw little value in hospital league tables for the 'average patient' (Butler et al 1994). Patients Charters have been criticised for failing users of health services as they focus on waiting times and facts and figures which lack meaning. Instead it has been suggested that they should address issues related to actual patient

care. In view of this Patients Charters were regarded as a self serving tool for managers and the government (Hogg and Cowl 1994).

However some would argue that public opinion has influenced key decisions regarding the delivery of health care (Moore 1995) but this appears to be confined to particularly public and emotive issues such as hospital closures. Journalists have highlighted how Health Authorities could have filled the democratic gap that existed between themselves and the local community they served (Millar 1996b). Others have sought to address more fundamental concerns such as a clearer understanding with regard to with whom, how, and at what level consultation takes place (Williamson 1995).

The Department of Health, recognising the lack of clarity with regard to 'consumer's in the NHS, commissioned a leading academic to provide some discussion and focus on the issue which resulted in a well researched and informative document (Blaxter 1995). The difficulty in defining the word 'consumer', and also resistance to the concept in a health service context was acknowledged (Blaxter 1995, p4). But it was made explicit that the key concept of 'consumerism' was to encourage participation and empowerment with the core aim of promoting informed choice, a concept fundamental to *Changing Childbirth.*

Whilst Williamson (1992) argued that the interests of consumer groups (consumerists) does not always match those of individual consumers, others would argue that the underlying lack of real choices available to patients creates a fundamental contradiction to the whole consumer culture in the NHS, " *given that all health services in the world, including the British NHS, practice differing methods of cost containment, their chief characteristic is rationing of services which automatically removes choice from the consumer* ", (Ebrahim 1993, p263).

As noted previously *Changing Childbirth* appeared to offer real opportunity to address this contradiction and provide real opportunities for choice. More recently at a macro

and micro level patients and members of the public have been labelled stakeholders as well as consumers. However an opinion survey revealed that the general public, from all social classes, rejected the idea of customer, (which has consumer connotations), and stakeholder in favour of 'member of the public' or 'citizen' (Partson 1996), which has a more collective overtone.

Williamson (1992) has explored the role of the 'consumer' in health care in some detail and came to the conclusion that, *"there is a lack of models of how patients can be brought into the decision making effectively"*, (Williamson 1992, p111). What the above discussion has attempted to highlight is the development of the concept of moving 'patients' from the role of passive recipients of care to active consumers beginning to take on the role of lay corporate rationalizers, i.e. determining priorities in their local communities and influencing decision making. However what is also apparent is the gap between central government's promotion of these roles and a disjunction between how patients see themselves, and, how far the system has 'allowed' them to participate as 'consumers' of health care.

With the creation of Primary Care Groups (PCGs) (DoH 1997) this agenda of patient as decision maker has been expanded. The efforts of Health Authorities to grapple with the issues of public/patient involvement in decision making and more importantly priority setting are made more explicit through the development of Health Improvement Programmes (DoH 1997, NHSE 1998). Further guidance emerged in 1999 (DoH 1999) about the roles of patients and the public and the 'new NHS' which signalled an eight year span of initiatives stemming from Local Voices (DoH1991). In view of this the relationships between so called 'consumers' of health care, providers of health care and purchasers of health care warrants further attention. Williamson (1992, 1995) has generated many ideas about interests and ideologies of different professionals and their impact on standards and rights for service users. This will be examined in brief next.

***'Consumers' of healthcare and their relationships with health managers and health professionals'***

Williamson (1992) suggested that interests between individuals and groups of people can be either *Synergistic* or *Non-Synergistic*, i.e., working together or in conflict. However when interests are in conflict, or being repressed by dominant interests, it may not always be apparent. For example she argues that non- synergistic / repressed interests can prevail on two levels:

(1) oppressed - the individual or group identified recognises the conflict of interest but has little power to change the relationship;
(2) suppressed - the dominant interest group secures power in such a way that groups or individuals are unaware there is an issue/ conflict at stake

(Williamson 1992,.pp 7-9).

In this context Williamson is therefore aligning her approach with Lukes (1974) and his theory on dimensions of power (discussed in the following chapter). Some would argue that the latter level has been more prevalent in the NHS and the iatrogenic effects of medicine and healthcare have been used to demonstrate this (Goffman 1961, Oakley 1983, 1993, Skrabanek 1994). This iatrogenic effect represents the ability of a professional group to secure power and authority through the status and actions attached to their role in society. This can then result in a negative outcome/effect, e.g. unnecessary interventions during childbirth, can create a system which excacerbates rather than reduces the problems it was set up to solve.

In the history of the NHS in terms of its relationship with patients and relationships between professionals, level 1 above appears to reflect its culture although there may be other levels that have emerged, for example

(a) patients as 'consumers' have achieved / been given more control, influence and choice with regard to the health care they need to access for themselves, and the community they live in. In addition to this they are 'jurors' and 'lay corporate rationalizers', as well as consumers ;

(b) patients as consumers may have achieved / been given slightly more choice and control regarding their access to health care needs but this was dependent on a shift from a provider led to a purchaser driven, needs based, health care. Thus proxy consumers, i.e. Health Authorities and GP fundholders, represented their interests.

What the 1991 reforms may have produced was a shift, and not a re-distribution, of power and control. Williamson's idea of central government civil servants as corporate rationalizers (1992, P34-7) could be expanded to include Health Authority purchasers as *'local corporate rationalizers'* and local provider Trusts as *'operational rationalizers'*. In this context however it is questionable as to whether or not purchasers could be proxy consumers in view of the following, " *corporate rationalizers support repressed interests...by helping consumer pressure groups ...but at the end of the day corporate rationalizers usually support dominant interests against oppressed or suppressed interests* ", (Williamson 1992, P35-6).

With regard to patients' relationships with providers of care some may prefer to give control, i.e. heteronomy, " *an autonomous choice of dependency* ", (Williamson 1992, p24), this is a form of autonomy but this is very different from taking control without informed consent. Negotiation and the capacity to assert one's preference based on informed choice is reliant upon skills, experience and access to appropriate information. Health professionals often have to give advice as part of their daily routine and, through their training, will be expected to take control of situations and make decisions. These decisions in turn could be influenced by a lack of resources or a form of professional control through suppressed interests (Williamson 1992), or both. The patient may

become aware of the effects of resource constraints on service delivery but be less able to determine and influence the effects of suppressed power on decision making processes.

Even if patient expectations are higher and improved staff training delivers a better service countervailing pressures may reduce the patients synergy, for example, if staff are suffering from stress, fear change and are understaffed this may negate the above and as a consequence, when patients identify these issues, reduce their expectations accordingly. Patients, in observing the above pressures may be restricted in their capacity as 'consumers' choosing to use goods and services, for a variety of structural and individual reasons. This situation could be further compounded by the roles of Health Authorities and GPs as proxy consumers who may not always have synergistic interests with the individuals and populations they represent (Tranter and Sullivan 1996).

*Consumerism versus self advocacy*

In making some observations about the debate at this stage of the thesis the issue of distinguishing between a consumerist approach and a self advocacy approach will be noted. The latter implies citizenship and democracy whilst the former regards health care as a commodity (May 1995). As a result of both the 1991 and 1997 NHS reforms Health Authorities in particular had been given the role of championing the needs of their local population but some have argued that, *"accountability is effectively abandoned.....public consultation is recast as a managerial rather than a democratic responsibility..."*, (Lupton et al 1995). Rights of patients however, advocated by the World Health Organisation (WHO 1994) but limiting in their ability to be enforced (Sheldon 1994), are much harder to assess and achieve. So a broadly consumerist approach in theory appears to exist without patients actually being real consumers in the undemocratic context of Health Authorities and GP's as proxy consumers. The focus therefore appears to have been on housekeeping aspects of a service as opposed to

involvement and participation in fundamental service change and strategy development. This case study will explore if *Changing Childbirth* has been able to challenge this process or, unwittingly, perpetuate it.

Bearing in mind that even 'proxy health care consumers' are at risk of being overridden by a clause to exclude or render inappropriate the views of 'lay' people, *"Further advice allows for the possibility that the responsibility to incorporate local views in the purchasing process may be over-ridden by epidemiological, resource or other considerations "*, (NHSME 1992). A policy drive towards involving the public in difficult rationing, or prioritising decisions (Lenaghan et al 1996, Obermann and Tolley 1997) has resulted in a slight shift in the agenda (NHSE 1996b). The use of Health Panels and Citizens Juries presented an attempt to harness concepts of public rights, responsibilities and citizenship in general (Calnan 1997, Dowsell et al 1997). Achieving an active citizenship role which would seek to align itself with the notion of a consumer exercising choice in the healthcare 'market' is at one end of a very broad spectrum. This spectrum begins with the 'patient' as sick and dependent rather than co-producer of their own care and well being. Health care as a commodity, and patients as commodities, may therefore be in conflict with self advocacy and citizenship.

Health Authorities, under the quasi internal market, also had to secure the purchasing preferences and priorities of GPs whose preferences may or may not have been synergistic with their patients. Patients and consumers of health care therefore may have been , and still be, in competition with each other for services and their choices in opposition to their local Health Authority and GPs. Thus to cast the patient as a consumer is an oversimplification. Their ability to influence the context and circumstances that health services are delivered to them are complex and dependent upon many factors.

Recipients of maternity care, and those who research their views, have been more active than most in their attempts to secure higher standards of care and services which are

more responsive to their needs (AIMS 1991, Kitzinger 1978, Morris-Thompson 1992, Oakley 1983, 1993, Richards 1982). Despite these efforts, concern at a national level had been expressed in relation to maternity services (Health Committee 1992). This report, often referred to as the 'Winterton Report', was well received by professional and consumer groups. Furthermore it was suggested that the wider reforms of 1991, in particular the purchaser and provider split, would create opportunities for services to respond to women's (consumers) wishes (Dobson 1992). As the above context of responsiveness to users and change in service delivery resonated in government documentation relating to the wider reforms (DoH 1989a, DoH 1989b, DoH 1991a, DoH 1991b, NHSME 1992) recommendations produced for maternity care provision will now be considered.

## Section two Changing Childbirth – the national context

### Introduction

This section addresses the macro context of *Changing Childbirth* which will be followed by a section which describes the local context in relation to the case study. *Changing Childbirth* as noted in the rationale to this thesis, has been chosen as a focus to further explore the issues described above: i.e. at a micro level managing change; the roles of purchasers and providers; the role of the patient as consumer; and at a meso level reorganisation of care in response to reorganisation of the NHS. The following sections will now illustrate these issues and the maternity policy agenda:

- the report of the expert maternity group;
- professional issues;
- *Changing Childbirth* and what it sought to promote for 'consumers' of maternity care; and
- *Changing Childbirth* and the wider national context of the NHS.

### The Report of the Expert Maternity Group

The Health Committee report on maternity services (Health Committee 1992) paved the way for *Changing Childbirth*, a report by the Expert Maternity Group ( DoH 1993). Both reports made several recommendations which effectively meant that all health purchasers and providers had to review the organisation and delivery of their maternity care. Recommendations sought to place women at the centre of service provision whilst advocating a more proactive and influential role for midwives in the organisation and delivery of care.

However, even before the publication of *Changing Childbirth*, it became apparent that a

consensus on priorities had not been reached. The Department of Health cited its main concern as the safety of mothers and their children whilst The Select Committee, chaired by Nicholas Winterton (Health Committee 1992), indicated that as much attention should be given to satisfaction as an outcome measure (Dobson 1992). Underlying this argument was a strong belief that women wanted safety and satisfaction but had been historically ill informed (AIMS 1991).

Changing Childbirth promoted three key principles of good maternity care:

> (i) the woman must be the focus of her care;
>
> (ii) maternity services must be readily accessible to all .....and based primarily in the community; and
>
> (iii) women should be involved in the monitoring and planning of maternity services...in addition care should be effective and resources used efficiently.
>
> (DoH 1993, P.8)

In addition to these three principles ten 'Indicators of Success" were listed and if met within five years purchasers and providers would be secure in the knowledge that they had fulfilled the three key principles of good maternity care (DoH 1993 P.70). Below is a list of the indicators, those highlighted (*) represent the key indicators which dominated discussions locally and nationally and perhaps had the most significant impact regarding the management of change.

**Figure 4 Changing Childbirth Ten Indicators of Success. (DoH 1993, P. 70).**

| | |
|---|---|
| Indicator 1 | All women should carry their own notes. |
| Indicator 2 | Every woman should know one midwife who ensures continuity of her midwifery care - the named midwife.* |
| Indicator 3 | At least 30% of women should have the midwife as lead professional.* |
| Indicator 4 | Every woman should know the lead professional who has a key role in the planning and provision of her care. |
| Indicator 5 | At least 75% of women should know the person who cares for them during their delivery. * |
| Indicator 6 | Midwives should have direct access to some beds in all maternity units.* |
| Indicator 7 | At least 30% of women delivered in a maternity unit should be admitted under the management of a midwife.* |
| Indicator 8 | The total number of antenatal visits for women with uncomplicated pregnancies should have been reviewed in the light of the available evidence and the RCOG[4] guidelines. |
| Indicator 9 | All front line ambulances should have a paramedic able to support the midwife who needs to transfer a woman in an emergency. |
| Indicator 10 | All women should have access to information about services available in their locality.* |

Providers of care, in particular Hospital Trusts, would have to, *"review their philosophies of care, their current practices and their organisation to assess how well they meet the key principles."* (DoH 1993, P. 69).

Purchasers of care, in this context Health Authorities, would have to, *" review the services available to their local population, and draw up strategic plans.....they should*

*agree targets with provider units in moving towards services that are more woman centred and community orientated "*, (DoH 1993, P. 69). As maternity care was not included in services GP fundholders were able to purchase independently, there was no specific consultation with them as a separate purchasing group, some pilot sites were initiated in 1996 to explore the potential of Fundholding practices contracting independently from the Health Authority for maternity care. However this did not become widespread and will have changed as a result of the introduction of Primary Care Groups and the dissolution of Fundholding nationally (DoH 1997a).

Purchasers and providers initially appeared to welcome the recommendations of *Changing Childbirth*, for example, *"....there is much to be gained from utilising midwives as lead professionals: it enhances their skills and is a more cost-efficient use of health service resources..."*, (NAHAT 1993a). The Department of Health formally accepted the recommendations of *Changing Childbirth* in January 1994 and required NHS authorities, *"to review maternity services in the light of the reports recommendations and develop a strategy for implementing these......"*, (NHSE 1994a).

Factors which could impact upon the success, or failure, of *Changing Childbirth* and schemes such as Team Midwifery, one could argue, are predominantly resource related, for example, staffing levels and the practical organisation and deployment of team midwives and core hospital staff. These factors, coupled with national disputes over local pay bargaining and the grading of midwives, may also affect staff morale. Local professional relationships and the general implementation and management of change may also influence these factors.

Purchasers had five years to implement recommendations and indicators of success set out in *Changing Childbirth.* The NHS Management Executive requested that purchasing plans and strategies prepared in 1994 had to incorporate plans which would detail how these recommendations would be fulfilled. (NHSE 1994a). 'Consumers', i.e. women, were also given a specific role Not only would services be re-organised to meet their

needs but they would also have a more strategic input, " *consumers should be fully involved in the planning of services, drawing up specifications, quality of standards and monitoring* "[5], (DoH 1993, P. 69).

It was immediately recognised that *Changing Childbirth* had far reaching implications for the way that maternity services would be delivered and the impact this would have on providers of care. However it was purchasers who were charged with managing the change process and producing clear aims and strategic objectives (NAHAT 1993a,1993b, 1993c). In view of the autonomous status of hospital, and community, Trusts the type of relationships which developed between purchasers and acute providers of care would be crucial to the local implementation of *Changing Childbirth.* A redefinition of roles at managerial and operational levels within both organisational structures, i.e. Health Authorities and Trusts, would be of key significance to the nature of the change process.

At a national level *Changing Childbirth* recommended the development of new payment criteria for GP, hospital, midwifery and Community services to encourage more appropriate patterns of care (DoH 1993, P.104). Yet a contradiction emerged as the document also recognised, "*...the fee at present paid to the GP is for ensuring that antenatal care is provided it is not for providing the care. The antenatal fee is part of the more complex fees for services arrangement of the GPs contract*", (DoH 1993, P.35). Thus there appeared to be an acknowledgement that midwives were often providing most care in a primary care setting (DoH 1993, P.35) and a recommendation that changes to service delivery would financially formalise this. On the other hand current payment arrangements for GPs would continue regardless of changes to maternity care provision. An inherent tension in the system of provision was explicitly not being addressed.

---

5 This is interesting to note if consideration is given to the notion of pregnant women being 'contested patients', i.e. the majority are not 'sick' (although they are often given a sick role by the system of care they find themselves in) and as such the patient –consumer debate could be potentially more visible.

The role of obstetricians, particularly in relation to women with uncomplicated pregnancies, had financial implications, *" the resources tied up in consultants seeing these same women, if the women themselves do not seek consultant involvement, needs to be reviewed "*, (DoH 1993, p.66). It was also suggested that the Government, *"provide pump priming and transitional funds to facilitate a diverse range of care and consequent training that will be needed to implement these changes"*, (DoH 1993. P.105). However in January 1994 (NHSE 1994a) there was specific guidance to purchasers and providers that change was to be managed *'within the resources available'*. Grants for pilot projects were subsequently made available through the National *Changing Childbirth* Implementation Team which was set up in August 1994 to, *" identify and promote good practice within the maternity service "*, (*Changing Childbirth* Implementation Team 1995a).

The National *Changing Childbirth Team*, a part of the National Health Service Executive, produced quarterly 'Update Newsletters', first published in February 1995. The Team and the Newsletter served to function as a means of communicating models of good practice of care in relation to maternity services, particularly innovation, research and consumer issues. They also organised national *Changing Childbirth* conferences to disseminate information and bring together professionals working in a purchaser and provider setting to discuss the implementation of *Changing Childbirth*. The grants process administered through the *Changing Childbirth* Implementation Team resulted in some provider units accessing additional funds to implement changes in service delivery, but these resources were in effect 'pump priming' grants, i.e. to stimulate a change in service delivery without a long term financial commitment to sustain it. They were not available to 'roll out', i.e. further develop and expand, existing pilot schemes and only those projects which met strict criteria were supported in their bids.

The financial impact of *Changing Childbirth* although perhaps difficult to predict at the time proved to be a major cause for review of the implications of changes to maternity

services midway through the five year implementation period. (This became apparent during attendance I made to *Changing Childbirth* Conferences in February and October 1996 and this is described more fully further on in the thesis). Although a lack of economic evaluation and rigorous study of resource implications were weak at a national and local level, researching changes to service delivery was only one of the many potential barriers to implementation of *Changing Childbirth.* Initial concerns and potential barriers were related to professional roles, and relationships between, providers of maternity care, namely midwives, GPs and consultant obstetricians. In the following section responses to and interpretation of *Changing Childbirth* will be considered.

**Professional Issues**

Analysis of responses to *Changing Childbirth* from professionals highlighted ongoing inter-professional concerns about changes to services to meet the indicators of success highlighted above. The responses from midwives, GPs and obstetricians are now described below.

*Midwives*

Recommendations and indicators of success in *Changing Childbirth* and the Health Committee report (HMSO 1992) explicitly supported an enhanced role for midwives. Midwives generally viewed the recommendations as long overdue believing that their role had become compartmentalised over the years as childbirth had been transformed from a natural phenomena to one which required medical interventions and lengthy hospital confinement, (Oakley 1983, 1993, Savage 1994). The Royal College of Midwives published a detailed response to *Changing Childbirth* (RCM 1993) and, whilst welcoming the report they stated, *"...maternity care will be facing a radical change within a fairly short period of time "*, (RCM 1993, P.1).

Five areas of activity were identified as essential components of the change process for professionals and women:

(i) information and communication - for women and between professionals;

(ii) the management of change to achieve changes in the pattern of care - to minimise negative effects upon the professionals involved;

(iii) education and training - for midwives, and other professions;

(iv) audit - to evaluate the effectiveness and impact of the changes;

(v) legislative change. (RCM 1993, P.1)

The document also recognised that, *" the financial and manpower implications of the change from hospital based to primary care based services should be fully researched "*, (RCM 1993, P5). Further concerns were noted such as inter-professional reluctance to co-operate, poor dissemination of information from senior managers and the potential shift of resources from the medical to midwifery budget amidst growing 'rationalisation' of staffing in NHS provider units (RCM 1993, pp 8 -9).

Some argued that midwives would *'have to adopt a revolutionary new way of working'* (Flint 1994) requiring a process of re-learning their role as practitioners responsible for their own practice. However this responsibility and reorganisation could have impacted upon midwives in a less favourable way, *"........discussions on the impact of flexible working patterns should explore ways of minimising the potential negative effect upon a largely female workforce........ "*, (RCM 1993, p.5).

Consideration of the effect on working patterns for midwives was deemed particularly important as the most favourable model of maternity care which could potentially provide more continuity to women was Team Midwifery (IMS 1993) and One to One

midwifery care (Page et al 1995). Both of these models required flexible working patterns and required an increase in night cover duty. Others have suggested that not all midwives wanted to change either their professional or personal lives to accommodate recommendations of *Changing Childbirth*, (Cardale 1994). Midwives who had recently been involved in midwifery practices which sought to provide 'woman centred care' and 'continuity of care' had reported increased job satisfaction, (Hynes, 1991, Taylor 1994, Williams 1994).

However the Royal College of Midwives appeared to remain sceptical as to how far recommendations in *Changing Childbirth* would facilitate an enhanced role for midwives and suggested, *" ....primary legislation should be amended to allow direct purchasing of midwifery care through an NHS contract and independent contractor status "*, (RCM 1993, p 13).

The relationships between nurses and doctors in a hospital setting are dependent upon practices which revolved around legitimisation, authority, negotiation and moral order (May 1992). The concepts of legitimisation and authority could be expanded to include midwives in a community setting. For example if midwives provided more care in a community setting this could enhance their autonomy as professionals and re-define their roles in relation to the amount of authority they exercise between themselves and other care givers. A community setting approach would free them from the confines of the hospital hierarchy. However the hospital doctor's authority could be replaced by the general practitioners authority with regard to inter-professional relationships. Assessing General Practitioner's response to *Changing Childbirth* may provide some answers.

### *General Practitioners (GPs)*

The Royal College of General Practitioners and Royal College of Midwives had apparently reached an agreement regarding the role and responsibilities of the midwife, *" A woman may wish to refer herself directly to a midwife. In these circumstances it is*

*essential that the midwife keeps the GP informed of her obstetric progress throughout pregnancy.."*, (RCGP and RCM 1993). Comments in the RCGP's annual report suggested that GPs expected to be more involved, *" It is essential that they (GPs) are involved in maternity care from the outset, and work closely with midwives as each pregnancy proceeds"*. (RCOG 1993, p.161).

It is not clear from the statement above however what this may entail in practice, for some GPs it may mean regular meetings with midwives caring for their respective patients as opposed to hands on care for the patient directly from the GP. Conversely it may mean that GPs increasingly want to become more involved as direct care givers in conjunction with midwives. Continuity of care had financial implications for GPs, *" greater emphasis on midwifery as the profession most likely to provide continuity of care to the majority of women may have an impact on the systems of remuneration both for GPs and midwives"*, (DoH 1993, p.103). Impact on remuneration coupled with a greater role for midwives had the potential to have a negative effect on the relationships between community midwives and GPs.

The British Medical Associations (BMA) response to *Changing Childbirth* detailed several concerns and in particular the belief that there was, *" implicit encouragement in the document to increase the numbers of home births. We would not consider home births a suitable alternative to delivery in hospital ....."*, (BMA 1993, p.3). This is worth noting when one considers the document also stated that promoting greater choice for women may be too problematic because they, *" .....will not be able to make a reasoned choice when the options open to them have not been fully evaluated....choices regarding childbirth should be made in consultation with the doctor "*, (BMA 1993 p.5). This presents problems, first there is a need to debate and establish who the main carer is and how choices are made available to women. Secondly there is no evidence to suggest that all women should give birth in hospital purely on the grounds of safety (Health Committee 1992). A study exploring GP's attitudes to providing intrapartum care, i.e. care during birth, found most unwilling to do so (Browne 1994).

*Obstetricians*

The national response to *Changing Childbirth* from obstetricians, whilst acknowledging the role of the midwife, indicated a preoccupation with semantics. This in turn also highlighted their views on midwives skills, *"The RCOG strongly supports the midwife as an independent practitioner....the adjective link rather than lead would be less confusing...the link professional ...would usually be the midwife for a healthy woman.....we cannot recommend that a woman should go straight to a midwife and stay with her alone for the entire pregnancy"*, (RCOG 1993, p.1).

Additional comments appeared to concentrate on the lack of attention to clinical and fetal matters in the report, it was also suggested that, *" separating the midwife from the general practitioner and obstetrician might be detrimental to the care of the woman and her baby "*, (RCOG 1993, p.1). Concern was also expressed regarding the potential mis-interpretation of *Changing Childbirth*, i.e. it directed attention to home births (RCOG 1993, p.2). The response from the Royal College of Obstetricians and Gynaecologists very much drew attention to morbidity in pregnancy and appeared to criticise *Changing Childbirth* for not doing likewise.

## Section three Changing childbirth - the Local Context

### Introduction

This section will describe the local circumstances of a North West District Health Authority in relation to its attempt to implement *Changing Childbirth* through a district wide review process and development of a district wide maternity strategy. This will include a brief description of what the review process involved. This is a description of the establishment of a Maternity Services Strategy group and the work it commissioned to inform the development of a five year Maternity Strategy document will be described. This work preceded the case study period but it provides the background context for the fieldwork undertaken.

The acute hospital Trust in the district was the main provider of maternity care, in-patient care and community midwifery. This was due in part to historical reasons but the predominant factor was geographical, few women travelled elsewhere to deliver their babies. The hospital Trust had already begun to plan a service change in maternity care in 1993 prior to the publication of *Changing Childbirth,* the proposal being the introduction of Team Midwifery . This proposal was discussed with the purchasers in more detail after the publication of *Changing Childbirth* and during the development of a local five year maternity strategy.

The maternity strategy incorporated support for a pilot Team Midwifery project which was subsequently implemented and evaluated. Findings from the evaluation will not be presented in any detail, however sub-sections in the chapter will seek to consider and explore how the findings were received by the various stakeholders, in particular the purchasers and providers.

### The review process

The Maternity Services Strategy group was established in November 1993 and included health professionals, GP's, Consultants, hospital managers and purchasing managers, representatives from the local Community Health Council and the National Childbirth

Trust. The Health Authority in partnership with the acute hospital Trust set up the group. The Strategy group were given the task of examining *Changing Childbirth* in relation to existing local services with a view to identifying any changers necessary to meet recommendations of *Changing Childbirth.*

The group had to review existing services and also produce a strategy for development of maternity care over a five year period to reflect the implementation timescale for the indicators of success set out in *Changing Childbirth* (DoH 1993, p.70). Their overriding aim was to ensure, " *existing good practice is built upon......maternity services are flexible and responsive to women's individual needs* ", (Chairman, local Maternity Services Strategy Group).

**Local Consultation with key stakeholders, Spring 1994.**

Professionals were asked to comment on *Changing Childbirth* and local women were asked to comment on their recent experiences of maternity services. GPs were chosen by structured random sampling, women were selected from three GP Practices from different localities in the district: an affluent locality; a less affluent locality; and a locality with a more mixed socio-economic population. Midwives were selected to reflect differences in grades, community/hospital practice and part/full time hours of work. All local career obstetricians were invited to interview, some refused and some were not available at the time of the research.

**Table 1. Preliminary research – local maternity services strategy group.**

| **Respondent type.** | **Method of data collection** | **Number consulted** | **Conducted by:** |
|---|---|---|---|
| Women | Focus Groups and semi-structured interviews | 17 | Researcher from the Health Authority and a CHC member. |
| Midwives | Semi-structured interviews | 18 | Two Health Authority researchers and a independent researcher |
| General Practitioners | Semi-structured interviews | 18 | Registrar in Public Health from the Health Authority |
| Consultant Obstetricians | Semi-structured interviews | 4 | Registrar in Public Health from the Health Authority |

This work was used to inform the review and influence the long term strategy. Below is a very brief overview of the findings which will have some relevance to future observations in this case study. (It must be noted that I was responsible for consultation with women and also conducted some of the interviews with midwives.)

*Women's views*

There was a wide range of experiences reported with consensus on some key areas, those being:

- a lack of availability of, and access to, information;
- a lack of choice about their care;
- not feeling involved and in control; and
- a lack of continuity of care and carer.

The views expressed by this small sample of women with regard to existing services did appear to reflect issues put forward in *Changing Childbirth* and the 'Winterton' report which preceded it (Health Committee 1992). Most women said they would choose a midwife to care for them throughout their pregnancy and during delivery. However a few suggested *how* they were cared for was more important than *who* cared for them, with competence and a caring attitude being the essential requirements. This implied that some women may not have a preference over the care giver in terms of their professional status as long as they had the necessary skills and approach to the care they were providing. None of the women expressed a particular desire for a home birth, but none had experience of this type of care. (Tinkler and Barrow 1994).

*Midwives views*

Most midwives felt that *Changing Childbirth* would create tensions between midwives and doctors and they also suggested tensions existed between midwifery management. They were keen to take on an enhanced role but were split regarding the provision of home births. Doubts regarding Team Midwifery and achieving continuity of care for women were expressed, *"...with Team Midwifery she could see 6 - 7 faces and then again in hospital she could meet other midwives. It dilutes the continuity of care, I realise the system isn't perfect but..."*, (Smith et al 1994). There was recognition that effective communication between all stakeholders involved in the purchasing and provision of care was vital for change to be successful.

*Obstetricians views*

Obstetricians agreed that some improvements to services were needed but in the main suggested *Changing Childbirth* was encouraging *'change for changes' sake*' and thus was *'a waste of resources'* (Cullen 1994a). This last comment implied anticipated changes would require additional resources. Obstetricians did not support the view that the term 'lead professional' could be applied to midwives and it was evident that further debate and clarification was required. Opinions about the term 'lead professional' echoed nationally expressed views (RCOG 1993), although there was an acknowledgement that debates about the meaning of 'lead professional' had proved unhelpful. For example 'lead' could infer a number of scenarios: lead care giver during individual episodes of care; or overall named lead care giver throughout pregnancy and childbirth regardless of type and frequency of patient contact. The debate was also potentially related to risk as well as in relation to professional hierarchies. Opinions about other issues were mixed although all obstetricians interviewed suggested that midwives, based on current experience and recent training, were not equipped to take on the additional responsibilities and skills that implementation of Team Midwifery , for example, would require. (Cullen 1994a).

With regard to their own role obstetricians felt that they primarily had responsibility for all high risk patients but should also review documentation for all women, regardless of risk, be present on the labour ward and contribute to midwifery training, (Cullen 1994a). They also supported the involvement of GPs in delivering antenatal and postnatal care to women and were generally not in favour of home births.

*General Practitioners views*

GPs views were based upon varying levels of knowledge and understanding of the recommendations of *Changing Childbirth.* Some believed the main thrust of the report was to increase the number of home births. Others defined continuity as a concept

which goes beyond pregnancy and childbirth for which GPs were the professionals best placed to address this (Cullen 1994b). Thus being 'informed of a woman's obstetric progress' may not be sufficient involvement for these GPs. As a group they expressed concern about 'hidden agendas of power and financing', most of the GPs felt that teamwork would be lost and unnecessary inter-professional friction would arise as a result of implementing *Changing Childbirth.* The GPs, like the obstetricians were aware of the possibility of Team Midwifery being introduced to the district and were generally not in favour of this approach.

Although practical difficulties were given as reasons for a lack of support for Team Midwifery concern was also voiced with regard to the possibility of loss of practice income. This was particularly interesting as nationally there had been re-assurance that GPs would continue to receive payments for organising maternity care, regardless of any actual provision of care or not. (DoH 1993, p.35).

As a result of the above consultation a one day workshop was organised by the Health Authority in May 1994 to present the findings to a multi-disciplinary audience. This audience included health professionals, health managers and some of the women who had participated in the research. Discussions from this event were also used to help inform the Maternity Services Strategy.

**Proposals for service change**

***The Acute Hospital Trust***

In 1994 the acute hospital Trust produced a document entitled *The Way To Midwifery Change* which amongst other things suggested services should be based upon, *"....extending choice and continuity of care to women ..."*, (North West acute hospital Trust 1994). The document advocated that maternity services should be midwifery led. Proposals for adopting a hospital and community based team approach for the whole

process of care for women emerged. However plans to implement this model of maternity care had been developing for several months prior to *Changing Childbirth.* This had included visits to other maternity units providing Team Midwifery care and a detailed bid for additional funding of £90,000 was submitted to the National *Changing Childbirth* implementation team.

Additional monies identified were required for staff costs. There was union opposition to E grade midwives participating in the pilot because of the additional responsibility a team midwife's role would require. Therefore E[6] grade midwives would have to be temporarily upgraded to an F grade if they worked as a team midwife. Audit costs and operational costs, i.e. equipment, uniforms, printing, communication (mobile phones) and additional mileage allowances would all contribute to an overall cost of £90,000 mentioned above. Unfortunately they did not receive any additional monies from the national team. The hospital Trust did **not** approach the Health Authority for additional funding. At this point it is worth considering the concept of Team Midwifery before progressing with a description of local events.

*Team Midwifery*

Team Midwifery is not a new concept and a study of recent and existing schemes, commissioned by the DoH and conducted by the Institute of Manpower Studies, highlighted the diversity and complexity which exists within and between teams (IMS 1993). The survey adopted a triangulation approach to methodology and data collection which combined a literature review, postal survey and semi-structured interviews with midwifery managers and group discussions with clinical managers. Forty five of the 269 maternity units in England and Wales (16% at the time of the study in 1993) had established teams both in a hospital and community setting. It appears that no consensus existed regarding the definition of Team Midwifery although the report determined that

[6]Midwives have a structured grading system in terms of renumeration, i.e. E rising to H, although recent local changes (1998) have resulted in a unified grading system with less hierarchy

all schemes shared two common features:

(i) reducing the number of midwives women come into contact with; and
(ii) improving the continuity of care. (IMS 1993)

In addition the IMS highlighted some definitions of Team Midwifery as reported by midwifery managers in the survey.

**Box 1 Defining Team Midwifery**

"A group of midwives working together to reduce the number of professionals involved in a woman's care, to ensure that each woman will meet the same midwives throughout her pregnancy"

"A community based system which involves midwives working flexible hours and delivering their women in hospital"

"A small group of midwives providing total midwifery care in a defined number of women. There is a named midwife who is the main carer, when she is not available the care is provided by another team member"

"Being on call 24 hours a day"

"A team of midwives with an allocated workload from a particular geographical area or GP practice"

(IMS 1993, p37)

Three main models of Team Midwifery were identified in the IMS survey.

(i) Teams of midwives providing hospital care only.

Midwives worked as teams covering antenatal wards, labour and delivery suites and postnatal wards, enabling some continuity of care for women during their hospital stay. Women would be cared for in the community either by a midwife who worked at their GP practice or in some instances by a team of community midwives.

(ii) Teams of midwives providing community care only.

Women would receive most of their antenatal and postnatal care from a team of midwives working in a community setting but hospital based midwives would care for them during labour and delivery, if they delivered in a hospital setting. The hospital midwives would, in most cases, not know the women prior to their admission to the hospital/maternity unit. The women however would receive continuity of care before and after delivery of their babies from the community team.

(iii) Teams of midwives providing care in both hospital and the community.

Women would receive care from the same team of midwives who work in a community and a hospital setting therefore increasing the likelihood of those women being delivered by a known midwife. A comprehensive system of care would be provided throughout pregnancy, delivery and the postnatal period. This aspect of continuity of care was considered the most popular reason for re-organising midwifery services in the survey.

However the survey noted that, *"there were, however, several modified versions of these main models illustrated both within the survey and during the interviews"*, (IMS 1993, p 51). Team Midwifery, in particular delivered from a community and hospital based setting, had been found to provide women with more opportunity to be the focus of their care with an emphasis on, *"the needs of the woman and not just as a carrier of her baby; more time is given than in hospital or by the GP to explaining things in detail and*

*answering questions....",* (Health Committee1992, p.xiv).

Others have been more sceptical about whether Team Midwifery could provide woman centred care, *" Team Midwifery may be the answer......however having watched the evolution of teams over the last decade.....I believe that the caseload practice pioneered by the independent midwives is the one which will serve women best",* (Savage 1994). This type of practice does place demands on the midwife who would be responsible for a defined number of women, providing 24 hour cover. Support for on-call duties would be shared with a partner midwife, as opposed to sharing the defined caseload with a team. However the caseload model would guarantee continuity of care and carer to both women and midwives.

Some concern about the level of commitment required by midwives to a team approach was expressed as were implications for staffing and finances (Browne 1994). Existing schemes, in particular the community and hospital based teams, were resource intensive and had raised issues about sustainability of commitment in relation to increased workload for midwives. Teams providing all the care for women often involved over time working and additional on-call duties, i.e. being available during night time hours for women who went into labour and were admitted to hospital.

However a hospital and community based approach, it has been suggested, offers women the best opportunity to be delivered by a known carer, *"the schemes where midwives worked in both the hospital and the community appeared to show the most success in providing the woman with a midwife for her intrapartum care who was not a stranger",* (IMS 1993). Being delivered by a known carer is one of the key indicators of success of *Changing Childbirth* and also offers midwives the potential of increased job satisfaction as they would be using a range of skills on a continuous basis. Underlying this concept was the potential for improved continuity for midwives as the team approach offered the scope to move away from task centred care (hospital) to a more holistic 'package of care' (predominantly community).

**Potential barriers to implementing Team Midwifery.**

In the local case study hospital midwifery managers had spent eight months prior to the implementation of the pilot project (September 1994) presenting their proposals at GP locality meetings and they had also targeted individual GP's to gain support. They encountered strong opposition from many GPs but secured enough support to be able to plan to produce a proposal which would cover approximately a third of all births by Team Midwifery in the district.

Consultant obstetricians had not been in favour of the Team Midwifery approach for reasons outlined above, however the clinical director of the maternity unit during this period was supportive of the midwifery managers, who were the driving force behind the proposals for change. The introduction of a pilot Team Midwifery approach would not have a direct impact on the day to day working practices of consultant obstetricians, in fact it would benefit them as practitioners allowing them to make better use of their skills and time caring for women who were considered high risk and in need of specialist support.

However as professionals they may have felt threatened as Team Midwifery could result in most women being less dependent on them as practitioners. Team midwives would have an enhanced role and be capable of providing most, if not all of a woman's maternity care in the hospital and community setting. Thus the support of the clinical director for Team Midwifery was significant. Midwifery managers had also encountered opposition to Team Midwifery from hospital and community midwives. This was revealed more explicitly during the qualitative evaluation of the Team Midwifery pilot project which will be discussed briefly in subsequent chapters.

**The Health Authority's Maternity Strategy.**

In November 1994 the five year Maternity Strategy was published and disseminated.

**Figure 5. Five key aims of the local Maternity Strategy.**

| | |
|---|---|
| Aim 1 | To enable women to be fully informed throughout their maternity care |
| Aim 2 | To ensure women are familiar with the people who care for them throughout their pregnancy, labour and postnatal period |
| Aim 3 | To improve access to and provision of maternity services |
| Aim 4 | To address professional issues to ensure that maternity services achieve the best outcomes for women. |
| Aim 5 | To ensure women are actively involved in planning and reviewing maternity services. |

(North West District Health Authority 1994)

Aim 1 sought to enable women to make more informed choices about their care and the hospital Trust had lead responsibility to fulfil this aim. Team Midwifery was cited as a model of care which would be piloted as a priority for action to meet aims 2 and 3, the hospital Trust was also given lead responsibility for these aims. The regional advisor in general practice and the hospital trust had responsibility for aim 4 whilst the Health Authority had lead responsibility for aim 5. This would involve the production of a service specification agreement reflecting recommendations in the maternity strategy.

The most significant and radical changes were related to the pilot Team Midwifery project as this had implications for the way services would be delivered in the hospital and community setting. It would impact upon midwives, GPs, consultant obstetricians

and of course women using maternity services. The pilot Team Midwifery project had in fact already started in September 1994, one month prior to the publication of the maternity strategy. However the Health Authority had made explicit it's support for the project and the maternity unit at the hospital trust had secured support from enough GPs to forge ahead. As noted above no additional monies were secured by the hospital Trust therefore the pilot project was implemented within existing resources.

**Team Midwifery - Implementing organisational change**

The pilot Team Midwifery project commenced in September 1994 in two localities for a twelve month period. Some of the key objectives were to :

(i) improve continuity of care for women leading to a more personalised service with less conflicting advice;

(ii) give the pregnant woman the opportunity to familiarise herself with a dedicated team of midwives in the knowledge that one of these midwives will be present at the birth; and

(iii) further develop working relationships between GPs and midwives.

(North West acute hospital Trust 1994)

Purchasers had the responsibility for providing a strategic focus for the change process whilst managers from the maternity unit in the acute hospital Trust had to manage operational changes. *Changing Childbirth* therefore had the potential to provide an impetus for the Health Authority to support Team Midwifery, as this model of care had the potential to meet many of the *Changing Childbirth* recommendations. Thus the Health Authority had to monitor the change process and ensure that service changes met government policy, i.e. the indicators of success (DoH 1993). This was an example of

national responsibilities and local freedoms trying to work together. The Health Authority had to adopt a strategic implementation role whilst the provider (the acute hospital Trust) endeavoured to pursue a local freedom, as a self governing trust, with their model of maternity care.

*Changing Childbirth* (DoH 1993) also focused additional attention, and pressure, on Health Authorities who would have to ensure that service changes benefited local people. Providers, through the contracting process, would be expected to give detailed information as to how effectively they were performing.

**Evaluating organisational change**

The Health Authority provided funding for an independent qualitative evaluation of the pilot Team Midwifery project, This commenced in November 1994 and concluded in November 1995. I was seconded from the Health Authority to Liverpool University to undertake the evaluation. The aim of the evaluation was to identify and explore the views and experiences of women, midwives, GPs and obstetricians involved in the pilot project. The specific objectives were to:

(i) identify models of good practice and examples of appropriate and effective maternity care elsewhere;

(ii) assess the impact of Team Midwifery in relation to women's experiences of their care during pregnancy and childbirth by comparing the experiences of those women who receive Team Midwifery care with those receiving no change maternity care[7] during the same period;

(iii) assess the impact of the pilot project on the professional roles of midwives, GPs

[7] The term 'non-pilot' and 'no change' maternity care used throughout this document refers to those women who participated in the evaluation and were not receiving care from teams of midwives.

and obstetricians;

(iv) identify the experiences and perspectives of those professionals involved in the pilot project and responsible for the delivery of care;

(v) consider whether or not the pilot scheme has contributed to improvements in maternity care as opposed to' no change' maternity care.

This qualitative evaluation complemented the quantitative in-house evaluation of Team Midwifery, conducted by a research midwife employed by the hospital Trust. The quantitative evaluation sought to assess Team Midwifery in relation to two specific indicators of success:

(i) every woman should know one midwife who ensures continuity of her midwifery care; and

(ii) at least 75% of women should know the person who cares for them during their delivery. (DoH 1993, p.70)

In addition, attention would be focused on outcomes of delivery and the concerns expressed by obstetricians that, " *new patterns of care in Team Midwifery may adversely affect referral patterns for at risk women* ", (Report of the quantitative evaluation of Team Midwifery, North West acute hospital Trust). This latter comment gives an indication of local obstetricians' views regarding the competency of local midwives.

Findings from both evaluations would be presented to the Maternity Services Liaison Committee (MSLC) which replaced the maternity strategy group in December 1994. Membership still reflected the multi-agency approach of the strategy group but there was an effort made to include more service users. This was in part a response to national guidance on membership of MSLCs and also reflected a desire by quality managers

from the Health Authority to continue to engage service users in work related to local maternity services. Two women, originally consulted as part of the preliminary research process mentioned above, joined the group which was also chaired by a lay person. However service user involvement met with resistance from obstetricians which resulted in small sub-group meetings for the service users to enable them to fully participate in the formal MSLC and not feel overwhelmed by the presence or behaviour of the obstetricians.

The evaluations would be used to inform the decision making process with regard to the future of Team Midwifery and maternity care. In parallel to this was a move by the Health Authority to introduce a separate contract for maternity care, as previously monies and quality standards for maternity care were incorporated into a wider block contract for acute hospital services. At this stage of the change process it was unclear as to how and who would make the final decision about Team Midwifery and whether or not providing a better service to women would necessarily be the most influencing factor. The following chapter will present a description of how primary data was collected in relation to observing events after findings from both evaluations were presented and disseminated. All too often research appears to be conducted and little attention is given to the processes which take place after findings have been disseminated. This is why I chose to conduct the case study during the post evaluation stage of the pilot Team Midwifery scheme and why I adopted a researcher/employee ethnographic approach to the case study.

Although there appears to be a lack of attention to post service evaluation and research and the effects of specific policy implementation there has been some recognition of its importance, *we need a clearer understanding of how: to handle new products or service development; to create positive incentives within contracts to reinforce high standards of performance; and to manage risk-sharing between purchasers and providers* ", (DoH 1994a). In addition there has also been a need identified for, " *...informed environmental scanning within the health service and at its many*

*organisational levels, and, second, an understanding of how this wider picture interacts with internal processes and structures "*, (Tilley 1993, p286).

## Section four Summary and conclusions from the literature review

The NHS policy context of the early to late period of the 1990's was based on a political will to challenge the existing order of medical dominance and a provider driven health care system. Policy reform of public sector services during this period was also associated with a political drive to curb expenditure on the welfare state and encourage members of the public to 'go private', i.e. contribute to private health insurance schemes (Mohan 1991). The NHS was not considered cost effective and the Thatcher Government, reluctant to raise taxation, wanted value for money from the public sector, despite a relatively historic modest Gross Domestic (GDP) spent on health compared to other European countries (Ham 1996).

Management reform, the introduction of the internal market, more emphasis on evidence based medicine and the promotion of the patient as a 'consumer' all sought to weaken the power of the acute sector and introduce more accountability from senior medical professionals in particular. There were mixed responses to the reforms from various professional groups, for example some GPs embraced the notion of Fundholding whilst others rejected it for fear of becoming further embroiled in the rationing of health care. The purchaser provider split together with Fundholding was seen as a mechanism to make financial transactions between different sectors of the NHS more transparent. The conservative government wanted to break down professional barriers, get rid of outmoded practices and make patients and potential users of health care more central to the NHS system.

League tables were introduced for NHS hospitals to enable greater public scrutiny of the performance of the acute sector. The Government had some expectation that either the public would challenge poorly performing and unresponsive services and/or Fundholders would use their purchasing power to switch contracts to better performing hospital Trusts. Evaluation of the reforms however was lacking and initially there were few studies conducted making it difficult to assess the overall impact of the reforms and,

perhaps more importantly, service specific changes to patient care. So it was difficult to determine whether or not the reforms actually fulfilled what they had set out to achieve, (these issues are explored in more detail in later chapters).

*Changing Childbirth* was published in 1993, two years after the introduction of the internal market to the NHS. The Department of Health formally accepted its recommendations in 1994. Purchasers, i.e. Health Authorities but not Fundholders, had up to five years to implement the recommendations and in particular the ten indicators of success the document promoted as key to achieving a quality maternity service. Although Health Authorities were expected to manage the implementation of *Changing Childbirth* GPs, midwives, obstetricians, hospital Trust managers and women all had a key role to play in the service development process.

Although many of the recommendations set out in *Changing Childbirth* were welcomed several issues emerged that had the potential to hamper its implementation and these were: dis-agreement about the term 'lead professional', re-grading of midwives in recognition of their newly enhanced role, a lack of clarity about remuneration for GPs type of involvement in the process of care, a lack of resources to pump-prime new initiatives, a lack of workforce planning to ensure the relevant level of skills were matched to new ways of working and a general under-estimation of the professional resistance to change.

Inter-professional concerns were highlighted through a series of national responses to *Changing Childbirth.* Midwives in particular welcomed *Changing Childbirth* but expressed concerns about such radical change being implemented in a relatively short space of time. They also suggested that it would be difficult to shift resources from a medically orientated model of maternity care to a more community based approach. Whilst GPs appeared to be in favour of changes to the way maternity services were currently being delivered they expressed reservations about the potential increase in home births they perceived would take place and indicated a reluctance to support such

a choice. They also stated that any choices made by women in respect of their care would have to be done in consultation with a doctor. Obstetricians acknowledged the role of midwives but were unhappy with the term 'lead professional' being associated with a midwife. This issue tended to dominate both national and local discussions in the early stages of implementation of *Changing Childbirth.*

The local hospital Trust had already begun to make plans for changes to maternity services in 1993 and the publication of *Changing Childbirth* provided something of an impetus for local midwifery managers to drive the change forward. The key initiative was a pilot Team Midwifery project, views had already been canvassed from local professional groups which had highlighted some resistance to change. Women's views had also been sought and those views reflected key themes for service improvement featured *in Changing Childbirth,* in particular continuity of care, more information, more informed choice about their care and more involvement in the process of care.

The views expressed by local GPs and Obstetricians in particular revealed inter-professional tensions regarding *Changing Childbirth* and a lack of support for the pilot Team Midwifery project. However a maternity strategy was launched in 1994 and the pilot project was implemented and subject to an internal and independent evaluation.

The following table depicts issues and themes that inter-relate the 1991 reform agenda with the policy intent of *Changing Childbirth* and some of the key aspects of the local case study. These issues and themes are also central to informing the direction of the case study and partly determine the initial hypotheses and data collection processes. For example did local policy implementation redefine working relationships, professional roles and the decision making process?

**Table 2 Commonality of issues pertinent to the case study**

| Key aspects of the 1991 reforms | Changing Childbirth – National context – key aspects | Changing Childbirth - Local context - key aspects |
|---|---|---|
| Re-structuring of the planning and delivery of NHS services | Re-organisation of maternity care promoted with a shift away from the medical model | New maternity strategy – citing Team Midwifery as a preferred model of service delivery |
| Better use of existing resources – cost effective | More efficient use of resources | Promoting a re-distribution of existing resources through skill mix |
| Changes to management structures and professional responsibilities | Midwives as lead professionals encouraging them to have, overall, a more pro-active and influential role in the organisation and delivery of care | Changes to the roles of midwives, GPs and consultant obstetricians |
| A more pro-active role for 'consumers' of health care | Women should be involved in the monitoring and planning of maternity services | Service users consulted about their experiences of local maternity care |
| Re-distribution of power<br>More accountability established through the purchaser / provider split | Midwives as lead professionals - encouragement of better monitoring systems for the cost and process of care | Team Midwifery enhanced the roles of midwives and the local maternity module separated costs out of the block contracting process |
| Breaking down professional barriers through the purchaser / provider split and local policy implementation | Promotion of better use of midwives skills and more targeted use of GP's and obstetricians skills – more appropriate use of existing resources | Re-designing the delivery of maternity services and enhancing the roles of midwives – the resistance to Team Midwifery resonated with old professional hierarchies |

| Key aspects of the 1991 reforms | Changing Childbirth – National context – key aspects | Changing Childbirth - Local context - key aspects |
|---|---|---|
| Greater integration between the primary and secondary care interface | New models of maternity care encouraged to provide continuity of care for both women and midwives | Introduction of a pilot Team Midwifery scheme – midwives worked in the community and hospital setting |
| National standards and evidence based medicine | Ten indicators of success designed to achieve overall improvements to maternity care provision - if implemented | Evaluation of the Team Midwifery pilot conducted with some outcomes compared to the ten indicators of success |
| A lack of evaluation was regarded as a weakness in the whole NHS reform agenda from the outset. | Evaluation, including economic evaluation, of new schemes was encouraged but dependent on extra resources which were not abundant. | Evaluation was conducted but did not include an economic evaluation and was implemented during the early stages of the pilot project |

There seemed to be a connection between the notion of national responsibilities and local freedoms, promoted by the 1991 NHS reforms, for the local case study and how this was translated into everyday service delivery and local policy and strategy development. This had implications for how resources were used, who became involved in policy implementation and local decision making and also how the process was managed between key stakeholders. Therefore it became important to consider processes from a macro, meso and micro perspective to gain a more complete understanding of roles and relationships during periods of reform and re-organisation. A description of the methodology and why certain approaches were adopted to conduct the case study and shape the analysis will now be presented.

# Chapter four Methodology

## Section one Choice of method

### Qualitative versus Quantitative

Quantitative research methods are very well designed to enable the researcher to inform the reader *what* has happened under a particular set of circumstances and to quantify this but they are not always able to tell the reader *why* that something has happened. Quantitative methods normally aim to provide data which can be translated into quantified answers to specific research questions whereas qualitative approaches seek to understand concepts and provide explanations as to what happens in a certain way.

Randomised Controlled Trials (RCTs) are regarded as the gold standard for quantitative studies and they are reliant on hypotheses testing through experiments controlled through various randomisation techniques. However experimental methods, which usually impose very strict controls on the research subject/setting, are rarely appropriate to study interaction between people and interpretation of that interaction. Quantitative approaches using for example postal surveys may give you data on the number of people who behaved in a certain way, i.e. non-compliance with medication regimes, but they cannot provide a great deal of insight or theories on why this non-compliance takes place.

To understand human behaviour and decision making, on any scale, requires methods which enable the researcher to gain an understanding of why events have happened in a certain way. This therefore requires either observation of behaviour and interaction in natural settings and/or direct face to face interviewing with research subjects. These approaches can also be supplemented by secondary data sources such as policy documents, written forms of communication and documents related to the research subject. As Pope and Mays have suggested, *'people are complex and should be studied*

*by watching them, joining in talking and reading what they write'* (1995a)

Although the dichotomy presented between qualitative and quantitative methods is often related to inductive (generating hypotheses from observation) versus deductive (hypotheses testing) this is not always as distinct as it is presented. There is scope for some hypotheses testing in qualitative research whereby the researcher moves from some initial hypotheses through to emergent hypotheses. This combines a deductive and inductive approach enabling the researcher to move backwards and forwards between the raw data, analysis and conceptualisation so that the whole research process is an inter-related piece of work from beginning to end, (Bryman and Burgess 1993). This combined approach would be conducive to, for example, a case study approach where the researcher wanted to explore aspects of an organisations decision making processes using a variety of methods over a period of time.

**Why a case study approach using participant observation?**

To observe policy implementation in its raw form required an approach that facilitated analysis of interactions and processes in a natural setting to observe the subtle and not so subtle dynamics of local decision-making processes. Today's health professionals work in an increasingly dynamic and complex environments and this has created both the need for and opportunities for the development of new approaches to health services research, (Pope and Mays 1995a).

A case study approach was chosen, with a triangulation of data collection techniques comprising participant observation, analysis of written communications and documents, and informal verbal communication with key research subjects. This methodology was chosen because it was applicable to my intention to study and question the contemporary phenomena of policy implementation at meso and micro levels in the NHS system. Observation of natural phenomena over a period of time would enable me to contextualise both my initial and emergent hypotheses through the exploration of local

policy implementation.

Observation was selected as opposed to, for example, direct face to face interviewing because I wanted to participate in the research context, i.e. the fieldwork role, over a long period of time experiencing day to day routines and interactions. It seemed to me important to be part of the research context and not be a transitory researcher conducting interviews with pre-set questions time limited by interview schedules. I needed to understand why people acted and communicated in a certain way and whether or not there was consistency in this. As Mays and Pope have commented when describing the value of observational techniques in qualitative research, *'it can help overcome the discrepancy between what people say and what they actually do'* (1995). This can be applied to both the written and oral word and suggests that it may highlight behaviours and actions that one to one interviews may fail to uncover. Observational methods can therefore be used to avoid bias which is found in what people actually do as opposed to how they present themselves to others.

In circumstances that require an in-depth study of day-to-day actions and routines observational methods are the favoured option for the study of the working practices of organisations and the interaction that takes place within them.

**The sampling technique**

This section briefly describes the sampling technique and criteria used for inclusion in the case study and subsequent observations. Because of the nature of the data collection process and initial and emergent research questions I sought to answer, a theoretical sampling technique was adopted. This technique guided the process of data collection which involved who I collected data from and the type of data collection that was required to further the research and respond to initial and emergent research questions. It was therefore not a fixed process and was dependent on developing theories and explanations before and during data collection and an ongoing analysis of emergent

findings (Glaser and Strauss 1967). This meant that both the number and type of informants and data sources in general could be extended and adapted to respond to continuing issues for exploration of new and related issues that provided insight to the research context.

As I had conducted a qualitative evaluation of the pilot Team Midwifery project just prior to the commencement of my case study I had a baseline source of key contacts and documentation relevant to the research context. This informed the initial criteria for selection of the samples and was developed through a systematic expansion of samples by continuing to establish which people and forums would be a valuable source of data relevant to the social phenomena being studied. Theoretical sampling also provided me with an alternative check on existing data as I could use new subjects, events and documentation to assist with validation of existing data.

*Research subjects*

Research subjects were selected for initial inclusion in the case study based primarily on their role as either a health professional or health service manager working in a maternity care related role, on the provider side of service delivery, or managerially responsible for policy implementation and decisions related to resource allocation, on the purchaser side of service provision. This initial selection also included key people who were involved specifically in the pilot Team Midwifery project, for example a research midwife and the quality manager at the Health Authority. Additional research subjects were included for observation when decisions about the future of Team Midwifery became more critical for the purchaser and provider relationship, i.e. the Chief Executive of the hospital Trust and the Director of Public Health.

As the research context expanded and the decision about Team Midwifery continued to be inconclusive further research subjects were included, for example GPs not involved in the pilot project.

*Meetings and key events*

A key source of data was the systematic observation of behaviour and verbal discussions that took place during forums organised to present the findings from both the qualitative and quantitative evaluations. As a result of some of these findings further meetings were set up with representatives from the hospital Trust and Health Authority to resolve issues related to the future of maternity care provision, this provided a valuable source of data regarding decision making processes. In addition, in my employee role, I was asked to provide briefing reports on key national issues and attend national conferences on *Changing Childbirth*. This provided me with a further means of assessing the relationship between the local policy context and the national policy context. A site visit to another north west district implementing Team Midwifery took place and data obtained form this visit was used in the case study.

The above was supplemented by data obtained through informal contact and exchanges of information with some key informants, i.e. quality manager, midwives, Chief Executive of the Health Authority, commissioning manager from the Health Authority.

*Documentation*

Documentation available to me was varied and obtained through both formal and informal routes. Local strategies, the maternity module, copies of notes from meetings and memorandums were disseminated to me in my employee role. Copies of letters and faxes relevant to the negotiation process between the health authority and hospital Trust were given to me on request by senior managers at the health authority. I also generated reports, memorandums and emails through my own work for the health authority pertinent to maternity services and *Changing Childbirth*.

This local documentation was supplemented by national documentation in the form of directives from central government, Changing Childbirth newsletters, studies and

service evaluations of other pilot midwifery schemes and academic literature on maternity care. This was collected before, during and after the data collection period.

(For a full list of relevant published and unpublished local documentation used as key source material for the thesis see the references section at the end of the thesis).

## Section two Primary data collection

### Introduction

This section describes my role as opportunistic observing participant using primary observational data collection methods in the post evaluation stage of the case study. The description of my role is preceded by an overview of the ethnographic approach and the value of fieldwork as a means of reflexive inquiry of particular phenomena. I aim to show that qualitative research and more specifically the research method itself should also form part of the interpretation of the study. This is because I want to show that the fieldwork experience cannot be separate from theory, conceptualisation or (political) reflexivity (Okely and Calloway 1994, p4). An explanation of how the evaluation was transformed into a research study and some comments on the value of developing the overall research process in relation to a case study approach will be explored. Concepts for developing an interpretation of the implementation of policy are also presented in the next section.

Having conducted the qualitative evaluation of the pilot Team Midwifery project (November 1994 - November 1995) I returned to full time employment at the Health Authority. My participation in the evaluation and my position as an employee of the Health Authority allowed me access to both documentation and key people in the organisation as well as gaining acceptance by these senior officials. This facilitated formal and informal gathering of data to be undertaken between November 1995 and April 1997. I was thus able to interact and move between different levels of personnel and key stakeholders within the Health Authority and externally with staff from the acute hospital trust and some GPs. It was during this period that the role of opportunistic observing participant was adopted.

## Qualitative research

### *Background rationale*

The adoption of qualitative methods within a health service setting is increasing (Patton 1987, Popay and Williams 1994, Pope and Mays 1995). Associated which such an approach is often a requirement to produce recommendations for service delivery. However the nature of qualitative approaches, and often the short time period in which to conduct the research, means there may be less opportunity to gain an understanding of some of the more complex issues that may be encountered. Nevertheless I was certain that by using a qualitative approach to my research it would provide more opportunity to spend time attempting to uncover some of the complex issues that are often revealed but not always explored and understood, " *instead of testing hypotheses which are already known, qualitative research can produce new insights not yet available",* (Faltermaier 1997).

So the intention was not only to produce exploration of the issues but also seek to gain a further understanding of what these 'insights' mean and how, in the context of this thesis, they may contribute to improvements in successful policy implementation. Furthermore if the research produced was more meaningful to policy makers, policy implementers and health service planners there would, potentially, be a more direct relationship between research, policy, effective practice and effective change.

The prevalent focus of clinical effectiveness and evidence based medicine dominant in British health care settings can detract from the context and culture of the organisation of the provision of care and implementation of health policy. Research into new forms of organisation and evaluation of reforms which impact upon those responsible for re-formulating and delivering change has been seen to be explicitly lacking, " ......*the most neglected part of the whole exercise is evaluation..*(and a need was identified to).....*to upgrade and profoundly change the nature of the traditionally neglected research*

*function as it relates to NHS organisation, management and control",* (Tilley 1993, p282).

Tilley and others, most notably the Kings Fund (Le Grand and Robinson 1994), paved the way for more use of (and funding for) both qualitative and evaluative organisational research and, although still the poor relation to medical research, recognition of its value is increasing (DoH 1995). With the introduction of a quasi market type system to the whole of the NHS in 1991 new functions, roles and new identities emerged and this would have an impact on how care was purchased and how it was delivered. The combined effect of these structural and operational changes presented a seemingly complex and challenging research environment. I wanted to know more about policy implementation and its effects on the organisation of care and professional roles. In particular I wanted to consider the dynamics and competing priorities, if they existed, between national responsibilities and local freedoms.

In order to examine policy implementation at a local level and gauge its impact on managers, professionals and service recipients, an in depth study, building on existing local research was pursued. Official audit forms and responses to regional information requests could provide routine data but this did not provide answers to the research questions I posed, for example:

- what factors and processes influenced decision making when implementing change in response to national policy;
- how did the above shape the negotiation for and ownership of resources between organisations and between groups of individuals;
- what impact does the context and culture of the NHS system have on roles when change is being implemented; and
- what effect does change have on inter-organisational and inter professional and intra-professional relationships.

Answers to the above would be difficult to quantify and warranted a methodology that enabled scope to assess and re-visit real life situations. The research approach had to facilitate a process which allowed me to re-formulate concepts as data emerged and re-conceptualise findings over a period of time. The qualitative approach offered me a choice of methods which would enable me to address my research questions, i.e. an in-depth case study, conducted over a period of time using a form of participant observation. This approach would help me to provide an account of the day to day inter-organisational activities between purchasers and providers. I could also observe first hand interaction between key managers and professionals which had the potential to open up further avenues of exploration and connectivity between concepts.

Therefore as I was seeking to research policy implementation and its consequences for individuals and groups of individuals, i.e. managers, health professionals and women, qualitative methods were appropriate because they concentrate on individual and group experiences and can be sensitive to meanings attached to those experiences, *"....giving more room for meaning in life, allowing for more openness, for unanticipated meanings and connections, ...and generalising from understanding...... aiming more at the formation of concepts and theories"*, (Faltermaier 1997, p357).

**The significance of choice of method - self study and researcher role.**

Personal affiliation with certain methodological and theoretical schools of thought, i.e. positivism or phenomenology for example, is often claimed or alluded to in research reports and papers but there is usually little or no explanation as to why it was adopted. Garfinkel (1967) drew attention to the influence of researcher role on findings and analysis. Recently, in sociology, there have been attempts to re- highlight the importance of this (Hak 1997). Scheff and Starrin (1997) have noted the value of Garfinkel's promotion of self study, *"..to become accurate and effective, all studies, whether quantitative or qualitative, need to become intensively conscious of the part their own methods and pre-conceptions play in generating findings"*, (Scheff and Starrin 1997,

p355).

In pursuing this notion of the researcher as integral to the research process itself I suggest that it creates more openness about the research process enabling an awareness of what actually happened so that the data, and how and why it was collected, becomes more visible.[8] This may help to address issues associated with validity and reliability (discussed below), and also what Hammersley describes as 'credibility' and 'plausibility' (Hammersley 1990, p 73). These terms are fundamentally about assessing whether or not the researcher has been consistent in their approach to the study (credibility) and reasonable in any inferences and conclusions made (plausibility).

This notion of self study and reflexivity is of course familiar territory to many anthropologists (Okely and Calloway 1994) whose research approach, ethnography, and research method, fieldwork, are also used by researchers who are themselves 'sociologists'. Whilst I do not wish to become involved in debating the disciplinary origins of ethnography, I regard my research approach as synonymous with ethnography (Wolcott 1995, p63). I consider that my fieldwork approach also combines elements from sociology and anthropology. The description and justification detailed in this chapter seeks to show why I chose particular methods for the study and why I deemed this appropriate. From a sociological perspective, policy, power and negotiation were related issues that offered avenues of exploration and consideration whilst from a methodological perspective I was interested in my opportune fieldwork role.

**The Ethnographic approach**

To consider ethnography and show its relevance to my study, i.e. give some 'credibility' and 'plausibility' to its use in relation to the topic of study, I feel it is important to make reference to some definitions and characteristics.

---

[8] I am not suggesting the argument for more researcher self awareness be confined to academic study merely pointing out that scope to do so is perhaps historically dependent on the original purpose and context for the research and to a lesser extent the type of methodology employed.

Ethnography has been defined as, *" the direct observation of an organisation or small society and the written description produced. Often the method of observation involves participant observation."* (Jary and Jary 1995, pp 207-8). Hammersley and Atkinson (1995) suggest it is characterised by the ethnographer, *" participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions - in fact collecting whatever data are available to throw light on the issues that are the focus of the research"*, (Hammersley and Atkinson 1995, p 1).

Hammersley has noted (1992) dis-agreement does exist over definitions nevertheless ethnography is also seen to have some key distinct features :

(i) people's behaviour is studied in everyday contexts rather than under experimental conditions created by the researcher;

(ii) data are gathered from a *range* of sources, but observation and/ or relatively informal conversations are usually the main ones;

(iii) the approach to data collection is 'unstructured' in the sense that it does not involve following through a detailed plan.......the data are collected in as raw a form, and on as wide a front, as possible.

(Adapted from Hammersley 1990, pp1 -2)

In addition the use of ethnography has been just as prevalent in sociology as it has in cultural and social anthropology although it is a method usually associated with the sociology of deviance and medicine (Hammersley 1990). Goffman's classic study of illness and institutions (Goffman 1961) is an example of the scope to examine in detail the 'routine' and the 'construction' of identities and roles from the 'inside'. Therefore

analysis, and interpretation, of the social world requires the unobtrusive study of a case, or cases, in their own 'natural' context, i.e. the environment in which action and interaction takes place.

Ethnography as a method has also been associated with what it produces through its documentation, *"the term ethnography is used to refer both to a particular form of research and to its eventual written product"*, (Davies 1999, p4). with the emphasis of the written product being the observable individual actions and interactions that take place during the fieldwork. However the ethnographic account I have produced goes further than the descriptive detail of observed actions and interactions as I have placed my findings and fieldwork within a national policy context which was running in parallel to the fieldwork. As Gans has recently highlighted in his reflections on ethnography and participant observation, *"little attention is paid to the socio-economic and political aspects of social injustice however, or to the uses of ethnography for reducing these"*, (Gans 1999, p542).

Yet I suggest using ethnography as a method for researching policy implementation may offer scope for the above. In America opportunities for fieldwork study in to welfare reform and social policy issues have 'blossomed' (Gans 1999, p546). This case study is ethnographic in its fieldwork approach but the descriptive goes beyond the purely local context in an attempt to produce a historical picture of a specific NHS policy implementation process. Within this attempt lies an affiliation with Denzin's view of ethnography for this century, one which, " *....asks how power is exercised in concrete human relationships.... attempts to better understand the conditions of oppression and commodification that operate in the culture, seeking to make these ways of the world more visible to others"*, (Denzin 1999, p511-512).

Therefore my data is primarily from the fieldwork experience but additional national literature collected in parallel with the local case study facilitated an external check on emergent findings. It also enabled me to move in and out of my dual research role and

help with the detachment process necessary for analysis and interpretation of the fieldwork and critical to the principles of participant observation, *"beginning with researcher detachment and ending with systematic analysis"*, (Gans 1999, p543).

Ethnography has been the subject of a post modern critique and Davies (1999, p15) highlighted the attention given to the fieldwork context where objects of study were seen to be created and not discovered. Davies (1999) found that the post modern criticisms of ethnographic 'perspectives' produced a more self conscious approach, 'a spiral inward' that left less scope for understanding the fieldwork data, (Davies 1999, p17). A balance is therefore required which encompasses reflexivity and at the same time produces meaningful explanations of an external social world. Davies points to Bhaskar (1989) and his notion of critical realism which offers an integrative position aspiring to, *"provide explanations, not simply descriptions, which have applicability beyond the confines of their specific* research question.......*and the reflexive implications of their research practice"*, (Davies 1999, p18).

Bhaskar (1989) promoted a realism in which human agents are neither passive products of social structures nor entirely their creators, people are part of the production of knowledge about society. For example local cultures and relationships will have an impact on how national policy is interpreted and subsequently implemented but the policy itself will have an impact on behaviour and roles within that local context. The value of ethnography is its ability to capture historical explanations of social structures and human relationships without postulating grand narratives and theories. Bhaskar (1989) acknowledges this and suggests that the strength of ethnography lies in its recognition of the relationship and interdependency between human actors and social structures.

## The ethnographic approach and this case study

Health service organisation and re-organisation had increasingly become a major focus

of policy and public scrutiny during the 1980's (Cox 1991, p109). Although Cox found a relative neglect of research on organisational cultures within the NHS and, where there was evidence, a lack of detailed analysis of decision making and NHS organisational culture (Hunter 1986, 1988 and Pettigrew et al 1988). Cox found, *"frustration that such policy relevant work is not having much influence on national policy makers "*, (Cox 1991, p110).

As health care policy creates organisational structures and then is constantly seeking to change and refine identified weaknesses in the NHS system (Dixon and Harrison 2000) ethnography appeared suitable for the subject of my proposed study. This is primarily because implementation of health policy does not take place in a static environment and as such to research it requires a methodology that can accommodate not only a context and agenda that is prone to constant variation but that is also responsive to re-formulation of concepts.

Any policy which introduces organisational change, to the management or delivery of services, or both, has the potential to create inter and intra-organisational conflict. As Cox has highlighted, *"the pace and diversity of organisational change in the health service means there is considerable value in surveys, descriptions and more sophisticated ethnographic accounts of the process of policy implementation"*, (Cox 1991, p110). Changes to the NHS, recent and current[9], make it an ideal context to conduct ethnographic case study research.

Observation of the routines and systems of daily living involve a sensitivity to intentions, motives, beliefs, roles and values. It is unrealistic to have standard laws of human behaviour because 'human behaviour is continually constructed' (Hammersley and Atkinson 1995, p8) but by using ethnography I suggest I began to interpret and understand what those constructions were. Large public sector organisations usually

---

[9]During various stages of writing this thesis the Labour government produced a White Paper, The new NHS - modern - dependable (DoH 1997) and a new National Plan (DoH 2000). Considerable structural change to the organisation of the NHS will emerge as a result of both these documents.

have complex divisions of labour and can often create conditions that stimulate the creation or re-construction of roles, often in response to a constantly changing environment. Ethnographic accounts can show how 'insider' comments and actions are part of the roles that key players create for themselves and others. The use and availability of unstructured data meant that I was able to harness and use a reflexivity towards findings as they emerged.

The use of the term naturalism in relation to ethnography has been deemed appropriate when it is applied to a recognition, *" that social events and processes must be explained in terms of their relationship to the context in which they occur",* (Hammersley 1990, p7). As I was an 'insider' and part of the research process itself the relationship between context, action, interaction and processes was a dominant feature of the case study. So studying a case, or cases, in their natural state requires interpretation and not just physical description. It has been suggested that the role of ethnographer in producing ethnographic accounts, is to either represent accounts and observations verbatim or to de-construct accounts in order to present an understanding of findings (Hammersley and Atkinson 1995, p20). I would argue that neither way is correct, or incorrect, and that a researcher should attempt to do both so the reader of such accounts is able to gain an insight into what the field work role entailed and also be privy to the researcher's analytical processes and conceptualisation. As previously mentioned it is important therefore to consider the ethnographic researcher as part of the research process but not to the extent that the ethnographic account becomes 'basically autobiography written by sociologists' (Gans 1999, p542).

There has occasionally been a lack of clarity about the ethnographic method as it is sometimes referred to as fieldwork (Jary and Jary 1995, p201). I suggest that the distinction is related to a general approach to a research problem or topic of investigation and then applying the methodology within that approach. Ethnography therefore encapsulates the methodology of fieldwork which in turn, through a specific mode of data collection, reflects back to the underlying ethnographic approach, namely

participating in the research context and focus of study. Therefore my research comprised of taking an ethnographic approach to the case study and the case study being dependent upon a fieldwork methodology.

*A note about tense.*

It has been suggested that to use the present tense in ethnographic writings indicates a more participatory role for the researcher (Davis 1994, p207). However Davis also points out that one has to consider who you are writing for and whether features you are describing are continuous and permanent (Davis 1994, p208.) The features of this study are about events, and people in certain positions at the time these events took place, which are located in a particular context which is both historical and political. The events and key actors involved are not permanent and continuous to the structures and context which continue to exist and which are constantly changing. Therefore I have chosen to write in the past tense because I have chosen to locate my descriptions to a particular period in the history of the NHS. New developments in health care provision and the way it is managed create distinct environments, I wanted to capture this and reflect on it so as to present a detailed case study which attempts to 'understand' these distinct environments.

I have chosen to write in the first person however because this reflects my participatory role in the research process and the fact that the text is the final construct and responsibility of the researcher.

## Fieldwork

This section will begin by establishing some definitions and features of fieldwork and how they relate to my research and research role. I will then describe how I entered and worked in the field and how fieldwork and qualitative approaches to research impact

upon research questions and hypotheses. I will also consider some issues associated with interpretation and analysis.

In seeking out a definition of fieldwork I started with a basic definition which stated that fieldwork is, *" research carried out in the field, as opposed to the laboratory, library etc. Fieldwork is the investigation of real-life situations through observation and informal or unstructured interviewing..... "*, (Jary and Jary 1995, p 233). I would suggest that my field work incorporated a personal element because I felt it was an experiment with the methodology I employed, I was part of the process of data collection (the tool). I was a self conscious 'occupational fieldworker'[10] who started off with an uncertainty of how the role would develop and how it would be sustained. Because of the nature of the roles I fulfilled in the fieldwork environment, employee and participant observer, I could not, and did not intend to be, confrontational nor superficially observational. This duality of roles however did necessitate a particular awareness in relation to the experience of fieldwork and sensitised me to be more reflexive of my employee role.

The role of the field worker, regardless of how the entry into the research process was secured and conducted, does then require personal involvement, *" ...fieldwork is a form of inquiry in which one is immersed personally in the ongoing social activities of some individual or group for the purposes of research. Fieldwork is characterised by personal involvement to achieve some level of understanding that will be shared with others"*, (Wolcott 1995, p66). However researchers do have a responsibility to ensure the research is more than just personal experience, simply being there is not fieldwork. Being sensitive to contextual issues and interaction and having the insight and capability to interpret and make some sense of them is.

The fieldwork conducted for this case study and presented and discussed in this thesis was very much concerned with the investigation and exploration of real life situations,

[10] This is a label I have created to describe a dimension of the role I adopted for primary data collection

decisions, experiences and negotiation for role status and role fulfilment. Although the research design was somewhat less rigid than experimental and interventionist studies, I was nevertheless aware that some form of basic structural process was required to guide the study. Fieldwork, for example, has been seen to have some basic prerequisites, "*interaction with people on their own turf and in their own language, and the systematic recording of it all are the bare essentials of fieldwork*", (Kirk and Miller 1987, p 6).

However Kirk and Miller (1987, pp 59 - 70) also determined that the ethnographic tradition, and qualitative research specifically whether it be sociological or anthropological, needed to fulfil four key phases, invention (research design)[11], discovery (data and findings), interpretation (analysis and discussion) and explanation (the communication of a message or theory). This thesis in its description of the methodology adopted, in particular the role of opportunistic observing participant, and the development of frameworks for analysis to communicate research messages has sought to align itself with this logical structure for conducting fieldwork research.

Before describing the systematic approach I took to the fieldwork research I would like to focus on the fieldwork role in relation to it being an interpersonal experience. Some of the issues highlighted have more resonance in relation to the participant observer role so the next section will be brief but paves the way for themes that will emerge in subsequent sections and chapters.

*Fieldwork role*

My pre-existing links with the organisation and key professionals (decision makers) meant that I was not operating as an employee and researcher in a contextual vacuum. On the contrary this dual role enabled links between the research context, the fieldwork experience and theoretical concepts to be established with an interconnectedness that

[11]the use of brackets denotes my corresponding identification with the four phases

may not have been readily perceived to an 'outside' researcher. In my unique insider role I was able, at times, to make a judgement about how I was perceived as an employee and what effect this had on my researcher role in terms of opportunities for type of data collection and how information was presented to me. It is probably worth reminding the reader at this point that as my research role was semi-covert (see below for a fuller description) the primary focus had to be perceptions of my status in relation to the employee role. Being a participant in the organisation meant I could not be divorced from political reflexivity, that is by being a member of an organisation (administrative and bureaucratic) which had certain powers to determine the amount of money another organisation received involved a recognition of the importance that power played in inter and intra-organisational activities.

As I was a middle manager in the organisation I was studying this involved negotiation for both my employee role (primary given role) and less obtrusively my study role (secondary taken role). This was potentially complex, not necessarily for others but for me, and warranted a substantial amount of reflexivity particularly after the fieldwork had been completed. This reflexivity, e.g. self-reference to one's role in a social account of a given situation, was about reflecting on the production of knowledge, by others and by myself, which involved experience (roles) and reality (the observable).

This 'consequential reflexivity'[12] had the potential to act as a sub-text to the data I was collecting as I was writing about knowledge at the time I was experiencing it (fieldwork) and also subsequently assessing my own role as an employee and a researcher (dual role). The reason for selection of the case study was pragmatic and opportunistic in the first instance but this in itself provided the scope for something unique to be studied - my research role. However reflexivity in relation to my dual role did not extend into what has been termed 'autoethnography' (Gans 1999, p542), where the research analysis becomes primarily autobiographical. Analysis and interpretation of the methodology

[12] I have chosen to introduce this term as a means of defining the type of reflexivity my role(s) in the research process and analysis created.

adopted was critical to the thesis but did not take precedence over the primary aim of studying policy implementation.

*The gendered researcher*

A researchers own persona, as perceived by others, in the field is often difficult to ascertain unless for example direct post research interviews take place to specifically address this issue. However adoption of a reflexive approach may allow for insight to be gained about how the researcher may have been perceived by research subjects through specific attention to what took place during particular events and conversations. This not only led me to question my own reasons for choice of study and focus on particular aspects of the case study setting and its (political and historical) context, but I also had to consider if there was a 'gendered' context that already existed as a result of my previous research role (evaluation of the Team Midwifery pilot project). I had to consider if key professionals and decision makers had constructed a persona for me. This meant that analysis of data, information and events that I had engaged in would have to be subject to an interpretation which involved gender relations to some extent. Okely and Calloway have observed the importance of considering the role of researchers and those being researched in terms of gender and they refer to them as 'gendered subjects' (1994, p36). For me this came to have significance because of the subject matter the policy implementation was concerned with, i.e. maternity care, and the wider relationship it potentially had with the wider effects of the NHS reforms, i.e. more explicit prioritisation.

Here I have attempted to highlight the significance of the role of the researcher in relation to the research setting and context which includes roles, gender and their association with professional status and organisational structure. I have already described the importance of the fieldwork role and how it should be integral to analysis of a case study of the type I adopted and as such I will return to these issues when discussing the findings of this study.

**Participant Observation**

*Introduction*

In this section I will describe some key features of the methodology of participation observation and then introduce and illustrate the type of participant observation I employed. Participant observation as a method of data collection is often favoured because it affords the researcher the scope to uncover phenomena that would not have been revealed using other methods of study, "*participant observation offers learning opportunities that cannot be duplicated by any other method* ", (Whyte 1984, p.23).

It is a method that has been used extensively in anthropological and sociological studies and involves getting close for example to communities, organisations and significant social and historical events and activities. This involves getting close to people participating in those events, for the purpose of observing and recording processes and interactions. What is learnt from this methodology is then usually located in a wider discourse with the aim of either discovering a theory, adding to existing knowledge and / or gaining an understanding of what influences and shapes communities, organisational activities and processes of change, or continuity. As Davies has commented it should be *'more properly conceived of as a research strategy'* (Davies 1999, p69).

There is the additional opportunity to observe activities and relationships which are either taken for granted, unexpected, or not usually observable, " *participant observation offers the advantage of serendipity: significant discoveries that were unanticipated* ", (Whyte 1984, p.27). Participant observation has been referred to as *'a humanistic methodology'* as its practice and application requires the researcher to adjust and adapt (unobtrusively) to (new) conditions of daily life, (Jorgensen 1987, p7). It requires sensitivity, judgement and a greater comprehension of the language, culture of a society, community or organisation (Hall 1975). Participant observation can provide direct experiential insight and access to worlds of meaning and understanding, " *the*

*methodology of participant observation is exceptional for studying processes, relationships among people and events, the organisation of people and events, continuities over time, and patterns, as well as the immediate socio cultural contexts in which human existence unfolds* ", (Jorgensen 1989, p 12).

***My role - a dimension of participant observation.***

Observing events from the inside, as with this study, provided a further dimension to the role. Historically participant observation has been recognised as being, *"an umbrella word covering several combinations of participation and observation and that different combinations were relevant for different studies and study sites"*, (Gans 1999, p540). Fieldwork roles do differ and one distinction is that described by Russell (1994) as being either a participant observer or an observing participant. One role lays emphasis on the researcher participating in a process of observing events, whilst the other infers that the researcher is participating in events that she or he is also engaged in observing, (Russell 1994, pp 136 - 164). A similar concept to the role of observing participant is what Whyte refers to as 'semi-overt participant observation' (Whyte 1984, p30), this concurs somewhat with the role I assumed as a legitimate participant who used this as an opportunity to be an observer. I was engaging with a recognisable research setting but still had to negotiate my own research role and determine when I participated and when I observed. Often this may have involved moving from opportunistic participant to opportunistic observer during any given incident of fieldwork, (see fig. 6). Thus based on the above I suggest the correct title to use which best describes my role may well be 'opportunistic observing participant'

In this role I also strove to be unobtrusive in my observing capacity which meant I yielded data from both direct and indirect observation, which was legitimised by my official role as an employee. Direct observation occurred, for example, during my participation in organisational meetings and formal presentations specifically related to maternity services and the pilot Team Midwifery project. Indirect observations occurred

through informal conversations with Health Authority managers and exchanges of information based on telephone calls with hospital Trust staff. Indirect observation of this type could be viewed as 'interpretation second hand' however for me opportunities arose to validate and / or receive an alternative account of events. For example the conversation which took place between myself and a team midwife revealed inconsistencies in how information was provided depending on the recipient of that information.

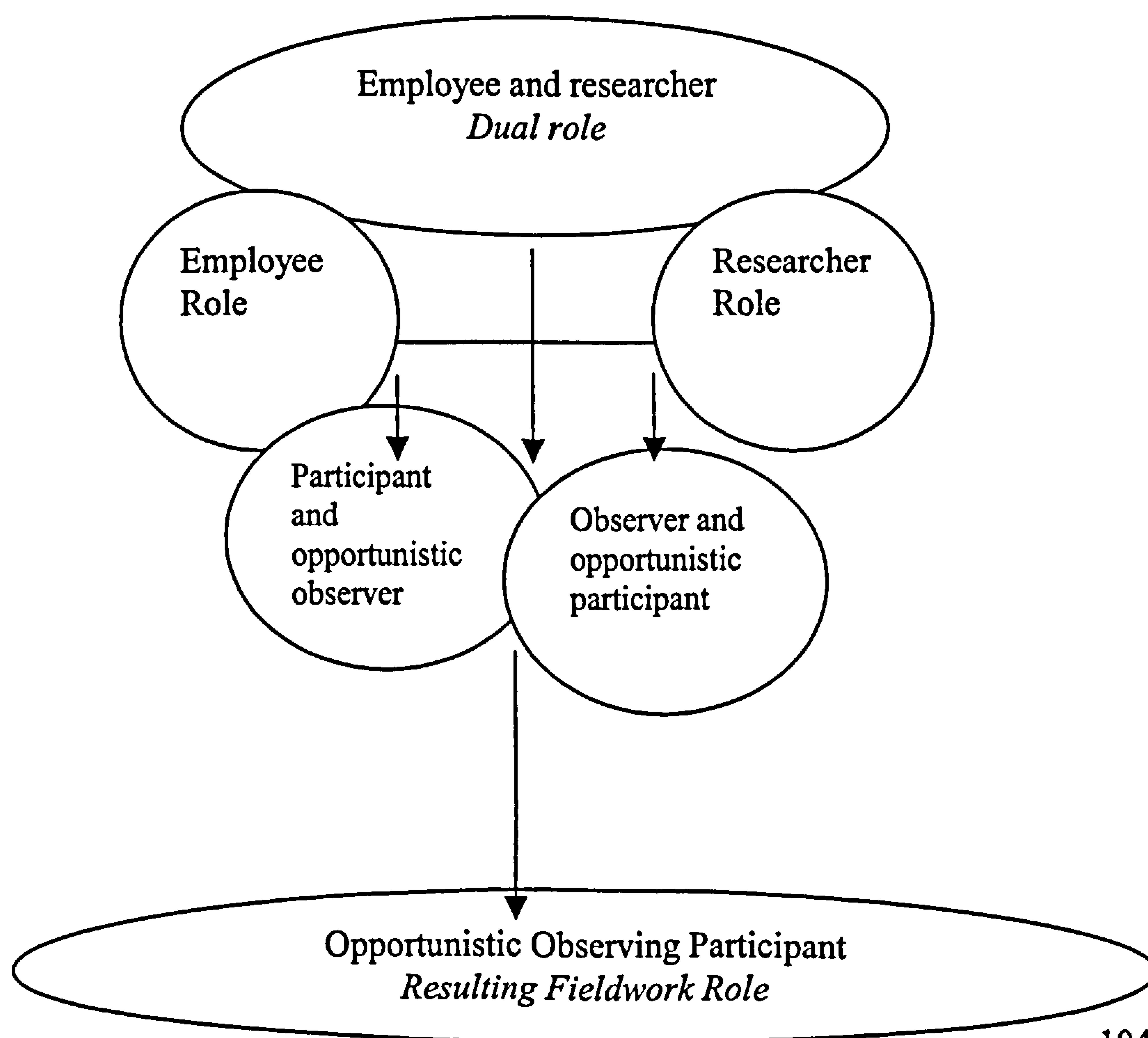
The Health Authority were made aware that information collected and related to maternity service provision was being used for an academic study, however I chose not to conduct additional data collection, for example interviews with key managers, as this would make my role particularly visible and explicit. It may have prevented participation in subsequent internal and external discussions and formal presentations regarding the future of maternity care provision in the district. A potential advantage of deciding not to interview is related to an observation made by Russell who suggests examination of secondary evidence (i.e. in this instance letters and faxes) may give a more accurate reflection of behaviour (and beliefs) than direct informant reports (Russell 1994, p 335)

I also provided support and relevant information to senior Health Authority managers whose purpose was to help inform the decision making process with regard to the future of Team Midwifery . In addition I had contact and professional relationships with midwives and managers from the maternity directorate at the acute hospital Trust. Thus the research role was participatory and observational, intra and inter-organisational and with regard to "access' to the field the role was also legitimate.

A reciprocal arrangement also existed regarding access to knowledge and information in the research setting. My employee status meant I was a 'giver' of information, for example researching other examples of Team Midwifery , but this also resulted in me being 'given' relevant information and documentation because of my expressed interest

in the subject matter. Once the local negotiating and decision making process between the Health Authority and hospital trust predominated the research context there were less demands on my role as a giver. The reciprocal arrangement continued to be legitimised but more emphasis was placed on me being 'given to', as a result of me 'asking for'. The limitation of the role as an employee at middle management level, at times, may have denied access to some of the more senior negotiations but this, to a certain extent, enabled a more impartial analysis of the overall context. As Whyte (1984. p29) has highlighted the nature of a persons job and role will determine the type of information and organisational insight they achieve. I was 'legitimately' able to approach 'informants' maintain an informal interview situation and disengage from that process in a manner which left it open to revisit the 'informant' at a later date. I was not a 'threat' to any power structures because I was not a decision maker, but I was a provider of information that may influence decisions so my employee role was deemed useful enough for me to be engaged in significant meetings and events.

**Figure 6 – My dual Fieldwork role**



As depicted above and described in previous sections my role of opportunistic observing participant was achieved through a combination of aspects of both my employee role and researcher role. The diagram has been presented to convey these different aspects and show how they are linked together. For example the duel role of researcher and employee enabled me to combine participation and observation of events within the fieldwork setting. In certain circumstances, i.e. presentation of findings from the Team Midwifery pilot project evaluation, my role was focused on the participation element of the fieldwork role with observation being the secondary element and in other circumstances, i.e. managerial meetings, more emphasis was placed on the observing element of my duel role, with participation being the secondary element.

In my employee role I was not expected to lead discussions and make decisions but rather inform and contribute to the decision making process. This meant that I could observe freely in meetings and contribute when it was appropriate and relevant to the discussions taking place. When I needed to be more proactive for data collection, for example to check out and verify information gleaned from meetings and presentations, I would usually approach key individuals on a one to one basis. Therefore my employee role gave me the opportunity to move with relative ease 'in' and 'out' of the fieldwork environment without compromising the research or my duties as an employee.
The role I adopted in the post evaluation stage of the study enabled an 'evaluation' of a change in service delivery to develop into a wider research process encompassing the effects and impact of local dynamics in relation to local and national policy.

I was particularly concerned with what influenced the outcome from a policy perspective, i.e. how much the model of care reflected policy content, and also how dependent the outcome was on professional roles and the type of culture a market type environment creates. My role allowed me to explore this unobtrusively and in effect the role adopted generated the research questions, it was an inductive process which generated its own theory. I was able to develop the reactive and unobtrusive fieldwork method which could depict *what* happened to a more multi-layered proactive study

aiming to understand *how and why* it happened.

## Section three How the fieldwork was conducted

### Entering the field

In November 1995 I returned to the Health Authority after completing a one year secondment to Liverpool University. During my secondment as an academic researcher I provided the Health Authority with a qualitative evaluation of the Team Midwifery pilot project from the perspective of samples of women, midwives, GP's and obstetricians. For a short period, between November 1995 and March 1996, I had to present findings from the evaluation to various audiences. The importance and value of comments and discussions which took place during these presentations became more evident as I engaged in the fieldwork process. If I had remained in my purely academic role I would not have engaged in the local Health Authority process beyond the presentation of findings from the pilot Team Midwifery project. However as I returned to the environment and organisations involved in the evaluation after findings had been disseminated I was able to research and explore reactions to the findings from a structural and operational perspective over a substantial period of time. As my concern was primarily focused on policy implementation at a local level it was essential to my mind that any research had to include an analysis of the strategic and operational decision makers during and beyond the post pilot stage.

Therefore there was a distinct difference in this study, I suggest, between traditional entry processes in anthropological and sociological ethnographic research. I was first and foremost not labelled as an outsider but an insider fulfilling two roles, firstly the primary role as legitimate employee with a work related interest in the subject matter, i.e. Team Midwifery, and secondly the semi-covert researcher with an acknowledged 'secondary interest' in the subject matter. Work colleagues therefore were aware of my continued academic study but their lack of interest in this role and my unobtrusive field role as opportunistic observing participant (see above) resulted in a fluid almost indistinguishable field entry process. These definitions of my roles were used in relation

to how I was perceived by my work colleagues. Whether these roles remained strictly primary and secondary to me is discussed below in 'Moving in and out of the field'.

So although entry was relatively easy due to its opportunistic context identifying points of access and sources of data still required negotiation. I therefore had to decide what data I wanted and how I was going to get it, to do this required 'finding my field' within the organisation and its structures. This process also involved utilising both employee and research role depending on what I wanted and who I wanted it from.

**Finding the field**

Finding the field, as opposed to entering the field seems to be about locating what a field researcher wants to find out: (aims and objectives); identifying how to access relevant information which will involve access points in the organisation; and the variety of sources of information available (discovery). In relation to my primary role as an employee, my field, on a more superficial level, was established, however I still had to define and access the research field of wider exploration and observation through my secondary research role. This meant I had to negotiate access to information and senior officials unobtrusively but also in a way which enabled continuation of this access. This, for example, would involve attending meetings and offering to follow up certain issues raised during the meeting which required clarification. I would often have a defined task such as a visit to a maternity unit outside of the district or attending a conference. Providing a written summary of my findings, either as an internal memo or paper, also meant I had a chronological source of information to draw upon for my thesis.

So finding my field involved defining my preliminary research context, i.e. what I deemed necessary to study, and this was predominantly concerned with :

(i) the Health Authority's response to national policy and the local

evaluation of Team Midwifery ;

(ii) analysis of relevant national and local documentation relevant to *Changing Childbirth* ;

(iii) observation of relationships and interaction between key local decision makers; and

(iv) observation of relationships and interaction between key service providers.

Having defined them I then needed to identify what sources of information and events would provide me with the opportunity to collect data which I hoped would enable me to gain insight to and an understanding of the following key questions.

**Figure 7 preliminary underlying research questions**

1. Would the strength of inter-professional rivalry and the (perceived) power of Chief Executives, as public sector entrepreneurs, determine whether or not local policy reflects national policy intentions ?

2. What were the key features of the decision making process ?

3. What, therefore, was the outcome of attempts to implement national policy ?

4. What implications will the above have for health policy ?

5. What implications does the case study have with regard to health policy research, including consideration of the ethnographic approach and researcher role?

**Sources of information for field notes**

The sources of information I required to test the above initial research questions were

dependent on me utilising both my employee and research role. Access to local and national policy documentation was relatively easy. In my employee role, where I negotiated opportunities to supplement existing information, I produced internal papers for the Director of Public Health, Director of Contracting, quality manager and Chief Executive, as well as conference summaries. When presenting findings from the independent qualitative evaluation I was able to make observations and brief notes, which were expanded upon immediately after the presentation took place. In my research role I requested copies of letters and faxes sent between Health Authority and Trust senior managers, including the respective Chief Executives. These are just examples of sources of data and information for the thesis what follows is a comprehensive list of the key sources of information.

**Figure 8 key sources of fieldwork data.**

*observations and notes from the presentation conducted by midwives;
*observations and notes from the presentations made by myself and the researcher who conducted the quantitative evaluation of the pilot Team Midwifery project;
*my own notes made during internal meetings and presentations;
*attendance's at national conferences;
*informal and formal meetings with GPs and professionals from the Health Authority and the hospital Trust;
*letters and telephone conversations to other maternity units seeking data on pilot schemes and economic evaluation;
*visit to a maternity unit where Team Midwifery had been extended as a district wide service;
*copies of letters and faxes sent between Health Authority and trust managers, including chief executives; and
*internal memo's and papers produced by me.

I was not overtly specific about what data I was collecting primarily because I wanted

multiple access to information sources. Accessing one piece of information often generated the need to access more with a certain degree of inquiry and refinement of direction.

**Field notes**

Field notes were predominantly made during, or immediately after, a presentation or meeting that was either wholly or partly related to the pilot Team Midwifery project. I always made a distinction between what were my own observations and interpretation of them by using for example brackets and exclamation marks. If something observed was particularly significant to any of the key themes of the thesis, i.e. the aims and objectives and hypotheses noted above, an exclamation mark and two stars would define them. Any comments made by participants at the presentations or meetings which were written down verbatim would be placed in double quotation marks. Brackets were used in my field notes to encapsulate on the spot observations and later when supplementary notes were made double brackets would be used to denote additional thoughts and formulations on the subject matter. This type of technique is not dissimilar to that advocated by Kirk and Miller's basic field note inventory (1987, p57).

**Working in the field - re-formulation of hypotheses**

Although I have outlined above (figure 7) my initial primary research questions hypotheses making continued during the field research and was re-formulated as the research process unfolded. I was engaged in a process whereby I drew tentative conclusions from my current understanding of the situation which led me in a particular direction for the next stage of observation and local data collection. For example a lack of economic evaluation of the local Team Midwifery project suggested a gap in local policy planning. When this was investigated further I discovered that the provider of services, the acute Trust, had not incorporated an economic evaluation in to the pilot project due to financial constraints. However when the issue of economic evaluation

emerged on the managerial agenda at the Health Authority the Chief Executive made a decision not to commission an economic evaluation. Despite this being a gap in knowledge which would have a bearing on whether or not it was viable to extend the Team Midwifery service to the whole of the District.

The above issue was made all the more complex when the Chief Executive of the Health Authority announced, at the Maternity Services Liaison Committee (MSLC), that Team Midwifery would continue but only in the pilot localities of the district boundaries due to the economic uncertainty about the cost implications of the current pilot model. This led me to explore the issue of economic evaluation further, both in my employee role through contact with other pilot sites as requested by my employers, and in my research role through direct conversations with the Chief Executive to gauge the reasons for his decisions. This therefore is an example of how the fieldwork environment, and my duel role, facilitated a re-formulation of research questions and re-focused initial hypotheses.

With regard to national policy and the issue of economic evaluation a national conference was held in February 1996 to discuss this very issue. I attended to ascertain if this was a gap in national policy and if so how was it being addressed. The conference confirmed my concerns that it was a gap in national policy. It was at this conference that an underlying sense of disillusionment and waning commitment was beginning to be displayed by managers and practitioners. This led me to begin to reformulate my ideas about implementation of policy at a national and local level, the labels of 'symbolic' and 'diluted' policy emerged which steered me towards focusing my attention on the strategic delaying tactics of both Health Authority managers and the service managers of the hospital trust, as I perceived it to be. The uniqueness of my research role and opportunistic context meant that I was in a position to study whether this was happening in a controlled way, it was 'forced to happen', or if it was a combination of circumstance and genuine uncertainty. Consequently I could test out initial and emergent research questions.

I turn therefore to Kirk and Miller's definition of the four phases of qualitative research and the ethnographic method, described above (1987, pp 59 - 60). Their argument that hypotheses testing need not be confined to interpretation and analysis, " *..it is almost fair to say that qualitative research is defined by the location of hypotheses testing activity in the discovery rather than interpretation phase* ", (ibid pp 66 - 67), describes my position. Thus my choice of study and choice of role enabled exploration of events (discovery) as they happened which often resulted in a re-assessment of existing hypotheses and refinement of the direction of the study.

**Moving in and out of the field**

On a practical level I was not explicitly moving in and out of the field as my employment status warranted a continued presence in the organisation and a legitimate information seeking role. However this still required that I adopted certain roles and conducted certain tasks that were first and foremost identifiable with my employment status.

How I operated in certain situations would depend on which role I felt was appropriate for the context and this did not always automatically result in my employee role taking precedence. For example sometimes during an internal meeting I would make little effort to verbally contribute to discussions preferring to listen and observe the other participants, this was obviously easier in large meetings as opposed to small meetings. Although even in small meetings I would sometimes choose to remain relatively quiet usually offering to take on some information seeking role if it was deemed necessary when the meeting came to its conclusion.

In view of this I moved in and out of the field in an unusual and discreet manner, however there was movement, i.e. when I was more vocal at meetings and presentations it would be due to my particular knowledge, and expected response to questions, and in this context I felt I was adopting my perceived primary role. However when able to be

less vocal and essentially less 'visible' I adopted my research role and took it as an opportunity to make notes that would not perhaps, if seen by others, be obviously related to the immediate concern of the meeting being held.

**Leaving the field**

This proved somewhat problematic, not because I had to make an announcement that I was leaving the field and thus behave in a different way but mainly because I continued to be an employee of the organisation I had been studying. Although I had officially ceased collecting fieldwork data in March 1997 I was still asked to do more work related to maternity care. This proved difficult because it was so tempting to include more information in the findings as developments emerged. The fact was I had ceased data collection at the end of March 1997 because it was a natural conclusion to the process and context I had been studying. The beginning of April 1997 heralded a new financial year and the activities which took place during the end of March 1997 had been the culmination of a complex and illuminating process.

I did however make a symbolic gesture which perhaps signalled me leaving the field in my role of opportunistic participant observer when I declined a request to attend the Maternity Services Liaison Committee (MSLC) and be the designated minute taker. I did not want to take on the role of minute taker, an important but thankless task, but I also knew that I had to resist further opportunities for extending the data collection period.

**Additional relevant literature and written documentation.**

The roles detailed above were complemented by a collection of written material that can also be categorised as direct and indirect. Direct written material presented in the findings chapter were the result of researching and assimilating information about, for example, other similar models of maternity care being piloted during the data collection

period. The indirect, but ultimately crucial, written material obtained was primarily copies of letters and faxes exchanged between Health Authority and Trust managers, including the Chief Executives. It must be noted here this indirect written material was not obtained covertly, I requested copies of this type of documentation and always indicated that I did not want to be given anything that was considered confidential, or that I (in my employee role) should not have access to.

**Additional material.**

Traditionally the use of literature to complement the types of data collection described above would not typically be found in a description and analysis of the findings. In choosing the words 'additional material' as opposed to additional data I am conscious of this. However the literature in this context, i.e. presenting new literature in the findings chapter, is used to reflect on issues as they happened during data collection and is consistent with examining local circumstances in relation to national developments. Additional 'literature' was collected for the purpose of the discussion and conclusion. In particular to reflect on recent critiques of NHS policy and relate some of my findings to the recent NHS policies from the Labour government.

## Section four Some Theoretical Constructs

### Guiding principles for a theoretical approach to interpreting and understanding data and relevant literature.

The research context warranted an awareness of the different levels of influence on policy implementation. Policy change, and any problems associated with it, is dependent on macro, meso and micro dynamics which are both structural and inter-personal. Nationally professional problems in the NHS had been explicitly defined, (as described in the previous chapter) but locally they became immersed in a culture created by the quasi market system approach. Being sensitive to emerging theory and analysis of one's data throughout is thought to be intrinsic to grounded theory proper (Glaser and Strauss 1967). I have ascribed to this approach in many ways without initially having any pre-conceived ideas that it was going to be my chosen method. It emerged with the role I adopted. The theoretical formulations and conceptual depth derive from an eclectic, semi-structured fluid process.

In keeping with my overall approach to this thesis, which is use of induction, I also strove not to make any grand theoretical assumptions about my research intentions or subsequent findings and analysis. In doing this I am not seeking to distance myself from theories about society which I believe have stood the test of time and are evident in all spheres of our society, such as the use of 'professional' power over others and the use of knowledge as power, particularly in health care settings. (Hugman 1991, Turner 1987, Lukes 1974, Friedson 1970).

Theory always poses a challenge because a researcher is often faced with addressing a problem or research question and producing an explanation which is original but at the same time located within a wider recognised and established theoretical framework. In discussing, what I describe as some theoretical underpinnings (in chapter 6) I seek to show my identification with existing theories that relate to my research but do not form

the basis of it. As Wolcott suggests, *" Theory addresses the issue of sense-making...as a fieldworker - a self consciously self appointed researcher you are already in the business of sense-making"*, (Wolcott 1995, p 116). He also suggests that a search for theoretical implications begins rather than ends with the closing chapters of a thesis (Wolcott 1995, p 119).

I felt very much that I was discovering, or unravelling, concepts and theoretical constructs as they emerged before me. This process led me to continually refocus what data to collect, whilst at the same time locating this refocusing in a wider context reflective of my original research aims and objectives and preliminary research questions. The research and analysis I conducted was not, I suggest, dis-similar to grounded theory, *" the process of data collection is controlled by the emerging theory, whether substantive or formal"*, (Glaser 1978, p.36).

Problems and further research questions did emerge from the data and hence what I focused on changed in response to this. For example initially I concentrated on researching examples of other similar models of maternity care attempting to assess their acceptability in other districts. I also sought to tease out any financial problems or evidence of economic evaluation. However, as some data was indicating that financial issues were perhaps being used to mask continued and new inter-professional barriers to change, locally I re-visited some of these issues. This in turn led me to observe that both wider contractual dis-agreements and an implicit power struggle between senior management and the Chief Executives from the Health Authority and the hospital Trust generated such mis-trust that traditional and existing inter-professional rivalry was being sub-sumed. One idea, or understanding, about the cause of why a decision was made generated another as to how it was influenced in the first place and as Glaser (1978) suggests, *" these became hypotheses* (or in this instance ideas) *that guide the researcher back to the locations and comparative groups in the field to discover more ideas and connections from the data"*, (ibid. p.40). The analysis and conceptual frameworks I developed could have only emerged from a reflective and inductive process which

sometimes meant I had to re-formulate some of my original ideas about what determines policy implementation at a district level.

I realised that once I had adopted the role of opportunistic participant observer, I was embarking on a study which embraced more than one methodological and theoretical standpoint. I was first and foremost a social scientist pre-occupied with policy, power and negotiation for resources, secondly I was stimulated by the actual fieldwork role itself. I believe adopting only one theoretical or methodological frame of reference distracts from enriching the data, I wanted to be inclusive as opposed to exclusive. During my fieldwork it became apparent that techniques used to gather data were linked to the research questions I was investigating. I felt this duality would enrich the research and engage me in a process which facilitated a fluid context for interpretation of the data and further analysis.

# 5 Analysis

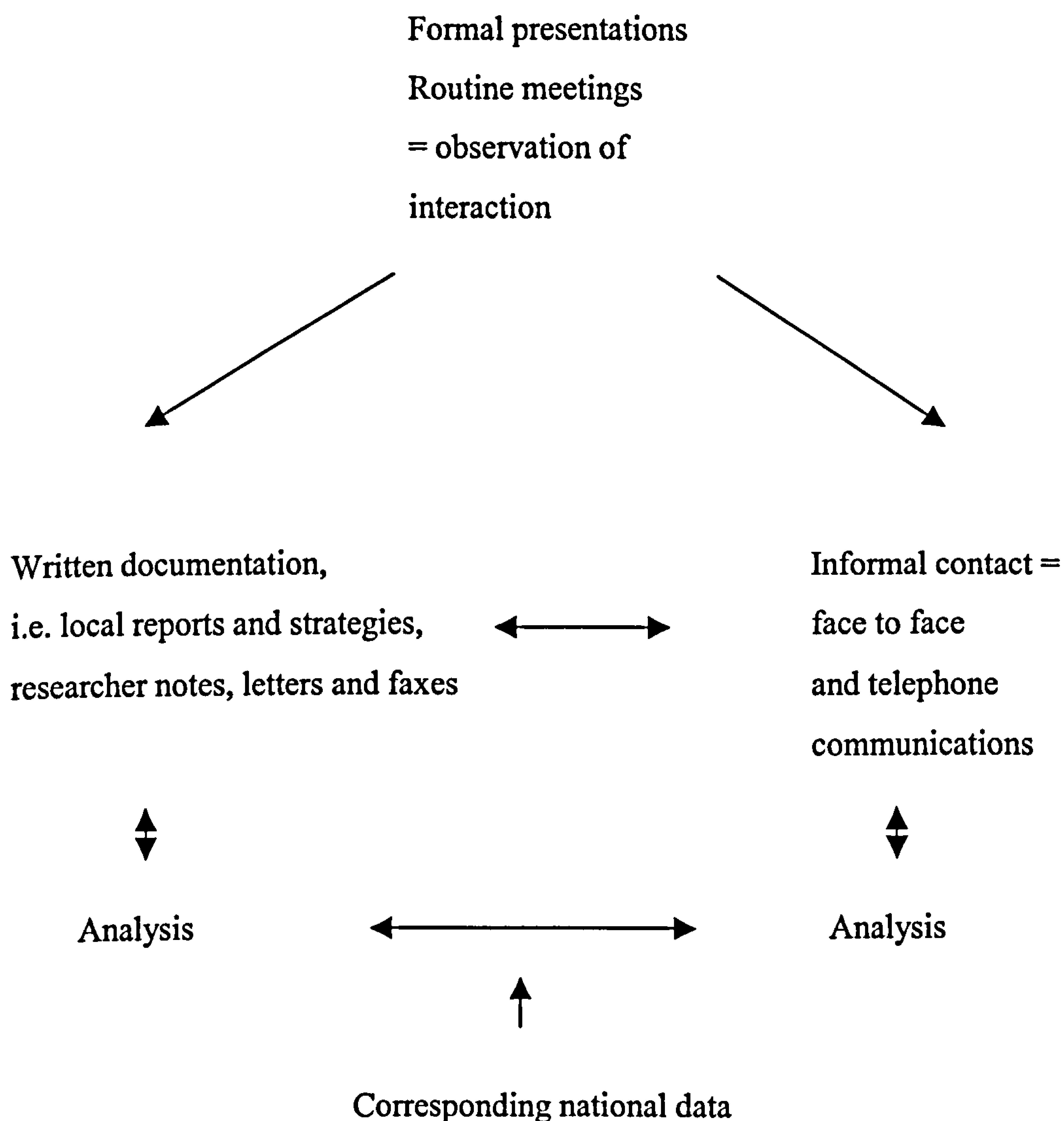
## Introduction

Analysis of qualitative data can be as time consuming as the data collection process itself and unlike quantitative analysis often begins during data collection. Quantitative analysis normally takes place at the end of the data collection period, which is usually time limited from the outset of the research. Any results from quantitative research are mostly explicit in their presentation and to an extent the statistics 'can speak for themselves'. Sequential or interim analysis is often associated with qualitative research because it takes place during the fieldwork period of data collection, as with this case study, and is used to help shape and refine ongoing retrieval of information and data sources which will complement the purposeful sampling techniques. This combination of interim analysis and purposeful sampling enables refinement of concept formulation and enhances the capacity to check alternative data sources against one another to help verify or refute emerging theories about the data.

## What was analysed

The qualitative researcher has to provide a meaningful and adequate account of findings and concepts derived from the data that are rendered intelligible. The reader therefore has to be given insight to the process that was applied to the analysis and interpretation and feel the account of reality presented is one that offers a valid representation of the particular social phenomena under scrutiny. For example I made use of a variety of data sources and purposeful sampling, (see figure 9 below ). This helped depict the day to day type of environment that key professionals were exposed to that affected decisions on the implementation of national policy. This in effect is what was analysed, an environment and context that constituted many inter-related parts that had potential influence on the way national policy was implemented at a local level.

**Figure 9 Routes for analysis and testing emergent findings**




As depicted above the different types of data collection led to a continuum of analyses between the different related parts. A system of checking for example observations with written data and then using informal communication processes to further validate emerging patterns from the data was adopted. For example an observation would be made by me at a formal presentation, i.e. the Health Authority Chief Executive's apparent lack of support for Team Midwifery, this would then be checked out via documentation, i.e. correspondence between the Chief Executive and others, and informal encounters with other key stakeholders. This would include the Chief

Executive himself and as an additional perspective the quality manager at the Health Authority. This meant that initial and emerging concepts were tested against the data collection and this was an on going process which concluded after data collection was completed. As Stacey has suggested, *"data were collected on the assumption that they would demonstrate certain patterns of human behaviour and now they must be sorted out to see if they do yield any patterns",* ( Stacey 1969, p 108).

**The process of analysis**

The process of analysis was based on layers of description and interpretation to help formulate an understanding of the social phenomena under study. Descriptions in themselves can contain some form of explanation that resonates with the raw data if the links between the purpose of the study and the description are explicit. Although I concentrated on the chronological account of significant events and actions during the fieldwork period of the study I also sought to re-visit the wider policy context of the NHS reforms in my latter analysis. This was in keeping with the original intentions of the study in assessing local freedoms and national responsibilities.

The amount of communication that each of us is subject to on a daily basis is actually quite substantial, and at times exhaustive, and involves using our visual, verbal and written communicative skills. All of these communication activities have meaning and content analysis is one method of studying that meaning and this method is not just confined to the written word. In the case study I used a form of content analysis whereby different forms of communication and interaction were analysed in terms of who said what to whom and with what effect, and how was this communication and interaction then turned into further action. Analysis needs to go beyond the conveying of information to look for social acceptance, or rejection, of key messages and intentions. This did not involve a word search for example of written communication and documentation but was based on interpreting messages communicated through verbal and non-verbal communication. These messages were related to concepts associated

with implementation of maternity services policies. For example did communication and action reflect financial issues, power issues, inter-professional issues and the effects of the 1991 NHS reforms through the introduction of the internal market.

Both social processes and policy implementation were being analysed at a meso and micro level. This study of interaction within and between organisations was then contextualised through analysis of national circumstances which were unfolding as a result of *Changing Childbirth.* Changing Childbirth did not resolve inherent problems within the NHS system, it appeared to cause new crises. My interpretative framework was based on who determined health care needs, and what services were deemed suitable to respond to those health care needs.

Description and interpretation of events and actions and the written word are therefore analysed to establish connections between social phenomena and build theoretical concepts that are new or add to existing knowledge. To complement this process an a further dimension was added in the form of corresponding national documentation related to changing childbirth. This data source acted as a further route for analysis and interpretation of emerging concepts to gauge the relevance and validity of the local case study findings. This iterative approach, where ideas and data are tested through a systematic process of ongoing analysis requires a dialectic relationship, *"you cannot analyse data without ideas, but then the ideas must be tested and shaped by the data"*, (Day 1993, p7).

Emergent finding and concepts had to be checked not only with raw data but also with the national context of *Changing Childbirth* in order for me to test if local freedoms could be exercised in policy implementation and if so to what extent could they be exercised. This posed an additional challenge because it meant a certain amount of measurement was required to ascertain the extent of policy implementation at a local level. In order to do this I had to compare the decisions on local maternity service policy and service provision with national intentions and with other districts where pilot

projects had been used to implement *Changing Childbirth.*

## Deviant cases

In the process of qualitative analysis whereby analysis takes place during data collection and is iterative, the need to search and consider deviant cases is deemed essential. In the case study this was not easy because divisions between professionals and managers appeared to mirror national perspectives. However there were key stakeholders that were deviant in the implementation of Team Midwifery and *Changing Childbirth.* The first deviant case was a local GP who, although resistant to Team Midwifery , agreed to participate in the pilot for practical reasons only, her community midwife was about to retire. This GP turned out to be an ally for the team midwives in supporting its broader implementation having publicly expressed her scepticism about changes in maternity services. There was also another stakeholder who 'turned deviant' during the course of the case study and this was the quality manager from the Health Authority. She converted to Team Midwifery after spending over three years expressing a lack of confidence in the approach, for financial reasons, and a lack of confidence in the support expressed by hospital managers including the Chief Executive. Explanations for this change in opinion of Team Midwifery are not conclusive but both of the above are considered in later chapters.

In addition through the analysis, moving backwards and forwards through the data, I also attempted to assess if there were unintended as well as intended outcomes and how this related to local freedoms and national responsibilities.

## Some methodological implications regarding the approach I adopted

### *Objectivity.*

It has been suggested by Kirk and Miller (1987) that essentially validity (truth) and

reliability (accuracy) are the key components of objectivity whilst at the same time recognising that absolute objectivity is not possible. Wolcott also presents this latter observation, " *.....even the most scientific of research procedures, regardless of how systematic and objective, can be neither perfectly systematic nor ultimately objective........on close inspection the investigative process is (of necessity) totally susceptible to human judgement......what is, in fact, a dialectical process in which all critical judgements are made by humans"*, (Wolcott 1995, p94). Essentially, I propose, reliability and validity both have a place in qualitative research if they are related to the following definition, " *reliability is the degree to which the finding is independent of accidental circumstances of the research and validity is the degree to which the finding is interpreted in a correct way* ", (Kirk and Miller 1987, p20).

The following sections will attempt to relate concepts of validity and reliability with the way this thesis was conducted.

*Validity.*

Using concepts of reliability and validity does not sit comfortably with qualitative researchers not because they lack methodological discipline but because it is terminology rooted in quantitative research. However they are concepts which can be applied to qualitative techniques to demonstrate consistency in acquisition of data and whether or not the researcher is applying labels to observed phenomena which accurately reflect concepts that exist. An example to illustrate how I was able to confirm some of my original observations from the evaluation of the pilot Team Midwifery project was the confidence and professionalism team midwives displayed during their own presentation. This re-affirmed my findings from the evaluation which had highlighted their increased autonomy and expertise which had given them professional confidence.

Another example of validating my labels and observations regarding both Chief

Executives acting as 'public sector entrepreneurs' was demonstrated through their use of power and control on two specific occasions. Firstly the hospital Chief Executive announced, at a public meeting, that the costs of Team Midwifery equalled the cost of a kidney dialysis machine. Secondly the Health Authority Chief Executive announced at an internal meeting that an agreed figure of £90, 000, allocated for maternity service development in the current financial year (1996) had not been transferred to the hospital Trust, but clever accounting had made it difficult to determine that the money had not been transferred to Trust accounts for its intended purpose.

These actions illustrated how the use of power can help reveal different agendas which are competing to influence the implementation of policy at a local level. For example the hospital Chief Executive wanted to highlight competing priorities within the local health economy. By doing this at a public meeting about the success of Team Midwifery he led me to question the level of support he was committed to for the development of maternity services. However as I was privy to existing knowledge about his privately held views of maternity services through colleagues at the Health Authority, his public comments helped verify that he did not consider maternity services a priority. An audience faced with these stark facts without the supporting context, evidence and more detail of implications for patients and users of maternity services, could potentially be influenced by one senior managers' view of priorities.

The issue regarding the lack of transfer of additional monies for maternity service development reflected a capacity not only in the quasi-internal market NHS system to manipulate allocation of resources but the power and willingness to do so by a senior manager. Re-organisation and re-definition of roles created features in a system that appeared to facilitate agenda setting power partly based on relationships between key decision makers. This will be further highlighted in relation to the concept of the public sector entrepreneur in later chapters.

The duel role I adopted enabled me to pursue this. For example the lack of attendance at

presentations about Team Midwifery by GPs and consultant obstetricians led me to believe that opposition to it and midwives as professionals in their own right was strong and influential. This was then confirmed by the attitudes of GPs I encountered in my employee role. During a visit to the district of Bolton, where Team Midwifery had been extended district wide, a senior midwife, when asked, commented that the lack of opposition from local GPs and obstetricians had been crucial to extending the pilot project.

Therefore field research, of the nature I have conducted, also presents an opportunity to act as a validity check, with multiple exposure to sources of information and data. So the role of opportunistic observing participant involved the fieldworker, i.e. me, being, *"continuously engaged in something very like hypotheses testing ... ",* (Kirk and Miller 1987, p25). Others have suggested that participant observation results in, *" highly valid concepts because of the pre-occupation of defining what concepts mean and how they are used in everyday life - the researcher must collect multiple indicators",* (Jergenson 1989, p 36).

The next pressing concern was related to keeping a focus and maintaining consistency in what data to collect which is associated with issues regarding reliability. Although an absolute literal truth maybe unobtainable in the real world of social science research, (see above) meaningful research that presents new knowledge or adds to an existing body of knowledge is obtainable if the researcher is mindful of certain criteria. In observational studies particularly akin to this type of case study the researcher is in effect the research instrument and therefore the reader needs to be able to judge the credibility of the account presented. This can be conducted by assessing how well the research context is described; whether there is an adequate account of the research design and fieldwork process, whether the analysis explains how concepts and explanations of action and behaviour were derived; and whether the conclusions fit with existing knowledge and evidence.

In this case study I have sought to pay particular attention to describing both how the research was conducted and presented a structured account of the findings, including supporting excerpts from local documentation. This was then supplemented by data from national documents and other local studies pertinent to *Changing Childbirth* so the reader could relate the local context to a wider policy agenda. This also acted as an independent source of information for me. In effect a form of triangulation was adopted so that evidence was sought from a wide range of different internal and external sources. I also sought to examine my own research role as the approach I adopted, opportunistic observing participant, although not unique is, I suggest, a novel method to assess implementation of NHS policy.

***Reliability***

Reliability within the confines of replication of the research process in terms of for example a laboratory experiment is difficult to conceptualise in relation to this case study and subsequent findings and analysis. I attempted to capture an explanation and understanding of the complexities and dynamics of implementation of national health service policy at district level during a particular time when parallel changes to the structure of the NHS were occurring. The research was observing policy, implementation, and all the local power struggles that this entailed, therefore it was unique in relation to the historical and political context it was conducted in. This does not however mean that it made it impossible to determine if the information and subsequent interpretations were reliable.

Recently Searle and Silverman have suggested that *'authenticity rather than reliability is often the issue in qualitative research'* (1997, p379). Although it seems to me that the two are interrelated for to show that something is authentic I feel any researcher would have to also demonstrate how they authenticated data and interpretation from that data. This in turn would surely be related to consistency in terms of reference to the aims and objectives of a research project and the methods adopted for collecting and analysing

qualitative data. Searle and Silverman do advocate the use of certain approaches for analysing data, including grounded theory, which *"ensure that generalisations are supported by adequate evidence",* (ibid:380).

As with validity, seeking the truth, internal reliability, seeking accuracy, can be evaluated by collecting data from other sources. For example I was keen to not only understand why the Health Authority delayed decisions regarding Team Midwifery, by extending the pilot for one more year, but also if it was related to the apparent lack of trust and lack of honesty that existed between Health Authority and Trust management. Copies of letters described in the findings chapter eventually confirmed this. The importance of consistently studying the same phenomena and relevant issues during the study period became apparent after I had decided to extend the period of time for data collection. By extending it to the end of the financial year this enabled me to observe critical decision making actions and also confirm some of my original and emergent ideas, and subsequent understanding of the issues, about local policy implementation.

So a concern about ensuring that observations are consistent with the original aims and objectives and interests of the researcher and the thesis are a form of reliability referred to as internal reliability or 'synchronic reliability', *" ..observations that are consistent with respect to the particular features of interest to the observer ",* (Kirk and Miller 1989, p42). In my dual role I found that I had additional scope for internal validity and reliability. This additional scope presented itself in the form of 'opportunities' to check and compare emergent findings through local and national processes. I had day to day contact with key decision makers and key professionals through formal and informal meetings and conversations. Because of my network of contacts I could be systematic in the process of establishing and checking facts as I knew who was most appropriate to provide me with answers or checks on facts and statements I had been given by other key stakeholders. This check on validity also gave me scope to assess when mixed messages were being conveyed, e.g. costs associated with the Team Midwifery pilot project.

In addition further opportunities arose to assess the reliability of emergent findings by comparing them with issues being debated and presented through national forums and conferences and through evaluations and reviews of *Changing Childbirth* and other pilot models of maternity care. This was primarily through the national newsletter and work of the national implementation team. This process provided an external check for me to gauge similarities and differences between the local case study and national issues regarding policy implementation and barriers to change.

***Researcher role***

For me one of the main benefits of undertaking a higher degree through research conducted over a substantial period of time was a discovery and acquisition of knowledge which you as the researcher are part of. It was important to ensure I did not exert control over the research process or context, knowing that this may otherwise constrain discovery of some tentative explanations of why certain decisions were made. Thus in turn would lead to a greater understanding of the dynamics of local policy implementation. I also knew that a straight forward cause and effect approach was unworkable and unrealistic.

As already noted above, I aimed to conduct myself unobtrusively and was able to do so in my fieldwork because of the opportunity afforded me by my employment status. However this type of fieldwork is implicitly open to criticisms which I will now attempt to address. Some social scientists and anthropologists may view my research role as unacceptable for its semi-overtness and opportunism, which was taken and not given. But in adopting a semi-overt role it was never my intention to deceive, on the contrary I displayed a genuine interest in my work and the work of others, I was unobtrusive and most importantly ethically comfortable with my research role.

*Strategies to protect against bias*

There were two main approaches I adopted to protect against bias both within the research setting and outside the research setting.

*1. Within the research setting*

1.1 The planned approach

I set up a system within the research setting that enabled me to re-check various data sources. For example, I was able to review formal notes from meetings and compare them to my observational notes taken during, or after, my participation in those meetings. I also set up monthly meetings during the course of the fieldwork with the quality manager and the Director of Commissioning from the Health Authority to check both written and verbal data. These meetings were usually one to one and I used them to explore some of the emergent concepts I was beginning to develop through the fieldwork process. These meetings also generated further data as both professionals from the Health Authority were part of the research context.

1.2 The opportunistic approach

In addition to the above I was also able to use opportune contacts with the medical director at the Health Authority and midwives from the hospital Trust to discuss and at times verify or refute information given to me regarding the future direction of maternity care. Discussions with the medical director tended to be more open ended and broad in context as we discussed issues related to the operation of the health authority and the dynamics of the purchaser provider split. We also discussed some of my emergent findings and this gave me an additional internal perspective on the natural phenomena I was observing and helped me guard against the potential bias that may occur when the researcher is the research instrument. I met with the medical director, on average, at

quarterly intervals, although several ad hoc interim discussions took place during the course of the fieldwork.

I had contact with pilot team midwives, a research midwife and two midwifery managers. Some of the contact either took place via phone calls or corridor meetings at the hospital when I would be attending other formal meetings, i.e. Ethics committee meetings. Midwives contacted me on approximately ten occasions either about the evaluation or to ask for assistance on research they were undertaking. I would use these contacts as an opportunity to check on information I was being supplied with at the Health Authority and by their midwifery managers. I also used this communication opportunity with pilot team midwives to gauge the general mood and morale amongst the midwives. More formal contact with the research midwife and midwifery managers occurred throughout the course of the fieldwork during meetings to discuss the direction of maternity care provision and the maternity module. I also had monthly meetings with the research midwife during the first year of the fieldwork, i.e. after the evaluation had been completed and disseminated. We had also previously met on a regular basis during the course of the research we both conducted for the pilot Team Midwifery evaluation.

*Outside the research setting*

The check on bias external to the research setting was developed through contact with two research supervisors who had different professional backgrounds. My main supervisor was a social anthropologist who had conducted qualitative research related to *Changing Childbirth*. My secondary supervisor has a Chair in clinical psychology and combines an academic career with a clinical psychologist post in the NHS. This meant that I had two people with knowledge and expertise relevant to both the research subject and the research setting who could act as external checks on my emergent findings, concepts and final research conclusions.

Draft chapters and manuscripts were sent for review to both supervisors on a regular

basis and both verbal and written feedback was given during face to face supervisory sessions. In addition to face to face meetings telephone conversations took place and written commentaries were exchanged via the post on either draft chapters and /or the need to collect certain types of additional data. Both supervisors would expect me to demonstrate how I was collecting data, what checks were in place to verify my emergent findings and ensure I was accessing relevant literature on my research subject.

***Establishing rigour in qualitative research***

Although there is debate as to whether or not qualitative research can, and should, be free from subjectivity there is recognition that, *'all research is selective – there is no way the researcher can in any sense capture the literal truth of events'* (Mays and Pope 1995). There also needs to be some recognition that pure objectivity is not a facet of qualitative research because understanding natural phenomena is reliant on a certain degree of interpretation, *'purely objective observation is not possible in social science,* (Pope and Mays 1995). What is critical however in qualitative research is the demonstration of a systematic research process so that some form of generalistion can be made with regard to any conclusions reached and implications for further research highlighted.

This means that the research design, sampling technique and description and representation of events and action that form the basis of the research context need to be made explicit to the reader to enable them to judge if the conclusions reached are valid one's. My research design was organised to systematically represent the views of all professional groups through the research subjects in the fieldwork setting. I also used the literature review to compare local findings with national perspectives. If the study is able to recreate, with some plausibility, the research process and context then findings should be recognisable and any conclusions reached make sense to the reader. Qualitative research therefore presents a view of reality that can generate concepts pertinent to similar settings and research subjects.

I was a natural participant in the system, I did not change the order of events, (although I was a part of them), nor the structure of the organisation. I was not a new employee and did not return to my employment at the Health Authority to fulfil a new type of role. With regard to my own perspective and assumptions I recognised that a potential bias may have been my belief that the introduction of market type principles to the NHS were potentially incompatible with a system set up to care and cure, and therefore, more implicitly, incompatible with *Changing Childbirth*. (Although the emergence of Clinical governance since this study was conducted [13] offers the opportunity to be more compatible with NHS culture than the quasi-market system but it too has potential drawbacks). The effect being that my underlying frame of reference would lead me to view the local policy implementation process and negotiations as negative rather than dynamic.

In recognising this potential bias during the data collection period I was able to check some of my emerging concepts from the data and actually be more critical and also self disciplined. To a large degree the research process necessitated that I deferred judgement which enabled me to build upon the theoretical frameworks I was developing during my analysis.

*Ethics*

Due to the nature of participant observation, if conducted properly, it should remain an unobtrusive and sensitive method with regard to its application, generation of interpretation and knowledge and hence any subsequent production of reports, articles or books. Research subjects are not like the subjects who participate in a controlled laboratory experiment, for example, they are not receiving an intervention or placebo. I

13 Clinical governance, (DoH 1997a), could be viewed as more compatible with the ethos of the NHS than the quasi-market system because of its emphasis on standards of care, equity of access and the reduction of rationing by postcode. However it also has the potential to use 'evidence' from a positivist stance to impose decisions and therefore treatments on individuals and possibly re-inforce an already dominant medical model of NHS service delivery.

have anonymised this thesis so no individual, organisation or place can be identified within the text. Although I have tried to ensure complete anonymity I have also attempted to reflect the dynamics of decision making and negotiation in a public sector organisation. To do this I have used various data and information which I ethically feel comfortable presenting and discussing in this thesis. My research subjects were not interviewed as individuals for reasons noted above and permission was always sought if I wanted copies of correspondence not sent directly to me. There was an awareness of my research being conducted but due to the lack of importance attached to maternity services this awareness never went beyond just that, apart from several discussions with the Medical Director who expressed an interest in the thesis. My observations in the main were what I deemed 'public' observations as was much of the 'participation' in the research process. The observations were part of a day to day process I was participating in as part of my normal working routine.

The NHS, and consequently the organisations and individuals who constitute it, is a publicly accountable component of the public sector. There are specific policies which outline the need to ensure key documentation and decision making are in the public domain and therefore open to scrutiny: *accountability*; *everything done by those who work in the organisation must be able to withstand public and parliamentary scrutiny*, (Code of Conduct for NHS Boards DoH 1994e). Therefore in my research role, in addition to the open way I collected data noted above, I was also comfortable with material I collected from meetings, reports and correspondence because it had to be deemed open to public scrutiny.

What I did have to question however were my research findings in relation to other components of the code of conduct for NHS boards, in particular *probity;* absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers, contractors and customers, and *openness;* the organisations activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, contractors, suppliers, staff and the general public. (DoH 1994e). My

observations and data suggested that there was a certain lack of probity and openness between senior mangers at the Health Authority and senior managers at the hospital Trust and I wanted to understand the causes of this situation.

Returning to the specific issue of ethics and my fieldwork material I wanted to highlight that this material was derived from documentation available to external and internal auditors and was, as previously noted, subject to public scrutiny. In my employee role it may not have been information I routinely had access to but it was certainly made available to me readily on my request. Organisational hierarchies and the reality of set working patterns and channels of communication may prevent routine circulation of certain documentation but I was not going to neglect access to documentary resources which were fundamental to some of my research questions. Therefore I did seek out information and data on a regular basis.

Hammersley (1990:131-132) poses several questions in relation to the ethics of ethnographic studies which are concerned with deception, privacy and consequences for future research. On all counts I am confident that I have neither deceived or encroached upon anyone's privacy and I would hope that the nature of this case study would serve to promote further research of this type.

# 6 Policy analysis

This chapter will present an overview of policy analysis and research in relation to NHS reforms and the organisation of health care services. The remainder of the chapter will focus on the following:

- Transforming the evaluation and post evaluation stage into a wider research process
- The value of a case study approach for analysis of local policy implementation
- Policy analysis in practice – a multi-dimensional research context
- Concluding remarks on primary data collection methods and policy analysis

## Overview

Policy analysis was not high on the political agenda when the 1991 NHS reforms were introduced. Although service specific evaluations were commissioned by health authorities, as part of a response to Local Voices (DoH 1991b, NHSE 1992), I became increasingly aware that there was a gap in health policy analysis. This was evident at the meso (inter- organisational) and micro (organisational / professional groups) level as previously noted. This had also been observed by Stacey (1991) who found that the sociological contribution to health care centred on disease specific or practitioner issues rather than health care organisation and management. Having the opportunity to conduct local research which went beyond a straightforward evaluation and which also sought to generate analysis of organisational activity surrounding policy implementation, and decision making, had a distinct context for conceptual development, *".the advantage of local research is that it allows a much clearer linkage between research, policy and practice "*, (Davis and Howden-Chapman 1996, p 871).

Therefore to fully explore and gain a better understanding of what influences and shapes local policy implementation I suggest that interpretation and analysis has to take place where the research activity continues into the 'negotiation' stages of the policy

implementation process. This is particularly so when policy implementation undergoes experimentation as a pilot model of change administered to a sub-section of the local population, i.e. Team Midwifery. As changes to service structures and service delivery are increasing in the NHS more attention should be given to those structures and people that negotiate and implement such changes, *"the key defining attribute of policy relevant research is its focus on institutional structure.....insights into the nature of organisations and exchange and provides an exciting opportunity for social scientists to enrich policy at a theoretical and conceptual level "*, (Davis and Howden-Chapman 1996, p 868).

In addition I propose that the commissioners of change, i.e. Health Authorities and more recently Primary Care Groups/ Trusts, should be subject to closer scrutiny as the local policy makers and implementers. From a theoretical perspective to avoid a purely structurally determined, i.e. macro reductionism, explanation of policy it is, *"necessary that micro-situational analysis be incorporated into sociological investigation of the policy process "*, (Sibeon 1996, p129).

On a superficial level, policy can be regarded as something which is introduced to solve a problem which has often been identified in isolation from the structures intended to implement that policy. Organisations are thus instruments of the policy implementation process and in this context policy analysis may be concerned with assessing the outcomes of the implementation process rather than the process itself and the complex decision making negotiations that this may entail before, during and after implementation would be neglected. What I have chosen to do in this thesis is link analysis of policy with the structures and agents legitimised to deal with its implementation.

Policy analysis therefore, like policy implementation and policy experimentation, has to be pro-active as well as reactive. With the changing nature of the role of government in relation to the public sector during the early 1990's, as a strategic and less interventionist body, relaxing control over procedures at a more local level, it was no

longer adequate to view local policy makers and implementers as mere instruments of the policy making process. (This context may now have shifted in light of the more recent Labour reforms to the NHS, DoH 1997a, DoH 2000).

I would also suggest that, due to the changing roles of purchasers and providers of health care, different goal orientations will emerge as the division of labour and patterns of working practices change to accommodate this shifting culture. So a focus for policy analysis could legitimately be an examination of what role and function different professionals are involved in which are related to policy implementation. This may include evaluation of new ways of working by professionals to fulfil policy objectives and also an analysis of any decisions made and by whom. Analysis of decision making at a local level in relation to policy implementation could potentially provide an understanding of barriers to change to enable policy makers to be more responsive and sensitive to the dynamics of change management. As I was engaged in the evaluation process of the pilot, i.e. experimental implementation of policy, and subsequently observed the decision making actions the evaluation and pilot model of care stimulated, I was able to take on this policy analysis role.

I would therefore promote policy analysis which engages in a process which focuses on the structures, (Health Authorities and hospital trusts for example), and agents, (individual chief executives and public sector managers), legitimised by central government to give effect and action to national policy from the inside. Linkages between structure, process and outcome may then serve to generate more meaning and understanding of the dynamics of the realities of local policy implementation, as opposed to macro policy making.

**Transforming the evaluation and post evaluation stage into a wider research process.**

The 1991 NHS reforms had spawned some evaluation of service delivery and service

change, sometimes initiated in response to central policy, although not in any systematic or co-ordinated way. Often these evaluative studies were conducted by independent academic researchers who would be expected to dis-engage from the local study setting once the final report had been disseminated. In that context access to a fundamental component of policy implementation, namely the decision making process, i.e. what happens next, is denied.

Analysis and evaluation of the process of policy implementation has the capacity to reveal the unintentional and unknown outcomes which may never be revealed by more routine and traditional methods of data collection, i.e. patients records, hand-held notes and quantitative/structured surveys. But the analysis has to be more purposeful in its approach, observing organisational and professional power, interaction and the negotiation for the control of resources.

Organisations partly operate to fulfil policy intentions and it is through analysis of the structures and processes of organisational activity that a greater understanding of the dynamics of change can be revealed. As Colebatch has suggested (1995) an organisation is in fact a framework within which one will find a whole collection of separate organisations. With this system comes a history, a multitude of environments and goals which may often lead to 'trade off's' and compromise between sub-organisations, " *Program evaluation has to be understood as an organizational phenomena: it is a way of understanding and evaluating action in and between organisations. But it rests on assumptions about organization which need to be challenged, and which have to be understood as a particular framing of organizational activity which will facilitate hierarchical control* ", (Colebatch 1995, p149).

In this case study a large organisation was implementing a service change (the hospital Trust) whilst the corporate body, (the Health Authority), was charged with monitoring these operational changes which had to reflect national (*Changing Childbirth*) and local ('Making Childbirth Better') policy. The hospital Trust chose to conduct an internal

evaluation of the service change (Team Midwifery ) and at the same time the Health Authority commissioned an external independent evaluation. This led to a duality of judgement being imposed upon those undertaking and implementing change within an existing system of care.

Colebatch (1995) has suggested that early interest in evaluation was concerned with assessing outcomes whereas recently attention focused on budgeting and management objectives. This pre-occupation with economic issues neglected other existing barriers, or opportunities, for policy experimentation and implementation. Guba and Lincoln (1987, 1989) argue that evaluation as an activity has evolved into four distinct levels, or what they call 'generations', which I have adapted into the following:

**Table 3 Levels of evaluation**

| Level of evaluation | Purpose/ Activity of research |
|---|---|
| First generation | Measurement/ extent of change |
| Second generation | Description / account of change |
| Third generation | Judgement / assessment |
| Fourth generation | Negotiation / involvement |

To expand on this, some evaluations focus on the extent to which a change in practice or service delivery achieves its original aims and objectives, i.e. measurement, they can also provide an account of the changes which took place, i.e. description, or an external evaluator as an agent of the organisation contributes to an overall assessment of outputs, i.e. judgement.

The type of evaluations described above are often constructed in response to policy, but the evaluation may not always have the scope to locate its analysis and findings within a deeper context which considers the structure and process of organizational activity and interaction. I identified with analysis in a wider framework, *" a fourth generation of evaluation, one which recognises that the evaluator is engaged in the organizational process, not simply as the agent of the hierarchy, but as one who will be involved in negotiating with a wide range of stakeholders - people with a legitimate interest in the organizational process "*, (Guba and Lincoln 1987).

I acknowledge that my situation differed slightly from the above as I was working in the organisation responsible for monitoring service changes strategically and this constituted a role which spanned intra and inter organisational study. However I suggest that it is of benefit to the theory of policy making and policy analysis to pursue the level of evaluation, or research, that Guba and Lincoln refer to as fourth generation whereby the participation in the actual process of negotiation serves to provide lessons for decision makers and policy makers. Furthermore as a researcher this process should also provide more insight to the research context and enhance the analysis. The depth and breadth required for this approach necessitated a move away from an instrumental view of organisational activity and the adoption of a case study approach which I will now briefly discuss.

**The value of a case study approach for analysis of local policy implementation.**

Although I have discussed in some detail the research role I adopted it is perhaps worth considering why I chose to develop this research 'opportunity' which offered more than being in the right place at the right time. As already noted, evaluations of service experimentation are often limited in their capacity and application, their scope may be restricted to revealing explicit structural barriers to implementation. This may be useful with regard to, for example, describing professional rivalry or identifying a lack of

financial resources but it does not necessarily generate an understanding or explanation as to why this occurs, in what context it occurs and how it impacts upon policy implementation.

The significance of researching the actions and decisions of individuals in positions of power, and the actions of those with less power, I believe has been neglected in an emerging culture of evidence based medicine and randomised controlled trials. Agents of policy implementation, strategic and operational, are individuals who act and behave as professionals fulfilling roles and responsibilities, however, in doing so they also have the capacity to be more than instrumental. So, in some circumstances, as well as being re-active they would also be proactive thus having an effect on implementation of policy which may or may not reflect the national policy they have been legitimised to implement.

In adopting a case study approach I was seeking to consider both the structural and interactional effects of policy implementation, *" Case studies using qualitative methods are most valuable when the question being posed requires an investigation of a real life intervention in detail, where the focus is on how and why the intervention succeeds or fails, ...... "*, (Keen and Packwood 1995).

Studying implementation requires placing a certain value on a policy change, and by implication a change in service delivery, and subsequently judging an intervention in relation to outcomes. Case study research, of the nature described in this thesis, is often concerned with the 'how' and the 'why' as well as the 'outcome'. There may be no definitive answers or conclusions drawn but the research will encourage debate and inform future policy analysis and service organisation.

National policies, such as the introduction of the 'managed market' into the NHS (DoH 1989a), and *Changing Childbirth* (DoH 1993), have to be viewed from the context of how they work at a local level. This is not only to assess their success or failure but to

also understand any real limitations to their implementation as " *some of the most important questions in health services concern the organisation and culture of those who provide health care* " (Pope and Mays 1995). Pope and Mays highlight in this quote the significance of researching the structures and processes that result in patient care. For policy makers to understand what works best, and conversely what does not work, there does therefore have to be a focus on the study of local relationships and local systems. The NHS is a complex system of structures and hierarchies and researching what impact that the organisation and delivery of services has on policy implementation and its influence on outcomes for service users is now deemed important.

It has been suggested by Keen and Packwood (1995) that certain conditions enhance the value of a case study approach, in particular where an intervention consists of a complex context of change and is implemented in to a system experiencing many parallel and interrelated changes, i.e. the British NHS. The case study approach has been recommended for the study of government health policy at a level which seeks to analyse impact beyond methods reliant on inputs and outcomes (Pollitt et al 1990, Mays and Pope 1995).

Although some of the background to this thesis emerged from events prior to and during the qualitative evaluation of the Team Midwifery pilot project, evaluation at this stage were directed towards answering pre-set questions. For example, how the change in service delivery impacted upon the professional roles of midwives and what differences, if any, did the new service make regarding the experiences of women receiving care from teams of midwives.

The case study approach which emerged from this background stage was more concerned with understanding what the most influential factors, relationships and circumstances determining the future development of maternity care were. This latter approach, where research questions and development of theoretical interpretation form

part of the research process itself, I suggest, sits comfortably with the role of opportunistic observing participant. It is inductive and facilitates a reflective learning process which persists throughout all the stages of the development of the thesis, ultimately leading up to the concluding chapter.

**Policy analysis in practice - a multi-dimensional research context.**

*Introduction*

Here I would like to highlight some theoretical concepts which enabled me to develop my own frameworks for analysis. In doing so it will become clear that I have taken a sociological approach to this thesis but do not identify with one particular grand theory. Rather I have sought to remain non-deterministic. In addition I was not seeking to verify, or for that matter follow, any particular sociological theory. Although my initial research questions and subsequent interpretation of my findings may appear to be aligned with Marxist notions of power, i.e. commodification of midwives and women and the seemingly autocratic role of the Chief Executives.

Throughout the research process I felt that I was approaching the subject matter from a multi-dimensional perspective as I have already indicated a need to concentrate on both structures (organisations) and agency (individuals) influencing and developing the research process and analysis. In attempting to provide an adequate account of the parts played by action, interaction and the structuring of relations in and between organisations I was instinctively drawn to methodological and theoretical pluralism.

*Levels at which policy analysis takes place - a changing agenda.*

Historically social theorists have been preoccupied with the division between the individual and social relations (micro context) and wider societal and structural systems (macro context), but more recently some have focused on the need to understand how

the two are inextricably linked. (Layder 1994). An understanding of links between human activity (interaction order) and its wider social context (institutional order) provide a useful framework to consider change and what influences that change.

The historical dichotomy in sociological theory between micro and macro has also served to underplay the meso context where essentially, I suggest, macro and micro influences interact with one another. This may have more meaning when applied to the notion of national responsibilities and local freedoms in a health policy context. The meso level is about implementation of national policy where 'symbolic issues' (what I regard as broad policy statements and targets) become transformed into action of some description (i.e. problematic negotiations influenced by local power relations). For this thesis therefore meso and micro levels of analysis, and understanding the management of change driven by policy at a macro level, were a necessary focus for policy analysis and implementation, *" a multi-level strategy is required for investigating the ways in which policy materials are empirically manifest at different levels of social processes",* (Sibeon 1996, pp132-3).

As I was concerned with analysis of policy and activities that were initiated and consequently conducted at different levels, i.e. macro, meso and micro, and the linkages between policy, implementation and decision making, my reference point to the differing levels is based on the following descriptions:

*Macro* - national policy and guidance related to policy and functions of public sector organisations are formulated by government. Economic decisions are made by governments which determine the level of resources (prioritising) and the amount that each Health Authority received;

*Meso* - national policy and guidance is acted upon by organisations who have a responsibility to implement them, but implementation is localised and to this extent re-formulated into local policy. Resource allocation decisions were made by health

authorities, and GP Fundholding practices, and related to the amount of investment (rationing) that they assigned to services and specialities on behalf of their local population;

*Micro* - national and local policy and guidance is (expected to be) acted upon by local providers of services through local strategies, contractual arrangements and service agreements, i.e. commissioning. Resource allocation decisions are (implicitly) made by health professionals and determine which individuals receive services within the context of resource decisions made at the meso level.

From a macro perspective 'health care', a feature of society and its culture, and 'heath care systems', a structural phenomena, are both interrelated and co-exist with the meso and micro levels where strategic and operational professionals respond to (and create) demands of the health care system. For analysis purposes policy issues and activities have to be related to rules, resources and roles. This requires application of theoretical concepts which are concerned with action and meaning in a context where the macro, meso and micro are perceived to be influencing one another. Therefore applying sociological concepts which incorporate a less rigid approach to the subject matter of this research will seek to have a sensitising function which opens up policy analysis.

***Theoretical concepts used to inform theoretical formulations for the thesis***

A growing interest in applying sociological theory and methodology to the analysis of policy, which has traditionally been the concern of political scientists and economic theorists, has recently been explicitly identified by Sibeon (1994). As noted above I was interested in analysing policy within a context which considered an array of structural and locality specific phenomena. Here I would like to briefly present some concepts which subsequently shaped the approach I adopted for exploration of the themes I encountered during the research process. This will be followed by a section which describes the approach used to formulate analysis and my own conceptual frameworks.

As I was interested in the influences of structural and strategic factors (rules and resources) and interaction (roles and resources) on the management and negotiation for change this led me to focus on concepts related to organisations and professional groups, i.e. power and control. When considering, for example, theories about communication and action (Layder 1993, p 189) ideas about the role of negotiation and strategic activity, in and between organisations, and how those in power adopt different roles, and actions, to serve different purposes become linked. Communication as communicative action is a situation whereby individuals engage in negotiation, and even compromise, with a view to reaching a consensual outcome (Smelser 1994). Strategic action is however much less dependent on a consensual communicative approach and may be used by those in positions of authority 'negotiating' in a particularly autocratic and formal manner.

The difficulty in achieving a consensus view may be related to the existence of divergent and consensual issues, i.e. synergistic and non-synergistic, and the emergence of 'new' more pressing issues (new policy priorities). So some issues, i.e. *Changing Childbirth,* became immersed by parallel headline priorities, for example new cancer treatments. This and how power and control are translated into practices and decisions which are either accepted or at least tolerated, is of particular concern to this thesis. The task is to gain an understanding of what type of context, process and 'action' (or inaction) is used to shape and influence decisions. This in turn leads to a focus on the role of decision makers and consideration of how people negotiate their own roles in organisational life, (Layder 1993, p66). This consideration may reveal how power is legitimated and reinforced and is used to redefine change whilst maintaining underlying power structures.

A crucial question to address therefore may be whether or not a new policy which challenges existing structures results in an implementation process whereby the policy, becomes 'locally diluted'. Furthermore research may also need to determine if this process, and eventual outcome, is inevitable and acceptable.

*Power and control*

Concepts of power have been well formulated, e.g. Lukes (1974) particularly in relation to the 'caring professions' (Hugman 1991). Here I would like to introduce and consider some of those concepts which have particular resonance with central themes contained in the thesis. Lukes originally proposed that three dimensions of power existed :

**Table 4 Examples of sources of power.**

| **Type of power** | **Use of power** |
|---|---|
| 1.Pluralist - behaviour dominated | Decision making - overt conflict |
| 2.Agenda setting | Non-decision making - covert and overt conflict |
| 3.Social agenda - ideological | Latent conflict - overt and covert |

Developed from Lukes (1974, pp 10 - 25)

The first type of power which Lukes refers to is therefore observable (1-behaviour) and conflict would normally be displayed overtly. The second type of power is based on manipulation so that the conflict appears to have been resolved (2- agenda setting). Whilst the third form of power results in manipulation whereby the conflict appears not to have existed in the first place (3- ideological). This is seen to be the most powerful form of control, " .. *the most effective and insidious use of power is to prevent such conflict arising in the first place........a contradiction between the interests of those exercising power and the real interest of those they exclude* " (Lukes 1974, pp 23 -5).

Lukes was however particularly concerned with non-decision making, i.e. agenda setting (ibid p38), and this would involve study of what doesn't happen and what mechanisms are used to prevent things happening. This, I suggest, would necessitate consideration of institutional power and the selective perceptions and interpretations of particular issues by key decision makers. Agenda setting power and non-decision making have resonance with the case study findings as the data will depict in latter chapters. This led me to question whether a certain type of unity in non-decision making existed towards the end of the data collection for the case study, i.e. key decision makers deferring judgement together but for different reasons. I therefore felt, in view of this latter observation, it would be of some value to explore what types of power exist and operate to influence the decision making processes in relation to implementation of policy.

Power and its association with professions has been given its own typology:

(i) *collegiate* - power is exercised by members of the occupation itself, (e.g. GPs, obstetricians), not all power is equal and there will be a hierarchy at play but the occupation presents an image of unity;

(ii) *patronage* - power is exercised between the occupation and those who pay directly for its services, (e.g. NHS Trust's and their relationships with their employees, Health Authorities and their relationships with NHS Trusts);

(iii) *mediated* - power is exercised through a mediator between the occupation and the users of the services, the mediator may be another profession or it may be a patron - an agency of the state (e.g. Health Authorities)

(Adapted from Hugman 1991, pp 3-4)

General Practitioner Fundholders could be categorised as all three typifications of professional power. Although the above represents 'ideal types' it is useful, I suggest, for analytical purposes particularly if used to explain opportunities to exploit this power or possibly constrain it. In considering the role of the State, i.e. the macro context, Hugman argues that the State is a mediator and corporate patron (ibid, p 19), giving ideological legitimacy to reform and new policies.

Power is also exercised through the dynamic relationships between professions and organisations (which allow them to function as practitioners) because at any given time organisations are dependent on the expertise and knowledge base of professionals and this is particularly evident in the NHS. So it is important to observe that the shift in public policy towards de-centralisation of power through the 1991 NHS reforms had the potential to offer scope for the more autonomous professional, i.e. GPs and hospital consultants and to an extent senior managers to gain additional power. This scenario could lead to new tensions and conflict in the NHS system, particularly at a local level, as senior managers could be faced with some difficult negotiations with senior doctors over models of service delivery and the allocation of resources between directorates. So collegiate power would be pitched against mediated power and the knowledge base of professionals would be potentially challenged through the population approach adopted by health authorities, as proxy consumers, grounded in public health and health needs assessments.

National responsibilities (policy making) and local freedoms (policy implementation)

did not necessarily complement one another as local power struggles would emerge from the 1991 re-organisation. The use of power through patronage would also have a role to play as Trust managers needed to contain their expenditure, meet national objectives and at the same time keep senior professionals on their side. Therefore the level and extent of power exercised through the above three typologies could be dependent on the mode of de-centralisation, local structures of control, authority and power relationships.

Power and knowledge, and the way it is exercised and communicated to others, is inter-connected and helps determine and sustain levels of control, *" this structuring of social relationships through dominant communication may be summarised as discourse. So power, in this view, is exercised in the structuring of the social framework within which interests, ideas and issues are formed and known "* (Hugman 1991, p 35). Once these frameworks, interests and ideas become established and fixed the use of language and the acquisition of knowledge as forms of power and control become routine, *" discourse analysis demonstrates that through knowledge and language caring professions.......define the object of their work "*, (Hugman 1991, p 36).

In her analysis of the politics of professional power in a changing NHS Elston has observed how the medical professions have a unique ability to block and resist change at a national and local level (Elston 1991, p58). Even where policy changes appear radical there is still the potential for weak implementation, *"expressions of desire for radical change should not be mistaken for that change"*, (Elston 1991, p61).

Elston considered Starr's work on the Weberian notion of medical power (Starr 1982) where he proposed that medical power over others was achieved through social and cultural authority. Medical control over others is achieved through commands and medical definitions of reality are accepted as valid. These types of authority allow for considerable autonomy which in turn can result in a significant amount of control over determining renumeration systems, policy making and self regulation. (All of which are

increasingly under threat, particularly the latter which has proven in recent years, since this study, to be inadequate. The case of the Bristol heart surgeons and the case of the GP Harold Shipman being the most notable).

Social authority has the capacity to be weakened and re-distributed through advanced technology systems, e.g. the Internet, as patients become more informed. Cultural authority has been shaken recently by the weakness of individual autonomy and self regulation (see above) but is arguably still strong. In addition recent labour processes within the health care system, such as nurse consultant posts and increased opportunities for unqualified staff to re-train has been regarded as an inevitable stage of advanced capitalism and as such is a 'proletariazation' or down grading of the medical profession (Elston 1991, p62). This notion of a down grading of the superiority of the medical profession however is threatened by the latest labour market pressures and the national lack of qualified nurses and doctors available to support the NHS system. So any changes in social and cultural authority may be weakened by economic factors. Although there are factors within society to challenge medical hierarchies and public confidence has been shaken society and government are still dependent on these professions and the knowledge base they control and use.

The above observations raise issues that have relevance to the case study and its focus on local inter-professional relationships and this in turn also has relevance in considering recent policy initiatives from the Labour government. For example clinical governance and the drive for evidence based medicine rather than exerting systematic control over clinicians and challenging their autonomy may in fact serve to increase their specialist status. Thus professionals, as evidence based practitioners, may compromise the role of patients as decision makers and co-producers of care and retain their 'expert' status. This is because clinical governance will deem it necessary to follow a specific set of principles for patient care and service delivery and this may not give a prominent role to patients, other than more rigorous informed consent procedures. Conversely it may serve to challenge the practices of some professionals and help

safeguard against scandals like Shipman.

Policy implementation can therefore provide the impetus to challenge the distribution of power between groups. For example *Changing Childbirth* promoted the role of the midwife as a professional who could be the 'lead' provider of care for women, theoretically increasing the potential to shift power from obstetricians to midwives and, more importantly, women. This shift in power, initially from one professional to another as changes in service delivery are implemented, would need to be monitored to assess whether it meant a better service for women and enhanced their relationships with care givers. This is because a shift in control of service delivery may not necessarily result in a significant re-distribution of power, it may actually transfer power from one profession to another at the expense of women using maternity services. A system which encourages a more equal distribution of power, i.e. all parties gain from changes to service delivery and benefit in particular those who have been historically powerless, i.e. women and midwives, was promoted by *Changing Childbirth.* But a system which enables women to become more equal partners in maternity services was going to be quite a radical approach to implement.

Professional power, and opportunities to either exercise or restrain that power, i.e. policy implementation, can operate selectively according to Jessop (1996). For example, policy is open to interpretation and therefore implementation of it will be subject to variation and dilution of policy aims through that interpretation. Therefore policy analysis is dependent on effects attributed to actions within a strategic context, i.e. who has interpreted what and how have they acted upon their interpretations. The analysis process may also reveal power in relation to agenda setting. People can reformulate their activities (local freedoms) but ultimately they may be constrained by a wider agenda which shifts during the reformulation process (new and emerging national responsibilities). These concepts have relevance for analysis where I will consider the potentially dialectical nature of policy implementation and the impact on roles, resources and the distribution of power.

In seeking to understand policy implementation at the meso and micro level attention has to be focused on the local decision makers, i.e. senior health service managers, and their roles and relationships. These relationships may help or hinder those redefining their roles as professionals and service providers depending on the communicative and strategic methods used. Negotiation was dependent on interpretation of policy and how important the service area was deemed and how changes and decisions were made and communicated to key stakeholders. Reform may generate opportunities which, if facilitated by corporate rationalizers and operational rationalizers (Health Authority managers and Trust managers and clinicians), challenges the status quo for both staff and patients (DoH 1993). The potential problem for those wanting change and those implementing change strategically was the existence of a quasi-managed market system. Managers were faced with the emergence of a system whereby professionals were competing for resources, i.e. patients, in a much more complex but at the same time more explicit way. *Changing Childbirth*, for example, challenged the historical pattern of the distribution of resources as the delivery of care was increasingly encouraged to be provided in a community setting.

The 1991 NHS reforms and the policy initiatives which stemmed from them sought to redefine the organisation (and culture) of the NHS system and reshape relationships between management and clinical hierarchies. Deep rooted structures and systems of power were being challenged through national policy. Various dualities existed, i.e. elements of the old system and elements of the new system, hence there appears to have been opportunities and constraints as a result of this context which impacted upon power and control within the NHS.

**Concluding remarks on primary data collection methods and policy analysis**

In my role I was trying to seek an answer to some fundamental research questions, that had guided my decision to adopt the approach I did pertaining as to whether or not the

internal market had created a new kind of management culture and; if so what impact might that have on implementation of national policy. In attempting to research this I hope I have achieved what Russell alludes to in the following quote, " *.....natural experiments are going on around you all the time. They are the result of people making decisions about the allocation of their time, money, and human capital resources. All you have to do is figure out how to cleverly monitor them and evaluate their outcomes* ", (Russell 1994, p343, 1994).

The potential that policy research can offer if it embraces new ways of investigation and dissemination has recently been recognised as a process which could be used to engage decision makers by, " *providing alternative possibilities and enlightening policy makers through their interaction with researchers and exposure to new perspectives* ", (Bulmer 1982, quoted in Davies 1999, p59).

As a key informer in the research process this meant I was integral to the fieldwork and I will consider my research role and how it evolved in relation to researching a setting again towards the end of the thesis.

# 7 The case study data: local and national findings

## Introduction

This chapter will describe primarily the local events which took place after both evaluations of the pilot Team Midwifery project had been completed. Findings represented below are the result of observations of dissemination of evaluation findings; associated events and critical incidents that took place during the fieldwork period, November 1995 to March 1997). This will be supplemented by data from national literature and key conferences related both to *Changing Childbirth* and findings emerging from the local case study. This wider data collection context was necessary for two reasons: my interest, as a researcher in locating the case study within a wider policy framework; and, in my employee role, a requirement to gather further 'evidence' to help inform the decision, from the perspective of the Health Authority, as to the future of Team Midwifery and maternity care.

A tri-partite approach has been adopted to describe and consider the data and this comprises of: a chronological presentation of the case study findings particularly in relation to critical events; this local context is then related to national policy and relevant published literature; and finally both sets of data are supplemented, where relevant, by some personal observations and commentary. Before describing local events and key findings from the post evaluation period of the Team Midwifery pilot project a brief summary of samples and findings from both evaluations will be presented as it was anticipated they would have some impact on future negotiations and local decisions regarding the delivery of maternity care.

## Section one Local evaluation studies

### The qualitative evaluation

The first section presents an overview of the qualitative evaluation including sample details (see table 5 below) and key findings related to *Changing Childbirth* and the indicators of success.

**Table 5 sample details, qualitative evaluation of Team Midwifery . (Tinkler and Quinney 1995)**

| Category of respondent | Number consulted | Method of data collection |
|---|---|---|
| Core pilot sample<br>Eight women, referred to as the core pilot sample, were interviewed on more than one occasion. | 8 | Individual interviews<br>i.e. antenatally and postnatally |
| Antenatal pilot sample | 14 | Group interviews and individual interviews |
| Postnatal pilot sample | 16 | Group interviews and individual interviews |
| Antenatal - non-pilot sample | 14 | Group interviews and individual interviews |
| Postnatal - non-pilot sample | 16 | Group interviews and individual interviews |

| Midwife | 12 | Individual interviews |
|---|---|---|
| General Practitioner (GP) | 10 | Individual interviews |
| Consultant Obstetrician | 2 | Individual interviews |

[14] See footnote.

***Summary of key findings***

*Information*

A complex and diverse range of information needs emerged. Yet generally *all* women wanted consistent advice and information, the opportunity to ask questions and feel comfortable with the people they needed to communicate with. Where the team approach appeared most successful was in the provision of consistent information and advice to women.

*Choice*

Many women were not aware that they had a choice regarding provider unit. The extent of choices available to women and the actual choices that women made varied. However some of the data indicated that women on the pilot, generally, had more choices than non-pilot respondents. Women on the pilot scheme appeared to have more opportunity to discuss options and make verbal plans. Ultimately choice was dependent upon having information, relationships with carers and to a greater or lesser extent the choices professionals 'allowed' women to have .

*Involvement in the process of care*

Whilst not all pilot respondents reported high levels of involvement they were more likely to feel higher levels of involvement than respondents receiving no change

[14] The term 'non-pilot' and 'no change maternity care' used here refers to those women who participated in the evaluation and were not receiving care from teams of midwives.

maternity care. Team Midwifery appeared to offer women the opportunity to become more involved in the process of their care and consequently more involved in the decision making process.

*Team Midwifery and continuity of care*

For many women continuity of care had improved as a result of the team approach for many women but opportunities for women to meet midwives prior to delivery occasionally appeared fragmented. As a result of this some women had raised expectations. Care from 'familiar faces', and the delivering midwife in particular, during the postnatal period was welcomed and appreciated by those respondents who received it.

*Benefits of the team approach for women*

The important aspects of the team approach which appeared to benefit women were primarily:

(i) being able to identify with a team of professionals who communicate with each other;

(ii) provision of a more integrated system of care;

(iii) more involvement in the process of care; and

(iv) consistent advice and information from the team.

*Professional issues*

Midwives appeared to be generally positive in their new role but had to cope with the practical stresses that this role entailed. Data from the evaluation suggested implicit and explicit conflict between professionals and the potential effect this may have on the care that women receive, for example, regarding informed choice and continuity of care. Other schemes where a team approach and woman centred care appeared successful occurred when midwives had the support of obstetricians and GPs (Hynes 1991, Taylor 1995).

*Conclusions from the qualitative evaluation*

*The Team Midwifery approach*

The qualitative evaluation indicated that the timescale for implementing and thus evaluating the pilot scheme was very short and inevitably impacted upon professionals and women's responses. It became apparent during data collection that 'time' was very important in allowing midwives to build up relationships and confidence within their respective teams and with the women they were caring for. Midwives established working patterns and found a common focus through hard work but the pace was such that some midwives questioned the feasibility of maintaining this commitment. A lack of team building and comprehensive induction appeared to hinder initial implementation.

When considering some of the objectives the team approach hoped to achieve it is clear that the pilot had moved close to them. For example, women were provided with a more personalised service, 24 hour access to a team member and less conflicting advice. Some of the key aims of Making Childbirth Better (North West District Health Authority 1994) were also beginning to be realised through the team approach, i.e.

Aim 1
*"to enable women to be more fully informed throughout their maternity care"*
Aim 2
*"to ensure women are familiar with the people who care for them throughout pregnancy, labour and postnatal period"*, and
Aim 5
*" to ensure women are actively involved in planning and reviewing maternity services"* (North West District Health Authority 1994).

Achievement of these aims were important steps towards achieving some of the key

indicators of success in *Changing Childbirth*, indicators 1, 3, 4, 6, and 7 (DoH 1993 p.70)

**The quantitative evaluation (Russell 1996).**

A research midwife from the hospital Trust, with the help of a statistician, conducted a quantitative evaluation of the pilot project over a nine month period. This involved collecting routine statistical data with a specific emphasis on health outcomes for both women and their babies.

***Samples***

Data collection commenced on 1 January 1995 and was completed on 30 September 1995, the number of women who delivered during this period was 3051 (pilot and non-pilot). 969 women were excluded from the study due to:

(i) 685 incomplete forms;

(ii) 284 unaccounted forms.

The above resulted in the following being used in the final analysis:

**Table 6 final sample used in the quantitative evaluation of Team Midwifery**

| | |
|---|---|
| Total number of pilot deliveries | 746 |
| Total number of non-pilot deliveries | 1336 |

Data for the quantitative evaluation was collected via the analysis of case notes and proformas that midwives filled in for each woman they provided care for, antenatally,

intranatally[15] and postnatally. The focus of the quantitative evaluation was concerned with continuity of care (antenatally, intranatally and postnatally) and the impact this may have on, for example, use of pain relief during labour and delivery outcomes.

*Summary of Key Findings*

There was a clear emphasis on medical data. However for the purpose of this thesis an overview of findings which relate to *Changing Childbirth* and in particular continuity of care, will be presented.

**Table 7 key findings from the quantitative evaluation.**

| Key Issue analysed | Pilot Women | Non-pilot women |
|---|---|---|
| First meeting between midwife and woman. | 100% met a team midwife who would be caring for them | 0% met a community midwife who would be caring for them. |
| Knowing the delivering midwife. | 76% | 37% |
| Episiotomies (tearing during delivery) | 13% | 24% |
| No pain relief during labour | 14% | 5% |
| Postnatal visits at home by a midwife the woman had previously received care from | 93% | 57% |

The final report (Russell 1996) concluded that Team Midwifery provided:

[15] Intranatally refers to the period when labour commences and finishes one hour after delivery

- better continuity of care;
- greater numbers of women knew the midwife caring for them in labour;
- improved outcomes in labour;

and recommended that, *"..outcomes for the Pilot Midwives are consistent with the objectives of 'Changing Childbirth' and therefore Team Midwifery would benefit the women in (NW district) using their local Maternity Services"*.

The results from the quantitative study were used to complement findings and data from the qualitative evaluation. The combined results suggested that not only was Team Midwifery favourable to women and team midwives but that it improved health outcomes for women and resulted in less medical intervention compared to traditional maternity care.

## Section two A description of the chronological critical incidents

### The Fieldwork period

This section, which forms the main body of the chapter, presents data from the fieldwork period. The table below gives an overview of the critical incidents related to the post evaluation period. These events will be described separately and will be related to the key themes of the case study and the wider context of the thesis. Additional information presented will either highlight any relevant new guidance and policy from the DoH or the NHSE during the fieldwork period, or comment on reports assessing similar models of maternity care. The issues emerging from the local and national policy context will also be subject to interpretation and some personal observations and commentary. This will then form the basis of a wider discussion leading to some overall conclusions presented in the final chapters.

## Table 8. The post evaluation fieldwork period, November 1995 - March 1997.

| Date | Local developments. |
|---|---|
| November 1995 | The beginning of the 'maternity module'. Local GP seeks information. |
| January 1996 | Locality funds made available to GPs – maternity deemed a key strategic objective by Health Authority briefing paper. |
| 4 January 1996 | Team Midwives formal presentation to multi-disciplinary audience |
| January 1996 | Results from GP survey disseminated- views on maternity care. |
| 10 January 1996 | HA begin to discuss (and disagree) financial costs with Trust for extending the pilot project - letter sent to Midwifery Manager |
| 24 January 1996 | Visit to Bolton Acute Trust to discuss their expansion of a Team Midwifery project |
| 5 February 1996 | Midwifery manager from Trust replies to letter from HA |
| 22 February 1996 | Presentation of qualitative evaluation to HA board of directors. |
| 19 March 1996 | Presentation of both evaluations to the MSLC and invited guests |
| March 1996 | Further discussions regarding the 'midwifery module' |
| March 1996 | HA purchase MIDRS 'informed choice' leaflets. |
| April 1996 | I produce an A4 sheet highlighting the key 'quality' service issues from the qualitative evaluation of the pilot project. |
| 22 May 1996 | Internal meetings at the HA continue regarding Team Midwifery |
| 6 June 1996 | GP's continue to seek alternatives to Team Midwifery |
| July, Sept.Oct. November 1996 | Further attempts by the HA to assess costs of Team Midwifery , via letters of correspondence, phone calls and meetings between HA and Trust senior managers. |
| Dec. 1996 | Formal update by HA quality manager on local maternity Strategy |
| January 1997 | HA outline key areas for GP locality growth monies. Trust outlines its key objectives and existing financial 'pressures' |
| February 1997 | Internal middle management HA meeting – maternity issues are discussed in-depth. GPs continue to seek alternatives to Team Midwifery |
| February 1997 | HA and Trust Chief Executives prepare to go to formal arbitration re: contractual arrangements, including unresolved maternity service agreements |
| March 1997 | Chief Executives of Trust and HA 'negotiate' a way forward |
| March 7th 1997 | Formal arbitration is avoided and the contract is agreed |

**Development of a local maternity module - November 2nd 1995**

In parallel to the Team Midwifery pilot project a process had been set up to develop a distinct local maternity module. The module was a service delivery plan for maternity care devised separately to avoid being incorporated into the traditional process of block contracting. This was the first time that a distinct contractual plan had been developed for maternity care and would have been beneficial to the Health Authority if it meant more routine data could be made available for monitoring purposes. It also had the potential to ensure that monies specifically designated for maternity care were allocated accordingly. For the maternity directorate at the hospital Trust the benefits would include clarity regarding exact funding for the service as a whole and service developments for specific areas. Prior to this approach it would have been difficult to determine the exact amount of money spent on maternity care. For example monies may have been allocated on an annual basis but that did not guarantee that all of the allocation was spent on maternity care if there were pressures on other directorates during the year.

Two quality managers and the director of contracting represented the Health Authority whilst the director of corporate planning and contracting, directorate manager of the maternity Unit, clinical Director of Obstetrics and the Women's services manager represented the acute hospital Trust. This was to be the first of several meetings arranged specifically to produce a maternity module which would be primarily concerned with 'activity, cost and quality' issues. Because of sensitivities arising from concerns expressed by obstetricians and GPs regarding 'contracting' the term 'module' was used in an attempt to diffuse any potential antagonism with a view to concentrating on quality issues. The Health Authority were however attempting to gain more information to assist them with future contract negotiations. This was partly due to the historical nature of block contracting which revealed little data with regard to the above issues and also partly driven by the purchaser provider split as a result of the 1991 reforms.

The 1991 NHS Conservative reforms may have sought to break from a supposed inefficient system dominated by (medical) professionals to a more rationalised system which was purchaser led and based on quality and efficiency (NAHAT 1993a, 1993b,1993d). However much of this was dependent on robust information, as well as managerial relationships, as cash allocations had to be documented in contracts and not operational and strategic plans. Quality in particular was becoming more of a focus but this was partly because the detailed information about contracts was not available to purchasers. This suggests that there was less rather than more information available as a result of the purchaser provider split (Radical statistics Group 1995) and the validity of what was available came under attack (Brindle 1996b).

The amount of influence and control Health Authorities had in their purchasing role has been the subject of much debate (Dorrell 1996, Ham and Woolley 1996, Hamlyn 1996, Treloar 1996). This raised questions in relation to contestability, as this was meant to be a tool for leverage with providers as health authorities were therefore expected to 'threaten' a shift in contracts in order to flex their purchasing muscle.

I suggest problems locally emerged from numerous sources and this included a dependency on block contracts which resulted in a lack of detailed information being made available to the purchasers. If the purchaser (Health Authority) was geographically dependent on one main provider, as in this case, it would prove difficult to overcome this type of problem, i.e. a lack of contestability would leave little room for practically moving the contract elsewhere. As Propper has suggested a bilateral monopoly therefore has little impact on improving choice and responsiveness to patients and offers no real incentive to do so (Propper 1995). This local purchaser/provider relationship, which was essentially constrained by geography, poor information systems and a lack of choice, would also potentially have an effect on how local systems were managed and how managers roles were defined by themselves and others. It would also constrain policy implementation particularly if the source of resistance was rooted

within the provider arm of the relationship.

Concerns related to financial implications of changes to maternity services locally had been previously raised with the North West regional Director of Public Health in a letter from a quality manager from the local Health Authority. The contents of this letter reflected local and national barriers to change. At this stage of the local process of implementation of service change problems were related to wider national implications of recommendations for introducing locally designed pay schemes for midwives (NHSE 1995). The letter indicated that compliance with new national recommendations (NHSE 1995), (which explicitly recognised the additional responsibilities midwives adopted as they sought to fulfil *Changing Childbirth* and how remuneration should take this into account), could have resulted in local additional costs in the region of £288,000. The letter from the quality manager also stated, *" the Chief Executive of the Health Authority has indicated that implementation of Changing Childbirth will not be a priority for use of Health Authority growth monies given the pressures from other areas, e.g. Continuing Care, Mental Health ".* (September 1995).

Nationally the Secretary of State for Health had announced that responsibility for challenging variations of quality within the NHS would rest firmly with *'Health Authorities and their partners in primary care'*, (Dorrell 1996a). He also stated that he expected decisions made by Health Authorities or GPs regarding particular forms of treatment, and for that matter care, commanded public confidence. The role of primary care was singled out for particular attention in relation to the purchaser/provider split of the 1991 reforms, *" in their pursuit of best value Health Authorities and GP purchasers (Fundholders) will need to ensure priorities are not distorted in favour of the hospital service..........each Health Authority needs to look at the range of primary care available to its population and ensure that they use the weapons at their disposal to promote the generalisation of good practice".* (Dorrell 1996a). It is not made clear what 'weapons' the Health Authority would have had at their disposal although allocation of growth monies was an obvious one.

**The 'lead professional' issue lacks clarity**

Although the local maternity module initiative was developing as a separate project in relation to Team Midwifery there were some parallel issues. For example financial concerns and accessing data in particular, as events described below will reveal. It is also worth noting that one of the items on the agenda for this first meeting was 'professional issues' which was resonant with discussions taking place at a national level about the terminology used in *Changing Childbirth*, i.e. lead professional. It also reflected local tensions in relation to the role of team midwives and their relationships with other midwives, GPs and obstetricians.

The 'lead professional' issue had been a topic of much debate locally amongst healthcare professionals, i.e. GPs and obstetricians who insisted it was misleading. These issues were being reflected nationally as demonstrated by the editorial in the *Changing Childbirth* newsletter, *" the lead professional is expected to be the main carer and to co-ordinate the woman's care. If during the course of a woman's care circumstances alter, following discussion with the woman, the lead professional may need to change",* (*Changing Childbirth* Implementation Team, 1995d). There was also an indication that whoever the woman booked her care with was the lead professional, however, it was noted that, *"the term lead professional has no intrinsic legal meaning. Liability.....does not depend on who is the lead professional but, rather, on the approach adopted by the professional(s) involved at the time of the event",* (ibid). It would appear that the issue of 'lead professional' lacked clarity and was being left open to interpretation. Local resistance to change displayed by some professionals had the potential to be used to continue to disrupt local negotiations.

**GP seeks information from the qualitative evaluation**

The only significant local event to take place during the remainder of November 1995 was a meeting I had with a local GP. The GP, from one of the localities not participating

in the pilot project, made a request to the Health Authority for information pertaining to any views from women from his locality, or practice, who had participated in the qualitative evaluation. His practice and the locality generally were investigating whether any changes to the provision of antenatal care were necessary. As a result of this request I produced an A4 sheet of paper containing common themes emerging from anonymised data collected from seven women from the locality in question who had participated in the qualitative evaluation . A telephone conversation had subsequently taken place with the GP, who indicated that the locality were not interested in pursuing a Team Midwifery approach to maternity care. This would inevitably have an impact on any proposal to extend the Team Midwifery pilot project on a district wide basis.

Formal presentations of findings from both the qualitative and quantitative evaluation reports were planned for early 1996. In view of this there was little activity at the Health Authority with regard to maternity care provision during December 1995. The qualitative evaluation however was disseminated widely, including the Local Medical Committee (LMC) and Community Health Council (CHC) and all evaluation participants received a summary copy of the report.

Health Authorities were expected to start supporting and facilitating organisational change, offering leadership and promoting partnerships between themselves and GPs post 1991. This (forced) partnership had however been perceived as grounds for an obvious power struggle, *"who will emerge victorious from the clash between the new Health Authorities and GPs."* (Munday 1996). This type of attitude appeared to ignore the need to strive for what is best for patients and residents above what is best for GPs and health authorities. Although some commentators on new structures and relationships were conscious of the importance of time and underlying cultural factors, *"'the major...challenge will be cultural ......it is hoped that ....the politicians will give us sufficient time to see it through"* (Treloar 1996).

**Maternity services highlighted as a prime area for GP locality growth monies - January 1996**

Within the local Health Authority there had been some internal discussions regarding 'locality developments' and the distribution of locality development funds for 1996/97. This initiative was driven by a recognised need for Health Authorities in partnership with GPs to promote a primary care led NHS. Health Authorities therefore had a dual role, to negotiate with hospital Trust providers and also work with GPs in their capacity as providers, and in the case of fundholders as purchasers, of services too. A paper had been circulated within the local Health Authority which announced that, "*..the purpose of development funds is to encourage primary care led purchasing at a local level. Whilst wishing to facilitate maximum local flexibility the Health Authority would wish to see two criteria used to influence the application of locality resources*:

(1) the money should not be used to increase activity in the acute care sector (but it may be used to shift work from the acute sector to GPs and primary care staff or develop alternative models of care e.g. in collaboration with Trusts);

(2) the application of funds within a locality should be consistent with strategic objectives for all local residents (e.g. mental health, **maternity services**), and to take into account local public health advice. ". (Internal Health Authority paper January 1996, my emphasis)

This implied that maternity services were one of the key strategic objectives of the Health Authority and GPs, in partnership with their GP locality colleagues, could bid for monies to develop and implement changes to such services. In effect there was the potential for Team Midwifery , implemented in two of six localities, to operate in conjunction with up to four other different types of maternity care within one district; or for other localities to adopt Team Midwifery .

The National Association of Health Authorities and Trusts (NAHAT) published a briefing paper for Health Authorities in January (NAHAT 1996a). The focus of this briefing paper was *Changing Childbirth.* The purpose of the briefing document was to explain, *" the background, principles and recommendations of the Changing Childbirth report....clarify issues raised by some people working in maternity care around the country",* (NAHAT 1996a). It was evident from the local case study that clarification of issues was becoming increasingly significant given the uncertainty as to the future of Team Midwifery . The NAHAT briefing paper highlighted the importance of examining the use of existing resources and seeking out areas of duplication of provision, *"the Expert Maternity Group (EMG) had envisaged that it would be possible to look critically at the way in which resources are used - in particular at areas where duplication of care was apparent ".* If this was applied to the local case study, and comments noted above for locality development, there was a very real potential for resources to continue to be used ineffectively and maternity services to operate with a diversity of provision based on GP preferences. Unfortunately although the challenge of partnerships was given due attention prior to *Changing Childbirth* my field work experience did not find that " *the woman having a baby should be seen as the focus of her care; and that the professionals providing that care should identify their needs and develop arrangements to meet them which are based on full and equal co-operation between all those charged with her care ",* (House of Commons 1992, plxxx).

**January 4th 1996 - Midwives presentation – 'exploding the myth'**

The event entitled " Team Midwifery - Exploding the Myth" was organised by team midwives. In addition to their presentations the views of women who had experienced Team Midwifery were also included. This formed the basis of the session with an additional presentation from a GP involved in the pilot project. A wide multi-disciplinary audience attended and included managers from the Health Authority and the hospital Trust one obstetrician, four GPs, midwives from the hospital and

community, women who had used maternity services and representatives of the local National Childbirth Trust. The Director of Public Health was the most senior representative from the Health Authority and the Chief Executive from the hospital Trust was also in the audience. The hospital Chief Executive sat at the very back of the auditorium which sloped down on the rest of the audience and those presenting, this meant he was able to observe the actions and comments of every person in the room. This physical placement together with comments made after the presentation (see below) proved to have a potential negative effect on the overall tone of the event.

*Team midwives*

Three team midwives chose to set the scene by describing their own personal views about expectations and actual experiences of delivering maternity care through a team approach. One chose to describe her very real concerns and reluctance to participate and support Team Midwifery and she also explained how experience had proved her wrong. Another team midwife emphasised the importance of working and functioning as a team and how it takes a significant amount of time and effort to achieve this.

The remaining midwife focused on achievements and challenges for the future of Team Midwifery, acknowledging that there was still scope for improvement. Disappointment was noted at the lack of GPs in the audience, four out of a potential 87 had attended. However the general tone of presentations by the midwives was positive and their delivery was professional. Findings from the quantitative evaluation were described and a brief reference to the qualitative evaluation was used to highlight some of the more positive aspects of Team Midwifery.

*A General Practitioner's perspective.*

A GP participating in the pilot project had been invited to share her experiences. This was deemed important by the midwives not only because many GPs still needed to be

persuaded about the benefits of Team Midwifery but also because this particular GP had initially been opposed to its implementation. The GP explained her reluctance to participate in the pilot project but circumstances, i.e. the retirement of her Community midwife, had dictated otherwise. Her scepticism, she reported, had been unfounded, as she now believed Team Midwifery had benefited her patients and had not compromised her role as a GP providing the long term 'continuity of care'. She also described how Team Midwifery had improved the provision of care to women.

*The views of women who had experienced Team Midwifery.*

Three women spoke briefly about their experiences and several others seated in the audience were also asked to contribute if they wished to. All women spoke favourably of the team approach mentioning in particular the personalised and responsive service they had received. Those who had previously experienced traditional maternity care, and could therefore make a comparison, expressed a preference for Team Midwifery.

Several letters of support from women who had experienced Team Midwifery were also used to highlight positive aspects of this type of model of care. This approach to the evaluation of a new type of service was novel to both purchasers and providers of care but it was in keeping with recommendations set out in *Changing Childbirth* and advocated by NAHAT, *"fundamental to any planning of maternity care must be a dialogue with those using the service and those providing the care. The information gleaned from this should then influence the way in which services are developed".* (NAHAT 1996a).

*The wider discussion - significant incidents*

After the presentations team midwives encouraged the audience to ask questions and generate a discussion. Initially questions and comments were related to specific operational issues, for example, how the on-call duties operated and how many team

midwives women may see postnatally. The discussion then took on a more challenging direction and some more 'uncomfortable' comments were made. The shift in tone seemed to emanate from the only obstetrician in the audience who made the following comment, " *what we have here tonight is a sales pitch by the midwives .....we don't need women being paraded in front of us telling us how wonderful Team Midwifery is...these women have been hand picked anyway......* ", (verbal comment, consultant obstetrician, north west hospital Trust, January 1996).

One of the presenting team midwives informed the obstetrician that not all the women had been chosen to speak at the presentation, some had volunteered to express their views, and many more with similar views could have attended. The most notable observation as a result of this incident was not necessarily the content of the reply to the consultant but the way in which this particular midwife responded, her tone and composure were unfaltering throughout. It was shortly after this exchange that the Chief Executive of the Trust announced that financial considerations may emerge as the determining factors influencing how to sustain and expand Team Midwifery to other localities in the district. He indicated that the Trust would be asking the Health Authority for an additional £350,000 to implement Team Midwifery district wide. He also added, " *this sum of money could of course be used to purchase a kidney dialysis machine....at the end of the day we all have some difficult decisions to make......its up to the midwives to convince the purchasers to invest in Team Midwifery ..* ", (Chief Executive, hospital Trust).

This response contained within it a number of issues: on the one hand it displayed the potential difficult choices that had to be made within the NHS system regarding the use of finite resources; on the other hand it represented how the dynamics of the quasi internal market produced this type of scenario. In addition there was also the possibility that by placing the emphasis on the purchasers of local healthcare services, the Health Authority and to a lesser extent GP fundholders, a message was being given out that the Trust had little involvement or for that matter responsibility in the decision making

process. However the response was somewhat flawed because it made no reference to the preferences or needs of women or the key indicators of success in *Changing Childbirth* and appeared to negate statements presented by NAHAT that, *" there are many choices available for women, including choice of professional, choice of place of birth and choice about the type of carer they would like"*, (NAHAT 1996).

A team midwife responded to the comments made by the Chief Executive. The main thrust of her reply was a forthright acknowledgement of some additional costs incurred as a result of Team Midwifery . This was followed by an outline of what she perceived to be a concerted effort by all involved in Team Midwifery to seek ways of reducing costs. The examples she gave to illustrate this latter point was the reduction in on-call costs, i.e. night duties, by pairing of teams to cover night duties and a current focus on adopting ways to reduce the increase in mileage allowances as a result of more care being undertaken in the community. The midwives drew the discussion to a close by extending their thanks to midwifery managers for their consistent support.

In my research role, as opposed to employee role, I had several conversations with different professionals that evening to ascertain reactions to what had taken place and observed the following.

(i) In general the midwives remained positive in their attitude to how the presentation had been received in spite of comments made by the hospital Chief Executive and obstetrician. The progress of Team Midwifery appeared to provide them with a sense of achievement and I considered that comments made to me during the evaluation were re-enforced, i.e. team midwives would not want to return to the old fragmented system of care. Midwives and midwifery managers were evidently disappointed in the poor attendance by GPs.

(ii) Some of the women were upset at the comments made by the obstetrician. His comments, noted above, suggested that there was no need to take account of the views of women experiencing Team Midwifery . He had also suggested to the audience that

the views being presented were biased anyway.

(iii) One of the few GPs who had attended seemed impressed with the midwives and what they had achieved but indicated he would not introduce Team Midwifery to his practice because he believed women were currently receiving a satisfactory service. He was therefore unwittingly performing the role of proxy decision maker for his patients. Although some GPs learnt to value the team approach, others did not and this was true for pilot and non-pilot GPs, (Tinkler and Quinney 1995) and experiences and perceptions remained in conflict with one another. The culture the managed market created, I suggest, de-valued lower rank staff because market principles will inevitably create staff who become functional parts of a system which is set up to compete for resources (money and patients) with other organisations. Staff may not necessarily be valued for their contribution to a market type system as they would be allocated to the system as a resource to be manipulated for productivity, and as such be treated as commodities, above and beyond any form of value system or loyalty to a shared vision.

Team Midwifery appeared to have the potential to challenge this commodification of staff, i.e. from being non-reactive parts to being proactive participants, through its focus on providing a responsive and patient centred service that also enabled midwives as practitioners to use their full range of skills. The Team Midwifery approach also engendered more participation in the process of care from patients. This affected the recipients of care who perceived some, albeit temporarily, recognition of being a co-producer of their own health care, (Tinkler and Quinney 1998).

(iv) The Director of Public Health had been struck, above all else, by the confidence and composure of the team midwives, in particular the way they had responded to the comments made by the obstetrician. This resulted in the conclusion that Team Midwifery had empowered midwives to provide a better service to women. Therefore it was the quality of care and not Team Midwifery per se that achieved this. Thus indicating that Team Midwifery had been a vehicle for change but not necessarily the

only model of care to be developed. I was privately sceptical of this view, partly because the Director of Public Health did not perceive maternity care as a priority and was shocked rather than impressed by midwives 'empowerment'. In addition if Team Midwifery had empowered midwives to provide a better service to women then the model of care itself was responsible for this.

The Director of Public Health suggested that 'quality issues' needed to be sifted out of the qualitative evaluation to help inform the debate, it was made explicit that she did not favour investing additional monies into maternity services. The apparent tension between professional groups within the Trust, i.e. the Chief Executive, obstetricians and the midwives, and an obvious lack of interest from GPs were all potential barriers to expansion of the team approach. In addition the underlying, but increasingly crucial and seemingly irreconcilable, financial component of this complex situation was also persistent in subsequent events throughout the coming financial year.

The above context and observations were interesting to note in contrast to comments made by the then Secretary of State for Health, Stephen Dorrell, in a speech at Manchester Business School in January 1996. In his speech he emphasised the role of the new Health Authorities and argued that they were the spinal column of the health service, responsible for ensuring the central commitment of the efficient use of healthcare resources in accordance with clinical priorities in a context whereby patterns of care in, *" each district will inevitably involve a series of complex judgements which need to reflect local circumstances "* (Dorrell 1996). These sentiments were reminiscent of the flavour of documents described in chapter one i.e. Local Freedoms, National Responsibilities (i.e. NHSE, 1994d). National accountability, clinical priorities and thirdly local interpretation of these appeared however to create an environment for incompatible relationships. A further incompatibility appeared when it was suggested that individual practitioners should be encouraged to, *"use local discretion to try new approaches which also must be responsive to local needs and wishes.......it is something quite different to tolerate differences in the quality of healthcare which arise simply as*

*the result of historical accident or professional conservatism* ". (Dorrell 1996).

One of the assumptions arising from the above appeared to be the relative ease with which practitioners would change their working patterns of delivering care, yet as the local study began to demonstrate many GPs were resistant to change and 'professional conservatism' was in abundance. Evidence based medicine was mentioned more explicitly in the speech by Dorrell with the expectation that responsibility for challenging variations of quality within the NHS would rest firmly with 'Health Authorities and their partners in primary care'. Dorrell (1996a) stated that he expected decisions made by Health Authorities or GPs regarding particular forms of treatment commanded public confidence. The role of primary care dominated the next part of the speech, " *in their pursuit of best value Health Authorities and GP purchasers (Fundholders) will need to ensure priorities are not distorted in favour of the hospital service..........each Health Authority needs to look at the range of primary care available to its population and ensure that they use the weapons at their disposal to promote the generalisation of good practice*". (Dorrell 1996).

The scope of the role of the Health Authorities received further attention in relation to the task of being the guarantor of the quality of healthcare. The question of effective intervention by the Health Authority on debates about how patients are to be treated was raised with an apparently simplistic solution, "*....an important part of the answer to this question lies in involving clinicians directly in planning and developing health services....Health Authorities have available to them respected clinicians who are able to conduct a professional dialogue on equal terms*", (Dorrell 1996). Again it was open to interpretation as to what determined participants on equal terms, and unclear as to whether this implied the potential superiority of Health Authority managers skills in planning and development in relation to 'respected clinicians' skills or vice versa. In addition there was no consideration of impartiality and the ability of clinicians, in their specialist capacity, to be impartial in the decision making process. What was apparent in the local case study was an overt reluctance from consultant obstetricians to engage in

a dialogue about *Changing Childbirth.* The obstetricians in particular sought to rely on senior management from the hospital Trust to participate in direct negotiations with the Health Authority and to provide representation at events like 'exploding the myth' described above.

**Initial concerns and activity after the midwives presentation.**

The immediate focus for the Health Authority was to try and establish where the figure of £350,000 had arisen from and if it was reasonable in comparison to other units implementing similar Team Midwifery schemes. I, in my employee role, was asked to seek out information from other hospital trusts implementing Team Midwifery with a view to ascertaining costs incurred. The National *Changing Childbirth* Team provided me with a list of contact names and addresses of professionals willing to share information about Team Midwifery and similar models of care. Contact was made with all of the professionals listed via letters and phone calls. Initial data gathered by me yielded the following relevant information:

- Queen Mary's Hospital Trust, Sidcup, Kent - Caseload Team Midwifery . A cost benefit analysis had been conducted and the conclusion was, 'running costs for traditional maternity and caseload Team Midwifery are comparable but there was an indication given that additional core staff numbers may need to be increased'.

- Hammersmith Hospitals Trust, The Centre for Midwifery Practice (CMP) - One to One Midwifery. A progress report on this type of care indicated that 'introduction of the scheme was found to be broadly cost neutral'. In addition findings also suggested a reduced length of hospital stay for women receiving One to One maternity care. This is significant because in-patient hospital care is the most expensive component of any package of maternity care.

- Princess Ann Maternity Unit, Bolton - Team Midwifery. Team Midwifery had been fully implemented in this district at no extra cost. Telephone discussions resulted in an offer to visit Bolton maternity Unit to discuss how they had progressed from a pilot project to implementing Team Midwifery district wide within existing resources. This appeared to be a particular opportune and relevant invitation as Bolton was not dis-similar to the district being researched in terms of number of births per annum and socio-demographic population characteristics and geographical size.

This information was presented to the Chief Executive, Director of Public Health and quality managers at the Health Authority, on the 12th January 1996.

In my employee role I continued to search for relevant information which involved further contact with other maternity units during January. Attempts were also made to gather financial data relating to costs per episodes of care, i.e. how much was the hospital Trust charging for current services such as an antenatal visit, normal delivery, caesarian delivery. If data from other units could be collected comparisons could be made in relation to charges for packages of care. It would then, theoretically, be possible to compare these charges with Team Midwifery costs.

Unfortunately the information department at the local Health Authority could not produce this data because of the traditional and historical use of block contracting with the hospital Trust for maternity services this meant that no detailed information had ever been provided by the Trust, or requested by the Health Authority. During this period I had been made aware of a national *Changing Childbirth* conference being held in February 1996 to specifically address economic evaluation of pilot schemes. This indicated that financial implications of introducing different models of maternity care introduced to meet the recommendations of *Changing Childbirth* were causing problems for other purchasers and providers. I attended this conference and produced a conference report which was disseminated within the Health Authority. An overview of

its contents is given below.

Key speakers at the conference were health economists and research midwives who had been involved in implementing alternative models of maternity care whose evaluation had included an economic analysis. The conference did not provide any conclusive data which I could have taken back to the local Health Authority to aid the financial negotiation process. However, many useful issues were highlighted and discussed such as:

- problems with data collection, i.e. the barriers to it which were mainly poor information systems, inadequate data and insufficient financial and activity information and a dependence on the co-operation and commitment from hospital departments;
- resource analysis, as opposed to a cost analysis, was deemed a practically more robust and useful method to adopt when conducting an economic evaluation of a particular service if the results are going to be applied elsewhere. Cost analysis was useful to inform local decisions but was not considered comparable between different provider units;
- it became evident that economists were adopting different methods of economic evaluation and, regardless of the method, speakers suggested relationships between purchasers and providers could either hinder or facilitate the data collection process; and
- diversification in models of maternity care were matched by diversification in resource use, real financial costs and clinical and satisfaction outcomes for women.

Significant variations in charges between provider units, i.e. as much as £500 for the same episode, became apparent during the plenary session. Delegates spoke of a lack of national direction, co-ordination and support for the magnitude of change, and implications of it, taking place. The purchaser provider split was failing to provide

choices for women and appeared to lack systems to ensure the effective use of resources, yet the operation of the internal market was hailed as a success by the Conservative Government. They continued to attempt to focus on the role of patients and their 'relationships' with their local purchasers, *"Health Authorities will be expected to increase the involvement of local people in developing strategies to meet local needs. Patients should also be able to obtain better information about health services as purchasers and providers are obliged to produce relevant, accurate and timely information on a wide range of subjects."*, (DoH 1994b, p5.para 3.4).

Underlying the above rhetoric, I propose, were opportunities for professionals and patients. The success of a change in service delivery, in this case study Team Midwifery , is arguably dependent on how managers from purchaser and provider organisations come to a decision and what information they allow themselves to be influenced by. Other influential factors with a new Labour government in power became more prominent due to further emphasis on a primary care led NHS (DoH 1997a)

As the national conference, described above, was inconclusive and provided no easy answers to the local case study I continued to collect information and data from evaluations of other similar models of maternity care which were published during the data collection fieldwork period.

**Comparisons to other pilot projects**

In March 1996 a report describing an evaluation of Team Midwifery in west Essex was published (Farquhar et al 1996). The researchers concluded:

- the team approach was facilitated by the enthusiasm of one senior manager;
- the scheme may have been implemented too quickly;
- a number of midwives, in particular hospital midwives, were demoralised;
- some GPs preferred Team Midwifery because it had reduced their workload;

- both groups of midwives expressed concern about the deterioration in communication with their midwife colleagues and interdisciplinary issues were paramount in the staff surveys;
- women receiving care from the original pilot team, i.e. operational for 3 years at the time of the evaluation, were most likely to have met all their of their labour/delivery and postnatal midwives before; and
- attempts to increase continuity of carer for women during labour and delivery, through the team approach, appeared to have occurred at the expense of continuity in the antenatal and postnatal periods in West Essex.

The researchers also pointed out, " *within the case study the evaluation lacks any costing data: it was not within the remit of this study to consider the cost effectiveness of care provided by the Team Midwifery scheme in West Essex*". (Farquhar et al 1996). In contrast to these issues many team midwives, despite disruption to home life, still favoured the team role because of the enhanced professional status it provided. This finding in particular was reflected in the views expressed by most of the team midwives interviewed for the North West District evaluation, (Tinkler and Quinney 1995).

In April 1996 the final report of the South Camden Community led maternity project was produced (Fleissig and Kroll 1996). The service was re-organised in July 1993 after consultation with GPs, maternity managers, midwives and obstetricians, and representatives of the local Maternity Services Liaison Committee. A large cross section (513) of professionals and service users participated in the service evaluation. Issues that emerged from the evaluation appeared to be about more deep rooted problems in the system, i.e. organisation of care, inter-professional relationships and the number of midwifery staff.

All obstetricians (6) stated that care initiated in the community setting limited women's choices about where antenatal care took place and they indicated home bookings reduced their influence. Four obstetricians were 'upset' that direct referrals from

community midwives to obstetricians bypassed GPs and two commented that expansion of community-led care had increased antagonism between different professionals. (Fleissig and Kroll 1996, p.29). There was no expansion in the final report as to why this model had increased antagonism but this suggests a certain amount already existed prior to implementation of community Team Midwifery . Staffing problems and omission and duplication of tasks were seen to be key problems associated with the introduction of community Team Midwifery as was the reduction in medical involvement and influence obstetricians had and the perceived low levels of hospital midwifery staff.

The researchers concluded that:

- community led care can be provided to the majority of women, even those with complications;
- difficulties arose from the organisation of the service and costs associated with its implementation - this impacted upon continuity of care;
- shared learning and multidisciplinary updating would enhance mutual respect, reduce isolation and encourage collaboration;
- further discussion about the evolving roles of different professionals and the effects on practice would help reduce feelings of marginalisation and reduce duplication; and
- further research is needed to compare alternative models of care and their costs. (Fleissig and Kroll 1996).

It would therefore also appear that other districts were facing similar difficult decisions as to the future organisation of maternity care in response to *Changing Childbirth.* These findings suggest that the strength of deep rooted inter-professional conflict, a lack of direction and performance management from the DoH and poor financial systems would continue to impede full scale implementation of the ten indicators of success (DoH 1993). The shift in focus of the Conservative government initiatives in the early 1990's (DoH 1989a, DoH 1989b, DoH 1991a, NHSME 1992,.NHSE 1994) had

apparently resulted in the "empowered consumer" and the "accountable professional" (Williamson 1992, Blaxter 1995). The 'culture' of change within the NHS and the changing roles of 'consumer' and 'professional' should be considered as part of the context which may impact upon the implementation of specific changes and evaluation of them.

In view of the above information, and a lack of any local reliable data on maternity costs in relation to activity, there was a distinct mis-trust of the figure of £350,000 requested by the local hospital Trust. The lack of information to support this request for additional funding coupled with uncertainty from other schemes fuelled a cynical attitude from Health Authority managers towards the Trusts motives and intentions. This resulted in speculation about a 'hidden agenda' and monies being used to 'bail out' other hospital directorates in financial difficulties. This situation prompted an exchange of letters between the respective senior managers and Chief Executive of the Health Authority and hospital Trust (see below).

**GP's views on local maternity care - January 10th 1996.**

Results from a survey of GPs views on maternity care conducted by the local Medical Audit Advisory Group (MAAG) were disseminated. The MAAG, who worked specifically with GPs and were independent of the Health Authority and NHS Trusts, had used a structured questionnaire to collect data from GPs. The response rate was relatively high (67%) when one considers it was a postal questionnaire and GPs were offered no payment for completing it. This suggested strong local feelings, unfortunately the data collected (see below) did not necessarily provide a clear picture of the type and extent of maternity care being provided by GPs. Analysis of the questions asked in the survey appeared ill-defined which made if difficult to assess if the questions had yielded the right data for the purpose of the survey, which has implication for the validity of the work, (see appendix 1).

To illustrate the above point, consideration will be given to a few of the small number of results from the survey reported in the annual report of MAAG 1995 :

(i) "the majority of GPs provide antenatal care (94%)";

(ii) "74% share antenatal clinics with their midwives";

(iii) "postnatal visits are carried out by 98% of doctors and all midwives";

(iv) "comments by patients are not very frequent and a substantial number are happy with the present system".

This data, as well as being ambiguous (iv), provides little information about how much antenatal and postnatal care GPs actually provided. GPs are paid for ensuring antenatal care is provided, the fee is not for providing the care itself, *"The fee at present paid to the GP is for ensuring that antenatal care is provided ;it is not for providing the care. A GP can therefore claim the fee while referring the woman to a midwife for her care "*, (NAHAT 1996a). This statement reinforced the fact that GPs could continue to be paid sums of money without actually having to provide care to women.

Data from the qualitative evaluation (non-pilot women) indicated very few women saw their GP for most, or even some, of their antenatal care other than confirmation of pregnancy. Most of the care was provided by community midwives attached to the Practice (Tinkler and Quinney 1995). This indicated that parts of the service, and therefore some professionals too, were still rooted in traditional methods of service delivery. It also suggests that if GPs were able to continue to be paid for arranging rather than delivering care it could be difficult to make changes to services that would result in this payment being unfeasible. Policy implementation can be viewed as a dialectical process under these circumstances where parts of a whole system operate and function in different ways and at different times, consideration of Berwick's model of change will illustrate this further.

One of the GPs who participated in the original pilot scheme was what Berwick (1997)

would describe as an 'early adopter' who engaged in change at an early stage through interest tinged with scepticism. These early adopters however if convinced of the value of the change they engage in can be instrumental in securing the support of the 'early and late majority'. Berwick (1997) suggests that 'innovators' are deemed too radical and 'traditionalists', those who are more likely to resist change and are unlikely to be swayed by their peers, too conservative. Early adopters select ideas they would like to try out perhaps for a combination of practical and pragmatic reasons.

The early majority are usually more prone to accepting advice and information from people they know, i.e. their own professional group. Whilst the late majority participate in innovation or change when it appears to be safe, well established and I would suggest less of a threat to their own status and ways of working. Findings from the local case study suggested elements of these different groupings existed. For example those midwives and GPs who engaged in the pilot could be viewed as early adopters, (not innovators as such because ultimately the idea had to be 'sold' to them). Uncertainty remained for the majority of GPs and a significant number of midwives, (the potential early and late majority) whilst a few GPs and all but one of the obstetricians could easily be referred to as traditionalists. Implications for policy implementation within this context appear to unfold as follows: not only does change have to emerge from within existing systems, i.e. this notion of a dialectical process I have alluded to previously, but it also has to be evolutionary. Research findings therefore become part of this dialectical process, with their influence affecting professionals in different ways and at different times.

**Quality manager sends letter to Directorate manager of maternity unit.**

There were several key statements and requests made in this letter that focused on issues previously highlighted, e.g. opportunities for cost savings within the team approach, improved communication between professionals and team building for the midwives. The quality manager, in her letter, did suggest that the Health Authority *may be willing*

*to contribute towards the cost of continuing the present pilot scheme for another year".* This offer of assistance, however, was based on some clear conditions that the Trust had to agree to including a detailed breakdown of running the pilot scheme alongside the conventional model of maternity care, additional information on team costs in relation to staff grades, equipment, travel and, out of hours cover. The letter concluded by making it clear that the Trust had to demonstrate "a willingness to share the costs of continuing the pilot scheme for another year."

**Visit to Bolton Hospital Trust January 24th 1996**

The quality manager from the Health Authority and myself, in a dual role of employee and researcher, visited the above hospital to learn more about their district wide Team Midwifery service. A morning was spent discussing how Team Midwifery was implemented on a district wide basis with no additional funding from within the hospital Trust or from the Health Authority. It became evident that there were significant differences with regard to organisation of Team Midwifery in Bolton. This helped to explain some of the additional costs incurred at the district under study.

The key organisational differences were:

- No on call - a shift system was in operation, particularly for those midwives who chose to continue night duties - this would relieve the financial burden of on-call payments (the local hospital Trust conducting the pilot had previously re-organised the working patterns for all nursing and auxiliary nursing staff, no one was allowed to work night duties only;
- no mobile phone rentals because of regular night duties;
- 15 pool cars - this resulted in a reduction in travel costs with regard to private mileage claims;
- the core staff were kept to a minimum - all staff were involved in teams and as such undertook all duties, this included E grade midwives; and

- teams comprised of G, F and E* grades - this was perhaps the most significant point as E grade midwives participating in the pilot Team Midwifery project reported in this thesis were temporarily re-graded to F.

(* G grade is the higher grade with respect to pay and responsibility, a G grade would normally be the team leader. The difference in pay between each grades would vary, taking experience/length of service into account, but would normally be between £2,000 and £3,000.)

I asked the midwifery manager how Bolton Midwives felt about the lack of re-grading bearing in mind Team Midwifery demanded increased responsibility. The reply to this was, *" obviously they would all prefer to be on an F grade but now they have experienced working on a team they will not go back to the old rotational system of maternity care"*.

Questions were also asked regarding opposition from other professionals, in particular the hospital Consultants and GPs. Again it would seem that the culture in Bolton was different as there was a clear indication that all but one Consultant and most GPs were in favour of the Team Midwifery approach. There was also a perception, by the Bolton midwifery manager, that implementation district wide would have been much more difficult if the Consultants had not been as supportive as they had been. In comparison to the Bolton experience the local case study appeared to be floundering due to many factors and not least inter professional conflict.

The impetus for change, i.e. women centred care, had become overshadowed by operational and structural conflict, i.e. contract agreements and power struggles, both professional and resource driven. The values of the 'managed market' NHS and the culture of the pre 1991 reforms interacting with one another were at there most visible during this period. Professional tensions and conflict between professionals within the hospital and community setting needed to be resolved if the pilot was to have fully

achieved its potential, much work around consensus and cooperation was necessary. The difficulties of introducing a new way of providing care within an existing and established structure, i.e. traditional maternity care, must be recognised. This will involve identifying clearer roles and relationships between GPs and teams of midwives, not only to avoid duplication but also to help women understand what they can expect from the service

**Directorate manager of Women's and Children's Services, local hospital Trust, sends letter of reply to quality manager. February 5th 1996**

The hospital Trust provided information regarding increased costs for the pilot based on three elements. The following data has been extracted from the aforementioned letter:

(i) staff costs - due to the midwives working more enhanced hours, i.e. unsociable, weekends and on call to provide continuity of care, the individual midwife's remuneration had risen by approximately 9%. This meant costs of approximately £52,000 more per annum;

(ii) travel - this was costing approximately £36,000 per annum; and

(iii) communication - the Trust had rented a mobile phone for each team to enable mothers to contact a team midwife, the approximate cost was £3,000.

Therefore the total cost for six pilot teams was £91,000 per annum.

The letter made no reference to if, or how much, the Trust was prepared to contribute to these 'approximate' costs. The final sentence however reflected a belief that more private discussions would determine the outcome of negotiations, *" I am sure that..... (Chief Executive of Health Authority) and ..... (Chief Executive of acute hospital Trust) are in discussion regarding the costs of the scheme and will be negotiating the finance"*.

As the future of the Team Midwifery scheme was in part dependent on additional resources, in the short term at the very least until more resources could be shifted from the acute sector to primary care, then a few senior managers were increasingly leading negotiations.

So in addition to the continued underlying inter- professional tensions, relationships between senior managers, and in particular the Chief Executives were increasingly having an impact on the future direction of maternity services. The notion of national responsibilities and local freedoms was beginning to feel more like a tenuous relationship rather than a complementary marriage of top down and bottom up priorities. It did not appear compatible to manage this juxtaposition of priorities and circumstances indicated that either a local or a national agenda had to dominate, the acute sector were not going to relent without a fight for resources. This also suggested that the impetus of the internal market, to shift the power base of the acute sector, was under threat if local circumstances were reflective of a broader struggle within the purchaser provider management of the NHS. It also pointed to the emergence of a new type of manager/management style: the Chief Executive as public sector entrepreneur.

Boyett (1996) has suggested that for markets to operate successfully, i.e. efficiently, there is a requirement for 'entrepreneurial activity.' He has sought to apply this theory to explore whether in the public sector quasi market's entrepreneurial activity creates a new kind of managerial leadership. This new kind of manager appears to gain rewards which are not driven predominantly by money but what I have interpreted as ego-centric activity. The constant re-organisation and re-structuring that has dominated the NHS recently, radical or incremental, offers the 'public sector entrepreneur' an opportunity to exercise this ego-centric role and as a variation from previous decision making behaviour often allows the more perceptive to deliver what is demanded of them whilst at the same time setting some of their own parameters, *"entrepreneurship occurs in the public sector where there is an uncertain environment, a devolution of power, and at the same time re-allocation of resource ownership, to unit management level. It is driven by*

*those individuals, particularly susceptible to the 'manipulation' of their stakeholders and with a desire for a high level of social 'self satisfaction', who have the ability to spot market opportunities and who are able through follower 'manipulation' to act on them',* (Boyett 1996).

When surveyed, managers within the health service displayed a desire for more local freedoms and less direct control from central government. A first priority for retaining them in post was 'greater autonomy and less intervention from the centre' (Dix, 1996). However this was shortly followed by financial scandal at Yorkshire regional Health Authority and led to a suggestion that ministers felt, *" the free rein given to managers to run heath services without interference has become too slack"* (Butler and Crail 1997).

The juxtaposition of national responsibilities and local freedoms was apparently not an entirely feasible relationship yet the case study demonstrates a certain amount of local freedoms amongst managers despite the perception amongst some that they were constrained in their autonomy. The case study, I suggest, also illustrates how self satisfaction was gained through the annual contractual negotiation process, acting as a substitute for more radical autonomy that some chief executives would want to exercise.

**Further information regarding costs of Team Midwifery models of maternity care.**

On 20th February 1996 I received a letter from the Midwifery department, King's Lynn and Wisbech Hospitals Trust. The letter, from the head of midwifery, was a response to a request for information regarding the cost of their Team Midwifery pilot introduced in January 1994. One team of six midwives, (one grade G and five grade F) with a caseload of 260 women per year from three GP practices existed. However the pilot had not been extended because of the rural area covered by the hospital Trust.

The letter however was positive with regard to the acceptability of Team Midwifery as a model of maternity care to all stakeholders, *" the final assessment on the one team we*

*have is that we are at a break even position (financially) but we cannot increase the service (even though it is what midwives and mothers want) without an increase in resources to cover travel costs......given the negative financial position, it has been extremely rewarding to see just how good a service can be and that is not just my opinion but that of consultant obstetricians, midwives and clients."* (Personal correspondence, head of midwifery 1996)[16].

On the 23rd February 1996 I received a letter from the head of midwifery at Gloucestershire Royal NHS Trust who was responding to a similar request for information made above. This response was less conclusive as data for comparison of different models of maternity care, i.e. Team Midwifery versus traditional maternity care, was still being collected. A view was provided however on the potential financial implications of Team Midwifery , *" the cost may be offset by the clinical outcomes within each care system. For example we may find that although the team scheme is more expensive in manpower and mileage, it may result in less admissions to hospital in spurious labour and so cancel out the increased manpower costs.....we are liasing with a Health Economist to try and tease out similar issues in the project".* (Personal correspondence, head of midwifery, 1996).

Nationally resource implications of implementing *Changing Childbirth* were still not being addressed but it became evident that confusion in relation to meeting the ten indicators of success existed. This led to the following statement being made, *"When drawing up the indicators of success the EMG saw them as being national indicators, over the five year period, that change was taking place. They were not intended to be viewed as* **targets** *to be achieved without reference to the local situation. It is inevitable and desirable that local circumstances will vary and that some services will achieve percentages outside the national figures ".* (NAHAT 1996a, my emphasis).

---

[16] Letters were received as a result of contact from individuals whose names had been taken from a national database provided by the Changing Childbirth Team. I have decided to anonymise the names of those professionals, an ethical decision on my behalf, as I have chosen to use excerpts from these letters in this thesis.

Despite the above point each regional Health Authority was asked to submit information on progress towards the indicators and data were presented in the briefing paper in the form of graphs. The presentation of data in this format was not unlike league tables and performance targets, and seemed to bear little resemblance to indicators reflecting local circumstances and suggested mixed messages regarding the implementation of the indicators of success of *Changing Childbirth.* Although the indicators were not to be viewed as nationally set targets this conversely provided an opportunity for local managers to take implementation of *Changing Childbirth* less seriously. It also points to what may have been one of the most significant failures of *Changing Childbirth,* i.e., it was not given the authority of a National Service Framework (NSF). National Service Frameworks were introduced into the NHS in recent years for specific service areas, including older people, mental health and diabetes. An NSF sets out clear standards and guidelines for treatment and care and sets specific milestones with timescales to achieve them. Targets and milestones are monitored by central government and this can affect resource allocations to Primary Care Trusts, the new local purchasers of healthcare. *Changing Childbirth* was a forerunner of an NSF but lacked the leverage of an NSF because it neglected workforce planning and set indicators rather than national targets and standards.

**Presentation of the qualitative evaluation to Health Authority executive and non-executive directors. February 22nd 1996.**

This brief presentation was given primarily to inform the non-executive directors of the Health Authority of the results of the qualitative evaluation. The executive board comprised of a large gathering of members from the old structure of the district Health Authority and Family Health Services Authority. This old structure, which was due to be replaced officially by the creation of the new Health Authorities on the 1st April 1996 had little or no knowledge of Team Midwifery, with the exception of one practice nurse and one GP known for his opposition to the pilot.

The presentation itself comprised of an overview of data collection methods and sample details, followed by key findings that were illustrated by quotes from all the sample groups consulted. At the time of the presentation a decision as to which non-executive members would remain in the new Health Authority and whose services would no longer be required had yet to take place. In view of this the subsequent debate after the presentation was more lively than anticipated. Members were keen to show their interest in, and capacity to debate, the issues presented to them. This often however only served to reveal their lack of knowledge of the issues at stake and a poor understanding of different research methodologies and how and why they are used. In addition they also allowed themselves to be influenced by the negative comments made by the GP present.

Questions asked were initially about midwives workload and the implications of (physically) sustaining such commitments they felt this model of care warranted, as expressed by the midwives interviewed. I suggested that such a change in practice necessitated hard work during the implementation period but the midwives had experienced less upheaval once the pilot was well established for their respective teams. Non-executive members also wanted to know more about the concept of continuity of care, in particular during labour and delivery although they appeared sceptical about the need to know the delivering midwife. I explained that those women who had experienced both models of maternity care, and therefore could make some comparisons, had indicated it did make a (positive) difference.

At this point the GP present, as a non-executive member, suggested that continuity in the antenatal and post-natal period was actually reduced under Team Midwifery as women may see up to six midwives instead of one community midwife and added, *"this study is purely anecdotal, it is not representative of the views of women in ......(district)"*.

I attempted to elaborate on some further findings and pointed out that women receiving traditional maternity care often saw many community midwives, not just one attached to the practice as sickness and holidays could inevitably prevent this form of continuity. I also suggested that although the study was not statistically significant it did not mean that the views expressed by the women interviewed where no less real or valid if taken as accounts of real and recent experiences of maternity services. The Director of Primary care intervened at this point and assured the non-executive members that statistical information, i.e. the quantitative audit, would be available shortly. I felt that this, in addition to the obvious unfamiliarity with qualitative data of this nature, resulted in a further detraction from the qualitative findings.

The culture of organisations and those who manage them may have been a neglected area of research and evaluation in relation to its impact on the organisation of care (Tilley 1993, Davis and Howden-Chapman 1996). The lack of understanding of the issues emerging from the Team Midwifery pilot from Health Authority non-executive directors highlighted their unwillingness to engage in a very real and complex policy process. Thus women were uninformed quasi -consumers in a quasi/managed market overseen locally by uninformed quasi-accountable lay representatives. The response to both evaluations when presented formally and informally, although eventful at times, initially did not appear to generate much direct impact. Results from the quantitative evaluation were largely ignored (some statistical discrepancies were present in the main body of the final report). Although the qualitative evaluation appeared to be deemed useful and informative it was not considered appropriate to make any sort of conclusive decision about the future of maternity care in the district as a whole. This was as much indicative of the prejudice that qualitative research continues to experience as it was of the difficulties of implementing national policy at local district level. This led me to observe that although the quality of research is obviously paramount the context into which it is presented and received is also paramount in determining how far it will influence policy.

After the presentation had concluded the following comment was made by the GP present, *" I have spoken to women at my practice and they don't think it is necessary to know the midwife who delivers them and are quite happy with the service we provide".* (Non-executive member, male GP). Not only did this comment suggest an opinion based on 'anecdote' but a lack of consideration of women being unable to make an informed decision unless they have experienced more than one model of maternity care. The subject of cost implications was briefly discussed with the focus on midwives pay and a comment that, *" the hospital will have to sort this out, they don't want to take the midwives on do they"* (Non-executive member, male). This type of comment reinforced the role of the provider arm of the internal market as the route for control over the market system as opposed to it being purchaser driven. It also suggested an unsophisticated purchasing system supported by a lack of insight to the contractual role of an organisation supposedly charged with implementing national policy.

The Chief Executive concluded the discussion by suggesting that no final decisions would be forthcoming until a wider debate had taken place and more information was available such as the quantitative evaluation and details on the financial implications of extending and expanding Team Midwifery . This announcement did not quite tally with previous statements made on the 5th February (see above) which indicated that the Chief Executives would be conducting one to one discussions on the future of Team Midwifery and its resource implications. However an alternative explanation for this statement could be in relation to non-decision making if a resolution to the future direction of maternity care was still uncertain and formed part of a wider debate on the total budget allocation for the hospital Trust.

The national context which existed during the research period did appear to reflect many local issues such as; a lack of reliable information to conduct accurate economic evaluations; continued inter-professional issues; and the underlying tensions between purchasers and providers. As described previously, other pilot schemes had been successfully extended without substantial additional resources, some had sought further

help from health economists and several had been dissolved. I had suggested early in 1996 that seeking the advice of a health economist may be a useful short term measure, which may give a long term view and help the inevitable decision the Health Authority had to face in March 1997. The Chief Executive said he would not spend any more money on Team Midwifery and I was asked to seek out financial information from other districts.

The above scenario suggested to me a delay in the decision making process and seemed to form part of the 'dilution process' of policy implementation I had observed. During this interim period there was also the possibility of new guidance from the DoH or the NHSE that would have potentially aided the decision making process, although structurally and strategically this would have constrained the notion of local freedoms. In addition there is also evidence to suggest that the 1991 reforms did not generate the contractual shifts and competition that they had promoted, *"few Health Authorities have subjected services to tender or carried out thorough reviews that have resulted in decisions to shift contracts between providers"*, (Mulligan p33, 1998).

In an area where the Health Authority is dependent on one main acute provider the monopoly on service commissioning and delivery is relatively fixed. In this case study this scenario was compounded by the fact that opposition to Team Midwifery was evident from both purchasers and providers and this hindered its implementation from the out set. Therefore it was unlikely that all of the indicators of success in *Changing Childbirth* would have been met. Although a change in government has re-focused and re-defined NHS structures at district level the seemingly irreconcilable relationship between national responsibilities and local freedoms could continue.

**Presentation of the quantitative and qualitative evaluation findings to the Maternity Services Liaison Committee (MSLC). March 19th 1996.**

The MSLC comprised of representatives from the acute hospital Trust, the Health

Authority, local GPs, the local branch of the National Childbirth Trust (NCT) and two women who had recently used local maternity services, but not Team Midwifery. A wider audience had been invited and included team midwives, four GPs, midwifery managers from the Trust, additional representatives of the local branch of the NCT, the Director of Public Health, quality managers from the Health Authority and a psychologist with a specialist interest in women's health from the local NHS Community Trust. Chief Executives from the acute Trust and the health authority also attended, obstetricians were invited but none attended.

The chair of the MSLC welcomed the audience and expressed disappointment on observing the absence of any obstetricians. The absence of obstetricians at both key presentations of evaluation findings (January and March 1996) appeared to signal indifference and apathy to changes being made. Midwives had experienced internal hostility to the pilot scheme and this public lack of engagement was noted as further resistance to the new model of care. An alternative explanation to their absence was the possibility that consultant obstetricians expected Trust management to respect and represent their views, however this was never made apparent by the hospital Chief Executive. The research midwife from the hospital Trust presented an overview of the quantitative evaluation with an emphasis on the continuity of care team midwives had achieved and the reduction in use of pain relief during labour for women receiving Team Midwifery care. Findings from the qualitative evaluation were presented and, based on the experience above, I provided more detail about the methodology used and then focused on the data, which indicated women favoured the Team Midwifery approach. I also highlighted some of the 'teething problems' with the actual organisation and implementation of the pilot project. It was suggested a little more attention should be directed to team building and establishing relationships between team midwives and the GP practices they worked with.

The audience were then invited to ask questions about both presentations. Very few questions were directed at the research midwife, the majority of questions were about

the qualitative evaluation. It was evident that GPs in the audience remained sceptical as to the value of Team Midwifery suggesting that a team of six midwives only added to the number of professionals a woman would see during and after her pregnancy. The issues of poor communication between professionals, which I had already discussed in the presentation, were re-iterated by one GP who indicated Team Midwifery would hinder not help this particular problem.

Discussions then focused on financial aspects of Team Midwifery, the Chief Executive of the hospital Trust (who once again seated himself at the back of the room, enabling him to observe what was said and by whom) commented that he had read the *'long'* qualitative report which he found *'rather inconclusive'*, i.e. not overwhelmingly in favour of Team Midwifery. I replied that the purpose of the report was to provide the Health Authority and the hospital Trust with an overview of experiences of Team Midwifery, negative, neutral and positive. On balance, I stated, I had found that the team approach was favourable for both women and midwives who had participated in the evaluation. The Chief Executive of the hospital Trust argued that the evidence did not seem powerful enough to warrant the substantial financial investment the project required to be introduced to more than the existing two localities, given other priorities and pressures in the system. He also indicated that improvements appeared to be more about quality issues as opposed to Team Midwifery per se and argued that maternal satisfaction could be achieved by focusing on these quality issues, rather than changing the whole system of care. His comments were important because they were related to the context of policy implementation and the ability to make changes to whole systems of care. Change, I suggest, has to be:

(ib) legitimate for local professionals implementing it and acceptable for local service users (although the latter do not necessarily have the power or authority to endorse their views and preferences);

(iib) feasible, i.e. manageable and sustainable within the existing system and;

(iiib) supportable, the local corporate rationalizers, the Health Authority, have to be visibly seen to endorse it, from a financial and local and national policy perspective (prioritisation).

The macro, meso and micro conditions for policy implementation have to be working together for policy to be implemented successfully, they have to be synergistic. Therefore all sets of criteria have to be fulfilled if a change is to be successfully and fully implemented. However there is also a potential for the above criteria to be in conflict with one another. With regard to legitimacy, what is inherently legitimate for one group may not be so for another (non-synergistic). For example professionals may see one model of care as the best approach whilst midwives and women who are given information may want a different model of care. Furthermore it may not be possible to provide a responsive service to patients if the service is not cost effective and evidence based and not seen as a local or national priority and therefore not supportable. This may result in certain types of power dictating the decision making process, agenda setting power (Lukes 1974).

Other members of the audience appeared to find favour with the points raised by the hospital chief executive, notably GPs, the Director of Public Health, quality managers and the Chief Executive from the Health Authority Consensus regarding these comments was surprising and frankly suspicious, it suggested to me that private discussions had taken place between 'selected' professionals prior to this more public arena and implied a form of agenda setting power. There did, however, appear to be a lack of acknowledgement of the job satisfaction and opportunities to use a full range of professional skills that the Team Midwifery approach afforded midwives, despite this being a key finding in the qualitative evaluation and other studies. There appeared to be no linkage being made between midwives making fuller use of their skills, i.e. job satisfaction, through Team Midwifery and how this transferred to improving services for women.

I suggested that one of the biggest problems was a lack of scope to consider the potential long-term benefits of Team Midwifery . Reducing the length of hospital confinement, which has been demonstrated in similar schemes offering continuity of care. i.e. the *One to One midwifery scheme* had cost saving implications. Whilst reduced use of analgesia and the potential improved psychosocial outcomes for mother and baby had financial implications for primary and secondary care use and possibly social services. The rationale being that continuity of care, and improvements in medical and psychosocial outcomes may result in less use of services before, during and after the baby has been born, however only a rigorous longitudinal study could determine whether or not this hypothesis was correct. The local situation, I acknowledged, required a more immediate judgment, although Oakley et al had just published the results of a longitudinal study which supported the view that the more psychosocial aspects of maternity services provision could have a positive long term effect on women and children, (Oakley et al 1996). An overview of the results indicated a positive outcome for women in the experimental group who had received additional non-clinical care and support, through three home visits and 24 hour telephone contact. The positive outcome was a combination of both medical and psycho-social factors which resulted in less dependency on services overall, *" the results highlight the close relationship between social well being and physical health and also demonstrate the cost-effectiveness of investing in good quality maternity services"* (Sandwell 1997).

It must be noted that none of the team midwives, or the midwifery managers, posed any questions, or offered any answers to questions about their work or contributed to any of the discussions which took place after the presentations. Schemes such as Team Midwifery had potential implications for resource allocation, i.e. staffing levels and the practical organisation and deployment of team midwives and core hospital staff. These factors, coupled with national disputes over local pay bargaining and the grading of midwives, may also have affected staff morale. Professionals in the NHS have historically been organised hierarchically in a culture and a system which is concerned

with efficiency and dominated by bureaucratic depersonalised relationships between and amongst staff. Others capable of performing the necessary functions can replace individuals. Reform and re-organisation can offer development opportunities to staff but it can also de-motivate and de-stablise them, *"Increase staff anxiety and decrease commitment"*, (Gutteridge 1996).

The Chief Executive from the Health Authority expressed the view in the closing stages of the meeting that in considering the current uncertainty about cost implications of Team Midwifery the pilot project would continue for another year in the two localities it currently covered. This decision to make a deferred decision had not entailed an open wider debate with key stakeholders and given my observations made regarding the 'consensus' noted above I that this had been planned well in advance of the MSLC event or the MSLC event was being used as the main open forum for the wider debate previously promised at the HA board meeting. In the meantime the Chief Executive of the Health Authority indicated that further information from other schemes would be sought with a view to making a more definitive decision as to the future of Team Midwifery in March 1997. Once again this seemed to be a form of non-decision making and did not reflect the amount of information I had provided him and other key decision makers with in relation to other schemes and models of maternity care.

The Health Authority were in effect faced with an almost impossible decision. On the one hand they could agree to financially support implementation of Team Midwifery to the whole of the district at a potential cost of £350,000 knowing many GPs and most consultant obstetricians would oppose such a decision. This decision would also involve agreeing to a contract which would contain very little detail on cost and activity. On the other hand they could wait and see how, at a regional and national level, the dilemmas and decisions other Health Authorities and Trusts faced with the anticipation that the DoH may offer further guidance during the course of the next financial year. Although findings from both evaluations supported Team Midwifery as a model of care which appeared to be acceptable to both women and midwives, short term financial and

inherent inter-professional factors were continuing to prove difficult to sort out.

Individual GPs continued to oppose any change to maternity service delivery and lobbied senior managers at the Health Authority. In general there appeared to be a shift away from some of the original aims of the local maternity strategy and selective interest in evaluation findings. *Changing Childbirth* as policy was becoming more diluted as women were not being provided with informed choice and service provision was still dominated by the preferences of GPs and obstetricians. In addition achieving continuity of care and informed choice for all aspects of a woman's care, i.e., antenatally, intrapartum and postnatally, was deemed difficult to achieve within a climate of rationing and prioritising (Hunter 1993, Anon. Health Services Journal 1995).

If the pilot project had become the main model of maternity care national agreements regarding re-grading and renumeration for midwives may have helped influence local concerns E grade midwives had. However re-grading and any initial and recurring costs the team approach entailed had wider financial significance because implementing *Changing Childbirth* was regarded as a purchasing responsibility, (Allison 1995). Yet contents of the correspondence that took place between managers and Chief Executives indicated that purchasers were constrained in their decision-making capacity.

**Further information on financial issues - 20th March 1996**

In March I received information on cost implications of implementing Team Midwifery from another provider unit, the Lewisham Hospital Trust. An evaluation which included financial costs, had been conducted but results were not available in report form. However the clinical services manager was willing to share some initial observations, the main one being, " *..the costs in running a team of midwives is quite prohibitive....our experience with the pilot, and this is borne out with neighbouring caseload teams, is that the team is more expensive to run...the costs are those of pay and non pay amounting to the various grades of staff and essential equipment for*

*safety."* (Personal correspondence, clinical services manager, Lewisham Hospital Trust, March 1996).

Data and information I had collected over a period of nearly six months had failed to produce conclusive evidence to suggest the local hospital Trust's request for an additional £350,000 was a reasonable request or not. In the meantime the local Trust had still not provided the Health Authority with a detailed description of costs specifically in relation to maternity service activity so the situation was apparently no nearer a resolution. In the meantime different choices were available to women depending on where they lived and this did not reflect national guidance on the development of Primary Care which was published (DoH 996b). The document emphasised new ways of working and changing patterns of care. Underlying this would be services which were, *" properly co-ordinated so that professionals work well together, if necessary in partnership with secondary care and other agencies, to meet a patients needs"* (DoH 1996b, p.3). Principles of good primary care would be based on, 'quality, fairness, responsiveness and efficiency'. There was an explicit emphasis on quality and access, *"services should not vary widely in range or quality in different parts of the country. Patients' experience of primary care varies. There needs to be much greater consistency so that all patients have access to high quality care."* (DoH 1996b, p4).

During informal local discussions with a quality manager from the Health Authority I learnt that negotiations during what is termed 'the end of year signing off', for 1995/96 financial year, between the hospital Trust Chief Executive and the local Health Authority Chief Executive resulted in a reported £90,000 allocation to the Trust. This additional funding came with the unwritten proviso that this money be invested in maternity services. The implication being that it would be used to help sustain the existing pilot scheme for one more year when a more conclusive decision regarding its future would be made in March 1997. It must be noted however that information systems did not allow for the Health Authority to determine if this reported additional

money was invested specifically in maternity services. Furthermore I was not able to determine if this money had come from the NHS regional office with the sole intention of being spent on maternity care. Alternatively it could have been allocated from Health Authority growth monies but the 'gesture' remained unclear at the time.

**The local maternity module, some developments.**

During March 1996 a draft version of the maternity module was circulated for comment to staff at the hospital Trust and in addition the Health Authority requested :

(i) provision of a plan around new information which will be required in respect of midwife -led delivery episodes; and
(ii) criteria where a home visit would be acceptable with a view to including these in 'booking-in sessions'.

The maternity module was very much focused on quality issues and agreement was reached with relative consensus when the final version was produced in June 1996. However the other two key components the Health Authority were keen to incorporate into the overall service specification, namely cost and activity, had still not been discussed in any great detail.

**International research on Team Midwifery published March/April 1996**

Towards the end of March 1996 more international information on cost and outcomes of Team Midwifery care became available. The March/April edition of Evidence Based Medicine presented international data on the effects of care from a team of midwifes. The main results from the randomised controlled trail conducted in a teaching hospital in Australia were reported and indicated, *"prenatal and childbirth care from a midwife team was as effective as routine care from various physicians and midwives. Women assigned to the team approach were more satisfied "*, (Rowley et al 1996).

A commentary section accompanied the summary of the above study and observed that the methodologically sound trial provided results which were generalisable. In particular the author of the commentary concluded, " *hospital costs were lower for patients who received team care .......continuity of care by a team of midwives appears to be feasible, cost effective, and preferred by women when compared with care by multiple caregivers or caregivers who are not midwives*", (Hodnett 1996).

The publication of this research meant that there was evidence to support the implementation of Team Midwifery as a cost effective service. However there was no widespread acknowledgement of this at a national or local level. This suggested that factors other than funding were inhibiting implementation of models of care being designed to meet the indicators success set out in *Changing Childbirth.*

**Purchasing leaflets for local women – March 1996.**

The local Health Authority, during March, made a decision to purchase 4,500 'Informed Choice' leaflets for women produced by MIDIRS and the NHS centre for Reviews and Dissemination, York University. The leaflets, accompanied by 900 copies of professional leaflets, were produced to enable women, in partnership with their professional carers, to make informed choices based on the best available evidence. The hospital Trust had refused to purchase the leaflets at the request of the Health Authority. The Health Authority subsequently agreed to buy one years supply with a provisional agreement that the Trust would purchase yearly supplies thereafter.

The leaflets cost £4,125 and as this was such a small amount of money the Health Authority were concerned at the reluctance by the Trust to purchase the leaflets. The leaflets focused on the theme of choices for women, which raised speculation at the health authority as to the motives of the hospital Trust. For although the Trust had a monopoly on the provision of maternity care alternative providers were close enough to

pose some competition, with one provider being a new state of the art unit, looking for new business. The Health Authority could not prove that the leaflets would create more women making different choices about their maternity care and hence money following patients in accordance with the purchaser provider split. However the mis-trust between the purchaser and provider appeared to be creating some sensitivities in the local system.

Nationally the launch of a consumer awareness campaign was highlighted in the July edition of the *Changing Childbirth* newsletter. The campaign message was, *" ..health professionals want to talk about, and perhaps more importantly, listen to women's views about their care. The campaign will let women know that there will be choices available to them...",* (Cowl 1996). Purchasers and providers had a responsibility to ensure appropriate information about choices available for women. There appeared to be an assumption that professionals would listen to women and that purchasers, and perhaps more importantly providers, were willing and able to give women choices. It appeared that locally there was a reluctance from the hospital Trust to respond to national campaigns promoting more informed choice for women.

Only a third of women would have been offered alternatives to traditional maternity care during the case study and none were consulted about the original proposals. This had implications for equity of delivery of services. Research has shown that during the post 1991 period Health Authorities had a tendency to concentrate on monitoring costs and activity levels rather than broader policy implications like quality of care and equity issues (Majeed et al 1994). Some women were given the opportunity to describe their experiences and opinions of local maternity care (Tinkler and Quinney 1995). However none were involved in any detailed contract or service specification negotiations after the pilot had been evaluated. Three lay representatives from the MSLC did contribute to the discussions regarding the maternity module, so the level of involvement was minimal.

**Team Midwifery - internal discussions continue at the Health Authority, April and May 1996**

At the beginning of April 1996, as requested by the Chief Executive and Director of Public Health, I produced an A4 sheet of paper which highlighted the favoured elements of the Team Midwifery approach for women. I was specifically asked to tease out quality issues and outcomes from the qualitative data which could, theoretically, be achieved by other models of maternity care. The underlying rationale for this was a belief at the Health Authority, originating from the Chief Executive and Director of Public Health, that improvements to maternity care via the team approach were more dependent upon midwives attitudes and less to do with the actual model of care. (There appeared to be no recognition that the model of care could actually influence the midwives attitudes).

There was also an indication that support for continuing and expanding the pilot from Trust management, previously in favour of Team Midwifery , was diminishing. Information was filtering through to the Health Authority from various informal discussions between myself and hospital personnel which included face to face contact with the research midwife and telephone conversations with two team midwives. These discussions suggested that increasing opposition to the pilot from Trust management appeared to centre on the following two factors:

(i) G grade midwives, who were team leaders, working additional hours were earning similar amounts to some local GPs on the lower end of the GP remuneration scale, i.e. newly qualified junior partners; and

(ii) hospital midwifery managers expressed concern at the lack of control they had over team midwives who were now spending so much more time providing care in a community/primary care setting.

The team midwives had earned autonomy and the pilot scheme had enabled them to use a wider range of skills. The midwives were capable of making change happen, yet it would appear that the local NHS system did not know what to do with them. Concerns expressed above also resonated with the historical systems of professional hierarchy within the NHS. For instance it was apparently unacceptable that senior midwives could command the same salary as a newly qualified GP.

In the first week of May 1996 a meeting took place between the Health Authority director of contracting, quality managers and unusually I was included. Discussions focused on Team Midwifery and financial implications of the scheme. It was clear that the Health Authority were not prepared to provide £350,000 for maternity services in the immediate or long-term future. This was primarily because there was no comparative costs available to determine if this was a reasonable amount of money to request, apart from the fact that the service was also not considered a priority area for investment anyhow.

Health Authority management remained convinced that service costs were being used to divert attention away from internal professional conflict. Health Authority senior staff attended a meeting which took place on June 13th 1996 to discuss the maternity module in order to gain more financial information regarding maternity care and the Trust's plans for maternity services. This meeting resulted in further written correspondence highlighted below (June 18th) and reflected frustration from within the Health Authority at not being able to obtain clear and distinct information as to the Trust's future intentions for maternity care.

A national conference organised to look at barriers to implementing *Changing Childbirth* in the Trent region, and reported on in the November edition of the *Changing Childbirth* newsletter, had generated concerns relevant to the local context. In particular issues about contracting and purchasing were highlighted at the conference, "*.........NHS systems are not well suited to planning for a Changing Childbirth style service and do*

*not reflect the complexities of the new mixed economy of purchasing........the difficulties of implementing major change within existing resources were highlighted, along with concern about inequality of services, which can sometimes occur when pilot projects are established, Financial constraints may make it necessary to decide which ten indicators should be progressed. There was concern that little work had been done on the financial implications of indicators and that such work would assist purchasers in decision making ",* (Howcroft 1996).

The point about implementing change in the new and complex mixed economy of purchasing was a valid one as progress with implementing *Changing Childbirth* locally and nationally had been hampered by unsophisticated information systems and immature purchasing mechanisms. The introduction of the internal market to the NHS did not appear to have generated 'local freedoms' for purchasers to the extent the government may have intended and the acute sector appeared to continue to have a strong influence on those 'local freedoms'.

Minutes from the local maternity module meeting held on the 13th June 1996 indicated a consensus regarding the actual content of the module but a lack of clarity about service development, pricing structures and the Trust's commitment to *Changing Childbirth* and Team Midwifery . The director of contracting from the Health Authority had suggested that some additional monies could be made available, for example pump priming, on the basis that significant service change occurred. As these issues had been discussed verbally and Health Authority managers were aware that any mention of additional funding for the acute Trust could potentially be mis-interpreted, the position of the Health Authority was confirmed in writing.

The letter sent on the 18th June acknowledged the work that had to be undertaken with GPs *'to gain their commitment to Cumberledge'*, i.e. *Changing Childbirth.* The director of contracting had also indicated, during internal discussions at the Health Authority, that suggesting additional funding may be available was, *'one way of finding out if*

*problems are really financial or to do with more deep rooted professional conflict'.* He was prepared to be explicit about this as the following extract from the aforementioned letter demonstrates, " ...*(the) Health Authority may be willing to invest additional resources.....dependent upon significant service change. We agreed in the meeting that the Trust would consider its response to this proposal on the basis that there is a need to:*

(1) *confirm its commitment to Changing Childbirth and especially the commitment of Consultant Medical Staff;*

*(2) confirm its commitment to Team Midwifery and if, indeed, Team Midwifery is essential to deliver some of the changes previously discussed;* and

*(3) review the costs associated with Team Midwifery, if implemented over time and in the context of the Trust's Pay Strategy. We would be looking to see some reinvestment of resources within the Trust as a contribution, if Team Midwifery is the agreed way forward.*

*Clearly the Health Authority are not in the habit of writing blank cheques but we are keen to establish if the problem with implementation is one of resources or of irreconcilable professional differences of opinion. ".* (Health Authority Director of Contracting, June 18th 1996).

I had attended a national *Changing Childbirth* conference in May 1996 whose aim was to share experiences of implementing different models of maternity care in response to *Changing Childbirth*. I was mindful that the local situation continued to reflect experiences elsewhere and the conference presenters conveyed the following: *the Midwifery Group Practice pilot at Airedale NHS Trust had provided midwives with more job satisfaction but tensions with GPs and between practices, i.e. those not receiving the new service, had caused disharmony; the pilot at mid-Cheshire had ceased to exist in March 1996 because it could not be sustained without additional funding. Local obstetricians had expressed reservations about the scheme and many GPs*

*continued to refer women directly to consultants instead of team midwives, who perceived this as resistance to the project; the pilot projects at Bradford NHS Trust and Newcastle were still being evaluated at the time of the conference but issues experienced so far were similar to those already mentioned, i.e. professional attitudes to change and lack of resources.*

The above suggested that many provider units continued to experience common difficulties regarding their attempts to implement change successfully. The nature of the meetings and exchange of correspondence that took place in the local case study highlighted an emerging conflict in the managerial negotiation process. In parallel to this conflict GP opposition to the pilot Team Midwifery approach continued as did a national debate on the meaning of 'lead professional'. Therefore structural and communicative factors were concurrently operating at different levels to inhibit change as promoted by national and local policy initiatives.

Despite the above, midwives participating in the local pilot had been able to re-define their roles and demonstrate the confidence this experience had given them both personally and professionally. They had a potential respite from the recently de-humanised market orientated NHS and a chance to regain professional autonomy. However a lack of senior support from their Chief Executive displayed in the January 1996 presentation noted above and the decision to delay district wide implementation but continue with the pilot for a further 12 months (March 1996) left the pilot in a vulnerable position.

This interim decision appeared to be a tactical delay, i.e. non-decision making, which was agreed between the Health Authority and hospital Trust senior management this was essentially the beginning of a dilution process of local and national policy. In addition to this and perhaps more significant to midwives locally senior midwifery managers had begun to express concerns at the amount of autonomy teams were achieving in their management of care for women. This suggested that negotiation for

power and control had, to an extent, been transferred from certain professional groups, i.e. GPs and obstetricians, to another professional group, i.e. hospital midwifery managers. The general reluctance to allow midwives to attain a certain level of status and corresponding remuneration was reflected in some of the discussions held at the Health Authority. Although already detailed above it is worth observing again the fact that it was deemed unacceptable for a senior midwife leading and managing a pilot team to receive pay that equaled that of a newly qualified general practitioner. Locally held views by key decision makers together with more inherent structural issues did not therefore appear to offer much support for Team Midwifery, midwives or service users.

The pace of change in the NHS from 1991 onwards was inevitably going to make the implementation of *Changing Childbirth* difficult and problematic. In effect Team Midwifery had been part of a dialectical process, it was a vehicle for change and as such during the course of the fieldwork and beyond came to represent 'diluted' policy implementation locally. The relationship between hierarchies of the old NHS (pre 1991) and the principles of the new NHS (post 1991) created a conflict. This was a conflict of roles and purpose, which again through the case study became more evident.

**GP's continue to seek alternatives to Team Midwifery – June 1996.**

At the beginning of June, at the request of a Health Authority locality manager, I visited a GP locality facilitator to discuss proposals for maternity care service development. The locality that this GP represented were proposing to implement changes to maternity care which appeared no different to traditional maternity care, although it was presented as being different. There was an indication that closer links with the hospital Trust would be developed but when questioned about consultation with women, midwives and Trust staff it became apparent that no consultation had taken place. Although arrangements to meet with Trust management were planned there was no indication that wider consultation would take place. Furthermore when I asked about continuity of care and choice for women the GP stated that, *"none of the women coming to this practice*

*have ever asked if they could be delivered by a midwife they would know "* (GP, Northwest district Health Authority).

I provided the GP with a summary sheet of key issues to be considered regarding maternity service change (see appendix 2) and suggested he contacted me for further discussion about proposals for further change. The meeting however served to highlight the potential fragmentation of maternity services to women living in this particular district. The local NHS system was already offering a two tier service with access to different models of care dependent upon where women lived and which GP they were registered with. It was apparent from the written information I was given and discussions I had that this locality agenda was not linked into the discussions taking place at a district level, and therefore running in parallel to local policy implementation and decision making. This highlighted further problems with the purchaser provider split; a lack of co-ordinated planning between purchasers and proxy consumers.

Isolating and identifying the effect of a specific change, in this instance the introduction of Team Midwifery , ideally would require all other things to remain relatively static. However the reality is that change, however subtle or radical, is influenced by a wider context. This wider context may be societal, organisational or sectional. In addition roles and relationships, which predate the introduction of new changes, are often redefined or reinforced depending on power relations and the structural and operational capacity to change. This in effect leads to a 'dialectic change process', whereby the negotiation for change involves a compromise based on prevailing and emerging organisational conditions, and roles and relationships operating within them.

**The hospital Trust respond to the Health Authority – July 1996.**

On the 31st July the Director of Corporate Planning and Contracting from the hospital Trust responded to the questions posed in the letter sent on the 18th. Internal discussions at the Trust had yielded the following response:

(1) *the Trust can confirm its agreement to the Maternity Module attached to your letter. This includes the Consultant Obstetricians;*

*(2) Team Midwifery adopted by the pilot scheme is considered the best approach to meeting the requirements of the Maternity Module;*

*(3) the costs have been reviewed in the light of the experience gained from the pilot scheme. The full implementation costs using the current pay scales would be £370,000 If the pay scales included in the Jarrold letter are adopted (which we are strictly required to do) the costs would be £459,000 in the light of this we are currently making proposals for our own pay structure for this group of staff. The financial implications of this will be given to you once they are finalised. The investment might be phased but Team Midwifery would need to be implemented across the district over a maximum period of three years.*

The letter also stated that the Trust had, *"borne all the costs of the pilot teams.....the full implementation of the model of care you have specified will require substantial additional investment from the Health Authority"*. This appeared somewhat confusing as managers from the Health Authority had previously indicated they had provided £90,000 for the continuation of the pilot project for one more financial year (March 1996 - March 1997). It also indicated some creative accounting on behalf of both the hospital Trust and the Health Authority, a situation the internal market seemed to have generated. The letter did not provide the Health Authority with any specific data on what the £459,000 would be spent on other than the additional costs incurred for revision of midwives pay. However any pay inflation would be accounted for in the Trust's annual block allocation of resources. All provider units, i.e. NHS Trusts, were dependent on funding from those purchasers that they have contracts with, these contracts therefore had to include an allocation for inflation and pay increases. District Health Authorities usually found themselves 'second guessing' amounts they received from central

government during the contract negotiation period and had to estimate a reserve, or 'inflation drift', for pay awards.

Discussions I observed at the Health Authority indicated managers were still not convinced Team Midwifery was the only way to fulfil either recommendations set out in *Changing Childbirth* or the local maternity strategy and maternity module. The hospital Trust however appeared to choose to use their interpretation of the maternity module as recognition of support for Team Midwifery from the Health Authority. This response from hospital Trust also suggested a shift in attitudes from the Chief Executive and obstetricians to Team Midwifery.

On June 6th 1996 the NHSE produced the latest NHS Priorities and Planning Guidance for 1997/98. (NHSE 1996d). Although the guidance was directed towards Health Authorities and regional offices, hospital Trusts and GPs were encouraged to take account of the priorities when developing their own business plans. The dual planning function for Health Authorities continued with some apparent ambiguity, *" the guidance sets out a **national** context for planning, it also acknowledges the importance of **local** priorities reflecting local needs and circumstances. Local health strategies and purchasing plans will need to address the national requirements and priorities set out in this guidance...."*, (NHSE 1996d) (My emphasis).

There was no mention of maternity care or *Changing Childbirth* in the main body of the document, reference to maternity services appeared under the Patients Charter section in relation to maintaining national and local standards. This would make it difficult locally to keep investment in maternity care a top priority and is an example of how some priorities lose their momentum at a national level. In contrast to this the new primary care paper reflected issues affecting maternity care during the case study research period, for example, *" discussion locally of strategic direction, proposed changes, the implications for particular professional groups and funding are important to making progress.......the movement of care also raises questions about pay and*

*contracts......professional and financial rewards for new developments were both regarded by contributors as important if change was not to be seen just as extra tasks"*, (DoH 1996b).

**The Health Authority respond to the hospital Trust – September 1996**

In September further correspondence took place with the director of contracting from the Health Authority communicating his concerns. It was noted the Health Authority were disappointed at the new figure for district wide implementation of Team Midwifery and the provision of existing additional funding was re-affirmed, *" during our 1996/97 contract negotiations it was agreed that the £90,000 invested against midwifery services would be retained by the Trust, even in the event of the current pilot scheme not continuing. Our view is that this money is currently ring-fenced to Midwifery and would be available for reinvestment should another model of service be developed"*, (Letter from Health Authority director of contracting, September 1996).

From this it seemed apparent that the Health Authority were not only concerned about monies being spent on those areas they were originally intended for but also invested in 'midwifery' as opposed to obstetrics. The letter requested additional information regarding staffing levels, grading and re-grading of midwives and concluded, *"you will be aware that the view within the Health Authority is that the principles of Cumberledge be implemented using different models and at significantly reduced costs. I would be helpful to understand what alternative models have been considered, prior to the present proposal. It would be also helpful to know if these alternative proposals were costed,"* (Letter from Health Authority director of contracting, September 1996).

The Health Authority would have already been aware that alternative proposals had not been worked into a format which included detailed costs and where in effect trying to use their role as purchasers to manage the Trusts core business. In the literature review I was concerned with introducing the wider context, i.e. the NHS reforms since 1991,

within which *Changing Childbirth*, at a national and local level, was introduced. The 1991 reforms generated structural change at a macro, meso and micro level and the enormity of them, I suggest, created a volatile context for policy change which was service specific. The introduction of market principles involving devolvement of budgets and the creation of an environment which supposedly had a duality of purpose, i.e. national responsibilities and local freedoms (NHSE 1994d), was a real shift away from a culture and philosophy of collectivism. The purchaser provider split and its lack of sophistication may have become, as the research depicts, far more fragmented for the NHS system of care.

**Mixed messages – September 1996**

During September I had a meeting with a pilot team midwife who was seeking advice on the best way to consult with women receiving Team Midwifery care. Team midwives wanted to re-assess women's views and experiences. Having discussed the different approaches the midwives could adopt a brief conversation took place regarding the future of Team Midwifery. The midwife informed me that two additional consultant obstetricians had been appointed since the publication of *Changing Childbirth.* She indicated that this had caused some concern amongst midwives who felt it was not in keeping with recent local and national maternity care developments. It is also worth noting that the appointment of two additional consultants would not make it easy for the hospital Trust to implement any type of maternity care at a reduced cost. It is also evidence of the failure of the quasi internal market, as the Health Authority would have had little control over these appointments. The midwife had also recently attended an internal meeting with hospital midwifery managers who had informed her that the current position regarding financial implications of Team Midwifery was one of resolving the additional travel costs the pilot had incurred. The midwife appeared confident that financial implications for extending the pilot were minimal and was surprised to learn that the hospital Trust had requested an additional £495,000.

It would appear that there was a mis-match between information being presented externally to the Health Authority and information being exchanged internally at the hospital Trust. The internal market did not appear to have had a huge impact on controlling the demands of a provider driven NHS. This in turn was having an impact on implementation of new policies lead by the purchasers, i.e. *Changing Childbirth*.

**Local and national priorities – October 1996**

In October the Health Authority Purchasing Plan for 1997/8 was circulated for comment and consultation. It outlined what it believed to be the key challenges and priorities in the coming year which were:

- supporting the development of primary care provision and developing the Health Authority as a Primary Care led organisation;
- maintaining access to acute care;
- re-focusing adult mental health services;
- delivering local change in the provision of services for people with Learning Disability; and
- providing appropriate care for the elderly particularly in their own homes.

Maternity care was not included which was critical at both a local and national level as district purchasing plans traditionally reflected guidance on priorities from central government. This meant that *Changing Childbirth* appeared to have slipped down the prioritisation agenda nationally as noted above and likewise local planning had responded to this. The difficulty, however, in this instance was that the local work had not come to a neat and agreed conclusion with many issues still to be resolved in relation to the current and future state of maternity care. It also highlighted that centrally new priorities are added to an existing list before those existing priorities have been fully implemented.

National *Changing Childbirth* Conference in Derby, ' Making it happen - Trials and tribulations'. The panel debate was useful and at times controversial. The main themes and arguments were: we can only give women so many choices within a limited budget, let us be realistic and more open about priorities, *"I don't think the HA can afford choice"* others argued that there needed to be a total rethink / re-planning., three years on from *Changing Childbirth* and no one appeared closer to solutions; professionals (purchasers and providers) have the responsibility to offer and provide real choices and not raise expectations which could not be met; the need for a longitudinal study to establish long term psycho-social benefits of different approaches to maternity care, if commitment to change was to continue, was highlighted. Eric Caines, who was chairing the discussion, concluded that purchasers and providers still did not appear to 'have a grip on the issues' particularly the financial implications of changing services to better meet women's needs.

The facilitators argued that maternity services were the poor relation of the NHS and good midwifery management was the key to successful implementation. Purchasers and providers in the workshops discussed issues regarding trust and disclosure of what budgets are used for, i.e. how providers use monies. There was agreement that growth monies are often used to' bail out' other directorates overspent. The conference appeared to offer a forum for a long awaited public discussion of privately held beliefs. Some of the issues discussed resonated with the local case study and pointed not only to nation wide problems with implementation of *Changing Childbirth* but a general lack of sophisticated purchasing and commissioning systems. Managing the internal market was open to question.

**Continued written negotiations – November 1996**

On the 15th November 1996 the Director of Contracting at the Health Authority received a letter from the Director of Corporate Planning and Contracting. This formal written response to correspondence mentioned above, i.e. 17th September, did not

explicitly address requests made by the Health Authority but reflected continued unresolved internal issues related to maternity care. The hospital Trust re-affirmed its commitment to *Changing Childbirth* but acknowledged the 'doubters amongst some doctors working in primary and secondary care'. Cost implications were the subject of ongoing internal discussions, *"...the costs of fully implementing changing childbirth will not be known until we have completed our discussions about a new structure with our staff. The costs quoted in my last letter reflect costs of implementation using the current pay scales and those included in the Jarrold letter. They do give an indication of the expectation of the staff and reflect the difficulties we anticipate in reaching a local agreement. We would expect that discussions will take some time"*,(Letter, Director of Corporate Planning and Contracting, hospital Trust, 15th November 1996).

The Health Authority therefore would have to continue to wait for further information from the Trust. In the meantime, and at the request of the lay chair of the local MSLC, Health Authority staff produced an update of the local maternity strategy and presented it at a formal Health Authority meeting held in December 1996. The local update paper suggested that some of the key objectives of the local strategy, 'Making Childbirth Better', had been realised, a revised MSLC with lay membership and the development of a maternity contract module. The paper also identified areas where less progress had been made. For example the financial and activity components of the maternity module and the provision of unbiased information for women about local maternity services had yet to be fulfilled. Team Midwifery was highlighted in relation to achieving three objectives of the local strategy and the current situation was described as follows, " *positive aspects of community Team Midwifery identified by the evaluation are currently being reviewed by the maternity unit and the Health Authority with a view to achieving the benefits in a cost effective way* ", (Update of local maternity strategy – paper for MSLC, December 1996).

Strauss (1978) has argued that analysis often fails to describe the structural conditions within which negotiations take place and later (Strauss and Glaser, p165, 1990) he

developed a 'negotiations paradigm'. This paradigm sought to directly relate various levels of conditions with the interactive process of negotiation. The two key conditional contexts are namely structural and negotiation. The structural context is concerned with broad conditions such as national policy, resource allocation, priorities and guidance, very much the macro criteria of key values and attributes associated with policy. On the other hand the negotiation context represents components encompassing meso and micro action and interaction which include:

(1) the number of negotiators and their experience at negotiating ;

(2) the characteristics of the negotiations themselves*, for example, whether they occur only once or repeatedly, or all at once, or in several phases;

(3) the balance of power displayed by the respective parties;

(4) their respective stakes;

(5) the number and complexities of the issues involved in the negotiations; and

(6) the clarity and boundaries of the issues involved in the negotiations;

(7) the alternative options of action perceived by the negotiators.

(Strauss and Corbin, 1990, pp165-166 )

(* I would also include the management style (personality) of the negotiators / key stakeholders).

In the local case study there were numerous activities associated with the negotiation and decision making process, some of which were 'general' and routinized, i.e. meetings,

letters, faxes whilst others were more 'specialised', i.e. presentations, contractual specifications and the ability to exercise power and authority. These activities were also reflective of organisations and decision-makers operating to fulfil a function that has to appear distinctive to legitimate their existence.

With regard to the above negotiations paradigm several levels of negotiation were active during the pilot Team Midwifery scheme and after it had been evaluated. This context was further complicated by inter-organisational conflict and inter-professional conflict and at times the lack of distinction between decision making and implementation, *"some aspects of implementation may start before decision processes have been finalised and some sub-decisions may be taken thereafter "*, (Miller S, 1997, p577).

Negotiation and decision making activity repeatedly occurred and it engaged different stakeholders. Obstetricians mainly contributed to the negotiation process with senior managers at the hospital Trust, their managerial colleagues were then expected to convey their terms and conditions on their behalf. In addition their lack of attendance at open meetings suggested both opposition to change but also elements of anxiety as Team Midwifery was in part effectively challenging their protected status.

I suggest this activity was also adopted to display obstetricians' opposition to involvement of Health Authority managers in their professional and operational delivery of care. On the other hand midwives attempted to gain support for their new roles as service providers through more public and open means, i.e. formal presentations to a multi-stakeholder audience. Whilst the chief negotiators, i.e. Chief Executives, had to function and participate in the process at all levels as they had to be seen to make informed and deliberated decisions. Although the hospital Trust Chief Executive chose to undermine Team Midwifery midwives because the potential of extending the pilot district wide had implications for their pay and remuneration, i.e. use of their full range of skills would warrant increased pay for lower grade midwives.

The effect of this multi-issue context was a series of complex and often unresolved negotiation points resulting in the continuation of a two-tier system of maternity care. Final decisions, during the period of the post evaluation case study, were actually inconclusive and based on the need to agree end of year financial agreements as opposed to any long term commitment to a model of service delivery based on an informed consensus. This non-decision making context reflects Lukes dimension of power referred to as agenda setting (Lukes 1974) previously discussed, which is used to react to overt and covert sources of conflict.

Nationally in December 1996 a further Primary Care white paper, Delivering The Future (DoH 1996c), was published. Key themes continued to focus on service development in the community which would provide, " *better opportunities for professional development and satisfying careers........better team working between professionals......and patients will be better informed about the services provided and how to use them*", (DoH 1996c). At the beginning of March 1997 the eighth edition the *Changing Childbirth* Update newsletter was published (*Changing Childbirth* Implementation Team 1997a) and articles contained within it suggested there were still many unresolved issues regarding implementation of *Changing Childbirth* and the development of new and sustainable models of maternity care, (Duggan 1997).

**Local negotiations continue into 1997**

On the 24th January 1997 the Chief Executive of the Health Authority received a written outline of the hospital Trust's key objectives, and their financial implications and intentions for the end of year negotiations, March 1997. The projected annual budgetary contractual costs for 1997/8 were also included. *Changing Childbirth* figured strongly in this correspondence with evidence of a re-adjustment of resource implications once again. The hospital Trust now expected, " *to implement changing childbirth throughout (the district) as currently provided in the pilot scheme......it will be necessary to reach a local agreement with the staff. If it is not possible to negotiate an agreement with staff*

*the resource would be available for other developments (250k)"* (Letter from Director of Contracting and Corporate Planning, hospital Trust 1997).

In effect the hospital Trust continued to make the assumption that the Health Authority fully supported the implementation of Team Midwifery district wide and appeared to forget their own concerns regarding continued GP resistance to this approach. The hospital Trust did appear to anticipate difficulties with midwives regarding local pay scales and in view of this wanted re-assurance that additional monies for maternity care would still be forthcoming whatever the resulting model of care would be.

The figure of £250,000 would be in addition to the £90,000 previously earmarked for the continuation of the pilot. This resulted in a total figure of £ 340,000, very close to the original figure of £350,000 quoted by the hospital Trust 12 months previously after the evaluations had been published. The Health Authority however were still waiting for detailed information on what this money was required for, how it would be spent and over what period additional monies would be expected before a shift in care, i.e. more community based, would offset the initial pump priming. The hospital Trust and the Health Authority had two months to resolve and agree the maternity contract otherwise they would have to go to arbitration. This would initially involve informal guidance from the regional NHSE outpost. If the matter could not be resolved in this environment a more formal arbitration procedure would take place.

The hospital Trust had recently publicised difficulties in the recruitment of midwifery staff at the January 1997 meeting of the Hospital Trust Board of Directors. An annual increase in the average sickness absence rate was also noted and the Women's Services Directorate was one of three directorates where this problem was identified as *'serious'*. The key priority for next year's contract was specifically, *" to secure additional resources from the purchaser (Health Authority) to support the Hospital's current and anticipated serious financial deficit - projected to be 523,000 by the end of the financial year (March 1997)... "*, (Taken from minutes of the Trust Board of Directors meeting,

January 1997).

The complex series of judgments required to implement policy locally depended less on the needs of local health care users and more on the relationships and personalities of key senior health care managers, clinicians, and some GPs, and often on the contract negotiation process. As Gutteridge has pointed out, *"pressure to meet demanding financial and statistical targets instead of focusing on patient care is breeding a new sort of NHS manager"* (Gutteridge 1996). The amount of time spent on contractual processes and negotiation about finite detail, if available, and the number of people from the Health Authority and the hospital Trust who dedicated many hours over a period of four years (1993 - 1997) to this work was substantial. This was based on efforts to influence the strategic and operational direction of the implementation of national policy at a local level. It was also made more problematic because of a suspicion of cross subsidisation of services within the hospital Trust, although it was made clear from NHS executive guidance that there should be no planned cross-subsidisation between contracts, (Tilley 1993, p147).

As the end of the financial year drew closer there appeared to be a number of unresolved, financial and inter-professional issues. This coincided with the end of the extended period of the pilot Team Midwifery project. For more than three years locally, and nationally, health service managers, midwives, GPs, obstetricians and (some) women had been working to implement *Changing Childbirth.* In January 1997 the local situation appeared to have become far more complicated with a fragmented maternity service offering different types of care depending on areas of residence and GP preferences rather than informed choice for women.

**Understanding implications of national guidance on local contract negotiations**

Early in 1997 I arranged to meet with the Director of Contracting from the Health Authority to gain further understanding of the financial aspect of the contractual

negotiation process. He explained that the Health Authority had originally assumed three quarters of a percent for pay award costs from any growth allocation, however, when they received notification of the real amount of growth allocation (2.18%) and inflation (2%) they realised they had over estimated this percentage, it would be 0.3% (£400,000). This 0.3% would then be used to estimate the amount of monies in each contract required for staff costs including the amounts recommended by the pay review bodies. This approach placed the Health Authority in an improved negotiation position but data of this nature only became available in late February resulting in a lot of 'last minute activity' between Trusts and Purchasers.

**Local attempts to resolve contract negotiations and agree a way forward for implementation of Changing Childbirth - the final stages.**

Correspondence between the Health Authority and the hospital Trust continued and on the 19th February 1997 the Trust requested an additional £910,000 for 'recurring pressures', this figure included £250,000 for extra costs for pay awards. The hospital Trust did not accept the current offer from the Health Authority of £600,000 recurrently for pressures and made explicit their position regarding *Changing Childbirth*, and Team Midwifery , " *this is a national policy requirement........the pilot has been very successful and the joint evaluation had demonstrated that all the groups of staff and the mothers agree that the service should continue in its current form and be extended ......this is a service which it would be politically untenable to dismantle and it is not feasible for the pilot to be extended for a further period. It is therefore important that we incorporate a resolution of this issue into our final agreement......recognising the resolution of changing childbirth is important we would be prepared to absorb costs of changing childbirth (250,000) and this years pressures with an additional 850,000 recurring....*", (Letter from hospital Trust Chief Executive to the Chief Executive of the Health Authority, February 1997).

It is worth noting that the Chief Executive of the hospital Trust chose to refer to the

evaluations and use them as a source of support for his request for additional resources. This presented inconsistencies in his attitude to the qualitative evaluation in particular as he had previously made a public statement regarding it as inconclusive. This suggested that he had either changed his mind about the findings from the evaluation or he may have been using it as a delaying tactic to enable him more room for negotiation for the new financial year. This was therefore an example of agenda setting power where views on Team Midwifery shifted to suit a particular moment in the contractual process for the annual allocation of resources.

Five days later a letter of reply was sent which indicated the Health Authority planned to *'involve the Regional Office in our contract discussions this year'* and also responded to the issue of *Changing Childbirth, " ......we do accept that this is a national priority ......we simply cannot support an extra £250,00 p.a. in addition to £90,000 p.a. already in the system to deliver continuity of service through Team Midwifery. This is simply one aspect of changing childbirth. Our stance is not new, we discussed this over a year ago and had a detailed discussion when our executive teams met in Autumn. I accept that this will mean that we will need to agree how to deal with the current pilot. Given that steer from us, we would want the resources you have offered used against your baseline pressures rather than against changing childbirth.....there would be no gap between us and we could then work together to agree how to deliver change in midwifery, short of Team Midwifery.."*, (Letter from Health Authority Chief Executive to the Chief Executive of the hospital Trust, February 1997).

This was a clear message from the Health Authority who were stating that *Changing Childbirth,* although a national priority, was not a local priority for investment. The contents of the letter also demonstrated how *Changing Childbirth* and Team Midwifery appeared to be used as a negotiating tool for the wider budget setting negotiations between the local purchaser and provider. If the 1991 reforms had not been instigated the decision making process with regard to full implementation of Team Midwifery and delivery of *Changing Childbirth* would not have been subject to such a lengthy resolve.

**Further attempts by GPs to introduce alternatives to Team Midwifery – February 1997.**

Towards the end of February the Health Authority received a five page fax from one of the GP locality leads outlining proposals for maternity care provision. This particular locality had never been in favour of Team Midwifery . However having analysed their proposals I came to the conclusion that neither *Changing Childbirth* indicators of success (DoH 1993) or objectives in the local maternity strategy would be achieved through this model of care. The proposals described a service which would resemble existing traditional maternity care, the only difference being a fostering of closer links between community and hospital midwives, the actual organisation of care however would remain unchanged. For example the proposals suggested, " *Primary Care Midwives to be practice based, but formally linked to another one or two midwives (secondary care based......this would mean no more than three different midwives should be seen throughout the pregnancy (excluding intra-partum care).........secondary care midwives at the Hospital Trust would be allocated to the Locality and a core staff established on the Labour Ward.....the primary care midwife attached to the Practice would follow up all her deliveries...*", (Locality GP proposal, February 24th 1997).

The proposal was circulated to the Health Authority and the model of care presented was rejected in its current state, however this did not mean a rejection of the possibility of a further model of maternity care being developed on a locality basis. So local freedoms had the potential to generate several models of maternity care, based in part on the views and beliefs of a few selected professionals who had some purchasing power and wee still acting as proxy consumers.

**Internal middle managers meeting at the Health Authority – February 1997.**

The Health Authority held its monthly internal middle managers meeting, where

executive directors informed other senior members of staff about Health Authority business. It was also an opportunity for informal discussions, with middle managers being encouraged to raise issues for debate. At this particular meeting, held on the 27th February 1997, the first half was dominated by the contractual process for the coming financial year between the Health Authority and all of the provider units they had contracts with. Of the 33 provider units the Health Authority contracted with six remained 'unsigned' and one of those was the local acute hospital Trust with whom the Health Authority, it was announced, were going to arbitration. The Chief Executive of the Health Authority had received a further offer from the hospital Trust as noted above but he reported that his response to this recent offer was a resounding no. The Chief Executive of the Health Authority commented that if the hospital Trust could suddenly find monies to absorb maternity costs then as maternity care was not a priority for the Health Authority they would not have the capacity to financially contribute further to the Trust's stated pressures, i.e. the Health Authority wanted the hospital Trust to spend it on other cost pressures.

At this point in the meeting the quality manager responsible for developing the maternity module described a recent telephone conversation which had taken place between herself and a Trust midwifery manager. The quality manager was told quite explicitly that any additional monies secured for maternity care were specifically for midwives pay and not Team Midwifery . The hospital Trust were currently considering the introduction of a single grade pay structure for midwives, which could disadvantage higher grade midwives. The hospital Trust did not, in her opinion, appear to have a grand plan to roll out Team Midwifery and this may or may not have been influenced by resistance from some GPs.

During this telephone conversation it also became apparent that midwives had been informed that the Health Authority had no plans to pay for Team Midwifery and a group of midwives had begun to consider different ways of working which would involve larger teams covering more practices. This system would also incorporate a

night duty rota thus eliminating on-call payments. This was interesting to note as it seemed that midwives were proposing alternatives based on a reduced cost service whilst their Chief Executive was trying to access additional funding from the Health Authority. This raised previous speculation that monies were required to support an overspend in other directorates. This speculation was backed up by comments made at the recent Trust Board meeting regarding the need to address *'the current and serious financial deficit – projected to be 523,000 by the end of the financial year '*.

The quality manager perceived that the new system would improve communication but not continuity of care although it could have been more acceptable to those midwives who would find it difficult to commit themselves to the existing Team Midwifery model of care. The quality manager concluded that the alternative model being proposed may suit midwives but in her mind women did receive a better quality service from the existing Team Midwifery pilot scheme. The alternative models being considered may not have achieved the same quality and continuity of care.

These concluding comments were interesting to me as previous discussions with the quality manager, a trained midwife, had indicated a lack of support for the local Team Midwifery model of care. Further information about maternity services and resource allocation continued when the Chief Executive commented that the hospital Trust had not received an additional £ 90,000 for the continuation of the pilot, 'a juggling of figures' had meant that they 'appeared' to have received it'. If this had happened it would partly explain why the directorate manager of women's services at the hospital Trust had indicated she had never received any additional monies. Conversely it may also explain why there was a reluctance to give additional monies, of the magnitude the hospital Trust were asking for, when it appeared they had absorbed existing Team Midwifery costs internally. This scenario also suggested that figures requested did not reflect real costs incurred. Both the Health Authority and hospital Trust through their respective Chief Executives appeared to be agenda setting.

Senior management at the Trust and the Health Authority appeared to be negotiating and making decisions on partial and unreliable information and the amount of explicitness and trust between purchasers and providers was evidently lacking. The 1991 NHS reforms arguably created a new type of entrepreneur then, a negotiator motivated by 'self satisfaction' and although some financial incentives existed (performance related pay) I suggest it was the position of 'power negotiator ' and 'game negotiator' that provided non-financial rewards. By 'game negotiator' I am labelling activity from the case study and as such focusing more on the roles of the most senior of managers, i.e. chief executives, although other senior managers could share similar characteristics to the public sector entrepreneur role.

For example the respective managers from the Health Authority and hospital Trust who dealt specifically with contractual arrangements displayed similar characteristics in their manner and approach to their roles, neither wished to disclose more information than was absolutely necessary, communication via letters was typical but never appeared to generate a satisfactory outcome, until the 'final hour'. This activity in itself became a ritual, for me as an observer with additional insight into the organisational and temporal context, I came to perceive this process as a 'game' between organisational opposites, who interestingly could have fulfilled each other's roles.

The unacceptable existence of power struggles within the NHS were also noted by its former chief Executive, *"we are not here to play politics, to worry about how much power we have relative to others, to outwit our peers or to impose change on people against their will "*, (Langlands 1997), at the same time there was also recognition of, *" how difficult it is to resource planned changes in the pattern of service and to build consensus in support of them.....there can be no national blueprint. Local problems need local solutions led by local managers......Health Authorities and trusts have to pace developments and make the sort of trade-offs between competing priorities .. "*, (Ibid). This notion of trade offs becomes apparent in the local case study and will be discussed in the final chapters.

**Outcome of the local financial end of year negotiations – March 1997**

Locally informal arbitration had been sought and correspondence which had taken place between the Health Authority and the hospital Trust was sent to a regional manager who, on viewing it, recommended both parties should agree to 'split the difference' of the outstanding figure. In view of the hospital Trust indicating the need for an additional £850,000 and the Health Authority agreeing to provide £600,000 against the disputed figure, this amounted to £250,000 between the two organisations. By March 1997 neither parties had reached an agreement and formal arbitration, which would involve both Chief Executives being interviewed by the regional Chief Executive who would make a decision in favour of one party or the other with no compromises negotiable, was becoming a possibility.

However both Chief Executives were attempting to reach a contract agreement via verbal discussions and on the 6th March 1997 a letter from the Health Authority confirmed the verbal decisions that had recently been made. The Health Authority had received an additional £75,000 recurring funding for the development of a high dependency unit at the hospital Trust, so a new figure of £675,000 recurring plus £100,000 non-recurring, i.e. a single payment not to be repeated, was offered to the hospital Trust. The revised offer was however, " *subject to the Trust absorbing any costs of implementing Changing Childbirth ..(and specifically Team Midwifery ). We will need to agree a timetable for implementation recognising the major implications this has for Midwifery grading and the sensitivities of this from the GP community...* ", (Health Authority Chief Executive letter, March 1997).

The hospital Trust responded to the above letter the next day by fax, "*......I was pleased that we have been able to reach a full and final contract settlement and confirm our acceptance of these arrangements ..*", (Hospital Trust Chief Executive fax, March 1997). To complicate this environment even further is the problem of what I perceive to

be over compensation in one area of organisational activity at the expense of another, for example Berwick (1996) has observed, " ........*how difficult it is to maintain a focus on aims that matter to society - that affect the external customers of our work, like patients' families, and communities. It is sometimes easier to focus on internal reorganisation and improve in ways that are unimportant to outsiders"*, (Ibid).

This is certainly resonant of the local case study where the contracting process took precedence, lower rank professionals were excluded from decision making processes and the aims of health strategy programmes that appear divorced from managerial relationships, " *last minute negotiations can see considerable sums of money switching between provider and purchaser with no explicit relationship to strategic need.......conciliation has a record of arbitrating 50/50, then one could say it is in Trusts interests to go forward to conciliation.....the divide between purchasers and providers has in too many cases led to confrontation rather than collaboration* ", (Milner and Meekings 1996).

Not only does the above point support the view that dominant groups have a partial vision in comparison to subordinate groups (Oakley 1993, 215) but it also suggests problematic leadership. The lack of wholescale change as it was originally intended was an underlying lack of co-operation at inter-organisational and inter-professional levels. Isolated improvements will not improve the system as a whole (Berwick 1996) and recognition of the need for medical practitioners in particular to become *'more willing to develop partnerships'* (Abelson et al 1997) was regarded as long overdue but also a long-term challenge.

Locally speculation would continue as to what type of maternity care would be provided on a district wide basis. The Health Authority did not have any formal channels to assess whether or not monies allocated for maternity care were distributed to the appropriate directorate within the hospital. Team Midwifery in its pilot form did not appear to be a viable option for a variety of reasons, not least professional rivalry and GP resistance

and an underlying lack of support from both purchaser and provider management. Despite the use of agenda setting power in the latter stages of the financial negotiation process once additional monies for the hospital Trust had been secured the hospital Chief Executive reverted back to his original view of maternity services regarding its low priority status. A decision about its future was not made explicit at the end of the financial year which coincided with the end of the data collection period for the thesis. Many GPs remained sceptical and some, on a locality basis, were still attempting to develop their own plans to submit to the Health Authority and hospital Trust. In the meantime traditional maternity care continued to be the dominant model of care available to women with the minority receiving Team Midwifery .

**What happened to Team Midwifery**

Having completed the fieldwork data collection I learnt that a 'diluted' version of Team Midwifery was extended to the whole of the district. The new version of Team Midwifery introduced in the autumn of 1997 differed from the original pilot as follows:

- Teams were extended to cover more practices which meant up to 10 midwives constituted a team (pilot = 6 midwives) depending on the mix of whole time and part time staff
- On call duties were shared between teams reducing the number of on call duties any one midwife would have to do

This had the following impact on the model of care offered:

- The number of midwives a woman could meet increased and as such reduced continuity of care overall
- The sharing of on call between teams resulted in a reduction in the opportunity to be delivered by woman's own team midwife – again reducing continuity of care – a woman could therefore be delivered by a midwife she had previously had no contact

with. This would have had an impact on meeting some of the indicators of success in *Changing Childbirth*.

Extending the pilot in a diluted way did result in a change to the way that maternity services were delivered overall. However it resulted in a shift of power between key stakeholders, not a redistribution as *Changing Childbirth* intended. Tensions therefore continued in the NHS as a result of the purchaser provider split and the 1991 reforms. This will be considered in more detail in the next section.

## Section three The context of the 1991 reforms and its impact on the local case study

### How the 1991 reforms affected the implementation of Changing Childbirth.

The introduction of the 'managed market' in 1991 resulted in opportunities for more negotiation points, i.e. the purchaser and provider split, and this in turn required different types of negotiation and negotiators, " *dispersal makes the exercise of managerialised power and decision making unstable....* ", (Clarke and Newman, 1997, p 31). Managers were grappling to define their roles and the NHS system also experienced an influx of managers from the private sector. Organisational change, and the way it is managed, can for a period create instability and this was compounded by the political agenda of national responsibilities and local freedoms, previously discussed. If local freedoms, and actions, are divergent to the national agenda then negotiators in the system, operating within a system of dispersed power, no matter how innovative are going to meet resistance to a nationally set agenda.

Relationships between, and within, professional groups may be subject to change as new policies can magnify existing tensions, i.e. between midwives and obstetricians, and activate new tensions and conflict, i.e. between managerial staff. So whilst the policy intention may be to dilute the professional power of one group over another it may also create new power struggles. Dispersal of power vertically, i.e. from central government to local decision makers, may have brought transparency at a devolved level with regard to decision making. However as the 1991 NHS reforms created a new type of managerialism the field work I conducted indicates that the confrontational culture I experienced served to negate the potential for transparency. For example evidence of uncertainty about the true costs of maternity care and a lack of clarity about the true allocation of resources deemed to have been agreed between the Health Authority and acute Trust. Health service managers have to seek ways of managing this complex situation. The very confined and closed decision making that this type of context

appeared to necessitate meant devolved responsibility was devolved to a select few.

Schemes such as Team Midwifery had potential implications for resource allocation, i.e. staffing levels and the practical organisation and deployment of team midwives and core hospital staff. Although in some cases it was proven that this model of care could reduce the us e of hospital beds, (Hodnett 1996). These resource factors, coupled with national disputes over local pay bargaining and the grading of midwives, may also have affected staff morale. Professionals in the NHS have historically been organized hierarchically in a culture and a system which is concerned with efficiency and dominated by bureaucratic depersonalised relationships between and amongst staff. Constant reform and re-organisation can offer development opportunities to staff but it can also de-motivate and de-stablise them, *"Increase staff anxiety and decrease commitment"*, (Gutteridge 1996).

Team Midwifery provided a context for re-discovery of caring for and caring about women and midwifery roles became less instrumental and transient as midwives status as professional caregivers and policy implementers improved. A whole system of care was on offer to a sub-section of the local population, more whole than previous compartmentalised service delivery. However midwives' were pacified with the continuation of the pilot scheme because they had realised some professional gain for themselves. Although Team Midwifery afforded the scope to bring together practice and management, in the long term it proved to pose too much of a threat to managers and practitioners alike. The diluted version of Team Midwifery eventually implemented on a district wide scale was more acceptable to the majority of stakeholders because managers, GPs and obstetricians were able to retain their power and control whilst visibly endorsing increased autonomy for midwives.

Non-decision making activity, or quasi decision making (i.e. agenda setting) was influenced by the institutional power of GPs, obstetricians and health service managers, these groups and individuals were united in the deferred decisions. For example GPs

were still evidently defensive as were obstetricians who saw Team Midwifery as a threat to their professional status but perhaps more significantly, but less overtly apparent, as a threat to their claim on patient care. As such, patients are viewed as commodities and the shift in the delivery of care was a threat to the economic power of both GPs and obstetricians. Managers on the other hand were attempting to resolve a complex policy and service delivery issue within ongoing broader financial negotiations which did not consider maternity care a priority. Chief Executives as the key negotiators and decision-makers are faced with 'difficult' decisions and 'difficult' individuals on a daily basis but the semi-autonomous role of 'paid rationalizer' serves to legitimate and perpetuate their power.

The managerial drive of the 1990's in the NHS was concerned with efficiency and effectiveness and competition in relation to economic control and competing claims on budgets. As the case study has depicted maternity services were not deemed a local priority by either the Health Authority senior management team or the hospital Trust senior managers. In view of this I suggest that demands for service development monies stand little chance of influencing the decision making process if not deemed a local priority, despite the national impetus for change. Team Midwifery was therefore dis-engaged from corporate objectives. This also created a lack of agreement and synergy between key stakeholders and decision makers. Therefore both senior managers and senior medical professionals, i.e. Chief Executives and obstetricians, were subject to a policy system and working environment that pitched their own self preservation against each other. Conflict may therefore become embodied in single individuals (Clarke and Newman 1997, p77), and depending on the managerial style of those individuals, the conflict may be welcome. Conflict in this instance, i.e. the case study, therefore legitimises roles and actions of certain key decision-makers.

The semi-autonomous status of senior NHS managers, i.e. as devolved decision makers and with devolved responsibility for national policy implementation, coupled with the relationships engendered by the purchaser provider split served to legitimate the

entrepreneurial managerial role of Chief Executives in particular. Agenda setting power (Lukes 1974) may serve to compromise any real debate about future events. For example both chief executives' in the case study made their views on the prioritisation of maternity services quite explicit prior to the evaluation of the new pilot model of care. Implementation of *Changing Childbirth* was problematic from the outset as the key decision makers under the auspices of the purchaser/provider split should have been the Chief Executive of the Health Authority. However the geographical issue posed a barrier to change and the notion of contestability, i.e. threatening to switch contracts to another provider, failed to have any real practical impact.

Policy implementation is an important area to study because of its implications for how services are organised and delivered to patients. Studying the local response to a national policy agenda has provided an assessment of local dynamics, power and the negotiation for control of the decision making process. To further enhance the policy making process and make it more manageable for those implementing it policy makers need to understand both the opportunities and constraints that exist during the policy implementation process.

I suggest that policy will become diluted during the implementation process for a multitude of reasons, some driven by power relations, and some structural. This case study has revealed that deferred decision making (power relations) coupled with reformed organisational managerial structures (structural) is one way of diluting policy at a local level, intentional or not. Issues that were discussed (in relation to the decision making agenda in the case study) appeared biased towards those with power and authority, i.e. medical and managerial professionals. The former because they wanted to retain their power and economic claim on patients and the latter because they were, and are, creating and legitimising power which they have to sustain for self-preservation. The 'inevitable' outcome I argue for policy implementation at a meso level is dilution and in addition at a micro level diversification. The 1991 NHS reforms perpetuated this policy environment. The qualitative evaluation demonstrated that women preferred

Team Midwifery as a model of service delivery but real choice was restricted by the beliefs and actions of individual practitioners (Tinkler and Quinney 1995). As research has suggested access to services is not just dependent upon where you live but also which professional you come into contact with (Ben-Shlomo 1995).

The process of challenging regimes of power, new and old, through continual NHS reform becomes weakened as power struggles become increasingly multi-dimensional, i.e. between managers and the medical profession and within managerial and professional groups. The impact of continual reform also de-stabilizes previous attempts to challenge historical power structures. For example the creation of Primary Care Groups and subsequently Primary Care Trusts in England has been rapid and it is too early to gauge the impact of these changes on the acute sector and its domination of the national NHS budget. The weakening of challenges to powerful regimes and processes in turn serves to have an effect on implementation of policy at a localised level and potentially dilutes the policy intention for service change. Policy implementation at any level is complex and the case study has sought to show this complexity through analysis of the day to day tasks and processes that influenced and shaped the model of maternity care developed in response to *Changing Childbirth*. If this complexity is not recognised and accounted for by policy makers then national policy will remain divorced from local structures and local decision making and policy implementation will always be diluted in relation to its original intentions.

**Policy implementation as a dialectical process**

Policy implementation understandably in its application at a local level is subject to a certain level of interpretation, or local freedoms as the NHS promoted (DoH 1994a, NHSE 1994d). However the nature of the local context also determined the extent to which the model of service delivery and / or provision of care resembles the original policy. This context which is fluid, as demonstrated by the case study, and the different types of conflict within it will dictate the extent to which the policy becomes diluted.

The delaying tactic in the case study was an essential component of the dilution process and became more apparent through observation of the process of negotiation and decision making which appeared to be a dialectical one. Assertions and contradictions are resolved in a context of new emerging priorities, new policy directives and re-construction of professional and managerial roles, (welcomed or not). It may also be dialectical because factors which inhibit and factors which facilitate change are often operating concurrently. Although the scope and range of responsibilities Health Authorities adopted increased their power, it was still challenged by dominant hospital Trusts and decentralisation (local freedoms) had provided a climate for the growth of institutional and market orientated interests where corporate images, logos and business plans predominated. In addition a lack of data on activity and costs and an immature purchasing function inhibited the implementation of *Changing Childbirth.*

Control over resources is an explicit and obvious form of power (the Health Authority as purchaser) but irrespective of this, and the intentions of policy makers, service providers can still determine and dictate how a service is delivered at a micro level and also determine what role the patient will play. For things to (radically) change for middle and lower rank professionals and indeed patients themselves a system would need to exist which embraces, " *plurality of provision, contractual accountability, decentralisation and participative decision making* ", (Hugman 1991, p213).

Although the purchaser provider split had some impact (see table below) on the levels of conflict within and between organisations and professionals it probably failed to deliver the impact the 1991 reforms sought to make, i.e. a sizeable shift in the dominance of the acute sector.

**Table 9 Type of conflict and the policy context - a process of re-adjustment**

| | **Historical policy context** | | |
|---|---|---|---|
| **Position of different types of conflict during the policy implementation process** | *Pre- 1991/1993* | *Immediate policy context (1993 - 1995)* | *Post policy context (1995 - 1998)* |
| First | Inter-professional conflict | Inter-professional conflict | Inter-organisational conflict |
| Second | Intra-organisational conflict | Inter-organisational conflict | Intra-organisational conflict |
| Third | Inter-organisational conflict | Intra-organisational conflict | Inter-professional conflict |
| Fourth | Intra-professional conflict | Intra-professional conflict | Intra-professional conflict |

The following definitions of conflict are intended to represent my findings:

- **Inter-professional** conflict represents the relationships between some midwives, GPs and Obstetricians and is based on professional power struggles;
- **Intra-professional** conflict represents relationships between the same professional groups, e.g. there was conflict between team and hospital midwives, conflict between GPs about the future of maternity care and conflict between obstetricians about Team Midwifery . There was also conflict between managers about maternity services;
- **Inter-organisational** conflict represents the relationship between the Health

Authority and the acute hospital Trust in particular. The conflict was predominantly between managerial staff, although several GPs and some obstetricians also had dis-agreements with the Health Authority, i.e. one GP 'threatened' to ensure that all 'his women', those registered with him who became pregnant, booked their maternity care with a completely different provider; and

- **Intra-organisational** conflict represents some of the relationships within both the purchaser and provider organisations. For example the midwifery mangers experienced conflict with the Chief Executive and Obstetricians in the acute Trust. However the midwifery managers changed their position and actually ended up in conflict with team midwives. In the Health Authority there was more unity in their approach to maternity services, although in the latter stages of negotiation the quality manager began to be more supportive of the Team Midwifery approach.

During the course of the post 1991 reforms and subsequently the introduction of *Changing Childbirth* inter-professional conflict continued as the most dominant (i.e. first position) but gradually, at a meso level, inter-organisational issues and conflict shifted the nature and focus of the local policy context and hence the form of conflict. This reflected the role of the Health Authority as a commissioner rather than the administrative role pre 1991, the purchaser provider split therefore increased inter and intra organisational conflict.

For example local inter-professional issues at the hospital Trust appeared to be less fraught during late 1996 and 1997, consultants gave midwives what I have termed 'concessions', i.e. their names as lead professional could appear first on the patient notes. In addition suggestions to extend a diluted version of Team Midwifery district wide met with less opposition from consultant staff. However in contrast to this inter-organisational issues which I would see as being particularly associated with the post 1991 reform period increasingly impacted upon the policy implementation context, i.e.

commodification of lower rank staff and patients, action motivated by money and decisions underlined by individuals engaged in entrepreneurial type relationships.

Managers in district Health Authorities, and Trusts, in relation to their location in the post 1991 NHS, have been subject to a creation and re-invention of roles and legitimisation of activity and consequently new regimes of organisational power. This also resulted in a new set of languages and practices, a new discourse, which would be used to sustain these identities and professional activity. Sustaining this new discourse and purpose of action I suggest can partly explain why the contracting process had the potential to become all consuming. In addition the identity of the hospital Trust as a quasi-business meant their independent status created tensions which resulted in inter and intra-organisational conflict. In summary the local case study was able to demonstrate that there had been some movement in the system in relation to power shifts and so the case study has given some insight into the effects of policy implementation at a meso level of the NHS system.

In reflecting on events since data collection for the case study was completed there is scope to consider how policy has the potential to re-invent itself and at the same time provide more radical solutions to those that have preceded it. This is something I would label the dialectical transformation of historical power systems. A process of some form of continuation of central themes and structural processes struggle and survive but they do become diluted. For example the White paper (DoH 1997a) focused on all of the aspects Hugman (1991) suggests as important to a varying degree, but new tensions emerge constantly as GPs want to retain control of their status and patients whilst the state is still struggling with the notion of consumerism and devolved decision making. 'Consumers' of health care are still subordinate and at the mercy of both medical and managerial control.

However the new national plan (DoH 2000) has created an even more radical policy context for professionals, managers and patients and presents the potential to further

dilute entrenched power relations within the NHS. National responsibilities and local freedoms persist as a feature in this latest overhaul of the NHS. The concluding chapter will consider findings from the case study and the literature review in relation to the new national plan. First however I will present a broader discussion on the case study returning to some of the themes which emerged from the literature review. A discussion on my research role and general implications for policy research will complement this.

# 8 Discussion

**Policy and change - revisiting the issues within a macro context.**

This section aims to consider the wider implications of policy in terms of priorities and guidance and new emergent policy implications which affect conditions for change. The immediate focus will be at a national / macro level incorporating observations made by key opinion leaders in the health care field, i.e. professionals and academics, as well as some of my my own observations and ideas. These observations will be used to add to the eclecticism of the overall interpretation and also contribute to a further assessment of the impact of the 1991 NHS reforms. It will become apparent how important consideration of the above is in relation to the local case study as the chapter progresses and attention is focused on policy and change, process and power. Assessment of policy implementation with regard organisational change will be highlighted and the focus for final observations will be concerned with linking these wider concepts with the local research context and policy research.

This review of the macro policy issues will concentrate on literature from 1996 and early 1997 providing a continuation of themes from relevant literature presented in the first chapter. This will complement themes for interpretation which emerged from the local research during 1996 and early 1997. This is primarily because of the relevance and importance of exogenous factors such as the prevailing cultural, political and professional values and beliefs which exist during, or emerge from, policy implementation.

**Effects of the 1991 reforms**

Commentators on the 1991 reforms of the NHS, and other health care systems, have observed that the introduction of market orientated principles had sought to, " *make resource allocation in health care more efficient, more innovative and more responsive*

*to consumer preferences while maintaining equity "*, (Van De Ven 1996). Through the internal market, patients could potentially use the system with Fundholders to dictate where they had treatment and care delivered and this could have posed a threat to providers in the system that were know to be under performing. Money was therefore meant to follow patients.

Recent observations indicate restructuring in this context has increased administrative overheads and at the same time generated a continuation of inadequate information systems and inefficient practices (Posnett et al 1998). This suggests the market system may not have been compatible with efficiency and evidence based medicine and also not been responsive to patients as consumers of health care. The notion of the introduction of GP Fundholding as a means to prevent purchasers and providers developing a cosy relationship, as made explicit by Kenneth Clarke, former health secretary, (Crail 1996a), suggests an intention to divide and rule by fragmentation and uncertainty. Furthermore the proliferation of 'career managers' in the NHS, whose selection and subsequent role in the management of change were ultimately the key to decision making may have created new (and stronger) tensions and conflict.

One of the original aims of the 'internal market' was to break down the professional dominance of hospital clinicians and yet the drive towards a primary care led NHS seemed to be encouraging one dominance to be replaced by another, i.e. GPs. *Changing Childbirth* policy explicitly demonstrated a lack of willingness to address existing GP power structures with regard to payment systems for provision of maternity care in the community. This remuneration issue may be minimal in comparison to the size of budgets being negotiated annually but it represents the historical power, and control, GPs exercise. Team Midwifery enabled GPs, if they chose, to do even less, (Farquar et al 1996, p96.), without loss of income. As a result of this some members of the primary care team may have been dis-empowered by this type of relationship. During the fieldwork period payment scales for GP reimbursement to provide maternity cover and the corresponding birth rate meant a figure of £48,000 was paid in maternity and

obstetric fees to GPs for this particular district in 1998. (Source NHS, General Medical Services Red Book, DoH 1996d). There was no correlation between this figure and the episodes of care provided by GPs or not.

The apparent persistence of the historical dominance of the acute sector indicated that the original intentions of the 1991 NHS reforms did not seem to be successful. Health Authorities may have had a limited impact on operational matters via the contractual process but even this mechanism was not robust enough to ensure local policy intentions were realised. For example it was impossible under existing arrangements for the local Health Authority in this case study to ascertain the true cost of maternity care for their local population. Mis-trust became endemic between purchasers and providers with no obvious gain for patients.

The concern about funding for the NHS continued throughout 1996 and resulted in one senior manager 'exposing' a manipulation of figures to disguise the failure of the internal market (Brindle 1996b). The significant, or perhaps more public, casualty of the quasi internal market in terms of the purchaser provider split was the demise of Anglian Harbours Trust, unable to compete with larger rival Trusts. However its decline was reported to be the result of a combination of factors reflecting, " *not only local conditions and personalities, but national policy* ", (Glasman 1996).

Inevitably purchasers were responsible for making difficult decisions but their role and how they functioned in the new internal market also attracted new criticisms, " *purchasers negotiate different deals. So how quickly a patient is treated can often depend on who is purchasing the care, not on their clinical need* ", (Dickson 1996a). So issues regarding equity and clinical effectiveness were not necessarily determining allocation of patient care. However the issue of prioritisation based on finances as opposed to clinical need was predominantly reserved for criticism of GP Fundholding. Some chose to present research data which indicated this existed, (Kammering and Kinnear 1996), whilst those angered by circumstances which challenged their principles

used the media to highlight the issue, *".... I have looked consultants in the eye and told them to see Fundholding patients in advance of Health Authority patients... "*, (Drown 1996).

The desire of the government to convince the public that the NHS was an equitable provider of care was going to be difficult to maintain as the effects of the reforms unfolded. Studies of GP Fundholding and locality commissioning found that their influence on improving services was variable and dependent on the local context and the attitude of the Health Authority (Goodwin 1996).

The intensity of media interest with regard to the introduction of the internal market culminated in a series of three television programmes screened on BBC 2 during September 1996. The mini series was aptly entitled 'Safe with us' and Naill Dickson, BBC Social Affairs editor, sought to document, through the eyes of ministers, media professionals and health service managers, the origins and impact of the 1991 reforms. The first programme (BBC 2, September 1st 1996) described the background to the reforms with emphasis on those politicians and senior managers responsible for its implementation whilst the second programme (BBC 2, September 8th 1996) focused on GP Fundholding. The third and final programme (BBC 2, September 15th 1996) concentrated on Trust status of NHS hospitals and their increasing introduction of private wards to generate income. The increasing unrest that the two -tier system of Fundholding had created was also highlighted.

The final programme also attempted to draw some conclusions from its observations and interviews which indicated the 1991 reforms had failed to achieve what they had set out to do and suggested more change was inevitable. One observer of the nature and context of the programmes suggested that one of the more implicit failures, not exposed, was a lack of attention to the process of change and the possibility that conflict was part of the change process that key stakeholders may have to accept (Klein 1996b). This observation resonated with findings from the local case study.

This apparent environment of conflict, dis-placed-management and increasing patient demands on the NHS system did not appear to resonate with an environment where equity, efficiency and effectiveness and responsiveness could work in parallel. The growing disquiet with the 1991 reforms and emerging conflicts between professional groups and health service managers during 1996 and early 1997 were reflected in literature about the NHS. The 'perverse' incentives that the purchaser -provider split appeared to have created was one of many key issues highlighted, *" ..more efficient (cheaper) providers will get paid less in the future, and the market's whole motivational ethos is turned on its head "*, (Paton 1996).

Fundholding, as noted above, continued to attract criticism, (Audit Commission 1996, Stewart-Brown et al 1996), although some GP Fundholders responded to the Audit Commission report by suggesting that the information used was out of date and politically biased (Scott 1996). However the central role of the GP in the market healthcare system appeared to be generating momentum with a specific focus on a primary care led NHS although some believed that the dominance of hospital providers could still prevail, *"...the trust system perpetuates acute sector dominance, hospitals are starting to emulate their US counterparts by attempting to extend hospital based services into the community"*, (May 1996).

There appeared to be an emerging dis-agreement about who were the real power brokers, Health Authorities were accused of being irresponsible and incapable of managing GPs whilst trust managers were seen to lack control over the 'medical mafia' (Maynard 1996). The market system had resulted in Health Authorities reacting to short term contract negotiations rather than a long term pro-active focus on health care strategies based upon health needs assessments, (Hunter 1996). There was also an argument that GP Fundholders had also focused on the commissioning aspect of their role, neglecting the development of community based care and health promotion. This was deemed problematic because of a 'general fuzziness around their accountability'

(Chambers 1996).

The costs of what had been termed a two tier commissioning system have been subject to scrutiny and the results, summarised in the Health Service Journal (Millar 1997), indicated that the 'market' system was expensive, " *...Health Authority costs have not decreased as GP Fundholding has increased.....substantial costs that HA's incur administrating and supporting the development of GP purchasing ...increase with the number of Fundholders* ", (Millar 1997).

In contrast to this some GP fundholders argued that they could become 'super fundholders' taking on more responsibility in a system where financial incentives would be used to relate performance to pay enabling any surplus from budgets to remain with them. There appeared to be a mis-match with regard to perceptions about what the market system could have achieved and the patient, increasingly labelled as the demanding consumer, was often left in the background. In addition the replacement of Fundholding with Primary Care Groups and Primary Care Trusts (DoH 1997a) may yet prove expensive to administrate.

An interesting contradiction also emerged whereby some GPs did not identify with the 'super fundholder' role. For example a small sample of GP registrars indicated they were not the appropriate professionals to ration resources, (Vaughan et al 1995), and some GP's reported a real reluctance to fulfil the role of rationer at the time of consultation with their patients (Ayers 1996). This presented something of a dilemma as GPs are implicit rationers yet some of their views indicated a revision of this role which suggests a transfer of responsibility.

There appeared to have been opposition to the Conservative government proposals for primary care with many GPs making it explicit that they wanted to decrease their core responsibilities (Roland 1996). Significantly their protest was essentially a demand for more money and a recognition that services in excess of core responsibilities would

require separate contracts. However as Roland (1996) highlighted this scenario may have created further competition with acute and community Trusts willing to provide these non-core services. Others argued that GPs were already capable of 'boosting' their income via existing NHS payment structures, i.e. immunisation, child surveillance, and through 'non-core' tasks such as the signing of private medical insurance claim forms, (Lilley 1996).

Health Authorities had been charged with assessing the needs of their populations and the increasing role of public health had helped to pursue this goal but Directors of Public Health were also drawn into the contracting process. This had advantages as they could produce evidence to influence decisions on a population basis whereas GPs as purchasers and providers for smaller populations could argue on the basis of responsiveness. Hospital Trusts on the other hand were dependent on historical patterns of care and the expertise they could provide. However the case study had demonstrated that in reality the above 'potential' to develop services in the interests of patients could be hampered by local power relationships and inter-professional rivalry. This amounted to patients and lower rank professionals being used as commodities. The 1991 reforms may not have created this commodification but they certainly perpetuated it. In addition the case study data indicates there was an increase in inter and intra organisational conflict post 1991.

A recent reflection by Rudolf Klein on Enthoven's own personal review of the impact of the 1991 reforms highlights some key concepts that I have sought to unravel and understand. For example there is reference to the internal market model being a 'myth' and the reality that, "*the reforms disappointed both the hopes of their advocates and the prophecies of their critics .......the whole enterprise, like Enthoven's own 1985 monograph, was much more pragmatic and less ideological than the outraged reactions to the reforms suggested*", (Klein 1999).

The fact that a Conservative government introduced such reforms may have put a 'spin'

on their impact initially and it is worth noting that the latest reforms by the Labour government have not entirely replaced the notion of a purchaser and provider split, Primary Care Groups and Trusts are in essence larger scale versions of Fundholding, (DoH 1997a, DoH 2000).

**The new public management - trials and tribulations**

Clarke and Newman (1997) suggest there are three variants of the new public management:

(i) efficiency orientated (productivity and managerial control);

(ii) market orientated (contracting and competition ); and

(iii) user orientated (quality and responsiveness)

All variants may potentially exist in an organisation because, I suggest, different individuals in managerial positions will have a 'style ' of working and functioning this will have an impact on their particular value and belief systems. As a consequence of this exercise power in relation to these individual value systems, *"I would maintain that power is one of those concepts which is ineradicably value dependent.....its very definition and any given use of it"*, (Lukes 1974, p26) .

So although national policy may dictate an agenda, locally, there is scope for individual preferences. Because the 1991 NHS reforms introduced a quasi-market system this left scope for variant (i) to co-exist with variant (ii). Variant (iii) was given priority as well but with regard to policy implementation it was more difficult to achieve because variants (i) and (ii) took precedence at any given time. Therefore new roles are likely to emerge which do not necessarily displace old one's (medical and bureaucratic dominance) but co-exist and cause different tensions at a meso and micro level of

service planning and service delivery. This was found to be evident in the local case study where the role of Public Sector Entrepreneur emerged to co-exist with historical professional conflict and roles and relationships. However NHS management became increasingly subjected to scrutiny, evaluation and inevitable criticism. The audit commission published a report (Audit Commission 1997) which indicated that poor management was the cause of a variation in staff turnover between NHS organisations.

There was also evidence of the continued existence of a gulf between doctors and managers with one junior doctor publicly criticising NHS managers arguing that they, " *possess no commitment to the NHS as a nationalised health industry....their betrayal starts with their own subscriptions to BUPA.....less money should be spent on wages for finance managers whose agenda seems so removed from that of those with real patient contact*", (Gaba, 1996).

This attack pointed towards implying that post 1991 NHS managers neglected the traditional values of the NHS and were more aligned to short term financial outcomes. Whilst it is difficult to accept such a stinging attack of managers and questionable whether managers who are doctors would perform in a less ego-centric way the speed at which Chief Executives change jobs is understandably not viewed in a positive light. It has been suggested by a recent study the average length of time in post is two years and eight months (Simpson and Smith 1997).

However 1996 and 1997 also saw many managers publicly displaying their angst at accusations of over-management and government policy seeking to impose tighter control on management costs (Health Service Journal, 1996, June 13, pp 12-19,). Manager's health and poor image also became the focus of attention (Millar 1997) and surprisingly *'role ambiguity or conflict and lack of influence over decisions'* were blamed as the cause of stress (Moore, 1996). Whilst others acknowledged that before convincing the public of the worth of managers internal perceptions had to be changed, (Millar 1996), so intra and inter-organisational relationships still required development.

This has been elaborated on further since the publication of the English NHS White paper (DoH 1997) and managers in particular have seemingly failed thus far, *" if there has been a serious management failure in the NHS it has been the inability effectively to micro-manage the organisation and provision of care.......the history of the NHS from its outset has been marked by the constant oscillation between central and local control..it is all a matter of balance and judgement and in this managers will have a central role to play "*, (Hunter, 1998).

A return to more humanistic values and less emphasis on private sector concerns have recently been called for particularly in relation to NHS management styles and the culture of the NHS (Health Service Journal, 1998, 23 April, pp 10-11, p15). Others had previously suggested that NHS management styles were outdated and lacked a holistic approach, *" managing is more about processes and not about controlling people through the manipulation of financial resources....the concept of management is organic, complex and much more significant than the 'business' management introduced into the NHS"*, (Bazalgette and Crooke 1997).

Nationally there appeared to be genuine identifiable problems with the NHS and its many components. The success of *Changing Childbirth* was explicitly grounded in the need for collaboration between purchasers, service providers and patients. If health authorities' were truly incapable of 'managing' GPs, and in parallel NHS Trusts were unable to exercise 'control' over hospital consultants the 1991 reforms had in effect failed. Bureaucracy had evidently not diminished and, intentional or not, the NHS was increasingly exposing itself to further potential divisions between and within administrative and professional groups. The wider context of the reforms was inevitably having an impact on local circumstances and post maternity policy.

The above also introduces a recurring theme which I have yet to give due attention to, but is crucial to any examination of the 1991 reforms and how decisions about implementing or extending new models of care, i.e. Team Midwifery, were made. The

recurring theme, in a context of equity, efficiency and effectiveness and responsiveness being rationing.

**Policy - underlying (political) factors and influences - the rationing debate.**

The emergence of a report entitled 'Priority setting in the NHS' (NHSE 1997) revealed the growing pressures Health Authorities in particular were experiencing. The report also argued for a more public, rational and open debate about resource allocation and the methods, or lack of them, adopted to guide this process.

Priority setting in the NHS (Working Party Priority Setting in the NHS 1997) described three levels at which priorities were determined at that time:

(1) **macro** decisions are made by governments and determine the level of resources devoted to health and the amount that each Health Authority receives;

(2) **meso** decisions are made by Health Authorities and GP Fundholding practices and relate to the amount of investment that they assign to each programme or speciality on behalf of their residents; and

(3) **micro** decisions are made by health professionals and determine which individuals receive or are referred to specific services within the resources allocated as a consequence of meso decision-making.

(Working Party Priority Setting in the NHS 1997.p10).

Inevitably the meso level is determined by the macro level and consequently the micro level is determined by the meso level, however one should not underestimate the potential 'devolution of power' this structure allows for. Furthermore the role of NHS

provider Trusts, as operational rationalizers was not conveyed by this approach and yet findings from the local case study have demonstrated an implicit prioritisation and rationing role via the contractual negotiation process.

The priority setting report also noted the governments response to a Health Committee report on priority setting which included the three levels of prioritisation described above, government definitions were:

* *equity* - a service available to all on the basis of clinical need, regardless of the ability to pay;

* *efficiency* - provides patients with treatment and care which is both clinically effective and a good use of taxpayers' money; and

* *responsiveness* - meets the needs of individual patients and ensures that it changes as the needs of patients' change and as medical knowledge advances.

(House of Commons 1995)

The use of 'priority setting' was adopted throughout the report to encompass rationing as well, however there are recognised difficulties with both concepts illustrated by two plausible definitions presented below. Klein (1996b) suggests, *"priority setting is the process by which politicians and managers determine the envelopes of resources to be allocated to specific service within the NHS. Rationing is the process by which resources within those envelopes are then allocated to individual patients"*, (Klein 1996b).

Whilst New (1996) acknowledged that rationing could be defined as withholding resources from an individual for effectiveness reasons and priority setting could involve

value judgements about the amount of resource allocation to specific groups, the reality he felt was, that, " *..semantic distinctions are merely variations on the same fundamental question relating to the allocation of NHS resources* ", (New 1996). Klein may have been attempting to make a distinction between macro resource allocation (prioritisation) and meso and micro allocation of resources (rationing). Priority setting therefore appeared to be related *to 'how to make choices between competing priorities when resources are scarce'.*

It is at the meso level, i.e. Health Authorities in particular, where application of prioritisation and rationing have increasingly become more explicit (Redmayne 1996). Although, efficiency, has often attracted most attention (Entwhistle et al 1996). However the increasing pressures on Health Authorities to become more explicit about their purchasing decisions and the inevitable exclusion of certain procedures this has increasingly involved created two related key concerns. The first being inequity and a situation whereby access to treatment was dependent on geographical location (New and Le Grand 1996a, 1996b) or 'treatment by postcode' (Snell 1997), the second issue was about who should make these decisions in the first place, (Maynard 1996a, 1996b, Coast et al 1996, Smith 1996b, Wall 1996). The debate extended to include assessment of the role of GP's and resulted in a draft policy on the ethical use of resources which acknowledged that the *'differences of opinion between GP partners about the use of resources are inevitable'* (Crisp et al 1996).

Dis-agreement as to where 'prioritisation' should take place, at national or local level continued (Lenaghan et al 1996). Whilst others argued this debate was premature in a context which lacked any underlying rationing principles (Maynard 1996) and there appeared to be increasing pressure for decision makers at the meso and micro level to be more explicit.

The debate about 'rationing' intensified, (Doyal 1997, Coast 1997, Lenaghan 1997, Williams 1997, New 1997, New and Le Grand 1996a, 1996b, Ham 1996c, Klein 1997).

Some commentators argued that improved management and more efficient use of existing resources would solve the problem of rationing within the NHS, (Roberts et al 1996) thus suggesting that existing funding was at an acceptable level. However there was also a counter argument that indicated the NHS survived through a parsimonious financial basis which has historically existed on a comparatively small investment of about 6% of Gross Domestic Product (GDP), (Ham 1996). Although the recent budget announcement and spending plans on health by the Labour government is set to change this historical pattern, (DoH 2000).

In the context of the case study I suggest rationing and prioritisation can both be used if we consider that the findings indicate seniors managers from the Health Authority agreed maternity care was not a 'priority' and they could not justify allocation of additional resources the hospital Trust demanded. At the same time the local case study also revealed that having used the exaggerated figures for proposed district wide implementation of Team Midwifery the hospital Trust then finally agreed to fund the maternity developments at a significantly reduced figure suggesting a rationing of resources. Therefore the Health Authority prioritised and the Trust rationed in respect of individual directorates within the acute hospital setting. The problem with this particular scenario is that the Health Authority in this case study prioritised, I suggest, for four reasons,

(i) a general view that maternity care in relation to other service developments was not a priority;

(ii) an underlying assumption that the hospital Trust were exaggerating the true costs of district wide implementation based on information yielded from other pilot schemes;

(iii) an underlying suspicion that any additional monies would be internally re-directed to subsidise other non-maternity directorates, (lack of information on prices and detailed hospital activity data makes it difficult for this issue to either be confirmed or refuted ); and

(iv) an underlying concern that professional conflict was the real issue hampering further developments to maternity care.

So prioritisation was based upon individual managerial views and interpretation, a lack of trust between decision-makers and concerns about professional conflict. The above has relevance for some of the issues which were emerging from the growing prioritisation debate. Decisions were influenced and determined by far more complex, structural and individual factors and from a consumer perspective, individual professionals continued to determine what choices they were given.

**The role of the 'consumer' in the 'prioritisation' and 'rationing' debate**

The involvement of the consumer in the prioritisation and rationing agenda appeared to have two main strands to it. Firstly should the public be involved in this type of debate and secondly and if so, to what degree should they be engaged, (Lenaghan et al 1996). The latter point raised issues about the type of process and approaches that would need to be adopted to engage consumers/members of the public in this type of debate. Opinion was generally in favour of public involvement (Bowling 1996, Coote and Hunter 1996, McIver 1996.) The re-launch of the Patients Association (Patients Voices 1996) seemed to confirm a growing voice for the role of the consumer. Indeed the

continued publication of guidance to Health Authorities about 'public involvement' in influencing delivery of care suggested different levels and reasons for that involvement which would include, *"....greater voice and influence to users of NHS services and their carers in their own care, the development and definition of standards set for NHS services locally and the development of NHS policy both locally and nationally"*, (NHSE 1997).

However there was a recognition that although certain priorities were set at a national level there is a potential dichotomy between central and local priority setting, *"different structures, historical patterns, local 'needs' and available resources all indicate the need for some priority setting at the local level"*, (Obermann and Tolley 1997). This generated interest in the type of involvement the public might have (Calnan 1997, Huntington 1997, Evans 1996) with the main options being at a broadly 'informed' strategic planning level or at a 'deliberated' decision-making level. There has been an attempt to represent options available to the public to become engaged in the consultation process,

**Figure 10 – a matrix for public involvement in decision making**

| | **Informed** | **Uninformed** |
|---|---|---|
| **Deliberated** | Citizen's Juries / Heath Panels / Community groups | Focus groups |
| **Undeliberated** | Questionnaires/ interviews with written information | Questionnaires / one off interviews |

(Adapted from Dowsell et al 1996, p19)

There appeared to be a continuing drive toward a public engaged in the decision making process who were informed and had the capacity and resources to 'deliberate' issues in their own right (Dowsell et al 1997). This raises questions regarding how to 'weight' these opinions in relation to professional expert opinion, lay expert opinion (interest groups and CHC's) and accountable paid decision makers, i.e. (Health Authority Boards).

Thus the increasingly normative view of active citizenship may be perceived by some as a detraction from the responsibility of the state and accountability of local health service managers. However research has shown that whilst the public want to be consulted and given the opportunity to inform the decision making process they regard the crucial decision making process as the ultimate responsibility of those paid to do it (Bowling 1993). Recent international research (deliberate polling in Ontario) supports this view but also highlights the fact that local people do want to be involved from an informed perspective, *" they (local people) rated a combination body involving several community groups as the most suitable overall decision making body......as the complexity of devolved decision making became clear, participants tended to assign authority to traditional decision makers such as elected officials......but also favoured a consulting role for attenders at town hall meetings (i.e. interested citizens)"*, (Abelson et al 1995).

However achieving genuine 'consumer' involvement in the planning and implementation of health service delivery, where change has been difficult to implement, I suggest remains elusive. Engaging service users in more detailed discussions is difficult (Lenaghan et al 1996, McIver 1996), where real choices have to be made about funding of healthcare provision in a context of competing priorities. The mis-trust made transparent by using excerpts from inter-agency correspondence in the local case study gives a greater understanding as to why the notion of consumer and informed deliberator playing a role in the decision making process has been relatively slow in the British NHS.

The re-launch of the Patients Association noted above suggested patient empowerment was gaining momentum and provided patients with a choice of consumer groups (Butler 1996). An alternative explanation for its re-emergence was the lack of empowerment available through existing organisations. The NHS internal market of the 1990's, and subsequent policy rhetoric, promoted consumerism as one of its core principles, yet observers of this facet of the reforms questioned its impact on the decision making process. This lack of impact of consumer involvement was seen to relate both to the service delivery aspect of the NHS and, significantly in relation to power, how consumer involvement was defined by managers *" despite a critical mass of evidence for the effectiveness of involving individuals in treatment and of involving communities in the wider policy making debate, typically the process is fudged in all directions, often ending in hair splitting arguments about what constitutes a change in services and what is or is not a management decision ".* (Millar 1996b).

This is because internal definitions would help define the level of influence senior managers and consequently services users would have in the policy implementation process. For example the Director of Primary Care at the Health Authority in the case study saw virtually no role for consumer involvement as she considered that non-executive Directors constituted a form of consultation and representation of patients and potential service users views. So although the 1991 reforms promoted consumerism through more involvement in the process of care and the decision making process with regard to local policy there are arguments which indicate bureaucracy and internal disputes negated accountability and diminished the value of consultation and the role of consumers. One of the few attempts to assess lay and professional views on the choice between equity and cost effectiveness has suggested that, *" people place greater importance on equity than is reflected by cost effectiveness analysis.....basing health care priorities on cost effectiveness may not be possible without incorporating explicit considerations of equity into cost effectiveness analysis",* (Ubel et al 1996).

With regard to the local case study, women were consulted about their experiences of

Team Midwifery and no-change maternity care and these views were subsequently fed back to the key decision makers via the final evaluation report (Tinkler and Quinney 1995). However there was no scope for local women to engage in any of the negotiations which took place after findings from both evaluations had been disseminated. This was a missed opportunity for the local public to observe the complexities and difficulties the purchaser and provider relationship had created. The public had been consulted but they had not been given the opportunity to engage in a process where they were informed, allowed to deliberate and contribute to the end result. This imbalance in the decision making process undermines 'consumerism' promoted by all of the recent NHS reforms and recommendations for woman centred care and informed choice in *Changing Childbirth.*

Prioritisation as an issue has moved up the political and public agenda but this conversely works against the patient in less obvious ways, i.e. patient expectations can no longer be met because those expectations are increasingly deemed to be unrealistic.

**Patients as consumers - pure rhetoric ?**

Being a 'consumer' implies the power to purchase and the power to choose what to purchase, I would argue that patients are not consumers and even their proxy consumers, Health Authorities and GP Fundholders (and now primary care group/Trust boards), are either constrained in their choices, financially, or restrict the choices they give to women, professionally. The introduction of the notion of the patient as a consumer of healthcare was a key component of the 1991 reforms which Margaret Thatcher hoped would contribute to the weakening of medical professional autonomy and control. At the same time she wanted to promote and generate a culture of 'consumers' willing to pay for private health care via individualised insurance policies.

The purchaser/ provider split did not appear to stifle the power or autonomy of clinicians and competition between hospital Trusts resulted in the need for them to attract highly

skilled consultants with powerful reputations to attract 'customers' and contracts. Health Authorities had little control over these appointments other than restricting monies allocated to particular hospital departments. However, as I have revealed in this case study, where Health Authorities are geographically dependent on only a few key providers block contracting prevailed, allowing the potential in-house redistribution of resources beyond the control of the district Health Authority.

Although managerialism, as a legacy of Thatcherism, may challenge bureau-professional power, the position of users of health care, in this instance women, is limited in relation to their involvement in expressions of choice and the decision making process. There may have been an increase in the structural opportunities to complain about services for example but little opportunity to participate in normative and agenda setting arenas of power. Devolved decision making (local freedoms) has not yet achieved the 'transparency' it promotes.

The restructuring of maternity services in the local case study was promoted in the interests of women and to a lesser extent midwives. Women, and midwives as women and thus potential service users, became caught up and sub-sumed by organisational power struggles associated with legitimising decisions and roles. Women 'perceived' they were receiving better care (Tinkler and Quinney 1998) but a lack of further consultation denied more comprehensive verification of this. In addition women were also denied the opportunity as service users, and potential service users, to even enter the debate about competing demands on Health Authority resources and difficulties associated with this. If more transparency was available, women may have opted to agree with the Health Authority and their scepticism about additional costs. For example citizens juries and health panels have shown the capabilities of members of the public in their ability to make informed opinions. (Dowsell et al 1997).

Consumerism, I propose, is therefore an inappropriate term to use in relation to patients, partly because it does not reflect the real role of patients or the potential role they could

have as contributors and participants in their own care and service use. Choice in this case study was firmly rooted in a context of restrictions and selective choices based on professional judgement and preference and availability of information.

I saw little evidence of any 'consumer involvement' in the post evaluation stages of the negotiation and decision making process that followed. Given that this was conducted over a substantial period of time there was scope to either re-visit issues highlighted by women who had experienced Team Midwifery or at least build upon the information yielded from those experiences. Introducing market principles to the NHS was seen as a means of addressing the needs of the consumer but this was set at a macro policy level. At a meso and micro level it was contested through the continued dominance of professionals and not fulfilled by the new managerialism because they too were creating a power base and reconstructing their own roles.

The case study has demonstrated that implementation of national and local policy initiatives, and the decision making process integral to it, was relatively exclusive, i.e. in the domain of a few powerful key individuals. Devolvement of decision making does not therefore necessarily result in a more democratic or equitable policy implementation outcome, although the relationship between policy and the democratic process has recently been highlighted, *" health policy is about the well being of the people. If those people are excluded from the process of framing it, its effectiveness is almost certainly weakened. It is time for health policy to emerge from the shadows and become truly democratic"*, (Neuberger 2000). The challenge therefore is to make sure that health policy does not dis-empower either the recipients or the providers.

**Policy implementation and power**

Despite the efforts of local initiatives, i.e. Team Midwifery , *Changing Childbirth* as a policy and a political statement has perhaps ran out of time. An incremental approach to change, although perhaps more legitimate for a consensual approach, has resulted in

other more urgent and politically sensitive issues emerging during times of constant change, i.e. mental health and care of the elderly. Choice based on women's, and midwives, preferences in a climate of efficiency and rationing and prioritising seem fundamentally contradictory, particularly without a great body of rigorous economic evidence to support the wider implementation of Team Midwifery . The continued struggle by the medical profession to maintain their status and power will continue, perhaps even more so in an evidence based climate of service delivery. However their 'influence' regarding organisational and financial matters will probably remain as Consultants may attract additional funding via research projects and relationships with drug companies. More junior staff usually do not have that type of financial attachment, *" in the health field high status medical professionals may have an important direct or indirect effect on, for example, health manpower policy. Doctors often hold the last card in negotiating .........hospital porters or midwives do not have the same level of influence"*, (Walt 1994, p38).

If, as Walt suggests, there is a lack of opportunity for lower rank health professionals to influence decisions then it is questionable whether a supposed culture of consumerism promoted by the reforms of the early nineties would have enough strength to alter power relations between staff and patients. That is why I have persisted to suggest that national policy may create the opportunity to *shift* power relationships between groups but because it is implemented in a dialectical way a *radical re-distribution* is unlikely in the short and medium term..

Walt (1994) has suggested the policy process, and by this I also mean its implementation and any associated problems (barriers) are never resolved straightaway with revision being a constant feature of the process (ibid, p 49), then an incremental approach is inevitable. The key early failures of the incremental approach adopted in the case study (by default) was a structural and strategic inability to allow and engender participatory negotiation. Subsequent negotiations and a continued effort within the hospital Trust to develop a model which suited financial and acceptable working arrangements for

midwives resulted in a district wide model of Team Midwifery in April 1998. The purchaser provider split and the culture it created contributed to this failure, which is in opposition to 'consumerism', choice and involvement in the process of care that the 1991 reforms promoted The incremental approach, as a potential unintended consequence of policy implementation appeared to produce a slight re-adjustment in the power relations and levels of conflict between professional and managerial groups. For patients however the incremental approach does not appear to have resulted in a significant re-definition of their role in the NHS system as a result of the 1991 reforms.

This policy outcome then leads me to question whether or not this implementation context has implications for the culture of macro policy making, i.e. society centred or state centred. As maternity services were not perceived to be a priority this became a 'rational' basis for negotiation by the local key decision makers, and consequently less state intervention and more local freedoms can result in less palatable decisions for certain groups of service users. Therefore the rise of 'corporatism' with power transferring from elected representatives to institutional interests, (Walt 1994, p36) and the hands of a few corporate rationalizers, i.e. chief executives as public sector entrepreneurs, was evident. Primary Care Groups and Primary Care Trusts (DoH 1997) as new organisational structures at district level may only replicate the above policy implementation process, *" implementation of policy is therefore heavily dependent on the extent to which the centre can expect lower level authorities to follow its guidelines "*, (Walt 1994, p161).

In relation to different existing models of maternity care and in terms of delivering and targeting healthcare based on an assessment of different needs, women could potentially be receiving less choice as there is a very real potential that services will be based on GP preferences in a particular primary care group/Trust. Policy developments in primary care are increasing the role of GPs as proxy consumers for their patients. Assessment of need at a more localised community level may lead to more responsive services. However the formation of Primary Care Groups and Primary Care Trusts assumes to a

certain extent that some sort of cohesion exists between general practices and health centres in a given geographical area. Yet the diversity of general practice was apparent in the evaluation of Team Midwifery (Tinkler and Quinney 1995). Informed choice for maternity care and other types of health care is an ideal and only as good as the information provided by assessors and providers of care unless patients have the time to study, understand and access computer based information systems, i.e. the Internet and the Cochrane reviews. Medical practitioners will for the foreseeable future dominate choice and consequently care. In relation to the local case study this type of situation negates the likelihood of a district wide maternity service based on consensus, collaboration and participation.

The Health Authority has to ensure (explicitly) provision of good quality effective health care, kept a control on spending and be accountable for its distribution of funds and decisions. Hospital Trust's competed for these funds, particularly a share of any growth monies and at the same time trying to manage their own industrial relations. Primary care groups/Trusts, at board level, have managerial decision making responsibilities of Health Authorities and in time will be assessors and providers of care. Policy locally will therefore become increasingly dependent on the role and style of management, when the operational and corporate are merged the need for research into policy implementation and organisational analysis will be paramount.

Implementation of national policy at a local level will inevitably be diluted policy partly because national policy documentation will contain political statements that are not fully translated at a local level for cultural and historical reasons and partly because of the dialectical nature of the policy implementation process. In addition to this, or rather in parallel, are the contradictions which previous and subsequent polices generate - therefore the 'dilution' is not only a facet of local power relations and the historical context of professional roles and relationships but an inescapable response / constraint of NHS reform in the late twentieth and early twenty first century.

**The research process – my role and the methodology**

The role I adopted was opportunistic but it served to place me in an ideal situation from a research perspective. This post evaluation role which embraced the dynamics of organisational decision making was in the tradition of social research. Yet it also strove to break new ground as I was also attempting to gain an understanding of a process and culture I was part of and belonged to before and after the fieldwork took place. So although I adhered to the following, *"the qualitative analyst seeks to provide an explicit rendering of the structure, order and patterns found among a set of participants"*, (Lofland, 1971, p7). I also wanted to illustrate the value of the duality of the role and its relationship with research into NHS policy implementation.

Although sociological descriptions are in the main concerned with everyday life interactions and situations, interpretation can sometimes result in an element of dehumanisation as the researcher seeks to attach meaningful labels to what she or he has observed. To an extent this resonates with the role I adopted in fulfilling the duality of being an employee and an opportunistic observing participant. Detachment was required for interpretation and validity checks but attachment was required for the research context overall and the policy system under study.

Being an employee of the organisation I chose to study meant that I did have to distance myself from the situation I was studying to conceptualise the research context and findings. But the process and duality of roles meant I moved in and out of the field with relative ease and gave me some control over my fieldwork role. The value of adopting a 'fourth generation' stage of research meant that studying the 'process' of policy implementation, i.e. post pilot service evaluation, revealed culminating factors of a particular outcome. Attachment to the organisation and area of research prior to the fieldwork provided the scope to do this also.

The dual role I adopted served to provide a unique fieldwork context to conduct policy

research in. The role afforded me the opportunity for internal validation of observations enabling a reliability check with some of my research questions. This process served to generate further research questions and helped frame the research into concepts that developed the structure of the thesis. Reflecting on my employee role as a result of the research process enabled me to consider the role and function of the organisation in more depth and enhanced my reflexivity. This enhanced insight, as I deemed it, meant I could structure the interpretation on the basis of a better understanding of those cultural and relational components which would have had an influence on how *Changing Childbirth* was received and implemented. I also came to perceive my role in the organisation as superficial in terms of it being used to fulfil a function which was confined to enhancing the role of evaluation of service delivery but not using the process, the methodology or the findings to their full potential. Analysis of *Changing Childbirth* activity in other areas provided some external judgement of the impact of my role, as researcher and employee, on the process I was engaged in for the three year span of the case study.

The research process therefore did enable me to generate an understanding of why my role as an employee felt limited as I concluded that non-decision making, as a source of power, was evident locally. This was strengthened by a lack of target setting and performance management nationally and underpinned by inter-professional conflict.

In the role of opportunistic observing participant I also reflected on the significance of researching the organisation I was employed by. The critical aspect of this role was how I was able to re-visit and re-assess the post Team Midwifery evaluation context and observe how findings were received and used. One key observation in relation to my role was an unfulfilled expectation that my objectivity and independence would be questioned on my return from secondment. As this was not forthcoming and as non-decision making ensued I was left to conclude that I had either managed successfully to re-integrate myself into the system or it was related to a general apathy on the behalf of colleagues and research subjects.

However it may also represent the importance of being able to research an organisation from the inside with a given role that meant a contribution to the organisation was established through legitimate means. The importance and value of qualitative research and methodologies is recognised even within some spheres of the medical journals , most notably the BMJ. Others have gone as far as suggesting that, *"qualitative analysis may be crucial for good policy decisions"*, (Jessop 1999, p365-366).

I would add that it may be useful in determining bad policy decisions so lessons can be learnt and shared more openly. It is encouraging to see that one of the most respected health policy analysts has chosen a qualitative approach to reflect on the conservative reforms of the late eighties and early nineties, (Ham 2000). Now that qualitative research is more acceptable the use of innovative adaptations of existing methodologies should be further explored and promoted.

# 9 Concluding Observations

**Effects of the 1991 reforms - the failure of organisational control and inadequacies of inter-professional relationships.**

The remit of a Health Authority in the managed market was to try and ensure that the best use of resources was being made for the benefit of patients and the NHS. Reforms to the NHS have persistently sought to change relationships, *" between the state and the economy, the state and society and the state and the citizen",* (Clarke and Newman, 1997, p1).

National responsibilities and local freedoms is a situation that almost immediately suggests contradictions and the erosion of values embedded in a national equitable system set up to care. In contrast to this but operating at a parallel level was the continued, *"tortuous negotiations about the place and role of medical power in the formation of the National Health Service",* (Clarke and Newman, 1997, p6).

Recent reforms to the NHS have then created the potential for a role exchange in terms of characteristics related to professional dominance and hierarchical control. Managers have had to demonstrate expert knowledge, autonomy, informed judgement and innovation whilst doctors are expected to comply with more routinized practices and standardisation of procedures and decisions to treat, i.e. evidence based medicine. It would appear that something akin to a role reversal may have taken place with entrepreneurial managers making use of local freedoms in their capacity to implement and manage change whilst senior clinicians are potentially subject to more controls in their day to day working practices.

However any effect from this context is likely to be weak as demonstrated by the various scandals involving the lack of control over inadequate clinicians which emerged during 1998 and which led to the profession having to highlight its own inadequacies

publicly (Horton 1998a, 1998b). Additionally the power of managers charged with ensuring that money follows patients and that resources are deployed effectively is also questionable if we consider that in the case study a lack of detailed contractual information made it impossible to assess the true costs of episodes of care and treatment. *This would therefore make it almost impossible to fully demonstrate how resources were deployed and meant that* "the conception of management ..centred on subordinating public sector organisations to the principles of what might be described as good housekeeping", *(Clarke and Newman 1997, p58), appear something of a redundant concept.*

Medical and more recently managerial dominance and intra and inter organisational power relations are probably the analytical key to understanding and explaining the inadequacies of health service policy implementation. I conclude from the case study that policy implementation can create a shift but not a re-distribution of power. Further research is required to gauge whether this finding is applicable to other NHS policies. A real change in power structures could take another ten years of 'consistent' policy making which continues to challenge (implicitly and explicitly) professional dominance, particularly medical. That is why I consider the National Plan (DoH 2000) from the Labour government is a significant document. The long term vision it encompasses and the whole systems approach it sets out has the potential to challenge the root causes of the inadequacies of the NHS, i.e. professional power, inequity and beaurocratic decision making. This challenge also has to incorporate processes and structures which ensure that one powerful group is simply not just replaced by another.

This case study has sought to highlight the potential for the emergence of public sector managerial power based on egocentric personalities and a policy context which appeared to necessitate a continual re-invention of roles and power relations. 'Career managers' (Tilley, 1993) are then engaged in a system where, in the long term, they offer little stability to the organisation they are employed by and this has inevitable consequences for policy implementation. Not only is policy diluted because of historical inter-

professional power and conflict but also because those charged with ensuring its strategic direction are not around long enough to 'manage ' its full implementation. The individualism engendered by changes to the culture of the NHS through the 1991 reforms and the legacy of Thatcherism mean staff, particularly senior managers, are concerned with securing their next professional career move again.

If Primary Care Groups and Primary Care Trusts are to succeed in local policy implementation as it is intended by central government a culture of mutual respect between professionals and managers, new patterns of working relationships and partnerships with patients are crucial to their strategic and operational plans. The corporatisation of the public sector , i.e. organisational logo's, mission statements and business plan's gives an identity to an organisation which in effect divorces it from a national identity. The NHS becomes secondary to the Health Authority or Trust, their semi-autonomous roles are thus engendering a loyalty to the organisation (or no loyalty at all) and this creates new dynamics and conflicts.

A constantly changing policy environment generated such instability in the workplace that any remaining remnants of some of the more positive aspects of the 'old NHS', (i.e. caring, commitment, vocation and a sense of worth) were beginning to be displaced by more instrumental and transitionary conditions. Structural and operational changes to the NHS during the last two decades have been concerned with a change in ideology of how health care should be 'managed'. Clarke and Newman (1997) have argued that this has been a movement towards a managerial state. I have sought to understand in this thesis what some of the new structures and operational changes have meant for managers, providers of care and to a lesser extent (but arguably the most important) recipients of services. I have attempted to do this through interpretation of implementation of national policy at a local district level which has revealed general overt and hidden complexities.

Policy implementation is a complex process particularly when the policy is promoting

changes to the way services are managed and delivered. This change process is often related to challenging hierarchies, control systems and power relations between professional and managerial groups. Yet health care re-organisaton in recent years has become the norm and appears to have generated regular movement of senior key decisions makers (i.e. chief executives) from post to post in relatively short spaces of time. This creates the potential for constant destablisation of systems making it difficult to implement policy as it was intended and ripe for continual conflict between individuals and groups in positions of power. The historical inability of the NHS to control the medical profession has possibly been exacerbated by continual national policy making. But the fact that the NHS is used time and time again as a political football between the main political parties, particularly during election times, has ensured that the policy machine will continue, *" the proliferation of policies stems from a government seeking to control an unstable field of policy delivery in which issues and problems repeatedly refuse to be depoliticised"* (Clarke and Newman 1997, p145)

Primary Care Groups and Trusts (DoH 1997) require flexible, innovative organisational planning and effective management to fare better than the now defunct GP fundholder and Health Authority purchaser role. The managed market approach appears not to have been appropriate for patients or providers of care and escalated management costs in the NHS.

The labour government in the New NHS Plan recognise the failure of the 1991 reforms and introduction of the internal market in the following way, *"by fragmenting the NHS, standards remained variable and best practice was not shared. Competition between hospitals was a weak lever for improvement because most areas were only served by one or two local general hospitals......the market ethos undermined teamwork between professionals and organisations vital to patient-centred care. And it hampered planing across the NHS as a whole....."*, (DoH 2000, p56).

## Changing Childbirth

Midwives and other less senior professionals still face restrictions on their capacity and professional resource to influence policy. Many midwives will not have been equipped to meet the challenges of *Changing Childbirth* (DoH 1993) nor the consequential power struggles with other professionals and managers that ensued. Their working patterns, ways of thinking and opportunities for development will have been controlled to suit the continuation of a fragmented medically orientated system of care.

Developments in maternity policy have historically reflected an ideological pursuit of improvement to maternal satisfaction with care coupled with a desire to make midwifery as a chosen profession more fulfilling and rewarding. Both of these factors sit comfortably with a broad public health perspective in relation to the planning and delivery of health care. However reconciling this agenda with an increased emphasis on technical and pharmaceutical innovation within an increasingly more explicit rationing agenda is problematic to the extent that the concept of 'health' needs to be redefined, *" the purpose of health care for individuals and society will be found elsewhere than in the complex network of political and economic forces that give it institutional definition and significantly control its operation "*, (Hill 1996, p785).

Despite more apparent control and scrutiny of clinicians and GPs through clinical effectiveness, medical audit and evidence based medicine, these dominant professional groups are still the gatekeepers of different aspects of treatment and care and as such will continue to maintain positions of dominance. The physical and *'social arrangement of the hospital relies on practices which revolve around legitimation'* (May 1992) and in addition doctors still continue to determine who the patient is and what should be done to them (Porter 1992).

Team Midwifery in its form for the local pilot scheme had the potential to challenge professional dominance and knowledge. It afforded the opportunity to empower women

as service users and as midwives. It was apparent that midwives were having to struggle to obtain greater autonomy in their working practices and this could have had an impact on the amount of autonomy they were able to transfer women. There was a potential danger in the new model of service delivery that meant midwives may have replaced GPs and obstetricians in their roles as proxy consumers for women. The Thatcher government did not want citizens as a collective entity, they wanted consumers as individuals in pursuit of their own ends but neither existed in the quasi- market system.

Patients may have been more informed but I am not convinced that exercising real choice was achieved. Therefore midwives, by creating a certain autonomous space for themselves, ran the risk of adapting themselves to a system of care which mirrored the one they had been subordinate to, i.e. a hierarchy of professionals exercising power and caring *for* patients not *with* them.

In 1998 a report by the standing nursing and midwifery advisory committee (DoH 1998c) was published which sought to provide an overview of current midwifery practice and models of maternity care. It located its findings within a historical policy context, identifying issues which still needed to be addressed. Some of the key conclusions and recommendations are listed below. The report found:

(i) a wide variation in midwifery practice;
(ii) progress towards national policy, i.e. *Changing Childbirth* faces real problems;
(iii) midwives have an important contribution to make to strategic planning, purchasing and risk management;
(iv) the transition to models of care providing continuity of care and carer should be properly planned, resourced and evaluated;
(v) national policies.....have not been universally translated into commissioning strategies at Health Authority and Board level;
(vi) Team Midwifery is in the middle of a continuum of a structural transition

towards caseload midwifery[17];

(vii) more flexible arrangements in primary care should provide the opportunity and incentive for professionals to use their skills to the full; and

(viii) the midwifery profession is in transition and effective education and training is paramount

Reference was also made to research which noted that midwives and their supervisors acknowledged the need for more effective skills in the management of change, accountability and autonomy and the effective use of resources, (DoH 1998c, p27). This reflects not only a profession recognising the effects of historical limitations on their role but indicates a structural lack of progress towards enabling midwives to reach their full potential as practitioners.

The report re-iterated recommendations set out in *Changing Childbirth* and it highlighted slow but steady progress towards this national policy. However it also demonstrated that maternity care and service delivery in Great Britain was, and still is, in transition and working towards original policy intentions. In effect it has took one district Health Authority five years to reach a half way stage on a continuum that regards Caseload midwifery as potentially the most appropriate and effective model of maternity care (DoH 1998c, p15).

*Changing Childbirth* as a policy document was too symbolic, it lacked robust performance monitoring, failed to address remuneration to GPs and lacked indicators which were not formally enforceable targets. This weakened its impact from an early stage. Midwives, in the main, have 'developed' in a bureaucratic and monetarist culture where they are rewarded for meeting indicators which may bear little relation to relationships and quality of care to women. *Changing Childbirth* was introduced into a system whose dominant principles are contradictory to it.

---

[17] The Caseload Model - an individual midwife or a small team of midwives provide the majority of maternity care for a defined number of women, with the intention to be available for the birth whenever possible (DoH, 1998c, pp 10 - 11)

The interpretation and discussion have attempted to demonstrate how implementation of *Changing Childbirth* was continually being undermined by struggles for professional dominance and the legacy of the medicalisation of childbirth, encouraged by the creation of the NHS since 1948. In addition policy and guidance from the 'Centre', i.e. the National Health Service Executive (NHSE) and the Department of Health often served to undermine rather than enable the implementation of *Changing Childbirth*.

The substance of *Changing Childbirth* was however not unproblematic. The weakness of the indicators of success to effectively drive the implementation of policy and service change and the potential duality of evidence based medicine to deny patients the recognition as co-producers of their own healthcare hampered its acceptance. Ironically if *Changing Childbirth* had been a National Service Framework (NSF) there may have been more effective implementation of this policy and it would have been viewed as a forerunner to a whole systems approach to service delivery. The lack of targets and clear strategic organisational and workforce development plans resulted in something of a crisis for the NHS when an article in the BMJ suggested that over 350 obstetricians and gynaecologists could be made redundant, *"the BMA has warned that by May 2001 there will be an additional 500 specialists with the certificate of completion of specialist training in obstetrics and gynaecology to fill an estimated 50 consultant posts"*, (Beecham 1999).

Thus a lack of performance management and workforce planning were, I suggest, fundamental to the success or failure of its implementation. *Changing Childbirth* had many of the components essential for an NSF as it attempted to embrace the primary and secondary care interface but it lacked levers and ultimately national literature and the case study findings point to 'local freedoms' having determined its failure.

The Royal College of Midwives have recently argued for an NSF for maternity care (Ryan 2000) and have produced a new document outlining their vision of the future

development of maternity services, *Vision 2000* (RCM 2000). Twelve key principles are described and an emphasis on shifting the management of services to primary care, developing autonomous midwifery group practices and reducing the unnecessary medicalisation of normal pregnancy reflect continuing problems that have yet to be addressed through previous policies.

The fact that a new vision has had to be produced indicates a wider failure of *Changing Childbirth* beyond the confines of the findings of this case study. A further irony is the seemingly increasing medicalisation of childbirth as the level of caesarean sections is reported to have risen to 20% with an acceptable level being deemed 10% (Shifrin and Agnew 2000). The concern raised by such an increase is reflected both in the NHS as a national audit of Caesarean sections has recently been funded by the DoH (RCOG 1999) and in the media were one report on the issue listed those hospitals with the highest percentages of caesarean rates which ranged from 27% - 22%, (Marsh 1999).. It seems a poor reflection on *Changing Childbirth* which sought to also promote more care in the community and less unnecessary intervention that the above has happened and the new vision has to further emphasise the need for pregnancy to be seen as 'normal'.

The new national plan (DoH 2000) makes little reference to midwives specifically although their capacity to be public health practitioners is recognised (DoH 2000, p.84). The need to enable them to progress from an E grade to an F grade rapidly, (DoH 2000, p52) may be recognition of the additional skills and responsibilities required to deliver models of care like Team Midwifery . The RCM may however still have some difficulty convincing the government to invest in a NSF for maternity care despite obstetric claims amounting to approximately 50% of the costs of the clinical negligence scheme administered by the NHS litigation authority, (Shifrin and Agnew 2000).

**Managerialism**

'Failure' of the 1991 reforms could be attributed to management and the lack of suitable

performance systems to judge them by. As Hunter suggests, *'an assessment of the value of many activities in government generally, and healthcare in particular, requires soft judgement which lies outside of the sphere of hard measurement',* (Hunter 1996a).

In addition he also acknowledged that 'trust' is essential for any successful enterprise and managerially in the local case study a lack of trust undermined the successful implementation of the pilot model of Team Midwifery . Public sector entrepreneurs shaped the dynamics of some of the power relationships associated with contract negotiations. The threat of arbitration was a tactic and used to create more tension and define a managerial reference of significance, i.e. a role dimension. The final last minute agreement reached during a one to one telephone conversation between the hospital Trust and Health Authority Chief Executives demonstrated the autonomous power such individuals can have. This, it would seem, is a significant function of their role. The annual contracting cycle the 1991 reforms created supported this almost maverick behaviour, not unlike the role historically occupied by hospital consultants. Although the new Labour government have partly dismantled the internal market (DoH 1997a) the purchaser provider split between commissioners of health care and providers of healthcare will still remain in part and as such this new policy context provides further scope for Chief Executives to nurture their entrepreneurial role. The creation of Primary Care Groups/Trusts will actually increase the number of Chief Executives operating within each district Health Authority so justification and legitimisation of these newer roles will create further power struggles.

The introduction of Primary Care Groups and Primary Care Trusts (DoH 1997a) may enable other less powerful professionals, i.e. community nurses, therapists, to engage in more strategic and influential roles but to assess the impact of this quite radical re-organisation of the NHS necessitates analysis of practices and processes at a meso and micro level. With the continued pace of change and reform it would be interesting to further study the roles of managers who may have difficulty sustaining their power and status. As I suggest they have less long term' job currency' than medical and nursing

professionals. Managers thus have more to lose and more to prove which therefore necessitates a Public Sector Entrepreneur type. However the continuing re-organisation of the NHS has made it a dynamic but challenging place to function in as a manager and it has been suggested that the discordance and conflict and stress this engenders prevents managers from managing, (Borrill and Haynes 2000). The capacity of chief executives to lead may be constrained by the political climate, central policy and local clinicians, or all three.

Arguments put forward by Mechanic in 1991 regarding the alleged proletarization of physicians hold some relevance now, *"while physicians are less autonomous than they used to be, the constraints imposed on them fall within a medical paradigm "*, (Mechanic, 1991, p485). In turn the State has encouraged dependency and the need for healthy people to be reassured, the legacy of over 50 years of 'coercive healthism' will continue in spite of a new policy drive to make the health service a public health NHS. Managers are trying to compromise the Thatcherite legacy without returning to old regimes of bureaucracy and dominance of medical professional power. The lack of real competition and even contestability in the district discussed in the thesis reveals how purchasers had to find ways of fulfilling their purchaser role. Identities had to be established inter and intra-organisationally, *" one of the key characteristics of managerial discourse is the way in which it constitutes managers as active agents - as change mobilizers, dynamic entrepreneurs...... "*, (Clarke and Newman 1997, p93)

However it has also been suggested that purchasers in their role as commissioners of services were intrinsically operating to contain the existing demand for health care (Opit 1993, p88). In view of this purchasing managers handled the issue of maternity care in the case study against a culture of cost containment and a view that 'need' as such was being met. Although real purchasing is about proper needs assessment involving the public, the spatial monopoly in the district studied suggested that other than contestability, translated into quality in contracts, there was little scope for real 'purchaser' influence as it was intended.

**Implications for research and the NHS R&D programme**

A Lack of research on policy implementation and 'policy consequence' (Clarke and Newman 1997, p21) has been noted. The case study has attempted to address this gap and also stimulate more research which focuses on the process of policy implementation at a meso and micro level. There is a definite need for case study research which focuses on processes, negotiation and decision making to learn about barriers to policy implementation other than historically accepted one's, i.e. inter-professional rivalry. Research of this type is required to understand local power relations and their impact on policy implementation and to inform future planning and service delivery. It is necessary because successful and consensual policy implementation is needed which reduces the time and effort it takes to effect change for the benefits of patients and potential service users.

The identification of the need for descriptive and hypothesis generating primary research was identified after the publication of *Changing Childbirth*, *"studies are needed to examine the process of research implementation and the role of policy influences. This would be particularly helpful in particular services where policy guidance has resulted in changes in practice......research in this area might use case studies to examine particular policy initiatives and explore the factors affecting changes in practice in health care"*, (DoH 1995).

Five years later this message is re-iterated in a policy book on the future of the NHS, *"the resources devoted to understanding the NHS as a system for example in the area of service delivery and organisation, and human resources remain tiny...... the priorities of the NHS R&D programme need to be pushed further towards operational, organisational and policy issues"*, (Harrison and Dixon 2000, p8).

Not only is there a need therefore for different research approaches to address health

policy questions but also exploration of factors which may (or may not) affect changes in practice. From this case study and the unique and opportunistic field role adopted I have been able to gain an insight into some of these 'factors' which have been the result of wider macro structural policy initiatives. Whilst I cannot make any generalisations from my findings I have been able to show the significance of local structures and power relations and their impact on policy implementation.

The importance of using a particular type of methodology at certain stages of the implementation process has also been highlighted in the methodology and through a description and analysis of my research role. This has implications for research into NHS policy, organisations, staff and patients. There is a need for more primary research which focuses on the meso level of policy and strategy development both during and after its implementation, "*managerialised politics does not just concern the effectiveness of institutions, but involves the managerialisation of the policy domain itself, which influences not only the structures and institutions, but the discourses and frameworks within which deliberation and evaluation takes place* ", (Clarke and Newman 1997, p148)

This is why there is a need for fourth generation evaluation (Guba and Lincoln 1987), " *research that is system orientated, that introduces new paradigms.....will be ignored unless it fits with policy makers ideology......research on routine health services may well feed directly into policy changes....*", (Walt 1994, p200). With a quasi-market ideology and economic imperatives still setting boundaries in health care decision making there is an urgent need to address and research policy changes that seek to change the structure of delivery of health care , i.e. *Changing Childbirth*, in a meaningful way to local decision makers.

**Policy implementation: local freedoms and national responsibilities**

The above interpretation and study of power roles of the key negotiators in the policy

implementation context were fundamental to the thesis because it demonstrated support for my suggested arguments, most notably the shift, and not anticipated re-distribution, of power. It also raises questions however about the relationship between national responsibilities and local freedoms and how the demands of one may affect the intentions of the other. Ultimately, from the perspective of material presented in the case study it would appear that national policy remains distant whilst strategic and operational change can become bound up in ritualised negotiations removed from the real organisation and delivery of care.

The case study has demonstrated that, during times of a general policy shift in the culture of the NHS, policy introduced to fundamentally challenge local decision makers can further complicate professional dominance. The use of local freedoms and the capacity to prioritise locally can lead to inequity of provision of a type of care within and between districts. This type of inequity is far more subtle and potentially hidden from the more explicit rationing of expensive drugs, i.e. beta interferon for people with a diagnosis of multiple sclerosis. Primary Care Groups/Trusts (DoH 1997a) have the potential to integrate policy and produce operational change and delivery of care for the benefit of patients and lower rank professionals. Conversely they also have the potential to replicate the above scenario, i.e. a shift in power resulting in ritualised negotiation for the benefit of senior professionals ego's.

The future of health policy and health care delivery still remains unclear and Klein (1997b) has suggested that there are two potential scenarios. One where 'social solidarity' engendered by the NHS cannot be supported by a continued drive to contain the tax burden. The other representing a continued incremental approach to existing organisational patterns of care whereby, as I have argued, the 'new style NHS' succeeds in re-inventing itself. The 'third way', (DoH 1997) still reflected a commitment to national responsibilities and local freedoms, i.e. decentralisation of decision making. The new national plan continues with this theme (DoH 2000), *"the relationship between central government and the NHS has varied between command and control and market*

*fragmentation. Neither model works. The NHS cannot be run from Whitehall"*, (DoH 2000, p30). Yet leading academics have suggested that the government may have to take a more interventionist role, *" it is arguable that the NHS in its present form is unmanageable in the sense that the centre cannot reliably set out a policy in the secure knowledge that it will be implemented in line with its expectations... either the centre must be able to control the NHS or reduce the scope of its ambitions"*, (Harrison and Dixon 2000, p257).

However there has also been the perception that the sub-text of the national plan does promote centralisation and the cost of this is stifled innovation in favour of setting national standards and reducing variations, (Klein and Dixon 2000). The theme of 'trade-offs' for me therefore persists in this analysis of the new National Plan. Variations can be good with the potential for inequity for patients and centralisation can be good but may/ will hamper policy implementation at a local level. The extra funding the NHS will receive (£14.9 billion by 2004) should make a difference to staff and patients but top down policy making does not appear to sit comfortably with NHS professionals, managers or academics.

The historical lack of control and direction evident throughout the life of the NHS represents the 'political' agreement that took place between the medical profession and the government in power when the NHS was first introduced in 1948. This compromise laid the foundations for a legacy of professional medical dominance of the NHS in both a hospital and primary care setting. The medicalisation of childbirth, in my view, epitomises this legacy. The NHS and Community Care Act of 1990 had the potential to address 'system design' in its attempt to reduce provider dominance, particularly in the acute sector. However the impact of Health Authorities as purchasers has been viewed as limited, *"they did not have the knowledge, data or the clinical expertise"*, (Harrison and Dixon 2000, p128).

The new national plan echoes the above observations, *"managers cannot compare costs*

*of services or establish how different staff and organisations are delivering different results for patients. Too often they have to rely on outdated or generalised data....."*, (DoH 2000, p29). The growing emphasis on whole systems of care (DoH 2000) is being used to ensure that there is greater equity of provision and this I suggest leads inevitably to a trade off between national responsibilities and local freedoms. This trade off may mean less scope for local freedoms but it may ensure more equitable provision of services thus ending treatment by postcode. It may also engender more robust performance assessment mechanisms although the development of primary care groups and primary care trusts could still produce wide variations in service delivery. Recent research in the Netherlands (Stronks et al, 1997) has shown that patients are more likely than healthcare professionals to exclude relatively inexpensive services when faced with prioritisation dilemmas. Therefore localising decisions within districts and between primary care groups in a culture of individualism as opposed to collectivism could see further inequities in health care provision. Policy analysis of national responsibilities and local freedoms has its work cut out.

I have learnt that change is constant and dialectical and that an appreciation of this is essential for public policy research. This leads me to make some concluding comments which focus on observations in the thesis in relation to NHS Policy.

**Implications for the future NHS policy agenda**

Health care reform has in the main failed to effectively monitor the process of policy implementation. Decision making has not always had a positive impact on the division of labour or outcomes for patients. The marketisation of health care systems and intensive organizational change it demands generates a need for, *".....a framework of change that will inform policy and technical decisions about the direction of reform, its potential impact and desirable, as well as undesirable, consequences."*, (Duran-Arenas and Lopez-Cervantes 1996).

Through my analysis of the local case study I have attempted to show that policy implementation is dependent on power relationships and the prioritisation process at a meso and micro level. In addition the national policy agenda does not remain static long enough to allow local policy implementation as it was intended. NHS policy also appears to have a habit of perpetuating an implicit struggle for resources between parts of the system that serve to negate collaborative working practices between health sectors.

As Walt (1994) has argued health policy is synonymous with health politics, an interplay of power relations and a struggle for resources (budgets and patients) between professional groups. Inevitably with the rise of the public sector entrepreneur there was also a power struggle regarding the decision making process, the control of it and justification of that control. The dilution of policy and conditions which determine participation in the decision making process have been revealed through the case study.

Through the new national plan (DoH 2000) de-centralisation is still promoted and commissioning at community and primary care level is pursued through the proposed developments of Care Trusts (DoH 2000, p73). Although the Labour government have disbanded Fundholding on the basis of inequity I envisage conflict between the level of autonomy a Primary Care Trust and Care Trust may be given and performance management mechanisms that expect compliance with a national agenda of priorities, i.e. NSFs. Local freedoms and national responsibilities may co-exist but so too will inequity, *"it is possible that in five years time the NHS will continue to display a variety of purchasing and providing structures within primary care. The same might be true of management structures administering primary care groups"*, (Harrison and Dixon 2000, p156)

The NHS and the public are constantly faced with a 'trade off' scenario, and always have been, because for greater equity to exist I suggest that more direct control is inevitable. Some services may actually benefit from this approach thus ending treatment

and service delivery by postcode. However professionals will also continue to resist impositions and restrictions on their autonomy and professional decision making. Local freedoms and national responsibilities presents a dynamic that requires one component to dominate the other. Policy makers need to be far more sensitive to this dynamic and the NHS as a whole system needs to decide whether equity takes precedence over local freedoms and local innovation.

The complexity of policy making and its implementation has increasingly meant the government in power and its civil servant arm, the National Health Service Executive, have made policy making more ambitious and more constant. The NHS as a system has been deemed, *"so complex that for any person or organisation to understand it in its entirety is impossible",* (Harrison and Dixon 2000, p258)

This recognition only adds pressure to those researching NHS policy but it also leaves scope for the potential of policy research to add to the knowledge base required to help make the impossible more possible.

## REFERENCES

Abelson.J, Lomas.J, Eyles.J, Birch.S, Veenstra,G. (1995) Does the community want devolved authority? Results in deliberative polling in Ontario. *Canadian Medical Association Journal.* Vol.153(4) 403-412.

Abelson.J, Maxwell.P.H, Maxwell.R.J. (1997) Do professions have a future? *BMJ.* Vol.314 :382.

Appleby. J. (1995) Managers on the up? In: *Health Director.* October, pp20-21. Published by National Association of Health Authorities and Trusts (NAHAT) Birmingham.

Association For Improvements in the Maternity Services (AIMS), (1991). *Childbirth Care - Users Views.* Submission to the House of Commons Health Committee.

Allison J. (1995) A fairer pay structure is born. *Health Service Journal.* July 13.

Anon. (1995) *Opinion, Health Service Journal,* November 23, p.19.

Appleby.J, Smith.P, Ranade.W, Little.V, Robinson.R. (1994) *Monitoring managed competition.* In: *Evaluating the NHS Reforms,* (1994) Kings Fund, Editors, Robinson, R. and Le Grand, J.

Audit Commission (1996) *What the Doctor Ordered: a case study of GP Fundholding in England and Wales.* London HMSO.

Audit Commission (1997) *First Class Delivery: Improving Maternity Services in England and Wales.* Audit Commission Publications. London.

Ayers. PJ (1996) Rationing Health Care: Views from General Practice. *Social Science and Medicine.* Vol.42. No.7: pp.1020-1025.

Baggot.R. (1994) Reforming the British Health Care System: a Permanent Revolution? *Policy Studies.* Autumn. Vol. 15 (3), pp 35-47.

Bazalgette.J. and Crooke.L. (1997) At the heart of the matter. *Health Service Journal.* April 3, pp 28 - 29.

Beecham. L. (1999) UK obstetricians face redundancy. *BMJ.* Vol.318:688

Ben-Shlomo.Y, Chaturvedi.N. (1995) Assessing equity in access to health care provision in the UK: does where you live affect your chances of getting a coronary artery bypass graft? *Journal of Epidemiology and Community Health.* Vol.49: 200-204.

Berens.C. (1996) Spanner in the works. The Guardian. *Society*. April 17, p5.

Berwick.D.M. (1996) A primer on leading improvement of systems. *BMJ*. Vol.312. 619-622.

Berwick.D.M. (1997) Spreading innovation. *Quality Connection*. Winter, Vol.6, No.1, pp1-3.

Best. G. (1996) NHS managers: surfeit or shortage? *Health Director*. February, p.16. Published by National Association of Health Authorities and Trusts (NAHAT) Birmingham.

Borril.C, Haynes.C. (2000) Stressed to kill. *Health Service Journal*. February 10, pp24-25.

Bowling.A.(1995) Paper presentation at *Royal Society of Medicine's Conference*: knowledgeable patients - who needs them ? London

Bowling.A, Jacobson.S, Southgate.L (1993). Explorations in consultation of the public and health professionals on priority setting in a inner London Health District. *Social Science and Medicine*; 37:851-7.

Bowling A. (1996) Health care rationing: the public's debate. *BMJ*. Vol. 312: 670-4.

Boyett. I. (1996) The public Sector entrepreneur - a definition. *International Journal of Public Sector Management*. Vol.9, No.2, pp 36-51.

Bhaskar. R. (1989) *The possibility of Naturalism: A Philosophical Critique of the contemporary Human Sciences* (2nd edn), New York: Harvester Wheatsheaf.

Blaxter, M. (1995) *Consumers and Research in the NHS : Consumer Issues within the NHS*. In (DoH) (1995) Consumers & Research in the NHS : An R&D contribution to consumer involvement in the NHS.

Bradbury.M. (1995) Lets do the Popomo a-go-go. *The Guardian*. December 9, p29.

Bradshaw. A. (1995) Nursing and medicine: co-operation or conflict? *BMJ*, Vol.311, 304-305.

Brazil.R. (1994). Pursuing the nature of the accountability debate. *Kings Fund News*. Vol. 17. No.2. Kings Fund Publishing. London.

Brindle D. (1995) The consultation cure. The Guardian *Society* . p. 6 - 7. May 10.

Brindle.D. (1996a) After the revolution , a time for peace. The Guardian. *Society*. April 3, p. 6.

Brindle. D. (1996b) The internal market, warps and all. The Guardian. *Society*. April 24, p.6-7.

Brindle.D. (1997a) '.....as managers wilt'. The Guardian. *Society*. June 11, p11.

Brindle.D. (1997b) Straits talking. The Guardian. *Society*. July 2, p6.
British Medical Association (BMA) (1993) The British Medical Association's Response to the Department of Health Report "Changing Childbirth". London.

Browne. A. (1994) Are midwives ready for the proposals for change ?. *Nursing Times*, vol. 90, No. 47, 36-37.

Buck. D. (1996) What are the net costs ? *Health Service Journal*. September 12, p

Bulmer.M. (1982) *The Uses of Social Research*. London: Allen and Unwin.

Butler.J. (1994) Origins and early development, in Evaluating the NHS Reforms, (1994) Kings Fund, Editors Julian Le Grand and Ray Robinson.

Butler. P. (1996a) Consuming passions. *Health Services Journal*. November 14, p. 12.

Butler P (1996b) A cut above the rest. *Health Service Journal*. 22 August, p10-13.

Butler. P, Chadda.D, Crail. M, Davies.P. (1996) IHSM focus: conference focus. *Health Service Journal*. June 13, pp 13-17.

Butler.P. and Crail.M. (1997) News focus: time to draw in the reins. *Health Service Journal*. April 3, pp 10-11.

Caines.E. (1996) Crisis time. *The Health Summary*. The briefing paper for policy makers in Health. Vol. XIII, No III. March, pp 2-3. London.

Calnan.M. (1997) Citizens, users and health care. *European Journal of Public Health*. 7:1-2.

Cardale. P. (1994) Changing Role for Midwives, *Nursing Times*, Vol. 90. No 28, 60 - 62.

Caress.A.L. (1997) Patient roles in decision making. *Nursing Times*. Vol.93, No.31, pp 45-48.

Caulkin.S. (1997) NHS organisation goes under the knife. *The Observer*. July 6, p.8.

Changing Childbirth Implementation Team (1995a), *Changing Childbirth Update*, Issue No. 1, NHSE, Cambridge

Changing Childbirth Implementation Team (1995b), *Changing Childbirth Update*, Issue No. 2, NHSE, Cambridge

Changing Childbirth Implementation Team (1995c), *Changing Childbirth Update*, Issue No. 3, NHSE, Cambridge

Changing Childbirth Implementation Team (1995d), *Changing Childbirth Update*, Issue No. 4, NHSE, Cambridge

Changing Childbirth Implementation Team (1996a), *Changing Childbirth Update*, Issue No. 5, P2, NHSE, Cambridge

Changing Childbirth Implementation Team (1996b), *Changing Childbirth Update*, Issue No. 6, NHSE, Cambridge

Changing Childbirth Implementation Team (1996c), *Changing Childbirth Update*, Issue No. 7, NHSE, Cambridge

Changing Childbirth Implementation Team (1997a), *Changing Childbirth Update*, Issue No. 8, NHSE, Cambridge

Changing Childbirth Implementation Team (1997b), *Changing Childbirth Update*, Issue No. 9, NHSE, Cambridge

Chadda D. (1996) News Focus: Fundamental flaws. *Health Service Journal.* March 7, p11.

Chambers.J. (1996) Put primary care in proper focus. In: *Medical Interface.* September, pp 53-56.

Clarke.J, Newman.J. (1997) *The Managerial State.* Power, Politics and Ideology in the Remaking of Social Welfare. Sage Publications Ltd.

Clarke. R.A. (1995) Divide and Rule: The politics of Midwifery, *Midwives,* April, p 126.

Clinical Standards Advisory Group CSAG (1995): Women in Normal Labour. *Report of a CSAG Committee on Women in Normal Labour.* London HMSO.

Coast J, Donovan J, Frankel S. (1996) *Priority setting: the health care debate.* Chichester: J. Whiley & Sons Ltd.

Coast.J. (1997) Rationing: the case against. *BMJ.* Vol.314:1118-21.

Cohen.A.P. (1994) Self conscious anthropology. In, *Anthropology and Autobiography*

(1994) Editors, Okley.J, Callaway.H. Routledge , pp.221-235.

Collee. J. (1996) Computers are a threat to our basic humanity. *Observer*. Life. Magazine April 7, p62.

Colebatch.H.K. (1995) Organizational meaning of program evaluation. *Policy Sciences*. 28: 149-164.

Comment (1998) *Health Service Journal*. April 23, pp 10-11 and p.15.

Coote. A, Hunter. D. (1996) Our starter for the next ten. *Health Service Journal*.November 7, p.22.

Coulter. A. (1995) Counselling takes the screen test. Guardian. *Society*, November 15, p 2-3.

Cowl. J. (1994) Beyond the Patients Charter : working with users. *Kings Fund News*. Vol. 17. No.2. Kings' Fund Publishing. London.

Cowl. J. (1996) National Consumer Awareness Campaign. In: Changing Childbirth Implementation Team (1996b), *Changing Childbirth Update*, Issue No. 6, NHSE, Cambridge

Cowl. J. (1997) Maternity Services Liaison Committees – making them work. In: Changing Childbirth Implementation Team (1997a), *Changing Childbirth Update*, Issue No. 8, NHSE, Cambridge

Cox. D. (1991) *Health Service Management – a sociological view: Griffiths and the non-negotiated order of the hospital*. In: Gabe J. Calnan. M. Bury. M. (1991) (Editors) *The Sociology of the Health Service*. Routledge.

Crail.M. (1996a) Future-perfect? *Health Service Journal*. March 28, P.13-16

Crail. M. (1996b) Slip Sliding away. *Health Service Journal*. September 12, p. 14.

Crail. M. (1996c) Role play. *Health Service Journal*. May 23, p 12.

Crail. M. (1996d) Behind the scenes of the NHS. *Health Service Journal*. August 29, pp 10-11.

Crail M and Millar B. (1996) News Focus: Unkindest cuts of all. *Health Service Journal*. May 9, p8.

Crail.M. (1998) News focus: The nuclear option. *Health Service Journal*. March 26, p11.

Crisp R, Hope T, Ebbs D. (1996) The Asbury draft policy on ethical use of resources. *BMJ*. ol 312: 1528-31.

Crook. J. (1996) Monitoring the indicators of success – the way forward. In: Changing Childbirth Implementation Team (1996b), *Changing Childbirth Update*, Issue No. 6,

NHSE, Cambridge

Davies C.A. (1999) *Reflexive Ethnography. A Guide to Researching Selves And Others*. Routledge. London.

Davies.R. (1996) The fight for quality control. *The Guardian. Society*. p.6. March 27.

Davis.J. (1994) *Tense in ethnography - some practical considerations*. In: *Anthropology and Autobiography* (1994) Editors, Judith Okley and Helen Callaway. Routledge pp.207-220.

Davis.P, Howden-Chapman.P. (1996) Translating Research Findings into Health Policy. *Social Science and Medicine*. Vol.43. N0.5, pp 865-872.

Denzin.N.K. (1999) Interpretative ethnography for the next century. *Journal of Contemporary Ethnography*. Vol.28 No.5, October. 510-519.

Department of Health and Social Security (DHSS). (1983) *Griffiths NHS Management Inquiry Report*. London.

Department of Health (DoH) (1989a). *Working for Patients*, London. HMSO.

Department of Health (DoH) (1989b). *Caring for people : Community Care in the Next Decade and Beyond*, London HMSO..

Department of Health (DoH) (1990) *National Health Service and Community Care Act*. London. HMSO.

Department of Health (DoH) (1991a). *The patients Charter*, London HMSO

Department of Health (DoH) (1991b). *Local Voices*. London HMSO.

Department of Health (DoH) (1992) *The Health of the Nation*. Public Health White Paper. London HMSO.

Department of Health (DoH) (1993). *Changing Childbirth : Report of the expert maternity group*. London HMSO.

Department of Health (DoH) (1994a) *Local People must be involved in purchasing*. Press release. 94/177. April 13.

Department of Health (DoH) (1994b) *Greater Choice For Women in Maternity Services*. Press Release 94 / 200, April 22.

Department of Health (DoH) (1994c) *Managing The New NHS: Functions and Responsibilities in the New NHS*. London HMSO.

Department of Health (DoH) (1994d), Testing the Vision : *A report on progress in the first year of " A Vision for the Future".* London HMSO.

Department of Health (DoH) (1994e) *Corporate governance in the NHS: code of conduct; code of accountability.* London HMSO.

Department of Health (DoH) (1995) *Centrally Commissioned Research Programme.* London HMSO.

Department of Health (DoH) (1996a) *In the patients interest: multi-professional working across organisational boundaries.* Report by the Standing Medical and Nursing & Midwifery Advisory Committees. London HMSO.

Department of Health (DoH) (1996b) *Choice and Opportunity: Primary Care the future.* Cm3390. London stationary office.

Department of Health (DoH) (1996c) *Primary Care: delivering the future.* Cm3512.London stationary office.

Department of Health (DoH) (1996d) *NHS General Medical Services Red Book.* Statement of Fees and Allowances payable to General Medical Practitioners in England and Wales. 1996 Edition.

Department of Health (DoH) (1997a) NHS White Paper. *The new NHS: modern, dependable.* London HMSO.

Department of Health (DoH) (1997b) *Government Accepts Recommendations of the Two NHS Pay Review Bodies.* Press Release. 97/033. London.

Department of Health (DoH) (1998a) *A first class service: quality in the new NHS.* London, Department of Health.

Department of Health (DoH) (1998b) *Health Improvement Programmes: Planning for Better Health and Better Health Care.* HSC 1998/167.

Department of Health (DoH) (1998c) *Midwifery: Delivering Our Future.* Report by the Standing Nursing and Midwifery Advisory Committee. London, Department of Health.

Department of Health (DoH) (2000) *The National NHS Plan.* London. HMSO.

Dey.I. (1993) Qualitative Data Analysis. Routledge.

Dickson.N. (1996a) Blood, sweat and tears. *The Guardian: Society,* September 11, p.2.

Dickson. N. (1996b) BBC Social Affairs Editor. *Safe with us.* Three part series on the 1991 NHS reforms. *BBC 2,* Sundays, September 1st, 8th, and 15th 1996.

Dix, A. (1996) Down, but not out. *Health Service Journal.* June 6, p39.

Dixon, J. (1998) *Introduction: the context.* In: Le Grand, J., Mays, N. and Mulligan J-A. (1998) *Learning from the NHS Internal Market.* Kings Fund Publishing. London. pp 1-15.

Dobson, J. (1992) Thirty years' hard labour. *Health Service Journal.* March 12, p10.

Dorrell, S. (1996) NHS 2000. *The Millenium Lecture.* Manchester Business School. University of Manchester.

Dowsell,T. Harrison,S. Mort, M. Lilford, R. (1997) *Health Panels - A Survey.* University of Leeds and University of Birmingham.

Doyal. L. (1995) Needs, rights, and equity: moral quality in healthcare rationing. *Quality in Health Care,* 4: 273-293.

Doyal. L. (1997) Rationing within the NHS should be explicit: the case for. *BMJ.* Vol. 314:1114-8.

Drife.J, Johnston.I. (1995). Handling the conflicting cultures in the NHS. *BMJ* Vol.310.1054-1056.

Drown.J. (1996) Quoted in Brindle (1996) The internal market, warps and all. *The Guardian: Society,* April 24, p6.

Duggan. J. (1997) Letters page. In: Changing Childbirth Implementation Team (1997a), *Changing Childbirth Update,* Issue No. 8, NHSE, Cambridge

Duran-Arenas.L, Lopex-Cervantes.M (1996) Health Care reform and the labour market. *Social Science and Medicine.* Vol.43, No.5, pp. 791-797..

Ebrahim, S. (1993) *Health care of the elderly and the internal market.* In: Tilley.I.(1993) *Managing The Internal Market.* Paul Chapman Publishing Ltd. pp 261-274.

Elston M.A. (1991) *The politics of professional power: medicine in a changing health service.* In: Gabe J. Calnan. M. Bury. M. (1991) (Editors) *The Sociology of the Health Service.* Routledge.

Evans. M. (1996) PR must be more than PS. *Health Service Journal.* October 17, p.20.

Farquhar, M. Camilleri-Ferrante, C and Todd, C. (1996) An Evaluation of Midwifery Teams In West Essex. Public Health Resource Unit & Health Services Research Group, Institute of Public Health, University of Cambridge.

Faltermaier.T. (1997) Why public health research needs qualitative approaches: subjects and methods in change. *European Journal of Public Health.* Vol. 7. No.4, 357-363.

Flannery N. (1996) Why the tables are bare. *Health Service Journal.* August 22, p19.

Fleissig, A and Kroll, D. (1996) *Evaluation of community led maternity care in South Camden, London*. Department of Epidemiology and Public Health. University College London Medical School.

Flint. C. (1995) Hailing a new philosophy, *Nursing Standard*, Vol 8, No 20, pp.19-20.

Flint.C, Poulengeris. P and Grant. A .(1989). The know your midwife scheme - a randomised trial of continuity of care by a team of midwives. *Midwifery*, Vol. 5, 11-16.

Forester.J. (1995) Response: Toward a critical sociology of policy analysis. *Policy Sciences* 28: 385-396.

Freidson.E. (1970) *Professional dominance: the social structure of medical power.* Chicago, Aldine.

Gaba.M. (1996) How the other half loathes. *Health Service Journal.* June 13, p.33.

Gabe J. Calnan. M. Bury. M. (1991) (Editors) The Sociology of the Health Service. Routledge.

Gans.H.J. (1999) Participant Observation in the era of "ethnography". *Journal of Contemporary Ethnography*. Vol.28 No.5, October. 540-548.

Garfinkel. H. (1967) *Studies in Ethnomethodology*. Cambridge. Polity Press.

Goffman. E. (1961) *Asylums*. New York: Doubleday Anchor

Goodwin.N. (1996) Power and responsibility. *IHSM Network.* Vol. 3. No. 5. March. Birmingham University.

Gosling.P. (1997) Jobs for life join the critical list. *Independent on Sunday.* September 21, p/2.

Gough. I., Thomas. T. (1994) Need satisfaction and Welfare Outcomes: Theory and Explanations. *Social Policy & Administration*. Vol. 28. No.1 March . ?
Gregson.B. (1997) Community Maternity Care Project. In: Changing Childbirth Implementation Team (1997a), *Changing Childbirth Update*, Issue No. 8, NHSE, Cambridge

The Guardian Newspaper (1997) (author wished to remain anonymous, executive

director of a large Health Authority). Room for recovery. *Society.* October 1, p17.

Guba.E.G, Lincoln.Y.S. (1987) *The countenances of fourth generation evaluation: description, judgement and negotiation,* in Dennis.J, Palumbo, ed., The Politics of Program Evaluation.. Newbury Park:Sage, pp. 202-234.

Guba.E.G and Lincoln.Y.S. (1989) *Fourth generation evaluation.* Newbury Park:Sage.

Gutteridge.D. (1996) Not at your disposal. *Health Service Journal.* p.25 February 22.

Guardian, (1995) Baby units go boom, *Society.* April 19, p.6 - 7.

Glaser, B. (1978) *Theoretical Sensitivity.* Mill Valley, CA: Sociology Press.

Glaser,B. & Strauss,A. (1967) *The discovery of Grounded Theory.* Chicago:Aldine.

Glasman. D. (1996) Rights of passage. *Health Service Journal.* September 12, p.12.

Hak.T. (1997) Coding effects in comparative research on definitions of health: a qualitative validation study. *European Journal of Public Health.* Vol. 7. No.4, 364-372.

Hall.P, Land.H, Parker.R and Webb.A. (1975) *Change, choice and conflict in social policy.* Heinemann: London.

Hallet.C. (1996) *Women and Social Policy: An Introduction.* Prentice Hall/ Harverster Wheatsheaf publications in association with Social Policy Association.

Hallet.J. (1996) Making ourselves redundant ? *IHSM Network* Vol. 3. No.5 March.

Ham.C. (1991) Revisiting the internal market: And finding its all gone slow. *BMJ.* Vol.302. 250-251.

Ham. C. (1992) *Health Policy in Britain: the politics and organisation of the National Health Service.* (Third edition). The Macmillan Press td. London.

Ham.C. (1993a) How go the NHS Reforms ?. *BMJ* Vol.306. 77- 78.

Ham. C. (1993b) Health care reform. *BMJ.* Vol.306. 1223-1224.

Ham. C. (1993c) The latest reorganisation of the NHS. *BMJ.* Vol. 307. 1089-1090.

Ham.C. (1994) *Management and Competition in the new NHS.* Radcliffe Medical Press. Oxford.

Ham.C. (1996a) Contestability : a middle path for health care. *BMJ.* Vol. 312. 70-71.

Ham.C. (1996b) Nine-point path to harmony. *Health Service Journal.* June 20, p.25.

Ham. C. (1996c) Making sense of NHS priorities. *Health Services Management Centre Newsletter*, Vol.2 issue 3. University of Birmingham
Ham. C. (2000) *The politics of NHS reform 1988 – 1997 – metaphor or reality.* Kings Fund.

Ham. C., Maynard. A. (1994) Managing the NHS market. *BMJ.* Vol. 308. 845-847.

Ham.C, Hunter.D.J, Robinson.R. (1995) Evidence based policy making. *BMJ*. Vol. 310. 71-72.

Ham.C, Shapiro.J. (1996) Learning curve. *Health Service Journal.* January 18, pp.24-25.

Ham.C. Woolley.M. (1996) How does the NHS measure up ? Assessing the performance of Health Authorities. *National Association of Health Authorities and Trusts and Health Services Management Centre*, University of Birmingham.

Hammersley.M. (1990) *Reading Ethnographic Research: a critical guide.* London. Longman.

Hammersley.M. (1992) Introducing Ethnography. *Sociological Review.* November, pp 18-22

Hammersley.M, Atkinson.P. (1995) *Ethnography. Principles in Practice.* 2nd Edition. Routledge. London

Hammond.V. (1997) Was it good for you? *Health Management.* July, pp14-15.

Hamlyn.C. (1996) The real challenge for the new health authorities. *IHSM Network.* Vol.3 No.5 March.

Hancock C. (1996) Stand and deliver. *Health Service Journal.* March 7, p23.

Hand. R.(1996) Maternity Care Packages : a feasability study. *In Changing Childbirth Update.* Issue No. 5, March 1996. National Changing Childbirth Implementation Team, NHSE Cambridge,.

Harrison, A. and Dixon, J. (2000) *The NHS: Facing the future.* Kings Fund Publishing. London

Harrison, S. and Hunter, D. J. (1989) General Management And Medical Autonomy In The National Health Service. *Health Services Management Research.* Vol.2, No.!. pp38-46.

Hastrop.K. (1994) *Writing ethnography: state of the art.* In: *Anthropology and Autobiography* (1994) Editors, Judith Okley and Helen Callaway. Routledge. pp. 117-126

Herbet. S. (1994) Changing for the better, *Nursing Times*, Vol 91, No 28, 55-56.

Health Authorities Bill. (1995) The stationary Office. London HMSO.

Health Committee . Second report (1992) *Maternity Services* . London HMSO.

Healey. P. (1998) The appliance of compliance. *Health Service Journal.* April 23, p. 11.

Henderson.C, Grant.J. (1996) Team Midwifery in Birmingham. In: Changing Childbirth Implementation Team (1996c), *Changing Childbirth Update*, Issue No. 7, NHSE, Cambridge

Higson.N. (1996) GPs lack information about Changing Childbirth. In Changing Childbirth Implementation Team (1996b), *Changing Childbirth Update*, Issue No. 6, NHSE, Cambridge

Hill.P. (1996) Health Care: A Social contract In Transition. *Social Science and Medicine.* Vol. 43, No.5. pp783-789.

Hodnett. ED. (1996) Care from a midwife team was effective: commentary. *Evidence Based Medicine.* March/April. P.94.

Hogg C, Cowl J. (1994). Different Strokes. *Health Service Journal.* May 13, pp28-9.

Holm.L, Smidt.S. (1997) Uncovering social structures and status differences in health systems. *European Journal of Public Health.* Vol. 7. No.4, 373-378.

Horton.R. (1998a). Doctors, the general medical council, and Bristol. *Lancet.* Vol.351, May 25, pp.1525-6.

Horton.R. (1998b) How doctors have betrayed us all. *Independent on Sunday.* Section 2. June 14, p 1.

House of Commons Health Committee (1995) *Priority setting in the NHS: Purchasing.* Volume 1. London HMSO.

Howcroft.J. (1996) Maternity services in the Trent Region. In: Changing Childbirth Implementation Team (1996c), *Changing Childbirth Update*, Issue No. 7, NHSE, Cambridge

Hugman.R. (1991) Power in caring professions. London, Macmillan Education Ltd.

Hughes.D, Griffiths. L, McHale. J. (1997) Do quasi-markets evolve? Institutional analysis and the NHS. Cambridge Journal of Economics. 21: 259-276.

Hunter. D. J. (1993a) *The internal market: The shifting agenda.* In: Tilley.I.(1993) *Managing The Internal Market.* Paul Chapman Publishing Ltd. pp 31-44

Hunter. D. J. (1993b) Rationing Dilemmas in Healthcare, Research Paper No.8, NAHAT..

Hunter. D. J. (1995) The Last Ethical Frontier. *Health Services Journal.* May 18, p19.

Hunter. D. J. (1996a) Heed the history lessons. *Health Service Journal.* January 25, p21.

Hunter. D. J. (1996b) Beware the enemy within. *Health Service Journal.* May 9, p17.

Hunter.D. J. (1996c) Managers, myths and malaise. *Health Service Journal.* July 25, p21.

Hunter.D. J. (1996d) The changing roles of health care personnel in health and health care management. *Social Science Medicine.* Vol.43, No.5, pp 799-808.

Hunter. D. J. (1997) When opportunity knocks. *Health Service Journal.* June 19, p24.

Hunter. D. J. (1998) Come the revolution. *Health Management.* February, pp. 16-17.

Huntington. J.(1997) Electing for real change. *Health Service Journal.* May 1, p. 20.

Huntington. J.(1996) The shape of things to come. *Health Service Journal.* October31, p.17

Hynes. E. (1991) Home From Home. *Nursing Times*, Vol.87, No. 28.

Institute of Manpower Services (IMS) (1993): *Mapping Team Midwifery.* A report to DoH. IMS Report Series 242.

Jackson. K. (1997) The future of the Changing Childbirth Implementation Team. In: Changing Childbirth Implementation Team (1997a), *Changing Childbirth Update*, Issue No. 8, NHSE, Cambridge

Jarrold. K. (1996) Quoted in Opinion. *Health Service Journal.* May 23, p.15.

Jary. D, Jary.J. (1995) *Collins Dictionary of Sociology.* Second Edition. HarperCollins Publishers. Glasgow.

Jessop.B. (1996) Interpretive Sociology and the Dialectic of Structure and Agency. *Theory Culture and Society.* Vol. 15(1): 119-128. Sage Publications, Inc.

Jessop.B. (1999) Public meetings deserve proper science. *Journal of Public Health Medicine*. Editorial. Vol.21, No.4, pp.365-366.

Jones.J. (1996) Hospital bosses want a facelift. *Observer.* April 7, p.10.

Jones.J., Hunter.D. (1995) Consensus methods for medical and health services research. *BMJ.* Vol. 311. 376-380.

Jorgensen.D.L.(1989) *Participant Observation: A methodology for human studies.* Applied Social Research Methods series. Vol.15. Sage Publications, Inc.

Kammering.M, Kinnear.A. (1996) The extent of the two tier service for fundholders. *BMJ.* 312:1399-1401.

Keen.J, Packwood.T. (1995) Qualitative research: case study evaluation. *BMJ.* Vol.311: 444-46.

Kings Fund (1996) Involving Patients *.PACE Bulletin.* September.

Kirk.J, Miller.M.L. (1987) *Reliability and validity in qualitative research.* 3rd Edition. Sage Publications, Inc.

Kitzinger. S. (1978) *Some mothers experiences of induced labour.* National Childbirth Trust. (NCT) London.

Klein. R. (1995) Labour's health policy: marks a retreat from ideology. *BMJ* Vol. 311. 75-76.

Klein R. (1996a) Who's to decide the NHS menu? *The Guardian: Society.* September 25, p6.

Klein.R. (1996b) The NHS reforms revisited. *BMJ.* Vol.313: 504-5

Klein.R. (1997a) Rationing: the case against. *BMJ.* Vol.314:506-9.

Klein.R. (1997b) The King's Fund and the future of health policy. *King's Fund News.* Spring, pp8-9.

Klein. R. (1999) Markets, politicians and the NHS – Enthovan's analysis still illuminates the NHS. *BMJ.* Vol.319: 1383-4

Klein. R. Dixon. J. (2000) Cash bonanza for NHS – the price is centralisation. *BMJ.* Vol. 320: 883-4

Langlands A (1994) *Forward to: The operation of the NHS internal market-Local Freedoms, National responsibilities.* NHSE (1994).

Langlands A (1996) The what and the how. *The IHSM Network.* Vol. 3, No.10, May, p2. Birmingham University.

Layder. D. (1994) *Understanding Social Theory.* SAGE Publications.

Lee. G. (1995) 'The Named Woman', *Midwives*. May, p.162

Le Grand, J and Bartlett, W. (1993) *Quasi markets and social policy.* London Macmillan.

Le Grand, J., Mays, N. and Mulligan J-A. (1998) *Learning from the NHS Internal Market*. Kings Fund Publishing. London.

Lenaghan. J, New. B, Mitchell E. (1996) Setting priorities: Is there a role for citizens' juries ? *BMJ* Vol.312: 1591-3.

Lenaghan. J. (1997a) *Citizens' rights to health care in the UK: developing a national framework of entitlement*. In : *Hard Choices in Health Care*. BMJ Publishing Group. Edited by Lenaghan, J. pp. 68 - 92.

Lenaghan.J. (1997b) Central government should have a greater role in rationing decisions - the case for. *BMJ*. Vol. 314:967-70.

Lessof M. (1996) Treating a rash of predictions. *Health Services Journal*. May 16, p23.

Lilley.R. (1996) Scrap GPs, bring on Florence Nightingale. *Sunday Times*. January 7th.

Limb.M. (1996) Share Issues. *Health Services Journal*. October 14, p11.
Linton.M (1996). Serving grace-social attitudes. Guardian, *Society*. March 27, p6.

Lofland.J. (1971) *Analysing Social Settings*. A Guide to Qualitative Observation and Analysis. Wadsworth Publishing Company Inc.

Lukes, S. (1974) *'Power: A Radical View'*. London. Macmillan.

Lupton C, Buckland S, Moon G, (1995). Consumer involvement in health care purchasing : the role and influence of Communty Health Councils. *Health and Social Care in the Community*, 3 :215-26.

Lupton. C., Taylor. P. (1995) Coming in from the cold : involving consumers. *Health Service Journal*. March 16, p. 23-24.

Lyle. J. (1994). Be my guest - should hospitals treat patients in the same way hotels treat their customers ? *Health Service Journal*. March 3, p.14.

Macara.A.W. (1997) Setting the agenda for health after the election. *BMJ*. Vol.314:767-8.

Macfarlane.A, Campbell.R. (1994). Baby Boon. *Health Service Journal*.December 8, p.33.

Majeed. F, Chaturvedi. N, Reading. R, Ben-Shlomo. Y. (1994) Monitoring and promoting equity in primary and secondary care. *BMJ.* 308:1426-1429.

Manning S, Sang B (1994) Involving the public in health service decision making. *Kings Fund News*. Vol. 17. No.2.

Marks. D. (1995) Balancing act. *Health Service Journal.* April 13, p.28-27.

Marchment. M (1992) Spirit of trust. *Health Service Journal.* March 19, p.29

Marsh.B. (1999) Curb on Caesareans. *Daily Mail.* Wednesday, November 24, p.19.

Mason.A, Morgan. K. (1995). Purchaser-provider: the international dimension. *BMJ.* Vol. 310. 231-234.

Massey-Davis (1995) Developing Community Participation. In: Changing Childbirth Implementation Team (1995d), *Changing Childbirth Update*, Issue No. 4, NHSE, Cambridge

May. A. (1995a) Game of patients. Guardian. *Society.* November 1, pp. 2-3.

May. A (1995b) The irrational lottery. *Health Service Journal.* November 30, p.16.

May.A (1996) The public must be told. *Health Service Journal.* September 26, p.19.

May. C. (1992) Nursing work, nurses' knowledge, and the subjectification of the patient. *Sociology of Health and Illness.* Vol. 14, No. 4, 472- 487.

Maynard, A. (1993) *Creating competition in the NHS: Is it possible? Will it work?* In: Tilley, I.(1993) *Managing The Internal Market.* Paul Chapman Publishing Ltd. pp 58-69

Maynard.A. (1996a) Nature abhors a vacuum. *Health Service Journal.* March 14, p.25.

Maynard.A. (1996b) Rationing health care. *BMJ.* Vol. 313, p149.

Maynard.A. (1996c) Get your priorities right. *Health Service Journal.* August 22, p17.

Maynard. A. (1997) Time to send on the subs. *Health Service Journal.* January 23, p.20.

Mays. N, Pope.C. (1995a) Rigour and qualitative research. *BMJ.* Vol. 311: 109-12

Mays. N, Pope.C. (1995b) Observational methods in health care settings. *BMJ.* Vol. 311: 182-184.

McIntosh. K. (2000) What's up docs? *Health Service Journal.* February 24, pp16-17.

314

McIver. S. (1996) Partnership with the public: the role of the Community Health Council. *Health Services Management Centre Newsletter*. University of Birmingham. Vol.2. Issue 3.

Mechanic. D. (1991) Sources of Countervailling Power in Medicine. *Journal of Health Politics, Policy and Law*, Vol. 16, No. 3, 485-498.

Mellors. J. and Chambers. N. (1995) Addressing the patient's agenda in the reorganization of antenatal care and infant health care: experience in one general practice. *British Journal of General Practice*, 45, 423-425.

Meyer. D.S., Whittier.N. (1994) Social Movement Spillover. *Social Problems*. Vol. 41. No2. May.

MIDIRS and The NHS Centre for Reviews and Dissemination. (1995) *Informed Choice in Maternity Care - Informed Choice Leaflets*. University of York.

Millar.B. (1996a). Court in the act - citizens juries. *Health Service Journal*. 11 April, p.8-9.

Millar B. (1996b) Performing right? *Health Services Journal*. May 16, p13

Millar B. (1996c) Free range. *Health Service Journal*. May 2, p12-13

Millar B. (1996d) Devil of a job: hell of an image. *Health Service Journal*. October 24, pp24-26.

Millar.B. (1997) Telling tales. *Health Service Journal*. June 26, p16.

Miller P. (1997) Are GP fundholders wasting money? *Health Service Journal*. 6 March, p.28-29.

Miller.S. (1997) Implementing Strategic Decisions: Four Key Success Factors. *Organization Studies*. 18/4: 577-602

Milner.P, Meekings.J. (1996) Editorial: failings of the purchaser-provider split. *Journal of Public Health Medicine*. Vol.18, No. 4. pp.379-380.

Mohan.J (1991) Privatization in the British health care sector: a challenge to the NHS. In Gabe J. Calnan. M. Bury. M. (1991) (Editors) The Sociology of the Health Service. Routledge

Moore.W. (1995). Power of the people. *The Guardian Society*. 12 April, p.6.

Moore.W. (1996a) And how are we feeling today ?. *Health Service Journal*. March 28, pp.30-32.

Moore.W. (1996b) All stressed up and nowhere to go. *Health Service Journal.* September 5, pp.22- 25.

Morrison.I, Smith.R. (1994) The future of medicine. *BMJ.* 309:1099-100.

Mulligan, J-A. (1998) *Health Authority Purchasing.* In: Le Grand, J., Mays, N. and Mulligan J-A. (1998) *Learning from the NHS Internal Market.* Kings Fund Publishing. London. pp 20-43.

Munday.D. (1996) And the Winner is..... *Health Service Journal.* March 14, p.6.

National Association of Health Authorities and Trusts (1993a) *NAHAT Briefing: Response to Changing Childbirth.* The Report of the Expert Maternity Group.

National Association of Health Authorities and Trusts. (1993b) *NAHAT Briefing . Purchasing for health.* No. 49. July

National Association of Health Authorities and Trusts. (1993c) *NAHAT Briefing Changing Childbirth.* No. 52 September.

National Association of Health Authorities and Trusts. (1993d) *NAHAT Briefing Managing the new NHS.* No. 55. November

National Association of Health Authorities and Trusts. (1994a) *NAHAT Briefing. Team building in the NHS.* No. 68 June.

National Association of Health Authorities and Trusts. (1994b) *NAHAT Briefing. Managing Change in the NHS and Department of Health.* No. 73 August.

National Association of Health Authorities and Trusts. (1996) *NAHAT briefing: Changing Childbirth.* No. 92. January.

National Health Service Executive (NHSE) (1994a), *Woman- Centred Maternity Services.* EL(94)9, January.

National Health Service Executive. (NHSE) (1994b) *Priorities and planning guidance for the NHS : 1995/96.* (EL(94)55) July 22.

National Health Service Executive (NHSE) (1994c). *Purchasing for Health: Involving Local People*, NHSE, Leeds.

National Health Service Executive (NHSE) (1994d) *The Operation of the Internal Market, Local Freedoms, National Responsibilities.* Health Service Guidelines, HSG(94)55.

National Health Service Executive (NHSE) (1995). *Changing Patterns of Maternity Care: Implications for pay and grading for Midwives and for Midwifery Senior Management Posts,* EL (95) 77, July

National Health Service Executive (NHSE) (1995a) *Ensuring The Effective Involvement Of Professionals in Health Authority Work.* Health Service Guidelines, HSG(95)11,

National Health Service Executive (NHSE) (1995b) *Patients not paper - implementation.* EL(95)104.

National Health Service Executive (NHSE) (1996a) Local Pay 1996/97: Guidance for Purchasers. EL(96)9.

National Health Service Executive (NHSE) (1996b) *Patient Partnerships: building a collaborative strategy.*

National Health Service Executive (NHSE) (1996c) *Maternity Services Liaison Committees: Guidelines for working effectively.* Leeds.

National Health Service Executive (NHSE) (1996d) *Priorities and planning guidance for the NHS 1997/98. (EL(96)45).*

National Health Service Executive (NHSE) (1997) *Priorities and planning guidance for the NHS 1998/99.*

National Health Service Management Executive (NHSME) (1992). *Local Voices: the views of local people in purchasing for health.* Leeds.

Neuberger. J. (1994) Ask the patients for once . *Health Service Journal.* p. 21. July 7.

Neuberger. J. (1995) A maze that needs a map. *Health Service Journal.* p. 23. January 19.

Neuberger .J. (2000) Preface to: Ham. C. (2000) *The politics of NHS reform 1988 – 1997 – metaphor or reality.* Kings Fund

New. B. (1996) The rationing agenda in the NHS. BMJ. Vol. 312: 1593-601.

New.B. (1997) Defining a package of health care services the NHS is responsible for. *BMJ.* Vol. 314:503-5.

New B, Le Grand J. (1996a) A la carte? No, choose from what's on the menu. The Guardian. *Society.* July 24, p6.

New B, Le Grand J. (1996b) Priority setting is a political process. *Health Director.* September, pp 6-7.

Oakley. A. (1983) *Social consequences of obstetric technology : the importance of measuring "soft" outcomes*. BIRTH. Vol. 10:2, p.99-108. Summer 1983.

Oakley. A. (1993) *Essays on Women Medicine & Health.* Edinburth University Press Ltd.

Oakley.A, Hickey.D, Rajan.L. (1996) Social support in pregnancy: does it have long term effects? *Journal of Reproductive and Infant Psychology*. Vol.14: 7-22.

Obermann.K, Tolley.K. (1997) The state of Health Care Priority Setting and Public Participation.. *Discussion paper 154. Centre for Health Economics*. University of York.

Okley.J, Callaway.H.(Editors) (1994) *Anthropology and Autobiography*. Routledge Press.

Opinion. (1996) Opportunity Knocks. *Health Service Journal*. October 17, p.17.

Opinion (1998) Villians no more ? *Health Service Journal*. April 23, p15.

Opit, L. (1993) *Commissioning: An appraisal of a new role.* In: Tilley.I.(1993) *Managing The Internal Market.* Paul Chapman Publishing Ltd. pp 82-99.

Page. L, Lathlean.L, Campbell, M et al. (1995) *Progress report: One to One Midwifery Practice*. The Centre for Midwifery Practice: The Hammersmith Hospitals NHS Trust and Thames Valley University, London.

Partson. G. (1996). The citizens are always right. The Guardian. *Society*. p.7 March 27.

Patients Association (1996) *Patients Voices*. Newsletter. Issue Number 1, Autumn. Patients Association, London.

Pattison. S. (1998) NHS values : what are we here for? *Health Service Journal*. March 12, pp 26-28.

Paton.C. (1995) Contriving competition. *Health Service Journal*. March 30, pp30-31.

Paton.C. (1996) Lessons learned the hard way. *Health Service Journal*. September 26, p20.

Patton. M.Q. (1987) *How to Use Qualitative Methods in Evaluation*. London, Sage Publications.

Pfeffer.N, Pollock.A. (1993) Public opinion and the NHS. *BMJ*. Vol307:750-1.

Pollit.C, Harrison.S, Hunter.DJ, Marnoch.G. (1990) No hiding place: on the discomforts

of researching the contemporary policy process. *Journal of Social Policy*, Vol.19: 169-90.

Popay.J, Williams. G. (1994) *Researching the People's Health.* Routledge.

Pope.C, Mays. N. (1995) Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ.* Vol. 311: 42-45.

Porter. S. (1992) Women in a women's job: the gendered experience of nurses. *Sociology of Health and Illness.* Vol. 14, No. 4, 510-527.

Porter.S. (1997) Double indemnity. *Nursing Times*. Vol.93. No.8,

Price. D. (1996). Lessons for health care rationing from the case of child B. *BMJ.* Vol. 312. 167-169.

Propper. C. (1995) Agency and incentives in the NHS internal market. *Social Science and Medicine.* Vol.40:1683-1690.

Quality issues in maternity services (1993) - a consensus statement: a joint paper produced by the General Medical Services Committee, The Royal college of General Practitioners and The Royal College of Midwives and presented as evidence to The Expert Maternity Group.

Radical Statistics Group. (1995). NHS "Indicators of success": what do they tell us? *BMJ.* Vol..310. 1045-1050.

Redfern. L, Hull. C. (1996) Power and authority: is there a difference? *Nursing Times.* Vol. 92, No.37, pp36-37.

Reilly.B.J, DiAngelo.J.A.Jr. (1990) Communication: A Cultural System of meaning and value. *Human Relations*. Vol.43, No.2, pp. 129-140.

Redmayne.S. (1996) Small steps towards big goals. *Health Director.* University of Birmingham. April.

Richards.M.P.M. (1982) The trouble with "Choice" in childbirth. *BIRTH.* Vol. 9:4, P.253-260. Winter.

Richardson A and Bowie C.(1995) Public Opinion. *Health Service Journal.* May 11, p. 25

Rivett. G. (1998) *From Cradle to Grave – fifty years of the NHS.* King's Fund Publishing. London

Roberts. C. (1995) According to the evidence. *Health Service Journal.* March 2, p.23..

Roberts.C. (1996a) The wasted millions. *Health Service Journal.* October 10, p. 24-27.

Roberts.C. (1996b) Patient centred model of practice is unsuited to reforms. *BMJ.* Letters. Vol. 312. 142

Robertson.N, Baker.R, Hearnshaw.H. (1996) Changing the clinical behaviour of doctors: a psychological framework. *Quality in Health Care*; 5:51-54.

Robinson, R. and Le Grand, J. (Editors) (1994) *Evaluating the NHS Reforms.* King's Fund Institiute. London.

Robinson R and Whitmore H. ((1996) Getting engaged. *Health Service Journal.* September 5, p.28-29.

Roland. M. (1996) Defining core general practitioner services. *BMJ.* Vol.313:704.

Rowley. MJ, Hensley. MJ, Brinsmead. MW, Woldarczyk. JH. (1995) Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. *Medical Journal of Australia.* September. Vol. 163:289-93.

Royal College of General Practitioners.(1993) *Comment on the Expert Maternity Group's Report - Changing Childbirth.* London.

Royal College of Midwives. (1993) *Implementing Changing Childbirth: The response of The Royal College of Midwives.* London .

Royal College of Midwives (2000) *Vision 2000.* Royal College of Midwives. London.

Royal College of Obstetricians and Gynaecologists.(1993) *Response to the report of the expert maternity group*: Changing Childbirth, London..

Royal College of Obstetricians and Gynaecologists.(2000) *National Sentinel Caesarean Section Audit.* Letter to Regional Directors of Public Health, informing them of above audit and responsibility to distribute funding to conduct work at a local level. March 27.

Royce.R.G. (1995) Observations in the NHS internal market: will the dodo get the last laugh?. *BMJ* Vol. 311. 431-433.

Rudat K. ((1995) Survey shows public left in dark by NHS changes. *Health Service Journal.* July 6, p.15

Russell.H. (1994) *Research Methods in Anthropology: qualitative and quantitative approaches.* 2nd Edition. Sage Publications, Inc.

Ryan.C. (2000) Midwife 2000 takes centre stage. *Nursing Times*. Vol.96. No.19, p.11.

Sanders.J. (1995) Bristol study will compare patterns of antenatal care. In: Changing Childbirth Implementation Team (1995d), *Changing Childbirth Update*, Issue No. 4, NHSE, Cambridge

Sandwell.J. (1997) Social support in pregnancy – does it have long term effects? In: Changing Childbirth Implementation Team (1997a), *Changing Childbirth Update*, Issue No. 8, NHSE, Cambridge

Sang. B. (1994) The user as commissioner. In: *Kings Fund News*. Vol.17. No.4. Winter 1994, p1.Kings Fund Publishing. London.

Savage. W. (1994) Changing Childbirth: Would Mabel Liddiard approve ?, *Midwives Chronicle*, 411-413.

Scheff and Starrin (1997) Research methods and the role of the researcher. *European Journal of Public Health.* Vol. 7. No.4, 354 – 364.

Scott.K. (1996) Fundholders strike back. In: *Medical Monitor*. May, p.58.

Searle.C, Silverman.D. (1997) Ensuring rigour in qualitative research. *European Journal of Public Health.* Vol. 7. No.4, 379-384.

Secretary of State for Social Services and others (1987) Promoting Better Health. HMSO. London.

Sheaff.R. (1994) Health systems and health care purchasing. *Best Practice in Health Care Commissioning.*

Sheldon T (1994) Fighting Back. *Health Service Journal*. January 27, p.24-5

Shifrin.T, Agnew.T. (2000) Midwives push for normality 'under threat'. *Health Service Journal*. May 11, p10.

Sibeon.R. (1996) *Contemporary Sociology and Policy Analysis*. The new sociology of public policy. Tudor Business Publishing Ltd.

Sikorski.J, Wilson.J, Clement.S, Das.S, Smeeton.N. (1996) A randomised controlled trial comparing two schedules of antenatal visits : the antenatal care project. *BMJ.* Vol. 312. 546-543.

Simpson.J, Smith.R. (1997) Why healthcare systems need medical managers. *BMJ.* Vol.314 :1636-7.

Sims J (1996) Verdict awaited on first Citizens' Juries. *Health Director*. May, p.4 - 5.

Skrabanek P. (1994) *The death of humane medicine and the rise of coercive healthism.* Social Affairs Unit. London.

Smelser.N.J. (1994) Sociological theories. In: *International Social Science Journal.* Vol.139, pp1-13. Blackwell Publishers.

Smith.R. (1991). William Waldegrave : thinking beyond the new NHS. *BMJ.* Vol.302. 711-714.

Smith R. (1996a) Being creative about rationing. Editorial. *BMJ.* Vol.312 :391-2

Smith R. (1996b) Rationing health care: moving the debate forward. Editorial. *BMJ.* Vol.312 :1553-4.

Smith.J, Shapiro.J. (1997) Local Call. *Health Service Journal.* January 9, pp. 26-27.

Snell J. (1997). Blood money. *Health Service Journal.* March 13, p17.

Soderfelt.B, Soderfelt.M, Muntaner.C, Ocampo.P, Warg.L-E, Ohlson,C-G, (1996) Psychosocial work environment in human service organizations: a conceptual analysis of the demand-control model. *Social Science and Medicine.* Vol.42, No.9, pp. 1217-1226.

Soderfelt..B, Soderfelt.M, Jones.K, Ocampo.P, Muntaner.C, Ohlson,C-G, Warg.L-E. (1997) Does orgnanization matter? A multilevel analysis of the demand-control model applied to human services. *Social Science and Medicine.* Vol.44, No.4, pp. 527-534.

Spiers. J. (1995) The empowered patient. *The IHSM Network.* Vol. 2. No. 1 January.

Spear. S, Howell. H. (1995) The Searchers. *Health Service Jorunal.* p.21. April 20.

Stacey. M. (1991) *Medical sociology and health policy: an historical overview.* In: Gabe J. Calnan. M. Bury. M. (1991) (Editors) *The Sociology of the Health Service.* Routledge.

Stacey. M (1994). *The power of lay knowledge : A Personal View.* In, Popay.J. & Williams. G. (1994) *Researching the People's Health.* Routledge.

Stevenson. R., Hegarty. M. (1994). In the picture: consumer audit. *Health Service Journal.* Novmeber.24, pp22-24.

Stewart-Brown. S, Gillam.S, Jewell.T. (1996) The problems of fundholding. *BMJ.* Vol.312:1311-12.

Strauss, A. (1987) *Qualitative analysis for social scientists.* New York: Cambridge University Press.

Strauss.A, Corbin.J. (1990) *Basics of Qualitative Research. Grounded Theory.Procedures and Techniques*. 2nd Edition. Sage Publications, Inc.

Stronks.K, Strijbis.A-M, Wendte.J.F, Gunning-Scepers.L.J. (1997) Who should decide? Qualitative analysis of panel data from public, patients, healthcare professionals and insurers on priorities in health care. *BMJ.* 315:92-6.

Stewart.R. Divided loyalties. *Health Serivce Journal.* p.30-31. March 21.

Stocking B. (1995) Putting Power into Patients Hands. *IHSM Network.* Vol. 2 No.1

Taylor. A. (1994) Familiarity Breeds Contentment : Woman Centred Care, Midwifery Teams. *Nursing Times.* Vol. 90, No. 18.

Taylor. D. (1996) Quality and professionalism in health care: a review of current initiatives in the NHS. *BMJ.* Vol. 312. 626-629.

Tilley.I.(1993a) *Managing The Internal Market.* Paul Chapman Publishing Ltd.

Tilley, I. (1993b) *Concluding remarks: The value of an enhanced 'organizational R&D' function in a rapidly changing NHS.* In: Tilley.I.(1993) *Managing The Internal Market.* Paul Chapman Publishing Ltd. pp 281-299.

Tinkler.A, Quinney.D. (1995) An evaluation of a pilot Team Midwifery project. Health and Community Care Research Unit (HaCCRU), University of Liverpool.

Tinkler.A. Quinney.D. (1998) Team Midwifery: the influence of the midwife/woman relationship. *Journal of Advanced Nursing.* (28) 1, 30-35.

Tranter G, Sullivan S (1996) Whose Shout ? *Health Service Journal.* p. 31. May 2.

Treloar.D. Politicians give us time. *Institute of Health Services Management (IHSM) Network.* Vol.3 No.5. March.

Tremblay.M. (1996) Balancing accountability and autonomy: the new governance. *British Journal of Health Care Management.* Vol.2, No.12, 699-673.

Turner.B. (1987) *Medical Power and Social Knowledge.* London: Sage publications.

Ubel.P, DeKay M, Barox J, Asch D. (1996) Cost-effective analysis in a setting of budget constraints. *New England Journal of Medicine*; 334: 1174-7

Udall. E. (1996) The childbirth conspiracy. *Independent On Sunday.* April 21. ?

Vaughan.C., Higgs.R. (1995) Doctors and commitment. *BMJ,* Vol.311, 1654-1655.

Ven.W. de Van. (1996) Market orientated health care reforms trends and future options. *Social Science Medicine.* Vol.43. No.5, pp 655-666.

Vidal.J. (1996) Don't Look Now. Public Attitudes. *The Guardian. Society.* April 10, p.4.

Wall A (1996) Rationing rhetoric needs to be challenged. *Health Director.* Februray, p19.

Walshe K, Ham C. (1997) Who's Acting On The Evidence? *Health Service Journal* 3 April, p20-25.

Walt G. (1994) *Health Policy: An introduction to process and power.* Zed Books Ltd. London.

Watson. P. (1996) Knowing the score. *Health Service Journal.* March 14, p.28-31.

White. M. (1998) Politics : jolly good show- but mind out the asteroids. *Health Service Journal.* March 26, p21.

Whitehead. M. (1990) *The concepts and principles of equity and health.* World Health Organization (WHO) Regional Office for Europe, Copenhagen.

Whiting D S (1994) Consumer input: Turning local voices into local owners. *The Health Summary.* May.

WHO (1994) *A Declaration On The Promotion of Patients' Rights In Europe.* World Health Organization. Regional Office For Europe.

Whyte.F.W. (1984) *Learning from the field: A guide from experience.* Sage Publications Inc.

Williams.A. (1997) Rationing health care by age: the case for. *BMJ.* Vol. 314:820-2.

Williams. K. Home From Home (1994) Woman Centred Care. *Nursing Times*, Vol.90, No. 18.

Williamson C (1992) *Whose Standards ? Consumer and Professional Standards in healthcare.* Buckingham : Open University Press.

Williamson C (1995) A managers guide to consumers. *Health Service Journal.* p.28 - 9.

Wilson.G. (1993) Users and providers: different perspectives on community care services. *Journal of Social Policy.* 22. 4. 507-526.

Winkler F (1987) Consumerism in health care: beyond the supermarket model. *Policy & Politics* 15, 1 - 8.

Wolcott.H.F. (1995) *The art of fieldwork.* AltaMira Press. A Division of Sage Publications.Inc.

Working Party on Priority Setting in the NHS. (1997) Priority Setting in the NHS (the Crown Report). Acadamy of Medical Royal Colleges, BMA, NAHAT, NHS executive.

Wylie I (1995). Managers should sell it like it is. *Health Service Journal.* February 16, p.23.

Wynand P. M. M. Van De Ven. (1996) Market-Orientated Health Care Reforms: Trends and Future Options. *Social Science and Medicine.* Vol. 43. No.5. pp. 655-666.

Young. G. (1997) Home birth quadruplets. In: Changing Childbirth Implementation Team (1997a), *Changing Childbirth Update*, Issue No. 8, NHSE, Cambridge

**Local Documentation (anonymised)**

A North West District Health Authority Maternity Strategy (1994) *Making Childbirth Better: a five year strategy document.*

A North West acute hospital Trust (1994), *The Way to Midwifery Change.*

Cullen.M. (1994a) *General Practitioners and Changing Childbirth* North West District Health Authority.

Cullen. M. (1994b) *Changing Childbirth - Consultant review.* North West District Health Authority.

Smith.C, Stewart.S, and Tinkler.A. (1994) *Maternity Review - the Midwives views.* (Unpublished). North West District Health Authority.

Tinkler. A. and Barrow. M. (1994) *Women's views of Maternity Services - an Exploratory Project.* A North West District Health Authority.

Report of the quantitative evaluation of Team Midwifery (1994), North West acute hospital Trust.

**National Changing Childbirth Conferences**

Listen with Mother: consulting users of maternity services. (1994) *Changing Childbirth Implementation Team.* National Health Service Executive. November 21, Leeds. The Hotel Metropole.

Economic Evaluation: one day workshop. (1996) *Changing Childbirth Implementation Team*. National Health Service Executive. February 12. London. Voluntary Service Council organisation.

Learning from experience: Changing Childbirth. (1996) *Changing Childbirth Implementation Team*. National Health Service Executive. May 2, London.

Changing Childbirth: making it work, trials and tribulations. (1996) *Changing Childbirth Implementation Team*. National Health Service Executive. October 18, Derby. Mickleover Court Hotel.

Text cut off in original

ndix 1

### 3.2.2 Antenatal and Postnatal Care

**Introduction**: The provision of care for pregnant women is changing and it is hoped that women with nomal pregnacies increasingly see their GP and midwife for most of their care and their obstetrician less often. The Team Midwifery Project is aimed at developing further the working relationship between GPs and midwives.

**Aim:** To determine GPs views on antenatal and postnatal care.

**Study Design**: Postal questionnaire (Appendix VIII) sent to all GPs in Wirral with data analysed centrally by the MAAG.

**Results:** The response rate to this questionnaire was 64%. The majority of GPs (94%) provide antenatal care with 74% sharing antenatal clinics with their midwives. Postnal visits are carried out by 98% of doctors and by all midwives. All practices provides administrative support for the midwife's clinic. Comments by patients are not very frequent and a substantial number are happy with the present system. Some patients complained about the long wait at the hospital. Doctors are worried that the proposed changes will reduce exposure of patient to doctor during antenatal care - an important time for developing trust with the patient and their family. GPs are concerned that there will be less continuity of care although the proposed changes are aimed at improving continuity of care.

**Conclusions:** Most GPs provide antenatal care for their patients. Doctors are worried that the proposed changes will affect their relationship with their patients and there will be less continuity of care.

**Action:** These results are to be presented for discussion at the next steering group meeting for the team midwifery project.

Appendix 2

# Maternity Care / Models of care - some issues to consider.

## Organisational change

### 1 *Operational Issues*

i Implementing change is time consuming and complex
ii Communication - with women in particular and equally as important with and between professionals
iii practical issues = workload, training, skill mix, additional resources (i.e. equipment for midwives)
iv Co-ordination

### 2 *Strategic Issues*

i Evaluation - quality (women's views) and economic (viability)
ii Monitoring
iii Audit
iv Co-ordination
v Contract specifications

### 3 *Sustainability*

i Costs - efficiency and effectiveness
ii Commitment from midwives
iii Support - (from women)- and appropriateness of care
iv Professional rivalry

Angela Tinkler
June 1996.